REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF CHANGES
9/22/2016	Change Healthcare	Document Created
2/3/2017	Change Healthcare	Revision to Concurrent Claims Review
6/2/2017	Change Healthcare	Addition of Desk Claims Review
1/9/2018	Change Healthcare	Reviewed and Approved with No Changes
7/31/2018	Change Healthcare	Updated Desk Claims Review with Date of Death; Addition of LTC Returned Medication Claims Review; Updated Appendix A
1/23/2019	Change Healthcare	Reviewed and Approved with No Changes
7/31/2019	Change Healthcare	Addition of New Algorithms; Addition of Return to Stock Policy

TABLE OF CONTENTS

CHANGE HEALTHCARE

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, the Pharmacy Benefits Administrator for the ODM FFS program, has responsibility for the pharmacy claims review program. Change Healthcare 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.

ODM does not reimburse for retail prescriptions filled but not dispensed or picked up by the beneficiary or their representative, and does not allow restocking fees. For prescriptions not picked up, pharmacies must adjust or reverse the claim for any payments received, including the dispensing fee. The pharmacy should reverse claims in a timely manner. ODM policy allows claim adjustments or reversals to be submitted up to twelve months after the original date of service.

The main types of claims review are Concurrent, Desk, Long Term Care Returned Medication, and Onsite. A description of Concurrent, Desk, and the Long Term Care Returned Medication Claims Review programs are described in this manual. Information regarding Onsite Claims Review 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 Change Healthcare 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 reviewed via a telephonic intervention between a Change Healthcare Claims Review Specialist and a pharmacy staff member or the claims will be compiled into a report for the individual pharmacy and sent a Concurrent Review Initial Letter via FAX or email.

For claims reviewed via a telephonic intervention, the Change Healthcare Claims Review Specialist will ask the pharmacy staff member to access the hardcopy prescription for review. If the claim was correctly billed, the Change Healthcare Claims Review Specialist will note the claim is correct and no further action is necessary. If the originally submitted claim is NOT correct, the pharmacy staff member should reverse the incorrect claim and resubmit a corrected claim. These actions should occur while on the phone with the Change Healthcare Claims Review Specialist. If the pharmacy is unable to make the necessary changes at that time, aberrant claims remaining "unfixed" will be carried into a subsequent Desk Pharmacy Claims Review Process.

For pharmacy providers receiving the Concurrent Review Initial Letter, if the claim was correctly billed, the pharmacy provider should FAX/email 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 Review Specialist. Change Healthcare will review each claim with the pharmacy staff member. Any claim changes should occur while on the phone with the Change Healthcare Claims Review Specialist. If the pharmacy is unable to make the necessary changes at that time, aberrant claims remaining "unfixed" will be carried into a subsequent Desk Pharmacy Claims Review Process.

Concurrent Claims Review 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

- Claims with quantity decimal errors
- Claims submitted with medication discount cards
- Claims for brand multi-source drugs with dispense as written code equal to 1, indicating substitution not allowed by prescriber
- Claims with submission clarification code of 20 for pharmacies not on 340B Medicaid Exclusion File
- Other claim attributes as specified by ODM

PHARMACY DESK CLAIMS REVIEW

Pharmacy Desk Claims Review is a program designed to recover overpayments, through a retrospective review, that are primarily the results of billing errors. Desk Claims Review verifies adherence to ODM policies and procedures. Additionally, the program provides education to pharmacies to prevent future pharmacy claim submission errors. This type of pharmacy claims review occurs on a quarterly basis or as directed by ODM.

Desk Claims Review Algorithms (all algorithms in Concurrent plus those listed below)**:**

- Validation of proper billing practices
- Validation of prescription/drug order requirements
- Validation of prescriber specialty
- Validation of prescriber registration for buprenorphine products
- Validation of compliance to Tamper Resistant Prescription Pad requirements
- Claims filled after date of death

Change Healthcare will send to the pharmacy an Ohio Desk Record Request Letter asking for prescription copies and any related documentation for the potentially aberrant claims listed in the letter. The pharmacy has 30 calendar days from when the Ohio Desk Record Request Letter was received to provide the appropriate documentation back to Change Healthcare.

Change Healthcare will accept the following types of documentation:

- Retail
  - Original written prescription from the prescriber
  - Telephoned prescription called in by prescriber or the prescriber's representative
  - Scanned computer image of original prescription
  - Computer/FAX refill authorization containing all relevant information
  - FAXed prescription
  - Electronic prescription

  - Telephoned refill authorization containing required elements
- Long-Term Care
  - Original written drug order or prescription from the prescriber
  - Telephoned prescription or drug order called in by prescriber or the prescriber's representative
  - Scanned computer image of original prescription
  - Computer/FAX refill authorization containing all relevant information
  - FAXed prescription or drug order
  - Electronic prescription
  - Discharge orders
  - Medication order sheet for date of service
  - May provide a signed Monthly Physician's Order Summary (POS) dated within the previous 12 months of the fill date if open ended. If POS shows a range or stop date, that range or stop date prevails over the 12-month limitation outlined
  - Medication Administration Records (MAR) will be accepted in lieu of a POS, as long as it has all the elements of a valid prescription order

If the pharmacy does not respond to the Ohio Desk Record Request Letter within the allotted time frame, Change Healthcare will respond via an Ohio Desk No Response Letter within 45 calendar days from the date the original record request letter was received. The No Response Letter includes the Ohio Desk Claims Review Explanation of Findings Draft and Itemized Claims Reports. This letter gives the pharmacy 30 calendar days to reverse and/or resubmit the claim(s). Additionally, the letter provides the pharmacy information on how to request reconsideration of the findings if the pharmacy disagrees with the Draft Report Letter. The Reconsideration Process outlined below will then be followed.

Change Healthcare will review documentation received from the pharmacy and determine overpayments within 60 calendar days of receipt of documentation. If after review of the documentation, Change Healthcare determines no overpayment occurred, Change Healthcare will send an Ohio Desk No Recoupment Letter and close the claim review for those specific claims.

If after review of the documentation, Change Healthcare determines an overpayment occurred, Change Healthcare will send to the pharmacy a notification of claim review findings via the Ohio Desk Claims Review Draft Report Letter. This letter includes the Ohio Desk Claims Review Explanation of Findings Draft and Itemized Claims Reports. The information will be sent within 60 calendar days of Change Healthcare's receipt of the pharmacy's documentation. This letter gives the pharmacy 30 calendar days to reverse and/or resubmit the claim(s). Additionally, the letter provides the pharmacy information on how to request reconsideration of the findings if the pharmacy disagrees with the Draft Report Letter. The Reconsideration Process outlined below will then be followed.

RECONSIDERATION PROCESS

If the pharmacy disagrees with the Ohio Desk Claims Review Draft Report Letter, the pharmacy may request reconsideration of the findings and submit additional documentation to support the request. The request for reconsideration and additional documentation must be sent within 30 calendar days of receipt of the Ohio Desk Claims Review Draft Report Letter.

In response to the pharmacy's request for reconsideration, when findings are found Change Healthcare will respond within 30 calendar days with an Ohio Desk Claims Review Reconsideration Results Letter. This letter includes the Ohio Desk Claims Review Explanation of Findings Final and Itemized Claims Reports. Upon receipt of the reconsideration results, the pharmacy should reverse and/or correct the affected claim(s) within 30 calendar days of receipt of the letter. Once the affected claim(s) are reversed and/or corrected, Change Healthcare will close the investigation.

In response to the pharmacy's request for reconsideration, when no findings are found Change Healthcare will respond within 30 calendar days with an Ohio Desk Claims Review Reconsiderations Results No Recoupment Letter. At this point, Change Healthcare will close the investigation.

Change Healthcare will manage the reconsiderations process by responding to each reconsideration and attempt to resolve reconsiderations through an informal resolution process. Change Healthcare will conduct reconsiderations in accordance with existing Ohio law and procedures applicable to provider reconsiderations.

LONG TERM CARE RETURNED MEDICATION CLAIMS REVIEW

Change Healthcare identifies pharmacies who are returning medications back to the pharmacy shelf without properly crediting the ODM. This review is being conducted in accordance with OAC 5160-9-06 (E)(1)(b). Change Healthcare will utilize multiple methods to assess the return and credit or destruction of medications within the Long Term Care (LTC) facilities and the pharmacies. Change Healthcare will request the following documentation from the pharmacy and the documentation must be provided back to Change Healthcare within 30 calendar days:

- Request return-to-stock (RTS) policies and procedures from the pharmacy
- If onsite at the pharmacy, check shelves for possible re-use of medications and note the prescription number, member identification number, and date of service. Pharmacy staff will be responsible for copying bingo cards/unit dose box labels to ensure that no patient privacy violations occur.
- Request the name and license number of the consulting pharmacist provided to the LTC facility.
- Request the name and license number of the Pharmacist-in-Charge

Change Healthcare will request the following documentation from the LTC facility and the documentation must be provided back to Change Healthcare within 30 calendar days:

- Request LTC facility policies and procedures regarding the destruction or return of unused medications.
- Request LTC facility to provide documentation including chart notes, Census reports, medication administration records, or anything that documents the discontinuation of a medication, a deceased patient, a discharged patient, etc.
- Request the LTC facility to provide proof of destruction or return to the pharmacy for the medication claims reviewed.
- Request the destruction policy at the LTC facility for controlled medications. Change Healthcare will request a destruction document signed and dated by two staff members for any controlled substance medication that the nursing facility indicates has been destroyed.
- Request the monthly RTS/medication destruction record for each claim requested
- Request documentation of medication(s) returned to the pharmacy and documentation for any medication sent with the patient upon discharge
- Change Healthcare ensures each claim evaluated documents the disposition including, but not limited to: patient discharged, patient deceased, prescriber discontinued medication, patient transferred to another facility, patient still on medication, drug therapy change, etc.

All documentation of disposition of medication must include the patient's name, medication name and strength, prescription number, quantity, date of disposition and involved facility staff, consultants, or other applicable individual.

Change Healthcare will provide a written report of findings and recommendations upon conclusion of the review. Change Healthcare will also provide a letter back to the facility notifying them of the outcome of the review.

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
DOD	Date of service after date of death
WDT	First filled 180 days past date written
DSCT	Medication discount card billed
DECI	Decimal error
340B	Claim submitted with submission clarification code 20, but pharmacy is not on 340B Medicaid Exclusion File
XX	Rx not reviewed; Pharmacy staff would not allow claims reviewer onsite to perform review
BB	Billed brand name drug when Rx was written for generic version without prior authorization
CC	Claim should have been billed as compound

Claims Review Code	Description
EXC	Claim excluded from claims review per ODM's request
NC	Claim incorrectly billed as compound
CRC	Claims review cancelled
CSA6	Claim for controlled substance filled more than six months from date written
RC	Claim was reversed by pharmacy
LTC	MAR/Census Report required to confirm validity of claim for LTC patient
TD	Duplicate therapy; medical justification required
ND	No directions/sig documented
PD	Incomplete/missing/unclear prescriber DEA number
PN	Incomplete/missing/unclear prescriber NPI number
DA	Incorrect days' supply originally submitted; days' supply changed to be consistent with directions/sig – no recoupment
OR	One Rx submitted with two different patients and/or drugs
DL	Exceeds maximum dispensing limits
IC	Ingredient cost calculated/billed inaccurately
BC	Billed as compound, but missing ingredients
DB	Drug billed is different than drug prescribed
IC	Incorrect compound ingredient NDC billed

Claims Review Code	Description
ICV	Ingredient cost submitted requires validation
RL	Response received after allowed timeframe
FM	FAXed Rx is incomplete; missing required FAX components
MRx	Prescription not on file or prescription incomplete
NA	No adjustment
PS	Package size submitted does not match package size dispensed
MR	Medication returned to pharmacy by LTC facility
DAW	Incorrect or invalid DAW submitted
DR	Drug regimen discontinued at LTC facility
OO	Other
IP	Invalid prescriber ID
PA	Prior authorization required
PC	Pharmacy closed/sold; Rx not available
PE	Prescription expired/Rx written after DOS
MN	Patient information is missing/incomplete on Rx
PI	Prescriber ineligible (Suboxone/Subutex claims); or veterinarian
EAR	Exceeded allowed refills
AM	Missing/incomplete or ambiguous prescriber's authorizing agent

Claims Review Code	Description
PM	Missing/incomplete prescriber information
PJ	Missing/incomplete or ambiguous prescriber signature
DW	Rx is incomplete – Rx date is missing/incomplete
DSM	Missing/incomplete or ambiguous drug strength
DNM	Missing/incomplete or ambiguous drug name
RQM	Rx incomplete; missing directions for use, drug name, strength, and/or quantity
BPC	Copy of Rx/documentation is illegible; pharmacy must provide legible copy of Rx/documentation
RA	Refill authorization documentation needed for DOS
WP	Prescriber indicated they did not prescribe Rx
MP	Member indicated they did not receive Rx
CSA2	CII Rx is not compliant
TR	Tamper Resistant Prescription Pad compliance not met
SLR	Signature log required; not available during onsite
QB	Quantity billed exceeds the quantity delivered based on review of delivery manifest
SLM	No signature on signature log
QD	Quantity reduction by pharmacy; split billing
RXU	Missing/incomplete or ambiguous directions/sig

Claims Review Code	Description
NOT	Copy of Rx not provided
DOS	Invalid date of service