

**Ohio Department of Medicaid Fee-for-Service
Pharmacy Claims Review Provider Manual**

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Introduction

Claims review is a necessary component of the Ohio Department of Medicaid (ODM) Fee-for-Service (FFS) pharmacy benefit. Claims review satisfies the federal requirements to help protect against fraud, waste, and abuse (FWA) in the Medicaid program. Change Healthcare (CHC), formerly Goold Health Systems (GHS), the Pharmacy Benefits Administrator for the ODM FFS program, has responsibility for the pharmacy claims review program. CHC provides services that include review of 100% of all paid claims for billing accuracy, recoupment of overpayments through claims review mechanisms, educational services to enrolled ODM FFS pharmacy providers, and fraud detection and deterrence.

ODM FFS pharmacy providers are subject to mandated elements for prescriptions and drug orders through Ohio statute and administrative rules promulgated by ODM and the Ohio Board of Pharmacy (or equivalent for out-of-state pharmacies). The ODM will recoup payments on claims associated with prescriptions or drug orders if the mandated elements are missing. All pharmacy providers enrolled with the ODM FFS program are subject to claims reviews. Please note, the information contained in this Provider Manual does not pertain to any policies and/or procedures for the ODM managed care plans.

There are three main types of claims review – Concurrent, Desk, and Onsite. A description of Concurrent Claims Review is described in the following section. Information regarding Desk and Onsite Claims Reviews will be added to this manual at a later date.

Concurrent Claims Review

Concurrent Claims Review is similar to a real-time claims review program. Concurrent Claims Review is performed via FAX, email, and/or telephone. The goals of Concurrent Claims Review are to:

- Decrease the burden on pharmacy providers as related to future Desk Claims Review documentation requests
- Decrease reoccurring instances of incorrect billing by correcting any errors before the subsequent refill
- Correct the billing error prior to the claim payment

Each day, the CHC Pharmacy Claims Review Department reviews all claims processed to a paid status the previous day. Claims processed on Fridays, Saturdays, and Sundays will be reviewed on Mondays. The claims are processed through a series of algorithms to determine billing accuracy. Any potentially aberrant claims will be compiled into a report for the individual

pharmacy. Pharmacy providers will receive an Ohio Concurrent Review Initial Letter via FAX or email. Pharmacy providers are required to review the claim(s).

If the claim was correctly billed, the pharmacy provider should FAX a copy of the prescription hardcopy to Change Healthcare.

If the originally submitted claim is NOT correct, the pharmacy provider should reverse the incorrect claim and resubmit a corrected claim. If the claim is not “fixed” or responded to within three (3) business days, the pharmacy provider will receive a telephone call from a Change Healthcare claims reviewer. Change Healthcare will review each claim with the pharmacy staff member. If after the telephonic intervention, aberrant claims remaining “unfixed” will be carried into a subsequent Desk Pharmacy Claims Review Process. Details for the Desk Pharmacy Claims Review Process will be provided once an implementation date is determined.

Algorithms

Below is the list of algorithms that will be utilized for the Concurrent Claims Review Program. Any claim exceeding the parameters associated with these algorithms will be “flagged” for additional review and included in the FAX/email received by the pharmacy provider.

- Duplicate claim
- Early refill
- Inconsistent days’ supply/dose
- Package size errors
- Claims with high quantities
- Claims with high cost
- Claims with Drug Utilization Review errors, such as age and gender discrepancies
- Other claim attributes as specified by ODM

Contact Information

For questions regarding claims review, you may email OHclaimsreviewdept@ChangeHealthcare.com and a staff member will assist you. You may also call the Claims Review Department at 1-877-518-1545, option 3.

Appendix A: Recoupment Codes/Description

Claims Review Code	Description
DDD	Duplicate claim – same provider, same Rx number, same member, same date of service, but drug is different
DSD	Duplicate claim – same provider, same Rx number, same member, same date of service, same drug
DRD	Duplicate claim – same provider, same date of service, same member, same drug, but different Rx number
ER	Early refill
MDD	Inconsistent days' supply/dose – quantity and/or days' supply billed exceed max daily doses (includes age errors)
PSE	Package size error – quantity billed is inconsistent with the product package size
HQ	High quantity
HC	High cost
MF	Gender error