PART II

POLICIES AND PROCEDURES
for
PHARMACY SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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2021 Policy Manual Revisions

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added D=Deleted M=Modified	(Revision required by Regulation, Legislation, etc.)
01/01/2021	603.10	Opioid Use Disorder Prescriptions	**M**	
01/01/2021	603.7	Prescription Refills	**M**	
01/01/2021	603.9	Pharmacist Administered Vaccines	**M**	
01/01/2021	607	340B Program is now in Section 605	**M**	
01/01/2021	802.3	Denial of Request	**M**	
01/01/2021	901.3	Removed Dollar Amount Reference	**M**	
01/01/2021	903	Renamed/Restructured Section	**M**	
01/01/2021	905	Duplication in Manual	**D**	
01/01/2021	1001	Determining Usual and Customary Charges	**M**	
01/01/2021	602, 603, 604, 605, 606	Section Restructures/Placement	**M**	
01/01/2021	Appendix G	Removed MFN Reference	**M**	
07/01/2021	Appendix J	Acceptable Corrective Documentation	**M**	
07/01/2021	Appendix H	Georgia Families	**M**	
07/01/2021	Appendix A	Drugs and Therapy Classes Requiring Prior Approval	**M**	

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I - CHAPTER 600

SPECIAL CONDITIONS FOR ENROLLMENT AND PARTICIPATION

In addition to those conditions for participation in the Medicaid program as outlined in **Part I**, the following also apply to Pharmacy Services.

601. License Requirements

- All pharmacies enrolling in the Georgia Medicaid program to provide Pharmacy Services must be licensed by the Georgia State Board of Pharmacy and be in good standing with that office.
- Pharmacies must ensure that all services billed are performed by or under the immediate supervision of a licensed pharmacist (as defined in OCGA Section 26 4 2 (9), Pharmacy Laws of GA).
- Pharmacists servicing Nursing Homes and Long-Term Care Facilities as a Vendor or Consultant must be licensed in the State of Georgia as required by the Georgia State Board of Pharmacy Rules, Chapter 480-24-.02. Authority Ga.L.1974, pp221-270; O.C.G.A. Secs. 26-4-37, 26-4-53.

602. Enrollment Requirements

The following information and/or documentation is required to complete the application for enrollment in the pharmacy programs:

- Provider Enrollment Application (DMA-001) *Must have the original signature of the authorized representative of the applicant*
- Statement of Participation (DMA-002) *Must have the original signature of the authorized representative of the applicant*
- IRS Form W-9 *the payee name on the W-9 must match the business name as registered with the IRS.*
- Power of Attorney *if the designated payee is different from the applicant, a signed and notarized Power of Attorney for Payee must be completed for Payee.*
- Electronic Funds Transfer Agreement (DMA-006)
- Copy of Pharmacy license issued by the state's Board of Pharmacy (027)
- National Council for Prescription Drug Program (NCPDP) number (Note: Dispenser Class and Type {7}) are not eligible for COS 300/321 enrollment)
- Copy of Drug Enforcement Administration Certificate
- Georgia Medicaid Disclosure of Ownership and Control Interest Statement form (or a copy of Form CMS 1513 filed with Medicare)

You may also find the above mentioned forms at the following on the GAMMIS web portal at www.mmis.georgia.gov → Provider Information → Forms for Providers.

602.1 Out of State Enrollment and Border Provider Enrollment

The Division will not enroll pharmacies outside the State of Georgia except for the following, and limited to the services listed:

A) Border pharmacies defined as retail pharmacies within fifty (50) miles from the Georgia border who service walk-in Medicaid members. Walk-in customers must represent at least (75%) of the pharmacy's prescription volume.

B) Retail pharmacies that are servicing foster children living out of state are allowed to temporarily enroll as a provider only for the length of time they are providing pharmacy services for a foster child enrolled in the Georgia Medicaid Program.

C) Out-of-State pharmacies servicing members receiving pre-approved transplants who require medication during after care while residing out of state.

D) Pharmacies providing products for which there is no such potential provider within the existing network. Pharmacies enrolled under this provision may only provide these specific products as approved by the Division of Medical Assistance (DMA).

- If a pharmaceutical manufacturer supplies a drug only to a pharmacy that is located outside of Georgia, and the drug is medically necessary for a Georgia Medicaid member, Georgia Medicaid may enroll such a provider for the limited purpose of dispensing that drug, and may only reimburse the pharmacy for the dispensing of that drug. The provider must agree to this restriction as a condition of enrollment.
- If a member is covered by other primary insurance and that carrier requires use of an out-of-state pharmacy, Georgia Medicaid may enroll that pharmacy for the purpose of submitting secondary claims only.
- If the drug later becomes readily available within Georgia, Georgia Medicaid may disenroll the limited purpose out-of-state pharmacy.

602.2 Internet Pharmacies

Effective February 1, 2000, the Division of Medical Assistance (DMA) of the Department of Community Health (DCH) does **not enroll internet** pharmacy

providers in the Georgia Medicaid program. An Internet pharmacy is defined as a pharmacy that is primarily engaged in receiving prescriptions over the Internet for later dispensation.

602.3 Notification of Change (Rev. 10/15, 01/16, 10/20)

If the Pharmacy's information submitted during enrollment (e.g., office location, change of an address, the payee, etc.) changes, the provider must report those changes within ten (10) days of the change by submitting the request on the web through the third party administrator's website at www.mmis.georgia.gov. (See Part 1, Section 105.8)

602.4 Change of Ownership or Legal Status (CHOW) (Rev. 10/20)

The successor provider must submit a new enrollment application and supporting documentation to become effective at the time of the change of ownership. A change of ownership includes, but is not limited to, a dissolution, incorporation, re-incorporation, reorganization, change of ownership of assets, merger, or joint venture whereby the provider either becomes a different legal entity or is replaced in the program by another provider.

Any person or entity that is a Medicaid/PeachCare for Kids provider, and any person or entity that replaces a provider, shall be deemed to have accepted joint and several liability, along with its predecessor, for any overpayment and/or provider fee sought to be recovered by the Division after the effective date of the successor provider's enrollment, regardless of the successor's enrollment status or lack of affiliation with its predecessor at the time the overpayment was made. An entity shall be deemed to have replaced a provider if it 1) effectively became a different legal entity through incorporation, re-incorporation, merger, joint venture, dissolution, creation of a partnership, or reorganization, 2) took over more than fifty percent (50%) of the predecessor's assets, Medicaid/PeachCare for Kids clients or Medicaid/PeachCare for Kids billings, or 3) has substituted for the predecessor in the program, as evidenced by all attendant circumstances. Reimbursement for services rendered prior to the effective date of enrollment of a successor provider (including any adjustments for underpayments made by the Division) shall be made to the provider of record at the time the payment is made or to that provider's payee as properly designated on the appropriate form(s) required by the Division. Any dispute or conflict, legal or otherwise, arising between the currently enrolled provider and the predecessor provider concerning either apportionment of liability for any overpayment previously made by the Division or the right to additional reimbursement for any underpayments previously made by the Division shall be the sole responsibility of such parties and shall not include the Division. **The new owner applying for enrollment**

may not request a change of the predecessor's provider number without the express consent of the Chief of the Division of Medical Assistance.

To allow for continuity of care and timely filing of claims, the successor shall submit claims using the predecessor's provider number while the Change of Ownership enrollment application is being processed. Failure to submit claims in a timely manner pursuant to Chapter 200 of Part 1 may result in denial of claims. Until the Change of Ownership is completed, claims will be processed, and payment will be made to the predecessor's payee number. (See Part 1, Section 105.9)

603. Prescription Requirements (Rev. 07/14)

Pharmacies must maintain a prescription on file for five (5) years to support any claim submitted for reimbursement by the Division. Prescriptions supporting claims submitted to the fiscal agent must be initiated and recorded in conformance with all State and Federal laws. Such prescriptions, whether new or refill, must include all original documentation containing proper information as required by Georgia State Board of Pharmacy Rules Chapter 480-10-15. Oral prescriptions must have the date, time, name of person calling in the prescription and initials of the pharmacist must be transcribed to hand written order and must include the date, time, name of person calling in the prescription accepting the order as required by 26-4-80 (i) O.C.G.A. In addition, pharmacies must maintain on file a prescription for any legend or non-legend drug, such as insulin, for which a claim is submitted. Please see Chapter 900.

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 physician, member, or other person acting as an agent of the member (i.e.: family member). (Rev. 01/13)

Long Term Care (LTC) Facilities: In the event the member is residing in a LTC facility or other institution, a nurse, pharmacist or other authorized agent of the facility pursuant to a valid physician's order may initiate the request for refills.

Documentation of the prescription number, member name, delivery date, and the receipt date is required by the Division for each prescription dispensed or administered to a LTC Medicaid member. Documentation of administration through a medication administration record or other method is required for members who do not self-administer their medications.

Prescribers must use tamper-resistant prescription pads for any new prescription with fill dates on and after April 1, 2008. This requirement applies to hard copy

prescription orders for any drug, device or product covered through the Medicaid FFS outpatient pharmacy program whether legend or over the counter. Please see Appendix G for a detailed description of this requirement.

Antihemophilic Factor: Effective August 1, 2016, patients receiving factor VIII or factor IX products for prophylaxis and on-demand (breakthrough bleeding) episodes are required to have two separate prescriptions. Prescriptions should be written with ±3% aggregate of the prescribed target dose. (Rev. 07/16)

603.1 National Drug Code Numbers

Pharmacies must bill the specific national drug code (NDC) number for the drug dispensed in the amount dispensed and maintain invoices of drug purchases that document proof of purchase for quantities of specific drugs reimbursed by the Division. Pharmacies must reflect purchase dates consistent with dispensing dates. These records should be maintained for a period of five (5) years. Claims identified as having been billed using the wrong NDC or quantity will be subject to recoupment.

603.2 Diabetic Supplies

All pharmacies enrolled as pharmacy providers are eligible to dispense insulin syringes, lancets, glucose monitoring strips and glucose monitors to non-nursing home Medicaid diabetic patients. Please see Appendix B for manufacturer details and therapy limitations. Legitimate prescriptions must accompany diabetic supplies dispensed for billing purposes.

Effective March 6, 2012, the Department of Community Health (DCH) implemented an enhancement to its prior authorization protocol for diabetic supply coverage (test strips and lancets). Prenatal vitamins (PNV) will be added to the list of medications that will allow a diabetic supply claim to process without PA if the PNV claim has been paid within 90 days (from the date filled) of the diabetic supply billing.

For a complete listing of covered diabetic supplies please refer online under www.mmis.georgia.gov → Pharmacy → Other Documents → Covered Diabetic Supplies. Prior Authorization (PA) requests should be directed to the OptumRx Clinical Call Center at 1-866-525-5827.

DCH will only accept ICD-10 codes on pharmacy claims with dates of service on or after October 1, 2015. Listed in the table below are the ICD-10 codes that when submitted on a point-of-sale pharmacy claim will bypass PA required for covered diabetic supplies. (Rev. 10/15)

Effective October 1, 2014	
ICD-10 Code	**ICD-10 Code Description**
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
O24.420	Gestational diabetes mellitus in childbirth, diet controlled
O24.424	Gestational diabetes mellitus in childbirth, insulin controlled
O24.429	Gestational diabetes mellitus in childbirth, unspecified control
O24.430	Gestational diabetes mellitus in the puerperium, diet controlled
O24.434	Gestational diabetes mellitus in the puerperium, insulin controlled
O24.439	Gestational diabetes mellitus in the puerperium, unspecified control
O99.810	Abnormal glucose complicating pregnancy
O99.814	Abnormal glucose complicating childbirth
O99.815	Abnormal glucose complicating the puerperium

603.3 Receipt of Prescription (Rev. 01/20)

Documentation of receipt for prescriptions is required by the Division for each prescription dispensed to a Medicaid Member. Documentation must include at a minimum, the date, prescription number, member name, and member's signature; or member's legal representative receiving the prescription, date filled, and date picked up.

603.4 Return to Stock (Rev. 04/17)

All prescriptions will be reversed and returned to stock within (14) calendar days of dispensing if not picked-up by the patient.

603.5 Exact Directions for Use Required

If a Prescriber does not provide exact directions or writes "as directed" or "prn", the pharmacist must call the Prescriber and obtain directions. The Pharmacist must document such directions on the prescription, initial same, and bill the Division for the exact days' supply based on those directions and the quantity prescribed.

Both the exact quantity and the days' supply must be billed to the Division based on the metric decimal quantity prescribed and the Prescriber's exact written directions.

603.6 Insulin Days' Supply (Rev. 04/19)

Effective April 1, 2019, the Department of Community Health is requiring that all pharmacy providers bill the smallest commercially available package size for Insulin Products and are required to bill the Division for the exact days' supply*,

based on the directions and quantity prescribed. In some situations, such as packaged insulin products, a day supply greater than 30 may be permitted. For the billing of a day supply value greater than 30 days to be reimbursed, one of the following circumstances must be met:

- The Prescription is written such that the smallest commercially available package size of the product will exceed a 30-day supply **or**
- The prescription is written so that the smallest commercially available package size is less than a 30 days' supply and requires an additional package that will supply the member as close to a 30 days' supply as possible. When billing Georgia Medicaid for multiple packages, the calculated days' supply cannot exceed 59 days.

In the instance that the smallest available package size will exceed a 59-day supply, providers may contact the Technical Help Desk at 866-525-5826 for further assistance.

*For multi-dose vials (MDV) of insulin, in the instance that the smallest available package will exceed the manufacturer's "use within" date range, do not bill for a days' supply greater than what is instructed per the manufacturer's requirement.

603.7 Prescription Refills (Rev. 01/17)

Any prescription, regardless of the authorization to refill given by the prescribing practitioner, may not be billed to the Department after one (1) year has elapsed from the date it was written. When refilled, the prescription may be billed only in keeping with the number of doses ordered and the directions for use. Members, pharmacies, physicians etc. may fax in documentation to 877-633-4765 to request an early refill related to lost, stolen, broken, or damaged products. The request must include the following information:

- Type of request
- Member's name and phone number
- Member's Medicaid ID
- Medication name, strength, quantity, and day supply
- Filling pharmacy name and phone number
- Police report, physician letter, etc.

Refills may be dispensed when at least 75% of the previous fill is used for non-controlled drugs and 85% for controlled drugs. Recipients must use drugs in accordance with the prescriber's orders.

603.8 Transmitting or Receiving Prescription Drugs via Facsimile Machine or Other Electronic Means

All prescription drug orders sent via facsimile or other electronic means must meet the requirements of O.C.G.A. § 26-4-5 and O.C.G.A. § 26-4-80 and Chapter 480-22, 480-27-.02 and 480-27-.04 of the Board Rules and the requirements for the electronic transmission of prescription drug orders. Prescription drug orders electronically generated and directly transmitted from the practitioner to a pharmacy must bear unique serial numbers to authenticate the transmission.

603.9 Pharmacist Administered Vaccines (Rev. 01/21)

Influenza Vaccine - GA Medicaid Fee-for-Service (FFS) members 19 years of age and older may obtain a seasonal flu vaccine from their pharmacy or physician.

Pneumococcal and Meningitis Vaccines - FFS members 21 years of age and older may obtain a Pneumococcal and Meningitis vaccines from their pharmacy or physician.

Zoster Vaccine - FFS members 50 years of age and older may obtain their Zoster vaccine from a pharmacy or physician.

Vaccine Billing - Effective November 1, 2020, all claims must be submitted through the Pharmacy Point of Sale System using the product ID of the vaccine being administered by the pharmacist.

Pharmacists must enter the patient's vaccination information in the Georgia Registry of Immunization Transactions and Services (“GRITS”) within fifteen (15) days of administration of the vaccination (O.C.G.A. Section 43-34-26.1).

If you have questions, please contact the OptumRx Call Center at 866-525-5827 or by email at GAMProvider.PortalTeam@optum.com.

Additional details pertaining to the vaccine program can be found in the weekly pharmacy banner message (www.mmis.georgia.gov → Pharmacy → Pharmacy Notices).

603.10 Opioid Use Disorder Prescriptions (Rev. 01/21)

Prescriptions for buprenorphine containing products for the treatment of opioid use disorder (OUD) must have the prescribers DEA and X-DEA (DATA 2000 Waiver Identification Number) on the hard copy prescription prior to dispensing and billing Medicaid. When prescriptions are phoned into the pharmacy,

pharmacists must have both validated numbers on the prescription for record. Pharmacy providers should verify a prescriber's DATA waiver by visiting https://www.samhsa.gov/bupe/lookup-form or by calling SAMHSA at 1-866-287-2728. In the instance that either the DEA or X-DEA numbers are not on the hard copy of the prescriptions, pharmacists should make the necessary efforts to obtain the information prior to dispensing the medication to the member. Not having these requirements at the time of claim submission to Medicaid will result in a discrepant claim.

In order to assert compliance of the DEA and X-DEA's presence on the hard copy of the prescription, all Preferred buprenorphine products for the treatment of opioid dependency will require a submission clarification code of 43 to be entered at the time of claim submission to Medicaid. For all Non-Preferred products used for the treatment of opioid dependency, a submission clarification code of 46 will be required to be entered at the time of claim submission to Medicaid and still require prior authorization approval.

Preferred Opioid Dependency Products	Non-Preferred Opioid Dependency Products
• Physician's DEA • Physician's X-DEA • Submission Clarification Code of 43 **serves as attestation that the DEA and X-DEA was verified and is on the hard copy prescription at the time of claim submission*	• Physician's DEA • Physician's X-DEA

604. Pharmacy Lock-In

Federal regulations provide that the Division may place restrictions on the provider or providers from which a member can receive items or services if the Division has determined that the member has utilized such items or services at a frequency or amount not medically necessary in accordance with utilization guidelines established by the Division. Members determined to be abusing the Medicaid Pharmacy Benefit shall be placed in Pharmacy Services Lock-in status for an initial period not to exceed twenty-four (24) months. Members will be restricted to one or more controlled substance prescriber to prescribe controlled substances and one pharmacy to obtain all their Medicaid prescriptions; other pharmacies will not be paid if they fill Medicaid prescriptions for the member. Also, the lock-in pharmacy will not be paid if they fill controlled substance prescriptions not prescribed by the member's designated controlled substance prescriber. The Point of Sale system will alert pharmacies of any lock-in restrictions placed on an individual member during on-line/real-time adjudication. The designated controlled substance prescriber must be an enrolled Medicaid

provider or a DATA 2000 waived physician. The member's lock-in pharmacy or any other pharmacy that has knowledge of the member being enrolled in Medicaid is prohibited from accepting cash payments from the member for controlled substance prescriptions that do not adjudicate. At the conclusion of the lock-in period, the member's usage will be reevaluated to determine whether or not restrictions should continue.

Pharmacy Services Lock-in will be under the purview of the Division's Program Integrity Unit who shall determine the need for lock-in according to established utilization criteria. Please review Part II Policies and Procedures for Pharmacy Services manual Section 606.1, and Part I Policies and Procedures Section 109.1.

604.1 Pharmacy Lock-in Criteria

The following Criteria are utilized in the recommendation for pharmacy lock in:

1. Drug therapy must correlate with either the primary or secondary diagnosis in The Department's claims data, if not it is the member's responsibility to have the prescribing physician submit the member's complete medical record.
2. Initial complaint indicates the member is suspected of drug abuse or fraudulent activities (forged prescriptions, borrowed ID cards, etc.)
3. The member has filled prescriptions at more than 2 pharmacies/month or more than 5 pharmacies/year. If greater, the address of the member should have changed.
4. The member has received more than 3 Controlled Substances/month.
5. The number of prescriptions for Controlled Substances filled by the member (this includes all drugs with abuse potential) exceeds 10% of the total number of prescriptions filled by the member.
6. The member was seen in the Hospital Emergency Room more than twice per year. If greater, the recorded diagnosis should be consistent with an emergency medical condition.
7. The member received duplicate therapy from different physicians.
8. The member received prescriptions from pharmacies or visited physicians located outside the member's county of residence.
9. The member purchased drugs of abuse without utilizing their Medicaid prescription benefits.
10. The member has a diagnosis of narcotic poisoning or drug abuse.
11. The member has previously been in one of the COM's lock-in programs.
12. The member is taking >120mg Morphine sulfate equivalents per day. Studies show patients receiving 100 mg/d or more have an 8.9-fold increase in overdose risk and a 1.8% annual overdose rate.

Morphine Equivalent Dose for Selected Opioids	
Opioid	**Approximate Equianalgesic Dose (oral & transdermal)***
Morphine (reference)	**30mg**
Codeine	200mg
Fentanyl transdermal	12.5mcg/hr
Hydrocodone	30mg
Hydromorphone	7.5mg
Methadone	Chronic: 4mg†
Oxycodone	20mg
Oxymorphone	10mg

Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, Weisner CM, Silverberg MJ, Campbell CI, Psaty BM, Von Korff M. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med 2010;152(2):85-92

Each member is given an opportunity to appeal the Lock-In determination by requesting a hearing in writing within 30 days of the determination to:

Department of Community Health
Legal Services Section
Division of Medical Assistance
2 Peachtree Street, NW, 40th Floor
Atlanta, GA 30303-3159

605. 340B Program (Rev. 04/18)

The 340B Drug Discount Program is a federal program created in 1992 that requires drug manufacturers to provide outpatient drugs to eligible health care organizations and covered entities (CE's) at significantly reduced prices. Maintaining services and lowering medication costs for patients is consistent with the purpose of the program. This requirement is described in Section 340B of the Public Health Service. The Office of Pharmacy Affairs (OPA) is the office responsible for administering the 340B Program and is part of Health Resources and Services Administration (HRSA). Federal Law prohibits duplicate discounts, which means that manufactures are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug; CE's must have procedures in place to prevent duplicate discounts from occurring. Other products available through the 340B pricing program includes vaccines and diabetic supplies (lancets, meters, strips, and syringes).

605.1 340B Participation

1. In order to participate in the 340B program, the eligible entity must first register by submitting a request on the OPA website within HRSA. A new site can only be added to the 340B database during the quarterly open

registration windows. Once registered, covered entities must recertify their eligibility annually.

Registration	Start Date
January 1st – 15th	April 1st
April 1st – 15th	July 1st
July 1st – 15th	October 1st
October 1st – 15th	January 1st

2. To ensure all the information on the HRSA Medicaid Exclusion File is accurate, the CE should review their information on the 340B OPAIS website and keep it up to date. **Note:** Please provide the correct Medicaid Provider Number (MPN) **and** National Provider Identifier (NPI) at the time of enrollment.

3. CE's must inform OPA at the time of enrollment on their intentions to carve-in or carve-out when purchasing drugs or other covered products for their Medicaid members.

605.2 Medicaid Carve-Out

- All prescriptions, physician-administered drugs, and all other products must be purchased **outside** of the 340B program.
- Bill in accordance with existing Medicaid (FFS or managed care) reimbursement methodologies, allowing rebates to be collected where appropriate.
- The CE's MPN and NPI should not be listed on the HRSA Medicaid Exclusion File.

605.3 Medicaid Carve-In

- All eligible prescriptions, physician-administered drugs, and all other products must be purchased through the 340B program.
- Purchase all drugs and other products billed to Medicaid (FFS and managed care) on the CE's MPN and NPI under the 340B program unless the product is not eligible for 340B pricing. **Do not** bill Medicaid (FFS and managed care) for 340B acquired drugs and products if your MPN and NPI is **not** listed on the HRSA Medicaid Exclusion File.

605.4 Vaccine and Diabetic Supplies

Submit claims for 340B acquired products to Medicaid (FFS or managed care) at your 340B actual acquisition cost (AAC) on the UB04 or CMS 1500 claim form.

605.5 340B Outpatient Pharmacy (Point-of-Sale) Billing

1. Effective April 1, 2017, all 340B covered entities are required to use a submission clarification code when billing the Georgia Medicaid Division on Fee-for-Service (FFS) and Care Management Organization (CMO) outpatient pharmacy claims.
2. Claims submitted via the NCPDP format to the Pharmacy Benefit Manager (PBM) must include:
    a) A “20” in the submission clarification code field 420-DK
    b) The National Drug Code (NDC)
    c) Actual Acquisition Cost (AAC)
3. If the product is not purchased at 340B pricing, do not include the basis of cost determination or the submission clarification code values and bill at the regular Medicaid (FFS or managed care) rate.

605.6 340B Outpatient Hospital/Clinic (Physician-Administered) Billing (Rev. 07/18)

DCH will use the MEF as the sole means to identify 340B drug claims. All CE’s should indicate their decision to carve-in or carve-out Medicaid to the OPA prior to the HRSA quarterly deadline for all 340B purchased drugs. The MPN and NPI should be provided for each CE that has been chosen to carve-in Medicaid. It is the CE’s responsibility to check the MEF at the start of each quarter for the accuracy of their specific Medicaid billing information to help ensure the overall validity of the data in the file and to avoid duplicate discounts.

605.7 340B Contract Pharmacies (Rev. 10/19)

Contract pharmacies are not allowed to bill DCH for 340B purchased drugs. All 340B acquired drugs identified and discounted at the claim level must be **carved-out** for Medicaid (FFS or managed care).

605.8 Definitions (Rev. 07/18)

- 340B Covered Entity (CE) is a facility that is eligible to purchase drugs through the 340B Program and appears on the OPAIS.
- 340B Drug Discount Program (340B) is section 340B of the Public Health Service (PHS) Act (1992) that requires drug manufactures participating in the Medicaid Drug Rebate Program to sign a pharmaceutical pricing agreement (PPA) with the Secretary of Health and Human Services.
- Actual Acquisition Cost is the net cost of a drug or product paid by a pharmacy.
- Contract Pharmacy is a pharmacy under contract with a CE that provides services to the CEs patients, which includes dispensing the entity-owned 340B drugs.

- Fee-for-Service (FFS) bills directly to Georgia Medicaid for prescriptions and physician administered drugs they provide to FFS members.
- Health Resources and Services Administration (HRSA) is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.
- Medicaid Carve-In means a CE has elected to use drugs purchased at 340B prices for all Medicaid members (FFS and CMO).
- Medicaid Carve-Out means a CE has elected to use non-340B purchased drugs for all Medicaid members.
- Medicaid Exclusion File (MEF) was established by HRSA to help support 340B covered entities and states in the prevention of duplicate discounts for drugs subject to Medicaid rebates.
- Medicaid Provider Number (MPN) is an identifier issued to health care providers by CMS that allows the provider to bill Medicaid for services.
- National Drug Code (NDC) is a drug product that is identified and reported using a unique, three-segment number, which serves as a universal product identifier for the specific drug.
- National Provider Identifier (NPI) is a unique identification number for covered health care providers.
- Not Otherwise Classified (NOC) codes are used when there is not a HCPCS code available that accurately identifies the service or procedure performed.
- Office of Pharmacy Affairs (OPA) is a part of the HRSA and is responsible for administering the 340B program.
- Physician-Administered Drugs are administered directly by a physician or a physician designee to a patient. This may occur in an outpatient clinic setting of a hospital.

If you have any questions regarding Georgia Medicaid's policy on the 340B program, please contact the DCH by e-mail at 340B@dch.ga.gov.

PART II - CHAPTER 700
ELIGIBILITY REQUIREMENTS

No special eligibility conditions other than those listed in Part 1, Chapter 106, are required for member utilization of Pharmacy Services.

PART II - CHAPTER 800
PRIOR APPROVAL

801. General

The Division may, with sufficient justification, approve exceptions to the limitations of therapy or number of prescriptions allowed monthly, or allows payment for drugs that require prior authorization. Medically necessary pharmacy services will be provided to all members under age 21 when documented by the prescriber and are provided in a manner consistent with the policies and procedures stipulated in this manual.

801.1 Drugs that Require Prior Approval

Drugs requiring prior approval will not be covered by Medicaid, unless prior approval is obtained prior to the drug being dispensed to Medicaid members. See Section 802 for a description of the prior approval process.

801.2 Drugs with Therapy Limitations (Rev. 1/21)

A complete listing of drugs with therapy limitations or Quantity Level Limits can be found on the GAMMIS web portal at: www.mmis.georgia.gov → Pharmacy → Other Documents → QLL List.

801.3 Drugs for ESRD Patients

To receive reimbursement for medications dispensed to ESRD patients, pharmacy providers must use only products from manufacturers participating in the drug rebate program. The following products are available to ESRD patients and require Prior Approval before dispensing:

> Calcium Carbonate, Aluminum Hydroxide, Calcium Acetate, Legend Vitamin D Products, Calcium Carbonate with Glycine, Calcium Lactate, Docusate Calcium, Docusate Sodium, Niacin, Pyridoxine Hydrochloride, Sodium Bicarbonate, Thiamine Hydrochloride and Vitamin B Complex.

Please review the Preferred Drug List (PDL) for other ESRD drugs requiring Prior Approval at www.mmis.georgia.gov →Pharmacy → Other Documents.

801.4 Compounded Prescriptions

Reimbursement for all drugs is contingent upon dispensing a drug that is manufactured by a company who has a signed rebate agreement for that drug with the Centers for Medicare and Medicaid Services (CMS) **and** the member's eligibility at the time of service.

Effective July 17, 2017, compound requests for select compounded ingredients (**in addition** to compounds for omeprazole, lansoprazole and common TPN ingredients) will no longer require a Prior Authorization (PA). Any ingredient utilized outside of the select ingredients will still require a PA. Please review your final claim submission to determine if any ingredients still require PA. Other non-rebateable and non-covered OTC ingredients continue to be not covered in all compounds. The Submission Clarification Code (Field: 42Ø-DK) of Ø8 – Process Compound for Approved Ingredients, should still be used to allow the claim to process for covered ingredients within the compound. PA requests for other ingredients, should continue to be faxed to OptumRx at 1-888-491-9742 using a Multi-Ingredient Compound Drug PA Request Form. This form may be found online under www.mmis.georgia.gov → Provider Information → Forms for Providers → Multi-Ingredient Compound Drug PA Request Form. As a reminder, the Department does not consider admixtures, e.g. vancomycin and NS, compounded prescriptions and therefore they should be billed as single line item ingredients.

Compounded products are covered for members less than 21 years of age when the physician documents that the drug is medically necessary. All compounded prescriptions are non-preferred products.

801.5 Compound Claim Segment Identification (Rev. 01/18)

Effective November 1, 2017, NCPDP Field 996-G1 – Compound Type will be required when submitting compound claims. The valid codes for this field are listed in the table below. Please contact your software help desk for assistance on locating and/or transmitting this field on compound claims.

996-G1 – Compound Type – Clarifies the type of compound	
Code	**Description**
Ø1	Anti-infective—a medicinal product intended to treat pathogens such as bacteria, viruses, fungi, or parasites
Ø2	Ionotropic—a medicinal product intended to correct irregular heart rhythms
Ø3	Chemotherapy—a medicinal product intended to treat cancer
Ø4	Pain management—a regimen of therapy intended to ameliorate mild to severe discomfort
Ø5	TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition—products intended to provide nourishment by central or peripheral veins for patients with compromised digestive tracts
Ø6	Hydration—a product intended to restore body fluids
Ø7	Ophthalmic—a product intended to be applied to or instill in the surface of the eye
99	Other—not defined by other available codes

802. Prior Approval Procedures (Rev. 10/15)

Effective January 1, 2007, the Georgia Department of Community Health - Division of Medical Assistance contracted the drug prior approval function to OptumRx. All pharmacy prior approval requests should be made to this agent. As a policy, the Division does not grant retroactive prior approval.

Should any of the drugs approved, later become non-covered or have dispensing limitations placed on them, the authorization for the drugs will be null and void. In addition, reimbursement is contingent upon the member's eligibility at the time service is rendered.

Obtaining prior approval does not guarantee reimbursement.

802.1 Override Code – To Exclude Copayment (populate field 416-DG)

As a reminder, all new nursing home patients will be exempted from drug co-payment, by using "**11111**". Nursing home member overrides are exempt from the co-payment requirement. Use of this code also requires a "04" in the Prior Authorization Type Code" field (461-EU).

802.2 Requests via Telephone or Facsimile

Requests for drugs to exceed therapy limitations or for drugs that require prior approval shall be directed to the agent, OptumRx by phone. Contact by fax or mail is not preferable but allowed.

The agent's Prior Authorization Department is staffed by associates and clinical pharmacists. The Prior Authorization Department hours are as follows: 8am-8pm M-F (EST), 8am-4:30pm Sat., Closed Sunday & Holidays. Associates and clinical pharmacists are available on-call after normal business hours. Prior Authorization requests may be made telephonically, via facsimile, or in writing via U.S. mail, to:

OptumRx
Prior Authorization Department
PO Box 25183
Santa Ana, CA 92799

Clinical and PA Support: 866-525-5827
Fax Line: 888-491-9742

802.3 Denial of Requests (Rev.1/21)

Any request, which cannot be approved by the agent, will be communicated at the time of the request to the requester. Appeals of denied requests must be submitted to the agent within thirty (30) calendar days of the denial. The appeal

must be reviewed, and the requesting provider notified of the results within seven (7) business days of the receipt of the appeal, unless additional information is required. In this case, the decision must be made within seven (7) business days of receipt of the additional information.

If an appeal is denied by the agent, a provider may request a 2nd level appeal by DCH within thirty (30) calendar days. 2nd level appeals must be faxed to OptumRx at 877-239-4565. OptumRx will prepare the appeal for DCH's consideration.

802.4 Requests Returned for Additional Documentation

Any prior approval request that cannot be approved due to insufficient information will be returned to the physician for additional information. Prescribers have three (3) business days to provide additional information requested.

PART II - CHAPTER 900
SCOPE OF SERVICE

901. General

Effective January 1, 1991, payment for pharmaceutical services is limited to those products of manufacturers who offer rebates to the states as required by the Omnibus Reconciliation Act of 1990. The Division covers the products of all manufacturers who offer such rebates with certain exceptions. The drugs or classes of drugs listed below represent those the Division has elected to exclude from coverage (as allowed by federal law).

901.1 Non-Covered Drugs

A) Agents used for anorexia weight loss or weight gain.
B) Agents used to promote fertility.
C) Agents used for cosmetic purposes or hair growth.
D) Drugs identified by the Center for Medicare and Medicaid Services (CMS) as less than effective (DESI), as provided under Section 1927(k)(2).
E) Legend Prescription Vitamins and Mineral Products with the following exceptions:
    a) Covered Legend Vitamin and Mineral Products include:
        i) Prenatal vitamins for women
        ii) Fluoride preparations that re not in combination with other vitamins
        iii) Carnitor
        iv) Folic Acid 1mg
        v) Vitamin B 12 injection
        vi) Vitamin and Mineral Products for recipients <21 years of age
F) Nonprescription drugs with the following exceptions:

    NOTE: all covered OTC drugs require a prescription

    a) Enteric coated aspirin (covered under per diem for nursing home members)
    b) Ibuprofen suspension for members < 21 years of age
    c) Diphenhydramine
    d) Insulin
    e) Meclizine
    f) Select generic over the counter (OTC) non-sedating antihistamines, H-2 Receptor antagonists, topical antifungals and proton pump inhibitors.

G) Legend agents when used for the symptomatic relief of cough and colds for members 21 years of age and over
H) Agents prescribed for any indication that is not medically accepted.
I) Drugs that are not listed in the CMS DDR system or do not have a signed rebate agreement
J) Any Medicare Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
K) Non-FDA approved drugs
L) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

Please see Section 801.3 for a description of covered OTC ESRD drugs.

901.2 Rebateable Manufacturers

The list can also be found at www.mmis.georgia.gov > Pharmacy > Other Documents

901.3 Quantity and Monetary Thresholds

The Department will pay for up to a maximum of a (30) day supply of medication calculated at maximum therapeutic levels established by Department of Community Health.

901.4 Co-Payment

Effective with dates of service on or after July 1, 2001, the Department will impose a nominal co-payment for each preferred generic or preferred brand drug of $.50 dispensed by the pharmacy.

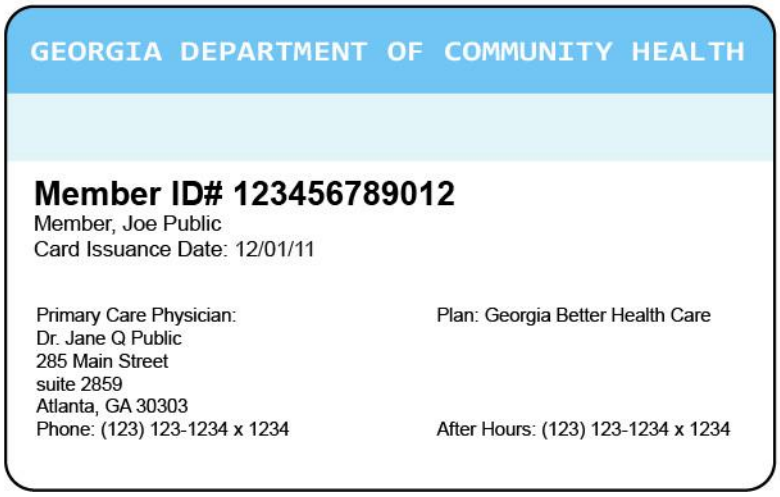
Category	Co-Payment
Preferred Generic	$0.50
Preferred Brand	$0.50
Non-Preferred Brand Or Non-Preferred Generic	Under $10.00 =$0.50 $10.01-$25.00 = $1.00 $25.01-$50.00 = $2.00 $50.01 or more = $3.00

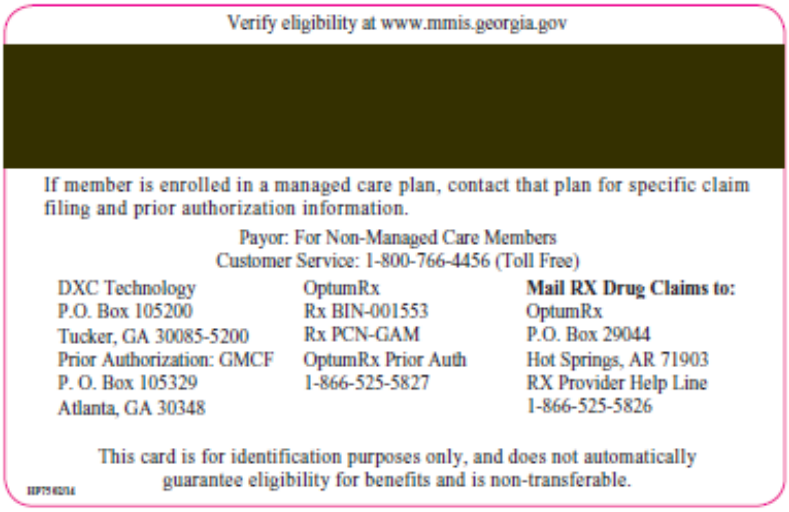
Medicaid members under age twenty-one (21), pregnant women, institutionalized individuals and hospice care members are not required to pay this co-payment. Emergency services and family planning services are also exempt from this co-payment. Members enrolled in the Breast and Cervical Cancer eligibility groups are also excluded from copayment.

902. Medical Assistance Eligibility Certification

Member Eligibility Verification:

Each member should present an Identification Card when getting a prescription filled. The new member cards will serve a dual purpose for medical & prescription covered services. Eligibility can also be determined by accessing the Gainwell Technologies web portal at www.mmis.georgia.gov and becoming a registered user.





If a person claims to be a Georgia Medicaid Member and does not have a card, submit the claim online, then if you receive a "*Missing/Invalid Cardholder ID*" rejection code, verify eligibility by contacting the OptumRx Call Center at 866-525-5826.
Eligibility must be verified before dispensing any medication through POS or direct contact with OptumRx.

NOTE:
Presentation of the card does not guarantee eligibility or reimbursement.

903. Duplicate Dispensing

The Division defines a one-month supply as thirty (30) days. The Division will not pay any provider a second dispensing fee for the same drug for the same member in the same month of service. In the event that a member requires a second prescription for the same drug in the same month of service, the provider will be reimbursed only for the cost of the drug.

Oral and IV antibiotics, DEA Schedule II, III, IV or V, oral contraceptives, Prempro/Premphase, all Fosamax, Boniva, Actonel weekly, Temodar, Estrogen replacement patches and Clozapine are exempt from this policy.

904. Emergency Prescriptions

With a written or oral prescription from the member's physician indicating the need for a drug due to an emergency situation or condition, the pharmacist may use the emergency billing code or submit a written request for payment to the Division **to override the member's co-pay only**. This emergency billing code will not override member eligibility, prior authorizations that are required, quantity limits exceeded, or refills-too-soon. The Division defines an emergency prescription as one in which:

A short-term (no more than thirty days) drug therapy is needed immediately for the treatment of an acute condition.

Emergency prescriptions must meet the following conditions:

- A log shall be maintained for each emergency or pharmacy generated override that provides at least the following information: date, patient name, and prescription number. Please see signature log requirements in Appendix G of this manual. These records will be subject to review by the Division.
- The emergency prescription must not have been dispensed based on a blanket physician authorization; and
- Maximum (6) emergency overrides per member per calendar year
- Abuse of the emergency prescription procedure code will subject a provider to adverse action.
- **99888** has been assigned for use as the drug code number for each emergency prescription billed. All five digits, 99888, must be entered in field (462-EV) "Prior Authorization Number Submitted". This code

requires “04” in PA Type-Code field (461-EW) on the claim. This code does not override member eligibility, prior authorizations that are required, quantity limits exceeded, or refills-too-soon.

905. Pharmaceutical Services Rendered in Nursing Facility

In providing pharmacy services and drugs to patients in nursing facilities, pharmacies must meet all requirements and special conditions for participation. Pharmacists should refer to Appendix C for the applicable sections of the Policies and Procedures for Nursing Facility Services manual that describes drugs that must be furnished to members by the nursing facility.

Pharmacists servicing Nursing Homes and Long-Term Care Facilities as a Vendor or Consultant must be licensed in the State of Georgia as required by the Georgia State Board of Pharmacy Rules, Chapter 480-24-.02. Authority Ga.L.1974, pp. 221-270; O.C.G.A. Secs. 26-4-37, 26-4-53.

Effective **January 1, 2006**, full benefit dual eligibles will receive Medicaid Fee-for-Service payment only for the drugs listed in Appendix C of this manual.

905.1 Unit Dose

The Division defines unit dose packaging as individual doses of drugs that preserve the identity and integrity of the medication from packaging to patient consumption. Each dose of oral medication is packaged in a sealed, tamper-proof container and carries full disclosure labeling.

Products labeled “For Institutional Use Only” and identified by the Center for Medicare and Medicaid Services (CMS) or the manufacturer, as entities **NOT** a part of the rebate program, are **NOT covered by Medicaid** and should **NOT** be billed to the Division. These drugs will deny with a “non-rebateable/non-covered” drug edit through the POS system.

906. Pharmacy Consultant Services

The Division requires that there be pharmacy consultant services in nursing facilities as a condition of participation in Medicaid. The furnishing of pharmacy consultant services and payment for these services should not be confused with the filling of prescriptions for covered prescribed drugs and payment for them. For pharmacy consultant services, payment is made by the long-term care facility for a service to the institution. Reimbursement is not available for such services from the Pharmacy Services program.

907. Drug Utilization Review (DUR)

Effective July 1, 1992, the Division will implement a DUR program designed to monitor the use of prescription drugs by Medicaid members. The goal of the program is to identify potential drug therapy problems to providers and seek their assistance in resolving them. As a part of this program, two additional pieces of information are needed on the pharmacy claim. These are (1) the identity of the prescribing practitioner and (2) the number of days the medication should last, based on the prescriber's directions for use.

907.1 National Provider Identification Number (NPI) for Georgia Medicaid

The National Provider Identifier (NPI) has been adopted by the U.S. Department of Health and Human Services to meet the HIPAA health care provider identification mandate. It replaces all existing health care provider identifiers including numbers assigned by Georgia Medicaid on standard HIPAA transactions. It will be the number used to identify providers nationally.

Effective with dates of service on or after May 23, 2008, use of the Georgia Medicaid dummy physician license number is strictly prohibited. All pharmacy claims submitted with a dummy physician license number will reject at the Point of Sale (POS). Paper claims submitted using the dummy physician license number will also reject.

To obtain the NPI of a prescriber not on file, please visit:

https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do?subAction=reset&searchType=ind

or

http://www.hmedata.com/npi.asp

Please, see the NPI-FAQ Guide located in Billing Section G of this manual.

Medicaid Enrollment Required for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definition in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must

indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers.

Also, the National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating (i.e., rendering) provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

To comply with the requirement, medical residents may obtain an NPI and Medicaid provider ID in order to prescribe outpatient prescription medications. Pharmacies may submit the NPI of the medical resident who has signed the prescription on the pharmacy claim in the prescriber ID field. Alternatively, facilities may continue to use a prescription that is countersigned by the attending or supervising physician if they do not wish to enroll their residents and those claims should be billed under the attending's NPI number in the prescribing provider field. Medical residents may only prescribe; they may not order, refer, or bill other services.

Beginning October 1, 2013, pharmacy claims will be denied if the prescribing provider is not enrolled as an OPR or rendering provider with DCH.

A provider may enter the following information to bypass the OPR reject, but a limited number of overrides will be available per member:

Type of Prescriber	Eligible for Medicaid Provider ID	Required Signature on Prescription	Required NPI# on Claim for Legend Drugs	Required NPI# on Claim for Controlled Drugs
Nurse Practitioner	Yes	Nurse Practitioner	Nurse Practitioner NPI#	Nurse Practitioner NPI# (CIII, IV, V drugs only)
Physician Assistant	Yes	Physician Assistant	Physician Assistant NPI#	Physician Assistant NPI# (CIII, IV, V drugs only)

- Field 461-EU PRIOR AUTHORIZATION TYPE CODE = Ø1 – Prior Authorization
- Field 462-EV PRIOR AUTHORIZATION NUMBER SUBMITTED = 44444444444 – Ordering Prescribing or Referring (OPR) Provider Override

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at http://dch.georgia.gov/publications
- Search to see if a provider is enrolled at www.mmis.georgia.gov → Provider Enrollment → Provider Contract Status (enter the NPI or Medicaid Provider # in the Provider ID section to search)
- Access a provider listing at www.mmis.georgia.gov – Provider Information – Reports (Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing)

907.2 Day Supply

This three-digit numerical field will indicate the number of days the medication should last based on the prescriber's directions for use.

For example, a prescription for a medication to be taken twice a day with a quantity of sixty (60) would be a thirty (30) day supply. Prescriptions written and dispensed with nonspecific directions, such as "PRN" or "As Directed" and prescriptions for topical preparations, aerosol inhalers or nitroglycerin should be billed as a 30-day supply. Please see Section 602.8.

907.3 Prospective Drug Review

Beginning January 1, 1993, the pharmacists dispensing drugs to Medicaid members shall perform a review of drug therapy before each prescription is filled or delivered to the member. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindication, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.

907.4 Patient Counseling

As a part of prospective drug review, pharmacists dispensing drugs to Medicaid members must meet the standards established for patient counseling by the Georgia State Board of Pharmacy in 480-31.01 and OBRA 90' federal legislation. That is, the pharmacist must offer to discuss with each Medicaid member or caregiver of such individual in person, whenever practicable, or by toll-free-

telephone for long distance calls matters which, in the exercise of the pharmacist's professional judgment, he/she deems significant including the following:

A) The name and description of the drug
B) The dosage form, dose, route of administration and duration of drug therapy
C) Intended use of the drug and expected action
D) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur
E) Techniques for self-monitoring drug therapy
F) Proper storage
G) Prescription refill information
H) Action to be taken in the event of a missed dose
I) Comments from the pharmacist relevant to the individual's drug therapy including any other information peculiar to the specific patient or drug
J) Compliance and persistence counseling

907.5 Patient Profiles

A patient record system shall be maintained by all pharmacies for patients for whom prescription drug orders are dispensed. The pharmacist or his/her designee shall record and maintain all the following information:

A) Full name of the patient for whom the drug is intended.
B) Address and telephone number of the patient.
C) Date of birth and gender.
D) Known allergy, drug reactions, idiosyncrasies, and chronic conditions.
E) A list of all prescription drug orders obtained by the patient at the pharmacy where the prescription drug order is being filled within the preceding five (5) years. This list shall contain at a minimum, the following elements: Prescription number, name and strength of drug, date and quantity dispensed, name of the prescriber, and the initials of the dispensing pharmacist.
F) Appropriate comments from the pharmacist relevant to the individual's drug therapy including any other information peculiar to the specific patient or drug. A patient profile shall be maintained for a period of not less than five (5) years from the date of the last entry in the profile record. This profile may be on paper or on a computer.

907.6 Refusal of Consultation

A pharmacist is not required to provide consultation when the member or caregiver of such member refuses such consultation. The pharmacist must document the refusal of consultation by having the member or caregiver sign a preprinted statement acknowledging the refusal. Such statements may be maintained with the member's prescription or on a log that identifies the member, the prescription, and the date dispensed.

908. Hospice Related Services

Medicaid members who elect to enroll in the Hospice program receive all care related to their terminal illness from the hospice. Prescriptions filled for these members relating to the terminal illness are to be paid by the hospice and should not be billed to the Medicaid drug program. Pharmacy hospice claims do not require paper or attachments and can be billed through POS effective 10/1/2000. However, should the Medicaid hospice patient require covered drugs that do NOT relate to the terminal illness, these prescriptions may be billed to Medicaid with some restrictions.

Effective 03/23/2010, children less than 21 years of age will no longer be required to forego curative care when electing hospice. They may concurrently receive palliative and curative treatment related to the terminal illness. All palliative treatment is to be provided by the hospice provider through hospice services reimbursed by Medicaid. Pharmacy services prescribed as curative treatment for children less than 21 years of age will also be paid by Medicaid when eligibility for concurrent care criteria is met. Providers wishing to prescribe drugs for curative treatment from the list of medications below should use the pharmacy services PA process to request an exception.

DCH considers the following drugs palliative in nature and therefore ineligible for coverage in the outpatient pharmacy program for hospice members. These include but are not limited to:

- analgesics
- antibiotics
- antidepressants*
- anti-emetics
- antifungals
- antihistamines for sleep
- anxiolytics
- appetite stimulants
- folic acid, multivitamins, iron
- hematopoetics (Procrit, Epogen, etc.)

- HIV Drugs
- hypnotics
- interferons
- laxatives
- megestrol
- anti-migraine drugs
- muscle relaxants
- non-steroidal anti-inflammatory agents
- oncology drugs
- sedatives
- stool softeners

*approval on a case-by-case basis.

909. Member Hearing Request

Please refer to Part 1 and Procedures for Medicaid/PeachCare for Kids Manual, Chapter 500

PART II – CHAPTER 1000
BASIS FOR REIMBURSEMENT

These policies are in accordance with federal regulation 42 CFR 447.331 and 447.332.

1001. Reimbursement (Rev. 01/18)

For claims with fill dates on or after April 1, 2017, the reimbursement methodology used will be contingent on if the product dispensed is a specialty drug.

The Professional Dispensing Fee (PDF) will be set to $10.63.

Reimbursement for specialty drugs dispensed under the Georgia Medical Assistance program shall not exceed the lowest of:

a) Select Specialty Pharmacy Rate (SSPR) plus the Professional Dispensing Fee (PDF), **or**
b) National Average Drug Acquisition Cost (NADAC) plus the Professional Dispensing Fee (PDF), **or**
c) Georgia Estimated Acquisition Cost (GEAC) plus the Professional Dispensing Fee (PDF), **or**
d) Georgia Maximum Allowable Cost (GMAC) plus the Professional Dispensing Fee (PDF), **or**
e) Federal Upper Limit (FUL) plus the Professional Dispensing Fee (PDF), **or**
f) Provider submitted charges (including Usual and Customary Charges)

Reimbursement for non-specialty drugs, which have an active National Average Drug Acquisition Cost (NADAC) price on file, dispensed under the Georgia Medical Assistance program shall not exceed the lowest of:

a) National Average Drug Acquisition Cost (NADAC) plus the Professional Dispensing Fee (PDF), **or**
b) Georgia Maximum Allowable Cost (GMAC) plus the Professional Dispensing Fee (PDF), **or**
c) Federal Upper Limit (FUL) plus the Professional Dispensing Fee (PDF), **or**
d) Provider submitted charges (including Usual and Customary Charges)

Reimbursement for non-specialty drugs, which do not have an active National Average Drug Acquisition Cost (NADAC) price on file, dispensed under the Georgia Medical Assistance program shall not exceed the lowest of:

a) Georgia Estimated Actual Acquisition Cost (GEAC) plus the Professional Dispensing Fee (PDF), **or**

b) Georgia Maximum Allowable Cost (GMAC) plus the Professional Dispensing Fee (PDF), **or**
c) Federal Upper Limit (FUL) plus the Professional Dispensing Fee (PDF), **or**
d) Provider submitted charges (including Usual and Customary Charges)

NOTE: Between May 15, 2002 – June 30, 2005 a 50-cent generic incentive dispensing fee was paid to providers.

Determining Usual and Customary Charges (Rev. 04/15, 04/19, 01/21)

The Division defines usual and customary as the lowest price routinely offered to any segment of the general public. For example, if a pharmacy offers discounts to Senior Citizens or children, the same discounted price must be billed to the Division. A pharmacy that provides prescription medications at no charge may transmit a claim to the Division for record keeping and patient care purposes. However, any amount submitted on the claim should not exceed the amount that would have been charged to the patient. Donations or discounts provided to a charitable organization or fees charged to or paid by federal or state funded programs are not considered usual and customary charges.

Georgia Maximum Allowable Cost (GMAC) Price List and Disputes (Rev. 07/18)

A complete Georgia Maximum Allowable Cost (GMAC) Price List is updated on a quarterly basis and is available online under www.mmis.georgia.gov → Pharmacy → Pricing List. Any changes to GMAC prices within the quarter are also posted online to this same location. Any disputes to current GMAC prices may be submitted by completing a Pricing Appeal Form and faxing it along with a copy of an invoice received within 30 days of the appeal date to OptumRx at 1-888-292-4814. A copy of the MAC Pricing Appeal Form may be found online under https://ga-providerportal.optum.com → click the link for Pricing Appeal Form.

Other pricing disputes may be submitted to OptumRx by accessing the Pricing Appeal Form online and following the same process as mentioned for GMAC pricing disputes. **Please note: The submission of a pricing appeal does not guarantee a change in pricing**.

Select Specialty Pharmacy Rates (SSPR) (Rev. 04/15, 01/18)

Effective July 1, 2012, the Georgia Department of Community Health implemented Select Specialty Pharmacy Rates (SSPR) resulting in a change to the reimbursement for Medicaid and PeachCare for Kids™ Fee-for-service pharmacy claims.

Select Specialty Pharmacy Rate (SSPR) is the Actual Acquisition Cost (AAC) for select specialty pharmaceuticals based on the product dispensed and the Department's ability to ensure access to the medication at that reimbursement level. All other established payment methodologies and rules continue to apply. Products identified by the Department as Specialty Pharmaceuticals and subject to this reimbursement change include but are not limited to the agents used in the treatment of the following conditions:

- Rheumatoid Arthritis/Crohn's Disease/Psoriasis
- Multiple Sclerosis
- Neutropenia
- Hepatitis
- Anemia
- Growth Hormone Deficiency
- Cystic Fibrosis
- Respiratory Syncytial Virus (RSV) Prevention
- Pulmonary Hypertension
- Hemophilia
- Cancer
- Orphan Diseases
- HIV

No less than quarterly, the Department reviews the appropriateness of the reimbursement methodology for Specialty pharmaceuticals and Hemophilia Blood Factor-related products and adjusts the reimbursement rate if needed to ensure recipients' access to the medications is maintained.

For a current list of Select Specialty Pharmacy Rates (SSPR) please refer online to www.mmis.georgia.gov → Pharmacy → Pricing List → SSPR → Select Specialty Pharmacy Rates (SSPR)

1001.1 Recoupment Resulting from Audit Findings

Recoupments of any disputed funds shall only occur after final internal disposition of the audit, including the appeals process. Only documentation that was submitted during the audit process will be considered for review during an appeal. For other appeals information please refer to Part I Policies and Procedures for Medicaid/PeachCare for Kids Manual, Chapter 500.

1002. Brand Necessary/Innovator Drugs/Mandatory Generic Dispensing

Medicaid requires A-Rated generic drug dispensing when generics are available unless otherwise specified. Brand name drugs for products that have a Federal Upper Limit (FUL) are subject to prior approval. **The only exceptions to this**

policy are Brand Tegretol, Brand Dilantin and preferred brand drugs that are listed on the Preferred Drug List (PDL).

To receive prior approval for the innovator product of a MAC drug, the following circumstance must prevail: (Rev. 10/15)

A) The generic equivalents have caused an allergic reaction, and this fact has been documented by the prescribing physician by letter or on the GA Watch Form. The GA Watch form is included in appendix G, Outpatient Pharmacy Billing. The form or letter documenting the specific allergic reaction must be provided to OptumRx

1003. DAW – Product Selection Code (PSC)

DCH does not accept DAW/PSC codes with the exception of DAW/PSC = 1 for brand name Dilantin and Tegretol. The physician must have hand-written on the face of the prescription “Brand Necessary”.

The State of Georgia does not prohibit substitution of any multisource products. Please be advised that the use of the DAW Code 7 is considered to be inappropriate for Georgia Medicaid.

APPENDIX A

(Rev. 07/21)

DRUGS AND THERAPY CLASSES REQUIRING PRIOR APPROVAL

Prior approval is required before the dispensing of certain drugs and classes of drugs. OptumRx can authorize clinical prior approvals when criteria is met for members without a Medicaid I.D. number in the database. The requestor must provide at a minimum, the member's Social Security Number and date of birth. OptumRx can also accept requests for prior approval from pharmacies not currently enrolled in Medicaid. The dispensing pharmacy must supply their NCPDP number.

The Medicaid Preferred Drug list including drugs and therapeutic classes requiring prior approval can be viewed at: www.mmis.georgia.gov →Pharmacy → Other Documents.

Please contact the Gainwell Technologies call center to obtain a hard copy of the PDL at 1-800-766-4456 or 770-325-9600.

Please note that the Preferred Drug List and Quantity Level Limit list is subject to change without notice. Contact OptumRx 866-525-5826 to determine the coverage status or quantity level limit of any covered drug.

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs), Cyclooxgenase-2 (COX-2) Inhibitors, and Meloxicam

The prior approval request for NSAIDs, including meloxicam, must include confirmation of trials with a combined total of (2) multiple source NSAIDS. The prior approval request for a COX-2 inhibitor must include claim history confirmation of the use of (2) generic NSAIDS for at least 14 consecutive days of therapy each.

Samples and OTC usage will not be considered as a trial. Once an approval has been issued, brands of NSAIDs or COX-2s may be interchanged without a new request within the approved time period of twelve months. All COX-2s and NSAIDs have quantity level limits (QLL) in place.

Brand Name Innovator Products of Multiple Source Generics

Effective July 1, 1996, all brand name drugs for products that have a Federal Upper Limit (FUL) are subject to prior approval unless otherwise specified. Exceptions to this rule can be found under Section 1002 Brand Necessary/Innovator Drugs/Mandatory Generic Dispensing.

Drugs with Age and/or Gender Limitations

The brand and generic forms of the following drugs or drug classes are covered with limitations based upon age and/or gender and require Prior Authorization.

- Xenical/Saxenda for members between the ages of 12-17 years
- Prenatal vitamins for women
- Vitamin and Mineral Products for recipients < 21 years of age
- Ibuprofen suspension for members < 21 years of age
- Diclegis for women
- Cough and cold products for recipients < 21 years of age

APPENDIX B

(Rev. 10/15, 04/19, 01/20)

DRUGS WITH THERAPY LIMITATIONS or QUANTITY LEVEL LIMITS

Therapy Limitations

A number of drugs have limits on the length of time they may be prescribed, dispensed and covered by Medicaid without prior approval. Each type of limitation is defined separately below, and the quantity level limit (QLL) listing follows Appendix B of this section.

1. Legend Histamine-2 (H2) Receptor Antagonists

Effective February 1, 2002, legend generic H2 receptor antagonists will be available without therapy limits. Quantity level limits will be set at a month's supply based on the dose and frequency of administration. Mandatory generic dispensing is required where applicable. See the current GMAC list located on the Department's web site at www.mmis.georgia.gov → Pricing List → GMAC List.

2. Prescription Limitation for Narcotics

Beginning April 1, 2013, the Department of Community Health is lowering its narcotic prescription limitation for Georgia Medicaid Fee-for-Service (FFS) members from 6 to 5 fills per month. Thus, Georgia Medicaid FFS members will be limited to 5 fills per month of narcotic prescriptions without a written letter of medical necessity. Cancer and hospice patients are exempt from the limit. Please refer all prior authorization requests to OptumRx (formerly SXC) at **1-866-525-5827**.

3. Benzodiazepines

Effective October 1, 2008, select benzodiazepines are covered for all adults without an annual prescription limitation.

Therapeutic Duplication (TD) Edits and Quantity Level Limits (QLL) for Select Benzodiazepines and Sedative Hypnotics

Effective October 1, 2008, the Department implemented therapeutic duplication edits and new QLLs for select benzodiazepines and sedative hypnotics. Therapeutic duplication (TD) edits are activated within each category of the anxiolytic benzodiazepines and sedative hypnotic benzodiazepines (see Table 1).

Table 1

Therapeutic Duplication Edit **only (1) product from each class allowed without PA**	
Anxiolytic Benzodiazepines	**Sedative Hypnotic Benzodiazepines**
alprazolam, chlordiazepoxide, clorazepate, diazepam, lorazepam and oxazepam	estazolam, flurazepam, temazepam and triazolam

A (TD) edit will post if claims for more than one drug in a 30-day period are processed within each of the benzodiazepine categories. Also, a quantity level limit (QLL) of 18 per 30 days across the sedative hypnotics (benzodiazepine and non-benzodiazepine) will be enforced (see Table 2).

Table 2

Sedative Hypnotic Group – Quantity Level Limit of (18) per 30 days (QLL applied across entire group for a combined total of 18 per 30 days**)**
estazolam, flurazepam, temazepam, triazolam, zolpidem ER/Ambien CR, Lunesta, Rozerem, zaleplon/Sonata and zolpidem/Ambien

The QLL edit will look for a combined quantity total of 18 per 30 days within the sedative hypnotic group. **Requests to override the (TD) or (QLL) edits will require a prior authorization (PA).** Providers may request a PA from the OptumRx Clinical Call Center at 1-866-525-5827.

4. Other Drugs with Limitations

Toradol (injectable and tablets) - Limited to one (5) day supply per rolling month.

5. Drugs or Devices with Quantity or Day Supply Limitations

Effective April 1, 1995, all prescriptions for **Ambien** will be limited to a maximum quantity of eighteen (18) per rolling month.

Effective October 1, 2009, all prescriptions for oral **Triptans** will be limited to (9) tablets per rolling month. These include, but are not limited to: **Imitrex, Amerge**, **Maxalt, Zomig, Frova, Axert and Relpax**. Please review the Preferred Drug List on the GHP Technology Web Portal at www.mmis.georgia.gov → Pharmacy → Other Documents → Preferred Drug List (PDL).

Effective July 1, 1999, all prescriptions for **Imitrex** injections will be limited to (4) units per rolling month.

Effective July 1, 1999, all prescriptions for **Imitrex Nasal Spray** will be limited to (6ml) per rolling month.

Effective July 1, 1999, all prescriptions for **Migranal Nasal Spray** will be limited to (6) spray units (24ml) per rolling month.

Effective October 1, 1999, all prescriptions for **Sonata** will be limited to a maximum of eighteen capsules (18) per rolling month.

Effective October 1, 2000, all **Relenza** therapy will be limited to (20) doses per rolling month. These prescriptions are available only to members ≥ 7 years old. Relenza therapy is restricted to two (2) courses of therapy every twelve (12) months.

Effective October 1, 2000, all prescriptions for **Tamiflu** will be limited to (5) days of therapy per (6) months. For institutional settings, Tamiflu will be limited to (21) days of therapy per (6) months. All therapy is restricted to (2) courses every twelve (12) months.

Effective October 1, 2000, all prescriptions for the following will be limited to (1) Rx per rolling month: **EpiPens (including EpiPen Jr.) , AnaKit** and **Plan B.**

Effective June 1, 2002, all **Stadol Nasal Spray** will be limited to a maximum quantity of two (2) spray units (6ml) per rolling month.

Effective February 1, 2005, all prescriptions for **Lunesta** will be limited to a maximum of eighteen tablets (18) per rolling month.

Effective October 1, 2005, all prescriptions for **Rozerem** will be limited to a maximum of eighteen tablets (18) per rolling month.

6. Members Requiring Diabetic Supplies & Insulin

Effective October 1, 2013, only select Abbott Diabetes Care brand blood glucose monitors, test strips, and ketone strips are covered through the manufacturer and are available to Medicaid members requiring diabetic supplies. A list of covered diabetic supplies is located on the GHP Web Portal at www.mmis.georgia.gov under Pharmacy→ Other Documents→ Covered Diabetic Supplies.

Blood Glucose Monitors

As of October 1, 2010, the Outpatient Fee-For-Service (FFS) Pharmacy Program no longer reimburses providers for blood glucose monitors. Covered blood glucose monitors by Abbott Diabetes Care should be adjudicated directly to the manufacturer for reimbursement.

A 2nd blood glucose monitor is available for Georgia Medicaid FFS & PeachCare for Kids Members who are in school and 18 years of age and younger.

Abbott Diabetes Care Blood Glucose Monitors

• **No Charge Meter Coupons:** Abbott Diabetes Care sales representatives distributed no-charge meter cards to network pharmacy stores that provide a unique ID number and billing instructions. If your store has an urgent need for meter adjudication cards you may call **Abbott Diabetes Care Customer Service at 1-888-522-5226 (24-hour service).**

• Georgia Medicaid FFS/PeachCare for Kids Members can receive a free FreeStyle Lite or FreeStyle Freedom Lite meter by calling Abbott Diabetes Care at 1-866-224-8892, or order online at www.choosefreestyle.com and entering offer code YXRFAQEK.

• For product training, please call Abbott Diabetes Care Customer Service at 1-888-522-5226 (24-hour service).

• To process claims for FreeStyle and Precision brand blood glucose monitors for Georgia Medicaid members, please use the below code, which is part of the Abbott Free Meter Program. This code must be accompanied by a blood glucose monitor prescription.

• Dispense one FreeStyle Lite (NDC 99073-0708-05), FreeStyle Freedom Lite (NDC 99073-0709-14), Precision Xtra (NDC 57599-8814-01), FreeStyle Precision NEO (NDC 57599-5175-01), or FreeStyle InsulinX (NDC 99073-0711-43) meter at no charge to the patient.

RxBIN: 610020
Group#: 99992432
Universal Member ID: ERXGAMED

For assistance with processing an Abbott meter please contact TrialCard at 1-866-740-8343. Their hours of operation are as followed:

Monday – Friday: 24 hours
Saturday: 8am – 7pm ET
Sunday: 9am – 5pm ET

Any blood glucose monitor dispensed pursuant to the terms of this code is dispensed as a sample and shall not be submitted to any third-party payer, public, or private for reimbursement.

Lancet Devices, Lancets, Syringes, and Pen Needles

A maximum allowed unit price will be set for the following products as indicated on the table below:

Product Name	Unit Price
LANCET DEVICES	$ 2.16

LANCETS	$ 0.09
INSULIN SYRINGES	$ 0.10
INSULIN PEN NEEDLE	$ 0.24

- Insulin Syringes - 120 per rolling month, without prior approval.
- Insulin Pen Delivery Systems and Cartridge – require Prior Approval for ≥ 21 years old. The quantity level limit is (1) insulin pen delivery system per rolling year
- Lancets - 150 per rolling month, without prior approval
- Lancet Device – one (1) device per calendar year, without prior approval
- FreeStyle and Precision Blood Glucose Test Strips – 150 per rolling month, without prior approval
- Pen Needles – 100 per rolling month, without prior approval
- Urine Glucose Test Strips - 100 per rolling month, without prior approval

Durable Medical Equipment (DME) Diabetic Supply Transition

Effective **November 1, 2011,** The Georgia Department of Community Health (DCH) transitioned the following Durable Medical Equipment (DME) diabetic supplies: insulin syringes, pen needles, lancing device, lancets, blood glucose monitoring strips, and blood glucose monitors to the Georgia Medicaid Fee-For-Service (FFS) Outpatient Pharmacy Program. The following supplies are no longer reimbursable under the DME Program Category of Service (COS) 320:

DME SUPPLY	CODE
Lancet	A4259
Glucose Strips	A4253
Monitor	E2100 (w/integrated voice synthesizer)

Only the insulin infusion pump (E0784) and its supplies (A4230, A4231, A4232, K0101, K0602, K0603 and K0604) continue to be reimbursed under the DME program.

Diabetic supplies are only available through enrolled Georgia Medicaid FFS Outpatient Pharmacies when prescribed by a physician. Georgia licensed pharmacies, when enrolled, are simultaneously assigned to COS 300 and 321. Only providers eligible to enroll in COS 300 and 321 are eligible to dispense approved FFS insulin syringes, pen needles, lancing device, lancets, blood glucose monitoring strips, and blood glucose monitors to non-nursing home Medicaid PeachCare diabetic patients.

Claims submitted by pharmacies for FFS members are processed by the Pharmacy Benefit Manager (PBM), OptumRx (COS 300), except for blood glucose monitors which are processed directly through the manufacturer. All claims (including blood glucose monitors) submitted by pharmacies for crossover members (dual eligible) are processed by Gainwell Technologies through the Medicaid Management Information System (MMIS) (COS 321).

Only dual eligible members are eligible to continue to receive services from DME suppliers.

7. Members Requiring Spacers and Peak Flow Meters

Effective January 1, 1999, asthmatic children (<21) may receive spacers and peak flow meters under Pharmacy Services per the following:

- One (1) spacer per calendar year – GMAC effective December 1, 2015, of $50.00 a spacer plus a dispensing fee.
- One (1) peak flow meter per lifetime – GMAC effective July 1, 2007, of $20.00 a meter plus a dispensing fee.

8. Generic OTC Drug Coverage-Products Previously Available as Legend Only

Effective on or after September 1, 2004, the following generic over the counter (OTC) drugs and/or classes will be covered with a prescription.

- **Low-Sedating Antihistamines & Combination Products**:
    - OTC generic **loratadine** and generic **loratadine–D** combination products are covered for all members.
    - OTC generic **cetirizine tablets** and OTC/RX generic **cetirizine syrup** are covered for all members.

9. Smoking Deterrent Products

Smoking deterrent products are covered with a prescription. All smoking deterrent products are covered up to a maximum duration of 24 weeks (168 days) per year 12 weeks at a time. Preferred OTC medications (generic nicotine gum, lozenges, and patches) do not require prior authorization (PA) for the 1st 12 weeks. All other smoking deterrent products require prior authorization for the 1st 12 weeks and the 2nd 12 weeks.

We appreciate your continued participation in the Georgia Medicaid & Peach Care for Kids Programs.

APPENDIX C

COVERED NURSING FACILITY SERVICES

Covered Services

The approved reimbursement rate established by the Division of Medical Assistance is an inclusive rate to cover the following:

A) Nursing facility residents are allowed to retain from their income each month “a monthly personal needs allowance - which is reasonable in amount for clothing and other personal needs of the individual while in an institution.” 43 USCA, Section 396a (q) (1) (A). The personal need allowance is currently set at $50.00 per month.

B) Nursing facility covered services. In addition to other services and items required by the Division’s policy, the following services and items shall be provided by the nursing facility at no additional charge to the Division, the member, or the member’s representative:

a. Patient’s room and board (including special diets and special dietary supplements used for tube or oral feedings, when specifically prescribed by a physician). Insofar as possible, privacy shall be accorded a member with a terminal illness; however, this shall not be interpreted to require a private room.

b. Laundry (including personal laundry).

c. Nursing and routine services:

Routine services include all nursing services and supplies, and other supplies and equipment related to the day-to-day care of the patient. Items of service which are covered in routine services regardless of the condition of the patient include, but are not limited to the following:

– Nursing services (excluding private duty nurses)
– Medical social services
– Physical therapy
– Speech therapy
– Restorative nursing care
– Hand feedings
– Enemas
– Assistance in personal care and grooming
– Nursing supplies and dressings
– Extra Linen
– Laboratory procedures not requiring laboratory personnel

– Tray service
– Durable medical equipment (such as, but not limited to, beds, bedrails, walkers, wheelchairs) excluding specialized equipment for individual use
– Incontinency care
– Incontinency pads, diapers, and sanitary pads
– Special mattresses and pads

Routine personal hygiene items and services including, but not limited to:

Shampoo, hair conditioner, comb, brush, bath soap, non-legend disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, petroleum jelly, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, towels, washcloths, hospital gowns, nail care, hair care, bathing, and shaving.

Over the Counter (OTC) Drugs and Related Items:

- Each nursing facility shall as part of nursing and routine services supply clinically necessary over-the-counter drugs and related items to be used for members as ordered by the attending physician without additional charge to the Division, the member, or the member's representative. Each item must be available in adequate supply to assure the member's timely receipt of the items as ordered. These items will be provided generically or in a brand of a nursing facility's choosing unless the doctor has a clinically necessary reason to choose a particular brand.
- The resident may only be charged for over the counter drugs if, after being informed of the options, he or she chooses to purchase a specific brand for non-clinical reasons from his/her personal needs allowance. The items to be supplied by the nursing facility shall include, but shall not be limited to the following:

    - <u>Stool Softener and Laxative</u>
        - Magnesium Hydroxide Liquid (Milk of Magnesia)
        - Glycerin Suppositories
        - Stool Softener
        - Bulk Laxative
        - Stimulant Laxative
    - <u>Antidiarrheal</u>
        - Non-legend antidiarrheal product
    - <u>Antacid</u>
        - Antacid
    - <u>Analgesic/Antipyretic</u>
        - Acetaminophen - tablets, liquid, suppositories
        - Aspirin - tablets, suppositories

- Ophthalmics
  - Artificial tears in multi-dose containers labeled for specific patients' use
- Diluents/Irrigants
  - Normal saline
  - Sterile water
- Treatment Solutions
  - Chlorhexidine gluconate (Hibiclens)
  - Rubbing Alcohol
  - Povidone-iodine 10% (Betadine)
  - Hydrogen Peroxide 3% (Peroxide)
- Vaccines
  - Influenza Vaccine
  - Hepatitis B Virus Vaccine (ICF-MR only)
- Other
  - Other clinically necessary non-legend drugs ordered by the physician for which there is no substitute covered by Medicaid.

Drugs Eligible for Coverage by Full Benefit Dual Eligibles Receiving Medicare Part D Benefits

Effective January 1, 2006, full benefit dual-eligibles may receive Medicaid Fee-for-Service payment for only the following drugs and/or therapeutic categories. All therapy, quantity, and service limits as well as prior approval requirements remain in effect.

- Cyanocobalamin Injection
- Generic Megace Suspension*
- Folic Acid 1mg
- Hep-Lock Saline Flush
- Legend prenatal vitamins for women
- Legend Injectable Iron
- Diphenhydramine
- Generic permethrin lotion 1%, pyrantel pamoate
- OTC generic Loratadine and Loratadine D-, OTC Cetirizine tablets and syrup
- Enteric coated aspirin
- Meclizine
- ESRD vitamins and antacids:

Calcium Carbonate, Aluminum Hydroxide, calcium acetate, sodium bicarbonate. Calcium Carbonate with Glycine, Calcium Lactate, Docusate Calcium, Docusate Sodium, Niacin, Pyridoxine Hydrochloride, Thiamine Hydrochloride, Legend Vitamin D products, Vitamin B Complex (All Require Prior Approval)

Members < 21 years old may receive all medications listed above as well as the following drugs and/or therapeutic categories. All therapy, quantity, and service limits as well as prior approval requirements remain in effect.

- Cough and cold products
- Vitamin E
- Children's Multiple Vitamins in combination with Fluoride
- OTC Multi-Vitamins and Multi-Vitamins with Iron (chewable or liquid drops)
- Legend Vitamin & Mineral Products
- Ibuprofen Suspension

Please Note: All covered OTCs require a Prescription. Please review Appendix B of this Manual for a description of applicable therapy limits.

*Generic Megace is covered for the duals unless its use is for anorexia, or an unexplained, significant weight loss in patients with a diagnosis of acquired immunodeficiency syndrome (AIDS).

APPENDIX D

(Rev. 04/16)

MEDICARE CROSSOVER CLAIMS

Effective for dates of service on and after May 11, 2012, payments for Medicare coinsurance and deductible obligations for dual eligible Medicare/Medicaid members, including Qualified Medicare Beneficiaries (QMB), will be limited to the Medicaid maximum allowable amount. This reimbursement structure is consistent with the public notice issued by the Department of Community Health (DCH) dated August 30, 2000. The August 30th public notice is summarized below:

If Medicaid approves the claim; the Medicaid reimbursement amount is determined as follows:

1. The Medicare coinsurance and deductible amount for the claim is compared to the Medicaid maximum allowable amount minus the Medicare payment. The Medicaid payment will be the lesser of these amounts less applicable TPL and copayments.

2. If Medicaid approves the claim, a payment of the lesser of the coinsurance and deductible up to the Medicaid maximum allowable amount for the claim will be made.

3. If the Medicare payment on the claim is equal to or greater than what Medicaid would have allowed for the claim; Medicaid will pay at $0.00.

A copy of the public notice issued on August 30, 2000 and/or applicable calculation examples are available upon request. Please submit your request along with any questions to crossoverissues@dch.ga.gov.

CO-PAYMENT

Effective April 1, 2016, dual eligible Medicare/Medicaid members, including Qualified Medicare Beneficiaries (QMB) are exempt from co-payment.

Thank you for your continued participation in the Medicaid program.

APPENDIX E

CO-PAYMENT FOR PHARMACY

Effective with dates of service on or after July 1, 2001, the Department will impose a nominal co-payment for each preferred generic or preferred brand drug of $.50 dispensed by the pharmacy.

Category	Co-Payment
Preferred Generic	$0.50
Preferred Brand	$0.50
Non-Preferred Brand or Non-Preferred Generic	Under $10.00 = $0.50 $10.01-$25.00 = $1.00 $25.01-$50.00 = $2.00 $50.01 or more = $3.00

Medicaid members under age twenty-one (21), pregnant women, institutionalized individuals and hospice care members are not required to pay this co-payment. Emergency services and family planning services are also exempt from this co-payment.

The Medicaid members listed below are not required to pay the co-payment.

1. **Members who are under twenty-one years of age**
   The member's age will be determined systematically during claims processing.

2. **Members who reside in a nursing facility**
   For new nursing facility members not yet identified on the card, providers should enter (**11111**) in the prior authorization number field on the claim and enter an "04" in field 461-EU (Prior authorization Type Code). This number will prevent the reduction of co-payment from the claim.

3. **Members who are pregnant**
   For newly diagnosed pregnant women, providers may indicate this exemption by placing (**22222**) in the prior authorization number field on the claim and enter an "04" in field 461-EU (Prior authorization Type Code).

4. **Members enrolled in hospice care**
   Hospice members are identified on the Medicaid card; no entry on the claim is required by providers.

5. **All emergency prescriptions are exempt from co-payment**
   The entry of the emergency number (**99888**) in the prior authorization number field and entry of an "04" in field 461-EU (Prior authorization Type Code) will exempt the prescription from co-payment. This code will not override drugs that require member eligibility, prior authorization, quantity level limit, or refill-

too-soon approvals.

6. **All family planning prescriptions are exempt from Co-payment**
   All oral and/or injectable contraceptives are exempt from co-payment. These prescriptions are identified systematically by their therapeutic category and the co-payment will not be deducted

7. **All Breast and Cervical Cancer AID Category Members, AID category (245 & 800) Only**
   Effective January 1, 2007, all members of the Breast and Cervical Cancer Aid category are exempted from co-payment. Utilizing the NCPDP (5.1) claim standard, enter (08) in field (#461 EU) to bypass drug co-payment for Breast and Cervical Cancer aid category members, not properly identified through POS adjudication. Please note that this only applies to members eligible in AID categories (245 and 800).

Effective with dates of service on or after July 1, 2005, the Division is implementing a tiered member co-payment scale on all evaluation and management codes (99201-99499), including Optometric visits--as described in 42CFR447.54. See co-payment scale below:

Payment for the service chargeable	Maximum co-payment to member
$10 or less	$.50
$10.01 to $25	$1.00
$25.01 to $50	$2.00
$50.01 or more	$3.00

§ The member co-payment will be deducted from each evaluation and management procedure code billed unless the member is included in one of the exempted, which include:

1) Pregnant women; 2) Nursing Home Facility residents; and 3) Hospice Care members.

§ The co-payments do not apply to emergency or family planning services.

§ The provider may not deny services to any eligible Medicaid member because of the member's inability to pay the co-payment.

A co-payment will be deducted from each prescription billed unless the member has been identified in an exempt group as defined above. Providers should continue to submit their usual and customary charge for each prescription billed to the Division. Do not deduct the co-payment from your submitted charges to the Division.

Providers who agree to provide pharmacy services to Medicaid members by accepting their Eligibility card, or by filing a request for prior approval for a member, are obligated to file the claim to Medicaid and accept Medicaid reimbursement as payment in full.

The provider may not deny services to any member on account of such member's inability to pay the co-payment. A member's inability to pay the co-payment does not eliminate his or her liability for such co-payment.

The application of co-payment will be identified on the remittance advice. A new explanation of benefit (EOB) code will indicate payment has been reduced due to the application of co-payment.

The services subject to the co-payment and the co-payment amount are listed below.

Service	Co-Payment
Inpatient Hospital	$12.50
Physicians	$2.00
Home Health	$3.00
Rural Health	$2.00
Nurse Practitioners	$2.00
Drugs	$ .50 $1.00 $2.00 $3.00
Non-Emergency Transportation	$1.00
Durable Medical Equipment	$3.00
Optometry	$1.00
Orthotics and Prosthetics	$3.00
Ambulatory Surgical Centers	$3.00
Podiatry	$2.00
Physician Assistants	$2.00

CO-PAYMENTS FOR PEACHCARE FOR KIDS

Effective for services provided on or after April 1, 2012, the Department of Community Health will implement co-payments for covered services to PeachCare for Kids members six years of age and older.

The co-payments are subject to fee-for-service rates. They will be deducted from the amount paid on each claim filed.

Co-pays are not required for children who are American Indians or are Alaska Natives. The provider cannot deny services to any eligible PeachCare for Kids member because of the member's inability to pay the co-payment. The provider should check member eligibility in order to identify those individuals who may be responsible for the co-

payment. If you have questions, contact Gainwell Technologies Provider Services Contact Center at (770) 325-9600 or (800) 766-4456.

Listed below are the PeachCare for Kids co-payment amounts:

ILLUSTRATIVE CO-PAYMENTS	
Pharmacy - Preferred Drugs	$0.50
Pharmacy - Non-Preferred Drugs	Cost Based
COST BASED CO-PAYMENTS	
Cost of Service	**Co-Payment**
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

APPENDIX F

STATEMENT OF PARTICIPATION

The new Statement of Participation is available in the Provider Enrollment Application Package. Phone your request to: (800) 766-4456

APPENDIX G

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OPTUMRX PHARMACY PROVIDER

(REV. 10/15)

SUPPORT PHONE NUMBERS AND HOURS

For all online inquiries including claims processing, eligibility prior approval or online messaging, contact

OptumRx Technical Support
866-525-5826
24/7/365

Prior Authorization and Clinical Support,
866-525-5827
Intended for Physicians/Pharmacist use
24/7/365

OPTUMRX-GDCH Paper Claims
PO Box 29044
Hot Springs, AR 71903

OptumRx FAX Number for Georgia Medicaid
888-491-9742

GEORGIA HEALTH PARTNERSHIP (GHP)

(REV. 10/15)

Provider Correspondence
Gainwell Technologies
P.O. Box 105200
Tucker, GA 30085-5201

Prior Authorization & Pre-Certification
GHP
P.O. Box 105329
Atlanta, GA 30348

Provider Enrollment
Includes Pharmacy Providers
www.mmis.georgia.gov →
Provider Enrollment
FAX: 1-866-483-1044

Electronic Data Interchange (EDI)
Includes:

- Asynchronous
- Web portal
- Physical media
- Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/
- Internet Protocol (TCP/IP)
- 1-877-261-8785

Provider Inquiry Numbers:

770-325-9600 (Metro area)
800-766-4456 (Toll free)

OptumRx– web address
https://ga-providerportal.optum.com

GHP – web address
The web contact address is http:// www.mmis.georgia.gov

ONLINE TRANSMISSION INFORMATION

In order to participate in the Medicaid provider network, you must be able to submit claims electronically to OptumRx. For providers who need to get online, OptumRx has a list of software vendors that offer software and/or hardware products for online claim submission. Contacting a software vendor should be your first step. The second step is to contract with a switching company. Your software vendor may offer recommendations for a compatible switching company. Please contact OptumRx Provider Relations at 866-525-5826 if you have questions.

GA Medicaid FFS/PeachCare for Kids

OptumRx

PAYER SPECIFICATION SHEET
REVISED SEPTEMBER 3, 2020

BIN #:	001553
States:	All GA willing Providers
Destination:	OptumRx / RxClaim
Accepting:	Claim Billing, Claim Rebill, and Claim Reversals
Format:	NCPDP Version D.Ø
Effective:	1/1/2012

You may find the Payer Specification Sheet at the following:

- www.mmis.georgia.gov → Pharmacy → Other Documents → OptumRx Payer Sheet
  or
- www.dch.georgia.gov → Provider → Provider Type → Pharmacy → OptumRx → OptumRx Payer Sheet

NCPDP Version D.0 Implementation
Georgia Department of Community Health

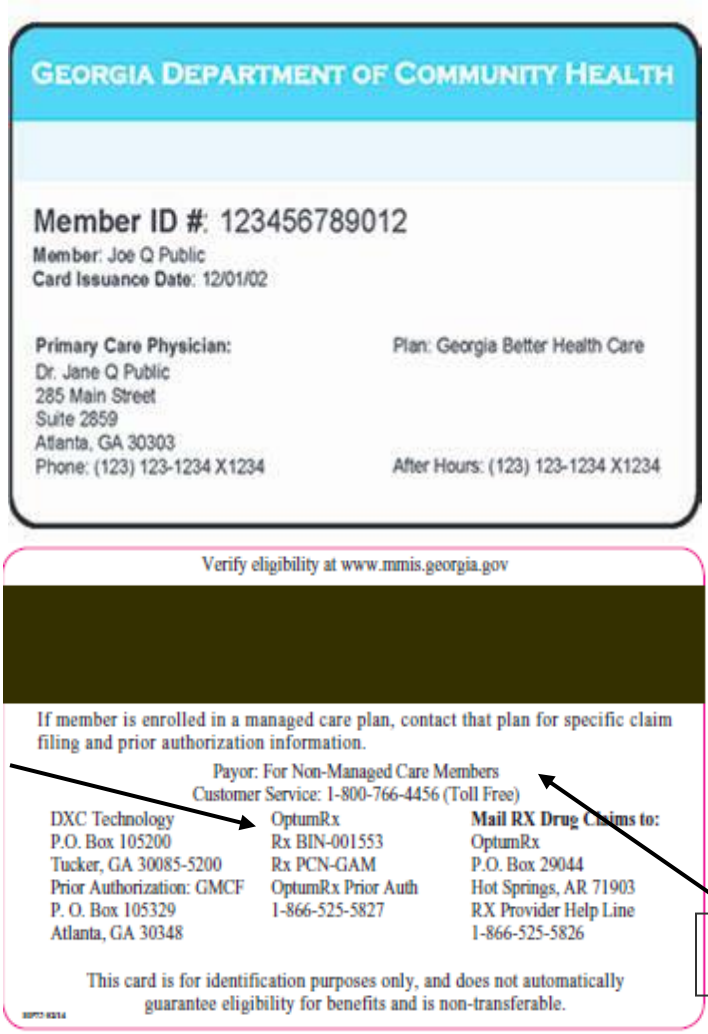
(Rev. 10/15)

- Effective January 1, 2012, GADCH will begin accepting claims via the HIPAA compliant NCPDP Version D.0 standard transaction.

- Please call the OptumRx Technical call center @1-866-525-5826 with OptumRx for questions specific to NCPDP Version D.0.

MEMBER ELIGIBILITY VERIFICATION

Each member should present an Identification Card when getting a prescription filled. The new member cards will serve dual purpose for medical & prescription card.



Rx BIN #/PCN #/Group Number: Required Information to process claim

Rx Provider # for Technical

If a person claims to be a Georgia Medicaid Member and does not have a card, submit the claim online, then if you receive a *"Missing/Invalid Cardholder ID"* rejection code, verify eligibility by contacting the OptumRx Call Center at 866-525-5826

Eligibility must be verified before dispensing any medication through POS or direct contact with OptumRx. Presentation of the card does not guarantee eligibility or reimbursement.

GENERAL CLAIM SUBMISSION POLICIES

(REV. 10/15)

All claims must be submitted to a primary payer when Medicaid is secondary. The secondary claim transmitted to Medicaid through OptumRx must include the applicable Other Coverage Code and the Primary Paid Amount as returned by the primary payer. (See section on Coordination of Benefits/Billing.)

All claims must be submitted with the actual NDC of the medication dispensed. Non-standard NDCs are prohibited by the HIPAA Standard.

All claims must be submitted with an appropriate Prescriber ID on all claims. The required identifier is the NPI. Failure to submit the complete and accurate required Prescriber identifier will result in a rejected claim (See section 907.1 of Policy Manual).

All paper claims should be submitted on a Universal Claim Form (UCF) DAH 2 pt.

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers.

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at http://dch.georgia.gov/publications

- Search to see if a provider is enrolled at

  https://www.mmis.georgia.gov/portal/default.aspx

Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last name.

- Access a provider listing at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx

Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

Georgia Medicaid FFS Tamper Resistant Prescription Pad (TRPP)-Pharmacy Update

On October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) tamper-resistant prescription law took effect requiring all handwritten and/or computer generated (by an electronic medical record (EMR) or ePrescribing applications) printed prescriptions for fee-for-service Medicaid patients contain at least one industry recognized feature from each of the three categories of tamper resistance.

The Georgia Department of Community Health (DCH) Office of the Inspector General Program Integrity division is required to enforce this federal requirement. Any payment made for a prescription that does not comply with this requirement will be recouped by the Department. The Center for Medicare and Medicaid Services (CMS) strongly supports both e-prescribing and the use of tamper-resistant prescription pads as methods to reduce instances of unauthorized, improperly altered, and counterfeit prescriptions.

Review of CMS Requirements for TRPP:

Required tamper-resistant characteristics include one or more industry-recognized features designed to:		**Examples include but are not limited to:**
1	Prevent unauthorized copying of a completed or blank prescription form	• High security watermark on reverse side of blank • Thermochromic ink technology • Photocopied prescription blanks show the word “Copy,” “Illegal,” or “Void.”
2	Prevent erasure or modification of information written on the prescription by the prescriber	Tamper-resistant background ink shows erasures or attempts to change written information
3	Prevent the use of counterfeit prescription forms	Duplicate or triplicate blanks

Summary of features that could be used on a tamper-resistant pad/paper in compliance with the CMS guidelines

Category 1 – Copy Resistance: One or more industry recognized features designed to prevent unauthorized copying of a completed or blank prescription form.	
Feature	**Description**
“Void,” “Illegal,” or “Copy” pantograph with or without Reverse “Rx”	The word “Void,” “Illegal,” or “Copy” appears when the prescription is photocopied. Except where state law mandates the word “Void” or “Illegal” – it is recommended that the pantograph show the word “Copy” if the prescription is copied. The pantograph should be placed so as not to obscure the security feature description contained on the prescription, the patient and prescriber demographics, or the medication

Category 1 – Copy Resistance: One or more industry recognized features designed to prevent unauthorized copying of a completed or blank prescription form.	
Feature	**Description**
	and directions. Some pantographs can be problematic because when the prescription is copied, the resulting “void” or other wording that appears makes the underlying prescription difficult to read. These types of pantograph should be avoided. Providers may wish to ask their pad vendor about hollow “VOID” pantograph lettering which is less likely to obscure the information. The Reverse Rx disappears when photocopied at a light setting – thus making the pantograph more effective in copy resistance. The pantograph may be used with a reverse Rx, but Reverse Rx is not effective as a feature by itself.
Micro printing – To be effective, this feature must be printed in 0.5 font or less making it illegible to the pharmacist when copied	Very small font which is legible (readable) when viewed at 5x magnification or greater, and illegible when copied.
Thermochromic ink	Ink changes color with temperature change.
Coin-reactive ink	Ink changes color when rubbed by a coin.
<u>Watermarking</u> Security back print (artificial watermark) Digital watermarks Watermarking on special paper	 Printed on the back of prescription form. The most popular wording for the security back print is “Security Prescription” or the security back print can include the states name. Can only be seen when viewed at an angle. Weak digital watermarks cannot be read if copied and strong digital watermarks provide digital rights management/“proof” of origin when copied. Special paper contains a watermark that can be seen when backlit.

Category 2 – Erasure / Modification Resistance: One or more industry-recognized features designed to prevent the erasure or modification of information written / printed on the prescription by the prescriber.	
Features to Prevent Erasure	**Description**

An erasure revealing background (erasure resistance)	Background that consists of a solid color or consistent pattern that has been printed onto the paper. This will inhibit a forger from physically erasing written or printed information on a prescription form. If someone tries to erase, the consistent background color will look altered and show the color of the underlying paper.
Toner Receptor Coating / Toner Lock or Color Lock paper (erasure resistance for computer generated prescriptions printed with a laser printer) OR Chemically reactive paper (erasure resistance for handwritten prescriptions)	Special printer paper that establishes a strong bond between laserprinted text and paper, making erasure obvious. Note – this is NOT necessary for inkjet printers – as the ink from inkjet printers is absorbed into normal "bond" paper. If exposed to chemical solvents, oxidants, acids, or alkalis that can be used to alter the prescription, the chemically reactive paper will react and leave a mark visible to the pharmacist.
Features to Prevent Modification	**Description**
Quantity check off boxes and refill indicator (circle or check number of refills or NR)	In addition to the written quantity on the prescription, quantities are indicated in ranges. It is recommended that ranges be in 25's with the highest being "151 and over". The range box corresponding to the quantity prescribed MUST be checked for the prescription to be valid. The refill indicator indicates the number of refills on the prescription. Refill numbers must be used to be a valid prescription.
Pre-printed language on prescription Paper Example: "Rx is void if more than XXX Rx's on paper"	Reduces ability to add medications to the prescription. Line must be completed for this feature to be valid. Computer printer paper can accommodate this feature by printing, "This space intentionally left blank" in an empty space or quadrant.
Quantity and Refill Border and Fill (this is the recommended for computer generated prescriptions)	Quantities and refill # are surrounded by special characters such as an asterisk to prevent modification, e.g. QTY **50** Value may also be expressed as text, e.g. FIFTY, (optional).

Category 3 – Counterfeit Resistance: One or more industry-recognized feature

designed to prevent the use of counterfeit prescription forms.	
Feature	**Description**
Security features and descriptions listed on prescriptions – this feature is strongly recommended on all prescriptions	Complete list of the security features on the prescription paper for compliance purposes. This is strongly recommended to aid pharmacists in identification of features implemented on prescription.
Thermochromic ink	Ink changes color with temperature change.
Encoding techniques (bar codes)	Bar codes on prescription. Serial number or Batch number is encoded in a bar code.
Security Thread	Metal or plastic security threads embedded in paper as used in currency.

Best Practices for Tamper Resistant Printed Prescriptions (Handwritten)

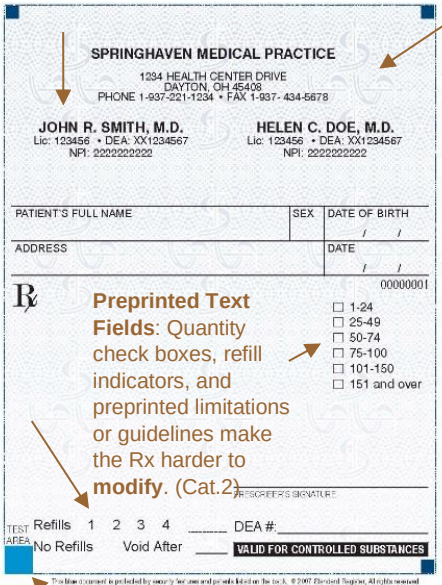
Category 1	A) Photocopied “COPY”, “ILLEGAL”, or “VOID” Pantograph
Category 2	A) An Erasure revealing background (resists erasures and alterations) B) Quantity check off boxes C) Refill indicator (circle number of refills or “NR”)
Category 3	A) Security features and descriptions listed on the prescription

Best Practices for Tamper Resistant Printed Prescriptions (Handwritten)

Front

Void or Copy Pantograph: displays "VOID" or "ILLEGAL" on a color copy of an Rx. It will appear on a wide range of copier settings. (Cat. 1)

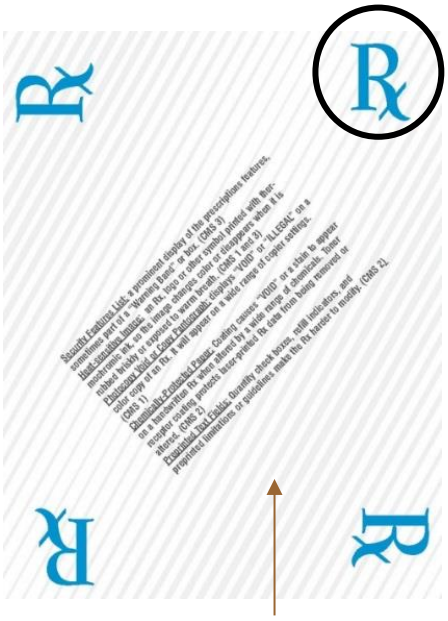
Chemically-Protected Paper: Invisible coating causes "VOID" or a stain to appear on a handwritten Rx when altered by a wide range of chemicals. Toner receptor coating protects laser-printed Rx data from being removed or altered. (Cat. 2) Recommended for use with Preprinted Text Fields



Preprinted Text Fields: Quantity check boxes, refill indicators, and preprinted limitations or guidelines make the Rx harder to **modify**. (Cat.2)

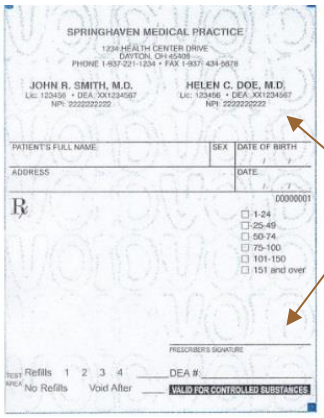
Heat-sensitive Image: An Rx, logo, or other symbol printed with Thermochromic ink, so the image changes color or disappears when it is rubbed briskly or exposed to warm breath. (Cat. 1 and 3)

Back



Security Features List: a prominent display of the prescription's features, sometimes part of a "Warning Band" or box. (Cat. 3)

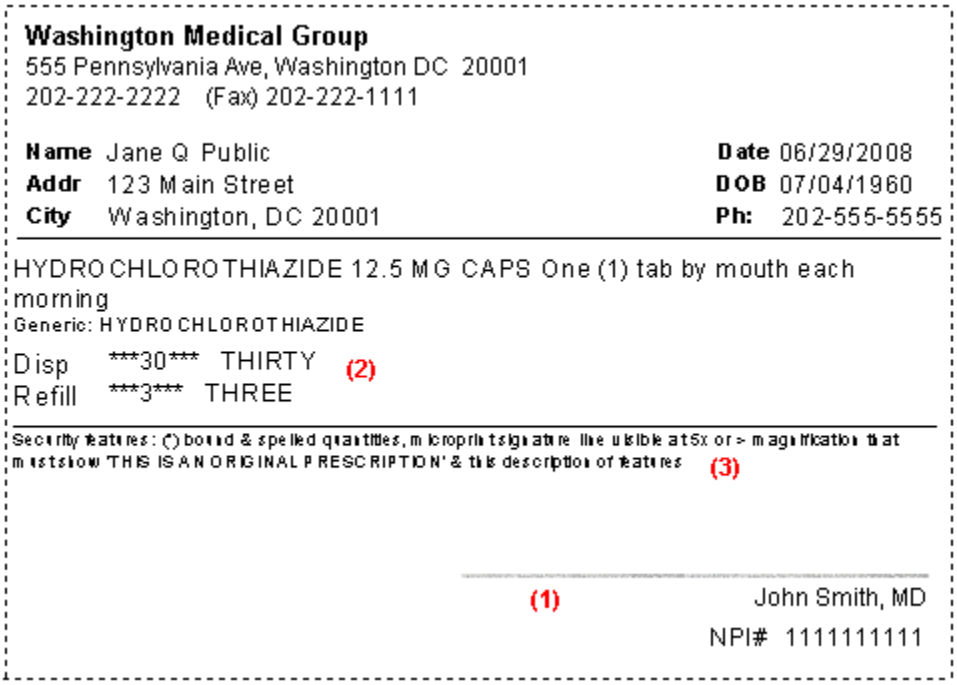
Example of a Color Copied Prescription



Hollow Pantograph: VOID or ILLEGAL is designed to not obscure or block vital information. Often showing strongest intensity at the "top" or the document. These pantographs generally do not "pop" on a black and white fax

Best Practices for Tamper Resistant Printed Prescriptions (Generated by an EMR)

Example A



Washington Medical Group
555 Pennsylvania Ave, Washington DC 20001
202-222-2222 (Fax) 202-222-1111

Name Jane Q Public **Date** 06/29/2008
Addr 123 Main Street **DOB** 07/04/1960
City Washington, DC 20001 **Ph:** 202-555-5555

HYDROCHLOROTHIAZIDE 12.5 MG CAPS One (1) tab by mouth each morning
Generic: HYDROCHLOROTHIAZIDE

Disp ***30*** THIRTY (2)
Refill ***3*** THREE

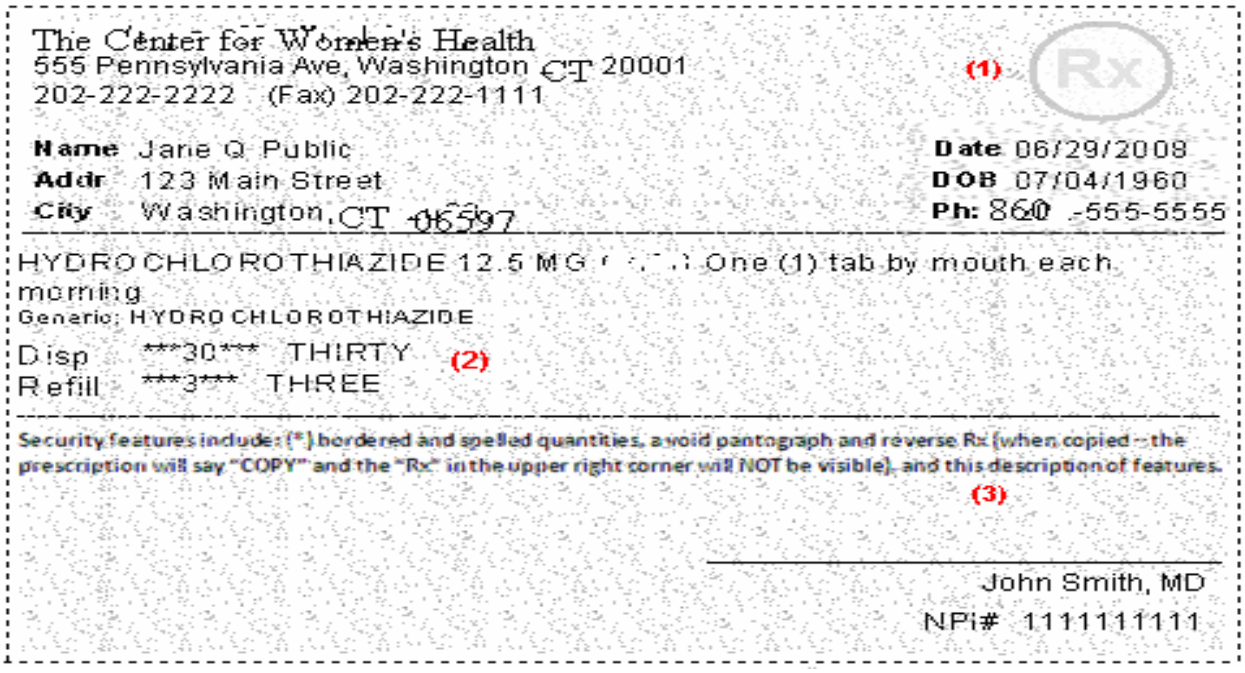
Security features: (*) bound & spelled quantities, microprint signature line visible at 5x or > magnification that must show 'THIS IS AN ORIGINAL PRESCRIPTION' & this description of features (3)

(1) John Smith, MD
NPI# 1111111111

Category #1 – Copy Resistance: Microprint signature line*
Category #2 – Modification / Erasure Resistance: Border characteristics (dispense and refill # bordered by asterisks AND spelled out)
Category #2 – Modification / Erasure Resistance: Printed on “toner-lock” paper
Category #3 – Counterfeit Resistance: Listing of security features

*Microprint Line viewed at 5x magnification
THIS IS AN ORIGINAL PRESCRIPTION-THIS IS AN ORIGINAL PRESCRIPTION-THIS IS AN ORIGINAL PRESCRIPTION-THIS IS AN ORIGINAL PRESCRIPTION

Example B


The Center for Women's Health
555 Pennsylvania Ave, Washington CT 20001
202-222-2222 (Fax) 202-222-1111

(1)

Name Jane Q Public
Addr 123 Main Street
City Washington, CT 06597

Date 06/29/2008
DOB 07/04/1960
Ph: 860 -555-5555

HYDROCHLOROTHIAZIDE 12.5 MG [illegible] One (1) tab by mouth each morning
Generic: HYDROCHLOROTHIAZIDE
Disp ***30*** THIRTY (2)
Refill ***3*** THREE

Security features include: (*) bordered and spelled quantities, a void pantograph and reverse Rx (when copied -- the prescription will say "COPY" and the "Rx" in the upper right corner will NOT be visible), and this description of features.

(3)

John Smith, MD
NPi# 1111111111

Category #1 – Void/Illegal/Copy Pantograph with or without Reverse Rx
Category #2 – Modification / Erasure Resistance: Border characteristics (dispense and refill #
bordered by asterisks AND spelled out)
Category #2 – Modification / Erasure Resistance: Printed on “toner-lock” paper for laser printed
prescriptions, and on plain bond paper for inkjet printed prescriptions
Category #3 – Counterfeit Resistance: Listing of security features

Georgia Department of Community Health • Program Integrity Division

Tamper Resistant Prescriptions
PROVIDER COMPLIANCE REFERRAL FORM

On October 1, 2008,the Centers for Medicare and Medicaid Services (CMS) tamper-resistant prescription law took effect requiring that all handwritten and/or computer generated (by an electronic medical record (EMR) or ePrescribing applications) printed prescriptions for fee-for-service Medicaid patients contain at least one industry recognized feature from each of the three categories of tamper resistance.

This form is designed to assist the Department in coordinating educational efforts for non-compliant prescribing providers. Questions about this form or its use should be directed to the Program Integrity Division at (404) 463-5273.

Fill in the information and fax to: **(770) 344-4257**.
Submitting Pharmacy should provide the following information for non-compliant prescribers
(* denotes required information):

Prescriber Name*:	
Prescriber License Number*:	
Prescriber NPI Number*:	
Phone Number: (include area code)	
Street Address:	
City, State, Zip:	

Prescriber Name*:	
Prescriber License Number*:	
Prescriber NPI Number*:	
Phone Number: (include area code)	
Street Address:	
City, State, Zip:	

Prescriber Name*:	
Prescriber License Number*:	
Prescriber NPI Number*:	
Phone Number: (include area code)	
Street Address:	
City, State, Zip:	

Submitting Pharmacy*:_____ Date:_____
GA Medicaid Provider #*:_____
Phone # (incl. area code): _____

Additional Resources

http://www.cms.gov/DeficitReductionAct/30_GovtInfo.asp

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Medicaid Fee-for-Service
Multi-Ingredient Compound Drug Prior Authorization Form
Fax to 888-491-9742

*******Ages 2 and under Prevacid Compound requests- please contact OptumRx directly for approval at 1-866-525-5827. Completion of this form is NOT required.******
Requests for Proton Pump Inhibitors (PPI) additionally require a completed PPI Prior Authorization Form available from:
www.mmis.georgia.gov → Pharmacy → Prior Approval Process → Proton Pump Inhibitor Prior Authorization Form

Compound Request- The form should be completed in its entirety to ensure proper processing. An attached prescription is necessary to process the request. Additional pertinent information may also be submitted.

MEMEBER Last Name	**MEMBER First Name**
MEMBER ID number	**MEMBER Date of Birth** -- --
PRESCRIBER Last Name	**PRESCRIBER First Name**
PRESCRIBER NPI#	
PRESCRIBER Phone	**PRESCRIBER Fax**
PRESCRIBER Address	

1 Member Diagnosis	**2 Compound Requested**

3 If applicable, indicate why a commercially available product is not acceptable and include the specific medical need for the compound; list previous failed therapies if known.

4 Ingredient Name	**5 11-digit NDC**	**6 Quantity**	**7 Unit (e.g. mls)**
1.	**1.**	**1.**	**1.**
2.	**2.**	**2.**	**2.**
3.	**3.**	**3.**	**3.**
4.	**4.**	**4.**	**4.**
5.	**5.**	**5.**	**5.**
6.	**6.**	**6.**	**6.**
7.	**7.**	**7.**	**7.**
8.	**8.**	**8.**	**8.**
9.	**9.**	**9.**	**9.**
10.	**10.**	**10.**	**10.**

8 Pharmacy Name	**9 Pharmacy NABP**
10 Pharmacy Phone	**11 Pharmacy Facsimile**
12 Pharmacist Signature and Date	

*******Updated 09/10/12*******

Compounded Prescriptions

Reimbursement for all drugs is contingent upon dispensing a drug that is manufactured by a company who has a signed rebate agreement for that drug with the Centers for Medicare and Medicaid Services (CMS) **and** the member's eligibility at the time of service.

Effective July 17, 2017, compound requests for select compounded ingredients (in addition to compounds for omeprazole, lansoprazole and common TPN ingredients) will no longer require a Prior Authorization (PA). Any ingredient utilized outside of the select ingredients will still require a PA. Please review your final claim submission to determine if any ingredients still require PA. Other non-rebateable and non-covered OTC ingredients continue to be not covered in all compounds.

Compounded products are covered for members less than 21 years of age when the physician documents that the drug is medically necessary. Common TPN ingredients may be covered for patients over the age of 21. All compounded prescriptions are non-preferred products.

To be considered for reimbursement, each component of the compound must:

- Have a valid and published NDC
- Be a covered benefit
- Be a drug that is manufactured by a company who has a signed rebate agreement for that drug with the Centers for Medicare and Medicaid Services (CMS)

Compounded Prescription Billing

Compounded prescriptions must be submitted electronically using the following guidelines:

- At least one of the components in the compound must be a federal legend drug
- NCPDP Partial Fill functionality is not allowed

Compounded Prescription Prior Approval

- Effective July 17, 2017, compound requests for select compounded ingredients (**in addition** to compounds for omeprazole, lansoprazole and common TPN ingredients) will no longer require a Prior Authorization (PA). Any ingredient utilized outside of the select ingredients will still require a PA. Please review your final claim submission to determine if any ingredients still require PA. Other non-rebateable and non-covered OTC ingredients continue to be not covered in all compounds.
- The prescriber is required to submit a request for Prior Approval using the "Georgia Medicaid Fee-for-Service Multi-Ingredient Compound Drug Prior Authorization

Form" via fax to OptumRx at 888-491-9742.
- The compound PA request form requires the prescriber to justify the absence of commercially available products containing the same or similar ingredients to achieve the same therapeutic outcome.

Reimbursement

- Ingredient line item reimbursement will be paid using the methodology detailed in Section 1001.

Submission Clarification Code

- If one or more ingredients submitted in the compound is not covered, the claim will reject. Normal drug coverage edit 7Ø (NDC not covered) will be applied to each line item submitted within the compound, but quantity level limit rules (QLL) will be ignored.
- The provider may decide to accept payment excluding the non-covered ingredient(s). In the Submission Clarification Code (42Ø-DK) field, a value "Ø8" is resubmitted on a rejected compound prescription when the provider decides to accept payment for all other ingredients, except those not covered by the plan.
- A Submission Clarification Code value of "Ø8" will allow a claim to continue processing if at least one ingredient is covered

This billing reference has been created for use in conjunction with the *NCPDP Telecommunication Standard Implementation Guide Version D.Ø*. It should not be considered a replacement for the *NCPDP Telecommunication Standard Version D.Ø Implementation Guide*, but rather used as an additional source of information.

Compound Claim Submissions

- Must submit a minimum of 2 ingredients – single-line compounds are not accepted.
  - The Department does not consider simple admixtures e.g., Vancomycin and Normal Saline a compounded prescription, and they should not be billed using this process.
- A maximum of 25 ingredients are allowed per compound prescription

When submitting a compound claim, use the following Claim and Pricing Segment fields:

Field	Field Name	Description
4Ø6-D6	Compound Code	Submit compound claims using value '2' in this field.
4Ø7-D7	Product/Service ID	Defaults to zero. Enter as "Ø" on the claim segment to identify the claim as a multi-ingredient compound.
436-E1	Product/Service ID Qualifier	Defaults to "ØØ". The Product/Service ID must contain a value of "Ø" and Product/Service ID

		Qualifier must contain a value of "ØØ" when used for multi-ingredient compounds.
442-E7	Quantity Dispensed	Enter the quantity of the entire multi-ingredient product.
354-NX	Submission Clarification Code Count	Required if Submission Clarification Code (42Ø-DK) is used.
42Ø-DK	Submission Clarification Code	A value of "Ø8" will allow a claim to continue processing if at least one ingredient is covered.
995-E2	Route of Administration	When used in multiple ingredient processing, this field contains the route of administration of the complete compound mixture.
4Ø9-D9	Ingredient Cost Submitted	Sum of all individual ingredient costs.

The Compound Segment must be submitted on all compound claims which includes the following fields:

Field	Field Name	Description
45Ø-EF	Compound Dosage Form Description Code	The dosage form of the complete compound mixture.
451-EG	Compound Dispensing Unit Form Indicator	The total compound metric decimal quantity expressed as Each, Grams, or Milliliters. Describes the units' form of the entire compound, such as 1Ø each, 3Ø grams, or 1ØØØ milliliters.
447-EC	Compound Ingredient Component Count	A count of each ingredient (both active and inactive) in the compound mixture submitted. The Compound Ingredient Counter Number is incremented for each ingredient submitted.
488-RE	Compound Product ID Qualifier	Code qualifying the type of product dispensed. Qualifies 'Compound Product ID' (489-TE).
489-TE	Compound Product ID	Product identification of an ingredient used in a compound. Qualified by 'Compound Product ID Qualifier' (488-RE).
448-ED	Compound Ingredient Quantity	The quantity in metric decimal format of the product included in the compound mixture.
449-EE	Compound Ingredient Drug Cost	The ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in field 448-ED.
49Ø-UE	Compound Ingredient Basis of Cost Determination	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.

Compound Transaction Claim Example

Tetracycline 5ØØmg cap, Nystatin 1ØØØØØu/ml Susp, Diphenhydramine 5Ømg

cap

Field	Field Name	Value	Comments
1Ø1-A1	BIN Number	ØØ1553	
1Ø2-A2	Version/Release Number	DØ	DØ Transaction Format
1Ø3-A3	Transaction Code	B1	Rx Billing
1Ø4-A4	Processor Control Number	GAM	
1Ø9-A9	Transaction Count	1	One occurrence
2Ø2-B2	Service Provider ID Qualifier	Ø1	National Provider ID (NPI)
2Ø1-B1	Service Provider ID	123456789	
4Ø1-D1	Date of Service	2Ø12Ø2Ø1	February 1, 2Ø12
11Ø-AK	Software Vendor/Certification ID	ØØØØØØØØØØ	Use value for Switch's requirements. If submitting claim without a Switch, populate with blanks.
111-AM – Segment Identification – Ø1 – Patient Segment			
3Ø4-C4	Date of Birth	1997Ø92Ø	September 2Ø, 1997
111-AM – Segment Identification – Ø4 – Insurance Segment			
3Ø2-C2	Cardholder ID	123456789Ø12	Enter member's 12-digit ID from Medicaid ID card
111-AM – Segment Identification – Ø7 – Claim Segment			
455-EM	Rx/Service Reference Number Qualifier	1	Rx Billing
4Ø2-D2	Rx/Service Reference Number	123456789102	12-digit Rx number
436-E1	Product/Service ID Qualifier	Ø3	NDC
4Ø7-D7	Product/Service ID	ØØØØØØØØØØ	Ø Default NDC for Compounds
442-E7	Quantity Dispensed	12ØØØØ	12Ø.ØØØml
4Ø3-D3	Fill Number	1	First dispensing for Rx
4Ø5-D5	Days' Supply	3	3-Day Supply
4Ø6-D6	Compound Code	2	Compounded Rx
4Ø8-D8	DAW/Product Selection Code	Ø	Substitution allowed
414-DE	Date Prescription Written	2Ø12Ø2Ø1	February 1, 2Ø12
354-NX	Submission Clarification Code Count	1	Required if Submission Clarification Code (42Ø-DK) is used.
42Ø-DK	Submission Clarification Code	Ø8	Process covered ingredients

Field	Field Name	Value	Comments
995-E2	Route of Administration	11	Oral
111-AM – Segment Identification – 1Ø – Compound Segment			
45Ø-EF	Compound Dosage Form Description Code	11	Solution
451-EG	Compound Dispensing Unit Form Indicator	3	Milliliters
447-EC	Compound Ingredient Component Count	Ø3	3 Ingredients
488-RE	Compound Product ID Qualifier	Ø3	NDC
489-TE	Compound Product ID	ØØ591223Ø1	Tetracycline Capsule 5ØØmg
448-ED	Compound Ingredient Quantity	12.ØØ	12 capsules
449-EE	Compound Ingredient Drug Cost	$1.2Ø	
49Ø-UE	Compound Ingredient Basis of Cost Determination	Ø1	AWP
488-RE	Compound Product ID Qualifier	Ø3	NDC
489-TE	Compound Product ID	ØØ6Ø3148158	Nystatin 1ØØØØØunit/ml Susp
448-ED	Compound Ingredient Quantity	12Ø.ØØØ	12Ø.ØØØml
449-EE	Compound Ingredient Drug Cost	$8.4Ø	
49Ø-UE	Compound Ingredient Basis of Cost Determination	Ø1	AWP
488-RE	Compound Product ID Qualifier	Ø3	NDC
489-TE	Compound Product ID	ØØ9042Ø5661	Diphenhydramine 5Ømg cap
448-ED	Compound Ingredient Quantity	24.ØØ	24 capsules
449-EE	Compound Ingredient Drug Cost	$4.6Ø	
49Ø-UE	Compound Ingredient Basis of Cost Determination	Ø2	Local Wholesaler
111-AM – Segment Identification – 11 – Pricing Segment			
4Ø9-D9	Ingredient Cost	$14.2Ø	Sum of all individual ingredient

Field	Field Name	Value	Comments
	Submitted		costs
426-DQ	Usual and Customary Charge	$28.ØØ	
43Ø-DU	Gross Amount Due	$18.83	

TPN Billing

- When billing a TPN, the quantity of any component billed must be consistent with the actual quantity used unless the component is drawn from a single dose container.
- In the event the component utilized is drawn from a single dose container, the package size must be consistent with the smallest commercially available package size from which the dose can be obtained. However, if doses are withdrawn from a single dose container by a closed-system compounding device, the quantity billed should be reflective of the actual quantity utilized or justification for full package size billing must be noted on the prescription.
- All other policy requirements for the billing of compound claims also applies.

IMPORTANT NOTICE
PARTIAL FILL

Effective 10/16/2003, DCH began supporting Partial Fill transactions on point-of-sale claims.

What is a Partial Fill Claim?

Partial Fill claims occur when a pharmacy attempts to fill a script and determines that there is not enough of the drug in stock to provide the entire prescribed quantity/days' supply. The Partial Fill functionality accommodates the need to fill a prescription partially on one day and complete the dispensing on a different date.

What unique fields are used in a Partial Fill transaction?

OptumRx will accept a Partial Fill transaction from a pharmacy using NCPDP vDØ to process claims for Medicaid and PeachCare for Kids. The unique fields used in a Transaction Code B1, Billing, Partial Fill transaction:

Partial Fill Field Name	Field Description
Dispensing Status 343-HD	The code in this field indicates that the quantity dispensed is an initial partial fill **"P"** or the completion of a partial fill **"C"**.
Associated Prescription/Service Date 456-EP	Date of the initial transaction in a partial fill. Used when submitting the "completion" transaction.
Associated Prescription Service/Reference Number 456-EN	The prescription or service reference number of the initial transaction in a partial fill. Used when submitting the "completion" transaction.
Quantity Intended to be Dispensed 344-HF	The metric decimal quantity that would have been dispensed if adequate inventory were available. This field is used only in association with a "P" or "C" in the Dispensing Status field. NOTE: If populating this field, an assumption is made that the "Days' Supply intended to be Dispensed" is also sent.
Days' Supply Intended to be Dispensed 345-HG	Days' supply for the metric decimal quantity that would have been dispensed if adequate inventory was available. This field is used only in association with a "P" or "C" in the Dispensing Status field.

How will OptumRx edit a Partial Fill transaction?

If you decide to use the Partial Fill transaction, the following information describes how OptumRx will edit that transaction:

1) The Intended field information will be edited in order to notify the pharmacy when

the intended days' supply or quantity would cause the claim to reject if the claim had been submitted as a full claim

2) The Actual Days' Supply and Quantity will be edited according to the member's benefit
3) The Completed Claim will be edited based on balancing exactly to the Intended Days' Supply, Quantity, and NDC of the Partial Claim. If these fields do not balance or the NDC does not match, the claim will reject
4) The Completed Claim will be edited against the files that existed during the partial fill date of service (e.g. the member was eligible during the partial fill date filled, the member is still eligible). The exception would be if a member is retro-termed, if the retro-term date encompasses the Partial Fill Claim date of service, the claim will reject
5) The Partial and Completed Claim will be counted as one filled script
6) The Refill Too Soon and Quantity Level Limit edits will apply to the Partial and Completed Claim since a full claim could be filled between these two transactions
7) Ample supply editing will be based on the fill date of the Partial Claim
8) A Completed Claim does not need to be submitted in order to fill a subsequent full claim

How will the claim be priced, and the member co-pay determined?

1) The claim will be priced, and a co-pay assigned based on the Intended Days' Supply and Quantity
2) The claim will be priced based on the final cost calculation of the Intended Quantity
3) The Partial and Completed Claim will be prorated based on the Actual Days' Supply and Quantity dispensed on each claim
4) The member will pay a prorated co-pay based on the actual quantity dispensed
5) The pharmacy will receive a prorated dispensing fee based on the actual quantity dispensed for both the partial and completed claim. This was necessary in order to accurately balance the payable amount to the pharmacy and the member co-pay between the two claims

Questions:
OptumRx 1-866-525-5826

PHARMACY PROVIDER AGREEMENT INFORMATION

For Pharmacy Provider Agreement requests, contact Gainwell Technologies Provider Relations Dept:

Gainwell Technologies

Provider Services Contact Center

PO Box 105200
Tucker, GA 30085-5200
1-800-766-4456 or 770-325-9600

Pharmacy Additions/Deletions or Address Changes

Gainwell Technologies must be notified, in writing, when a chain or independent requests to add, change, or delete a Pharmacy in the GA Medicaid Network. Only claims from enrolled Pharmacies will be accepted.

Mail to:

Gainwell Technologies
P O Box 105200
Tucker, Georgia 30085-5200

PHARMACY AUDIT INFORMATION

OptumRx maintains an ongoing Pharmacy audit program as a service to our plan Sponsors as well as to assist network Pharmacies in complying with the terms of their Pharmacy Provider Agreement.

For up to five years from the date a prescription is dispensed to a Georgia Medicaid Member, the Pharmacy must permit OptumRx or a third party authorized by OptumRx to inspect, review, audit, and reproduce, during regular business hours and without charge, any business, financial, and prescription record maintained by the Pharmacy pertaining to the member or the Pharmacy Provider Agreement. The Pharmacy must cooperate and participate with OptumRx in all quality assurance procedures, peer review, credentialing processes, audit systems, and any complaint resolution procedures established by OptumRx.

DCH AUDIT TIPS

DCH does not seek recovery on any prescription whose days supplied is consistent with the quantity prescribed and/or the quantity remaining on the prescription including all valid refills as long as such days' supply does not exceed (30) days and provided through the most appropriate package size. Please review Section 104.2 of Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual. Bulk packages such as but not limited to inhalers, ophthalmics, otics, kits, etc. who due to their packaging cannot be divided or dispensed in an exact quantity to fulfill the prescribed days' supply, should be handled as follows:

- If the quantity dispensed is sufficient for less than a (30) day supply, the days supplied on the claim should be consistent with the quantity dispensed and the directions on the prescription +/- 25% of the days such quantity should last.
- If the quantity dispensed provides greater than a (30)-day supply given the directions on the prescription and the most appropriate commercially available package size, the days' supply on the claim should be not less that (30) days.
- In each case, DCH will continue to monitor utilization for patterns that may be considered as fraudulent or inappropriate.
- In each case, DCH will monitor to assure the pharmacy dispenses the product in the commercially available package size that is closest to the quantity needed for the directions on the prescription.

AUDIT TRIGGERS

The OptumRx audit program is supported by continuous in-house analysis of statistical dispensing triggers. These triggers include, but are not limited to:

- Generic, Multi-Source Brand, and Single Source Brand fill rates
- Generic substitution
- Dispense As Written (DAW) code usage
- Average claim amount
- Quantity dispensed versus days' supply and FDA guidelines
- Days' supply versus quantity dispensed and FDA guidelines
- Usual and Customary retail prices
- Reversals
- Compounding
- Formulary Compliance
- Prescriber Profiling

Other non-statistical audit triggers include, but are not limited to:

- Referral from plan Members
- Referral from plan Sponsors
- Random selection

AUDIT PROGRAMS

NorthStar HealthCare Consulting, (NHC), the sub-contractor for OptumRx, utilizes the following types of audit programs. This list is not intended to be all-inclusive:

- Onsite Audits: The NHC auditor visits the Pharmacy to perform a comprehensive review of claim and quality assurance documentation, procedures, and credentialing.

- Written Desk Audits: Targeted documentation is requested from the Pharmacy and reviewed with in-house Pharmacy dispensing information.

- Next Day Online Desk Audits: Online claims from the previous day are automatically flagged utilizing predetermined criteria and subjected to audit procedures.

- Physician Audits: Targeted Pharmacies, Members and claims are comprehensively verified by the prescribing physician.

- Member Audits: Prescription receipt and specific claim information are substantiated through Member contacts.

On-site audits are normally scheduled with two weeks' notice. However, under certain circumstances, less or no advance notice may be given.

If any claim was paid based on incorrectly submitted data, OptumRx will disallow reimbursement for that claim.

AUDIT GUIDELINES

- Quantities Dispensed: Always submit the quantity prescribed and submit the exact calculation of days' supply per the Prescriber's dosing instructions. "As directed" or "PRN" Prescriber directions must be clarified with Prescriber or Member. Verifying pharmacist must document and initial the information on the prescription.

- Dispense As Written Codes: Submission of DAW 1 code must be supported by hard copy prescription documentation on the original prescription, the telephone order, or prescription update, and is subject to local regulations. OptumRx will disallow reimbursement for any claim submitted with missing or incorrect DAW Codes.

- Signature Logs: All prescription claims paid by OptumRx are subject to signature log verification. Claims not properly supported by documentation verifying receipt of the medication will be reversed on audit (see example signature log).

- Compliance with Audit Procedures: Failure to comply with any OptumRx quality assurance or audit process will result in reversal of all applicable paid claims and may result in termination of the Pharmacy Provider Agreement.

- Audit Response: Pharmacies are given the opportunity to respond to audit findings within 30 days from receipt of the final audit report. OptumRx at its sole discretion, may consider certain follow-up documentation. Findings regarding missing or incorrect Dispense as Written Codes, days' supply or quantity, and Usual and Customary Retail Pricing are not subject to response.

- Only the following will be accepted as documentation to correct audit discrepancies, if applicable for "clerical error" corrections:

    - Submitting the claim under the incorrect physician
        - Non-correctable; the prescription was misfiled
    - Missing date on original or phoned-in prescription
        - Re-written prescription from physician
    - Unsigned Physician's order
        - Re-written prescription from physician
    - On phoned-in prescription that are missing the name of the agent calling it in and/or the hand-written initials of the RPh who took the call
        - Re-written prescription from physician
    - Incomplete signature log; meaning if any of the policy required information is missing
        - Signed patient attestation

- Eye Drops: Georgia Medicaid uses the conversion standard of (16 drops/ml) for the purpose of dose calculations.

PROVIDER RELATIONS AUDIT &COMPLIANCE POST AUDIT DISPUTE FORM

PHARMACY NABP #: _____

DATE OF AUDIT: _____

Prescription #(s) Audited _____

_____

_____

_____

OptumRx maintains an ongoing pharmacy compliance and review program. OptumRx is committed to working with you to continuously increase the overall quality of our Provider Networks. You have been the subject of a recent quality assurance audit. If you do not agree with results of the audit, we want you to have the opportunity to present additional information you feel may be relevant to the audit results. Please complete this form, providing your reasoning below for disputing the audit findings, and attach any documentation supporting your stance. Please be sure to include a photocopy of the original prescription(s) hard copy. Please fax this documentation to our secure Audit e-fax server at # 1-877-295-0836, NorthStar LLC, Attach additional sheets if necessary.

SIGNATURE LOG REQUIREMENTS

Each Pharmacy must maintain a signature log for all claims in chronological order as prescriptions are received by the Member, including off-site delivery, with the following information:

RETAIL SAMPLE

Name of Patient	Fill Date	Rx Number	Signature of Member (or Legal Representative)	Date Rx is picked up
John Doe	1/2/97	123456	J. Doe	1/3/97

The signature log must be kept for five years from the date a prescription is dispensed.

LONG TERM CARE FACILITIES

When picked up at the LTC facility:

- Patient Name
- Prescription number(s)
- Date(s) of Service
- Member or member's legal representative's signature or representative of the facility
- Date picked up
- Documentation of administration through a medication administration record or other method is required for members who do not self-administer their medications.

When delivered to a facility:

- Patient Name
- Prescription number(s)
- Date(s) of Service
- Facility delivered to
- Date of delivery
- Name of person who received delivery
- Documentation of administration through a medication administration record or other method is required for members who do not self-administer their medications.

Medication Delivery Report
Sample

Facility:_____ Date Received:_____
Nursing Station:_____

Patient Name	RX Number	Date Filled

Received By:_____

GRIEVANCE REQUEST FORM

Pharmacy _____
NCPDP_____
Audit Number _____

In order to file a grievance, the following must be submitted: a copy of the prescription in question; all other supporting documentation that you would like for the committee to review, and an explanation of the rationale for the dispute. Upon review of the documentation, the committee will provide notification of their decision via mail.

Please provide the rationale in the section below, with as much **detail** as possible. Please print clearly (if you need additional space please feel free to provide extra pages). If you prefer, you may attach a typed written report.

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Upon completion of the form, please fax all documentation to (678) 672-4196.
If you have any additional questions, please feel free to contact NHC at (678) 672-4206.

Thank you for your cooperation,

Program Compliance Director
NorthStar HealthCare Consulting

COORDINATION OF BENEFITS (COB) BILLING

Effective 6/1/01, Georgia Department of Community Health (GDCH) implemented Coordination of Benefits (COB). In order to implement COB, an online environment was created which allows pharmacy providers to submit claims through the NCPDP v D.Ø compliant Point of Sale (POS) processing system.

In those cases where members have private insurance coverage, the provider must attempt to exhaust all third-party benefits prior to submitting a claim to the Department of Community Health. Claims with private insurance must be submitted to Medicaid within twelve (12) months from the date of service. The POS processing system will reject claims when the recipient has primary coverage with another insurance carrier and Medicaid as secondary coverage.

Online Processing Steps

If the recipient has primary coverage other than Medicaid, you will receive **Rejection 41 "Submit Bill to Other Processor or Primary"** with the following messages:

> Free Form Text Message:
> OC: "Primary Carrier Group #", "Primary Name", Telephone: XXX-XXX-XXXX
>
> *Example: OC: APFG, Principal Financial Group, 800-888-8888*
>
> Additional Message:
> Questions regarding primary coverage call Gainwell Technologies: 800-766-4456, in Atlanta area 770-325-9600.

Bill the claim to the appropriate primary carrier and then online to GDCH using the following Other Coverage Codes for processing.

Other Coverage Codes:

Value	NCPDP Definition	Practical Use	Medicaid Payment Type
Ø	Not specified by patient	Primary Claim	Primary
1	No other coverage	Primary Claim	Primary
2	Other coverage exists/billed-payment collected	Secondary claim submitted to Medicaid as payment was received from primary payer	Secondary
3	Other Coverage Billed – claim not covered	Primary claim rejected for plan benefit coverage reasons	Primary
4	Other coverage exists-payment not collected	Primary Paid Amount = $0– member Co-pay reflects 100% of Primary Allowed Amount.	Primary

8	Claim is billing for patient financial responsibility only	Primary claims' copay charged	Secondary

Tertiary Claims

If multiple primary carriers exist, you will receive Rejection 41 with the following messages:

Free Form Text Message:
"Multi-Rx Plans-Ask PT for all Rx Cards"

Additional Message:
Questions regarding primary coverage call Gainwell Technologies: 800-766-4456, in Atlanta area 770-325-9600.

If your system does not allow for tertiary claims processing, you may bill GDCH on paper and attach a copy of each EOB or pharmacy screen print/profile reflecting payment or denial.

Common online rejections you will see:

Rejection Code	NCPDP Definition
DV	Missing/invalid other payer amount paid
13	Missing/invalid other coverage code
41	Submit bill to other processor or primary payer

Paper Processing Steps:

Paper processing is allowed if your pharmacy system does not allow for online processing of Medicaid secondary or tertiary claims.

If the carrier returns payment for the claim, the pharmacy provider must include EOB from primary carrier or a pharmacy screen print/profile with primary carrier detail that should include: the primary amount billed, primary amount paid, and recipient amount paid (co-pay/deductible), and remaining amount due that is being been billed to GDCH.

If the other carrier denied the claim, attach the denial statement from the other insurance carrier to your claim form for processing.

If no response is received from the insurance carrier, attach the Coordination of Benefits Confirmation Statement to the back of your claim for payment.

Old UCF Fields:

UCF Field	Instructions
Ingredient Cost	Submit lower of MFN or U&C (exclusive of DF)
Dispensing Fee	Submit MFN rate
Tax	Leave blank
Total price	Total of IC, DF, and Tax (above fields)
DED Amount	Submit Other Payer Co-pay Amount with OCC 2
Balance	Submit Net Amount Due from Other Payer "Other Payer Amount"
Other Third Party Coverage	Check no if applicable, if yes, write in the appropriate Other Coverage Code (1-8) rather than check the box.

New UCF Fields:

Non-COB Transaction	
UCF Field	**Instructions**
Ingredient Cost	Same as online claim amount (exclusive of DF)
Dispensing Fee	Leave blank
Incentive Amount	Leave blank
Other Amount Submitted	Leave blank
Tax	Leave blank
Gross Amount Due	Ingredient Cost Submitted + Dispensing Fee Submitted
Patient Paid Amount	Leave blank
Other Payer Amount Paid	Leave blank
Net Amount Due	Leave blank
Other Coverage Code	Other Coverage Code of Ø or 1 as this is a non-COB transaction

New UCF Fields:

COB Transaction – Primary Insurance Paid a Portion of the Claim	
UCF Field	**Instructions**
Ingredient Cost	Same as online claim amount (exclusive of DF)
Dispensing Fee	Leave blank
Incentive Amount	Leave blank
Other Amount Submitted	Leave blank
Tax	Leave blank
Gross Amount Due	Ingredient Cost Submitted + Dispensing Fee Submitted
Patient Paid Amount	Leave blank
Other Payer Amount Paid	"Total Amount Paid" from previous payer
Net Amount Due	"Gross Amount Due" – "Other Payer Amount Paid"

Other Coverage Code	Other Coverage Code of 2 – Other coverage exists/billed-payment collected

New UCF Fields:

COB Transaction – Co-Pay Only Billing	
UCF Field	**Instructions**
Ingredient Cost	Same as online claim amount (exclusive of DF)
Dispensing Fee	Leave blank
Incentive Amount	Leave blank
Other Amount Submitted	Leave blank
Tax	Leave blank
Gross Amount Due	Ingredient Cost Submitted + Dispensing Fee Submitted
Patient Paid Amount	Leave blank
Other Payer Amount Paid	Leave blank
Other Payer-Patient Responsibility Amount	"Patient Pay Amount" from previous payer
Net Amount Due	"Gross Amount Due" – "Other Payer-Patient Responsibility Amount"
Other Coverage Code	Other Coverage Code of 8 – Claim is billing for patient financial responsibility only

Please mail paper claims to:
GME Paper Claims –OptumRx
Attn: Pharmacy Claims Rte# GME-01
PO Box 29044
Hot Springs, AR 71903

COB Billing Tips

Review the Medical Assistance Eligibility Certification for third party carrier information each time service is requested.

Always bill third-party insurance carriers first. Use the information provided online, prior to billing Medicaid. If the member denies having Primary coverage, the member or pharmacy should contact Gainwell Technologies to correct any incorrect information returned in the online message. The pharmacy provider may bill the claim online to OptumRx once the primary carrier information has been updated.

If Gainwell Technologies is not able to correct the primary carrier information within (3) business days, then the pharmacy provider may process the claim using the appropriate Other Coverage Code.

All Pharmacy providers must maintain all records and proof that Medicaid was the payor of last resort. Any claims unable to be validated may be reversed upon audit.

All documentation should be retained for a period of no less than five years for compliance review purposes

The recipient name and third-party payments on the EOB should match what is entered on the claim. If dollar amounts do not match, use the COB Confirmation Statement to give a detailed explanation of third-party payment.

Do not use a highlighter on claim forms or other documents. All claims are microfilmed, and highlighted areas are darkened and illegible when claim copies are retrieved for review.

Write "**COB**" in bold letters on the attachments.
Enter *only* third-party payments in the "Balance" or "Other Payer Amount Paid" block of the claim form.

Bill **Medicare** first for diabetic supplies and any drug products covered by Medicare.

Medicare crossover claims are transmitted to DCH directly from the COBC. Pharmacies who bill Georgia Medicaid for Medicare Part-B Rx drugs must submit claims via X12 837 Professional format or paper. Presently, Georgia Medicaid does not support the NCPDP Version D.0 Batch format for **Crossover Claims**. To submit claims via the X12 837P format, providers must contact Gainwell Technologies-EDI at 877-261-8785.

All paper claims and/or correspondence should be submitted to Gainwell Technologies at the following address:

Gainwell Technologies
P.O. Box 105200
Tucker, GA 30085-5200

Bill only one calendar month of service per claim. Span billing over one calendar month will result in a denied claim.

Please note: If the COBC receives a Medicare Part B pharmacy claim in the NCPDP D.0 format for Georgia Medicaid, they must send it out in the NCPDP D.0 format. Since Georgia Medicaid does not support this format, the claim will not crossover and we will not receive it.

COMMON COORDINATION OF BENEFITS (COB) QUESTIONS

1) When do I file a claim with a third-party insurer for a Medicaid recipient?

A claim must be filed when there is information indicating that the recipient has other 3rd party coverage. The enrolled provider must make reasonable efforts to collect funds from third parties. Reasonable efforts include, but are not limited to:

- Requesting the third-party ID card from the recipient or asking them to identify any third-party benefits.
- Filing claim(s) online or via UCF with the appropriate third parties prior to filing with Medicaid.

If all online billing methods have failed, the pharmacy provider must submit claims via UCF that include an EOB from primary carrier or a pharmacy screen print/profile with primary carrier details including primary amount billed, primary amount paid, and recipient amount paid (co-pay/deductible).

2) When we receive payment, how do I bill Medicaid?

Submit the claim online using Other Coverage Code 2 and indicate the Net Amount Due from the Other Carrier in the Other Payer Amount field or submit the claim via UCF using the before mentioned procedure.

3) If I receive no third-party payment, how do I bill Medicaid?

Submit the claim online using the appropriate Other Coverage Code (3 and 4) or submit the claim via UCF using the previously mentioned procedure.

4) How long do I have to file my third-party claim to Medicaid?

When eligible members have other insurance coverage, you have up to one (1) year from the date of service to send your claim to OptumRx for payment.

5) How should we bill compounds?

Bill Compounds online for primary and secondary processing. If the primary carrier is not online, the provider must bill the primary carrier via paper first and then bill Medicaid online or via paper. Compounds are not covered for persons over the age of 21 for the Georgia Medicaid Pharmacy Program. Compounds may be covered for members <21 years old and require prior approval. Common TPN ingredients may be covered for patients over the age of 21. Refer to the Policy Manual for more information regarding the Compound Policy.

6) What if the primary carrier is not online?

If the primary carrier is not online, the provider must bill the primary carrier via paper first and then bill Medicaid online or via paper once the primary payer's response is received.

7) What if the pharmacy provider is not in the network for the primary carrier?

If the provider does not participate in the patient's managed care plan, the provider should direct the recipient to a participating pharmacy.

8) What if my payment from the other carrier meets or exceeds the Medicaid payable amount?

The online claim will be returned payable with all dollar fields filled with zeros to indicate no payment returned with the message "Other Carrier Payment Meets or Exceeds Payable".

9) What if recipient states they no longer have the other coverage that is listed in the online message?

Bill the other coverage first, using the information provided online, prior to billing Medicaid. If the recipient denies having Primary coverage the recipient or pharmacy should contact Gainwell Technologies (1-800-766-4456 or 770-325-9600) to correct any incorrect information returned in the online message. The pharmacy provider may bill the claim online to OptumRx once the primary carrier information has been updated.

If Gainwell Technologies is not able to correct the primary carrier information, please escalate your inquiry to the OptumRx Technical Call Center at 1-866-525-5826. If the claim rejects from the primary carrier listed in the online message due to the recipient not being eligible, the pharmacy provider may contact Gainwell Technologies (1-800-766-4456 or 770-325-9600) or escalate the inquiry to the OptumRx Technical Call Center at 1-866-525-5826.

10) What if the pharmacy submits a claim to the primary carrier and it pays, but when it is submitted to Medicaid, they receive drug not covered rejection or prior authorization required rejection?

If the claim rejects from Georgia Medicaid for "Drug Not Covered," Georgia Medicaid will not approve the claim and the pharmacy provider should collect the applicable co-pay.

Prior Authorization may be obtained by calling OptumRx. Prior Authorization will be considered pursuant to the policy requirements. If Prior Authorization is denied under Georgia Medicaid policy requirement, the pharmacy provider should collect the applicable co-pay.

11) What if the primary payer allows a 60-day supply but Medicaid only allows a 30-day supply?

The claim will reject for NCPDP Reject 76 - Plan Limitations Exceeded. The secondary message will state the Max Day Supply that is allowed by Georgia Medicaid is 30. If the member has active Deeming Waiver, NOW, COMP or SSI-Disabled Aid category and primary insurance that covers a 90-day supply, an override may be obtained by contacting the PBM call center to exceed the maximum day supply of 30.

12) Primary carrier is mail order only, does the provider still bill Primary carrier first?

The present system will not specifically identify a pharmacy plan as “mail order only.” Provider must bill the identified carrier and if claim is denied for that reason, bill Medicaid using OCC3. GDCH will review and verify claims submitted with OCC3 for the denial reasons and if plan is determined to be “Mail order only,” will apply the “pay and chase” methodology as necessary.

13) Will providers be allowed a 2nd dispensing fee on COB claims for the same drug filled previously in the same month?

The policy will remain as is.

14) If the provider receives “claim too old” from the Primary carrier, can the provider bill Medicaid as primary?

No.

Use Case	1	Title	**Flat Copay, Brand Drug, No MAC**

Field Name	**Value**
Primary Carrier Pricing	
AWP	**$ 100**
U&C	**$ 98**
Submitted	**$ 100**
Primary Allowed/Contracted	**$ 91 (89 + 2)**
Primary Copay	**$ 15**
Primary Net Amt Due	**$ 76**
OptumRx Secondary Pricing	
U&C	**$ 98**
Submitted	**$ 100**
Gross Amount Due	**$ 91**
Medicaid State Rate Maximum	**$ 91 (89 + 2)**
Medicaid Copay	**$ 0.50**
Other Coverage Code	**2**
Medicaid Allowed	**$ 91**
Other Payer Amount	**$ 76**
OptumRx Compute	
Ingr. Cost	**$ 15 (91 – 76)**
Dispensing Fee	**$0**
Tax	**$0**
Copay	**$0.50**
OptumRx Total Amt Due	**$14.50 (15 - .50)**
Basis of Reimbursement	**09**
Notes	

Use Case	2	Title	**Flat Copay, Brand Drug, No MAC**

Field Name	**Value**
Primary Carrier Pricing	
AWP	**$ 100**
U&C	**$ 98**
Submitted	**$ 100**
Primary Response	**REJECTED**
OptumRx Secondary Pricing	
U&C	**$ 98**
Submitted	**$ 100**
Gross Amount Due	**$ 88**
Medicaid State Rate Maximum	**$ 93.63 (89 + 4.63)**
Medicaid Copay	**$ 0.50**
Other Coverage Code	**1 or 3**
Medicaid Allowed	**$ 88**
Other Payer Amount	**$ 0**
OptumRx Compute	
Ingr. Cost	**$ 88**
Dispensing Fee	**$0**
Tax	**$0**
Copay	**$0.50**
OptumRx Total Amt Due	**$87.50**
Basis of Reimbursement	**09**
Notes	

Use Case	3	Title	**Flat Copay, MAC Drug**

Field Name	**Value**
Primary Carrier Pricing	
AWP	**$ 100**
U&C	**$ 98**
Submitted	**$ 100**
Primary Allowed/Contracted	**$ 91 (89 + 2)**
Primary Copay	**$ 15**
Primary Net Amt Due	**$ 76**
OptumRx Secondary Pricing	
U&C	**$ 98**
Submitted	**$ 100**
Gross Amount Due	**$ 91**
Medicaid State Rate Maximum	**$ 54.63 (50 + 4.63)**
Medicaid Copay	**$ 0.50**
Other Coverage Code	**2**
Medicaid Allowed	**$ 54.63 (MAC)**
Other Payer Amount	**$ 76**
OptumRx Compute	
Ingr. Cost	**$ 0**
Dispensing Fee	**$0**
Tax	**$0**
Copay	**$0**
OptumRx Total Amt Due	**$0**
Basis of Reimbursement	**09**
Payable Message	**Other Carrier Payment Meets or Exceeds Payable**
Notes	**Primary Paid Amount meets or exceeds the Medicaid Allowed so all cost fields will be returned with $0 payable and the payable message Other Carrier Payment Meets or Exceeds Payable.**

When reversing secondary claims:

- Please submit the Other Coverage Code (3Ø8-C8) value used on the original online COB claim submission when reversing secondary claims.

- Omission of the Other Coverage Code will cause the primary COB claim to be reversed. You must submit the applicable Other Coverage Code value if you desire to reverse the secondary COB claim. These OCC valid values are 1 through 8 as listed below.

- For your reference, please review NCPDP's Data Dictionary field guide regarding the Other Coverage Code values that OptumRx supports:

Field	Name of Field	Values and Definitions of Field Codes indicating whether or not the patient has other insurance coverage	Medicaid Payment Type
3Ø8-C8	Other Coverage Code	Ø = Not specified by patient	Primary
3Ø8-C8	Other Coverage Code	1 = No other coverage	Primary
3Ø8-C8	Other Coverage Code	2 = Other coverage exists/billed-payment collected	Secondary
3Ø8-C8	Other Coverage Code	3 = Other Coverage Billed – claim not covered	Primary
3Ø8-C8	Other Coverage Code	4 = Other coverage exists-payment not collected	Primary
3Ø8-C8	Other Coverage Code	8 = Claim is billing for patient financial responsibility only	Secondary

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

IMPORTANT NOTICE
ONLINE COORDINATION OF BENEFITS (COB)

Georgia Department of Community Health

- Effective immediately for providers submitting NCPDP Version D.0 claims, please submit the Other Coverage Code (3Ø8-C8) value used on the original online COB claim submission when reversing secondary claims.

- Omission of the Other Coverage Code will cause the primary COB claim to be reversed. You must submit the applicable Other Coverage Code value if you desire to reverse the secondary COB claim. These OCC valid values are 1 through 8 as listed below.

- For your reference, please review NCPDP's Data Dictionary field guide regarding the Other Coverage Code values that OptumRx supports:

Field	Name of Field	Values and Definitions of Field Codes indicating whether or not the patient has other insurance coverage	Medicaid Payment Type
3Ø8-C8	Other Coverage Code	Ø = Not specified by patient	Primary
3Ø8-C8	Other Coverage Code	1 = No other coverage	Primary
3Ø8-C8	Other Coverage Code	2 = Other coverage exists/billed-payment collected	Secondary
3Ø8-C8	Other Coverage Code	3 = Other Coverage Billed – claim not covered	Primary
3Ø8-C8	Other Coverage Code	4 = Other coverage exists-payment not collected	Primary
3Ø8-C8	Other Coverage Code	8 = Claim is billing for patient financial responsibility only	Secondary

Please remember this communication applies only to NCPDP Version D.0 claims.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

OPTUMRx

Proton Pump Inhibitor Prior Authorization Form
Fee-for-Service Medicaid/PeachCare for Kids
PHONE #: 866-525-5827
FAX #: 888-491-9742

Note: If the Following Information is NOT filled in completely, correctly, or legibly the PA process **can** be delayed. **(One form per member please)**

MEMBER Last Name	**MEMBER First Name**
MEMBER ID number	**MEMBER Date of Birth** -- --
PRESCRIBER Last Name	**PRESCRIBER First Name**
PRESCRIBER NPI#	
PRESCRIBER Phone	**PRESCRIBER Fax**
PRESCRIBER Address	

Medication Requested _____ **Strength** _____ _____

Directions _____ **Dosage Form**

_____

Duration of Therapy Requested _____ **Compound Y N** **G-tube Y N**

Diagnosis/Indication – Please do not include documentation that is not requested on this form.

Please circle which diagnosis/indication that applies to member:

- **a.** Barrett's Esophagus
- **b.** Peptic Ulcer Disease (PUD)/ Duodenal ulcer/ Gastric ulcer
- **c.** Erosive Esophagitis
- **d.** Gastroesophageal reflux disease (GERD) without complications
- **e.** GERD with complications- please specify:_____
- **f.** H. Pylori
- **g.** Zollinger Ellison (ZE) Syndrome
- **h.** Pancreatitis
- **i.** Cerebral Palsy
- **j.** Cancer
- **k.** Crohn's Disease
- **l.** Cystic Fibrosis
- **m.** Multiple endocrine adenomas
- **n.** Systemic mastocytosis
- **o.** Patient was recently discharged from the hospital (within the last 60 days) for an upper GI bleed, hemorrhage, perforation, or obstruction and was already started on PPI therapy in the hospital
- **p.** Gastric Bypass Surgery
- **q.** Premature infant with GERD and feeding difficulties

Please specify other diagnosis/complicated disease state:

H2 receptor antagonist use history:

Drug_____**Strength**_____**Directions** _____

Dates used: from_____ **to** _____**Failed due to:** _____

Drug_____**Strength**_____**Directions** _____

Dates used: from_____ **to** _____**Failed due to:** _____

Physician Signature: _____

Contact Person _____

OptumRx will provide a response within 1 business day upon receipt.

This facsimile transmission contains legally privileged and confidential information intended for the parties identified below. If you have received this transmission in error, please immediately notify us by telephone and return the original message to P.O. Box 3214; Lisle, IL 60532-8214. Distribution, reproduction, or any other use of this transmission by any party other than the intended recipient is strictly prohibited.

(Rev. 09/15)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

OPTUMRx

Prior Authorization
Claims Processing
Phone: 866-525-5827
Fax: 888-491-9742
P.O. Box 25183
Santa Ana, CA 92799

Non-Preferred Statin Request Form
Fee-for-Service Medicaid/PeachCare for Kids

FAX: 1-888-491-9742 TODAY'S DATE: _____
PHONE: 1-866-525-5827

Note: If the following information is NOT filled in completely, correctly, and/or legibly the appeal process **will** be delayed. **(One form per Member please)**

MEMEBER Last Name	**MEMBER First Name**
MEMBER ID number	**MEMBER Date of Birth** -- --
PRESCRIBER Last Name	**PRESCRIBER First Name**
PRESCRIBER NPI#	
PRESCRIBER Phone	**PRESCRIBER Fax**
PRESCRIBER Address	

Medication Requested: _____ Strength_____ Directions --

_____

A COPY OF THE MEMBER'S LIPID PANELS MUST BE INCLUDED WHEN SUBMITTING
(both Pre-Treatment LDL Value/Date and Current LDL Value/Date are required to complete the review)

Diagnoses	Yes	No	Unknown
Coronary Heart Disease (CHD)			
Diabetes Mellitus			
Carotid Artery Disease			
Peripheral Arterial Disease			
Abdominal Aortic Aneurysm			
Previous Coronary Event (Myocardial Infarction, Angina, Arrhythmia)			
Risk Factors	**Yes**	**No**	**Unknown**
Age: M >45yrs, F >55yrs			
Hypertension (≥130/≥85 mmHg or on HTN medication)			
HDL cholesterol: M <40 mg/dL, F <50 mg/dL			
Family history of premature CHD in first degree relative: M <55yrs, F <65yrs			
Cigarette smoking			

Metabolic Syndrome	Yes	No	Unknown			
Abdominal obesity (waist circumference: M >40in, F >35in)						
Triglycerides ≥150 mg/dL						
HDL: M <40 mg/dL, F <50 mg/d						
BP ≥130/≥85 mmHg						
Fasting glucose ≥110 mg/dL						

□ **Please check box if you are attaching page 2 with this request.**

Physician Signature (Required)_____

Member's Name: _____
*ID#:*_____*DOB:*_____

In the space below, please provide any further information certifying medical necessity for your patient to remain on current therapy.

_____
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_____

Physician Signature (Required):_____ **Date:**_____

*****EFFECTIVE JANUARY 1, 2006 ALL MEDICARE B DRUGS FOR MEDICARE B OR MEDICARE D ELIGIBLE MEMBERS MUST BE SUBMITTED TO EITHER MEDICARE, A MEDICARE PDP, OR A MEDICARE ADVANTAGE PLAN. CLAIMS SUBMITTED TO MEDICAID FOR A MEDICARE PART B DRUG OR SUPPLY WILL DENY FOR THESE MEMBERS. THE DENIAL CANNOT BE OVERRIDEN WITH AN 'OTHER COVERAGE CODE'*****

Tips for Medicare Billing:

Claims submitted to OptumRx for the drugs listed above will be denied for dually eligible members. You will receive the standard NCPDP error message **#41, "Submit Bill to Other Processor," followed by "Submit to Medicare."**

Bill Medicare electronically using Point of Sale software or by paper using the CMS 1500 available at **www.medicare.gov**. Complete billing codes and coverage criteria can be found at **www.palmettogba.com.** DCH encourages providers to access this site.

Once the Medicare claim has been processed, Medicare will automatically submit the balance of your claim as a "crossover" to Gainwell Technologies electronically. Gainwell Technologies will pay the coinsurance and/or deductible as allowed by Medicare. The provider should only collect the usual Medicaid copay where applicable.

You will receive a Medicare remittance notice from Medicare indicating one of the three following codes for your claim status:

- "A" code means that the claim was accepted for processing but either a payment or denial will be forthcoming.
- "R" code means that more information or additional paperwork is needed to complete processing of the claim.
- "D" code means that the claim was processed but denied.

Please see the attached flow chart on G-74 for further explanation of the crossover claim from Medicare to Medicaid.

To order copies of the CMS 1500 claim form, send your request in writing, including your provider number, the return address for the forms to be sent, and the quantity needed to Gainwell Technologies via fax at 866-483-1044 or via mail to:

Gainwell Technologies
P.O. Box 105200
Tucker, Georgia 30085-5200

For information on Medicare billing workshops, visit **www.palmettogba.com**. Click on provider, DME, Publication & Information, and then Advisory.

For the Palmetto GBA **Helpdesk,** call **1-866-238-9650**.

Directions on How to Obtain Medicare Enrollment Materials:

Via the Internet:

www.palmettogba.com/registration.nsf
Click on National Supplier Clearinghouse
Select option: publication & information
Select HCFA Form 855 DME POS

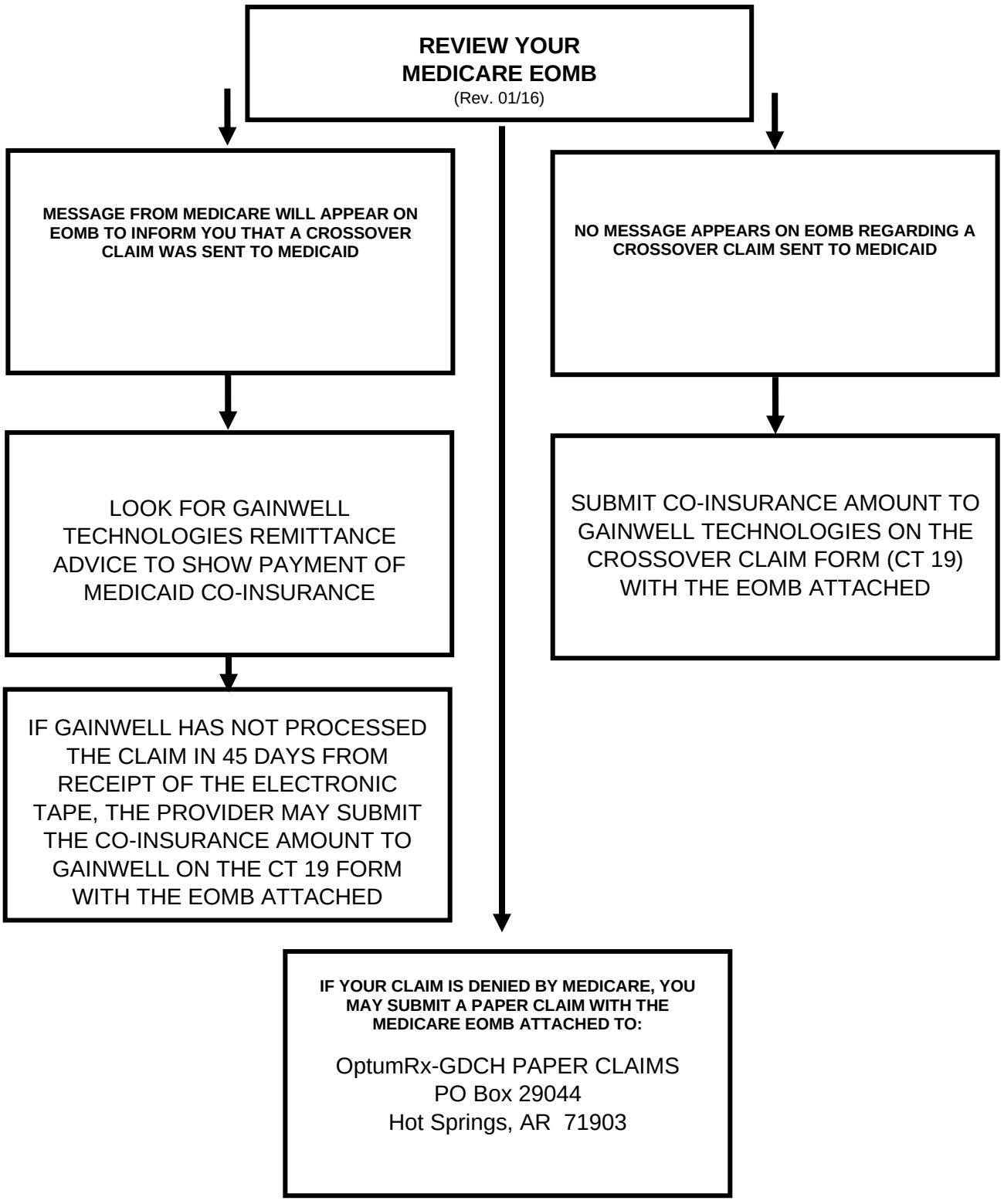
Via mail or phone:

National Supplier Clearinghouse
P.O. Box 100142
Provider Enrollment
Columbia, SC 29202-3142
1-866-238-9652, press “0”, ask for Medicare Part B Provider Application

Options for Obtaining Medicare Billing Software Include:

1. Contact your software vendor to see if specific Medicare software is available
2. Contact Palmetto GBA to inquire about their software available at 1-866-749-4301
3. Visit www.palmettogba.com. Click on Other Medicare Partners. Click on EDI.

NOTE:
Medicare policy states that enrolled providers must bill Medicare for all covered drugs or supplies for eligible members. It should be noted that Medicare policy supersedes DCH requirements.



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

OPTUMRx

Georgia Watch Form

Fee-for-Service Medicaid & PeachCare for Kids

Prior Authorization
Claims Processing
Phone: (866) 525-5827
P.O. Box 25183
Santa Ana, CA 92799

FAX TO: 888-491-9742

Today's Date _____

Note: All of the following requests for information must be answered completely, correctly, and legibly, otherwise the authorization process will be delayed.

First, Middle, Last
Member Full Name _____

Member ID# _____ Member DOB ____/____/____

Medication Requested _____ Strength _____ Dosage Form _____

Quantity _____ Directions _____

Generic products tried? *(Circle one)* NO or YES *If yes, list the names of the manufacturers of generic products*

1. _____ 2. _____ 3. _____

What was the patient's response to each generic product? *(A response description MUST be given.)*

Product Name	Response
1.	☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other
Response description:	
2.	☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other
Response description:	
3.	☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other
Response description:	

Please print legibly
Physician's Name _____

Physician's Signature _____

Required
NPI # _____

Physician Address _____

Physician Phone _____ Physician Fax _____

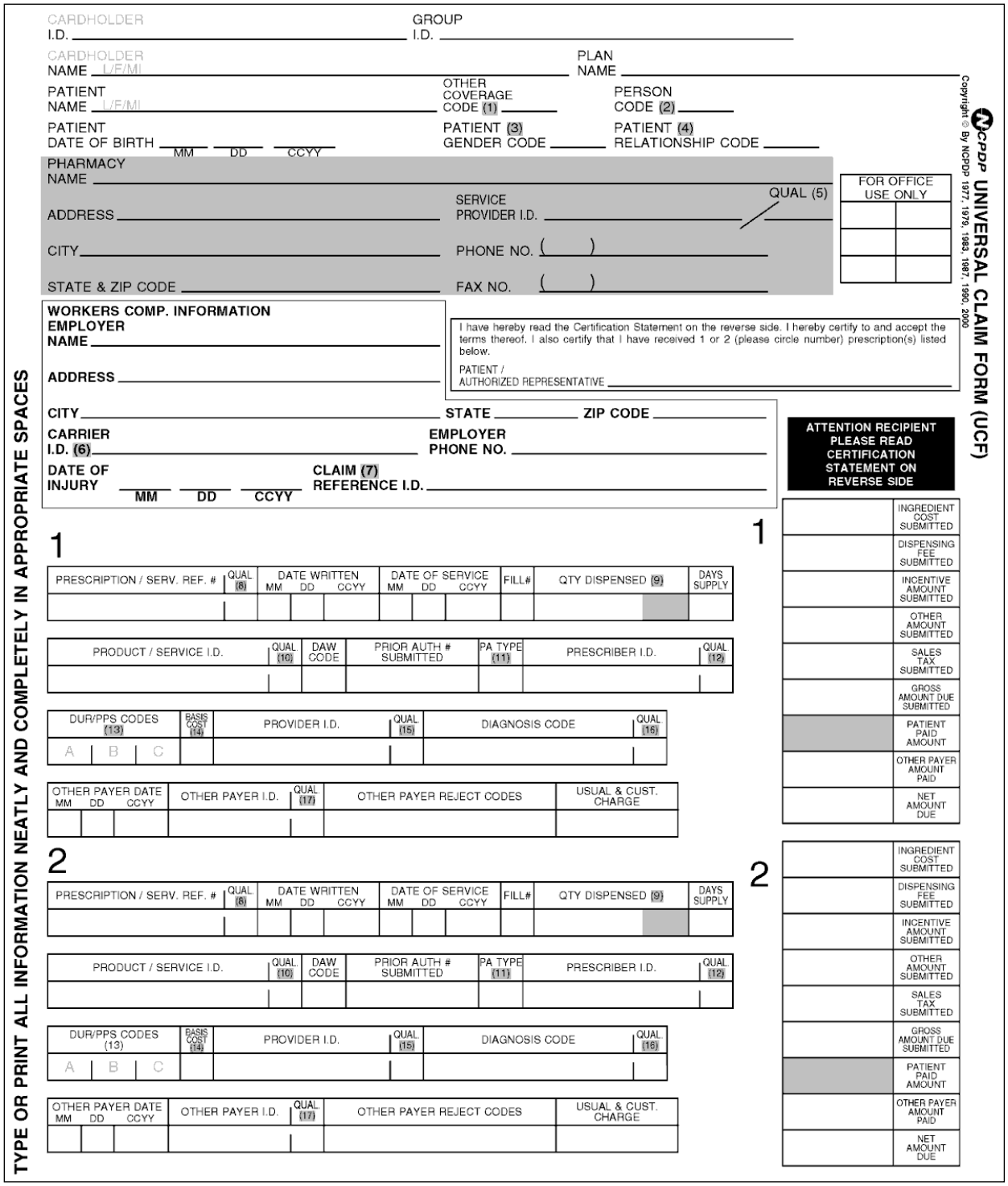
Medical Office Contact _____ Signature _____

Any additional information pertaining to this drug request should be included and attached to this form.

The documentation accompanying this facsimile may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are notified that any disclosure, copying, distribution or action taken in reference to the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Confidential

UNIVERSAL CLAIM FORMS



Universal Claim Forms can be obtained by contacting Moore North American at 1-800-635-9500. UCF version named (DAH 2 pt.) meets NCPDP vD.0 requirements and is preferred for Georgia Medicaid Pharmacy claim submissions.

(BACK)

IMPORTANT I certify that the patient information entered on the front side of this form is correct, that the patient named is eligible for the benefits and that I have received the medication described. If this claim is for a workers compensation injury, the appropriate section on the front side has been completed. I hereby assign the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsor, policyholder and the employer.

PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

1. Fill in all applicable areas on the front of this form.
2. Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient, name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
3. Worker's Comp. Information is conditional. It should be completed only for a Workers Comp. Claim.
4. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
5. Limit 1 set of DUR/PPS codes per claim.

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE

0=Not Specified | 1=No other coverage identified | 2=Other coverage exists-payment collected
3=Other coverage exists-this claim not covered | 4=Other coverage exists-payment not collected | 5=Managed care plan denial
6=Other coverage denied-not a participating provider | 7=Other coverage exists-not in effect at time of service | 8=Claim is billing for a copay

2. PERSON CODE: Code assigned to a specific person within a family.

3. PATIENT GENDER CODE

0=Not Specified | 1=Male | 2=Female

4. PATIENT RELATIONSHIP CODE

0=Not Specified | 1=Cardholder | 2=Spouse
3=Child | 4=Other

5. SERVICE PROVIDER ID QUALIFIER

Blank=Not Specified | 01=National Provider Identifier (NPI) | 02=Blue Cross
03=Blue Shield | 04=Medicare | 05=Medicaid
06=UPIN | 07=NCPDP Provider ID | 08=State License
09=Champus | 10=Health Industry Number (HIN) | 11=Federal Tax ID
12=Drug Enforcement Administration (DEA) | 13=State Issued | 14=Plan Specific
99=Other

6. CARRIER ID: Carrier code assigned in Worker's Compensation Program.

7. CLAIM/REFERENCE ID: Identifies the claim number assigned by Worker's Compensation Program.

8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER

Blank=Not Specified | 1=Rx billing | 2=Service billing

9. QUANTITY DISPENSED: Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

10. PRODUCT/SERVICE ID QUALIFIER: Code qualifying the value in Product/Service ID (407-07)

Blank=Not Specified | 00=Not Specified | 01=Universal Product Code (UPC)
02=Health Related Item (HRI) | 03=National Drug Code (NDC) | 04=Universal Product Number (UPN)
05=Department of Defense (DOD) | 06=Drug Use Review/Professional Pharm. Service (DUR/PPS) | 07=Common Procedure Terminology (CPT4)
08=Common Procedure Terminology (CPT5) | 09=HCFA Common Procedural Coding System (HCPCS) | 10=Pharmacy Practice Activity Classification (PPAC)
11=National Pharmaceutical Product Interface Code (NAPPI) | 12=International Article Numbering System (EAN) | 13=Drug Identification Number (DIN)
99=Other

11. PRIOR AUTHORIZATION TYPE CODE

0=Not Specified | 1=Prior authorization | 2=Medical Certification
3=EPSDT (Early Periodic Screening Diagnosis Treatment) | 4=Exemption from copay | 5=Exemption from Rx limits
6=Family Planning Indicator | 7=Aid to Families with Dependent Children (AFDC) | 8=Payer Defined Exemption

12. PRESCRIBER ID QUALIFIER: Use service provider ID values.

13. DUR/PROFESSIONAL SERVICE CODES: Reason for Service, Professional Service Code, and Result of Service. For values refer to current NCPDP data dictionary.

A=Reason for Service | B=Professional Service Code | C=Result of Service

14. BASIS OF COST DETERMINATION

Blank=Not Specified | 00=Not Specified | 01=AWP (Average Wholesale Price)
02=Local Wholesaler | 03=Direct | 04=EAC (Estimated Acquisition Cost)
05=Acquisition | 06=MAC (Maximum Allowable Cost) | 07=Usual & Customary
09=Other

15. PROVIDER ID QUALIFIER

Blank=Not Specified | 01=Drug Enforcement Administration (DEA) | 02=State License
03=Social Security Number (SSN) | 04=Name | 05=National Provider Identifier (NPI)
06=Health Industry Number (HIN) | 07=State Issued | 99=Other

16. DIAGNOSIS CODE QUALIFIER

Blank=Not Specified | 00=Not Specified | 01=International Classification of Diseases (ICD9)
02=International Classification of Diseases (ICD10) | 03=National Criteria Care Institute (NDCC) | 04=Systemized Nomenclature of Human and Veterinary Medicine (SNOMED)
05=Common Dental Term (CDT) | 06=Medi-Span Diagnosis Code | 07=American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)
99=Other

17. OTHER PAYER ID QUALIFIER

Blank=Not Specified | 01=National Payer ID | 02=Health Industry Number (HIN)
03=Bank Information Number (BIN) | 04=National Association of Insurance Commissioners (NAIC) | 09=Coupon
99=Other

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM.

Name	NDC	Quantity	Cost

COMPLETION OF THE NCPDP PHARMACY PROVIDER UCF
(UNIVERSAL CLAIM FORM)
Version (DAH 2pt.) preferred

(Items not required by Georgia DMA are not included in these instructions)

Once forms are completed, please mail them to**:**
OptumRx-GDCH Paper Claims
PO Box 29044
Hot Springs, AR 71903

This section provides specific instructions for completing the NCPDP-UCF form. A sample invoice is included for your reference.

Item 1 Pharmacy Provider Information
Pharmacy/Provider Name
Pharmacy/Provider NCPDP# or Medicaid Provider# or NPI # (must use qualifier when using NPI)

Item 2 Date of Service
The following information must be included:

- Date of Service (including month, date, and year)

Item 3 Recipient
The following information must be included:

- Recipient ID#
- Recipient DOB
- Recipient Name

Item 4 Prescriber Information
The following information must be included:

- NPI number

Item 5 (COB)
The following information must be included:

- Indicate “YES” if the recipient has insurance other than Medicaid

Item 6 Prescription Number
The following information must be included:

- Enter the prescription number, not to exceed seven digits, assigned by the pharmacy to identify individual prescriptions

Item 7 National Drug Code
The following information must be included:

- This field must contain eleven characters consisting of labeler, product, and package size.

Item 8 Quantity
The following information must be included:

- Enter the metric quantity of the drug dispensed.

Item 9 Charges
The following information must be included:

- Ingredient cost
- Dispensing fee
- Total price
- Deductible or copay amount
- Balance due

Item 10 Prior Authorization
The following information must be included:

- Enter any clinical authorization numbers or automated override codes that might apply to the prescription (enter them anywhere on the forma). For example, 11111, 22222, 99888, 987987987.

Item 11 Provider's Pharmacist's Signature
The following information must be included:

- Provider or Pharmacist's signature

REFUND ADJUSTMENTS AND REVERSALS

Reversing a Paid Claim (Pharmacy Initiated)

If a provider experiences an inaccurate claim payment, a reversal and resubmission may be processed online to OptumRx. Reversals of paid claims must occur within ninety (90) days of claim pay date. If the provider has questions or needs assistance with a reversal, please contact the OptumRx Pharmacy Help Desk at 866-525-5826.

Reversals may also be required in the event certain changes are made retroactive. At that time, the Department will send a communication requesting that providers reverse and resubmit their claims.

Remittance Advice

An Adjustment Request is processed by OptumRx and may result in an increase or decrease of payment. The adjustment appears as either a positive or negative amount above the summary section of the Remittance Advice.

If the adjustment is a Positive amount, it will be indicated below the last processed claim on the Remittance Advice. This amount will increase the payment to the Pharmacy.

If the adjustment is a Negative amount, it will be indicated below the last processed claim on the Remittance Advice. The amount will reduce the amount of payment. If the Negative Adjustment is more than the total processed paid claims, this will result in a credit to the Pharmacy. This credit will be applied against future processed paid claims through OptumRx.

Filing Limitation

Claim Reversal requests must be received within three (3) months from the first day of the month following the month in which the claim to be reversed was paid. The payment month is reflected in the date located in the top right-hand corner of the Remittance Advice page.

Adjustment of Inaccurate Medicare/Medicaid Payments

To appeal the amount paid for services to Medicaid/Medicare members, notify the appropriate Medicare Fiscal Intermediary of your appeal. (Any additional payments are through both Medicare and Medicaid). If the payments are made to an incorrect provider or are above the amount due, return the erroneous checks or issue refunds to Medicare and to Medicaid for their respective shares. Any erroneous Medicaid payments or refunds due the DCH must be forwarded to the following address:

Table 10.2 Addresses for all Erroneous Medicaid Payments or Refunds

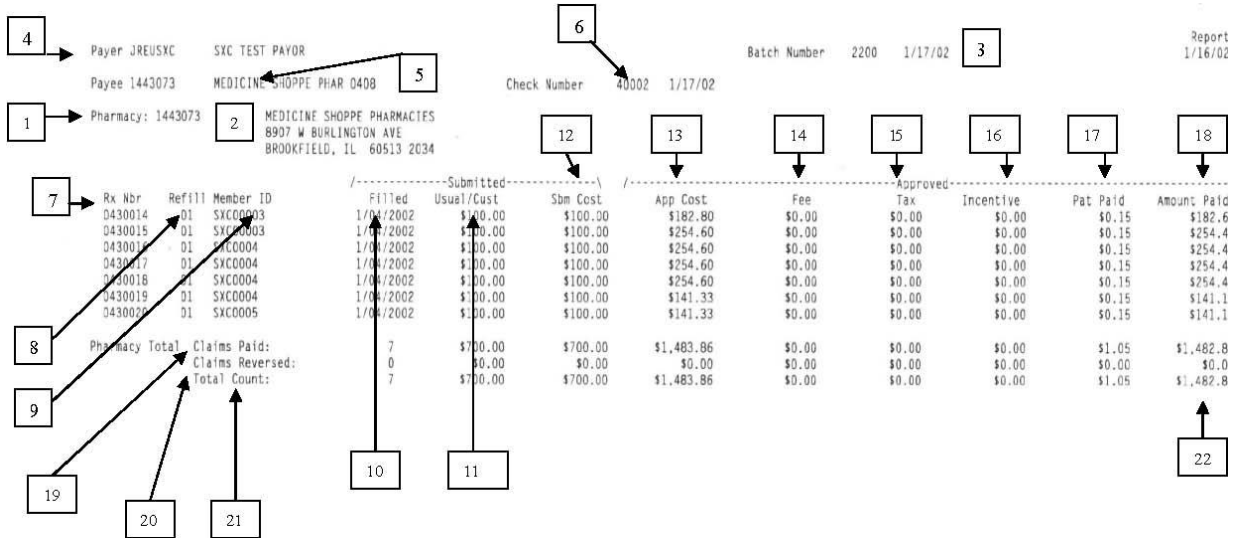
Provider	Hospital
Bank of America Lock Box 277941 Atlanta, GA 30384	Bank of America Lock Box 406867 Atlanta, GA 30384

Effective May 1, 2020: The Department of Community Health will be transitioning from Bank of America to JP Morgan Chase. The lockbox numbers where you are currently sending Erroneous Medicaid Payments or Refunds to will be changing, see table 10.3 below for new lockbox information.

Table 10.3 Addresses for all Erroneous Medicaid Payments or Refunds

Provider	Hospital
JP Morgan Chase PO Box 734660 Dallas, TX 75373-4660	JP Morgan Chase PO Box 734666 Dallas, TX 75373-4666

OptumRx Sample Remittance Advice



Remittance Advice Legend							
1	Pharmacy Number	7	Rx Number	13	Approved Cost	19	Paid Claim Count
2	Pharmacy Name, Address	8	Refill Code	14	Dispense Fee	20	Reversed Claim Count
3	Remittance Advice Date	9	Member ID	15	State Tax	21	Total Claim Count
4	Payer	10	Fill Date	16	Incentive Fee	22	Total Amount Due
5	Payee	11	U&C Amount	17	Copay Amount		
6	Check Number	12	Submitted Cost	18	Amount Due Pharmacy		

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Important Update – Banner Notification 12/4/2006

Effective January 1, 2007, OptumRx (formally SXC Health Solutions, Inc.) will become the pharmacy benefits manager for the GA Medicaid Fee-For-Service (FFS) Outpatient Pharmacy Program. In this role, OptumRx will be responsible for providing services to the FFS Outpatient Pharmacy Program that are currently provided by Express Scripts, Inc. DCH is working with both companies to ensure a seamless transition of services to your pharmacy.

The following BIN and PCN combination are required to successfully transmit claims effective January 1, 2007. No group number will be required for the transmission of a claim to OptumRx.

****REVISED****

BIN: 001553
PCN: GAM

There will be two dedicated pharmacy call lines; one line for Technical Support and one line for Clinical and Prior Authorization Support. They are as follows:

Technical Support
866-525-5826
Clinical and Prior Authorization Support
866-525-5827

For the processing of manual claims, please forward them to the following address:

OptumRx
Claims Processing
PO Box 29044
Hot Springs, AR 71903

georgia.gov Provider Portal



RxProvider/Prescriber Portal is Web-based interface utilized by physicians and pharmacists to obtain information on a member to assist in providing more accurate, timely and cost efficient prescription treatment.

Accessing The Site

The Provider Portal can be accessed by visiting https://ga-providerportal.optum.com. Physicians and Pharmacists are required to register using the registration form on the login page of the Portal.

Registration

Registration is a one-time process. To enter the Portal after a User ID and Password has been assigned, simply enter the information on the login page and click "Sign In".

Main Page

The main page contains short cut links to frequently requested information. The top horizontal menu bar will always be visible to quickly access information within the Portal.

Member Search

A search for members can be performed by entering the Member ID, Last Name and Birth Date. When a member is found the following information is displayed:

- Member ID
- Member Name
- Birth Date
- Gender
- Eligibility from and thru dates

Claim Detail

The details of the claim detail screen for a member include:

- Fill Date
- RxNumber
- Claim Status
- Group ID
- Product ID
- Product Description
- Prescriber Name
- Pharmacy Name
- Days Supply
- Quantity
- Bin
- PCN
- Reject Code if applicable
- Reject Message if applicable



Remittance Summary

*Pharmacies Only

The Remittance Summary page displays the Remittance History. Searches can be done by date range and check number.
Clicking on the check number outlines the following:

- Submitted Amount
- Approved Amount
- Taxes and Fees
- Patient Pay
- Amount Due
- And Sums of the above

Guidelines and Forms

The Guidelines and Forms section of the Portal contains information to assist Providers with member care and prescription management.



Banner Messages

Updated Banner Messages are loaded to this page to provide timely notifications that affect provider groups.

The Resources

The resources section of the Portal contain links to outside resources such as; HIPAA, PeachCare for Kids site and provider association sites.

OPTUMRx

Provider Portal New User Request

A separate Provider Portal Access Identification form is required for each User requested. Please provide identifying information for the one individual that should be receiving access to the Provider Portal.

Provider Information

I am a:

☐ **Pharmacist** **NCPDP:** **Payee ID** Internal Use Only

☐ **Pharm Other** **NCPDP:** **Payee ID** Internal Use Only

☐ **Physician** **MD State License:** **DEA Number (if applicable):**

☐ **Other Provider Type** **Description:**

NPI For Practice Location:

Medicaid ID

User Name:

Last *First* *MI*

Pharmacy or Clinic Name:

Address:

Street Address

City *State* *ZIP Code*

Phone: **Alt. Phone:**

E-mail:

To the best of my knowledge the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health Division of Medical Assistance for the purpose of Accessing the Provider Portal. I understand that falsification; omission or misrepresentation of any information in this document will result in a denial of access to the Portal, possible closure of current provider members and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions.

I understand that my signature certifies that I am authorized to make binding decisions on behalf of the Provider/Facility listed above.

Medicaid/PeachCare Provider Signature:

Date:

Email (preferred) the completed registration form to GAMProvider.PortalTeam@Optum.com or Fax to 1-888-292-4814.

Provider Enrollment FAQs

Each individual practitioner in a group must enroll to receive a provider number.

1) How long does it take to process an enrollment application?

The enrollment process should be completed within four to six weeks after we receive the complete application. Be sure to attach the supporting documentation required. Any omissions or missing forms will cause the application to be returned.

2) Can I fax my applications for processing?

No. Applications must contain original, not copied signatures.

3) Since I am a new applicant, what provider number should I enter on my EFT agreement?

Leave the provider number blank. Gainwell Technologies will enter the provider number for new providers. An Electronic Funds Transfer (EFT) Agreement is required for all providers.

4) Should I send my application via express or certified mail?

That would be your choice. Because of the volume of incoming mail, sending applications through certified mail helps to ensure proper delivery. It also serves as your proof of submission, provides a mechanism for tracking, and guarantees quicker delivery. The mailing address is Gainwell Technologies Provider Enrollment Unit, PO Box 105200, Tucker, GA 30085-5200. Applications are processed in the order they are received.

5) I was told that my application required a site visit. Why is that?

The Department conducts site visits to ensure that members receive quality care in a medical environment that provides easy access, clean treatment rooms and qualified staff. In the present environment, applications may be approved pending a future site visit.

Note: Facilities that are certified by the Department of Human Resources; Office of Regulatory Services will not be site audited by Georgia Medicaid.

6) How will I be notified of my new provider number?

A system generated Gainwell Technologies notification letter is sent to the provider once the application is approved. The letter is mailed to the address listed on the

application. Any corrections should be addressed to Gainwell Technologies immediately.

7) **Should I hold all claims until I receive confirmation of my provider number?**

   Yes. The division will not reimburse you for services rendered before the effective date of enrollment. The effective date of enrollment is the first day of the month in which the application is received or the date of licensure/certification (whichever is later).

8) **My old provider number is closed. How do I get it re-opened?**

   If your number has been suspended for inactivity, you may submit a written request to re-activate the number. If your number has been terminated for inactivity (no claims filed for more than 16 months), then you must submit a new application package.

9) **I am an individual practitioner and have (or had) a provider number at one location. I am now going to work from another location or open my own practice. What forms do I need to submit?**

   You should submit an additional location application package. If you will no longer be working from your previous location, please notify Provider Enrollment of the effective date to close that previous number.

10) **There has been a change in my practice information. What do I need to do to notify the Department of the change?**

    If your phone number(s), Legal name, Payee name, etc. changes, you will need to complete and submit a Change of Information form or a signed request on your letterhead listing the information to be corrected.

11) **My Company is buying an existing Medicaid provider. Will we need to apply for a new Medicaid number? (*Facilities Only)***

    Any enrolled provider that becomes a different legal entity or is replaced in the program by another provider must give the Department at least 10 days prior written notice. Possible circumstances include dissolution, incorporation, re-incorporation, reorganization, change of ownership of assets, merger, or joint venture.

    At the same time, the successor provider must also submit a new Provider Enrollment Application package to become effective at the time of the change. Medicaid will require a new application package if the facility is required to submit a change of ownership application to Medicare.

12) **I am a Georgia Medicaid provider that is interested in submitting claims electronically. What is the procedure for signing up?**

Please contact Gainwell Technologies EDI Helpdesk at (877) 261-8785, Monday – Friday 8:00am – 5:00pm or visit the website at **http://www.mmis.georgia.gov**.

13) I am building a new facility. When should I submit my application?

You should apply when the facility is ready for business. The site must be visited before your application can be approved.

Out of State Providers

The Department enrolls medical practitioners within 50 miles of the Georgia state border as in-state providers. Providers whose physical location is more than 50 miles from the Georgia border may be enrolled as Out-of-State providers under the circumstances outlined below.

Out-of-state providers may be reimbursed for covered services provided to eligible Georgia members while out-of-state if the claim is received within twelve months from the month of service, and if at least one of the following conditions is met:

a) The service was prior authorized by the Division; or
b) The service was provided as a result of an emergency or life-endangering situation occurring out of state.

Out-of-state claims submitted for reimbursement must have a copy of the authorization letter from the Department attached if services were prior authorized **or** medical justification if the services were due to an emergency or life-endangering situation. Requests for prior approval or questions regarding out-of-state services must be directed to:

Alliant Health Solutions
P. O. Box 105329
Atlanta, GA 30348
1-800-766-4456

Please request a Provider Enrollment Application or enrollment documents by one of the methods listed below:

Phone: (800) 766-4456, or in metro Atlanta (770) 325-9600

Download: www.mmis.georgia.gov → Provider Information → Documents and Forms

E-mail: www.mmis.georgia.gov → Contact Us

Apply Online: www.mmis.georgia.gov → Provider Information → Enroll as an Individual

Facsimile: 1-866-309-0935

GA Medicaid Fee-for-Service Pharmacy Provider NPI FAQs

(Rev. 04/13)

1) Is the pharmacy NPI required for electronic pharmacy claims?

Yes, Pharmacy NPI is required for electronic pharmacy claims effective May 1, 2008. Submit the ID qualifier '01' (NPI) in field 202-B2 and the pharmacy NPI (Service Provider ID) in field 201-B1.

2) Is the prescriber NPI required for electronic pharmacy claims?

Effective May 23, 2008, only the Prescriber NPI will be allowed when processing electronic pharmacy claims. Between May 1, 2008 and May 22, 2008, the prescriber NPI or the prescriber's state license number may be used. Dummy ID numbers will no longer be valid with the exception of GHS300 (Grady Hospital, Clinics, ER) and AOH300 (All other Hospitals, Clinics or Emergency Rooms) between May 1 and May 22. Effective May 23, ONLY NPI will be accepted for electronic claims.
Submit the ID qualifier '01' for prescriber NPI in NCPDP field 466-EZ and the prescriber NPI in field 411-DB.

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers.

Also, the National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating (i.e. rendering) provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

To comply with the requirement, providers who do not have NPIs or who are not authorized to enroll as a Medicaid or CHIP provider must provide the NPI of the supervising or attending physician on the order, prescription, or referral. Medical residents may obtain an NPI and Medicaid ID in order to prescribe outpatient prescription medications. Alternatively, facilities may continue to use a prescription that is countersigned by the attending or supervising physician if they do not wish to enroll their residents. Medical residents may only prescribe; they may not order, refer or bill other services.

Type of Prescriber	Eligible for Medicaid Provider ID	Required Signature on Prescription	Required NPI# on Claim for Legend Drugs	Required NPI# on Claim for Controlled Drugs
Nurse Practitioner	Yes	Nurse Practitioner	Nurse Practitioner NPI#	Nurse Practitioner NPI# (CIII, IV, V drugs only)
Physician Assistant	Yes	Physician Assistant	Physician Assistant NPI#	Physician Assistant NPI# (CIII, IV, V drugs only)

The following resources are available for more information:
Access the department's DCH-i newsletter and FAQs at
http://dch.georgia.gov/publications

Search to see if a provider is enrolled at
https://www.mmis.georgia.gov/portal/default.aspx

Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last name.

Access a provider listing at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx

Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

3) **I have used Dummy IDs for some hospital/emergency room physicians, Dentists, Podiatrists, Out of State Physicians, Optometrists, and new physicians granted a license number within 60 days. What ID should I use for those prescribers?**

All prescribers should have their own NPI. You may look up a prescriber's NPI at http://www.hmedata.com/npi.asp If appropriate, GHS300 and AOH300 will be accepted between May 1, 2008 - May 22, 2008 **only**.

4) **What should I do if I have a prescriber's correct and verified NPI but the claim is still rejecting?**

Contact OptumRx Customer Service: 1-866-525-5826.

5) **How can I process a pharmacy claim if the prescriber doesn't have a NPI?**

Providers who do not have NPIs or who are not authorized to enroll as a Medicaid or CHIP must apply the NPI of the supervising or attending physician to the claim.

6) **What is the NPI requirement for paper claims? (Universal Claim Form)**

The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating (i.e. rendering) provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

7) **Where can a pharmacy or prescriber obtain an NPI?**

An NPI can be obtained on-line at: **https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart** or a paper copy of the application can be obtained by phone, e-mail, or mail.

Phone: 1-800-465-3203 or TTY 1-800-692-2326

E-mail: customerservice@npienumerator.com

Mail: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

We appreciate your continued participation in the Georgia Medicaid program. If you have any questions, please contact OptumRx Customer Service at 1-866-525-5826.

Please share this information with appropriate staff. If you are the corporate office of a chain pharmacy, please provide this information to each of your stores located in Georgia.

Division of Medical Assistance
Pharmacy Services Unit: 404-656-4044

COUGH AND COLD PREFERRED DRUG LIST (PDL) INFORMATION

Effective November 1, 2008, the Medicaid Fee-for-Service Program will implement a Cough and Cold Preferred Drug List (PDL). Coverage applies to member's less than 21 years of age. This PDL listing is available online at www.dch.georgia.gov/pharmacy (Preferred Drug Lists → Related Links: Cough and Cold Preferred Drug List) and on the Georgia Medicaid Web Portal at: www.mmis.georgia.gov (Pharmacy → Other Documents).

Cough and Cold Preferred Drug List Frequently Asked Questions

1) Why did the Department of Community Health develop a Preferred Drug List (PDL) for cough and cold products?

Due to recent state level budgetary constraints, DCH has been asked to assist by further managing the outpatient pharmacy drug spend. Additionally, many of the products within this class have similar combinations, albeit with slightly varying product strengths. The abundance of similar products coupled with the Department's fiscal responsibilities lead to the simplification of covered products within this class.

2) Who is eligible to receive the products covered on the Cough and Cold PDL?

Medicaid Fee for Service (FFS) Members aged less than 21.

3) How were products selected for inclusion onto the PDL?

Products were selected for the inclusion on the PDL based upon several factors including available formulations, utilization as well as cost effectiveness. It is DCH's intent to continually update the PDL based upon several factors including rebate status, cost effectiveness, and availability.

4) Why were over-the counter (OTC) products not included on the Cough and Cold PDL?

Medicaid is funded by both state and federal funds. Generally, federal matching funds are not provided for OTC items as set forth in the Centers for Medicare and Medicaid Services (CMS) guidelines for state Medicaid programs unless authorization is approved in advance. DCH does plan to seek approval for coverage of these items. Hence, pending CMS approval, coverage may be allowed for OTC items.

5) Why were some products included on the Cough and Cold PDL that are no longer being manufactured or marketed?

The Department is aware that some of the products contained within the PDL may no longer be stocked by all pharmacies. However, the Department's policy does allow for the submission of claims for products that are inactive or no longer available until they become obsolete and the residual supply in dispensing pharmacies has been exhausted. Therefore, pharmacies who have stock of these medications available may still submit claims for adjudication, up to 18 months past the inactive date as reported by the manufacturer.

6) **Given the recent FDA guidance regarding the use of cough and cold products in children, why did the Department develop a Cough and Cold PDL?**

The Cough and Cold PDL was developed with many factors in mind including coverage for those members less than 21 years of age. Further, the Department does not have a position regarding the use of these products in any patient population. However, should a prescriber decide to initiate therapy with a product within this class, we have provided a simplified PDL from which to select reimbursable items.

7) **How do you get prior authorization for a product not listed on the Cough and Cold PDL?**

Only those products contained within the PDL are eligible for coverage. The Department plans to continually update and revise the PDL as needed.

8) **Where may I find the most up to date Cough and Cold PDL?**

This PDL listing is available online at www.dch.georgia.gov/pharmacy (Preferred Drug Lists → Related Links: Cough and Cold Preferred Drug List) and on the Georgia Medicaid Web Portal at: www.mmis.georgia.gov (Pharmacy → Other Documents).

APPENDIX H

(Rev. 7/21)

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The three licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	CareSource 1-855-202-1058 www.caresource.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)

Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All three CMOs are State-wide.**

The Department of Community Health has contracted with three CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult

119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION

124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver

251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child

446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact GAINWELL TECHNOLOGIES at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. GAINWELL TECHNOLOGIES will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services are provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- •Saves time
- •Increases efficiency
- •Eliminates duplication of data needed for multiple CMOs
- •Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing, and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	CareSource	Peach State Health Plan
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for clean claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. Dental: Checks are mailed weekly on Thursday for clean claims. Vision: Checks are mailed weekly on Wednesday for clean claims (beginning June 7th) Pharmacy: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for clean claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for

	any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN #	GROUP #	Helpdesk
Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031
CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630
Peach State Health Plan	CVS	004336	MCAIDADV	RX5439	1-844-297-0513

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:

Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929

APPENDIX I

(Rev. 07/18)

Information for Providers Serving Medicaid Members
in the Georgia Families 360°SM Program

Georgia Families 360° SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible, through its provider network, for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360°SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360° SM Every member in Georgia Families 360° is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov.

APPENDIX J

(Rev. 01/20)

Prescription Documentation Policy

- Both the exact quantity and the days' supply must be billed to Georgia Medicaid based on the metric decimal quantity prescribed and the prescriber's exact written directions, without exceeding the allotted plan amount per month. The billing system does not read the directions submitted, only the day's supply/quantity dispensed. **Per the Georgia Department of Community Health: Eye drops = 16gtts/1ml Inhalers = Use how many puffs per day the patient is taking vs. how many metered doses are in the canister.**

- **Quantities Dispensed:** Always submit the quantity prescribed and the **exact** calculation of days' supply per the Prescriber's dosing instructions. "As directed" or "PRN" Prescriber directions must be clarified with Prescriber or Member. Verifying pharmacist must document and initial the information on the prescription.

- Oral prescriptions must have the date, time, name of person calling, and the handwritten initials of the pharmacist/intern who took the call.

- **Automatic refills are not allowed.** All prescription refills shall be initiated by a request from the physician, member, or other person acting as an agent of the member, i.e., family 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. Any prescription, regardless of the authorization to refill given by the prescribing practitioner, may not be billed to the Department after one (1) year has elapsed from the date it was written.

- Documentation of receipt for prescriptions is required by the Division for each prescription dispensed to a Medicaid Member. Documentation must include at minimum, the date, prescription number, member name, and member's signature or member's legal representative receiving the prescription, date filled, and date picked up.

- **On-Site Audits:** A list of prescriptions will be provided at the time of the on-site audit.

  For On-Site audits, the following will apply:

  - If the pharmacy has electronic signature capture, signature logs may be reviewed on-site. Any missing signatures will have to be submitted to the Medicaid Pharmacy Audit Vendor within 15 days.
  - If the pharmacy has paper logs, paper delivery logs, or signature logs not reviewed on site, signature logs will need to be submitted to the Medicaid Pharmacy Audit Vendor within 15 days.

- Signature logs are not accepted after the initial audit results have been provided.

After 15 days, documentation submitted will be reviewed and an initial findings letter will be sent out. For those signature logs that were not received prior to the initial findings, a patient attestation will be accepted. Only the original signed attestation from the member, verifying receipt of the medication, should be provided to the designated Medicaid Pharmacy Audit vendor within the time frame allotted. The attestation must include the following: date, prescription number, member name, member's signature, date filled, dated picked up, the member's contact information, and permission for the designated Medicaid Pharmacy Audit vendor to contact them via mail or phone if necessary.

❖ **Acceptable Corrective Documentation:** When documentation from the prescriber is required to correct the discrepancy, such documentation must fully originate from the prescriber and may not be generated by the pharmacy. Additionally, the documentation must contain all elements to satisfy prescription requirements.

❖ **Long Term Care (LTC) Facilities:** In the event the member is residing in a LTC facility or other institution, a nurse, pharmacist, or other authorized agent of the facility pursuant to a valid physician's order may initiate the request for refills. Documentation of the prescription number, member name, delivery date, and receipt date are required by the Division for each prescription dispensed or administered to a LTC Medicaid member. Documentation of administration through a medication administration record or other method is required for members who do not self-administer their medications.

❖ All prescriptions must be reversed and returned to stock within 14 calendar days of dispensing if not picked-up by the recipient.

❖ **Only copies of original documentation from the prescribing physician are accepted post-audit for unauthorized refills, missing, or as directed prescriptions during an on-site audit. Telephone prescriptions and computer-generated prescriptions are NOT allowed to be submitted for review.** To receive credit post-audit, these copies must be sent to the Medicaid Audit vendor in the time frame allotted.

❖ Documentation must be sent in before the deadline of the appropriate discrepancy report. Information sent in post deadline will not be reviewed. If an extension is needed, please call the auditor provided one week prior to deadline. **Extensions will not be granted for requests made less than one week (7 calendar days) prior to the deadline or any time past the deadline.**

❖ Documentation received by the Medicaid Audit vendor may be rejected if the originator (example; physician, patient, etc.) is unwilling or unable to provide verification.

- Prescribers must use **tamper-resistant prescription pads** for any new prescription with fill dates on and after April 1, 2008. This requirement applies to hard copy prescription orders for any drug, device, or product covered through the Medicaid FFS outpatient pharmacy program whether legend or over the counter.

- When on-site or desk audits are being performed, **DO NOT** reverse the claims in question. Any discrepancies found will be corrected after the audit is completely closed.

Failure to comply with any of these guidelines can result in a charged back amount to the pharmacy. We hope to make your audit experience as convenient as possible. Also, we hope that you find these guidelines useful. Thank you for your time and cooperation.