CalOptima Pharmacy Services Program Procedures

CalOptima is the managed health care program for Orange County's Medi-Cal beneficiaries. CalOptima contracts with a Pharmacy Benefit Manager (PBM) to assist in the administration of CalOptima's Pharmacy Management Program. CalOptima is responsible for pharmacy management policy and overall program administration and oversees the PBM's role in assisting the pharmacy network with claims processing and daily operations.

Confidentiality Requirements

CalOptima has a responsibility to ensure confidentiality and to protect the interests of CalOptima and its members. Personal information related to CalOptima members is protected under confidentiality laws. The identity of an individual receiving public services/assistance is protected by federal law. Thus, names of CalOptima members are confidential and are to be protected from unauthorized disclosure. In addition, all information, records, data and data elements collected and maintained by participating pharmacies pertaining to members shall be protected by the pharmacies from unauthorized disclosure. Provision of such information shall be limited only to purposes of pharmacy service delivery.

Determination of Eligibility for Medi-Cal and CalOptima

Eligibility for Medi-Cal benefits is determined by the Social Services agency. CalOptima's role is to administer the Medi-Cal benefits for those persons deemed eligible in Orange County. CalOptima does not determine a person's eligibility for Medi-Cal benefits.

Member Eligibility Verification

Pharmacies are required to verify eligibility and provide services to CalOptima members in accordance with the Participating Pharmacy Agreement (PPA):

- Upon presentation at the pharmacy, ask to see the member's CalOptima ID card.
- If the member is not eligible via on-line transmission, call the Medi-Cal Automated Eligibility Verification System (AEVS) at 1-800-456-2387 or call CalOptima's Eligibility Verification System at 1-714-246-8540.
- If the member is eligible for services, contact CalOptima at 1-714-246-8471 and press 2 to request an eligibility update. The member will be added into the PBM system to enable on-line claims transmissions.

During the interim while the member's eligibility status is researched, pharmacies should exercise appropriate clinical judgment when determining whether to dispense medications pending eligibility verification.

Newborns

Newborns are covered for the month of birth and the following month, provided their mother is an eligible CalOptima member. To submit a claim for a newborn, please use the newborn's name and the mother's Client Index Number (CIN) and date of birth. Continued eligibility for the newborn will be determined by Medi-Cal eligibility requirements.

Share of Cost

Some CalOptima members must meet a specified Share of Cost (SOC) for medical expenses, including prescriptions, before they are eligible to receive Medi-Cal benefits within a given month. SOC dollar amounts can be verified through the Medi-Cal Automated Eligibility Verification System (AEVS) or the Point of Service (POS) device using the BIC Card. All medically necessary health services including medical services, supplies, devices and prescription drugs, whether Medi-Cal covered or not, can be used to meet SOC. Pharmacies must clear SOC transactions immediately upon receiving payment, or accepting obligation from the member, for the service rendered. Delays in performing the SOC clearance transaction may prevent the member from receiving other medically needed services. Once the member has met his/her SOC obligation for a given month, all future prescriptions for that month may be billed through the PBM. See the Medi-Cal Provider Manual Part 1 (Share of Cost (SOC), share 1) for specific Share of Cost Clearance instructions.

Obligating Payment

Providers may collect SOC payments from a member on the date that services are rendered or providers may allow a member to "obligate" payment for rendered services. Obligating payment means the provider allows the member to pay for the services at a later date or through an installment plan. Obligated payments must be used by the provider to clear Share of Cost. SOC obligation agreements are between the member and the provider and should be in writing, signed by both parties for protection. CalOptima will not reimburse the provider for SOC payments obligated, but not paid by the member.

Share of Cost Overlap Service

A Share of Cost Overlap Service occurs when a balance due to the pharmacy remains after the member has met his/her Share of Cost obligation for a given month. When a particular claim creates a SOC Overlap Service, the pharmacy must manually bill the claim to the PBM on a Universal Claim Form for the balance due after the SOC has been collected from the member.

Example: Assume three prescriptions are dispensed to a member on different dates. The member's monthly Share of Cost is $200. The following prescriptions were dispensed to the member:

Dates	NDC	Amount
7/1/2019	12345-67-89	$60
7/3/2019	00000-02-00	$80
7/5/2019	00001-02-03	$100
		Total: $240

Submit a Share of Cost clearance transaction for each of the three services. The first two prescriptions provided on dates prior to the overlap are the member's responsibility and should not be billed to CalOptima. Bill CalOptima for the Share of Cost Overlap Service on a Universal Claim Form. Enter the difference between the Rx Total Charge ($100 for this example) and the patient's remaining Share of Cost (for this example $40) in the Net Amount Due field (for this example $60).

Prescription Coverage Through Other Sources of Payment (Coordination of Benefits)

CalOptima members may have prescription coverage through other payment sources such as private health insurance plans. CalOptima is the payer of last resort for coordination of benefits claims. CalOptima is responsible for co-insurance, co-payments, and deductibles only after all prior authorization processes through the primary payer have been exhausted. Effective 6/11/13, when processing claims to CalOptima as the secondary payer, CalOptima will require the Government Coordination of Benefits (COB) method to process COB claims. The Government COB method requires providers to submit the Other Payer Amount Paid [431-DV] and the Other Payer-Patient Responsibility Amount [352-NQ]. Using this method allows CalOptima to reimburse claims based on the lower of Other Payer Paid Amount or Other Payer-Patient Responsibility amount calculations. All claims for Coordination of Benefits (COB) submitted for payment by CalOptima must be electronically submitted or reversed on-line through the PBM.

The following other coverage codes will be accepted when submitting Government Coordination of Benefits (COB) claims for CalOptima Medi-Cal members:

02 = Other coverage exists - payment collected: pays at POS up to $100
03 = Other coverage exists - claim not covered: PA required
04 = Other coverage exists - payment not collected: pays at POS up to $100

For claims over $100, a PA is required for insurance verification. PA forms should not be sent to the prescriber. Please fax PA forms directly to MedImpact 1-858-357-2557 or contact the MedImpact pharmacy help desk at 888-807-5705. The PA request should include any supporting documentation such as a denial letter from the primary insurance. All prior authorizations through the primary insurance need to be exhausted before billing CalOptima.

Refer to the CalOptima payer sheet for complete instructions on how to properly submit a Government coordination of benefits claim on-line.

CalOptima cannot cover co-payments for covered Medicare Part D drugs. CalOptima is the primary payer for excluded Part D drugs only. These are covered under the CalWrap plan and should not be billed as a coordination of benefits (COB) claim.

Pharmacies are required to identify the member's source of other health coverage. State law requires Medi-Cal providers to notify the Department of Health Services (DHS) if they believe a member may be entitled to OHC. Call DHS at 1-800-541-5555 between 8 a.m. and 5 p.m. to report possible coverage, or write to DHS at:

Department of Health Services
Health Insurance Section
P.O. Box 997421
Sacramento, CA 95899-7421

Be sure to indicate the member's name, Medi-Cal Beneficiary Identification Card (BIC) number and name of the insurance plan.

Serving CalOptima Members with California Children's Services (CCS)

The California Children's Services (CCS) Program is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases through their 21st birthday. CCS authorizes physicians or physician groups for specialty medical care. As of 7/1/2019, CalOptima is responsible for providing covered medical services and medications that were previously covered by the CCS program with the exception of carve out medications.

Blood factors and Coagulation Factors are carve out medications and should be billed to Medi-Cal FFS. Requests for Factor and Hemlibra should be sent to the ISCD CCS office for adjudication. SARs and all necessary medical documentation can be sent via the e-SAR process (preferred method) or manually faxed to a dedicated fax for specialty prescriptions: 916-440-5768.

Medicare Crossover Claims

For CalOptima Medi-Cal members who also have Medicare coverage (dual-eligibles), Medicare is the primary payer for drugs and supplies covered under Medicare Part B. Costs not covered by Medicare are covered as crossover claims. CalOptima members should not be billed for Medicare coinsurance or deductibles.

Medicare crossover claims should not be sent to the PBM. The Medicare carrier will automatically transfer the crossover claim for a linked provider to CalOptima for processing Medi-Cal reimbursement of coinsurance and deductibles.

All pharmacies must register their NPI used to bill Medicare claims with Medi-Cal. This will ensure that the crossover claim is **electronically** processed from the Coordination of Benefits Contractor (COBC) successfully. Medicare claims that crossover without an NPI registered with Medi-Cal will have to be submitted as a **"hard copy" paper claim** for reimbursement.

Pharmacies can register their NPI with Medi-Cal, so crossover claims can pay electronically by calling 1-800-541-5555 to request a National Provider Identifier Registration Form or by using the Medi-Cal on-line registration tool: http://files.medi-cal.ca.gov/pubsdoco/npi/npi_reginfo.asp

If these claims do not crossover automatically from the Medicare Part B carrier, they must be billed to CalOptima. Effective June 1, 2014 all paper claims submissions for dual eligible Medicare and Medi-Cal crossover claims should be submitted on the new CMS 1500 Form and sent to: CalOptima, P.O. Box 11070, Orange, CA 92856. For claim status, please contact Customer Service at 1-714-246-8885.

Becoming a Medicare Provider

All Pharmacies must have a Medicare supplier ID, accept Medicare payment and Medicare crossover payment (if any) as payment in full (see PPA). The regional carrier for Orange County (Region D) is Noridian Administrative Services, LLS. The first step to becoming a Medicare provider is to contact the National Supplier Clearing House in Columbia, South Carolina at 1-866-238-9652 and request an application for a Medicare supplier ID number.

CalOptima Plans

CalWrap
This plan includes CalOptima dual-eligible members who have Medicare and Medi-Cal benefits. The following drug categories that are excluded from Medicare Part D may be covered by CalWrap for dual-eligible member: some prescription vitamin and mineral products (vitamins or minerals used for dietary supplementation are not a benefit), some non-prescription (OTC) drugs (note: Medicare Part D covers insulin and syringes), and cough/cold medications.

CalOptima Direct
Newly eligible CalOptima members are initially assigned to CalOptima Direct to enable immediate access to health services, including pharmacy services. Most members subsequently select a primary care physician (PCP) in one of CalOptima's contracted Health Networks, usually within 30-45 days of becoming a CalOptima member. Some members remain in CalOptima Direct permanently.

CalOptima Health Networks
CalOptima members select a primary care physician (PCP) who is contracted with one of CalOptima's Health Networks. There are three types of health networks: PHC (Physician-Hospital Consortia), HMO (Health Maintenance Organization), and SRG (Shared Risk Group). PHCs include AMVI Care Health Network, CHOC Health Alliance, Family Choice Health Network, HPN - Regal Medical Group, Monarch Family Healthcare Health Network, and Prospect Medical Group. HMO is Kaiser. SRGs include AltaMed Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Group. In addition, CalOptima members can select a PCP who is contracted with CalOptima Community Network (CCN).

CalOptima Identification Card

- The nine (9) digit Client Index Number (CIN) on the member's CalOptima identification card will be used for claims adjudication. In addition, the member's date of birth must be submitted on each claim.

- Each covered member (with the exception of newborns, see "Newborns" below), is assigned a unique Client Index Number (CIN).
- Person code (i.e. 01, 02, etc) is not required for claim submission.
- The member's health network status and Medicare status are printed on the "Network" line on the card.

Claims Submission

Billing information to submit claims on-line via point of service to CalOptima's Medi-Cal and CalWrap plans:

Medi-Cal
RxBin: 017142
RxPCN: ASPROD1
Rx Group: CAT01

CalWrap
RxBin: 017142
RxPCN: ASPROD1
RxGroup: CAT03

Claims may be submitted or reversed to the PBM up to 180 days from the date of fill.

National Provider Identifier (NPI) Required for Pharmacies and Prescribers

Only the pharmacy's NPI number and prescriber's individual NPI number (National Provider Identifier) may be submitted online for pharmacy claims. The NPI Online Registry enables you to search for a provider's NPI number: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

If the prescriber does not have an NPI number or the prescriber's organizational NPI number is used, the claim will reject.

On-Line Drug Utilization Review (DUR)

The on-line Drug Utilization Review (DUR) process assists pharmacists in providing quality care by identifying potential therapeutic conflicts and drug-drug interactions. As claims are sent to the PBM, the DUR process assesses the prescription against the claim's history of the patient. An on-line message is sent to the pharmacy when a potential problem exists and should be reviewed by a pharmacist.
If assistance is required, please contact the PBM at 1- 888-807-5705.

CalOptima Prior Authorization Process

On-line claims submitted for medications that require prior authorization may be rejected with any of the following on-line messages:

- "NDC Not Covered" or "Product/Service Not Covered"
- "Drug Requires Prior Authorization" or "Prior Authorization Required" or "PA Required"
- "Plan Limitations Exceeded"
- "Cost Exceeds Maximum"
- "Patient Age Exceeds Maximum Age"

The purpose of the CalOptima prior authorization (PA) process is to allow members access to safe, effective, clinically appropriate and medically necessary medications not on the CalOptima Approved Drug List.

A PA is also required in the following situations:

- Claims that exceed plan limitations for quantity, refill frequency, or duration of therapy
- Claims exceeding $3,000
- Claims rejected due to failure to meet Step Therapy or Contingent Therapy restrictions
- Non-injectable compounded medications
- Most requests for brand drugs when generics are available

- Medication fills in excess of 6 per calendar month (unless the member is exempt from the monthly limit)

Prior to submitting a PA request, the pharmacist should assess whether the prescribed medication may be changed to a CalOptima preferred drug. If a clinically appropriate alternative exists on the Approved Drug List, pharmacists should discuss this option with the Prescriber first.

Overrides that do not require clinical review can be obtained via phone by calling the PBM Pharmacy Helpdesk at 1-888-807-5705. The following situations do not require clinical review:

- Hospital discharge medications up to a 10-day supply
- Lost/stolen/damaged medications
- Vacation supply requests

PA Submission Timeliness Guidelines for Retroactive Authorization

A retroactive PA received may be considered for review only under the following conditions:

- If the request is received within ten (10) days from the date of service for SNF or ICF members.
- The first fill of a medications prescribed upon admission to a SNF (Skilled Nursing Facility) can be authorized via a phone call to the PBM and does not require a prior authorization form to be submitted.
- If the request is received within 180 days of the date the drug was dispensed for non-SNF/non-ICF members and proof of notification of retroactive eligibility is submitted.

Indicate that the request is retroactive by checking the "Request is Retroactive" box on the PA form. All medical justification should be included. Retroactive requests cannot be submitted as urgent.

Prior Authorization Policy

Pharmacies are not permitted to fill non-formulary prescriptions for cash payment in lieu of the PA process. Pharmacists should exercise their best professional judgment to determine whether a request is clinically appropriate for the member before submitting a PA request.

PA requests may be submitted to the PBM via fax at: 858-357-2557 or by phone at: 888-807-5705.

Every effort is made to provide a decision for each PA request upon the initial submission. The decision to approve or deny each PA request is based upon demonstrated medical necessity of the requested item for the condition and clinical circumstances stated on the PA form by the submitting party.

If a PA is approved, the pharmacy may dispense the prescription and submit the claim on-line to the PBM. If a PA is denied, CalOptima/PBM will not be financially

responsible for the prescription. Pharmacists are encouraged to confer with the Prescriber and use their clinical judgment before filling and dispensing these prescriptions.
Note: If at any time, a CalOptima member insists on paying out of pocket for a medication instead of waiting for a PA decision, the pharmacy provider should have the member acknowledge their decision in writing.

Pharmacy Provider Responsibilities

It is the pharmacists' professional responsibility to provide correct information regarding CalOptima's drug coverage to members. CalOptima members rely on information provided by their pharmacists.

With very few exceptions, all drugs potentially are a CalOptima drug benefit, and those drugs not on the CalOptima Approved Drug List may be covered benefits with prior authorization. PAs may be submitted via fax to the PBM at 1-858-357-2557 or by phone at 1-888-807-5705. CalOptima shall provide a response to your doctor or pharmacy within 24 hours or the next business day of receiving a prior authorization. In situations where additional information is needed, a decision shall be made within 72 hours for urgent requests or up to 14 days for standard requests.

PA Procedures

The following procedures must be followed to submit a PA request:

- PA may be submitted by phone to the PBM by calling 1-888-807-5705 or by fax to 1-858-357-2557.
- PA form is revised periodically. Pharmacies/physicians must use the most updated version of the form. PA requests using an outdated form or using the Medi-Cal TAR form may be returned to the submitter without review.

The pharmacy shall not be solely responsible for completion of the PA but shall coordinate with the Prescriber in order to assist in the completion and submission of the form.

- PA forms should be typed and/or printed. Forms that are illegible may be returned to the Prescriber or result in a delay in processing.
- Enter the diagnosis or the ICD-10-CM code that most accurately describes the member's diagnosis or indication for the medication. Include all medically relevant diagnosis for review purposes.
- Documentation of appropriate clinical information that supports the medical necessity of the requested item, quantity, refill frequency, or duration of therapy must be noted on the PA form. Documentation of other drugs that the member tried previously, and their clinical outcomes is recommended.
- Include any additional documentation requested by the PBM to support medical justification (e.g. questionnaires, letters of medical necessity, consult evaluations & recommendations, lab results, etc.).

- Submit the PA form and any additional documentation to the PBM Prior Authorization Department by FAX at 1-858-357-2557. The PA form will be reviewed, and the prescriber will be notified within 24 to 72 business hours (Monday Thru Sunday) of the decision. For urgent requests during business hours, check the "Urgent" box on the top of the PA form. If necessary, please call the PBM Prior Authorization Department at 1-888-807-5705 to determine the status of a PA request.

- Delays in PA processing may occur if additional clinical information is necessary to support medical justification.

- If the pharmacist determines by his/her professional and clinical judgment that a member is in need of an emergency supply of medication that requires prior authorization, the pharmacist may dispense up to a ten (10) day supply of medication so that the member is not without medication until the prior authorization request is reviewed. Patients should not be required to pay cash while waiting for a PA review (see "Emergency Supply Policy" section).

- A PA request may be approved for specific time duration, refill limitation or both. It is the responsibility of the dispensing pharmacy to process the approved item prior to releasing it to the member to guarantee payment.

- An authorization is not a guarantee of payment. Payment is subject to member's eligibility and the pharmacy's participation in the CalOptima pharmacy network.

Contingent Therapy and Step Therapy

Claims for formulary drugs having Contingent Therapy (CT) and Step Therapy (ST) restrictions will process automatically if the specific therapy criteria are met. Pharmacy manual override is not available. Please note if the claim is rejected, a PA is required.

Dispensing Limitations

Most medication and medical supply prescriptions for items listed on the CalOptima Approved Drug List and the CalOptima Disposable Medical Equipment/Supply Items list, respectively, may be filled for up to a 60-day supply (see individual medications listed). Brand medications for members residing in long term care facilities are limited to a 14-day supply.

Monthly Prescription Limit (6 per month)

The monthly prescription limit is a limit of pharmacy drug claims submitted for dates of service within a calendar month, beyond which prior authorization is necessary. The prescription limit is not the number of drugs a recipient is currently taking. For example, a drug that is dispensed four times within a month will count as four towards the monthly limit. If this drug is dispensed in a quantity exceeding a one-month supply, the prescription limit will only apply to the month in which it was dispensed. Prescriptions from other pharmacies will count toward the monthly prescription limit. This limit does not apply to:

1. Members residing in nursing facilities
2. Members receiving adult and pediatric subacute care services;
3. Family planning drugs (e.g., oral contraceptives)

4. Claims that must be submitted on paper (e.g. member submitted reimbursement requests)
5. Claims for newborns, where the baby uses the mother's identification number
6. Members receiving:
    a) Medications for HIV or Acquired Immune Deficiency Syndrome (AIDS)
    b) Immunosuppressants for transplants
    c) Cancer medications
7. Individual medications or medication classes as determined by CalOptima
8. Individual members with multiple chronic illnesses as determined by CalOptima on a case-by-case basis
9. Drug claims submitted and subsequently reversed
10. Medical Supplies

Except for the exemptions listed, a PA is required for each prescription exceeding the monthly limit.

Summary of Pharmacy Benefits for CalOptima Members

- **Most Legend Drugs and Prescribed OTC Items** are the financial responsibility of CalOptima regardless of the member's assigned Health Network. However, OTC items are the financial responsibility of the facility for members who reside in a skilled nursing facility (SNF), a sub-acute unit of a SNF or an intermediate care facility (ICF).

- **Pharmacy-Dispensed Injectable Drugs** are the financial responsibility of CalOptima for all CalOptima Medi-Cal members, including those enrolled in a Health Network. Injectable medications must be processed online through the PBM. Prior authorization may be required.

Please refer to the CalOptima Medical Supply Item/Equipment Matrix for a summary of coverage and financial responsibility for medical equipment and supplies. Please refer to the "CalOptima Financial Responsibility Matrix for Pharmaceuticals, Nutritional Products and Disposable Medical Equipment/Supply Items" for a summary of coverage and financial responsibility of benefits under the CalOptima program.

Carve Out Benefits

Certain medications are not covered by CalOptima but may be covered by the state Medi-Cal program. These medications include:

- Antipsychotics
- Blood Factors
- Medications used to treat drug or alcohol addiction.

Non-Covered Benefits

Certain medications are not covered benefits under CalOptima and the Medi-Cal program. These include:

- Acetaminophen for adults
- Drugs used to treat erectile dysfunction
- Drugs for cosmetic conditions

- Multi-vitamins for members 6 years of age and over.
- Non-FDA approved drugs or medical foods
- Over the counter cough and cold products for adults

Oral / Enteral Nutrition Products

Enteral nutrition products are the financial responsibility of the member's Health Network. Enteral nutritional products are the financial responsibility of CalOptima for CalOptima Direct and CalOptima Community Network members only. If the member resides in a skilled nursing facility (SNF), sub-acute unit of a SNF, or an intermediate care facility (ICF), enteral nutrition products are the financial responsibility of the facility.

Enteral nutrition products when used by adult beneficiaries (over age 21) are limited to only those individuals who are on tube-feeding or have severe swallowing or difficulty chewing due to certain medical conditions and are unable to achieve adequate nutrition with soft or pureed food.

Disposable Medical Supplies

For supplies used to administer or compound home infusion medications, refer to the section "Supplies for Home infusion".

For all CalOptima members, a small number of Formulary disposable medical supply items listed in the table below may be dispensed at any CalOptima Network Pharmacy and billed on-line to the PBM. Providers must bill Medicare for all CalOptima members with Medicare Part B.

CalOptima Formulary Disposable Medical Supplies: Bill on-line to the PBM.

Respiratory Items	**Diabetic Supplies**
Inhaler assist devices (Limit 1/year) Nasal aspirator (Limit 1/year) Peak flow meters, non-electronic (Limit 1/year) **Miscellaneous** Ear Syringes (Limit 1/year) Eye Patches (Limit 1/year) Tablet Splitters (Limit 1/year) Thermometers (Limit 1/year) **Contraceptive Items** Condoms (Limit 1 box/month) Diaphragms (Limit 1/year)	Blood Glucose Monitors (Limit 1 every 3 years)** Insulin syringes (Limit 100/month) Insulin needles (Limit 100/month) Lancets (Limit 100/month) Lancet auto injectors (Limit 2/year) Blood glucose test strips (Limit 100/month) Urine test strips (Limit 100/month) Alcohol Prep pads, wipes, and swabs (Limit 200/month)

**Prior authorization required

Health Network Members

For members enrolled in a health network, non-formulary disposable medical supplies are the financial responsibility of the member's health network.

CalOptima Direct and CalOptima Community Network Members
Disposable medical supplies are the financial responsibility of CalOptima. **Please note that pharmacies must bill Medicare for CalOptima members with Medicare Part B.**

CalOptima Direct and CalOptima Community Network Disposable Medical Supplies: Billed Manually or Electronically to CalOptima Claims Department on a CMS 1500 form.

Ostomy Supplies* (Colostomy, Fistula, Ileostomy, and Urostomy) **Tracheostomy Supplies*** **Urological Supplies*** (Catheters, Drainage Bags)	**Wound Care Supplies*** (Dressings, Gauze, Tape, Film) **Miscellaneous Supplies*** (Gloves, Lubricant) **Enteral Feeding Supplies****

*Quantity limits are the same as listed in the Medical Supplies Billing Requirements in the Medi-Cal manual online
**The enteral nutrition product (formula) must be approved via the Prior Authorization process and billed through the PBM prior to billing the CalOptima claims department for Enteral Feeding Supplies.

A prior authorization request is not required for disposable medical supplies for non-dual eligible members if the quantity limit requested does not exceed the Medical Supplies billing requirements. Payment can be processed by mailing a completed CMS 1500 form and a copy of the invoice (if required) to the CalOptima claims department at the address listed below or submitted electronically online through Office Ally.

CalOptima Direct Claims
P.O. Box 11037
Orange, CA 92856

If a prior authorization is required, a completed CalOptima Authorization Request Form must be submitted to the CalOptima Utilization Management Department.

The CalOptima Authorization Request form is located here:
https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/Providers/CommonForms/2015-10_AuthorizationRequestForm_508.ashx

If the authorization is approved, a copy of the invoice (if required) and a completed CMS 1500 form which includes valid Medi-Cal billing codes should be mailed to the CalOptima claims department for payment at the address listed below or submitted electronically online through Office Ally.

CalOptima Direct Claims
P.O. Box 11037
Orange, CA 92856

For questions regarding disposable medical supplies manual claims billing and/or payment, call CalOptima Claims at 714-246-8885. You can also access claim status online via the web portal, CalOptima Link. Registration information for CalOptima Link is available on CalOptima's website at www.caloptima.org, "For Providers", "Claims and Eligibility", "Learn More about CalOptima Link".

Incontinence Supplies

Health Network Members
Incontinence Supplies are the financial responsibility of the member's health network.

CalOptima Direct and CalOptima Community Network Members
Incontinence Supplies must be provided by one of the following CalOptima-contracted suppliers and billed to the CalOptima Claims Department:
Byram (800) 552-2633
Caremax Pharmacy (800) 626-2600
Schraders' Medical Supply, Inc. (800) 258-9145

Compounded Prescriptions

TPN, injectable and non-injectable compounded medications should be billed with the NCPDP version D.0 compound segment. TPN and non-injectable compound medications require prior authorization.

The claim will be reimbursed at CalOptima's contracted rate for each ingredient and dispensing fee plus a level of effort compounding fee effective 3-1-2013. Information about online claim processing for compounds is available on the payer sheet.

Level of Effort			
LOE Rating	**DUR/PPS Code**	**Professional Allowance**	**Compound Type**
1	11	$15.00	Single Ingredient Batched Capsule Any Combination of Commercially Available Products
2	12	$20.00	Two or Three Ingredients Batched Capsule Transdermal Gel
3	13	$30.00	Four or More Ingredient Batched Capsule Three or Less Ingredient Cream/Ointment/Gel Three or Less Ingredient Capsule Suppository Two or Less Ingredient Troche Noncomplex Suspension Tablet Triturate
4	14	$45.00	Topical Containing Controlled Ingredient Three or More Ingredient Troche Four or More Ingredient Cream/Ointment/Gel Four or More Ingredient Capsule Complex Suspensions (e.g., pediatric) Custom Capsule (includes Rapid Dissolution Preparations) Chemotherapy Cream/Ointment/Gel Hormone Therapy (Capsules, Troches, and Suppositories)
5	15	$7.00	Sterile

Durable Medical Equipment (DME)

For CalOptima Direct members, Durable medical equipment (DME) and supplies used in the operation of DME are billed to CalOptima Direct Claims and are not a pharmacy benefit.

Health Network Members
For members enrolled in a health network, durable medical equipment is the financial responsibility of the member's health network. Refer to Telephone Support Numbers/Health Network and Medical Supply Vendor Numbers located on our website for health network contact information:
https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/Providers/Pharmacy/Medi-Cal/2018-11_CalOptimaTelephoneSupportNumbers_508.ashx

CalOptima Direct and CalOptima Community Network Members
Durable medical equipment is the financial responsibility of CalOptima. Authorization for non-formulary durable medical equipment must be obtained through the CalOptima UM department. Once authorization is obtained a CMS 1500 form should be submitted to the CalOptima claims department for payment. For detailed billing information please visit:

https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/Providers/ManualsPoliciesResources/ProviderManual/2019-08_ProviderManual_508.ashx or contact CalOptima Claims Customer Service at 714-246-8885 for assistance.

Supplies for Home Infusion

Supplies used to compound home infusion medications
Supplies utilized in preparing compounded IV home infusion drugs (cost of sterility testing, professional fee, and compounding fee) are reimbursed online through the level of effort fee. Supplies used to compound IV home infusion medications should not be billed separately.

Health Network Members
Supplies used to administer home infusion medications are authorized by the member's health network. Contact the member's Health Network for authorization and billing procedures.

CalOptima Direct and CalOptima Community Network Members:
Supplies used to administer home infusion medications are the financial responsibility of CalOptima. **Providers must bill Medicare for CalOptima members with Medicare Part B.**
Quantity limits are the same as listed in the Medical Supplies Billing Requirements in the Medi-Cal manual online.
A prior authorization request is not required for home infusion supplies for non-dual eligible members if the quantity limit requested does not exceed the Medi-Cal Supplies billing requirements. Payment can be processed by mailing a completed CMS 1500 form and a copy of the invoice (if required) to the CalOptima claims department at the address listed below or submitted electronically online through Office Ally.

CalOptima Claims
P.O. Box 11037
Orange, CA 92856

If a prior authorization is required, a completed CalOptima Authorization Request Form must be submitted to the CalOptima Utilization Management Department.

The CalOptima Authorization Request form is located here:
https://www.caloptima.org/en/Providers/~/media/Files/CalOptimaOrg/508/Providers/CommonForms/AuthorizationRequestForm_508.ashx
If the authorization is approved, a copy of the invoice (if required) and a completed CMS 1500 form which includes valid Medi-Cal billing codes should be mailed to the CalOptima claims department for payment at the address listed below or submitted electronically online through Office Ally.

CalOptima Claims
P.O. Box 11037
Orange, CA 92856

For questions regarding home infusion supplies manual claims billing and/or payment, call CalOptima Direct Claims at 714-246-8885. You can also access claim status online via the web portal, CalOptima Link. Registration information for CalOptima Link is available on CalOptima's website at www.caloptima.org, "For Providers", "Claims and Eligibility", "Learn More about CalOptima Link".

CalWrap Members (dual-eligibles):
For patients enrolled in MA-PD plans, please bill all supplies to the MA-PD. For patients with a stand-alone Medicare Part D plan, supplies used to administer Part D home infusion medications are the financial responsibility of CalOptima. All CALWRAP claims require prior authorization. Proof of payment for the Part D drug must be submitted with a completed CalOptima Authorization Request Form to the CalOptima Utilization Management Department.

The CalOptima Authorization Request form is located here:
https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/Providers/CommonForms/2015-10_AuthorizationRequestForm_508.ashx
If the authorization is approved, a copy of the invoice (if required) and a completed CMS 1500 form which includes valid Medi-Cal billing codes should be mailed to the CalOptima claims department for payment at the address listed below or submitted electronically online through Office Ally.

CalOptima Claims
P.O. Box 11037
Orange, CA 92856

For questions regarding disposable medical supplies manual claims billing and/or payment, call CalOptima Direct Claims at 714-246-8885. You can also access claim status online via the web portal, CalOptima Link. Registration information for CalOptima Link is available on CalOptima's website at www.caloptima.org, "For Providers", "Claims and Eligibility", "Learn More about CalOptima Link".

Vaccines

Vaccines recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) are covered thru the

	Vaccine for Children Program (VFC) for members age 0 to 18 years. VFC providers include California-licensed physicians, nurse practitioners, local health department clinics, hospitals and schools. Please refer patients under age 19 to their primary care physician to receive recommended vaccines. Information about the VFC program is available online at www.eziz.org. Members who are ≥ age 19 may receive vaccines at a network pharmacy. The vaccine must be billed on-line to the PBM. The nine dollar vaccine administration fee for pharmacy-administered vaccines is reimbursed online with the vaccine claim.
Emergency Supply Policy	If, in the pharmacist's clinical judgment, the provision of an emergency supply of medication is warranted, the pharmacist should dispense a 10-day supply of medication(s). For an emergency override claim, pharmacy must call the PBM Pharmacy Help Desk at 1-888-807-5705 for assistance. *Note: This emergency supply policy applies only after CalOptima's regular business hours (after 5:30 p.m weekdays, weekends and holidays). The use of this override is closely monitored for appropriate use.*
Hospital Discharge Medication Supply	If a request is received via phone or fax by the PBM for a hospital discharge medication and the medication is not a benefit exclusion, the PBM may approve up to a 10-day supply of medication(s) for continuation of hospital discharge therapy. For an emergency override claim for hospital discharge medications, pharmacies should contact the PBM Pharmacy Help Desk at 1-888-807-5705 for authorization.
Vacation Supply Request(s)	Vacation supply requests may be made by calling the PBM Pharmacy Help Desk at 1-888-807-5705. Vacation supplies of medications may be approved for no more than a 60-day supply. Only one vacation supply of medications will be approved per member per calendar year. If a member desires more than one vacation supply per year, the member may be financially responsible.
Lost or Stolen Medications	Replacement supplies of medications shall be approved for no more than a 30-day supply. Only one replacement supply for lost or stolen medications will be approved per member per calendar year. A police report is required for controlled substances medication or medications costing over $300. If a member desires more than one replacement supply per year, the member may be financially responsible. Lost or stolen medication requests may be made by calling the PBM Pharmacy Help Desk at 1-888-807-5705.
Return to Stock/Claim Reversal Required	Prescriptions filled and submitted for payment, but not picked up by the member within 14 calendar days of date of service, must be reversed on-line. This requirement applies to unused reusable stock in all types of pharmacies, including long term care and home infusion pharmacies. Pharmacies will be audited for compliance with this procedure. Pharmacies are advised to maintain written or printed documentation of all reversals to demonstrate compliance with this requirement.

Third Party Signature and Delivery Log	**Third Party Signature Log** The pharmacy must maintain a signature log acceptable to CalOptima for every prescription dispensed to a CalOptima member. The log must contain the prescription number, or a description of the item or items dispensed. If the recipient is not the member for whom the drug or device was ordered or prescribed, a notation of the recipient's relationship to that member and date the medication was picked-up must be included. Logs must be available for a minimum of five years for audit purposes. CalOptima does not require a separate signature log; the pharmacy's existing Third Party Signature Log is sufficient. A member may sign once for more than one medication dispensed at the same time on the same day. **Delivery Log** The pharmacy must maintain a delivery log acceptable to CalOptima for every prescription mailed or delivered to a CalOptima member. The Delivery Log must include the following: 1. Member name 2. Member address 3. Prescription number 4. Date and time of the delivery 5. Signature and name (printed) of the delivery personnel. 6. Recipient signature 7. If the recipient is not the member: Name (printed) and relationship to the member.
Payment Cycle	Pharmacies will receive weekly reimbursement checks from the PBM.
Complaint and Grievance Procedures	Members may contact CalOptima by phone or in writing about any aspect of his/her service provided or arranged by the pharmacy or plan. CalOptima's Customer Service staff will explain the complaint/grievance process to the member and mail a grievance form upon request. CalOptima Customer Service Department: 1-888-587-8088 CalOptima mailing address: CalOptima Attention: Customer Service 505 City Parkway West Orange, CA 92868
Pharmacy Audit Program	The CalOptima Pharmacy Management Department conducts a comprehensive audit program to assure pharmacy, member and prescriber compliance with CalOptima program policies and procedures.
Credentialing	CalOptima maintains a credentialed pharmacy network. Pharmacies are responsible for informing Medimpact of any changes in their credentialing information and or pharmacy certificates. Written updates should be **faxed** to MedImpact's Credentialing department at 858-357-2530. The credentialing process is repeated every 24 months, or upon CalOptima's request. Pharmacy providers who receive a claim rejection message "Pharmacy not

valid on date of service" should call the MedImpact Pharmacy Help Desk at 1-888-807-5705 for assistance.

Pharmacy Home Program

The Pharmacy Home program is intended to better enable physicians and pharmacists to provide quality care to our members. It will identify members who have utilized 4 or more pharmacies within a 2 month period and will require these members to select one pharmacy as their "Pharmacy Home" for all their medication needs for a 12 month period.

If a pharmacy attempts to process a claim for a member assigned to a different pharmacy, claim will reject. The member should take the prescription to his/her assigned Pharmacy Home to obtain the medication. If a member must use another pharmacy (e.g. Pharmacy Home is closed and the medication is urgent), please refer the member to CalOptima Customer Service at 1-888-587-8088 for assistance.

Prescriber Restriction Program

The Prescriber Restriction program assists primary care physicians to ensure members receive prescriptions that are appropriate for treating their health problems. It will identify members who have filled controlled substance prescriptions from 4 or more prescribers within in a 2-month period and will require the member to only fill controlled substances from their designated prescriber(s) for a 12-month period.

If the pharmacy attempts to process a controlled substance prescription for a member that is not prescribed by their designated prescriber(s), the claim will reject. The member should see their designated prescriber and obtain a new prescription. If the primary care physician is unable to provide the prescription, please refer the member to CalOptima Customer Service at 1-888-587-8088 for assistance.

Accessing Interpreter Services

Interpreter services are available to all contracted network pharmacies to ensure that CalOptima members are able to communicate their health care needs.

Telephonic Interpreter Services: Recommended for urgent situations or short and simple conversations. This service is available 24 hours a day, 7 days a week at no cost to the member. CalOptima's contracted vendor is Voiance Telephonic Interpreters. To access service, you will need to know the assigned "PIN #" and be able to facilitate a 3-way call on your telephone.

1. Dial 1-866-998-0338.
2. Enter your account # 22065
3. Enter your PIN #
4. Follow the voice prompts
5. When the interpreter comes on the line, give the interpreter a brief explanation of the call.

   Note: Please contact CalOptima's Pharmacy Management Department at 714-246-8471 if you do not have the PIN #.