PACE PROVIDER

MANUAL

March, 2011

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SECTION/SUBJECT **PAGE**

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I. OVERVIEW

A. The Pharmaceutical Assistance Contract for the Elderly (PACE) Program

The Pharmaceutical Assistance Contract for the Elderly (PACE) Program began on July 1, 1984. Its purpose, as stated in Act 1996-134 (P.L. 342, No. 36) (72 P.S. Section 3761-501-3761-522), is to establish a program of limited pharmaceutical assistance for qualified state residents. The legislation of 1996 expanded the PACE Program eligibility requirements and also created a new program, PACENET (Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier). In 2003, legislation was again introduced that raised cardholder eligibility requirements and introduced co-payment schedules for both PACE and PACENET. Pennsylvania has the largest pharmaceutical program for older people in the nation. Pennsylvania residents 65 years of age or older who meet certain income requirements are the Program beneficiaries. Financed with Pennsylvania state lottery funds, the daily operation of the Program is administered by **Magellan Health Services** following the guidelines of and reporting to the Pennsylvania Department of Aging.

B. The Patient Assistance Program (PAP)

The PA Patient Assistance Program, administered by the Department of Aging, is available to Pennsylvania residents who are ineligible for other pharmaceutical assistance programs including PACE and PACENET. Providers must request and sign an amendment to their PACE provider agreement to enroll in the PA PAP. The Pennsylvania Patient Assistance Program reimburses only in accordance with the terms and conditions set forth by each pharmaceutical assistance program accepted by the Department. Claims submitted under PA PAP are subject to the same limitations as the pharmaceuticals dispensed under the PACE Program including, but not limited to, the lesser of 100 units or 30 day supply, no vacation supplies, and no mailing of pharmaceuticals outside of Pennsylvania. Providers collect the applicable program's copay as set forth by the Department. As with PACE, PA PAP pays providers via EFT and distributes a separate PA Patient Assistance Program Remittance Advice. Enrolled cardholders received a unique ID card verifying their enrollment in any of the PA Patient Assistance Programs. Providers participating in the Pennsylvania Patient Assistance Program will be sent written notification of the Department's intent to adopt future pharmaceutical programs at least thirty (30) days prior to implementation of any program. Accompanying such notification will be all necessary information for the processing of claims for such programs

C. The Catastrophic Loss Benefits Continuation Fund (AutoCAT) and Workers' Compensation Security Fund (WCSF) Programs.

Pharmacy providers wishing to submit Auto CAT or WCSF compensation claims on line may also enroll in the Catastrophic Loss Benefits Continuation Fund (AutoCAT) and Workers' Compensation Security Fund (WCSF) Programs. Providers must request, complete and return an AutoCAT and/or WCSF Provider Enrollment form and Agreement to PACE Provider Services. Claims submitted to these programs are subject 30 day supply at retail pharmacies and up to a 3 month supply by mail order. As with PACE, these Programs pay providers via EFT and distribute a separate Remittance Advice for each Program. Providers enrolling in either the AutoCAT or WCSF Program receive NCPDP version 5.1 specifications instructing them in the specific fields to use to submit these claims on line.

II. CARDHOLDER INFORMATION

In order to be eligible for participation in PACE, an applicant must be a resident of the Commonwealth of Pennsylvania for at least 90 days prior to the date of application, be 65 years of age or older, have an annual income less than the maximum annual income and not be qualified for full payment for prescription drug benefits under any public assistance program.

A. Cardholder Requirements

1. Residency

   A cardholder must have lived in the Commonwealth of Pennsylvania for at least 90 consecutive days preceding the date of application to the Department of Aging. The cardholder must have a fixed place of abode in the Commonwealth. Residents of nursing homes located within the Commonwealth are included in these provisions.

2. Age

   A cardholder must be 65 years of age or older to participate in the PACE Program. A cardholder may submit a completed PACE application 30 days prior to his/her sixty-fifth birthday to assist in the timely determination of eligibility.

3. Income

   PACE

   A cardholder must have an annual income of not greater than $14,500 if single. A cardholder must have a combined income of not greater than $17,700 if married with the following exceptions:

   a. Married applicants maintaining separate residences and not receiving support from the other's income must file separate applications. Each must have an annual income not greater than $14,500.

   b. Married cardholders will be subject to the income provisions for single residents if either spouse is a resident of a long term care facility. Each must file separate applications and each must have an annual income of not greater than $14,500 to be eligible.

   PACENET

   a. A single cardholder is eligible for PACENET if his or her annual income is between $14,500 and $23,500.

   b. A married couple is eligible for PACENET if their combined annual income is between $17,700 and $31,500.

4. Other Prescription Drug Insurance Coverage

   The PACE Program is designed to be the payer of last resort. Although Medical Assistance participants receiving pharmacy benefits are ineligible (not including the "Medically Needy"), other prescription drug insurance coverage is acceptable. PACE and PACENET applicants must identify on their enrollment application any/all companies with whom they have health insurance coverage. In instances in which the provider is unable to bill the other carrier or is unable to ascertain the existence or extent of other benefits, the PACE Program will bill the cardholder’s insurance company for the benefits paid on their behalf.

5. Monthly Deductible

Cardholders eligible for the PACENET Program must satisfy a monthly deductible. This deductible is established each year based on the annual benchmark Medicare Part D premium as established by CMS. The PACENET deductible begins the first month the PACENET card is used. PACENET will reimburse for prescriptions when the cardholder has met their cumulative deductible. Providers are to transmit all prescription claims for which the PACENET cardholder is paying. PACENET will accumulate the monies spent and notify the provider in the response of the amount the cardholder is to pay.

6. Co-Payment

Eligible PACE cardholders are required to pay either a $6.00 (generic products) or $9.00 (single source/medical exception brands) co-pay. Upon attaining the Program's deductible, PACENET cardholders are required to pay either an $8.00 (generic products) or $15.00 (single source/medical exception brands) co-pay. PACE or PACENET co-pay amounts may be reduced by the Program if the Program's calculated reimbursement is less than the applicable co-pay.

PACE or PACENET cardholders insisting on an A-Rated multiple source product in lieu of an available generic when a Medical Exception has not been granted, will be responsible for the entire usual and customary price of the prescription.

B. Identification Card

PACE

PACENET

1. Examination of PACE/PACENET Card

Enrolled providers shall examine a cardholder's signed PACE card on each occasion pharmaceuticals are dispensed. PACENET cards are identified through the inclusion of the word "**NET.**" It is the provider's responsibility to establish the identity of the cardholder. Claims submitted for persons who are not approved cardholders on the date the prescription is dispensed will not be paid.

2. Explanation of PACE Card Fields

Please refer to the example above.

a. **PACE/PACENET Identification Number –** The cardholder's unique PACE number is a randomly generated nine (9) character identifier. The ID format is: 4 numbers, 1 letter and 4 numbers. The letters L, I and O are **NOT** used.

b. **The PACE/PACENET Cardholder's Name -** The pharmaceuticals dispensed must be for the cardholder whose name appears on the card.

c. **Lock-In -** If implemented, the letter **"L"** will appear in the lower right hand corner of the PACE card. The appearance of this **"L"** indicates that the Department of Aging has restricted or "Locked-In" the cardholder to a specific provider. Additionally, a cardholder may have an inclusive or exclusive restriction to a given therapeutic class.

The provider will be notified when a cardholder is restricted to his/her pharmacy, as well as the existence of any therapeutic drug restriction.

The cardholder will be notified which provider he/she must use. A cardholder will be restricted to this specific provider except in an emergency. In the case of an emergency, a provider who is not the cardholder's designated "Lock-In" provider may fill the prescription **upon receiving authorization from a Provider Services operator**. The claim must be submitted on a Universal Claim Form and the word "Emergency" must be written beside the cardholder's embossed name. The claim should be mailed separately to the attention of the Provider Services Manager.

d. **Other Coverage -** Indicated by **"Y"** (yes) if the cardholder has declared insurance by a private insurance company. The other insurance indicator must be included when submitting a claim on-line. Note: Situations may occur in which the cardholder has failed to declare another insurance carrier to the Program. In those cases, the existence of the other carrier, as identified during the on-line claim submission, supersedes the lack of the appearance of the "Y" on the PACE/PACENET card. In the event that third party insurance exists as evidenced by the appearance of the **"Y"** on the PACE card or ***as reported through a Point of Sale claim response,*** the provider **must** first seek reimbursement from the cardholder's other insurance company. If the provider is unable to pursue reimbursement from the cardholder's other insurance company (e.g., the cardholder has not met the deductible), then the provider may bill the PACE Program.

e. **Authorized Signature -** The cardholder's signature should appear in this space.

f. **Instructions -** Instructions and information for PACE/PACENET cardholders may be obtained by calling Cardholder Services (1-800-225-7223).

g. **Explanation of Other Indicators -** Providers may observe other letters embossed on the right side of a PACE/PACENET card. These letters and their purposes are:

1. **RL (Reissued/Lost)** indicates this is a replacement card for a card reported lost or stolen.

2. **RN (Reissued/Name)** indicates this replacement card has been issued for name correction.

3. **RE (Reissued/Eligibility)** indicates a correction made to the eligibility dates.

4. **RT (Reissued/Third Party Liability)** indicates an addition or deletion of the letter **"Y"** for other coverage.

5. **RR (Reissued/Restricted)** indicates a card reissued for a cardholder who is Locked-In or restricted to one pharmacy.

Providers are reminded that the PACE/PACENET card is not to be retained. PACE/PACENET cards are to remain in the possession of the cardholder.

C. Explanation of Benefits Statement

Upon request, the PACE Program will send an Explanation of Benefits statement (EOB) to PACE/PACENET cardholders. This letter summarizes each cardholder's PACE/PACENET drug activity and includes such information as the number of prescriptions, total cost to the cardholder, savings to the cardholder and the amount the prescriptions would cost the cardholder without PACE/PACENET.

D. Freedom of Choice

Cardholders are permitted to select participating providers from whom they receive pharmaceutical services unless the Department elects to restrict or "Lock-In" a cardholder to a specific pharmacy.

III. PROVIDER INFORMATION

A. Provider Categories

1. Retail Providers

The majority of PACE providers are in the retail environment and service the general public. PACE categorizes PACE pharmacies further as independent, chain (4 or more pharmacies owned by the same entity) and institutional pharmacies**.**

2. Nursing Home Providers

a. **Definition**
A nursing home provider is defined as either a pharmacy contained within the long-term care nursing facility or a provider who services nursing home residents.

b. **General Information**

The Department recognizes that some nursing home in-house policies and procedures direct that only small quantities (i.e., 7 days, 14 days) of a cardholder's monthly supply of medication be ordered at one time. However, nursing home providers and providers who service nursing homes need to be especially cognizant of the maximum dosage for those drugs that could be considered as chronic maintenance drugs. ***Repeated claims submitted for the same drug in small quantities within a thirty (30) day period impact an unnecessary financial hardship on cardholders. This also gives the appearance of provider "fee splitting" which is a violation of PACE regulations.*** Therefore, although the Department recognizes that it cannot dictate a nursing home's medication dispensing policy, ***the Program does encourage the submission of claims for those chronic maintenance medications to be on a monthly basis thereby including only one co-pay per prescription***.

Nursing home providers or those servicing nursing homes are subject to the same submission requirements as other PACE providers. Claims are to be submitted to PACE on the date they are dispensed. All PACE providers, including those enrolled as nursing home providers and providers servicing nursing homes, are advised the date the original claim is submitted to the Program is to be the date-of-service.

The Department has reviewed the information concerning internal drug utilization policies presented by nursing home providers and providers who service nursing homes. Recognizing the unique circumstances of the cardholders and assured of these continuing safeguards, the Department authorizes requests for Medical Exceptions received up to forty-five (45) days after the dispensing date for those cardholders residing in nursing homes. These cardholders must be identified in the Patient Location field on the incoming claim as residing in the type of facility which supervises and/or monitors the dispensing of medications to PACE/PACENET cardholders.

Although the Program permits claims to be accepted up to ninety (90) days from the date-of-service, all claims, as stipulated by the PACE Provider Agreement are to be submitted to PACE on-line, *prior to the dispensing of the prescription drug* (Section I.O. of the Provider Agreement).

Providers failing to follow this provision of the Provider Agreement and whose claim the Program denies may not bill the cardholder for the denied claim.

PACE providers enrolled as nursing home providers and those who service nursing homes whose internal billing or bookkeeping procedures misrepresent the date-of-processing as being the date-of-service are advised that this practice is not acceptable on audit. PACE providers enrolled as nursing home providers as well as those providers

servicing nursing homes who submit claims with incorrect dates-of-service will have these claims disallowed.

3. Mail Order Providers

This section summarizes the Rules and Regulations governing the dispensing of PACE prescriptions by mail when PACE/PACENET is the primary payor. All mail order PACE providers are obligated to abide by the current PACE Rules and Regulations. No statement contained in this summary can, or should be interpreted, as superseding the published Regulations.

The Mail Order Regulations address those providers who anticipate dispensing a total of more than ten (10) PACE prescriptions by mail in a given calendar month. Any provider expecting to fill and deliver eleven (11) mail ordered prescriptions in one (1) month, whether they are all for one (1) cardholder or for several cardholders, should contact the Provider Services Manager to discuss enrolling as a mail order provider.

NOTE: With the advent of PACE *Plus* and the integration of Medicare Part D with PACE and PACENET, the Department has developed a separate master Mail Order Provider Agreement for those mail order providers that are an integral part of a Medicare Part D plan or MAPD Plans. To permit the use of the Medicare Part D or MAPD plan's mail order provider as the primary payer, the Department may elect to waive certain provisions listed below.

a. Provider Information

1. Providers wishing to become mail order providers are subject to all eligibility criteria of walk-in (conventional retail) providers. Providers are enrolled either as a walk-in provider or mail order provider.

2. Only providers who have been enrolled in the PACE Program are qualified to receive payments under the Program.

3. Currently enrolled PACE providers seeking to enroll as a mail order provider should submit a written request. This request must contain your current walk-in PACE provider number and be sent to:

MAGELLAN HEALTH SERVICES
PACE Provider Services Department
P.O. Box 8809
Harrisburg PA 17105
Attention: Provider Services Manager

A Supplemental Agreement form will be mailed for your completion and signature. The effective date will be the date the signature of the Department's authorized representative has been affixed.

b. Conditions of Mail Order Participation

1. Providers may not charge PACE cardholders additional fees above the required co-payment for any mail order or delivery service.

2. Mail order providers must have, or take steps to develop a systematic mail order operation, to include the submission of all PACE claims using an on-line device.

3. Verification of Cardholder Identity

a. It is the responsibility of both walk-in and mail order providers to establish the identity and current eligibility status of all cardholders whom they serve

under the PACE Program. Although providers providing walk-in prescription services must observe a cardholder's signed PACE card on each occasion a prescription is dispensed under the Program, providers providing mail order services ***Shall Not*** request PACE cardholders to send a PACE identification card through the mail.

b. As a basis for establishing the identity of PACE cardholders, an enrolled mail order provider of PACE Program benefits shall have, or secure, and maintain on file a signature reference for each PACE cardholder requesting services by mail from the provider. This signature reference shall bear the original signature of the cardholder or the cardholder's authorized representative and shall form a basis for signature comparisons carried out under Section 22.63 (d) (1) of the Regulations. The Department reserves the right to waive this requirement, and the related requirement of Section 22.63 (d) (1) of the Regulations, for a provider who can present an alternative system of control which offers assurance to the Department that verification of cardholder identity and cardholder receipt of the ordered prescription drugs can and will be effectively accomplished without the signature references. Providers will only be reimbursed for on-line claims of active approved cardholders.

4. Designated Representative

An incapacitated cardholder who is, because of the incapacity, unable to personally claim PACE benefits, may designate another person to do so. The designated representative requesting PACE benefits by mail must have legal authority to represent an incapacitated cardholder as evidenced by power of attorney or other legal document, and must sign all forms requiring the cardholder's signature. Providers of prescription services by mail shall require all designated representatives to provide documentation of their legal authority to represent the cardholder.

5. Medication History

Enrolled providers offering mail order prescription service shall have or establish and maintain a medication history on all PACE cardholders provided with these services. This history must include, at a minimum, the following cardholder or equivalent information as approved by the Department of Aging:

a. name,
b. PACE/PACENET identification card number,
c. medication allergies and other allergies,
d. current medication utilization,
e. indication of all medical disorders known to the cardholder,
f. separate entries for each prescription medication dispensed by the provider.

6. Other Provisions for Prescription Services by Mail

a. Mail orders for prescription drugs.

b. Provider shall provide PACE cardholders with order forms and clear instructions for submitting mail orders. These forms must include, at a minimum:

i. the cardholder's signature (or legally designated representative),
ii. the cardholder's address,
iii. the cardholder's telephone number (where applicable),
iv. the cardholder's PACE/PACENET identification number.

c. Each initial mail order prescription must be accompanied by a valid prescription as written by the licensed prescriber.

d. If mail order prescription drugs cannot be delivered by mail, the provider shall, within two (2) working days of the receipt of the mail order, notify the cardholder and the prescriber by telephone or mail and return the written prescription(s) to the cardholder. The exception to this notification is Section 22.62 (i) (3), which states:

> "Providers shall refuse to fill prescriptions which they suspect are not authentic. If, in the professional judgment of the provider, a prescription does not appear to be authentic, the provider shall contact the indicated prescriber by telephone to check on its authenticity. Whenever, as a result of such a check, the provider is professionally convinced that the prescription is fraudulent, the provider may not return the prescription to the cardholder, but shall forward it to the Department accompanied by the name, address and PACE identification card number of the cardholder."

e. Telephone prescription orders.

1. Providers of prescription services by mail ***May Not Accept Initial*** prescription orders for PACE Program benefits by telephone ***except*** when all of the following control steps have been taken:

i. The provider has secured the name, address and telephone number of the licensed prescriber making the telephone order.

ii. The provider has secured the license number assigned by the appropriate State Licensing Board to the licensed prescriber making the telephone order.

iii. The provider has secured the United States Drug Enforcement Administration Registration Number of the licensed prescriber making the telephone order unless that prescriber has no registration number.

iv. The provider has verified that the information secured is correct and that the telephone order originated from the licensed prescriber.

v. The provider shall retain original hardcopy prescriptions for four (4) years at the principal place of business. The original hardcopy prescriptions which are not handwritten by the prescriber shall bear the date and the handwritten signature or the handwritten initials of the dispensing pharmacist.

2. Refill prescription orders may be accepted by telephone.

7. Dispensing Prescription Drugs by Mail

a. ***No Prescription Drugs Dispensed By Mail Shall Be Mailed To An Address Outside The Commonwealth.*** Packages used for the dispensing of prescription drugs by mail shall bear the words ***"Do Not Forward"*** on the face which bears the cardholder's Pennsylvania address.

b. A prescription drug delivered by first class mail shall be accompanied, at a minimum, by the following:

1. A Universal Claim Form.

2. Clear instructions to the cardholder about the completion, signing and return of the Universal Claim Form accompanied by all payments due from the cardholder if full payment has not been received in advance of delivery. These instructions must advise the cardholder that the Universal Claim Form and any payments due must be returned to the provider within five (5) days of the cardholder's receipt of the prescription drug.

3. Information regarding the use and storage of the prescription drug, as appropriate.

4. A postage paid, provider self-addressed envelope to facilitate the cardholder's response to receipt of the prescription drug.

5. Once the Universal Claim Form is returned by the cardholder, the provider retains the form for proof of signature and submits the claim.

8. Utilization Review

a. When a provider, who is authorized to provide prescription services by mail to PACE cardholders, observes any irregularities in prescriptions, dosages, medication history, prescriber utilization, mailing address, cardholder name or PACE identification card number or other similar kinds of irregularities, the provider shall make an immediate comparison of signatures in the cardholder's file.

b. The provider shall discontinue prescription services by mail to any cardholder who fails to return the Universal Claim Form appropriately completed, fails to submit all due cardholder payments, or is suspected of submitting a false or fraudulent prescription order, or false or fraudulent information on a Universal Claim Form.

c. Whenever a provider of prescription services by mail discontinues services under paragraph (b), the provider shall notify the Department of the cardholder's name and PACE identification card number and the name of the prescriber of any prescriptions related to the reasons for the provider's decision to discontinue services.

. 9. Provider Accessibility to Cardholders

a. Enrolled mail order providers must arrange for access by a cardholder or medical personnel to a registered pharmacist in the event of drug concerns or emergency situations.

b. Examples of these situations would include, but not be limited to, the following topics:

1. drug side effects and reactions,
2. drug interactions,
3. dosage,
4. drug ingestion or administration and proper storage,
5. drug identification (for example, in the event of lost labels),
6. emergency medical treatment of a cardholder.

c. This access must include either (1) the acceptance of collect phone calls or (2) the establishment of a toll-free number. This access must be available to the cardholder or appropriate medical personnel on a 9:00 a.m. to 5:00 p.m. basis during the days when the pharmacy is normally open for business.

d. The mail order provider shall issue clear instructions to the cardholder regarding the access phone number and its appropriate use.

4. Dispensing Physicians and Certified Registered Nurse Practitioners

PACE/PACENET enrolls physicians and certified registered nurse practitioners licensed by and whose practice is located in the Commonwealth of Pennsylvania. Dispensing physicians and certified registered nurse practitioners enrolling into PACE/PACENET must enroll themselves, not their practice. Dispensing physicians and certified registered nurse practitioners are subject to the same terms and conditions as pharmacy providers with two notable exceptions:

a. Dispensing physicians and certified registered nurse practitioners do not receive a dispensing fee.

b. Dispensing physicians and certified registered nurse practitioners cannot prescribe for and dispense DESI drugs to PACE/PACENET cardholders.

B. Provider Enrollment

PACE/PACENET provider enrollment consists of chain and independent pharmacies serving older Pennsylvanians in the retail environment, as well as mail order pharmacy providers located within the Commonwealth and nursing home providers. Although the Program's providers are overwhelmingly pharmacies, PACE/PACENET also enrolls dispensing physicians into the Program. The following paragraphs apply to **all** PACE/PACENET providers.

1. Assignment of Provider Numbers

A prospective PACE/PACENET provider must apply for, be enrolled, and agree to certain conditions of participation before payment can be made for services furnished to PACE/PACENET cardholders. Unless otherwise mandated by law, the provider identification number for all providers will be the National Provider Identifier (NPI).

2. Conditions of Participation

a. **Agreements**

Provider Agreements - Formal participation agreements with the Department of Aging must be filed by pharmacies, dispensing physicians and certified registered nurse practitioners. The provider agrees to all terms and conditions of the PACE On-Line Claims Adjudication System and Electronic Funds Transfer (EFT). The provider agrees to participate in the PACE and PACENET Programs and in the course of such participation to comply with all Federal and Pennsylvania laws generally and specifically governing participation in the PACE and PACENET Programs. The provider agrees to be knowledgeable of and to comply with applicable rules, regulations, rates and fee schedules promulgated under such laws and any amendments thereto. The provider agrees that in the event any part of the agreement is inconsistent with existing State or Federal statutory or regulatory authority, the statute or regulation in question governs. Providers enrolling in the PACE/PACENET Program agree to: (1) submit all claims via the Program's point of sale system and (2) have the capability to bill multiple providers on-line, real-time.

Provider agreements are specific to the enrolled provider and may not be transferred. The submission by or on behalf of the provider of any claim for payment under these Programs shall constitute certification by the provider that:

- ***The services or items for which payment is claimed were actually provided by the provider identified by the PACE/PACENET provider number on this agreement to the person identified as the cardholder; and***
- ***The claim does not exceed the provider's usual charge for the same items or equivalent services provided to the cash-paying public.***

b. **Licensure**

The provider must be currently licensed by the appropriate Commonwealth and Federal authorities and have their principle place of business in the Commonwealth, unless identified by a Medicare Part D plan as being a mail order provider.

c. **Records**

The provider must agree to keep any records necessary to disclose the extent of PACE services the provider furnishes to cardholders. On request, the provider must furnish authorized Commonwealth officials or their authorized agents any information maintained under the requirements of the preceding sentence and any information regarding payments claimed by the provider for furnishing services under the PACE/PACENET Program. All records must be retained for a minimum of four (4) years.

d. **PACENET**

To permit the accumulation of the required PACENET cardholder premium, PACE providers must transmit all prescription claims to the Program. The provider must agree to collect from the PACENET cardholder only what is returned by the Program in the response when the cardholder is meeting the premium. When billed as the primary payor, PACENET claims are subject to all edits, both during and after the premium is met.

C. Change in Ownership

A change of ownership includes a sale, a change in corporate structure or controlling interest in the pharmacy business, the addition of a partner or other corporate reorganization. When a change of ownership is to take place in a pharmacy which has, until that time, been an enrolled provider of the PACE Program, the following applies to avoid unnecessary interruption in the participation of the pharmacy and the PACE/PACENET cardholders who use the pharmacy:

1. Before the change of ownership occurs, the prospective provider shall file a PACE/PACENET enrollment application and agreement with the Department.

2. Immediately upon receipt of its pharmacy permit number, issued by the State Board of Pharmacy, the prospective provider shall notify the Department of the permit number.

3. Upon notification of the new owner's pharmacy permit number, the Department will execute the provider agreement and enroll the new owner's pharmacy in the PACE/PACENET Program.

4. The effective date of the new owner's provider agreement shall be the date of issuance of the permit number by the State Board of Pharmacy, unless the Department is reviewing the change of ownership. If the Department is reviewing the change of ownership, the Department will determine the effective date of the new owner's provider agreement. The Program will notify the new owner that a review of the change in ownership is occurring and that the Department will not pay the provider for prescriptions filled prior to the date of a valid and fully executed provider agreement.

During the period of review, the provider may service cardholders with the understanding that reimbursement under the PACE/PACENET Program may subsequently be disallowed if the Department determines that the provider will not be enrolled or that disenrollment of the provider is warranted.

PACE provider agreements are specific to the enrolled provider. **PACE Provider Agreements are non-transferable.** Pharmacy providers are reminded that they must comply with all State Board of Pharmacy regulations regarding proper notification, as well as the contractual obligations as set forth in the provider agreement with the Department of Aging. Dispensing physicians and Certified Registered Nurse Practitioners are reminded that they must maintain compliance with their respective regulatory Board, as well as the contractual obligations as set forth in the provider agreement with the Department of Aging

Prospective PACE/PACENET providers may request a provider agreement and enrollment form from PACE Provider Services or by accessing the Department of Aging Website at www.aging.state.pa.us . Provider Services will make these documents available to prospective new providers by conventional mail or fax. Prospective providers may return these documents by fax.

D. Rate of Provider Reimbursement

1. Providers are required to bill PACE at the usual charge for the drug dispensed.

   Usual charge is defined as an enrolled provider's charge to the cash-paying public for a prescription drug, in a specific strength and quantity within a specific calendar month. Discounts or coupons offered to the cash-paying public shall be considered to be offered to the Commonwealth as well. Discounts applied to cardholders or coupons presented by the cardholder shall be accepted by the provider and credited to the PACE Program payment and not the co-payment.

2. When the Department calculates the approved PACE Program payment, the following requirements apply:

   a. A pharmacy will be paid the lower of the following amounts:

      Eighty-eight percent (88%) of the average wholesale cost of the prescription drug dispensed, plus the dispensing fee, minus the co-payment and any TPL amounts.

      OR

      The pharmacy's usual charge for the drug dispensed, minus the co-payment.

      OR

      The FUL (Federal Upper Limits) price, plus the dispensing fee, minus the co-payment.

   b. A dispensing physician or certified registered nurse practitioner will be paid the lower of the following amounts:

      Eighty-eight percent (88%) of the average wholesale cost of the prescription drug dispensed, minus the co-payment and any TPL amounts.

      OR

      The dispensing physician’s or certified registered nurse practitioner’s usual charge, minus the co-payment and any TPL amounts.

      OR

      The FUL (Federal Upper Limits) price, minus the co-payment, and any TPL amounts.

   c. The Department's payments to enrolled providers will be remitted within twenty-one (21) calendar days of a complete and approvable claim.

3. Payment

The provider must agree to accept as payment-in-full the amount paid by the PACE Program and the cost sharing of the cardholder.

4. Third Party Liability/Other Coverage

In the event that third party insurance exists, as indicated by a **"Y"** on the cardholder's PACE/PACENET card or as indicated through an on-line claim response, the provider **must** first seek reimbursement from the cardholder's other insurance company.

Note: Instances may occur in which the cardholder failed to declare another insurance carrier which has subsequently been identified to the Program. In those cases, the existence of the other carrier, as identified via the on-line claim response, supersedes the absence of the appearance of the "Y" on the PACE/PACENET card.

The provider is to enter the appropriate value in the TPL/Other Coverage Code as defined by the NCPDP v5.1 and illustrated below:

0 = NOT SPECIFIED 1 = NO OTHER COVERAGE EXISTS 2 = OTHER COVERAGE EXISTS PAYMENT COLLECTED 3 = OTHER COVERAGE EXISTS CLAIM NOT COVERED 4 = OTHER COVERAGE EXISTS PAYMENT NOT COVERED	5 = MANAGED CARE PLAN DENIAL 6 = OTHER COVERAGE DENIED – NOT A PARTICIPATING PROVIDER 7 = OTHER COVERAGE EXISTS – NOT IN EFFECT ON DATE OF SERVICE *8 = CLAIM IS BILLING A COPAY Note: * Value not currently accepted

The other insurance amount is to be entered in the TPL/Other Payer Amount field.

E. Professional Responsibility

The provider assumes professional responsibility for dispensing drugs to eligible cardholders in the PACE Program. He/she may refuse to dispense any prescription which appears to be improperly executed or which, in his/her professional judgment, is unsafe as prescribed.

IV. CLAIMS PROCESSING

A. General Information

Providers are responsible for the timely submission of claims. In accordance with the provider agreement, claims are to be submitted at the time of presentation of the prescription and prior to the dispensing of the medication. In no case will original claim submissions be accepted beyond ninety (90) days from the date the prescription is dispensed. Providers wishing to correct errors or make adjustments are to do so within ninety (90) days of the date of dispensing using the point of sale system. The Department reserves the right to refuse payment of claims submitted more than ninety (90) days after the date the provider dispensed the prescription drugs covered by the claim.

A cardholder's prescription must be presented or be on file for PACE/PACENET services to be rendered. Each time PACE/PACENET services are rendered, the provider should verify that the cardholder is eligible by examining the PACE/PACENET card.

The claim submission process for the PACE Program is an on-line, real time system. All PACE/PACENET providers must submit claims using this real time system. The PACE on-line system is available 7am – 10pm, seven days a week, 365 days of the year except for required maintenance and/or upgrades.

With the PACE on-line system (POCAS), providers must maintain a signature log. It is the responsibility of providers to ensure that the logs are current. The Program acknowledges that a cardholder's pharmaceuticals may be received by an agent presenting the cardholder's PACE/PACENET card. In such cases, the representative must clearly identify his/her relationship to the cardholder. Providers having claims that cannot be verified on the date the prescription was dispensed by a clear and accurate signature log will have any such claims disallowed in an audit.

PACE providers are reminded PACE regulations (Section 22.63, (c) (1)) state, "Prescription drugs dispensed by mail may not be mailed to an address outside this Commonwealth. Packages used for the dispensing of prescription drugs by mail shall bear the words '***Do Not Forward***' on the face which bears the cardholder's Pennsylvania address."

B. Access to the On-line System

Providers can access the on-line system either through following the Program's On-Line Submission Specifications, included in this manual, or by contacting a software vendor.

1. Providers utilizing computer vendors to maintain the pharmacy's computer system should contact his/her vendor to have software installed using the included specifications.

2. Providers utilizing a software vendor can have their existing system modified to process PACE claims using the included specifications.

3. Providers may contact Provider Services to obtain a listing of software vendors currently supplying services to other PACE providers.

4. Providers or their software vendors must have their software certified with the Program and receive a certification number prior to submitting claims. Providers who have enrolled in the Program but have not completed their software certification **and elect to accept PACE claims during the interim may not bill cardholders for any claims subsequently denied**.

C. Adjustments

Adjustments are to be submitted by the provider using the on-line system.

D. PACE Claim Formats

Payer specification information necessary to process PACE/PACENET claims on-line using NCPDP Version 5.1 is included with this Provider Manual as a separate appendix.

E. Directions for Completing the Universal Claim Form (UCF)

The Universal Claim Form v5.1 instructions are included to assist providers in instances where the submission of a paper claim is necessary. An example of the v5.1 UCF is on page IV.6. The following information mirrors most data fields to be completed for claims, regardless of the means of submission. **EXCEPTION:** Providers do not enter the Program's copay in the v5.1 on-line claim transaction. Providers should familiarize themselves with the terms and definitions of these required data elements. Providers using vendor supplied software should use this guide in conjunction with the vendor's user manual.

NOTE: NR = Not Required – may be left blank.

I.D.: Cardholder identification number
Group I.D.: PACE
Name: Cardholder name
Plan Name: PACE
Patient Name: MUST match cardholder name
Other Coverage Code:
0 = NOT SPECIFIED
1 = NO OTHER COVERAGE EXISTS
2 = OTHER COVERAGE EXISTS, PAYMENT COLLECTED
3 = OTHER COVERAGE EXISTS, CLAIM NOT COVERED
4 = OTHER COVERAGE EXISTS, PAYMENT NOT COVERED
5 = MANAGED CARE PLAN DENIAL
6 = OTHER COVERAGE DENIED - NOT A PARTICIPATING PROVIDER
7 = OTHER COVERAGE EXISTS - NOT IN EFFECT ON DATE SER.
8 = CLAIM IS BILLING A COPAY

Person Code: NR (Not Required)

Patient Date of Birth: Required

Patient Gender Code: NR (Not Required)

Patient Relationship Code: Enter 1, 1 = cardholder

Pharmacy Name, Address, Phone and Fax numbers: Required - Self explanatory

Service Provider I.D.: National Provider Identifier (NPI)

Qualifier: Enter "01 for pharmacy and dispensing physicians /CRNP's.

Patient/Authorized Representative: Recognizing the special circumstances of older Pennsylvanians, cardholder's pharmaceuticals may be received by an agent presenting the cardholder's PACE card. The agent's signature and relationship to the cardholder (e.g., spouse, brother, daughter, etc.) must appear on the Universal Claim Form. Handwritten forms must be signed. Claims submitted with an agent's signature that is not an authorized representative of the cardholder could be invalidated. Providers using computer generated claim forms must maintain a signature log. It is the responsibility of providers to ensure that the logs are current and, in the case of the designated representative, clearly identify the relationship of the individual to the cardholder. Providers having claims that cannot be verified on the date the prescription was dispensed by a clear, accurate signature log will have any such claims disallowed in an audit.

Note: Mail order providers filling mail order prescriptions must abide by the mail order regulations regarding a cardholder's signature.

Workers Comp Information: Not Applicable

Prescription/Service Number: The number assigned to that prescription by the pharmacy (a maximum of seven [7] digits). Letters, special characters, e.g., commas, dashes, hyphens, etc. are not acceptable.

Qualifier: Enter "1" for Rx billing.

Date Written: The month, day and year in which the prescription was written.

Date of Service: The month, day and year the new or refilled prescription was dispensed. (Note: The date of service can not exceed six (6) months from the date the prescription was written)

Fill #: Enter **"00"** for a new prescription, or **"01-05"** to indicate a refill prescription. Refills will be covered up to and including five (5) refills or to provide a six-month supply, whichever occurs first from the original filling of the prescription.

Quantity Dispensed: Enter the metric quantity. The quantity cannot exceed 100 units for tablets or capsules. For compounds, use the metric quantity of each ingredient dispensed.

Days Supply: This amount cannot exceed 30 days for PACE (Exception: Timolol, 25% and .5% in 5ml. size must have a days supply between 45 and 60).

Product/Service I.D.: The 11-digit NDC code of the drug the cardholder is receiving. Providers must include all 11 digits of the NDC for the claim to be processed.

Qualifier: Enter "03" for National Drug Code (NDC).

DAW (Product Selection) Code: PACE requires **mandatory substitution** for A-Rated multiple-source products. The following are NCPDP's DAW (Dispensed As Written) Product Selection Code definitions. PACE regulatory responses follow in bold.

0 = No product selection indicated. **Prescription is for a generic or single source product. (Note "0" can also be used for an A-Rated product for which substitution is not mandated by PACE.)**

1 = Substitution not allowed by prescriber. **Claim REJECTS (for a Brand Name A-Rated multiple source product). "Brand Name" A-Rated products only reimbursed if a Medical Exception is approved by PACE. Claims receiving Medical Exceptions must have a prescription containing the words "Brand Necessary" or "Brand Medically Necessary" in the prescriber's own handwriting accompanied by the authorized prescriber's signature.**

2 = Substitution allowed – patient requested brand. **Claim rejects if submitted for an A-Rated multiple source product.** PACE/PACENET cardholders are responsible for the entire cost of the prescription if they insist on the brand name product in the absence of a Medical Exception.

3 = Substitution allowed – pharmacist selected product dispensed. **Claim rejects if submitted for an A-Rated multiple source product.**

4 = Substitution allowed – generic drug not in stock. **Claim rejects if submitted for an A-Rated multiple source product.** PACE/PACENET providers are responsible for the U&C minus the co-pay if the brand name product is dispensed for the generic because the product is not in stock.

5 = Substitution allowed – brand drug dispensed as generic. **Usual and Customary price is equal to or less than the lowest priced generic available. Note: In an audit, this must be substantiated. When PACE is the primary payer, claims will deny for A-rated brands unless a Medical Exception is on file. Effective 7/31/07 DAW 5 is no longer accepted for A-Rated brands without a Medical Exception on file.**

6 = Override. **Claim rejects if submitted for an A-Rated multiple source product.**

7 = Substitution not allowed – brand drug mandated by law. **Claim rejects if submitted for a multiple source product.**

8 = Substitution allowed – generic drug not available in Marketplace. **Claim rejects if submitted for a multiple source product.** *(Note: This code will not automatically permit processing. Providers receiving denied claims should contact Provider Services. If PACE review finds product is unavailable statewide versus locally, Program will modify Program drug file to permit temporary acceptance of brand.)*

9 = Other. **Claim rejects if submitted for a multiple source product.**

Prior Authorization # Submitted: Not applicable for PACE.

PA Type: Not applicable for PACE.

Prescriber I.D.: For claims when PACE is the primary payer, enter the prescriber's Commonwealth license number or their National Provider Identifier (NPI) . The license number may contain either 2 alpha, 6 numbers and 1 alpha, e.g., MD123456E or only 2 alpha and 6 numbers, e.g., OS 012345.

Physicians residing in a bordering state, Virginia and Washington, D.C. may issue prescriptions for Pennsylvania cardholders. If the bordering state physician does not have a Pennsylvania license, the claim may be accepted by writing the state's 2-letter abbreviation, 6-9's and an X, e.g., NY999999X or their NPI.

Providers filling prescriptions from physicians in these states must furnish, upon request, to the Department of Aging all necessary documentation; i.e., physician name, address, telephone number and out-of-state physician number. Claims for prescriptions issued by physicians in states other than the aforementioned will not be honored for any Program *except SPBP*.

Other Health Care practitioners who may prescribe for PACE /PACENET cardholders: Physician Assistants (PA's), Certified Registered Nurse Practitioners (CRNP's), Optometrists and Dentists. See **Section H. "Criteria for Claims Reimbursement"** of this manual for criteria regarding prescriptions written by these prescribers.

Qualifier: Enter "13" identifying value as State License Number.

DUR/PPS Codes: Not applicable for PACE.

Basis Cost: Not applicable for PACE.

Provider I.D.: License number of pharmacist, dispensing physician or certified registered nurse practitioner. Ancillary programs dispensing non-pharmaceutical products are to include the Social Security Number of the person dispensing the product in lieu of the pharmacist's or dispensing physician's state license number.

(Provider I.D.) Qualifier: 02 – state license; 13 – SSN

Diagnosis Code: May be required for certain DUR authorizations.

(Diagnosis Code) Qualifier: If code required, enter "01" for ICD9 code.

Other Payer Date: Payment or denial date of claim if submitted to other payer

Other Payer I.D.: Required when other coverage exists. Bank Identification Number contained in the response from the other payer.

(Other Payer I.D.) Qualifier: Enter "99"

Other Payer Reject Codes: Self-explanatory

Usual & Cust. Charge: PACE should be billed at the pharmacy's usual and customary charge including Senior Citizen Discounting Programs. PACE will adjust payment to match the lowest of the usual and customary charge, 88% of the Average Wholesale Cost (AWC) plus dispensing fee or Federal Upper Limits (FUL) plus dispensing fee. Note: Dispensing physicians and certified registered nurse practitioners do not receive a dispensing fee.

Ingredient Cost Submitted: Submitted product component cost of the dispensed prescription. For compound prescriptions, enter the total of all the cost fields on the reverse side of the v5.1 UCF.

Dispensing Fee Submitted: NR (Not Required)

Incentive Amount Submitted: Not Applicable for PACE

Other Amount Submitted: Not Applicable for PACE

Sales Tax Submitted: Not Applicable for PACE

Gross Amount Due Submitted: Not required in paper claim submission.

Patient Paid Amount: Amount the pharmacy received from the patient for the prescription dispensed for the **PACENET** premium. This includes the co-pay collected from the cardholder for another insurance co-pay. This does not include the PACE co-pay.

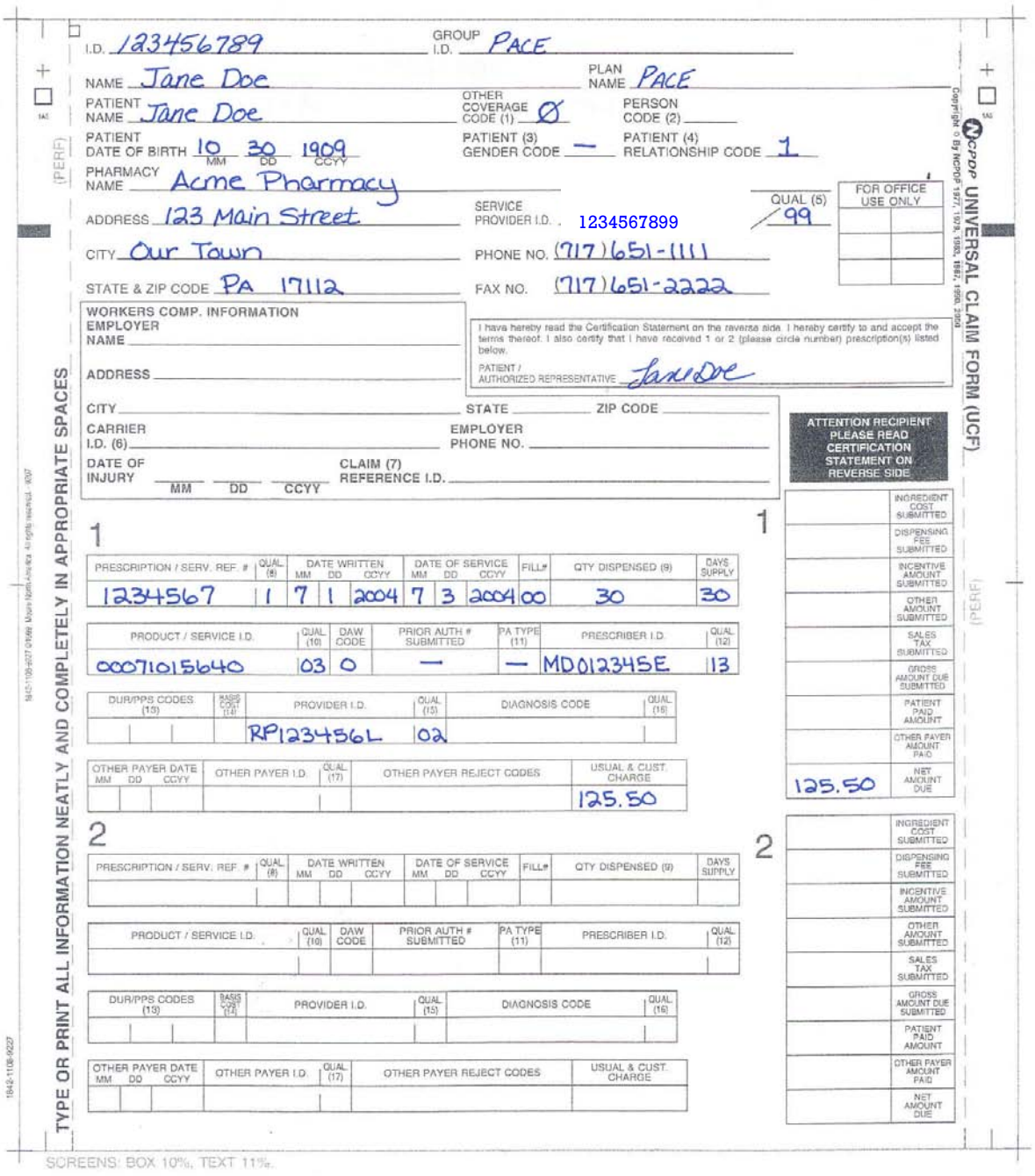
Other Payer Amount Paid: Amount of any payment known by the pharmacy from other sources.

Net Amount Due: Amount expected from the Program after all deductions are made.

Note: The Program will return the co-pay amount to be collected from the cardholder on the Remittance Advice in which the claim appears.

F. UNIVERSAL CLAIM FORM (UCF) Example

UCF Version 5.1



UNIVERSAL CLAIM FORM (UCF)

TYPE OR PRINT ALL INFORMATION NEATLY AND COMPLETELY IN APPROPRIATE SPACES

I.D. 123456789 GROUP I.D. PACE

NAME Jane Doe PLAN NAME PACE

PATIENT NAME Jane Doe OTHER COVERAGE CODE (1) Ø PERSON CODE (2)

PATIENT DATE OF BIRTH 10 30 1909 (MM DD CCYY) PATIENT (3) GENDER CODE — PATIENT (4) RELATIONSHIP CODE 1

PHARMACY NAME Acme Pharmacy

ADDRESS 123 Main Street SERVICE PROVIDER I.D. 1234567899 QUAL (5) 99 FOR OFFICE USE ONLY

CITY Our Town PHONE NO. (717)651-1111

STATE & ZIP CODE PA 17112 FAX NO. (717)651-2222

WORKERS COMP. INFORMATION
EMPLOYER NAME
ADDRESS
CITY STATE ZIP CODE
CARRIER I.D. (6) EMPLOYER PHONE NO.
DATE OF INJURY (MM DD CCYY) CLAIM (7) REFERENCE I.D.

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.
PATIENT / AUTHORIZED REPRESENTATIVE Jane Doe

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY
1234567	1	7 1 2004	7 3 2004	00	30	30

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)
00071015640	03	0	—	—	MD012345E	13

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)
		RP1234567L	02		

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE
				125.50

INGREDIENT COST SUBMITTED	
DISPENSING FEE SUBMITTED	
INCENTIVE AMOUNT SUBMITTED	
OTHER AMOUNT SUBMITTED	
SALES TAX SUBMITTED	
GROSS AMOUNT DUE SUBMITTED	
PATIENT PAID AMOUNT	
OTHER PAYER AMOUNT PAID	
125.50	NET AMOUNT DUE

2

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

INGREDIENT COST SUBMITTED	
DISPENSING FEE SUBMITTED	
INCENTIVE AMOUNT SUBMITTED	
OTHER AMOUNT SUBMITTED	
SALES TAX SUBMITTED	
GROSS AMOUNT DUE SUBMITTED	
PATIENT PAID AMOUNT	
OTHER PAYER AMOUNT PAID	
NET AMOUNT DUE	

SCREENS: BOX 10%, TEXT 11%.

G. Claims Submitted with Other Insurance

1. Provider able to obtain reimbursement from another insurance company.

   If the provider is billing the Program the difference between the amount reimbursed by the other payer and the provider's usual and customary price, the amount billed to the other carrier is included in the Other Payer Amount Paid field. The other applicable fields e.g., "OTHER PAYER DATE" are to be completed as described previously.

Usual & Customary Charge/ Gross Amount Due Submitted	$80.00
Cardholder's primary insurance pays ($60.00 is entered in Other Payer Amount Paid field)	$60.00
Net Amount Due – Amount billed to PACE	$20.00

   Note: The Program will return the co-pay amount to be collected from the cardholder on the Remittance Advice in which the claim appears.

2. Other Insurance is a discount plan.

   Provider is billing the primary insurance plan's co-pay only. If the provider is billing the Program for the primary insurance plan's co-pay, the provider should enter the other program's co-pay amount in the PATIENT PAID AMOUNT field.

   NOTE: If the provider is billing only the other program's co-pay, the Other Coverage Code should be "4."

Usual & Customary Charge/ Gross Amount Due Submitted	$80.00
Amount the cardholder's primary insurance pays is "unknown" i.e., the provider receives only a "paid claim" response or the provider is contractually bound to accept the primary insurance payment as sole payment, $00.00 is entered in the Other Payer Amount Paid field.	
Other Payor Amount Paid	$00.00
Patient Paid Amount/Other Program's co-pay	$25.00
Net Amount Due – Amount billed to PACE	$55.00

H. Compound Drug Submission, Version v5.1

1. Enter a **"2"** in the **Compound Code** field #406 to indicate the drug dispensed is a compound.

2. Compound drugs are to be submitted on-line.

3. The NDC number of the most expensive legend ingredient is entered in the **Product/Service I.D.** field**. Note: Providers will be notified when this interim policy is changed.**

4. THE METRIC DECIMAL QUANTITY OF THE MOST EXPENSIVE LEGEND INGREDIENT IS ENTERED IN THE **QUANTITY DISPENSED** FIELD. The entire

compound quantity is **NOT** to be entered. **Note: Providers will be notified when this interim policy is changed.**

5. The sum of the average wholesale cost of all the legend and non-legend ingredients that make up the compound is submitted in the **Ingredient Cost Submitted** field. **Note: Providers will be notified when this interim policy is changed.**

6. The pharmacy's usual and customary charge for the entire compound is entered in the **Usual and Customary Charge** field.

7. The Program will validate the claim and pay the lower of:

   88% of the AWC of the **Ingredient Cost** submitted plus the dispensing fee.

   OR

   The **Usual and Customary Charge** submitted (less the cardholder's **Co-pay Amount**).

I. Definition of Covered Services

1. Compensable Products

   Drugs that bear the Federal Legend, State Controlled Substances, insulin, insulin syringes and insulin needles are eligible for reimbursement in accordance with the rules and regulations governing the Program.

   a. Persantine and Dipyridamole

      Persantine and Dipyridamole (manufactured by Purepac or Barr) must have an indication on the prescription that it is being used as an adjunct to Coumarin anticoagulants for the prevention of post-operative thromboembolic complications of cardiac valve replacement.

2. Non-Compensable Products

   a. No over-the-counter drugs except insulin shall be covered by the Program.

   b. No drugs used for experimental purposes are covered by the Program.

   c. Drugs appearing on the Federal Food and Drug Administration's DESI list are not covered unless the physician writes "Medically Necessary."

   d. No prescriptions written for hair growth and wrinkles are covered.

   e. Pharmaceuticals manufactured by companies refusing to participate in the Commonwealth's mandatory Manufacturers' Rebate Program are not covered.

   f. Refer to Section V and Appendix XV.A for additional products not covered based on PACE/PACENET ProDUR criteria.

J. Criteria for Claims Reimbursement

1. Co-payment - All eligible PACE/PACENET cardholders who receive prescription drug services are required to pay the full co-pay amount for each prescription. Providers must be cognizant that PACE and PACENET have different mandatory co-pays. Currently the PACE co-pay is $6.00 (generic medication) or $9.00 single source or brand (with approved Medical Exception) per prescription, the PACENET co-pay is $8.00 (generic medication) or $15.00 single source or brand (with approved Medical Exception). Co-pays may be reduced if the Program calculation determines that the applicable co-pay exceeds the Program's calculated allowed amount.

   Rebates, reimbursements and discounting co-payments to cardholders are prohibited. Coupons and/or discounts although prohibited from being applied to the co-pay, are applicable to the amount billed to the Program.

2. Payment for prescription drugs dispensed shall be limited to those prescriptions whose size:

   a. Is consistent with the medical needs of the cardholder; and

   b. Does not exceed a 30-day supply or 100 units (tablets or capsules), whichever is less (Exception: Timolol, 25% and .5% in 5ml. size must have a days supply between 45 and 60); or

   c. In the case of acute therapies, does not exceed a fifteen (15) day supply and may not be renewed beyond fifteen (15) days; or

   d. In the case of a chronic maintenance drug, is the maximum dosage covered under the Act, except in those cases where a prescriber is utilizing a test dosage.

3. Refills will be covered up to and including five (5) refills or a six-month supply, whichever occurs first from the original filling of the prescription. The exception is for acute conditions where no refills are covered beyond fifteen (15) days total supply.

4. DESI (Drug Efficacy Study Implementation) Exclusions. When PACE is the primary payor, pharmaceuticals listed on the PACE Program's DESI list are not reimbursable without a Medical Exception on file. This list is available at:
   www.dhs.state.or.us/policy/healthplan/guides/pharmacy/misc_files/desi1.pdf .
   This regulation is waived if:

   a. The physician specifically prescribes a DESI drug and indicates **"Medically Necessary"** on the prescription;

   b. The physician is contacted and the provider is informed the DESI is **"Medically Necessary."** The following documentation must be recorded:

      1. Medically Necessary,

      2. the pharmacist's name or initials,

      3. the date,

      4. the person's name who authorized "Medically Necessary".

      (**Note:** This information is necessary for audit purposes.)

5. Prescriber's License Number

   a. The prescriber's Commonwealth license number must be included with claim submission data. Additionally, no payments will be made for drugs dispensed in response to a

prescription issued by a prescriber who has been precluded or excluded from the Medicare Program or the Medical Assistance Program. Error codes exist to alert a pharmacist if a prescriber is not on file or the prescriber is suspended or terminated.

b. PACE Program benefits are not available to cover the costs of filling prescriptions written by prescribers who are not licensed by the Commonwealth unless the pharmacist complies with the following:

1. At the time of dispensing, the pharmacist shall determine that a physician not licensed by the Commonwealth to practice has a valid license to practice in the District of Columbia or one of the following states: Delaware, Maryland, New Jersey, New York, Ohio, Virginia, or West Virginia.

2. The pharmacist shall submit upon request to the Department the name, address, telephone number and appropriate out-of-state physician license number.

c. Failure by the provider to comply with paragraph (5)(b1) and (5)(b2) constitutes grounds for denial of reimbursement under the PACE Program and termination of the provider agreement.

d. Prescriptions for PACE cardholders issued by physicians possessing valid licenses in the states cited in section (5)(b1) may be submitted to the PACE Program by entering the state's two (2) letter abbreviation, six (6) nines (9s) and an "X" (e.g. NY999999X, WV999999X).

e. The following PACE and NCPDP error codes and error messages exist to alert a provider if a prescriber is not on file or if the prescriber is suspended or terminated.

1. *Prescriber Not on File*

PACE Error Code = 130
NCPDP Error Code = 56

2. *Prescriber Suspended or Terminated*

PACE Error Code = 131
NCPDP Error Code = 71

f. Physician Assistants (PA's) - The Pennsylvania State Board of Medicine permits physician assistants to perform certain clinical procedures, including the limited prescribing of legend drugs. PACE will reimburse prescriptions written by physician assistants in accordance with the Board's regulations. Providers are encouraged to obtain copies of these regulations from the State Board of Medicine to assure compliance in the dispensing of medications.

g. Certified Registered Nurse Practitioner (CRNP) - The Pennsylvania State Board of Medicine and the State Board of Nursing permit certified registered nurse practitioners to prescribe and dispense a drug relevant to the area of practice of the CRNP. PACE will reimburse prescriptions written by CRNP‘s in accordance with the Boards’ regulations. Providers are encouraged to obtain copies of these regulations from the State Board of Medicine to assure compliance in the dispensing of medications.

Copies of these rules may be obtained upon written request from the State Board of Medicine, P. O. Box 2649, Harrisburg, PA 17105-2649.
This information is also available online at www.pacode.com, Title 49 Professional and Vocational Standards.

h. Optometrists - Section 4.1 of the Optometric Practice and Licensure Act permits the prescribing of certain medications by optometrists. These medications are identified in Appendix IV.B of this manual. The Program has not installed edits to deny claims for pharmaceuticals not appearing on this list. Providers are advised, therefore, that during a PACE audit, any pharmaceuticals prescribed by an optometrist and paid by the Program that do not appear on the accompanying list (Appendix XV.B) will be disallowed.

i. Dentists - Claims containing a dentist's license number in the prescriber license number field and submitted for pharmaceuticals **other than antibiotics, analgesics, non-steroidals or fluoride preparations** will reject with NCPDP Error 88, accompanied by the DUR response "CH." To receive an override for pharmaceuticals not in these aforementioned categories, providers must call PACE Provider Services to confirm that the prescription was ordered by the dentist identified on the claim. Either provider confirmation or correction of the prescriber number will result in continued processing of the claim.

6. List of Average Wholesale Cost Reimbursement Package Sizes (Yellow Book)

A listing of prescription drug strengths, forms and quantities, reviewed and approved by the Pharmaceutical Assistance Review Board is periodically distributed by the PACE Program. This list is used by the Program to determine reimbursement costs of the listed products and their generic counterparts. **Providers are to continue to enter the 11 digit NDC of the actual drug dispensed.**

7. Mandatory Dispensing of Multisource Drugs (Generic Substitution)

In accordance with Section 510 of the State Lottery Law amended November 16, 2004, reimbursement for pharmaceuticals shall be as follows:

When a pharmacist receives a prescription for a PACE or PACENET cardholder, if an A-rated generic therapeutically equivalent drug is available for dispensing to a claimant, the provider shall dispense the A-rated generic therapeutically equivalent drug to the claimant. The Department shall not reimburse providers for brand name products except in the following circumstances:

a. There is no A-rated generic therapeutically equivalent drug on the market. This does not apply to the lack of availability in the providing pharmacy.

b. An A-rated generic therapeutically equivalent drug is deemed by the Department, in consultation with the Utilization Review Committee to have too narrow a therapeutic index.

c. The Department of Health had determined that a drug shall not be recognized as an A-rated generic therapeutically equivalent drug.

d. At the time of dispensing, the provider has a prescription on which the brand name drug dispensed is billed to the Program by the provider at a usual and customary charge which is equal to or less than the least expensive usual and customary charge of any A-rated generic therapeutically equivalent drug reasonably available to the provider.

e. The brand name drug is less expensive to the Program.

The dispensing of an A-rated generic therapeutically equivalent drug in accordance with this regulation shall not be deemed incorrect substitution under the Generic Equivalent Drug Act.

The Generic Equivalent Drug Act requires providers to substitute a generic drug for a trade name product in the absence of a prescription that specifically prohibits substitution.

When a pharmacist receives a prescription for a PACE/PACENET cardholder, it must be treated in the following manner:

a. A prescription for a drug designated by a brand or trade name for which one or more equivalent drugs are substitutable in compliance with the FDA's Approved Drug Product List with Therapeutic Equivalence Evaluations (also known as Orange Book) shall be considered to be an order for the drug by its generic name.

b. The pharmacist shall fill the prescription with the least expensive generic in the pharmacy. (Note: For audit purposes, the brand name and the manufacturer must be noted on the prescription.)

c. The selection of a drug product shall not be more expensive than the brand or trade name originally written by the prescriber.

d. Subsequent refills shall be filled in compliance with Section 22.55(e) from Title 28 (Health and Safety) of the Pennsylvania Code which states:

"Prescription refills, where permitted by the practitioner, shall be completed using the identical product (same distributor and manufacturer) as dispensed on the original, unless the person presenting the prescription and the practitioner authorize, in advance, a different manufacturer's generic equivalent product. Advance authorization is not required in an emergency, but the physician shall be notified by the pharmacist as soon as possible thereafter."

The pharmacist shall fill prescriptions with the brand or trade name only when the prescriber indicates **"Brand Necessary"** or **"Brand Medically Necessary"** by a handwritten order or if the generic is not available from the manufacturer. This prohibition shall be documented in accordance with the most current regulations in effect by the Pennsylvania Department of Health.

Important: Claims submitted for prescriptions containing the words "Brand Medically Necessary" or "Brand Necessary" (as identified with the DAW Code 1) will only be considered for reimbursement by the PACE Program **if a Medical Exception authorization has been approved.**

K. Negated Prescriptions

Claims submitted to PACE for prescriptions not received by the cardholder violate Section 22.82 of 6 PA Code, Chapter 22, the Rules and Regulations governing the PACE Program.

If claims have been submitted to PACE/PACENET and paid for, and the prescriptions have not been dispensed to the PACE/PACENET cardholder, providers are to submit an on-line reversal **no later than thirty (30) days beyond the date of dispensing/submission.** Auditors may interpret the failure to void such claims as an attempt to defraud the Program.

The reversal will appear on the Remittance Advice as a **"VOIDED"** claim. **Providers are responsible for submitting all VOIDED claims as reversals utilizing the on-line system.**

For those providers sending in lists, remittance advices or other documentation requesting the Program to void these types of claims, a per claim line fee of $5.00 for the first 500 voids and $10.00 per claim line over 500 will be assessed. This administrative processing fee will appear in the remittance advice of the cycle in which the Program entered and processed the voids.

For those providers requesting either gross negative adjustments or sending in payments for claims paid by the Program more than one (1) year from the date of service, an administrative fee will also be assessed. The Program will base this fee on the estimated rate of interest

earned while the Program's money was retained in the provider's account or $100.00, whichever is greater. This administrative fee will also appear on the remittance advice of the cycle in which the negative adjustment was entered or the check processed.

L. Manufacturers' Rebate

PACE and PACENET Programs shall not reimburse for any covered prescription drug without a rebate agreement between the Department and the manufacturer of the covered drug.

V. DRUG UTILIZATION REVIEW

A. General Information

The Pharmaceutical Assistance Contract for the Elderly (PACE) Program currently provides a Surveillance Utilization Review Program to identify potential fraud and abuse. Complementing the SURS Program, the Department, using point-of-sale technology in the on-line real-time claims processing environment has developed a highly effective Prospective Drug Utilization Review Program.

B. Utilization Control

Enrolled providers are required, upon request, to furnish the Department of Aging or its agent with medical and fiscal records relating to participation in PACE/PACENET. Providers shall fully cooperate with audits and reviews made for the purpose of determining the validity of claims and the reasonableness and necessity of benefits provided or for any other purpose. Providers shall furnish, within seven (7) business days of request, complete information related to any PACE/PACENET transaction.

C. Utilization Review Process

The Utilization Review Process is comprised of two basic elements and approaches, which are dually therapeutical and empirical in perspective.

The Prospective Drug Utilization Review component addresses issues such as: 1) dosages which exceed levels generally accepted as safe and effective initial, acute or maintenance therapy; 2) duplicate therapies; 3) duration of treatment without reevaluation of the cardholder by the prescriber; and 4) drug-to-drug interactions. These reviews are done on-line prior to reimbursement authorization by PACE.

Surveillance Utilization Review (SUR), the second element addresses issues such as under-utilization, cardholder use of multiple physicians and/or pharmacies, and compliance with PACE Program Regulations.

D. Clinical Monitors and Regional Utilization Review Committees

Providers who detect patterns of drug misuse by cardholders or Program misuse by other providers should contact PACE's Utilization Review Department. The referral should include the cardholder's name and PACE number, and a request for a URC review. The primary benefit of the Utilization Review is to alert pharmacists and physicians of potential problems so that they may take corrective measures either alone or in cooperation with each other to correct patterns of misuse.

E. Prospective Drug Utilization Review (ProDUR)

Prospective Drug Utilization Review (ProDUR) means reviewing claims for therapeutic appropriateness before the medication is dispensed, reviewing the available medical history and focusing on those cardholders at the highest severity of risk for harmful outcome. Prospective Drug Utilization Review takes place at the point of sale and utilizes an interactive on-line processing system. See the referenced ProDUR criteria in the appendix of this manual.

The PACE ProDUR Program currently edits claims for:

- H2-Receptor Antagonists/PPI's
- Non-Steroidal Anti-Inflammatory Drugs
- Antibotics
- Benzodiazepines
- Cardiac Drugs
- Antidepressants, Antipsychotic Drugs
- Ace Inhibitors
- Beta Blockers
- Calcium Channel Blockers
- Cardiac Clycosides
- Angiotensin Receptor
- Blockers
- Antiobesity Agents
- Antidiabetic Agents
- Antiplatelet Agents
- Skeletal Muscle Relaxants
- Cholinesterase Inhibitors
- HMG Co-A Reductase Inhibitors
- Erectile Dysfunction drugs
- Miscellaneous Anti-Ulcer Agents
- Selected Benzodiazepine
- Antifungal Agents
- Sedative/Hypnotics
- Antihistamines
- Anti-migraine Agents
- Narcotic Analgesics

The PACE ProDUR criteria has its foundation in the current retrospective TDUR criteria file. This criteria base was created by a national working group, convened by the Geriatric Pharmacy Institute within the Philadelphia College of Pharmacy and Science and the Center on Drugs and Public Policy within the University of Maryland, and funded by the Health Care Finance Administration. The following drug compendia and publications were utilized as a resource of information for criteria development:

- Official product labeling,
- Facts and Comparisons,
- American Hospital Formulary Service,
- United States Pharmacopeia Dispensing Information,
- Hansten's Drug Interactions,
- MA Drug Evaluations,
- Publications in peer-reviewed literature.

An integral part of the PACE ProDUR program is the PACE Technical Advisory Committee. This committee is comprised of nationally recognized physicians and pharmacists with notable reputations in the area of geriatric medicine. The goal of the committee is to act in an advisory capacity to the Department of Aging by evaluating recommended criteria.

The PACE Clinical Pharmacy staff performs the necessary research and compiles support data and recommendations for the Committee to review. After the Committee arrives at a consensus that the criteria are appropriate, the criteria will be scheduled for inclusion in the Program.

The Program is continually reviewing and evaluating data referencing the proper utilization of pharmaceuticals. The ProDUR Criteria appendix in the back of this manual contains the Program's current edits. Additional criteria may be added as warranted.

1. Edit Criteria Assumptions:

In conducting a review of drug usage patterns, certain assumptions must be made. These assumptions are:

a. All entries from the provider (pharmacy) are accurate.

b. Drugs dispensed or administered on a routine basis are consumed by the patient.

c. Medication is correctly consumed by or administered to the patient as originally ordered by the physician.

2. Medical Exceptions:

Any DUR rejection *may* receive a Medical Exception under certain cardholder specific conditions. Providers should contact the Provider Help Desk to ascertain if the cardholder is eligible for a medical exception.

PACE/PACENET is a generic program. Claims for A-rated brand name drugs are denied at the point of sale. Providers may request a one-time Medical Exception for cardholders by contacting the Provider Help Desk. The Program will request documentation from the cardholder's prescriber to support the continuation of the Medical Exception. Cardholders refusing to accept the generic medication in the absence of supporting documentation are responsible for the cost of the brand name drug.

A Medical Exception will be considered if requested, in writing, by the prescribing physician. The request can be mailed or faxed to:

PACE
Utilization Review
4000 Crums Mill Road
Suite 301
Harrisburg, PA 17112
Fax Number: 717-651-3608

The request should contain sufficient information such as diagnosis, previous therapies and duration of therapy.

F. ProDUR Criteria Charts

The charts found in the appendix summarize the PACE ProDUR criteria edits for:

* High Dose
* Initial Dose
* Maximum Duration
* Duplicate Therapy
* Plan Protocol
* Appropriate Gender
* Drug-to-Drug
* Age-Dose
* Initial Quantity
* Excessive Quantity
* Hypnotic Therapy (Restoril/Halcion)

Note: As new drugs are added to the ProDUR Criteria Edits, providers are advised via provider bulletins of the edits, their application and implementation dates.

a. **Definitions of Drug Codes -**

1. ***DD – Drug-To-Drug Interaction***

   This medication may interact with another medication the cardholder is currently receiving and may cause serious harm. **This DUR edit can not be overridden by Program personnel.**

2. ***HD - Maximum Dose***

   The daily dose exceeds the normal dosage level for older persons using this medication or the daily dose exceeds the recommended starting dose in elderly.

3. ***MX - Maximum Duration***

   The number of days that the cardholder has used this medication exceeds the established norm for length of use.

4. ***PA - Hypnotic Therapy***

   The daily dose of this medication exceeds either the recommended dosage level or the recommended length of use.

5. ***PA - Age Dose***

   The daily dose of this medication exceeds the recommended dosage level for the age.

6. ***TD - Therapeutic Duplicate***

   The cardholder has very recently received another medication in the same or similar therapeutic class.

7. ***CH - Call Help Desk***

   This claim has been flagged by the system. Processing *may* continue if the provider contacts the Help Desk for clarification of the cause for the interruption of processing.

8. ***PP - Plan Protocol***

   This claim has been flagged by the system based on PACE Program protocol criteria. Processing *may* continue if the provider contacts the Help Desk.

9. ***EX - Excessive Quantity***

   Quantity exceeds total units reimbursable in a time period **or** quantity exceeds total units reimbursed on initial prescription for this population.

10. ***SX - Gender***

    Reimbursement only for allowed gender.

G. Exception Drug Processing

1. **Ace inhibitors, Beta blockers, Calcium Channel blockers HMG Co-A reductase inhibitors, H2 blockers/PPI's and anti-allergy -** These medications have edits applied for duplicate therapy and maximum daily dose as detailed in the Criteria Appendix .

2. **Antidepressants and Antipsychotics**

   PACE reviews claims submitted for antipsychotics and antidepressants. The medications previously identified are edited for both maximum initial and maximum daily dose. One time Medical Exceptions may be requested for claims failing the maximum initial dose criteria for the following reasons:

   The cardholder:
   - is new to PACE in the last 60 days, or
   - has been taking samples of the prescribed medication, or
   - has been hospitalized in the last 60 days, or
   - has paid cash to obtain the prescribed medicine in the last 60 days.

3. **Anti-nausea medications -** Medicare approved reimbursement of the oral anti-nausea drugs Kytril, Anzemet, Aloxi and Zofran when used immediately before, at or within 48 hours of cancer chemotherapy. Based on the current Medicare payment formula, PACE reimburses these products at 20% of AWP - 12%.

4. **Benzodiazepines -** The Program edits these agents for maximum initial dose, maximum daily dose and duplicate therapy as detailed in the Criteria appendix.

5. **Bronchodilator Drugs** - Medicare policies on bronchodilator solutions used in either intermittent positive pressure breath (IPPB) machines or nebulizers allow billing of these solutions to the Medicare Durable Medical Equipment Carrier. PACE bases its reimbursement formula on the amount that is not reimbursed by Medicare (currently 20% of the AWP - 12%).

   The following bronchodilator drugs are identified in our system as being eligible for Medicare reimbursement:

Acetylcysteine 10%	Isoetharine HCL 0.2%
Acetylcysteine 20%	Isoetharine HCL 0.25%
Albuterol Sulfate 0.083%	Isoetharine HCL 1.0%
Albuterol Sulfate 0.5	Isoproternol HCL 0.5%
Cromolyn Sodium	Isoproternol HCL 1.0%
Isoetharine HCL 0.1	Metaproternol Sulfate 0.4%
Isoetharine HCL 0.125%	Metaproternol Sulfate 5.0%

   The Medicare website is accessed daily to determine whether or not any medications have been added to their Formulary. If or when additional drugs or their generic counterparts are accepted for reimbursement by Medicare, they will be added to this list.

   Providers having claims denied by Medicare for bronchodilator drugs should contact Provider Services for consideration of a Medical Exception.

6. **Chemotherapeutics -** Reference the following: Injectable Chemotherapy Antineoplastics and Oral Chemotherapeutics and anti-nausea medication.

7. **Drug-to-Drug interactions -** Manufacturers' boxed warnings dictate what products PACE applies the drug to drug edit to. This history review occurs across all PACE providers. A Medical Exception may be granted upon notification by the pharmacist if he/she can document

that there is no overlap between the two therapies. Exceptions can also be granted if a physician sends in documentation containing his signature that he and the patient are both aware of the risk of the potential interaction.

8. **Epoetin (EPO) Injections** - see Injectable Chemotherapy Antineoplastics.

9. **Immunosuppressant agents -** Prograf®, Cellcept®, Neoral®, Rapamune® and cyclosporine are reimbursable for approved FDA indications, i.e., liver transplant rejection and kidney transplants. Providers should contact Provider Services for manual billing instructions.

   Medicare provides coverage for drugs used in immunosuppressant therapy for three years following an organ transplant. Prior to billing PACE, a date of transplantation should be obtained. A list of allowable drugs can be obtained from the Regional Carrier.

   Providers may bill PACE the 20% of AWP - 12% non-compensable Medicare amount; payment will be based on the Program's reimbursement formula.

10. **Injectable Chemotherapy Antineoplastics*** - Injectable Chemotherapy Antineoplastics are compensable under Medicare. These pharmaceuticals may be administered through a home infusion pump or in a physician's office. Therefore, by regulation, PACE can only base the Program's reimbursement formula on the percentage not covered by Medicare (currently 20%) of the following agents:

    *** Note: This list is <u>not intended</u> to be all inclusive. Additional products may be subject to this edit.**

GENERIC	**BRAND**
Aldesleukin	Proleukin
Asparaginase	Elspar
Bleomycin	Blenoxane
BCG	Tice BCG
Carboplatin	Paraplatin
Carmustine	BiCNU
Cisplatin	Platino; Platinol/AQ
Cladribine	Leustatin
Cyclophosphosphamide	Cytoxan
Cytarabine	Cytostar-U
Dacarbazine	DTIC-Dome
Dactinomycin	Cosmegen
Daunorubicin HCL	Cerubidine; DaunoXome
Dexamethasone Acetate 8mg/ml	Decadron LA (Rescue Agent)
Diethylsilbesterol Diphosphate	Stilphostrol
Doxyrubicin HCL	Adriamycin; Rubex
Epoetin Alfa	Epogen; Procrit
Etoposide	Vepesid
Filgrastim	Neupogen
Floxuridine	FUDR
Fludarabine Phosphate	Fludara
Fluorouracil	Adrucil
Goserelin Acetate	Zoladex
Idarubicin HCL	Idamycin
Ifosfomide	Ifex
Interferon Alfa-2A, 2B	Intron-A
Leuprolide Aceteate	Lupron
Mechlorethamine HCL	Mustargen
Melphalan HCL	Alkeran
Mesna	Ifosamide Mesnex
Mitomycin	Mutamycin

Pegasparagase	Oncaspar
Paclitaxel	Taxol
Pamidronate Disodium	Aredia
Pentostatin	Nipent
Plicamycin	Mithracin
Sargramostim	Leukine; Prokine
Rituxan	Xeloda
Remicaid	Benefix
Temodar	Visudyne
Campath	Neulasta
Eloxatin	Myfortic
Streptozocin	Zanosar
Strontium-89 Chloride	Metastron
Thiotepa	Thioplex
Vinblastine Sulfate	Velban
Vincristine	Oncovin; Velban; Etopophos

11. **Ketoprofen** - Ketoprofen being compounded for off-label use to treat arthritis will be disallowed when identified on utilization review reports.

12. **Lovenox** - Lovenox is only reimbursable using the Medical Exception process. The only approved diagnosis is for the prevention of deep venous thrombosis which may lead to a pulmonary embolism following surgery. For approved indications, Lovenox is indicated only for short term treatment – 7 to 10 days; therefore, a duration of therapy edit (maximum of 14 days) is also applicable. Verbal Medical Exceptions may be granted for the appropriate diagnosis accompanied by written confirmation from the prescriber on record.

13. **Miscellaneous Agents/Criteria**

Miscellaneous benzodiazepines and sedative hypnotics (not including Restoril and Halcion) are edited for initial maximum dose, initial dose and duration of therapy as detailed in the criteria appendix.

The skeletal muscle relaxants and the anti-obesity agents are edited for maximum dose and duration of therapy as detailed in the criteria appendix.

The anti-migraine agents are edited for maximum dose, duration of therapy and duplicate therapy as detailed in the criteria appendix.

The angiotensin receptor antagonists, the cholinesterase inhibitor, the irritable bowel agent Zelnorm and the antidiabetics are only edited for maximum dose as detailed in the criteria appendix.

The antifungal agents are edited only for duration of therapy as defined in the criteria appendix.

Narcotic analgesics are edited for high dose, maximum duration, age-dose, plan protocol and excessive quantity, initial quantity and as defined in the criteria appendix.

The erectile dysfunction agents and the single agent Lotronex® are edited for maximum dose and appropriate gender as defined in the criteria appendix.

14. **Ophthalmics** - PACE legislation states that payment for prescription drugs must be limited to a 30-day supply or 100 units (tablets or capsules), whichever is less. Liquids, ointments, **ophthalmics,** powders and other drug forms are subject to the 30-day supply restriction.

Based on the manufacturers' recommended maximum dispensing instructions, the following products in the size and strength listed, exceed this 30-day requirement. Additional drugs may be added at future dates.

Betagan	.25%	10 ml (twice/day)
Betagan	.5%	10 ml (once/day)
		10 ml (twice/day)
Betoptic	.5%	10 ml
		15 ml
Betoptic S	.25%	10 ml
		15 ml
Isopto Carbachol	.75%	30 ml
Isopto Carbachol	1.5%	30 ml
Isopto Carbachol	3%	30 ml
Levobunolol	.25%	10 ml
	.5%	10 ml
		15 ml
Ocupress	1%	10 ml
Optipranolol	.3%	10 ml
Phenylephrine	2.5%	(2 x 12 ml)
Propine	.1%	10 ml
		15 ml
Timoptic		10 ml
		15 ml
Lumigan		5 ml
		7.5ml

15. **Oral Chemotherapeutics** - Medicare Part B coverage includes oral anti-cancer drugs approved by the Food and Drug Administration Section 13553(a) of the Omnibus Reconciliation Act of 1993 (OBRA 93). The following drugs are identified as oral self-administered anti-cancer chemotherapeutic agents under OBRA 93:

Cyclophosphamide; Cytoxan® 25 mg/oral, 50 mg/oral
Etoposide; Vepesid® 50 mg/oral
Melphalan; Alkeran® 2 mg/oral

Therefore, by regulation, PACE can only base the Program's reimbursement formula on the percentage not covered by Medicare of these products and other A-rated generics (as they become available in the marketplace). Since each cardholder is eligible for Medicare, the remaining cost of the drug is to be submitted to the regional carrier for reimbursement.

Applications for a Medicare supplier billing number can be obtained by calling 1-866-419-9458. Cardholders are required by statute to pay the applicable co-pay.

For those providers receiving an Explanation of Medical Benefits Form from the regional carrier identifying a cardholder's other insurance available to pay the non-Medicare reimbursed amount, the claim should be voided from PACE and submitted to the other carrier.

These claims are subject to review by the Program's Compliance Department. Providers unable to supply proof of the non-payment of the 20% from Medicare will have the PACE [20% billed] claim disallowed.

16. **Serevent** - PACE legislation states that payment for prescription drugs must be limited to a 30-day supply or 100 units (tablets or capsules), whichever is less. Liquids, ointments, ophthalmics, powders, **inhalers** and other drug forms are subject to the 30-day supply restriction.

Based on the manufacturer’s recommended maximum dispensing instructions (two inhalations twice daily), claims submitted for greater than 13 mg of Serevent exceed this 30-day requirement.

Medical Exceptions will be accepted for Serevent, but only if the prescriber confirms in writing the reason for the higher than maximum recommended dose.

17. **Toradol** - To comply with the manufacturers' boxed warning, PACE reviews history across providers and disallows all Toradol (keterolac) claims that fail any of the following criteria:

a. contains greater than a 5 day initial supply,
b. totals more than a 5 day supply within the past 30 days,
c. is submitted with a calculated daily dosage exceeding: 40 mg orally or 60 mg by injection,
d. is submitted for a cardholder having any NSAID claim reimbursed by PACE within the previous 30 days.

No Medical Exceptions, other than for terminally ill patients, will be accepted by phone. All other Medical Exceptions for claims exceeding either the duration or dosing criteria must be submitted in writing by the prescriber.

18. **Ultram®** - PACE has implemented a maximum daily dose edit on Ultram® (tramadol). The maximum dose criteria are as follows:

a. 300 mg > 75 years of age
b. 400 mg < 75 years of age

Medical Exceptions for dosages exceeding these criteria will only be considered if submitted in writing from the prescriber.

19. **Vaccines** - Medicare Medical Policy Bulletin states that specific vaccines can be reimbursed in addition to the administration fee and payment for any visit service [to a physician's office].

Vaccines used to provide immunization against pneumococcal pneumonia and influenza **are not** PACE compensable. Reimbursement for vaccines used to provide immunization against Hepatitis B have the PACE reimbursement formula applied to the 20% that is non-compensable by Medicare.

20. **Vancomycin (Oral)** - Oral vancomycin is only reimbursable through the Medical Exception process and only for the treatment of staphylococcal enterocolitis, antibiotic-associated colitis, pseudomembranous colitis or clostridium difficult. Duration of therapy is established at 7 to 10 days. Medical Exceptions will be considered only for one of these diagnoses and for a days supply no greater than 14 days.

H. Therapy/Diagnosis Confirmation

To insure that accepted therapy protocol is being followed, the Program stops certain medications at the point of sale. These claims are denied as a DUR reject accompanied by the response of "CH" (Call Help Desk) or "PP" (Plan Protocol). Providers are directed to contact the Program's Help Desk to ascertain, what if any criteria or diagnosis must be documented for the prescription to be paid. In some instances, specific documentation and/or a Medical Exception form must be received from the prescriber prior to any authorization being granted.

The following medications are stopped at the point of sale and reviewed for appropriate diagnosis and/or required diagnostic information prior to therapy implementation.

Medication	Program requested information for continuation of reimbursement
Forteo®	Diagnosis and history of previous fractures
Enbrel®	Proof of previous DMARD therapy
Vfend	Diagnosis: aspergillosis, scedosporium, apiospermum or fusasium
Emend®	Verification of cancer chemotherapy; previous therapy with Zofran®
Anzement®	
Xolair®	Diagnosis verification, weight, pretreatment serum IgE Leveland/or history of positive skin or RAST test to a perennial aeroallergen
Synagis®	Denied—not indicated in adults
Humira®	Date of tuberculin skin test
Zyvox®	Supporting diagnostic and treatment must be received from prescriber before authorization considered.
Topamax®	Diagnosis consistent with seizures; migraines
Thalomid®	Diagnoses: Leprosy, Inflammatory Disease, Neoplastic Disease, GI Disorders
TOBI®	*Pseudomonas auerginosa* infections in Cystic Fibrosis patients
Nebupent®	Diagnoses: PCP pneumonia, Rhodesian sleeping sickness, African sleeping sickness
Provigil®	Diagnosis: Narcolepsy
Sulfamylon	Adjunct in treatment of second and third degree burns
Lariam®	Diagnosis: Malaria; Prevention of Malaria
Sandostatin®	LAR Depot Treatment of water diarrhea associated with carcinoid tumors or VIP tumors. Therapy initiated with Sandostatin injection.
Avonex®	Diagnosis: MS
Actimmune®	Diagnosis: Chronic granulomatosis; severe osteopetrosis
Lamictal®	Seizure disorder
Salagen®	Dry mouth in Sjorgen's syndrome
Agrylin®	Essential thrombocytopenia to reduce elevated platelet count and the risk of thrombosis and to ameliorate associated symptoms.
Botox®	Diagnosis: Blepharospasm; Dystonia of the cervical spine
Rilutek®	ALS
Temodar®	Anaplastic Astrocytoma
Humatrope®	Growth failure in children; severe burns
Genotropin®	Promote increased human growth hormone levels
Saizen®	Promote increased human growth hormone levels
Regranex®	Lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply
Doxil ®	Metastatic carcinoma of the ovary
Copaxon®	Multiple sclerosis
Trovan®	Antibiotic with specific indications for nosocimial pneumonia, cap, complicated intra-abdominal infections, and gynecological and pelvic infections
Renagel®	Hyperphosphatemia
Thyrogen ®	Adjunctive diagnostic toll for serum thyroglobulin
Gleevec®	CML and gastrointestinal stromal tumors
Aranesp®	Anemia associated with CRF

Tracleer®	Pulmonary hypertension
Remodulin®	Pulmonary arterial hypertension
Oral Contraceptives	Birth control only
Iressa®	Nonsmall cell lung cancer
Velcade®	Multiple myeloma
Bexxar ®	Non-Hodgkins lymphoma
Zavesca®	Gaucher disease

The following is a list of medications considered to be inappropriate in the elderly because they have the potential to cause side effects such as risk of falling. These drugs are stopped at the point of sale and physicians are requested to consider whether an alternative therapy would be appropriate:

Meprobamate
Chlordiazepoxide
Amitriptyline
Flurazepam
Cyclobenzaprine
Chlorpropamide
Amitriptyline/perphenazine
Orphenadrine citrate
Diazepam
Tebamide
Methocarbamol
Carisoprodol
Dipyridamole
Amitriptyline/chlordiazepoxide
Carisoprodol Compound
Meprobamate Compound
Orphenadrine/paracetamol
Isoxsuprine
Trimetholbenzamide

VI. REMITTANCE ADVICE

With each electronic funds transfer, the computer generates a Remittance Advice Report, referred to in this manual as an "R/A." This document gives a detailed breakdown of payment.

Providers wanting to receive their R/A electronically should consult the Program's 835 Remittance Advice Crosswalk specifications included in this manual as a separate Appendix. This document follows HIPAA 835 protocol as it applies to PACE/PACENET and other Programs under the auspices of the Department of Aging. Those providers wishing to receive the Program's R/A using the HIPAA 835 must contact the Program to be assigned an Electronic Biller Number. Providers are to inform the Program when they are prepared to receive an 835 test CD.

Following successful testing using the 835 R/A specifications, providers will receive their R/A electronically on CD. Those providers wishing to receive their R/A via FTP (File Transfer Protocol) will be advised of procedures currently in use by the Program.

Those providers receiving their R/A on CD or via FTP must use the received electronic media for reconciliation. The R/A is the acknowledged report for identification of all paid claims. In June 2009, with few exceptions, the Program will discontinue sending the paper remittance advice described on the following pages. Providers will be required to receive remittance advices by FTP, CD or CMS's Easy Print software products. The Medicare Remit Easy Print (MREP) software enables providers to view and print the Health Insurance Portability and Accountability Act (HIPAA) complaint 835 (remittance advice). This software, is available for free, can be used to access and print remittance advice information, including special reports, from the HIPAA 835. This software is described on the CMS website at: www.cms.hhs.gov/AccessToDataApplication/02_medicareremiteasyprint.asp. Although the Easy Print web-based product was designed for Medicare use, a user guide accompanies this manual thereby helping providers using Easy Print to easily reconcile his/her PACE remittance advice.

A. Format of the Remittance Advice (paper)

On receipt by the Program of a written request, the format of your R/A can be changed to any of the following:

1. Alphabetically by **Cardholder's Name** in date-of-service order,

2. **Date-of-Service** by cardholder's name in alphabetical order,

3. Sequentially by **Prescription Number**.

If no request is received, the system will default to the first example.

B. Cover Page (see page VI.2)

1. The Program Name and the provider's NPI number appear opposite of the PROVIDER NUMBER on each page.

2. Provider Name and Address - Changes or corrections to addresses must be conveyed in writing to:

PACE
P.O. Box 8810
Harrisburg, PA 17105

3. Cover Page Messages - Important information on either PACE/PACENET regulations or Program changes appears on the Remittance Advice page. Providers should review this information upon receipt of this R/A document.

REMITTANCE ADVICE

TO

PENNSYLVANIA PHARMACEUTICAL
ASSISTANCE CONTRACT FOR THE ELDERLY
FISCAL AGENT-FIRST HEALTH SERVICE CORPORATION
P.O. BOX 8809, HARRISBURG, PA 17105

DATE:

PAGE:

PROVIDER NUMBER: 0391234

CARDHOLDER NAME	CARDHOLDER I.D. NUMBER	DATE FILLED	NATIONAL DRUG CODE	DRUG NAME	PRESCRIP NUMBER	REF	QUAN	USUAL CHARGE	AMOUNT ALLOWED	DEDUCT AMOUNT	AMOUNT PAID	CONTROL REFERENCE NUMBER	MSG. CODE
R/A COVER PAGE EXAMPLE				PACE INFORMATIONAL MESSAGES APPEAR ON THIS PAGE									
PROVIDERS, PLEASE NOTE:									AS OF:	JANUARY 1, 2005			
PACE PUBLICATIONS ARE AVAILABLE ON THE DEPARTMENT OF AGING'S WEBSITE AT WWW.AGING.STATE.PA.US.													
MANUFACTURER'S REBATE REMINDER: PACE REIMBURSES ONLY FOR PHARMACEUTICALS FROM COMPANIES THAT PARTICIPATE IN THE COMMONWEALTH'S MANUFACTURER'S REBATE PROGRAM.													
				PACE PROVIDER NAME AND THE PAY-TO-ADDRESS APPEARS HERE									

C. POCAS Ratings and Comments Page (see page VI.4)

This page was added to the R/A as a means for providers to convey to the Program specific comments and suggestions regarding the PACE On-line Claims Adjudication System.

REMITTANCE ADVICE

TO:

DATE:

PAGE:

PENNSYLVANIA PHARMACEUTICAL
ASSISTANCE CONTRACT FOR THE ELDERLY
FISCAL AGENT-FIRST HEALTH SERVICE CORPORATION
P.O. BOX 8809, HARRISBURG, PA 17105

PROVIDER NUMBER: 0390000

CARDHOLDER NAME	CARDHOLDER I.D. NUMBER	DATE FILLED	NATIONAL DRUG CODE	DRUG NAME	PRESCRIP NUMBER	REF	QUAN	USUAL CHARGE	AMOUNT ALLOWED	DEDUCT AMOUNT	AMOUNT PAID	CONTROL REFERENCE NUMBER	MSG. CODE

POCAS RATING AND COMMENT PAGE EXAMPLE

PACE ONLINE CLAIMS ADJUDICATION SYSTEM RATINGS AND COMMENTS PAGE

FOR YOUR CONVENIENCE, WE HAVE INCLUDED A SECTION FOR COMMENTS OR SUGGESTIONS

PLEASE CIRCLE RESPONSE

RESPONSE TIME	EXCELLENT	SATIS.	UNSATIS.
APPROPRIATENESS OF SYSTEM MESSAGE	EXCELLENT	SATIS.	UNSATIS.
IF POCAS HOTLINE WAS CALLED RATE RESPONSE RECEIVED	EXCELLENT	SATIS.	UNSATIS.

COMMENTS OR SUGGESTIONS: _____

RETURN TO:

FIRST HEALTH SERVICES CORP.
PROVIDER RELATIONS DEPARTMENT
4000 CRUMS MILL ROAD
SUITE 301
HARRISBURG, PA 17112

OR

PENNSYLVANIA DEPT. OF AGING
OPERATIONS CHIEF, PACE
FORUM PLACE BUILDING , 5TH FLOOR
555 WALNUT STREET
HARRISBURG, PA 17101

FOR PROBLEMS REQUIRING IMMEDIATE ATTENTION CALL THE POCAS HOTLINE 1-800-835-4080 BETWEEN 7:00 AM AND 10:00 PM

D. Paid Claim Example – Fields defined (see page VI.7)

1. **Cardholder Name -** The cardholder's last name, first initial and middle initial.

2. **Cardholder ID Number -** The cardholder's unique 9-digit PACE/PACENET identification number.

3. **Date Filled -** The date the provider dispensed the medication (date-of-service).

4. **National Drug Code -** The 11-digit NDC number for the medication dispensed.

5. **Drug Name -** The drug name or description for this claim.

6. **Prescription Number -** The prescription number or medical record assigned by the provider.

7. **Refill Indicator -** The designation of **"00"** for New or **"01-05"** for Refills will be used to indicate if this prescription is new or a refill.

8. **Metric Decimal Quantity -** The metric quantity of the drug dispensed. Liquids are listed in cc's; capsules, tablet and suppositories by the number dispensed; and ointments and creams in the number of grams dispensed.

9. **Usual Charge -** The total amount to be billed is the pharmacy's usual and customary price.

10. **Amount Allowed -** The total amount allowed by PACE is either the pharmacy's usual and customary price, 88% of the AWP plus dispensing fee or FUL plus dispensing fee, whichever is lowest.

    Ex. 1 The claim for DG Smith has been submitted with no other insurance deductions entered. The Amount Allowed of $79.32 is the Program calculated reimbursement (88% AWP = $75.32 + $4.00 dispensing fee = $79.32).

    Ex. 2 The claim for SA Jones has been submitted with other insurance. The Amount Allowed of $21.19 is the Program calculated reimbursement (88% AWP = $17.19 + $4.00 dispensing fee = $21.19).

11. **Deduct Amount -** The amount entered by the provider (or calculated by the system), including the co-payment and/or amounts collected from another third party insurance. Amounts collected by the provider from a third party insurer are identified with the message code number of 918.

    Ex. 1 The claim for DG Smith has been submitted with no other insurance deductions entered. The Deduct Amount of $9.00 is the Program co-pay.

    Ex. 2 The claim for SA Jones has been submitted with insurance. The Deduct Amount is the Other Coverage Amount entered by the provider *and* the Program calculated co-pay to be collected from the cardholder. In this example the Other Coverage amount collected by the provider was $19.97. The co-pay to be collected (indicated on the provider's computer at the time of processing and included in the deductible amount) is $1.22. The total amount allowed as calculated by PACE is $21.19. The Amount Allowed of $21.19 minus the other coverage of $19.97 equals a co-pay to be collected of $1.22. [Explanation: Although the deduct field usually contains the PACE full co-pay plus the amount paid to the provider by another insurer, when the other insurer amount allowed by the Program plus the Program's co-pay of $6, $9, $8 or $15 exceeds the amount allowed, the co-pay amount is reduced so that the total deduction is no greater than the amount allowed by the Program.]

12. **Amount Paid -** The amount paid by PACE for this claim.

    Ex. 1 The amount reimbursed by the Program is $70.32. For this claim the provider has received a total of $79.32 ($70.32 Program payment + $9.00 cardholder co-pay).

    Ex. 2 There is no Program payment for this claim. The provider has received the maximum calculated reimbursement amount of $21.19 from the insurance entered in the Other Coverage field and the cardholder's reduced co-pay ($19.97 + the $1.22 = $21.19).

13. **Control Reference Number -** The unique 12-digit number assigned to each claim for internal control purposes. Please reference this CRN (Control Reference Number) on correspondence regarding claims.

14. **Message (Msg) Code -** Indicates error code or explanation message if full payment was not made. All message codes used in the R/A are explained on the last page of each Remittance Advice.

REMITTANCE ADVICE

TO: PROVIDER NAME & ADDRESS APPEARS HEF

DATE: 01/01/05 PAGE: 3

PENNSYLVANIA PHARMACEUTICAL
ASSISTANCE CONTRACT FOR THE ELDERLY
FISCAL AGENT-FIRST HEALTH SERVICE CORPORATION
P.O. BOX 8809, HARRISBURG, PA 17105

PROVIDER NUMBER:

1 CARDHOLDER NAME	2 CARDHOLDER I.D. NUMBER	3 DATE FILLED	4 NATIONAL DRUG CODE	5 DRUG NAME	6 PRESCRIP NUMBER	7 REF	8 QUAN	9 USUAL CHARGE	10 AMOUNT ALLOWED	11 DEDUCT AMOUNT	12 AMOUNT PAID	13 CONTROL REFERENCE NUMBER	14 MSG. CODE
R/A PAID CLAIMS EXAMPLE													
PAID CLAIMS													
EX. #1 SMITH DG	999999999	12/01/04	00078036405	LOTREL	123456	2	30	97 59	79 32	9 00	70 32	433581584301	910
EX. #2 JONES SA	888888888	12/01/04	00186109005	WARFARIN SOD 910 915 245	044123	0	30	30 99	21 19	21 19	0 00	433581695401	918

E. Rejected Claims (see page VI.9)

This section identifies those claims which have been rejected through Exception Processing (Section G.). Rejected claims are finalized and no additional action will be taken unless requested by the provider.

Note: Claims rejected during an on-line claim submission do not appear on the R/A.

REMITTANCE ADVICE

TO

DATE:

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PENNSYLVANIA PHARMACEUTICAL
ASSISTANCE CONTRACT FOR THE ELDERLY
FISCAL AGENT-FIRST HEALTH SERVICE CORPORATION
P.O. BOX 8809, HARRISBURG, PA 17105

PROVIDER NUMBER:

CARDHOLDER NAME	CARDHOLDER I.D. NUMBER	DATE FILLED	NATIONAL DRUG CODE	DRUG NAME	PRESCRIP NUMBER	REF	QUAN	USUAL CHARGE	AMOUNT ALLOWED	DEDUCT AMOUNT	AMOUNT PAID	CONTROL REFERENCE NUMBER	MSG. CODE
R/A REJECTED CLAIMS EXAMPLE													
REJECTED CLAIMS													
PEREZ JA	333222111	02 19 04	00069152068	NORVASC	678876	4	30	69 99	0 00	0 00	0 00	433567005301	227
REJECTED CLAIMS				TOTALS	1 TRANSACTIONS			69 99					

F. Error Codes and Message Description

This section contains PACE Error and Message Codes used on your R/A.

PACE specific	NCPDP 5.1	PACE/NCPDP DESCRIPTION
		"M/I" means MISSING/INVALID
709	01	M/I BIN NUMBER
713	02	M/I VERSION NUMBER
N/A	03	M/I TRANSACTION CODE
752	04	M/I PROCESSOR CONTROL NUMBER
002	05	PROVIDER NUMBER INVALID
015	06	M/I GROUP NUMBER
004	07	M/I CARDHOLDER NUMBER
N/A	09	M/I BIRTH DATE
N/A	11	M/I PATIENT RELATIONSHIP CODE
012	12	M/I PATIENT LOCATION
025	13	OTHER COVERAGE CODE INVALID
006	15	M/I DATE FILLED
128	16	M/I PRESCRIPTION/SERVICE REFERENCE NUMBER
N/A	17	M/I FILL NUMBER
029	19	M/I DAYS SUPPLY (DAYS SUPPLY=ZERO OR > 30 DAYS)
700	20	M/I COMPOUND CODE
129	21	M/I PRODUCT/SERVICE (NDC)
127	22	M/I DAW INDICATOR
701	23	M/I INGREDIENT COST
126	25	M/I PHYSICIAN
712	28	M/I DATE RX WRITTEN
036	29	M/I NUMBER OF REFILLS AUTHORIZED
710	32	M/I LEVEL OF SERVICE
N/A	33	M/I PRESCRIPTION ORIGIN CODE
N/A	39	M/I DIAGNOSIS CODE
N/A	4C	M/I COORDINATION OF BENEFITS/OTHER BENEFITS COUNT
202	40	PROVIDER NOT ELIGIBLE ON DATE OF SERVICE
041	41	SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYER
044	41	SUBMIT BILL TO MEDICARE DISCOUNT PROGRAM
N/A	5C	M/I OTHER PAYER COVERAGE TYPE
200	50	NON-MATCHED PROVIDER NUMBER (PROVIDER NOT ON FILE)
N/A	51	NON-MATCHED GROUP ID (CARDNUMBER NOT FOUND IN PACE, CRDP, ETC. FILE)
216	52	NON-MATCHED CARDHOLDER I.D. (CARDHOLDER NOT ON FILE)
231	54	NON-MATCHED PRODUCT/SERVICE ID (NDC NOT ON FILE)
N/A	55	NON-MATCHED PRODUCT PACKAGE SIZE
130	56	NON-MATCHED PRESCRIBER (PHYSICIAN NOT ON FILE)
N/A	6C	M/I OTHER PAYER ID QUALIFIER
746	6E	M/I OTHER PAYER REJECT CODE

PACE specific	NCPDP 5.1	PACE/NCPDP DESCRIPTION
718	60	PRODUCT/SERVICE NOT COVERED FOR PATIENT AGE
N/A	61	PRODUCT/SERVICE NOT COVERED FOR PATIENT GENDER
N/A	62	PATIENT/CARDHOLDER ID NAME MISMATCH
N/A	63	INSTITUTIONALIZED PATIENT. PRODUCT/SERVICE ID NOT COVERED
N/A	64	CLAIM SUBMITTED DOES NOT MATCH PRIOR AUTHORIZATION
N/A	65	PATIENT IS NOT COVERED
218	67	FILLED BEFORE COVERAGE EFFECTIVE
218	68	FILLED AFTER COVERAGE EXPIRED
218	69	FILLED AFTER COVERAGE TERMINATED (CARDHOLDER NOT ELIGIBLE ON DOS)
729	69	FILLED BEFORE SWIF COVERAGE EFFECTIVE
730	69	FILLED AFTER SWIF COVERAGE EXPIRED
747	7C	M/I OTHER PAYER ID
051	70	COSMETIC DRUG NOT COVERED
052	70	NOT ON FORMULARY
055	70	PRODUCT/SERVICE NOT COVERED
064	70	NDC NOT COVERED FOR PROVIDER TYPE
131	71	PRESCRIBER IS NOT COVERED
880	73	REFILLS ARE NOT COVERED
245	74	OTHER CARRIER PAYMENT MEETS OR EXCEEDS PAYABLE
	75	PRIOR AUTHORIZATION REQUIRED
040	76	PLAN LIMITS EXCEEDED
753	76	SUBMIT TO HIGHMARK WITH HIGHMARK SPECIFIC CODE
053	77	DISCONTINUED PRODUCT/SERVICE ID NUMBER
N/A	78	COST EXCEEDS MAXIMUM
705	79	REFILL TOO SOON
732	80	DRUG-DIAGNOSIS MISMATCH
227	81	CLAIM TOO OLD
006	82	CLAIM IS POST-DATED
865	83	DUPLICATE PAID CLAIM
799	84	CLAIM NOT PAID
799	85	CLAIM NOT PROCESSED
799	87	REVERSAL NOT PROCESSED
056	88	DUR REJECT/MAX DOSE DISPENSED
057	88	DUR REJECT/THERAPY MUST RE-INITIATED
058	88	DUR REJECT/QUANTITY DISPENSED INVALID
059	88	DUR REJECT/THERAPY INITIATED W/ INCORRECT DOSE
060	88	DUR REJECT/STRENGTH NOT COVERED
065	88	DUR REJECT/CRDP PREFERS ALTERNATIVE NDC
706	88	DUR REJECT
718	88	DUR REJECT/DRUG NOT COVERD FOR PATIENT AGE
722	88	DUR REJECT/EXCEEDS MAX INITIAL DOSE
N/A	90	HOST HUNG UP
N/A	91	HOST RESPONSE ERROR
N/A	92	HOST UNAVAILABLE TRY AGAIN LATER
N/A	95	TIME OUT
N/A	96	SCHEDULED DOWNTIME

PACE specific	NCPDP 5.1	PACE/NCPDP DESCRIPTION
N/A	97	PAYER UNAVAILABLE
N/A	98	CONNECTION TO PAYER IS DOWN
099	99	HOST PROCESSING ERROR
N/A	AA	PATIENT SPEND-DOWN NOT MET
N/A	AB	DATE WRITTEN IS AFTER DATE FILLED
054	AC	PRODUCT NOT COVERED, NON-PAR. MANUFACTURER
741	AD	BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLAIM TYPE
N/A	AE	QMB (QUALIFIED MEDICARE BENEFICIARY) BILL MEDICARE
N/A	AG	DAYS SUPPLY LIMITATION FOR PRODUCT/SERVICE
N/A	AJ	GENERIC DRUG REQUIRED
N/A	AK	M/I SOFTWARE VENDOR/CERTIFICATION ID
N/A	AM	M/I SEGMENT IDENTIFICATION
N/A	A9	M/I TRANSACTION COUNT
751	B2	M/I SERVICE PROVIDER ID QUALIFIER
738	CA	M/I PATIENT FIRST NAME
739	CB	M/I PATIENT LAST NAME
N/A	CC	M/I CARDHOLDER FIRST NAME
N/A	CD	M/I CARDHOLDER LAST NAME
N/A	CW	M/I ALTERNATE ID
740	DR	M/I PRESCRIBER LAST NAME
707	DQ	M/I USUAL & CUSTOMARY CHARGE
030	DU	GROSS AMOUNT DUE
702	DV	M/I OTHER PAYER AMOUNT PAID
N/A	DX	M/I PATIENT PAID AMOUNT SUBMITTED
733	DY	M/I DATE OF INJURY
734	DZ	M/I CLAIM REFERENCE ID
N/A	EC	M/I COMPOUND INGREDIENT COMPONENT COUNT
N/A	ED	M/I COMPOUND INGREDIENT QUANTITY
N/A	EE	M/I COMPOUND INGREDIENT DRUG COST
N/A	EF	M/I COMPOUND DOSAGE FORM DESCRIPTION CODE
N/A	EG	M/I COMPOUND DISPENSING UNIT FORM INDICATOR
N/A	EH	M/I COMPOUND ROUTE OF ADMINISTRATION
N/A	EM	M/I (ORIGINAL) PRESCRIPTION NUMBER/REFERENCE QUALIF.
N/A	EY	M/I PROVIDER ID QUALIFIER
N/A	EZ	M/I PRESCRIBER ID QUALIFIER
N/A	E1	M/I PRODUCT SERVICE ID QUALIFIER
N/A	E7	M/I QUANTITY DISPENSED
N/A	E8	M/I OTHER PAYER DATE
N/A	E9	M/I PROVIDER ID
N/A	HB	M/I OTHER PAYER AMOUNT PAID COUNT
N/A	HC	M/I OTHER PAYER AMOUNT PAID QUALIFIER
N/A	H7	M/I OTHER AMOUNT CLAIMED SUBMITTED COUNT
N/A	H8	M/I OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER
N/A	H9	M/I OTHER AMOUNT CLAIMED SUBMITTED
N/A	M1	PATIENT NOT COVERED IN THIS AID CATEGORY
223	M2	RECIPIENT LOCKED IN (TO PROVIDER)
224	M2	RECIPIENT LOCKED IN (TO THERAPEUTIC CLASS)
N/A	M5	REQUIRES MANUAL CLAIM
239	M7	HOST DRUG FILE ERROR
N/A	M8	HOST PROVIDER FILE ERROR

PACE specific	NCPDP 5.1	PACE/NCPDP DESCRIPTION
N/A	NN	TRANSACTION REJECTED AT SWITCH OR INTERMEDIARY
N/A	PA	PA (Medical Exception) EXHAUSTED/NOT RENEWABLE
N/A	PB	INVALID TRANSACTION COUNT FOR TRANSACTION CODE
N/A	PC	M/I CLAIM SEGMENT
N/A	PD	M/I CLINICAL SEGMENT
N/A	PE	M/I COB/OTHER PAYMENTS SEGMENT
N/A	PF	M/I COMPOUND SEGMENT
N/A	PJ	M/I INSURANCE SEGMENT
N/A	PK	M/I PATIENT SEGMENT
N/A	PM	M/I PHARMACY PROVIDER SEGMENT
N/A	PN	M/I PRESCRIBER SEGMENT
N/A	PP	M/I PRICING SEGMENT
N/A	PS	M/I TRANSACTION HEADER SEGMENT
N/A	PX	NON-MATCHED OTHER PAYER ID
N/A	P3	COMPOUND INGREDIENT COMPONENT COUNT DOES NOT MATCH NUMBER OF REPETITIONS
N/A	P4	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT DOES NOT MATCH NUMBER OF REPETITIONS
N/A	P6	DATE OF SERVICE PRIOR TO DATE OF BIRTH
N/A	P9	FIELD IS NON-REPEATABLE
N/A	RB	MULTIPLE PARTIALS NOT ALLOWED
N/A	RC	DIFFERENT DRUG ENTITY BETWEEN PARTIAL & COMPLETION
N/A	RE	M/I COMPOUND PRODUCT ID QUALIFIER
N/A	RF	IMPROPER ORDER OF DISPENSING STATUS CODE ON PARTIAL FILL TRANSACTION
N/A	RG	M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER ON COMPLETION TRANSACTION
N/A	RH	M/I ASSOCIATED PRESCRIPTION/SERVICE DATE ON COMPLETION TRANSACTION
N/A	RJ	ASSOCIATED PARTIAL FILL TRANSACTION NOT ON FILE
N/A	RK	PARTIAL FILL TRANSACTION NOT SUPPORTED
N/A	RM	COMPLETION TRANSACTION NOT PERMITED WITH SAME DATE OF SERVICE AS PARTIAL TRANSACTION
N/A	RN	PLAN LIMITS EXCEEDED ON INTENDED PARTIAL FILL VALUES
N/A	RP	OUT OF SEQUENCE “P” REVERSAL ON PARTIAL FILL TRANSACTION
N/A	RS	M/I ASSOCIATED PRESCRIPTION/SERVICE DATE ON PARTIAL TRANSACTION
N/A	RT	M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE DATE ON PARTIAL TRANSACTION
N/A	RU	MANDATORY ELEMENTS MUST OCCUR BEFORE OPTIONAL DATA ELEMENTS IN A SEGMENT
N/A	R1	OTHER AMOUNT CLAIMED SUBMITTED COUNT DOES NOT MATCH NUMBER OF REPETITIONS
N/A	R2	OTHER PAYER REJECT COUNT DOES NOT MATCH NUMBER OF REPETITIONS
N/A	R6	PRODUCT/SERVICE NOT APPROPRIATE FOR THIS LOCATION
N/A	R7	REPEATING SEGMENT NOT ALLOWED IN SAME TRANSACTION
N/A	R8	SYNTAX ERROR
N/A	R9	VALUE IN GROSS AMOUNT DUE DOES NOT FOLLOW PRICING FORMULA
N/A	TE	N/M/I COMPOUND PRODUCT ID

PACE ERROR/MESSAGE CODES

These codes are specific to PACE.

PACE SPECIFIC MESSAGE CODES (EOBs)	DESCRIPTION
245	TOTAL PRICE ZERO NO PAYMENT DUE
711	MEDICAL EXCEPTION APPLIED
715	AMOUNT APPLIED TO DEDUCTIBLE (PACENET)
716	PACENET DEDUCTIBLE SATISFIED
717	PACENET DEDUCTIBLE WAIVED
721	CARDHOLDER ALERT, REFILL TOO SOON
723	ONE TIME EXCEPTION
724	MEDICARE DISCOUNT PROGRAM COPAY ONLY
725	MDP TRANSITIONAL ASSISTANCE CUSP CLAIM
726	M/I USUAL AND CUSTOMARY CHARGE
727	PACENET MEDICARE DISCOUNT PROGRAM COPAY ONLY
728	PACENET MDP TRANSITIONAL ASSISTANCE CUSP CLAIM
735	CLAIM REFILLED TOO SOON
736	POSSIBLE DUR ERROR
742	MISSING/ INVALID DATE PRESCRIPTION WRITTEN
748	PLAN LISTS PROVIDER AS AN ENROLLED PHARMACY
749	CARDHOLDER COVERED BY MEDICARE PART D PLAN
750	BRAND DISPENSED PER PRIMARY PAYER DOCUMENTATION (PRIOR AUTH. EXISTS).
900	INTEREST HAS BEEN APPLIED TO CLAIM
906	NEWER NDC CURRENTLY AVAILABLE CHECK WITH MANUFACTURER
910	PAYMENT REDUCED BY RED BOOK AWP - 12% OR FUL (FEDERAL UPPER LIMITS)
915	PAYMENT REDUCED BY TPL AMOUNT
916	OTHER COVERAGE EXISTS, **MEDICARE** PRIMARY PAYER
917	EARLY REFILL, PRESCRIBER INCREASED DOSAGE
918	PRIMARY PAYER EXISTS, PACE COVERAGE SECONDARY

G. Adjustment Claims (see page VI.16)

Adjustments are accomplished through claim credit and debit. The claim debit adjustment replaces a previously processed claim whereby the claim being adjusted is then processed as a credit. The difference between the two is either paid to the provider or subtracted from the payment depending on the type of adjustment. The provider should be aware that one adjustment claim will print out on the R/A as three lines. (Credit, Debit and Adjustment Claims Total Line.)

The example shows a claim billed at $20.00, and adjusted to $40.00. The amount paid on the adjusted claim is $20.00.

TO

REMITTANCE ADVICE

DATE: PAGE:

PENNSYLVANIA PHARMACEUTICAL
ASSISTANCE CONTRACT FOR THE ELDERLY
FISCAL AGENT-FIRST HEALTH SERVICE CORPORATION
P.O. BOX 8809, HARRISBURG, PA 17105

PROVIDER NUMBER:

CARDHOLDER NAME	CARDHOLDER I.D. NUMBER	DATE FILLED	NATIONAL DRUG CODE	DRUG NAME	PRESCRIP NUMBER	REF	QUAN	USUAL CHARGE	AMOUNT ALLOWED	DEDUCT AMOUNT	AMOUNT PAID	CONTROL REFERENCE NUMBER	MSG. CODE
R/A ADJUSTMENT CLAIMS EXAMPLE													
ADJUSTMENT CLAIMS													
ADAMS WA	444555666	11 25 04	00093511298	DILTIAZEM HCL	787787	1	30	20 00	20 00	6 00	14 00	433587675301	
ADAMS WA	444555666	11 25 04	00093511298	DILTIAZEM HCL	787787	1	30	40 00	20 00	6 00	34 00	434386785401	
ADJUSTMENT CLAIMS				TOTALS	1 TRANSACTIONS			20 00			20 00		

H. Voided Claims (see page VI.18)

This section identifies paid claims which have been voided. Paid claims can be voided from the Program up to two (2) years from their submission date.

Providers voiding claims with the intention of resubmitting with corrected data are reminded that claims, or resubmissions, will deny if submitted beyond 90 days from the date of service.

As demonstrated on the example page, voided claims contain all information that appears on the paid claim page.

Please note:

- All monies paid to, or received by, the provider are now accompanied with a negative sign.
- The amount voided from the provider's account appears in the Amount Paid column with a minus sign.
- The CRN in the Control Reference Number column identifies the void transaction.
- The CRN of the original paid submission is listed as the Former CRN.
- The term "Dated" reflects the R/A date in which the void will appear.

PENNSYLVANIA PHARMACEUTICAL
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PROVIDER NUMBER:

CARDHOLDER NAME	CARDHOLDER I.D. NUMBER	DATE FILLED	NATIONAL DRUG CODE	DRUG NAME	PRESCRIP NUMBER	REF	QUAN	USUAL CHARGE	AMOUNT ALLOWED	DEDUCT AMOUNT	AMOUNT PAID	CONTROL REFERENCE NUMBER	MSG. CODE
R/A VOIDED CLAIMS EXAMPLE													
VOIDED CLAIMS													
WAYNE JA	111222111	12 30 04	49884060810	FAMOTIDINE	676614	4	60	59 99-	13 00-	8 00-	5 00-	433589105301	
FORMER CRN: 433584452401 DATED: 010105													
VOIDED CLAIMS				TOTALS	1 TRANSACTIONS			59 99-	13 00-	8 00-	5 00-		

I. Remittance Summary (see page VI.21)

This section defines the various terms used on the Remittance Summary page.

19. **Paid Claims -** Total number of claims and dollar amount allowed. The dollar figure is that amount allowed by the Program for services provided before deductions.

20. **Rejected Claims -** Total number of claims that have been denied payment through Exception Processing.

21. **Adjustment Claims -** Addition or subtraction for over or under payment claims.

22. **Voided Claims -** Total number of claims that have been negated, or reversed from previously paid claims.

23. **Total Deductions -** Total amount of deductions withheld from provider's payment.

24. **Generic Differentials -** No longer calculated. The amount identified is the total amount of PACENET deductibles collected.

25. **Third Party Payments -** Any third party collections made by the provider.

26. **Co-payments -** Total dollar amount of co-payments less claims voided for this payment cycle.

27. **Net Claims Transaction -** Amount allowed, less deductions for claims involved in this cycle.

28. **Refunds And Voided Checks -** Refund checks are sent by providers to reimburse the Program in instances of overpayment, negated prescriptions, etc. Voided transmissions are transactions payable to a provider, but returned to the Program by a provider or as directed by the Department of Aging as a result of an audit. Both types of transactions are also recorded in the Suspense category.

29. **Payout Financial Transactions -** Gross adjustments either credited or debited to a provider's account.

30. **Recovery Financial Transactions -** A lump sum deducted from the provider's account due to a gross negative adjustment.

31. **Net Financial Transactions -** The net sum of the financial transactions.

Suspense Transactions:

Suspense transactions involve monies returned to the Program by the provider. This amount immediately reduces the dollar amount reportable for tax purposes. The balance in the Suspense category is reduced as claims are voided from history. These transactions do not alter the weekly transmission amount.

32. **Prior Suspense Balance -** The balance carried forward from a prior week.

33. **Suspense Payments Withheld -** The returned check amount.

34. **Suspense Payouts -** Claims being voided from history. This voiding reduces the suspense balance.

35. **Net Suspense Transactions -** The net total of Suspense Payments Withheld and Suspense Payment.

36. **Current Suspense Balance -** The current total dollar amount in all Suspense categories. This balance is the dollar amount that will be voided.

37. **Total Payment This Remittance -** Total amount allowed, less the total deductions.

38. **Credit Release -** Release of credits which were being held until a provider has the EFT data pass the pre-note testing through the Automated Clearing House (ACH) system.

39. **Total Transmission -** Total amount transmitted to the provider's account via EFT (Electronic Funds Transfer) for this R/A.

40. **Last Remittance Date -** The date of the last R/A sent to the provider.

41. **Transmission Number -** Number of the transmission issued with the current Remittance Advice.

42. **Year-To-Date Amount Paid -** Cumulative provider income reportable to Federal and State governments for tax purposes.

43. **Negative Balance -** In some instances a provider may owe the Program money. In this situation, the claims in question would appear in the "Voided Claims" field (line 22). If the dollar amount in the "Net Claims Transactions" field (line 27) is less than the amount to be recovered, a section labeled "Negative Balance" will be added to the Remittance Summary page X.15. When this occurs, the provider owes money to the PACE Program. The negative balance amount will continue to show until sufficient monies are remitted (in line 27) to clear the amount due.

J. Summary and Uses of the Remittance Advice

1. The Remittance Advice is the provider's record of all paid, ProDUR rejected or voided transactions for a cycle and should be reconciled with in-house records upon receipt and filed for future reference.

2. Always refer to the Remittance Advice when questions arise about a particular claim.

3. If the Remittance Advice cannot resolve questions on claim payments, please follow the proper procedure for submitting inquiries as outlined in the "Inquiry" section of this manual.

4. **Providers who do not use the R/A for reconciliation, but request PACE to do provider pharmacy billing profiles to verify R/A information <u>WILL BE BILLED</u> for such extraordinary services.**

REMITTANCE ADVICE

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PENNSYLVANIA PHARMACEUTICAL
ASSISTANCE CONTRACT FOR THE ELDERLY
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P.O. BOX 8809, HARRISBURG, PA 17105

PROVIDER NUMBER:

CARDHOLDER NAME	CARDHOLDER I.D. NUMBER	DATE FILLED	NATIONAL DRUG CODE	DRUG NAME	PRESCRIP NUMBER	REF	QUAN	USUAL CHARGE	AMOUNT ALLOWED	DEDUCT AMOUNT	AMOUNT PAID	CONTROL REFERENCE NUMBER	MSG. CODE
R/A SUMMARY PAGE EXAMPLE													
								CLAIM TRANSACTIONS					
							NUMBER			AMOUNT			
	19			PAID CLAIMS			77			2,579			
	20			REJECTED CLAIMS			0						
	21			ADJUSTMENT CLAIMS			0						
	22			VOIDED CLAIMS			2			49 32			
	23			TOTAL DEDUCTIONS			2			450 00			
	24			GENERIC DIFFERENTIALS						$ 00			
	25			THIRD PARTY PAYMENTS						$ 00			
	26			COPAYMENTS						$450 00			
	27			NET CLAIMS TRANSACTIONS						$2,079 68			
								FINANCIAL TRANSACTION					
	28			REFUNDS AND VOIDS			1			29 00			
	29			PAYOUT FINANCIAL TRANSACTIONS			0						
	30			RECOVERY FINANCIAL TRANSACTIONS			1			29 00-			
	31			NET FINANCIAL TRANSACTIONS			0			$ 00			
								SUSPENSE TRANSACTIONS					
	32			PRIOR SUSPENSE BALANCE			0			29 00			
	33			SUSPENSE PAYMENTS WITHHELD			0						
	34			SUSPENSE PAYOUTS			0			29 00			
	35			NET SUSPENSE TRANSACTIONS			0			29 00			
	36			CURRENT SUSPENSE BALANCE						$ 00			
	37			TOTAL PAYMENT THIS REMITTANCE						$2,079 68			
	38			CREDIT RELEASE						00			
	39			TOTAL TRANSMISSION						$2,079 68			
	40			LAST REMITTANCE DATE	122404								
	41			TRANSMISSION NUMBER 823970									
	42			YEAR-TO-DATE-AMOUNT-PAID						$90,719 00			
	43			NEGATIVE BALANCE									

VII. PHARMACY AUDITS

A. General Information

This section identifies some relevant portions of the law and regulations governing the PACE Program. This is not intended to be all-inclusive. Providers are advised that violations of the PACE law and/or regulations may constitute civil and criminal conduct subject to civil and criminal penalties.

Audits of provider's adherence to the PACE Program are conducted by the Office of Budget, Comptroller's Operations and the Department of Aging. Each month the Comptroller's Operations conducts an audit review of selected pharmacies. Findings of these initial audits may indicate that a comprehensive Recovery Audit or further investigation by the Department of Aging is necessary.

The purpose of these on-site audits is to ensure that the provider is adhering to both federal and state laws as well as contractual obligations of the Program. Providers are reminded that Section II of the Provider Agreement states:

> It shall be unlawful for any person to submit a false or fraudulent claim or application; to aid or abet another in the submission of a false or fraudulent claim or application; to receive benefits or reimbursement under a private, State or Federal program for prescription drug assistance and claim or receive duplicate benefits under this chapter; to solicit, receive, offer or pay any kickback, bribe or rebate, in cash or in-kind, from or to any person in connection with the furnishing of services under this Act; to engage in a pattern of submitting claims that repeatedly uses incorrect National Drug Code Numbers for the purpose of obtaining wrongful enhanced reimbursement; or to otherwise violate a provision of this Act. Any person who commits a prohibited act may be charged with a criminal offense under Title 18 of the Pennsylvania Consolidated Statutes (Relating to Crimes and Offenses).

Additionally as stated in Section 22.82 of Title 6 of the Pennsylvania Code, Aging:

An enrolled provider submits a false or fraudulent claim if the provider directly or indirectly commits one or more of the following acts:

1. Submits false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled for dispensing prescription drugs under PACE.

2. Submits a claim for dispensing only part of a prescription amount which is less than the maximum limit of the Program except when the provider can document that insufficient inventory prevented the dispensing of the Program limit and that no additional dispensing fee or co-payments were charged for dispensing the remainder of the prescription at a later time.

3. Submits false information to obtain authorization to dispense prescription drugs under PACE.

4. Solicits, receives, offers or pays remuneration, including a kick-back, bribe or rebate, directly or indirectly in cash or in-kind, from or to a person in connection with the dispensing of prescription drugs or referral of cardholders for prescription drugs.

5. Submits a duplicate claim for prescription drugs for which the provider has already received or claimed reimbursement from any source.

6. Submits a claim for a prescription drug that was not dispensed by the provider at the provider's principal place of business or were not dispensed to a cardholder.

7. Submits a claim for prescription drugs dispensed which are not documented in the prescribed manner. See 49 Pa. Code Chapters 16-18 (relating to State Board of Medicine-general provisions; State Board of Medicine-medical doctors; and State Board of Medicine-practitioners other than doctors) and 49 Pa. code § 27.78 (relating to standards of practice).

8. Submits a claim, order or prescription, for prescription drugs that are of little or no benefit to the cardholder, are below accepted treatment standards or are not medically necessary, in the case of a dispensing physician who is a provider.

9. Submits a claim that misrepresents the description of the prescription drugs dispensed, the date-of-service, the identity of the cardholder, the identity of the prescriber or the identity of the actual provider.

10. Submits a claim for a prescription drug dispensed under PACE at a cost that is greater than the provider's usual charge to the cash-paying public.

11. Submits a claim for a prescription drug dispensed for which the provider has not collected from the cardholder all due payments, including the required co-payment and any applicable generic differential.

12. Enters into an agreement, combination or conspiracy to obtain or aid another in obtaining from the Department payment to which the provider or other person is not entitled.

13. Submits a claim for prescription drugs dispensed to a cardholder outside this Commonwealth.

B. Prescription Format

1. The following requirements specifically address telephone prescriptions:

   a. The generic equivalent drug law, as amended December 15, 1988, requires that for a brand name product to be dispensed, the prescriber ***Must Handwrite "Brand Necessary"*** or ***"Brand Medically Necessary"*** on a written prescription. Additionally, the law states that, in the case of an oral prescription, there will be no substitution if the prescriber expressly indicates to the pharmacist that the brand name drug is necessary and substitution is not allowed.

   b. PACE claims for brand medications contained on the Program's DESI (Drug Efficiency Study Implementation) may be disallowed unless the words ***"Brand Necessary Per Dr.'s Order"*** or ***"Brand Medically Necessary Per Dr.'s Order"*** are ***Handwritten and Initialed*** by the pharmacist taking the telephone order.

   c. It is ***Not Acceptable*** for the pharmacist to write on the prescription ***"No Generics," "BMN," "Do Not Substitute,"*** or any language other than that required by law. A ***Computer Generated Notation*** is also ***Not Acceptable***.

   d. In the event of a provider audit, reimbursement will be disallowed for any prescription that lacks the aforementioned documentation. The Department reserves the right to take further administrative action for failure to comply with these requirements.

2. For those brand name products reimbursed by the Program following the receipt of a Medical Exception, written statements from the prescribers indicating their desire to have ***Brand Name Medications Dispensed Must Be Patient Specific Per Prescription.*** These statements must

contain the words "***Brand Necessary*** **or "*Brand Medically Necessary*" *In The Physician's Own Handwriting And Must Be On File At The Time Of Dispensing.*** These statements must be at the pharmacy at the time of the audit. PACE will not accept such documentation after the audit has been conducted.

C. Maintenance of Prescription Records

As required under paragraph 22.11 (f) (13) of the regulations, the Department will not pay for claims when the following documentation cannot be presented, and the lack of this documentation may constitute grounds for terminating a provider agreement:

1. An enrolled provider shall retain original hardcopy prescriptions for four (4) years at the principal place of business. An original hardcopy prescription is one of the following:

    a. The original order as it was reduced to writing by the prescriber by hand, typewriter, computer or other mechanical or electronic means.

    b. The oral order, such as one issued over the telephone, as it was originally reduced to writing by the pharmacist by hand, typewriter, computer or other mechanical or electronic means.

2. As defined in paragraph (1), original hardcopy prescriptions that are not handwritten by the prescriber shall bear the date and the handwritten signature or the handwritten initials of the dispensing pharmacist.

3. In addition to the original hardcopy of the prescription, the provider shall maintain a daily hardcopy record of filled and refilled prescriptions. The daily hardcopy record shall identify the prescriber who ordered the prescription, the patient for whom the prescription is intended, the strength and dosage of the medication, the number assigned to the prescription and the date of dispensing. The daily hardcopy record shall bear the handwritten signature or the handwritten initials of the pharmacist who filled or refilled the prescription. The data that supports the daily hardcopy record may be maintained by a manual system or by an electronic data processing system which meets the requirements in this paragraph.

    a. The provider shall assure that the system prevents improper access to, and manipulation or alteration of, stored records. The Department may develop provider instructions for safeguarding of stored records. If the Department does develop provider instructions, they will be distributed to providers as technical assistance to facilitate the provider's compliance with this subparagraph.

    b. Arrangements shall be made which assure completeness and continuity of prescription records if the relationship between a pharmacy and a supplier of data processing services terminates.

    c. The system shall provide retrieval of information regarding the original dispensing and the refilling of prescriptions.

    d. A pharmacist, and a pharmacy intern, if applicable, using a computerized system shall sign or initial the original hardcopy prescription at the time of the first dispensing and the initials of the pharmacist shall be entered into the computer record of the dispensed prescription.

    e. The introduction of prescription refill records into the system shall meet the following criteria:

(1) The initials of the pharmacist who dispensed the refill shall be entered at the time of dispensing.

(2) One of the following:

- The system shall be capable of displaying a record of prescriptions refilled each day on a daily hardcopy printout of prescriptions refilled that day and the dated signature of each pharmacist whose initials appear on the printout shall be affixed, on a daily basis, to the daily hardcopy printout to certify that it is a complete and accurate record.

- Documentation of the required refill information at the time of dispensing shall be reduced to a hardcopy record of the prescription that contains the information required by this paragraph. The handwritten signature or the handwritten initials of the dispensing pharmacist shall be affixed on a daily basis to the hardcopy record to certify that it is a true, complete and accurate record.

- Documentation of the required refill information at the time of dispensing shall be reduced to a pharmacy dispensing log which contains the prescription number which leads directly to the hardcopy record of information under this paragraph in the provider's principal place of business; the signature of the PACE cardholder; and the date the prescription was refilled. The handwritten signature or the handwritten initials of the dispensing pharmacist shall be affixed on a daily basis to the pharmacy dispensing log to certify that it is a true, complete and accurate record.

(3) A pharmacy that employs a computerized system shall have an auxiliary procedure that shall be used for documentation of all new and refilled prescriptions dispensed during system downtime. The auxiliary procedure shall provide for the entry into the computer of data collected during the downtime, and the pharmacist shall ensure that the maximum number of refills authorized on the original prescription has not been exceeded.

(4) Only pharmacists, pharmacy interns or personnel authorized by, and under the direct supervision of, the dispensing pharmacist may enter prescription data into the computerized system. A person authorized to enter data into the computerized system shall be readily identifiable as being accountable for the entering of the specific data which that person entered.

f. A change of a prescription order shall be documented on the original hardcopy prescription. Changes in the nature of a medication, the brand or manufacturer of a medication, the strength of a medication, or directions for its use are acceptable only if the consent of the prescriber was obtained before dispensing. The written explanation of the pharmacy on the prescription shall state that this was done and give the reasons for the change.

g. Prescription records of PACE cardholders shall be readily available for review, copying or photographing by authorized Commonwealth officials or their authorized agents. "Readily available" means that the records shall be maintained in a reasonable and retrievable manner at the provider's principal place of business.

D. Maintenance of Other Records

1. Other records necessary to disclose the full nature and extent of prescription drugs, both covered and not covered by the PACE Program, which were dispensed by a provider shall be retained for four (4) years and shall be available for review and copying by authorized Commonwealth officials or their authorized agents within seven (7) business days of a request for the records. These records include purchase orders and invoices, billing records, computer user manuals and computer security information.

E. Access to Records

1. Enrolled providers shall agree to provide reasonable access to records necessary to comply with the provisions for Program review set forth in the provider agreement. ***Additional conditions of participation are set forth in the Pennsylvania Code, Title 6. Aging.***

VIII. AUDIT MANUAL

A. General Information

This section identifies general policies and procedures relevant to the performance of on-site audits of a provider's adherence to the PACE law and regulations. The manual has been prepared to provide providers with general information and guidance on the audit process. On-site audits will be performed by the Commonwealth's Office of the Budget, Public Health and Human Services Comptroller Office. The information presented in this manual is not intended to be all-inclusive.

B. Purpose

The purpose of the on-site audit is to ensure that a provider is adhering to both state and federal laws, as required by the PACE regulations, as well as contractual obligations specified in the PACE Provider Agreement and Provider Manual.

C. Types of Audits

On-site audits and reviews are performed solely to assist the Department of Aging in evaluating the provider's compliance with the requirements of the PACE Program. The on-site audits and reviews are performed in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States, standards established by the American Institute of Certified Public Accountants, and applicable Commonwealth policy and procedures. Copies of these documents are on file with the Comptroller's Office and are available for review by appointment during normal business hours.

A routine audit conducted for the purpose of evaluating compliance with PACE laws, regulations and contractual requirements is known as a "discovery audit." A discovery audit may result in the disallowance of all or part of the reimbursement for pharmaceutical services paid for by the PACE Program.

A "recovery audit" may be conducted if the findings from a discovery audit disclose substantial noncompliances with PACE requirements. A recovery audit may result in additional claim disallowances or may be referred to the Department for further investigation.

An "investigation" may be instituted if recovery audit findings indicate a pattern of abuse or misconduct by a provider; if information retrieved via internal reviews of PACE data indicate potential billing discrepancies on behalf of a provider; or if information is provided by other third party insurers or law enforcement officials of alleged abuse.

The policy of the Comptroller's Office is not to advise providers regarding the type of audit being conducted. Any inquiries regarding the scope or purpose of an audit may be addressed by a provider to the Department as provided by Paragraph F (4) (f) of this Manual. Regardless of the type of audit being conducted, the results of any type of audit may be shared by the Comptroller's Office or the Department with other agencies or potentially utilized for the purposes of imposing civil penalties or in criminal investigations.

D. Maintenance of Records

The provider is responsible to maintain all records necessary to disclose the full nature and extent of prescription drugs, both covered and not covered by the PACE Program, which were dispensed by the provider. These records shall be retained for four (4) years and shall be available for review, copying or photographing by authorized Commonwealth officials or their authorized agents within seven (7) business days of a request for the records. These records include original hard copy prescriptions, purchase orders and invoices, billing records, computer user manuals and computer security information. Information relating to prescription drugs not covered by the PACE Program may be reviewed to determine compliance with PACE laws, regulations or contract requirements or for the purpose of providing information to other state or federal agencies regarding the provider's compliance with other laws, regulations or contract requirements.

E. Responsibilities

1. ***Providers***

   a. Maintain appropriate records as specified in item D, above.

   b. Provide the auditor with adequate workspace and all required records and documentation necessary to perform the audit.

   c. Be available to respond to questions raised by the auditor during the performance of the audit.

   d. Inform the Comptroller's Office of any concerns or issues regarding the onsite audit.

   e. Cooperate with the auditors in a professional manner.

2. ***Auditors***

   a. Provide advance notification to the pharmacy regarding the audit and the documentation required to perform the audit as specified in Paragraph F (2), below.

   b. Never interrupt the pharmacist while he or she may be providing services to a patient.

   c. Conduct the audit in a professional manner.

   d. Ensure that the provider is informed promptly of the audit results as specified in Paragraph F (4) (d), below.

F. On-site Audit Process

1. ***Provider Selection*** **-** The selection of providers for a discovery audit is based exclusively on an automated risk analysis of PACE claims activity during the audit period. Risk factors are determined by the mutual agreement of the Comptroller's Office and the PACE Program. Audit selection is never undertaken in an arbitrary or discriminatory manner.

2. ***Audit Notification*** **-** A letter from the PACE Program Director will be sent to the provider approximately two weeks prior to a scheduled audit date. The content of the letter will indicate the proposed scheduled week of audit, the audit period, and details on the types of records that will be examined during the on-site visit and a request that the records be made available at the time of audit.

3. ***Audit Scheduling*** **-** Approximately one-and-a-half to two weeks prior to the audit date, an auditor from the Comptroller's Office will contact the provider by telephone to establish a date and time for the performance of the audit. The auditor will also provide additional details about the audit and the type of records that will need to be available for the audit. The provider at this time should ask any questions they may have about the conduct of the audit or the records required to perform the audit.

   The Comptroller's Office will make every effort to accommodate the provider's schedule and arrange a mutually agreeable date and time to perform the audit.

4. ***On-site Visit*** **-** The on-site visit will normally last approximately six to seven hours. The exact duration of the audit and the time required of the pharmacy manager or designated staff during this period will depend on a number of factors including: (1) availability of all required documentation upon arrival; (2) sufficiency of the documentation; (3) number of discrepancies

identified; and (4) availability of provider personnel in gathering documentation and answering questions. The on-site visit will normally consist of the following:

a. ***Entrance Interview****:* Prior to beginning test work, the auditor will conduct a short entrance interview, lasting approximately ten minutes, with the pharmacy manager or designated staff. During this interview, the auditor will reiterate the audit objectives and the test procedures. The auditor will also inquire about the availability of provider records and address any concerns raised by the provider. If desired, the provider may have present an accountant, attorney or other professional consultant of their choosing throughout the on-site visit.

b. ***Provider Questionnaire****:* Upon completion of the entrance interview, the auditor will complete a provider questionnaire with the pharmacy manager or designated staff. The questionnaire is designed to provide information about the operation of the provider, and to reiterate certain requirements of the PACE Program. Completion of the provider questionnaire will normally take approximately ten minutes.

c. ***Test Work:*** If provider records are readily available, the auditor will work independently during the majority of the test work phase. If provider records are not readily available or are insufficient, the auditor will be required to ask about the availability of additional records or the reason for the lack of documentation. In either instance, questions generally arise during the course of test work that will have to be addressed with the appropriate provider representative.

   The auditor will strive to give the provider every opportunity to address discrepancies identified during the on-site visit and to provide additional documentation to remedy the discrepancies.

d. ***Exit Interview****:* Upon completion of test work, the auditor will conduct an exit interview, lasting approximately fifteen minutes, depending upon the extent of noted discrepancies, with the pharmacy manager or designated representative. During the exit interview, the auditor will explain any noted discrepancies and provide a preliminary detailed listing of any claims to be questioned. The auditor will also explain the resolution process and ask the provider representative to sign a statement indicating the receipt of the detailed listing of questioned claims.

   The provider's signed acknowledgment of the questioned claims does not in any way constitute agreement with the findings or the waiver of any rights to challenge the results.

   The auditor is only to conduct a review of designated records and provider practices consistent with the audit scope of engagement. Auditors are not responsible for interpreting PACE policy and have no discretion in resolving audit findings. Issues regarding the interpretation of laws, regulations and contractual requirements or the fairness or appropriateness of any audit disallowance must be addressed with the Department as part of the audit resolution process.

e. ***Provider Evaluation Questionnaire:*** The provider representative will be provided with a PACE Provider Evaluation Questionnaire and a postage paid envelope at the time of the exit interview. On this questionnaire, the provider will be asked to answer a few simple questions about the conduct of the audit and will be given an opportunity to comment on any other aspect of the audit engagement. The provider is encouraged to complete this questionnaire in an honest and objective manner, and return it promptly to the Comptroller's Office.

   Comments that may be critical of the audit performance or Program policy will be reviewed independently of the audit resolution.

f. ***Complaints:*** A provider may submit complaints verbally or in writing at any time to the Department concerning the manner in which audits are conducted. Any complaints

critical of the audit performance or Program policy will be reviewed independently of audit resolution. Complaints may be submitted to:

Pennsylvania Department of Aging
The PACE Program
555 Walnut Street
Forum Place Building
6th Floor
Harrisburg, PA 17101
Telephone: (717) 787-7313

G. Supervisory Review

All audit information is returned to the Comptroller's Central Office where it is subject to supervisory review by an audit supervisor and manager. This phase of the audit will occur approximately six to eight weeks after the completion of the on-site visit. Adjustments to the preliminary listing of discrepancies occurring as a result of the supervisory review will be communicated to the provider either in writing or by telephone.

H. Reporting

Approximately two to three weeks after the completion of the supervisory review, the Comptroller's Office will issue a formal report to the Department of Aging. The formal report will mirror the discrepancies, if any, as discussed with the provider representative at the conclusion of the on-site visit or as a result of any subsequent communication and will disclose the basis or reason for any questioned costs. The explanation of the basis or reason for any questioned costs will include a reference to the applicable laws, regulations or contractual requirements.

I. Audit Outcome and Resolution

The Department of Aging, upon receipt of the findings from the Comptroller's Office, will review and forward the Comptroller's Report to the individual provider. The provider is given thirty days to file a response to the Comptroller's Report. The Department of Aging will evaluate the Comptroller's Report and the provider's response and make a determination regarding whether to disallow reimbursement for all or any portion of the claims for which costs were questioned by the Comptroller's Office. The process of reviewing the Comptroller's Report and the provider's response is known as audit "resolution."

In the audit resolution process, the Department will evaluate all of the facts and circumstances relevant to any disallowance of reimbursement, will interpret the relevant laws, regulations and contractual requirements, and will make a decision which is in the best interests of the PACE Program. In making a decision regarding whether to disallow reimbursement or impose penalties, among other factors, the Department may consider evidence regarding whether a provider acted in good faith and attempted to comply with Program requirements, and the extent to which violations of laws, regulations or contract requirements imposed any costs, damages or losses to the PACE Program.

The Department will advise the provider of the final date upon which a response to the report must be submitted. Any extension must be approved in writing by the Department prior to the date upon

which a response is required. A response will be considered to have been submitted in a timely manner if postmarked on or before the required date by the U.S. Postal Service. A provider may obtain a certificate of mailing from the Postal Service to document the date an item is sent to the Department. In unusual circumstances and for good cause shown, the Department may agree to accept a response after the date upon which the response is required, but the Department is not required to do so.

If no response is filed to the Comptroller's Report, the report will be deemed final and the Department may recoup the disallowed costs as a claim against the provider beginning on the first business day following the final date upon which a response to the Report was required. The Department may either recoup the disallowed costs from a future Remittance Advice or take other action as authorized by law for the collection of amounts due to the Commonwealth.

When a provider files a written response to the Comptroller's Report, the report along with the documentation submitted by the provider will be reviewed by the Department staff and the Department's Final Audit Report will be forwarded to the provider.

J. Administrative Appeals

A provider may file an administrative appeal of the Department's Final Audit Report in accordance with 6 Pa. Code Subsection 22.101, within 30 days of the date of the Department's Final Audit Report. The Department will advise the provider of the final date upon which a response to the report must be submitted. An administrative appeal will be considered to have been submitted in a timely manner if postmarked on or before the required date by the U.S. Postal Service. A provider may obtain a certificate of mailing from the Postal Service to document the date an item is sent to the Department. The deadline date for filing an answer will be strictly enforced.

If a timely appeal to the Department's Final Audit Report is not filed, the report will be deemed final and the Department may recoup the disallowed costs as a claim against the provider beginning on the first business day following the final date upon which the provider was entitled to file an administrative appeal. The Department may either recoup the disallowed costs from a future Remittance Advice or take other action as authorized by law for the collection of amounts due to the Commonwealth.

The form and content of the provider's appeal shall be under I Pa. Code Subsection 35.10 (relating to form and content of formal complaints). The provider shall attach either copies of or a summary of all documents or other evidence upon which the appeal is based and shall indicate whether a hearing is requested.

A hearing, if requested, will be conducted by a hearing examiner appointed by the Director of the Department of Public Welfare's Office of Hearings and Appeals at the request of the Secretary of Aging. Hearings shall be conducted in accordance with the Rules and Administrative Practice and Procedure as set forth in 1 Pa. Code Title I, Part 2. At the hearing, the provider has a right to representation by counsel, a right to present relevant and material evidence to the hearing examiner and a right to cross examine witnesses of the Department. Providers are not required to retain counsel to pursue an appeal, but may do so.

Information about the appeals process can be obtained from:

Department of Aging
Office of Chief Counsel
Forum Place Building - 6th Floor
555 Walnut Street
Harrisburg, PA 17101

The final decision of the Department regarding an appeal will be issued in the form of a written opinion by the Department that sets forth findings of fact, conclusions of law and a final order of the Department. A final decision will be binding as between the Department and the provider, both with respect to the audit subject to the appeal.

Pending the issuance of the Department's final decision regarding an appeal, the Department's action shall not be deemed final and no claim of the provider shall accrue against the Department under the contract between the provider and the PACE Program.

K. Discrimination

It is the policy of the Department of Aging not to discriminate based upon race, sex, religion, national origin, political affiliation, or upon the exercise of any rights of the expression of views and opinions contrary to those of the Department and its representatives.

IX. INQUIRIES

A. General Inquiries

Written or telephone inquiries ***must include*** the provider's PACE number.

B. Payment Inquiries

Inquiries regarding payments must include the Remittance Advice payment date, and the provider number. This information appears on your Remittance Advice (R/A).

Pharmacies not having payment remitted for approved claims within twenty-one (21) days of claim receipt by the Program will receive interest for the late payment.

All information on claim submission issues, whether written or telephoned, is to be directed to:

PACE
Provider Services Department
Post Office Box 8809
Harrisburg, PA 17105
Telephone Toll-free:
1-800-835-4080

C. Cardholder Services Inquiries

Inquiries from cardholders regarding cardholder application status or cardholder eligibility requirements should be directed to the Cardholder Services toll-free number:

1-800-225-7223

Providers should contact PACE through the 1-800-835-4080 number.

X. REFERENCE TERMINOLOGY

A-rated Generic Therapeutically Equivalent **-** A drug product that the Commissioner of Food and Drugs of the United States Food and Drug Administration has approved as safe and effective and has determined to be therapeutically equivalent, as listed in "The Approved Drug Products with Therapeutic Equivalence Evaluations" (Food and Drug Administration Orange Book), with a specific "A" code designation only.

Acute Condition **-** A short-term medical condition or ailment for which the normal and typically recommended drug therapy does not exceed fifteen (15) days.

Average Wholesale Cost **-** The cost of a dispensed drug based upon the price published in a national drug pricing system in current use by the Department as the average wholesale price of a prescription drug in the most common package size. The terms "average wholesale cost" and "average wholesale price" are synonymous.

Co-payment **-** The dollar amount that is required under the Program to be paid to enrolled providers by cardholders for each prescription.

Control Reference Number (CRN) **-** The twelve (12) digit reference number assigned to a claim for record identification.

Department **-** The Department of Aging of the Commonwealth.

"DESI" (Drug Efficacy Study Implementation) Drug **-** Those drug products introduced into the market as new drugs from 1938 - 1962 which were submitted for review by the National Academy of Sciences - National Research Council Drug Efficacy Study Group and are still considered by the Food and Drug Administration as less than effective in meeting their manufacturers' claims. This includes any identical, related or similar products as covered under 21 CFR Chapter 1, Sec. 310.6. These are the same drug products considered not reimbursable by the Medical Assistance Program under 42 CFR 441.25 (relating to prohibition of FFP for certain prescribed drugs.)

FDA **-** The United States Food and Drug Administration of the Public Health Service of the Department of Health and Human Services.

FUL – Federal Upper Payment Limits established in the Medicaid Program under CFR §447.332 (relating to Upper Limits for multiple source drugs).

Generically Equivalent Drugs **-** Prescription drug products, including those sold under brand names, having the same generic name, dosage form and labeled potency.

HCFA **-** The Health Care Financing Administration of the United States.

Less Expensive – "The lowest net cost to the Program. The net cost shall include the amount paid by the Commonwealth to a pharmacy for a drug under a current retail pharmacy reimbursement formula less any discount or rebates, including those paid during the previous calendar quarter and inclusive of all dispensing fees." (Senate Bill 1167)

X. REFERENCE TERMINOLOGY (continued)

Medication History **-** A pharmacy medication record established and maintained on each PACE/PACENET cardholder served by the pharmacy. This record must include, as a minimum, the following cardholder information as obtained from the cardholder or equivalent information as approved by the Department:

1. Name.

2. PACE/PACENET identification card number.

3. Medication allergies and other allergies.

4. Current medication utilization.

5. Indication of all medical disorders known to the cardholder.

6. Separate entries for each prescription medication dispensed by the provider.

Prescription Drugs **-** All drugs requiring a prescription in the Commonwealth of Pennsylvania and insulin, insulin syringes and insulin needles. Experimental drugs, DESI drugs, and drugs not approved by the Department of Health for use in the Commonwealth are excluded.

Principal Place of Business **-** A location in this Commonwealth where an enrolled provider can and will conduct all business directly related to the dispensing of prescription drugs under the PACE Program.

Unit **-** The measured quantity of a prescription drug to be used such as a single tablet or capsule. Oral liquids, aerosols, ointments are exempt.

Universal Claim Form **-** The standard form, copyrighted by the National Council of Prescription Drug Programs, and in current usage by pharmacies to document for third party payers prescription services provided to cardholders eligible for prescription benefits under a plan administered by a third party payer. Current usage connotes the most current official version of this form in use at this time and at any given time in the future.

Usual Charge **-** An enrolled provider's charge to the cash-paying public for a prescription drug, in a specific strength and quantity within a specific calendar month. Discounts or coupons offered to the cash-paying public shall be considered to be offered to the Commonwealth as well. Discounts applicable to cardholders or coupons presented by cardholders shall be accepted by the provider and credited to the PACE/PACENET Program payment and not the co-payment.

XI. APPENDIX