Policy:	MA.6107
Title:	**Pharmacy Claims Processing**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	*/s/ Michael Hunn 12/16/2024*
Effective Date:	01/01/2006
Revised Date:	12/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process by which CalOptima Health ensures accurate and timely processing, payment, and reporting of claims submitted by Contracted Network Pharmacies on behalf of OneCare Members.

II. POLICY

A. CalOptima Health's Pharmacy Benefit Manager (PBM) shall:

1. Operate an online claims processing system that operates in real time to adjudicate claims submitted by Contracted Network Pharmacies.

2. Operate a paper claims processing system to cover services from out-of-network Providers and pharmacies when a network Provider or pharmacy is not available.

3. Ensure Prescription Drug Event (PDE) records include active and valid prescriber National Provider Identifier (NPI) numbers;

4. Confirm the validity of prescriber Drug Enforcement Administration (DEA) numbers on Schedule II-V claims;

5. Rapidly adopt any new messaging approved by the National Council for Prescription Drug Programs' (NCPDP) workgroup to adjudicate a Part D claim, and appropriately coordinate benefits in real time; regularly update their systems with the most current information on the Office of Inspector General (OIG) sanctioned Providers and have processes in place to identify and prevent payment of Part D claims at point-of-sale (POS) when such claims have been prescribed by excluded Providers;

6. Utilize Health Insurance Portability and Accountability Act (HIPAA), as amended, Compliant transactions, where applicable;

7. Document the manner and extent to which it has tested benefit designs such as drug exclusions or quantity limitations and plan parameters such as co-payments and benefit intervals (phases) pre-implementation and ongoing;

8. Assign and exclusively use unique:

    a. Part D cardholder identification number (RxID) for each CalOptima Health Member, and

    b. Part D identifiers (RxBIN/RxPCN) for each Part D health program.

9. Maintain current policies and procedures documenting the process for negotiation with prescription drug manufacturers and others for rebates, discounts, or other price concessions on prescription drugs.

10. Provide annual reports of direct and indirect remuneration (DIR) dollars for payment reconciliation on an annual basis in the manner specified by Centers for Medicare & Medicaid Services (CMS).

11. Maintains records and documentation to verify the DIR data reported to CMS.

12. Provide information related to PBM transparency as specified in Section 6005 of the Affordable Care Act.

13. Apply True Out-of-Pocket (TrOOP) balances and gross covered drug costs when applicable to new Member Part D claims using updated external accumulator values provided in the Financial Information Reporting (FIR) transactions.

B. CalOptima Health and the PBM shall maintain policies and procedures detailing the claims adjudication process, claims detail management, access to claims information, and the claims data retrieval process.

C. CalOptima Health shall provide oversight of the PBM functions.

III. PROCEDURE

A. The PBM shall operate an online claims processing system that operates in real time to adjudicate claims submitted by Contracted Network Pharmacies. The online claims processing system shall:

1. Respond to ninety-eight percent (98%) of claims submitted within two (2) seconds or less after submission;

2. Adjudicate and pay (as applicable) ninety-nine and five tenths percent (99.5%) of all claims without errors; and

3. Have system availability ninety-nine and nine hundred sixty two thousandths percent (99.962%) of the time, twenty-four (24) hours a day, three-hundred sixty-five (365) days a year, excluding scheduled maintenance and downtime.

B. The PBM shall operate a paper claims processing system designed to pay claims submitted by non-network Pharmacies. The paper claims processing system shall process and pay (as applicable) one hundred percent (100%) of claims within fourteen (14) calendar days after receipt.

C. The PBM shall submit PDE reporting records to CMS no less often than monthly, and will meet year-end deadlines. Ninety-nine and twenty-five hundredths percent (99.25%) of PDE records submitted to CMS shall be accepted by CMS.

D. The PBM shall maintain a claims adjudication system available for CMS inspection that includes:

1. Hardware and software;

2. Operating system;

3. Commercial organization from which applicant receives pricing files, including file revision history;

4. Number of sites processing claims (including disaster recovery back-up systems); and

5. System volume in covered lives including the number of transactions the system can support per day and per hour.

E. The PBM shall make available to CMS, upon request, policies and procedures that include a complete description and flow chart detailing the claims adjudication process for each of the following:

1. Contracted Network Pharmacies;

2. Paper claims;

3. Out-of-Network pharmacy claims submitted by Members;

4. Non-electronic claims submitted by network pharmacies, and other payers seeking to coordinate benefits;

5. Batch-processed claims;

6. Retroactive claims adjustments;

7. Manual claim entry (e.g., for processing direct Member reimbursement); and

8. Long-term care (LTC) pharmacies, which:

a. May submit claims for reimbursement up to ninety (90) calendar days after the date of service; and

b. Shall dispense drugs and report information as required by Title 42, Code of Federal Regulations, Section 423.154

F. The PBM shall make available to CMS, upon request, policies and procedures that include a complete description of claim detail management, including:

1. The length of time that detailed claim information is maintained online (not less than twelve (12) months);

2. The data storage process after it is no longer online; and

3. The length of time that detailed claim information is stored when it is no longer online (no less than ten (10) years).

G. The PBM shall make available to CMS, upon request, policies and procedures that include a complete description of the accessibility of this information for data capture purposes, and flow chart of the claims data retrieval process for each of the following:

1. Entire claims history file;

2. File claims adjustments including records of reimbursements and recoveries due to network pharmacies and beneficiaries;

3. PDE file creation, monthly PDE submission, quality reviews and error resolution; and

4. Deductible files/ True Out-Of-Pocket (TrOOP) Expenditures/ and gross covered prescription drug cost accumulator;

5. Reporting of Financial Information Reporting (FIR) incoming and outgoing transaction responses;

6. Rx Transaction history and application to claims.

H. On a quarterly basis, CalOptima Health Pharmacy Management Department shall provide oversight of the following PBM functions:

1. PDE file accuracy and monthly PDE submission timeliness;

2. Claims processing oversight;

   a. TrOOP Expenditures calculations;

   b. Benefit phase;

   c. Formulary status;

   d. Ingredient cost and dispensing fee;

   e. Member Copay; and

   f. Member Eligibility.

3. Explanation of Benefits (EOB) accuracy and timeliness;

4. Transitions fills accuracy;

5. Pharmacy Network adequacy;

6. FIR Oversight;

7. Reversed Claims Oversight; and

8. Duplicate Claim/PDE Review.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Application from Medicare Advantage Prescription Drug Plans (MA-PD) Sponsors
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. Medicare Prescription Drug Benefit Manual, Chapter 5: Benefits and Beneficiary Protections
D. Section 6005 of the Affordable Care Act
E. Title 42, Code of Federal Regulations (C.F.R.), Part 423, Subpart G
F. Title 42, Code of Federal Regulations (C.F.R.), §§ 423.120(c)(4), 423.154, 423.504(b)(20), 423.520, 423.568(b), and 423.466

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2006	MA.6107	Pharmacy Claims Processing	OneCare
Revised	10/01/2012	MA.6107	Pharmacy Claims Processing	OneCare
Revised	03/01/2013	MA.6107	Pharmacy Claims Processing	OneCare
Revised	06/01/2015	MA.6107	Pharmacy Claims Processing	OneCare OneCare Connect
Revised	11/01/2016	MA.6107	Pharmacy Claims Processing	OneCare OneCare Connect
Revised	11/01/2017	MA.6107	Pharmacy Claims Processing	OneCare OneCare Connect
Revised	10/01/2018	MA.6107	Pharmacy Claims Processing	OneCare OneCare Connect
Revised	12/01/2019	MA.6107	Pharmacy Claims Processing	OneCare OneCare Connect
Revised	02/01/2020	MA.6107	Pharmacy Claims Processing	OneCare OneCare Connect
Revised	09/01/2021	MA.6107	Pharmacy Claims Processing	OneCare OneCare Connect
Revised	12/31/2022	MA.6107	Pharmacy Claims Processing	OneCare
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Revised	12/01/2024	MA.6107	Pharmacy Claims Processing	OneCare

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Contracted Network Pharmacies	Licensed pharmacies, including retail, home infusion, and institutional pharmacies, under contract with a Part D sponsor to provide covered Part D drugs at negotiated prices to Part D enrollees.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Member	A beneficiary enrolled in a CalOptima Health program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Provider (Part D)	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who are licensed to furnish Covered Services.
True Out-Of-Pocket (TrOOP) Cost	True Out-Of-Pocket (TrOOP) costs are the payments that count toward a Part D beneficiaries' Medicare drug plan out-of-pocket threshold. TrOOP costs determine when a beneficiaries' catastrophic coverage will begin.