

Pennsylvania
PROMIS*e*TM
Provider Handbook



pennsylvania
DEPARTMENT OF HUMAN SERVICES

NCPDP 5.1
Pharmacy Billing

December 2016, Version 2.12

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1 INTRODUCTION

The PA PROMIS^e™ Provider Handbooks were written for the Pennsylvania Provider Reimbursement and Operations Management Information System (PA PROMIS^e™) providers who submit claims on the 837 Professional/CMS-1500 Claim Form, the 837 Institutional/UB-92 Claim Form, the 837 Dental/ADA Claim Form – Version 2006, or NCPDP Version 5.1/Pharmacy Billing.

Four handbooks have been designed to assist PA PROMIS^e™ providers:

- PA PROMIS^e™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form
- PA PROMIS^e™ Provider Handbook for the 837 Institutional/UB-92 Claim Form
- PA PROMIS^e™ Provider Handbook for the 837 Dental/ADA – Version 2006 Claim Form
- PA PROMIS^e™ Provider Handbook for NCPDP 5.1/ Pharmacy Billing

The following sections detail the PA PROMIS^e™, providers who should access the PA PROMIS^e™, Provider Handbook for NCPDP 5.1/Pharmacy Billing, a general overview of each section of the handbook, and how to obtain a hardcopy PA PROMIS^e™ Provider Handbook for NCPDP 5.1/Pharmacy Billing.

NOTE: The PA PROMIS^e™ Provider Handbooks have been designed to be fully functional as paper-based documents; however, providers will realize the full benefit of the handbooks when they access them in their online version.

1.1 PA PROMIS^e™ Provider Handbook for NCPDP 5.1/Pharmacy Billing

The following PA PROMIS^e™ providers should access the NCPDP 5.1/Pharmacy Billing Handbook to obtain general information, eligibility verification instructions, Remittance Advice (RA) Interpretation, and billing instructions:

1.1.1 Pharmacies

This handbook also contains prior authorization information and instructions for pharmacies billing for medical supplies and durable medical equipment on the CMS-1500 Claim Form.

1.2 PA PROMIS^e™ Provider Handbook for NCPDP 5.1/Pharmacy Billing Sections

Section 2 General Information	This section contains a high-level introduction for PA PROMIS ^e ™ pharmacies, which includes information on the Commonwealth's delivery systems, Freedom of Choice, invoicing options, time limits for claim submission, 180-Day
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	Exception Request instructions, claim adjustment instructions, inquiries, Internet functions, and claim form reordering procedures.
Section 3 Policies	<p>This section contains links to the regulations, which pertain to PA PROMIS^eTM providers.</p> <p><i>For example</i>, the PA PROMIS^eTM Provider Handbook for the NCPDP 5.1/Pharmacy Billing will contain a link to the Pennsylvania Code, which houses Department of Human Services (DHS) regulations. If a pharmacy needs to access Medical Assistance (MA) policies, a link to 55 Pa. Code, Chapters 1101, 1121, 1123, and 1150 will be provided to ensure that the pharmacy is submitting claim forms in accordance with MA policy.</p>
Section 4 Recipient Eligibility	This section reviews how to determine if a recipient is eligible for service(s), it describes the Pennsylvania ACCESS Cards; reviews program specific requirements for waivers and base programs, Recipient Restriction/Lock-In Program, as well as Third Party Liability (TPL) and Medicare.
Section 5 Special Requirements for PA PROMIS^eTM Providers	This section includes information on record keeping requirements, business arrangements between pharmacies and nursing facilities, and prescription requirements.
Section 6 Provider Enrollment Information	This section contains information for a provider to understand how to enroll in PA PROMIS ^e TM . Provider information such as enrollment/provider agreements, termination information, provider notice information, changes to enrollment, provider certification, provider-specific rate settings, and provider responsibilities.
Section 7 Prior Authorization	This section reviews the Prior Authorization (PA) requirements and includes instructions and information regarding Program Exception (PE), Recipient Restriction/Lock-In information, and General Assistance (GA) Exceptions.
Section 8 Remittance Advice Interpretation and Claim Reconciliation Method	This section describes how to read and understand the contents of the Remittance Advice (RA) Statement for claims and adjustments, as well as a sample claim reconciliation method.
Section 9 HIPAA	This section presents an overview of the Health Insurance Portability and Accountability Act (HIPAA).
Appendix A	This section contains provider specific Billing Guides. Each

	Billing Guide provides comprehensive instruction on the proper completion of each block contained on the CMS-1500 Claim Form for medical supplies/durable medical equipment and the Billing Guide for NCPDP 5.1 electronic transactions.
Appendix B	This section contains MA Bulletins applicable to each provider using this handbook.
Appendix C	This section contains instructions for Pharmacies who will use the functions on the PA PROMIS ^e ™ Internet.
Appendix D	This section contains DHS required forms along with instructions for proper completion.
Appendix E	This section contains a glossary of PA PROMIS ^e ™ terms, acronyms, and phrases with their definitions

2 GENERAL INFORMATION

The General Information section provides a high-level overview of the Pennsylvania (PA) Provider Reimbursement and Operations Management Information System (PROMIS^eTM) and the various Offices and Programs whose providers will utilize PA PROMIS^eTM for claims processing. This section also provides an overview of Nondiscrimination, Freedom of Choice, Medical Assistance (MA) Delivery Systems, invoicing options, payment process, inquiries, time limits for claim submission, the 180-Day Exception Request Process, adjustments, and MA forms and CMS-1500 ordering instructions.

2.1 Overview for PA PROMIS^eTM

PA PROMIS^eTM is the name of the Pennsylvania Department of Public Welfare's (DHS) claims processing and management information system. PROMIS^eTM stands for **Provider Reimbursement and Operations Management Information System**. PA PROMIS^eTM incorporates the claims processing and information activities of the following DHS program areas:

- Office of Medical Assistance Programs (DHS)
- Office of Developmental Programs (ODP)
- Office of Mental Health and Substance Abuse Services (OMHSAS)
- Office of Long Term Living (OLTL)
- Healthy Beginnings Plus (HBP)

In addition, PA PROMIS^eTM processes some claims for the Departments of Aging, Education and Health. Each program area is described in this section of the handbook.

2.1.1 Office of Medical Assistance Programs

The Office of Medical Assistance Programs (DHS) administers the joint state/federal Medical Assistance Program that purchases health care for needy Pennsylvania residents. Based on an individual's eligibility category, covered services may include physician and clinic visits; inpatient hospital care; home health care; medical supplies and equipment; nursing facility care; inpatient and outpatient psychiatric and drug and alcohol services; prescription drugs; dental and other medically necessary services.

The Office of Income Maintenance's local county assistance offices determine eligibility for Medical Assistance. These offices also determine eligibility for Temporary Assistance for Needy Families (TANF), food stamps, and energy assistance. Family and individual eligibility criteria for Medical Assistance include income and resources.

MA purchases services through contracts with managed-care organizations and under an indemnity, or traditional, Fee-for-Service (FFS) system. Facility-based services are

reimbursed under case-mix for long- term care for the elderly, while other facilities are paid on a prospective, or cost, basis. A medical provider is required to enroll in the program and must meet applicable national, federal and state licensing and credential requirements.

DHS is also responsible for enrolling providers, processing provider claims, establishing rates and fees, contracting and monitoring of managed care organizations (MCO), detecting and deterring provider and recipient fraud and abuse, and administering some waiver services.

2.1.2 Office of Developmental Programs

The Office of Developmental Programs (ODP) provides a comprehensive array of services and supports for people with mental retardation of all ages. Services include supports coordination, residential, day and support services administered or operated by county MH/MR programs and contracted private and state operated intermediate care facilities for persons with mental retardation. Funding is provided through federal, state and county resources.

Community residential supports include small homes and apartments or family living settings. Additionally, individuals are offered the opportunity to participate in home-based services, provided in their own home or that of a family member. Day services, such as supported employment and vocational training are provided to individuals living at home or in community residential facilities. A wide array of services and supports are also available to families caring for a child or adult sibling with mental retardation. Many services are available for funding under the Medicaid Home and Community Based Waiver Program.

DHS is the lead agency responsible for administering the Early Intervention (EI) (birth to age three) Program through ODP. ODP administers the EI Program for children from birth through age two who are eligible for Early Intervention services and supports through the County MH/MR programs. All EI services are coordinated through a service coordinator who assists the family in gaining access to EI services and other services identified on the child's Individual Family Support Plan (IFSP). The MA EI program is operated in concert with DHS following all MA regulations. Early Intervention is services and supports designed to help families with children with developmental delays. Early Intervention is the total effort of a statewide coordinated, comprehensive multidisciplinary, interagency system of appropriate developmental and support services designed to meet the needs of eligible infants, toddlers and their families. EI services can include, among other things, information on how children develop, early childhood education and intervention services which can help a child with hearing, seeing, talking, moving or learning, ideas for how a family can help their child at home or in the community, and designs intervention plans to help a family enhance their child's growing and learning. The EI Program is currently implemented through three funding sources: Medical Assistance Early Intervention (MA EI), the Infants, Toddlers and Families Waiver (ITF Waiver) and County Base funds.

2.1.3 Office of Mental Health and Substance Abuse Services

The Office of Mental Health and Substance Abuse Services (OMHSAS) administers a comprehensive array of behavioral health services throughout the state. Community resources are emphasized with a goal of developing a full array of services and supports as alternatives to hospitalization. Behavioral health services range from community to hospital programs with emphasis on helping children, adolescents, and adults to remain in their communities. Community-based services are emphasized, with the goal to help people who have serious mental illness or serious emotional disturbance break the cycle of repeated hospital or residential admissions. The range of services includes outpatient, partial, residential, short-term inpatient hospital care, emergency crisis intervention services, counseling, information referral and case management services. These services are provided for all ages.

Services provided to adults are based on the Community Support Program (CSP) Principles: consumer- centered, consumer-empowered, culturally appropriate, flexible, strengths-based, community-based, natural supports, needs based and coordinated. In accordance with these principles, vocational/employment services, psychiatric rehabilitation services, community treatment teams, housing supports, consumer-run drop-in centers, and social/recreational services as well as other locally designed services for special needs and populations also are available to adults.

2.1.4 Office of Long Term Living

The Office of Long-Term Living is comprised of program and administrative offices under the direction of a Deputy Secretary. The Deputy Secretary oversees the Office of Policy and Strategic Planning, the Bureau of Individual Support, the Bureau of Provider Supports, and the Office of Quality Management, Metrics and Analytics.

The Office of Policy and Strategic Planning acts as a “clearinghouse” for all policy development activity within the agency. This Office is responsible for developing, coordinating, planning, assessing and evaluating policies across OLTL to ensure consistency in content, direction and application. Examples include coordination of the development of waiver renewals, waiver amendments, state plan documents, regulations and legislation. Its staff also assists other bureaus in developing policy, evaluating policy impact and establishing and improving strategic direction. When solicited, the Office provides direction to field staff and service providers for the implementation of OLTL policies. The Policy Office serves as a liaison with other DHS programs and policy offices, other state agencies and external stakeholder groups. The Policy Office is comprised of three divisions: the Division of Policy, the Division of Planning and the Division of Research, Development and Innovation.

The Bureau of Individual Support is comprised of two Divisions – Direct Services and Nursing Home Transition and Diversion. The Division of Direct Services provides services to individuals with disabilities through the Attendant Care Act 150 Program, the Attendant Care Medicaid Waiver Program, the administration of the Aging Attendant Care Waiver Program, the COMMCARE Waiver for individuals who experience a medically determinable diagnosis of traumatic brain injury, the OBRA Waiver for individuals with physical developmental disabilities, and the Independence Waiver. The

Division of Nursing Home Transition and Diversion oversees the Commonwealth's transition and diversion programs by working with key stakeholders, including consumers, advocates, and providers. This Division also reviews and approves special needs funding requests, provides oversight of Specialized Services provided to individuals "targeted" through the Pre-Admission Screening Process, and coordinates with the Bureau of Fee-for-Service (FFS) and managed care plans for people aging out of Early Periodic Screening and Diagnostic Treatment (EPSDT).

The Bureau of Provider Support serves as liaison to the provider community serving the long-term living continuum, including nursing facilities, Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) facilities, and Home and Community Based Services (HCBS) providers. Through the operations of three divisions, responsibilities include management of field operations staff that conduct Utilization Management Review, clinical and fiscal reviews in nursing facilities to ensure compliance with applicable state and federal regulations, including compliance with Minimum Data Set completion and submission accuracy. Responsibilities include licensing of Assisted Living. Additional responsibilities include certification and enrollment of nursing facilities, ICFs/MR and HCBS providers.

The Office of Quality Management, Metrics and Analytics conducts quality management and improvement monitoring of long-term living programs and services to ensure compliance with federal and state regulations and the delivery of quality programs to assure the health and welfare of consumers. Through the operations of two divisions, the QMMA staff ensures that program and service delivery systems achieve desired outcomes. This includes working closely with the Office of Policy and Strategic Planning to use data analysis to measure the effectiveness of program design and operations, recommend strategies for improvement, ensure fiscal accountability, and prepare financial reports as appropriate, including reports required by the Centers for Medicare and Medicaid Services (CMS) and other regulatory agencies.

2.1.5 Healthy Beginnings Plus

Healthy Beginnings Plus (HBP) is Pennsylvania's effort to assist low-income pregnant women who are eligible for Medical Assistance (MA) to have a positive prenatal care experience. HBP significantly expands maternity services that can be reimbursed by the MA Program. The intent of HBP is to render services that meet pregnant recipients' psychosocial needs in addition to rendering traditional medical/obstetric services. Federal legislation permits Pennsylvania to extend MA eligibility to pregnant women with family incomes up to 185% of federal poverty guidelines. Pregnant recipients may elect to participate in HBP or receive their prenatal care in the traditional MA system.

For detailed HBP provider information, please visit DHS's website at:

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/medicalassistance/healthybeginningsplus/index.htm>

2.2 Medical Assistance (MA) Delivery Systems

All eligible recipients presenting for services in Pennsylvania receive Medical Assistance (MA) services through either the Fee-for-Service or managed care delivery system. The instructions in this Provider Handbook for the CMS-1500 Claim Form apply to the FFS Program administered by DHS.

2.2.1 Fee-for-Service (FFS)

The traditional FFS delivery system provides payment on a per-service basis for health care services provided to eligible MA recipients.

2.2.2 Managed Care

Under the managed care delivery system, MA recipients receive physical and behavioral health care through a managed care organization (MCO) under contract with DHS or the county government.

2.2.2.1 HealthChoices

HealthChoices is the name of Pennsylvania's mandatory managed care program for eligible MA recipients. Through Physical Health MCOs, recipients receive quality medical care and timely access to all appropriate physical health services, whether the services are delivered on an inpatient or outpatient basis. The Office of Medical Assistance Programs oversees the Physical Health component of the HealthChoices Program.

Through Behavioral Health MCOs, recipients receive quality behavioral health services and timely access to appropriate mental health and/or drug and alcohol services. The behavioral health component is overseen by DHS's Office of Mental Health and Substance Abuse Services (OMHSAS).

When HealthChoices is fully implemented statewide, it will include approximately 90% of the total statewide MA population. The remaining 10%, who will remain in the FFS program, includes persons who are newly eligible (and in the process of selecting a managed care organization to serve them) and persons institutionalized for more than 30 days.

If an enrolled MA provider wants to participate in a HealthChoices MCO network, the provider must contact the participating MCO(s) directly. A provider can enroll with more than one MCO. Providers must submit documentation to the MCO verifying that they are an enrolled MA provider or have applied with DHS to be enrolled in the MA Program, and agree to meet the requirements and conditions for network participation set forth by the MCO.

For additional information on HealthChoices, visit the Managed Care section of the DHS Internet site at:

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/index.htm>

2.2.2.2 Voluntary Managed Care

Voluntary managed care is offered in some Pennsylvania counties where HealthChoices has not yet been implemented.

For additional information on the voluntary managed care plans in your area, visit the Managed Care Section of the DHS Internet site at:

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/index.htm>

2.3 Nondiscrimination

The provider agrees to comply with the Commonwealth's Contract Compliance Regulations which are set forth at 16 Pa. Code, §49.101, as follows:

- Provider shall not discriminate against any employee, applicant for employment, independent contractor, or any other person because of race, color, religious creed, ancestry, national origin, age, or gender.

Such affirmative action shall include, but is not limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training. Provider shall post in conspicuous places, available to employees, agents, applicants for employment and other persons, a notice to be provided by the contracting agency setting forth the provisions of this nondiscrimination clause.

- Provider shall in advertisements or requests for employment placed by it or on its behalf state all qualified applicants will receive consideration for employment without regard to race, color, religious creed, ancestry, national origin, age or gender.
- Provider shall send each labor union or workers' representative with which it has a collective bargaining agreement or other contract or understanding, a notice advising said labor union or workers' representative of its commitment to this nondiscrimination clause. Similar notice shall be sent to every other source of recruitment regularly utilized by Provider.
- It shall be no defense to a finding of noncompliance with Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission or this nondiscrimination clause that Provider had delegated some of its employment practices to any union, training program or other source of recruitment that prevents it from meeting its obligations. However, if the evidence indicated that the Contractor was not on notice of the third-party discrimination or made a good faith effort to correct it, such factors shall be considered in mitigation in determining appropriate sanctions.

- Where the practices of a union or any training program or other source of recruitment will result in the exclusion of minority group persons, so that Provider will be unable to meet its obligations under the Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission or this nondiscrimination clause, Provider shall then employ and fill vacancies through other nondiscriminatory employment procedures.
- Provider shall comply with the Contract Compliance Regulations of the Pennsylvania Human Relations Commission, 16 Pa. Code Chapter 49, and with all laws prohibiting discrimination in hiring or employment opportunities. In the event of Provider's noncompliance with the nondiscrimination clause of this contract or with any such laws, this contract may, after hearing and adjudication, be terminated or suspended, in whole or in part, and Provider may be declared temporarily ineligible for further Commonwealth contracts, and such other sanctions may be imposed and remedies invoked as provided by the Contract Compliance Regulations.
- Provider shall furnish all necessary employment documents and records to, and permit access to its books, records and accounts by the contracting agency and the Human Relations Commission, for purposes of investigation to ascertain compliance with the provisions of the Contract Compliance Regulations, pursuant to §49.35 of this title (relating to information concerning compliance by contractors). If Provider does not possess documents or records reflecting the necessary information requested, it shall furnish such information on reporting forms supplied by the contracting agency or the Commission.
- Provider shall actively recruit minority subcontractors or subcontractors with substantial minority representation among their employees.
- Provider shall include the provisions of the nondiscrimination clause in every subcontract, so that such provisions will be binding upon each subcontractor.
- Terms used in this nondiscrimination clause shall have the same meaning as in the Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission, 16 Pa. Code Chapter 49.
- Provider obligations under this clause are limited to the Provider's facilities within Pennsylvania, or where the contract is for purchase of goods manufactured outside of Pennsylvania, the facilities at which such goods are actually produced.

2.4 Freedom of Choice of MA Recipients

Title XIX of the Social Security Act, §1902(a)(23) (42 U.S.C. 1396(a)(23)), requires that a State Plan for medical assistance must provide that any individual eligible for MA may obtain such assistance from any MA enrolled institution, agency or person qualified to perform the service or services required. This freedom of choice provision allows MA recipients the same opportunities to choose among available MA enrolled providers of covered health care as are normally offered to the general public. For recipients enrolled in

voluntary or mandatory managed care programs, the freedom of choice provision is limited to providers enrolled in the managed care network.

As an exception to this policy, DHS may restrict certain recipients to specified providers (refer to Section 4.7, Recipient Restriction/Centralized Lock-In Program).

The following explanations provide an overview of how freedom of choice applies to each delivery system.

2.4.1 Fee-for-Service

MA recipients are permitted to select the providers from whom they receive medical services. Therefore, there will be no service referral arrangements, profit sharing or rebates among providers who serve MA recipients.

Although providers may use the services of a single pharmacy, laboratory, or other providers in the community, they are prohibited from making oral and written agreements that would interfere with an MA recipient's freedom of choice of providers.

2.4.2 Mandatory Managed Care (HealthChoices)

Recipients residing in a HealthChoices county in Pennsylvania maintain their freedom of choice by choosing one of the HealthChoices physical health plans to use for their MA covered health care services as well as a provider who works within that plan, to be their primary care practitioner (PCP).

Under the HealthChoices Behavioral Health Program, recipients will be assigned a behavioral health plan based on their county of residence; however, a recipient maintains the freedom to choose from among the providers in the behavioral health MCOs provider network. With regards to the behavioral health component of the HealthChoices program, counties are required to ensure high quality medical care and timely access to appropriate mental health and substance abuse services and facilitate effective coordination with other needed services.

2.4.3 Voluntary Managed Care

MA recipients exercise the freedom to enroll in a voluntary MCO or to receive services through the FFS delivery system.

Many of the voluntary managed care plans do not cover behavioral health services. In this situation, behavioral health services may be covered under the FFS delivery system. The recipient maintains the same freedom of choice of behavioral health providers as any recipient in the FFS delivery system.

2.5 The National Council for Prescription Drug Programs (NCPDP)

NCPDP is a not-for-profit ANSI-accredited Standards Development Organization consisting of over 1350 members representing all facets of the pharmaceutical industry. The mission of

the NCPDP is to create and promote data interchange standards for the pharmacy services sector of the health care industry, and to provide information and resources that educate the industry and support the diverse needs of its members.

The Health Insurance Portability and Accountability Act (HIPAA), Title II (Administrative Simplification) final rule on Transactions and Code Sets was published in the Federal Register on August 17, 2000 (and revised on February 20, 2003). The rule adopts NCPDP Telecommunication Standard Version 5.1 and Batch Standard Version 1.1 for pharmacy claims.

PA PROMIS^e™ accepts pharmacy transactions in NCPDP Version 5.1 and Batch Standard Version 1.1 as mandated by HIPAA.

2.6 Invoicing Options

Pharmacies can submit claims for compensable drugs/biologicals via NCPDP Version 5.1. Pharmacies approved by DHS to dispense medical supplies and/or durable medical equipment (DME) may submit medical supply or DME claims in ANSI 837 Professional (837P) format or on the CMS-1500 Claim Form.

1. NCPDP Version 5.1

PA PROMIS^e™ can accept billing submitted through Direct Connect, through a Clearinghouse, or Bulletin Board via Personal Computer (PC). For more information on these invoicing options, please contact:

HPE/PA PROMIS^e™
225 Grandview Avenue, 1st Floor
Mail Stop A-20
Camp Hill, PA 17011
Telephone: 800-248-2152 (in-state only)
717-975-4100 (local)

For information on submitting claims electronically via the Internet, please go to Appendix C, Provider Internet User Manual, of this document.

- Attachments

For claims that require an attachment(s) and are submitted using any electronic media, you will need to obtain a Batch Cover Letter and an Attachment Control Number (ACN). Batch Cover Letters and ACNs can be obtained via the DHS PROMIS^e™ website <http://promise.dpw.state.pa.us/> by accessing the Provider Claim Attachment Control Window. For more information on accessing the Provider Claim Attachment Control Window, refer to the Provider Internet User Manual found in Appendix C of this handbook.

- Attachment Control Number (ACN)

When submitting a claim electronically that requires a paper attachment, providers must obtain an Attachment Control Number (ACN) from the PA PROMIS^e™ website. The purpose of the ACN is to provide DHS with a means of

matching paper attachments to electronic claims. (For detailed instructions on obtaining an Attachment Control Number, see Appendix C of this handbook). A batch cover form with the ACN must be present on all paper attachment batches. The ACN on the paper batch must match the ACN entered on the related electronic claim. The Batch Cover Form can be located in Appendix D, Special Forms, of this handbook.

- Handbook

The provider must follow the billing requirements defined in the PA PROMIS^e™ Provider Handbook in addition to the electronic billing instructions.

- Claim Status

2. NCPDP Version 5.1

Providers submitting claims electronically will receive an electronic Remittance Advice (RA) in the Health Care Payment and Remittance Advices (ANSI 835) format as well as a hardcopy RA Statement after each weekly cycle in which the provider's claim forms were processed. For questions concerning the information contained on the RA Statement, refer to Section 8 (PA PROMIS^e™ Remittance Advice (RA) Statement Interpretation and Sample Reconciliation Method) of this handbook. If additional assistance is needed, contact the appropriate [Provider Inquiry Unit](#) at DHS.

NOTE: For tape-to-tape billers, the enrolled and approved Service Bureau (or the provider if producing his/her own magnetic tape) will receive a reconciliation tape after each weekly cycle in which claim forms were processed.

3. CMS-1500 Claim Form for Medical Supplies/DME

Pharmacy providers submitting claims for medical supplies or durable medical equipment (DME) may use the 837P format or the CMS-1500 Claim Form.

Mail completed CMS-1500 Claim Forms (claim forms and claim adjustments) to:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8194
Harrisburg, PA 17105-8194

Please see Appendix A, Billing Guides, of the handbook for detailed instructions on the proper completion of the CMS-1500 Claim Form.

4. Special Notes for Submitting the CMS-1500 Signature Transmittal Form

5. The Signature Transmittal (MA 307) must have a handwritten signature or signature stamp of a Service Bureau representative, the provider, or his/her designee.

The MA 307 contains ten spaces for ten different provider numbers.

6. Optical Character Recognition (OCR)

DHS has optical scanning as an alternative mechanism for claims processing. Optical scanning is a process whereby special equipment reads typewritten or computer-

printed information on a claim form. Since image scanning eliminates the need for keypunching, providers can expect improvement in the accuracy and timeliness of claims processed.

Guidelines for OCR Processing

To take advantage of OCR processing, claim forms must be typed or computer-printed in black or blue ink. Change the ribbon frequently to obtain clear and readable information. Center the data in each block using 10 or 12 character per inch font. Do not combine handwriting (other than signatures) and machine print on a claim form. Additionally, do not use special characters, such as periods, \$, etc., or space between data in the blocks. Do not use script or compressed print. Claim forms must not be folded.

For more information concerning the OCR billing mode, contact

HPE/PA PROMIS^eTM
225 Grandview Avenue, 1st Floor
Mail Stop A-20
Camp Hill, PA 17011
Telephone: 800-248-2152 (in-state only)
717-975-4100 (local)

2.6.1 Recipient Signature Requirements

Providers who bill via electronic media must retain the recipient's signature on file using the Encounter Form (MA 91). See Appendix D, Special Forms, of this handbook for a copy. The purpose of the recipient's signature is to certify that the recipient received the service from the provider indicated on the claim form and that the person listed on the Pennsylvania ACCESS Card is the individual who received the service.

When keeping recipient signatures on file, the following procedures shall be followed:

- Obtain the signature of the recipient or his/her agent for each date for which outpatient services were furnished and billing is being submitted to DHS for payment. Obtain the signature on the Encounter Form with the patient's 10-digit recipient number, taken from his/her Pennsylvania ACCESS Card.
- The Encounter Forms containing the recipient's signatures must be retained on file for a period of at least four years, independently from other medical records, and must be available for reviewing and copying by State and Federal officials or their duly authorized agents.
- Providers may photocopy and use the sample Encounter Form (contained in Appendix D, Special Forms, of this handbook). A separate Encounter Form must be used for each recipient (HIPAA Privacy). Currently, the Encounter Form can be obtained via the MA Provider Order Form (MA 300X) or a printable version is available on DHS's website at:

<http://www.dhs.state.pa.us/dhsassets/maforms/index.htm>

Situations, which do not require a recipient's signature also do not require signature on the MA 307. (Refer to Section 6 of this handbook for a complete list of DHS's exemptions to the signature requirements).

2.6.2 Provider Responsibility

DHS will hold the provider, not the Service Bureau or billing agent, if one is used, responsible for any errors, omissions, and resulting liabilities which are related to any claim form(s) submitted to DHS for payment under the provider's name or MA identification number.

2.6.3 Payment Process

PA PROMIS^e™ processes financial information up to the point of payment. PA PROMIS^e™ does not generate actual payments to providers. The payment process is managed by the Commonwealth Treasury Department's Automated Bookkeeping System (TABS). PA PROMIS^e™ requests payments to be made by generating a file of payments that is sent to TABS. From there, payments can take the form of checks or Electronic Funds Transfers (EFTs). PA PROMIS^e™ will produce a Remittance Advice (RA) Statement for each provider who has had claims adjudicated and/or financial transactions processed during the payment cycle.

Providers have the option of receiving a check via the mail from the Treasury Department or they may utilize a direct deposit service known as the Automated Clearinghouse (ACH) Program. This service decreases the turnaround time for payment and reduces administrative costs. ACH reduces the time it takes to receive payment from DHS. Provider payments are deposited via electronic media to the bank account of the provider's choice. ACH is an efficient and cost effective means of enhancing practice management accounts receivable procedures. ACH enrollment information can be obtained from DHS's website at:

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation/index.htm>

2.7 Time Limits for Claim Submission

DHS must receive claim forms for submissions, resubmissions, and claim adjustment within specified time frames; otherwise, the claim will reject on timely filing related edits and will not be processed for payment.

2.7.1 Office of Medical Assistance Programs (DHS)

<http://www.pacode.com/secure/data/055/chapter1101/s1101.68.html>

2.7.2 180 Day Exception Request Process

DHS will consider a request for a 180-day exception if it meets at least one of the following criteria:

- An eligibility determination was requested from the County Assistance Office (CAO) within 60 days of the date the service was provided. DHS must receive the provider's 180-day exception request within 60 days of the CAO's eligibility determination processing date; and/or
- The provider requested payment from a third party insurer within 60 days of the date of service. DHS must receive the provider's 180-day exception request within 60 days of the date indicated on the third party denial or approval.

To submit a 180-day exception request, the provider must take the following steps:

- Step 1. Review the claim to verify that it meets at least one of the above cited criteria.
- Step 2. Complete a claim form correctly (the claim form must be a signed original – no file copies or photocopies will be accepted).
- Step 3. Include all supporting documentation along with documentation to and from the CAO (dated eligibility notification) and/or third party insurer (explanation of benefits statement).
- Step 4. Complete a [180-Day Exception Request Detail Page](#) * and submit it to DHS with each exception request (mention instructions for completing the detail page). Instructions for completing the 180-Day Exception Request Detail Page can be found in Appendix D, Special Forms, of this handbook.

Please do not fold or staple your exception request documentation. Please use an "8 ½ by 11" envelope for mailing purposes.

Supporting documentation must consist of any or all of the following:

- Evidence that the Medical Assistance application was submitted to the CAO within 60 days of the end date of service and a copy of the eligibility notification; and/or
- Evidence that a payment request was submitted to a third party insurer within 60 days of the end date of service and a copy of the third party's explanation of benefits statement or Remittance Advice.

NOTE: The provider will identify and use all patient medical resources before billing DHS.

DHS may request additional documentation to justify approval of an exception. If the requested information is not received within 30 days from the date of DHS's request, a decision will be made, based on the available information.

Exceptions will be granted on a one-time basis. Claims granted an exception that reject due to provider error may be resubmitted for payment up to 365 days from the end date of service (see 180-Day Exception Approval letter for resubmission procedure).

Medical Assistance (MA) providers must send the 180-Day Exception Request Detail Page, supporting documentation, and the original claim form(s) to:

Department of Human Services
180-Day Claims Exception Unit
P.O. Box 8042
Harrisburg, PA 17105-8042

Providers will receive a letter stating DHS's decision. The fact that DHS approves a 180-day exception does not guarantee that the claim will not be rejected for reasons other than time requirements.

When a request for an exception is denied by the 180-Day Exception Unit, the provider has a right to appeal. **All appeals must be requested in writing within 30-days of the date of DHS's Notice of Denial.**

If the provider wishes to appeal the denial:

- Complete all denied claims correctly.
- Attach a copy of all documentation supporting your position to your appeal.
- Include a cover letter stating that you wish to appeal and the basis on which your appeal is being made. (The words "wish to appeal" must appear in the letter).

Send all of the above information along with a copy of DHS's Notice of Denial to:

Bureau of Hearings and Appeals
Federal Hearings and Appeals Services
117 West Main Street
Plymouth, PA 18651-2926

Please see [MA Bulletin 99-03-08](#) – "Change of Protocol for Certain Provider Appeals".

2.7.3 Internal Control Number (ICN)

Paper claims with attachments, paper claims without attachments and Special Handle claims processed via PA PROMISE™ will be assigned a 13-digit Internal Control Number (ICN) upon receipt. The ICN is returned to providers in the first column of the Remittance Advice (RA) Statement. The ICN consists of the following elements:

Region Code RR	Year and Julian Day YY JJJ	Batch Number BBB	Claim Sequence SSS
10	04 001	612	023

The first two digits of the ICN are the [region code](#). This code is used by PA PROMIS^e™ to denote the type of claim being processed.

The third and fourth digits of the ICN denote the year the claim was processed. For example, if the claim was processed in 2004, the third and fourth digits will be “04”.

The fifth, sixth, and seventh digits denote the Julian Day. In this example 001 is January 1st.

The eighth through 11th digit is the Batch Number and the 12th through the 13th digit is the Claim Sequence. The Batch Number and Claim Sequence are used internally by DHS.

When resubmitting a previously rejected claim, it is imperative that you use the **original rejected ICN with its corresponding RA** Number in Block 22 (Medicaid Resubmission) of the CMS-1500 claim form.

Electronic, internet, Point of Service (POS), and single adjustments submitted electronically through BES or Internet and all Mass Adjustments will be assigned a 13-digit Internal Control Number (ICN) upon receipt. The ICN is returned to providers in the first column of the Remittance Advice (RA) Statement. The ICN consists of the following elements:

Region Code RR	Year and Julian Day YY JJJ	Claim Sequence SSS
20	04 001	321654

The first two digits of the ICN are the [region code](#). This code is used by PA PROMIS^e™ to denote the type of claim being processed.

The year and Julian day (**YY JJJ**) comprise the next five digits, with the first two digits being the year and the next three being the Julian day.

The last six digits represent the claim sequence number (**SSSSSS**).

Sequences for all applicable regions will start at 000001 with the following exceptions:

- Region 77 will start at 2000
- Region 87 will start at 10000

2.8 Inquiries

Providers across the Commonwealth have multiple ways to make general inquiries, such as the PA PROMIS^e™ Internet Applications and the Provider Inquiry Unit. The following sections explain the various tools providers have at their disposal.

2.8.1 PA PROMIS^e™ Internet Applications

Via the PA PROMIS^e™ Internet Applications, providers can review information for specific procedures, drugs and diagnoses, and check pricing and eligibility limitation information. Providers can review and download remittance advice statements for the past two years and print an Adobe Acrobat (.PDF) copy of their original paper remittance advice.

Providers can download or review Provider manuals, forms, etc., from the DHS website. Additionally, providers can electronically file claims from any location connected to the Internet, retrieve electronic copies of remittance advice statements (RAs), and verify recipient eligibility. Providers can review the status of claims submitted to DHS for payment and can review specific Error Status Codes (ESC) and HIPAA Adjustment Reason Codes for rejected claims.

For more information on the Internet tools available and instructions on accessing the tools, please see Appendix C, Provider Internet User Manual, in this handbook.

2.8.2 Provider Services Inquiry Lines

The Provider Services Inquiry Lines will be open from 8:00 a.m. to 4:30 p.m., Monday through Friday, to assist providers with their questions/inquiries. Provider Services Representatives will be available until 5:00 p.m. to answer calls that are received prior to 4:30 p.m. Please contact the appropriate **toll-free telephone number for your provider type**. All questions regarding claim form completion or billing procedures and policy plus questions regarding claim status or inappropriate payments should be directed to:

Department of Human Services
Office of Medical Assistance Programs
Division of Operations
P.O. Box 8050
Harrisburg, PA 17105-8050

2.8.3 MA Tele-Response System

The MA Tele-Response System provides voice-recorded messages to the most frequently asked questions, which do not require dialogue with a service representative.

The MA Tele-Response System is available 24-hours a day, seven days a week. You must have a touch- tone telephone or tone generator pad to use it.

For General Information, providers may call the MA Tele-Response System at 1-877-787-6397.

When you call the MA Tele-Response System, you will hear the following options:

- Press 1. For information on the last three Remittance Advice Cycles and Check mail date information.
- Press 2. For information on how to report non-receipt of a check or Remittance Advice Statement.
- Press 3. For information regarding provider enrollment in the PA PROMIS^e™ Program, or how to report practice address or personnel changes.
- Press 4. For information on invoice submission time frames and reconciling claims.
- Press 5. For information on where to submit claim forms and information on billing electronically.
- Press 6. For information on NDC compensability, or information on how to determine recipient eligibility.

If you need to speak to a Provider Services Representative, you must **contact the appropriate toll-free telephone line for your provider type.**

2.9 CMS-1500 Claim Form Claim Adjustments for Medical Supplies/DME

There will be times when it is necessary to correct an approved claim (i.e., a claim that has appeared on your RA Statement as “Approved”) when payment was received in error.

When a claim is paid in error (overpaid or underpaid), DHS will offset/adjust future payment(s) to the provider to either:

- Recoup any money owed; or
- Compensate a provider if the provider was underpaid.

Claim adjustments can be used to:

- Correct an **overpaid** or **underpaid** claim.
- Remove a payment that was paid under the wrong recipient identification number.
- Remove a payment if the claim was submitted in error or if an unanticipated payment is received from another resource.
- Correct the patient history file with regard to copay. You **cannot** use a claim adjustment to:

- Correct a rejected claim.
- Correct a pended/suspended claim.
- Correct a claim that never appeared on an RA Statement.
- Correct a recipient number or provider number.

Completing a Claim Adjustment

The CMS-1500 claim form is used to submit claims for payment as well as to submit claim adjustments when you are in receipt of an overpayment or underpayment. It is important to note that when submitting a claim adjustment on the CMS-1500, the claim adjustment will be completed using the provider and recipient information exactly as entered on the original claim being adjusted. For claim line information, copy the corresponding information from the original claim for all items, which remain unchanged. Where a correction is necessary, enter the correct information.

When completing the CMS-1500 to adjust a claim that was paid in error, in addition to using the corresponding information from the paid claim, complete the following blocks:

- **Block 19 (Reserved for Local Use)** – Enter Attachment Code AT99 to indicate that remarks are attached. Attach an 8½ by 11 sheet of paper to the CMS-1500 containing an explanation as to why you are submitting a claim adjustment (e.g., the claim was paid under the wrong provider number or you billed for an incorrect number of unit, etc.). Be sure to list the recipient’s name and recipient identification number and the provider’s name and 9-digit provider number and 4-digit service location in the upper left corner of the attachment. This information will provide assistance in the event that the attachment becomes separated from the claim. This will assist the claims processor in matching the attachment back to the claim.
- **Block 22 (Medicaid Resubmission)** – Enter the letters “ADJ” in the left portion of this block. Enter the 13- digit internal control number (ICN), a space, and the line number of the claim, which paid in error. *If your claim was submitted prior to the implementation of PA PROMISE™, enter the 10-digit claim reference number (CRN) in place of the ICN.*

2.9.1 Examples of Claim Adjustments on the CMS-1500 Claim Form

The following examples explain how to perform a claim adjustment if you have been overpaid / underpaid or need to report information (e.g., copayment exemptions or copayment not collected) that was not contained on the claim submitted for payment.

Example #1:

If you have billed under the wrong recipient number or the wrong provider number and wish to return the payment received in error, complete Block 19 and Block 22 as per the aforementioned instructions. Complete Block 24F (Charges) with \$ 0.00 (all zeros). Upon receipt of an RA Statement reflecting that the adjustment has been made, you must

resubmit the claim under the correct recipient number or provider number. When returning a payment received in error, do not send a refund check.

Example #2:

If you failed to indicate the correct information on the claim, such as number of units, or failed to indicate information regarding the recipient's copayment (i.e., visit codes), do not return the payment. A claim adjustment can be submitted to correct this type of information.

If you have billed using an incorrect number of units, complete Block 19 and Block 22 as per the aforementioned instructions. Enter the correct number of units in Block 24G (Days/Units).

If you did not indicate that the recipient failed to pay his/her copayment at the time of service, complete Block 19 and Block 22 as per the aforementioned instructions and complete Block 24H (EPSDT/Family Plan) with Visit Code 11 (Copayment Not Collected). Review Block 24F and confirm that your usual charge reflects the correct number of units being billed.

Please note: DHS does not require providers to submit claim adjustments for an amount **less than one dollar**.

2.10 Ordering Forms

This section details the various forms providers may need when billing PA PROMIS^e™ and the addresses, telephone numbers, and website, when available, for obtaining these forms.

2.10.1 Medical Assistance Forms

Providers may order MA forms via the MA 300X (MA Provider Order Form) or by accessing DHS's website site at:

<http://www.dhs.state.pa.us/dhsassets/maforms/index.htm>

For providers who do not have access to the Internet, the MA 300X can be ordered directly from DHS's printing contractor:

Department of Human Services
MA Forms Contractor
P.O. Box 60749
Harrisburg, PA 17106-0749

Additionally, providers can obtain an order form by submitting a request for the MA 300X, in writing, to:

Department of Human Services
Office of Medical Assistance Programs
Division of Operations
P.O. Box 8050

Harrisburg, PA 17105
Telephone: 1-800-537-8862 or 1-800-932-0938

(Hours of Operation are Monday through Friday, 8:30 a.m. to 4:30 p.m.).

You can expect to receive your forms within two weeks from the time you submit your order. This quick turnaround time on delivery is designed to eliminate the need for most emergencies. You should keep a three to six month supply of extra forms, including order forms, on hand and plan your ordering well in advance of exhausting your supply. The MA 300X can be typed or handwritten. Photocopies and/or carbon copies of the MA 300X are not acceptable. Orders must be placed on an original MA 300X.

The MA 300X is continually being revised as forms are added or deleted. Therefore, you may not always have the most current version of the MA 300X form from which to order. You need to be cognizant of MA Bulletins and manual releases for information on new, revised, or obsolete forms so that you can place your requisitions correctly. If a new MA form is not on your version of the MA 300X, you are permitted to add the form to the MA 300X.

2.10.2 Ordering Claim Forms to Submit DME/Medical Supplies

DHS does not provide CMS-1500 claim forms. The provider can review the information listed below to obtain CMS-1500 claim forms for paper claim form submission.

You must use original claim forms. Providers are not permitted to submit laser and/or dot matrix produced claim forms. Laser and/or dot matrix produced claim forms will be returned by DHS.

2.10.3 CMS-1500 Claim Forms

DHS does not provide CMS-1500 claim forms. Providers may review the information listed below to obtain CMS-1500 claim forms for paper claim form submission.

To obtain copies of the CMS-1500 claim form:

- Contact the US Government Printing Office at (202) 512-1800 or your local Medicare carrier. You may access the website at <http://bookstore.gpo.gov>. For a list of local Medicare carriers in your state, including their telephone number, please go to the Medicare Regional Homepage.
- You may contact the American Medical Association Unified Service Center at 800-621-8335.

3 POLICIES

Policies are located on the Pennsylvania (PA) Code website. Listed below are the hyperlinks to the applicable regulations and PA PROMIS^e™ policies.

3.1 Policy Hyperlinks

Pharmacy [Chapters 1101, 1121, & 1150](#)

Pharmacy – Medical Supplies/Durable Medical Equipment (DME) [Chapters 1101, 1123, & 1150](#)

4 RECIPIENT ELIGIBILITY

This section explains the Eligibility Verification System (EVS) and how to verify recipient eligibility. It describes identification cards, all relevant recipient information supplied to providers, and details each eligibility verification access method available and how to use it.

Individuals eligible for Medical Assistance (MA) in Pennsylvania may have medical coverage under one of two delivery systems; through a traditional Fee-for-Service (FFS) system or a Managed Care Organization (MCO). Recipients enrolled in an MCO will receive most services through the MCO in which they are enrolled. The instructions in this handbook apply to the FFS program administered by the Department of Human Services (DHS).

4.1 Pennsylvania ACCESS Card

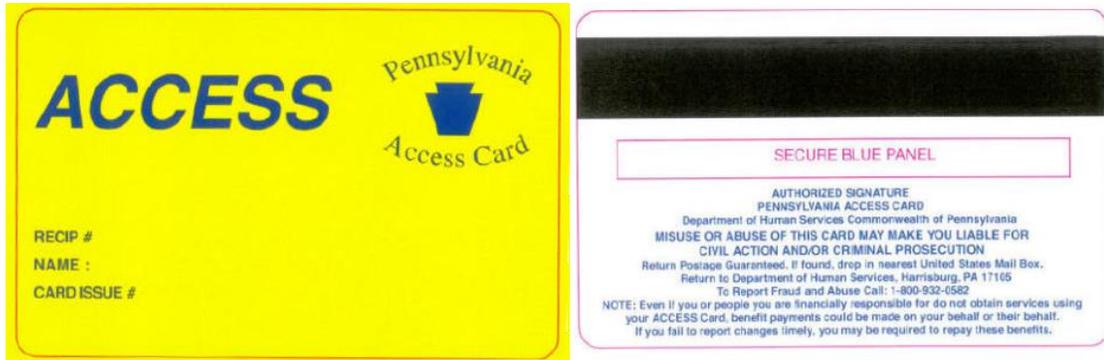
The following details the two types of Pennsylvania ACCESS cards providers may encounter.

4.1.1 Pennsylvania ACCESS Card (Medical Benefits Only)

All eligible recipients (including those recipients enrolled in an MCO) will have a permanent plastic identification card that identifies their eligibility for covered MA services. The plastic card, known as the “Pennsylvania ACCESS Card”, resembles a yellow credit card with the word “ACCESS” printed across it in blue letters. Recipient information is listed on the front of the card and includes the full name of the recipient, a 10-digit recipient number, and a 2-digit card issue number. The back of the ACCESS card has a magnetic stripe for “swiping” through a point-of-sale (POS) device or a personal computer (PC) with an attached card reader to access eligibility information through the Eligibility Verification System (EVS). The back of the card also has a signature strip, a return address for lost cards and a misuse or abuse warning.

Recipients who are eligible for medical benefits only will receive the yellow ACCESS card.

NOTE: The recipient’s social security number is no longer being printed on the ACCESS card in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule.



4.1.2 Electronic Benefits Transfer (EBT) ACCESS Card

The Electronic Benefits Transfer (EBT) ACCESS card is blue and green in color with the word “ACCESS” printed in yellow letters. This card is issued to MA recipients who receive cash assistance and/or food stamps as well as medical services, if eligible. The card is issued to individuals who are the payment names for cash and/or food stamp benefits. Remaining household members are issued the yellow ACCESS card, as well as recipients who are eligible for MA only.

Providers must verify eligibility through EVS when presented with either card. Providers will continue to use the recipient number and the card issue number to access EVS.

NOTE: The recipient’s social security number is no longer being printed on the EBT ACCESS card in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule.



4.1.3 Recipient Number and Card Issue Number

The Pennsylvania ACCESS cards contain a 10-digit recipient number followed by a 2-digit card issue number. The 10-digit recipient number is a number permanently assigned to each recipient. The recipient number and card issue number are necessary to access the Eligibility Verification System (EVS).

Providers must use the 10-digit recipient number when billing for services. The card issue number is used as a security measure to deter fraudulent use of a lost or stolen card.

4.1.4 Lost, Stolen or Defective Cards

When a Pennsylvania ACCESS card is lost or stolen, the recipient should contact his/her County Assistance Office (CAO) caseworker to request a replacement card. The card issue number is voided to prevent misuse when the new card is issued. A replacement card should be received in a maximum of seven days. If a card is needed immediately, an interim paper card can be issued by the CAO. This ensures recipients of uninterrupted medical services. The interim card contains the same Recipient Number and Card Issue Number as the previous ACCESS card. It is advisable that you request additional identification when presented with an interim card.

EVS does not provide eligibility information when a provider attempts to verify eligibility using a lost or stolen ACCESS card. EVS will return the response “The ACCESS card is invalid”. If the old card is found or returned after a new card is obtained, the recipient should destroy the old card, as it is no longer usable.

If the ACCESS card is damaged or defective, e.g., if the magnetic stripe does not swipe, instruct the recipient to return the defective card to the CAO and request a replacement card.

4.2 Eligibility Verification System

The Eligibility Verification System (EVS) enables providers to determine an MA recipient’s eligibility as well as their scope of coverage. Please do not assume that the recipient is eligible because he/she has an ACCESS card. It is vital that you verify the recipient’s eligibility through EVS each time the recipient is seen. EVS should be accessed on the date the service is provided, since the recipient’s eligibility is subject to change. Payment will not be made for ineligible recipients.

The purpose of EVS is to provide the most current information available regarding a recipient’s MA eligibility and scope of coverage. EVS will also provide details on the recipient’s third party resources, managed care plan, Family Care Network, the date of the last EPSDT screening and last dental visit and/or lock-in information, when applicable.

4.3 Methods to Access EVS

Providers or approved agencies can access EVS through one of six access methods.

4.3.1 Automated Voice Response System (AVRS)

You may access EVS via the AVRS through a touch-tone telephone. The EVS telephone access system is available 24 hours a day, seven days a week. The toll-free number is 1-800-766-5387.

The EVS Response Worksheet (MA 464) is a form designed to capture recipient information obtained through an EVS verification inquiry. A copy of the form is illustrated in Appendix D, Special Forms, of this handbook. The form can be ordered on the Provider Order Form (MA 300X). Copies can be ordered through or printed from the Medical Assistance Forms page of the DHS Internet site at:

<http://www.dhs.state.pa.us/dhsassets/maforms/index.htm>

4.3.2 Bulletin Board System (BBS)/Modem

The Bulletin Board System (BBS)/Modem enables providers to upload eligibility requests and download eligibility responses. Recipient eligibility information is requested by contacting an electronic bulletin board maintained by HPE. Currently, the Provider Electronic Solutions Software utilizes the bulletin board to provide eligibility responses upon receipt of a request.

4.3.3 Internet Batch

Web Batch files are submitted via EVS through the Internet and are protected by secure communication protocols built in to EVS.

4.3.4 Internet Interactive

A Web eligibility request window will be available to approved providers and other entities. To retrieve recipient information, click the appropriate button on the Web page. The result will be returned on a new Web page.

4.3.5 Direct Connect

Direct Connect is used by larger organizations that wish to have a high-speed dedicated connection to the EVS.

4.3.6 Value Added Network (VAN)

Value Added Networks (VAN) (PC/POS) collect requests for eligibility information in a real-time interactive processing mode. Both personal computer (PC) software and point-of-service (POS) devices will use this method to gather eligibility information.

4.4 HIPAA 270/271 – Health Care Eligibility Benefit Inquiry/Response

EVS will accept and return the standardized electronic transaction formats for eligibility requests and responses as mandated by the Health Insurance Portability and Accountability Act (HIPAA). The eligibility **request** format is called the HIPAA 270 Health Care Eligibility Benefit Inquiry format (also known as 270 Eligibility Inquiry). The eligibility response format is called the HIPAA 271 Health Care Eligibility Benefit Response (also known as 271 Eligibility Response). Both formats may also be referenced by the 3-digit transaction number: 270 and 271. Providers and other approved agencies that submit electronic requests in the 270 format will receive an EVS response with eligibility information in the 271 format.

4.5 How to Use EVS

To access EVS, providers must use one of the six access methods listed above with their individual provider identification (ID) or user ID along with their personal identification number (PIN) or password.

4.5.1 User Identification (ID) and Password

4.5.1.1 Web Interactive

When accessing EVS via the WEB Interactive Window, providers must request an initial user ID, which can consist of 11 alphanumeric characters and a 9-digit PIN. After the initial logon, providers must use their 11 alphanumeric ID and user assigned password, which will be 6-8 alphanumeric characters.

Registration information will be available at a later date.

4.5.2 EBX User Identification and EBX Password

4.5.2.1 Internet/BBS

When accessing a batch EVS method, via the Internet or BBS, providers/users will require an EBX User ID and an EBX password.

Registration information will be available at a later date.

4.5.2.2 VAN

When using a value added network to access EVS, a PIN is not required; however, you will have an EBX ID, which is similar to a user ID.

Registration information will be available at a later date.

4.5.3 User ID/PIN Not Required

4.5.3.1 Direct Line Users (DLU)

When using a direct line to HPE to access EVS, a PIN/password is not required as the access is set up through a fixed network path.

4.5.4 EVS Access Options

You have three options to access recipient eligibility information. You can use the:

- 10-digit recipient identification (ID) number and the 2-digit card issue number from the recipient's ACCESS card,
- 10-digit recipient identification (ID) number and the recipient's date of birth (DOB),
- Recipient's social security number (SSN) and the recipient's date of birth (DOB) or,
- Recipient's first and last name and the recipient's DOB (this access method cannot be used with the AVRS).

You must identify the date of service for which you wish to verify eligibility. **EVS does not verify future eligibility.**

4.5.4.1 Information Returned by EVS

The PA PROMIS^e™ EVS enables you to submit requests for eligibility information up to 10 years from a given date of service.

4.5.4.2 Eligibility Requests within Two Years of the Date of Service

If an MA recipient is eligible for medical benefits, EVS will provide a comprehensive eligibility response. Although you have the ability to verify eligibility for up to ten years from the date of service, you must access EVS on the date you intend to provide service to the recipient. The eligibility response will include the following information:

Recipient Demographics:

- Name
- Recipient ID
- Gender
- Date of birth

Eligibility Segments:

- Begin date and end date
- Eligibility status (as defined by HIPAA)

- Category of assistance
- Program status code
- Service program description

Managed Care Organization (MCO) (Physical), Family Care Network (FCN), and the Long Term Care Capitated Assistance Program (LTCCAP)

- Plan name/code and phone number
- Primary Care Provider (PCP) name and phone number, begin and end dates (up to 3 PCPs will be returned)
- Primary Care Case Manager (PCCM) name and phone number
- Begin and end date (if different from inquiry dates) Managed Care Organization (MCO) (Behavioral)
- Plan name/code and phone number
- Begin and end date (if different from inquiry dates) Third Party Liability (TPL)
- Carrier name/type
- Address of carrier
- Policy holder name and number (except for Medicare Part A or Part B)
- Group number
- Patient pay amount associated to a recipient and provider during a given time period
- Court ordered indicator
- Begin and end dates (if different from inquiry dates) Lock In or Restricted Recipient information
- Status (Y = Yes/N = No)
- Provider type
- Provider name and phone number
- Narrative (restrictions do not apply to emergency services)
- Begin and end dates (if different from inquiry dates) Limitations

- Procedure code and NDC (FFS only, not available when accessing EVS using the AVRS) – EPSDT
- Last screen dates (for under 21 only)
- Last dental visit (for under 21 only)

This information will be available to the provider for two years following the date of service.

4.5.4.3 Eligibility Requests More Than Two Years from the Date of Service

For eligibility inquiries on information older than two years, EVS will return a reduced list of basic eligibility information. The basic eligibility information provided when inquiring about a recipient's eligibility more than two years from the date of service is as follows:

Recipient Demographics:

- Name
- Recipient ID
- Gender
- Date of birth

Eligibility Segments:

- Begin date and end date
- Eligibility status (as defined by HIPAA)
- Category of assistance
- Program status code
- Service program description

NOTE: EVS will not provide MA program coverage (i.e., FFS or MC information), third party liability information, recipient restriction information (lock-in), limitations, or the date of the last EPSDT or dental screen for requests that are more than two years from the date of service.

4.6 Provider Assistance for EVS Software Problems

HPE maintains and staffs an inquiry unit called the "Provider Service Center" (PSC), to provide you with swift responses to inquiries and resolution of problems associated with the EVS function of the Provider Electronic Solutions Software. This service is available from

8:00 a.m. until 5:00 p.m., Eastern Standard Time, Monday through Friday (except holidays), at 1-800-248-2152.

4.7 Recipient Restriction/Centralized Lock-In Program

DHS's Recipient Restriction/Centralized Lock-In Program restricts those recipients who have been determined to be abusing and/or misusing MA services, or who may be defrauding the MA Program. The restriction process involves an evaluation of the degree of abuse, a determination as to whether or not the recipient should be restricted, notification of the restriction, and evaluation of subsequent medical assistance services. DHS may not pay for a service rendered by any provider other than the one to whom the recipient is restricted, unless the services are furnished in response to an emergency or a Medical Assistance Recipient Referral Form (MA 45) is completed and submitted with the claim. The MA 45 must be obtained from the practitioner to whom the recipient is restricted.

A recipient placed in this program can be locked-in to any number of providers at one time. Restrictions are removed after a period of five years if improvement in use of services is demonstrated.

If a recipient is restricted to a provider within your provider type, the EVS will notify you if the recipient is locked into you or another provider. The EVS will also indicate all type(s) of provider(s) to which the recipient is restricted.

NOTE: Valid emergency services are excluded from the lock-in process.

4.8 Third Party Liability, Other Insurance and Medicare

Medical Assistance is considered the payer of last resort. All other insurance coverage must be exhausted before billing MA. The MA Program is responsible only for payment of the unsatisfied portion of the bill, up to the maximum allowable MA fee for the service as listed in the Medical Assistance Program Fee Schedule.

It is your responsibility to ask if the recipient has other coverage not identified through the EVS (i.e., Worker's Compensation, Medicare, etc.).

If other insurance coverage exists, you must bill it first. You would only bill MA for unsatisfied deductible or coinsurance amounts or if the payment you receive from the other insurance coverage is less than the MA fee for that service. In either case, MA will limit its payment to the MA fee for that service. When billing DHS after billing the other insurance, indicate the resource on the invoice as indicated in the detailed invoice instructions.

When a recipient is eligible for both Medicare and MA benefits, the Medicare program must be billed first if the service is covered by Medicare. Payment will be made by MA for the Medicare Part B deductible and coinsurance up to the MA fee.

DHS does not require that you attach insurance statements to the invoice. However, the statements must be maintained in your files.

When recipients, their personal representative who can consent to medical treatment, or an attorney or insurer with a signed authorization request a duplicate copy of the claim forms, the provider may release a copy to the requestor, but shall submit a copy of the invoice and the request to the following address:

Department of Human Services
TPL - Casualty Unit
P.O. Box 8486
Harrisburg, PA 17105-8486 (717) 772-6604

The TPL Casualty Unit will follow-up and take appropriate action for recovery of any MA payment recouped in a settlement action.

This procedure **MUST** be followed by **ALL** providers enrolled in the MA Program for **ALL** requests for payment information about MA recipients. This includes recipients enrolled in an MCO.

4.8.1 Third Party Resource Identification and Recovery Procedures

When DHS discovers a potential third party resource after a claim was paid, a notification letter will be sent to the provider with detailed claim/resource billing information and an explanation of scheduled claim adjustment activity. Providers must submit documentation relevant to the claim within the time limit specified in the recovery notification. If difficulty is experienced in dealing with the third party, notify DHS at the address indicated on the recovery notice within 30 days of the deadline for resubmission. If the provider fails to respond within the time limit, the funds will be administratively recovered and the claims cannot be resubmitted for payment.

4.9 Medical Assistance Managed Care

HealthChoices is Pennsylvania's mandatory MA managed care program. As part of DHS's commitment to ensure access to care for all MA eligible recipients, it is important that providers understand that there will always be some MA recipients in the Fee-for-Service (FFS) delivery system and that all MA recipients are issued an ACCESS card, even those in managed care. A small number of recipients are exempt from HealthChoices and will continue to access health care through the FFS delivery system. In addition, there is a time lag between initial eligibility determination and managed care organization (MCO) enrollment. During that time period, recipients must use the FFS delivery system to access care.

All HealthChoices providers are required to have a current FFS agreement and an active Provider Identification Number as part of the HealthChoices credentialing process. Therefore, HealthChoices providers need not take any special steps to bill DHS for FFS recipients. They may simply use the current FFS billing procedures, forms and their Provider Identification Number and Service Location.

For questions concerning enrollment or billing the HealthChoices MCOs, providers should contact the specific MCO they are credentialed with or plan to be credentialed with.

4.10 Service Programs

4.10.1 Service Programs for PA PROMISe™ Medical Assistance Providers

The [Service Programs for PA PROMISe™ Medical Assistance Providers Reference Chart](#) must be used in conjunction with the PA ACCESS Card and EVS.

As part of an eligible EVS response, you will receive a 4 or 5-digit alphanumeric code designating a recipient's scope of coverage. Locate the type of provider you are at the left of the chart and locate the service program code along the top of the chart. At the intersection of these two elements, an alphabetical character reflects the recipient's scope of coverage. The corresponding legend defines the coverage limitations.

When determining a recipient's scope of coverage, all MA regulations and limitations noted in the PA Code, this handbook, and fee schedule apply.

4.10.2 Service Programs for Waiver and Non-Medical Assistance Providers

New service program information will be available at a later date.

4.11 Medical Assistance Recipient Copayment

Federal law permits the MA Program to require recipients (FFS only) to pay a small copayment for most medical services. Providers will ask for the copayment when the medical service is rendered.

A recipient is obligated to pay a copayment for each unit of service provided; however, if the recipient is unable to pay, the service may not be denied. If copayment applies to the service provided, MA will automatically compute and deduct the copayment from the provider's payment, even if it is not collected.

Pharmacists participating in the Pennsylvania MA Program are responsible for collecting \$1.00 (one dollar) for each prescription and refill dispensed, unless the recipient is exempt. Please refer to the [Copayment Desk Reference](#) * for details.

NOTE: All copayment amounts are doubled for General Assistance (GA) recipients.

The Department has available microfiche listings of the MA Copay Exempt Drug List. This identifies products or generic equivalents that are exempt from copay.

If you are interested in obtaining a microfiche copy or hardcopy listing, please complete Copay Exempt Drug List form, contained in Appendix D, Special Forms, of this handbook

4.11.1 Copayment Exemptions

There are a number of exemptions to the copayment requirement, such as emergencies, services to pregnant women, residents of nursing facilities, and recipients under the age of 18. Please refer to the [Copayment Desk Reference](#) * for a complete list of exemptions.

4.12 Client Specific Requirements

The recipient specific requirements section will include information on how to access waiver services and base programs.

4.12.1 Waivers

Medicaid-funded home and community based services are a set of medical and non-medical services designed to help persons with disabilities and older Pennsylvanians live independently in their homes and communities. The following sections detail the various home and community based waivers, functional eligibility information, and services, which can be obtained through each waiver.

4.12.1.1 Office of Mental Retardation (OMR) Waivers

OMR administers the Infants, Toddlers, and Families Waiver, the Person/Family Directed Support Waiver, and the Consolidated Waiver for Individuals with Mental Retardation. The following provides an overview of the waiver services available and their eligibility requirements.

Infants, Toddlers, and Families (ITF) Waiver

The Infants, Toddlers, and Families Waiver (Early Intervention) provides habilitation services to children from birth to age three who are in need of early intervention services and would otherwise require the level of care provided in an intermediate care facility for persons with mental retardation or other related conditions (ICF/MR-ORC).

Functional Eligibility:

Children, ages 0 – 3 (Birth until the 3rd birthday), may be eligible for ITF Waiver services if there is a need for early intervention services and the child is eligible for the ICF/MR (Intermediate Care Facility for Persons with Mental Retardation) level of care for mental retardation and related conditions.

Services:

The ITF Waiver provides habilitation services by qualified professionals with family/caregiver participation in the child's natural environment.

NOTE: income limitations may apply. To ensure that a child is eligible for waiver services, access EVS and review his/her service program.

Person/Family Directed Support Waiver (PFDS)

The Person/Family Directed Support Waiver provides services to eligible persons with mental retardation so

that they can remain in the community.

Functional Eligibility:

Recipients must be at least three (3) years of age or older with a diagnosis of mental retardation. The recipient must require OMR licensed community residential services.

Services

The PFDS Waiver provides adaptive appliances and equipment, environmental accessibility adaptations, habilitation services (residential, day, prevocational and supported employment), homemaker/chore services, personal support, respite care, therapies (physical, occupational, speech, hearing, language, visual/mobility and behavioral), transportation, and visiting nurse services.

NOTE: income limitations may apply. To ensure that a recipient is eligible for waiver services, access EVS and review his/her service program.

Consolidated Waiver for Individuals with Mental Retardation

The Consolidated Waiver for Individuals with Mental Retardation provides services to eligible persons with mental retardation so that they can remain in the community.

Functional Eligibility:

Recipients must be at least three (3) years of age or older with a diagnosis of mental retardation.

Services:

The Consolidated Waiver provides services, such as environmental accessibility adaptations, habilitation services (residential, day, prevocational, supported employment services, homemaker/chore services, adaptive equipment), permanency planning, respite care, specialized therapy, transportation, and visiting nurses.

NOTE: income limitations may apply. To ensure that a recipient is eligible for waiver services, access EVS and review his/her service program.

Consolidated Waiver for Individuals

The Consolidated Waiver for Individuals with Mental Retardation provides services to eligible persons with

with Mental Retardation

mental retardation so that they can remain in the community.

Functional Eligibility:

Recipients must be at least three (3) years of age or older with a diagnosis of mental retardation.

Services:

The Consolidated Waiver provides services, such as environmental accessibility adaptations, habilitation services (residential, day, prevocational, supported employment services, homemaker/chore services, adaptive equipment), permanency planning, respite care, specialized therapy, transportation, and visiting nurses.

NOTE: income limitations may apply. To ensure that a recipient is eligible for waiver services, access EVS and review his/her service program.

4.12.1.2 Office of Social Programs (OSP) Waivers

Attendant Care Waiver

The Attendant Care Waiver provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible.

Functional Eligibility:

Recipients must be between the ages of 18 – 59, physically disabled, mentally alert, and eligible for nursing facility services.

Services:

Attendant care services are available to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible

NOTE: income limitations may apply. To ensure that a recipient is eligible for waiver services, access EVS and review his/her service program.

Independence Waiver

The Independence Waiver provides services to

eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible.

Functional Eligibility:

Recipients must be 18 years of age and older, suffer from severe physical disability which is likely to continue indefinitely and results in substantial functional limitations in three or more major life activities. Recipients must be eligible for nursing facility services, the primary diagnosis cannot be a mental health diagnosis or mental retardation, and finally, these recipients cannot be ventilator dependent.

Services:

The Independence Waiver provides services, such as community integration, daily living, environmental accessibility adaptations, Personal Emergency Response System, respite care, service coordination, specialized medical equipment/supplies, therapies (physical, occupational, speech and visual), and visiting nurse.

NOTE: income limitations may apply. To ensure that a recipient is eligible for waiver services, access EVS and review his/her service program.

COMMCARE Waiver

The COMMCARE Waiver was designed to prevent institutionalization of individuals with traumatic brain injury (TBI) and to allow them to remain as independent as possible.

Functional Eligibility:

Pennsylvania residents age 21 and older who experience a medically determinable diagnosis of traumatic brain injury and require a Special Rehabilitative Facility (SRF) level of care.

Traumatic brain injury is defined as a sudden insult to the brain or its coverings, not of a degenerative, congenital or post-operative nature, which is expected to last indefinitely.

Services under this waiver may be provided to individuals living in community settings.

Services:

The COMMCARE Waiver provides services, such as service coordination, personal care services, respite services, prevocational services, supported employment, habilitation and support, educational services, environmental adaptations, non-medical transportation, specialized medical equipment/supplies and assistive technology, chore services, Personal Emergency Response System (PERS), extended state plan services, coaching and cueing, night supervision, structured day programs, behavioral specialist consultants, cognitive therapy, counseling (individual and/or family), and community integration.

NOTE: income limitations may apply. To ensure that a recipient is eligible for waiver services, access EVS and review his/her service program.

OBRA Waiver

The OBRA Waiver, also known as the Community Services Program for Persons with Disabilities, provides services to persons with developmental disabilities so that they can live in the community and remain as independent as possible (this includes relocating or diverting individuals from a nursing home to a community setting).

Functional Eligibility:

Recipients must be developmentally disabled, the disability manifests itself before age 22, and the disability is likely to continue indefinitely which results in substantial functional limitations in three or more major life activities. The recipient can be a nursing facility resident determined to be inappropriately placed. The primary diagnosis cannot be a mental health diagnosis or mental retardation and community residents who meet ICF/ORC level of care (high need for habilitation services) may be eligible.

Services:

The OBRA Waiver provides services, such as adult day services, community integration, daily living, education services, home support, minor accessibility adaptations/assistive technology, prevocational services, service coordination/resource management,

respite services, routine wellness, specialized therapy services (physical, occupational, speech, visual and behavioral), supported employment, transportation, and visiting nurses.

NOTE: income limitations may apply. To ensure that a recipient is eligible for waiver services, access EVS and review his/her service program.

4.12.1.3 Office of Medical Assistance Programs (DHS) Waivers

Michael Dallas Waiver

The Michael Dallas Waiver provides services to eligible persons who are technology-dependent (i.e. dependence upon a medical device to replace or compensate for a vital bodily function AND to avert immediate threat to life).

Functional Eligibility:

Recipient's must be technology dependent and must provide a physician's statement for the need of a mechanical device.

Services:

The Michael Dallas Waiver provides services, such as attendant care, case management, durable medical equipment (DME), private duty nursing, and respite care.

NOTE: income limitations may apply. To ensure that a recipient is eligible for waiver services, access EVS and review his/her service program.

Elwyn Waiver

The Elwyn Waiver provides community-based services to eligible persons who are deaf or deaf and blind and reside in Delaware County. Consumers in this waiver normally reside in the Valley View Facility on the campus of Elwyn Institute. However, a consumer may also be served in their home in the community in Delaware County.

Functional Eligibility:

Recipients must be at least 40 years of age or older, nursing facility eligible according to the Area Agency on Aging (AAA) functional review and they must be deaf or deaf and blind.

Services:

The Elwyn Waiver provides assisted living. Currently, the only approved provider is Valley View Facility in Media, Pennsylvania.

NOTE: income limitations may apply. To ensure that a recipient is eligible for waiver services, access EVS and review his/her service program.

AIDS Waiver

The AIDS Waiver Program is a federally approved special program which allows the Commonwealth of Pennsylvania to provide certain home and community- based services not provided under the regular Fee-for- Service program to persons with symptomatic HIV disease or AIDS.

Functional Eligibility:

Categorically and medically needy recipients may be eligible if they are diagnosed as having AIDS or symptomatic HIV disease, are certified by a physician and the Department as needing an intermediate or higher level of care and the cost of services under the waiver does not exceed alternative care under the regular Medical Assistance Program.

Medical Assistance recipients who are enrolled in a managed care organization (MCO) or an MA Hospice Program are not eligible to participate in this home and community-based waiver program. Contact your MCO for comparable services.

Services:

Services available through the AIDS Waiver include, additional nursing and home health aide visits, homemaker services, nutritional consultations and supplements, and certain medical supplies not available under the MA Program.

NOTE: income limitations may apply. To ensure that a recipient is eligible for waiver services, access EVS and review his/her service program.

4.12.1.4 The Pennsylvania Department of Aging (PDA)

PDA Waiver

The PDA Waiver provides long-term care services to qualified older Pennsylvanians living in their homes

and communities.

Functional Eligibility:

Recipient must be at least 60 years of age or older and nursing facility eligible according to Area Agency on Aging (AAA) functional review.

Services:

PDA Waiver provides attendant care, companion services, counseling, environmental modifications, extended physician services, and home delivered meals. Additionally, PDA waiver provides home health services, home support services, older adult daily living center, personal care services, Personal Emergency Response System (PERS), respite care, specialized DME and supplies, and transportation.

NOTE: income limitations may apply. To ensure that a recipient is eligible for waiver services, access EVS and review his/her service program.

For information on services provided under each of the waivers, visit DHS’s website at:

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/billinginformation/serviceprograminformation/index.htm>

4.12.2 Medical Assistance Early Intervention

Early Intervention (EI) – Infants and toddlers between the ages of birth and their third birthday are eligible for EI services as determined by one or more of the following:

- A twenty-five percent (25%) delay in one or more areas of development compared to other children of the same age.
- A physical disability, such as hearing or vision loss
- An informed clinical opinion
- Known physical or mental conditions which have a high probability for developmental delays

In order to obtain MA EI funding, the child must:

- Be referred through the County MH/MR program
- Be determined either eligible for EI or “at risk tracking” (see below)
- Be MA eligible

- Receive services from an MA EI enrolled agency/group or independent provider.
- Receive services which are MA EI eligible

“At risk tracking” – If a child is found ineligible for EI services by the screening/evaluation, they may still be eligible for follow-up screening and tracking. Children eligible for screening and tracking include:

- A birth weight under 3.5 pounds or 1500 grams
- Cared for in a neonatal intensive care unit
- Born to chemically dependent mother
- Seriously abused or neglected as substantiated pursuant to the Child Protective Services Law of 1975, as amended.
- Confirmed to have dangerous blood lead levels as set by the Department of Health

Service Coordinators are the only MA EI qualified professionals who can bill for “At risk tracking” services.

4.12.3 Targeted Service Management – MR (TSM-MR)

The MA Program provides payment for specific TSM-MR services provided to eligible recipients by enrolled providers. These services are covered when provided in accordance with the approved State Plan Amendment for Targeted Service Management – MR and applicable state regulations and policies.

Individuals served in a psychiatric or general medical hospital are eligible for TSM-MR services provided the stay is not longer than 180 days. If the stay is 181 days or longer, the 180-day transitional planning period applies. Additionally, TSM-MR provided during this transition cannot be a duplication of the discharge planning provided by the hospital.

Public and private ICF-MR residents are not eligible for TSM-MR services apart from the 180-day transitional planning period.

5 SPECIAL REQUIREMENTS FOR PA PROMIS^eTM PROVIDERS

5.1 Physician Prescriptions

The following information is required on all Medicaid prescriptions that have been written or verbally ordered by a licensed prescriber:

- Prescriber's License Number
- Name and address of the patient
- Name, strength, and quantity of the medication d. Directions for use
- Refills, if any
- Indication for "brand medically necessary", when applicable
- The DEA Number of the licensed prescriber, when controlled substances have been prescribed

The following codes must be used for all Medicaid prescriptions, which have been written for Family Planning Service and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT):

1. Family Planning Services – place the letters "FP" in the upper right hand corner of the prescription.
2. EPSDT – Place the letter "S" in the upper right hand corner of the prescription.

5.2 Pharmacy Record Keeping Requirements

Over the years, DHS has identified major problems with pharmacy providers' record keeping practices. These problems occurred primarily in pharmacies, which provide services to health care facilities such as nursing facilities; intermediate care facilities for the mentally retarded and assisted living, personal care facilities, and pharmacies, which engage in mail-order pharmacy business.

There is a growing practice within the pharmacy community to process new and refill medication orders without proper prescriber authorization, or any interaction with the health care facility. Processing a medication order without proper authorization, as well as the process of unauthorized "cycle fill", presents the problem of medications being dispensed on the second or subsequent months without a prescriber's written and/or signed order in the pharmacy. This often occurs when the pharmacy, based on the resident's current medication orders, supplies the nursing facility with unsigned prescriber order sheets, and then dispenses medication before it receives the hard copy signed prescriber's order. This problem is

compounded when a pharmacy receives hard copy signed prescription or prescriber order, enters the information into the computer and discards the hard copy. As a result of this practice, pharmacists cannot recheck the original prescription or prescriber order for accuracy before filling the prescription, nor prove that the prescription was filled as ordered. At times, medications have been dispensed to residents of health care facilities without a current order. This also leads to changed or discontinued orders being missed.

While DHS recognizes the advantage of current electronic data systems and being able to process, label and bill a prescription or medication order more rapidly using computers, it is concerned that failure to maintain the original hard-copy prescription or practitioner order may lead to incorrect dispensing of medication, a danger to the patient and improper use of public funds.

Prior to dispensing any medication, the pharmacy MUST receive authorization from the prescriber or his/her designee. In all cases, pharmacies shall maintain hard copy (paper trail) prescriptions and or signed and dated prescriber orders as required by Medical Assistance regulations 55 Pa. Code §1101.66(b), (c), and (d). A paper trail includes carbon copies or facsimile transmissions or the original handwritten orders a pharmacist transcribes when taking a telephone order from health care facilities and orders for mail order medications. In most cases, if the facility requests a medication order on behalf of the physician, DHS has recognized that as a medication order.

Failure to comply with Medical Assistance regulations will result in recovery or restitution of payment by DHS and may adversely affect participation in the Program.

5.3 Business Arrangements Between Nursing Facilities and Pharmacy Providers

Section 1407(a)(2) of the Human Services Code [62 P.S. §1407(a)(2)], and 55 Pa. Code §1101.75(a)(3), Medical Assistance General Provisions, make it unlawful for any person to:

Solicit or receive or offer to pay any remuneration, including any kickback, bribe, or rebate, directly or indirectly, in cash or in kind, from or to any person in connection with the furnishing of services or merchandise for which payment may be made in whole or in part under the Medical Assistance Program or in connection with referring an individual to a person for furnishing or arranging for the furnishing of any service or merchandise for which payment may be made in whole or in part under the Medical Assistance Program.

The purpose of the law and regulation is to eliminate fraudulent, abusive, and deceptive practices that may occur and to ensure that public funds will be properly expended for essential services to medical assistance recipients.

During the past few years, State and Federal criminal agencies have identified various kickback relationships, and providers involved in kickback relationships have been prosecuted. However, due to the increase in competitive pressures and creative marketing skills of certain providers, variations in the straight dollar-for service kickback have arisen.

While DHS recognizes that anti-kickback statutes and regulations were created to prevent fraudulent and abusive practices, the statutes and regulations were not created to inhibit

delivery of state-of-the-art pharmacy services. Therefore, DHS, through the Medical Assistance Advisory Committee, and in conjunction with an Ad Hoc Pharmacy and Nursing Facility Task Force developed guidelines to assist in preventing providers from offering or receiving improper kickbacks. The following listings, which are not all-inclusive, set-forth examples of items and practices that would be considered accepted or improper under the Medical Assistance Program.

Accepted Practices General Statement

Ancillary enhancements that are solely confined to the practice of pharmacy as described in the Pharmacy Act 62 P.S. §102(11) and remain in the control and ownership of the pharmacy would be considered an accepted practice under Section 1407(a)(2) of the Human Services Code and Medical Assistance Regulation §1101.75(a)(3).

Examples of Accepted Practices

- Medication carts whether the pharmacy uses unit dose or standard prescription containers.
- Treatment and medication forms that are already part of the pharmacy's software may be supplied to the nursing facility. However, the nursing facility must pay for the cost of paper.

Examples of Improper Practices

- Cash or equipment in which ownership or control is changed.
- Funding for parties. This includes, but is not limited to, money, food, or decorations.
- Vacation trips and professional seminars.
- Free or below market value:
 - Pharmacy consultations, which include, but are not limited to, reviewing charts, conducting education sessions, and observing nurses administering medication. (The market value of a pharmacy consultant's fee shall be no less than the average hourly wage of a pharmacist in that particular geographic area);
 - Drugs – legend or over-the-counter (OTC's)*
 - Intravenous drugs, tubing or related items*
 - Drugs for emergency carts*
 - Facsimile machines. (This is not to preclude the use of facsimile machines. The State Board of Pharmacy will continue to regulate the proper use of facsimile machines. The prohibition includes a pharmacy placing by loan, gift, or rental a facsimile machine in a nursing facility for the purpose of transmitting MA prescriptions).

- Treatment or external medication carts. (This does NOT include medication carts used exclusively to store drugs whether dispensed in a container or unit dose);
- Computers and software;
- Medical or pharmacy books and journals;
- Prescriptions for nursing facility staff;
- Administrative functions, which include, but are not limited to, billing, payroll, and nursing facility report preparation. (This does not include reports regarding drug usage); and
- Staff to perform nursing facility functions outside of the practice of pharmacy.

*DHS will accept a volume discount as market value if it remains equal to or above the Actual Acquisition Cost (AAC) of the product.

Providers shall not solicit, receive, offer to pay remuneration, including any kickback, bribe, or rebate, directly or indirectly, in cash or in kind, from or to any person in connection with furnishing services or items or referral of a recipient for services and items.

Pharmacy providers and nursing facilities should review their business arrangements to determine if they are in compliance with regulations and these guidelines. Violations of 62 P.S. 1407(a)(2) and 55 Pa. Code §1101.75(a)(3) are considered serious violations which may lead to criminal prosecution and are violations which may also affect a provider or person's future participation in the MA Program.

It is important to understand that if an improper relationship exists, both parties are responsible, and that the corporate officers of non-profit entities also may be held accountable.

Pharmacy providers and nursing facilities must ensure that recipients be given a freedom of choice. Therefore, business relationships between nursing facility and pharmacy providers, which preclude freedom of choice by recipients, are prohibited.

DHS recommends that providers involved in contract negotiations should document the spirit and intent of issues discussed.

Please be advised that this is meant to assist in preventing providers from entering into improper relationships. The final determination of any improprieties will be a review of the contract in relationship to the Medicaid Fraud Statute 62 P.S. §1407.

5.4 Reminder that Medical Equipment and Supplies Must Be Prescribed

DHS has found instances where pharmacies and medical suppliers have billed DHS for supplies and equipment dispensed from an incomplete prescription. According to MA General Provisions, Chapter 1101, MA Medical Supplies, Chapter 1123 and MA billing

procedures, prescriptions are incomplete if licensed practitioners fail to include the following required information:

- Name and address of the patient;
- Diagnosis or reason for needing the item;
- Item prescribed, including number and/or quantity to be supplied;
- Directions for use;
- Whether the equipment is to be purchased or rented and the length of time the rentals are needed;
- Specific requirements such as mask, cannula, nebulizer;
- Refills, if any;
- Practitioner's printed name;
- Practitioner's signature;
- Practitioner's license number; and
- Date of the prescription.

Only licensed practitioners may prescribe medical equipment and supplies. It is not the responsibility nor within the scope of practice for a pharmacist or medical supplier to make medical necessity decisions, especially regarding whether equipment is to be purchased or rented.

If the prescription for equipment or supplies is incomplete, the medical supplier must return the prescription to the prescriber for the required information.

Providers may not submit invoices for equipment or supplies that are not supplied in accordance with the terms of the practitioner's prescription.

Written prescriptions must be retained on file for at least four (4) years.

Failure to comply with DHS's regulations may result in demands for restitution and/or may affect participation in the Medical Assistance Program.

6 PROVIDER ENROLLMENT INFORMATION

This section contains information for providers of services under PA PROMIS_eTM.

6.1 Provider Participation Requirements

6.1.1 Licensure/Registration/Certification

To be eligible to enroll in PA PROMIS_eTM, practitioners in Pennsylvania must be licensed and currently registered by the appropriate State agency. Out-of-state practitioners must be licensed and currently registered by the appropriate agency in their state.

Other providers must be approved, licensed, issued a permit or certified by the appropriate State agency and, if applicable, certified under Medicare.

6.1.2 Enrollment/Provider Agreement

The provider is considered the legal entity and can be either a business or an individual doing business with DHS. Legal entities can complete the enrollment process in one of two ways:

- Complete a paper enrollment form and send changes on letterhead.
- Use the Internet and the Provider Enrollment Automation Project, known as ePEAP, to request changes to enrollment information.

6.1.2.1 Paper Enrollment Forms

Providers must complete a PA PROMIS_eTM Provider Enrollment Form, PA PROMIS_eTM Provider Agreement, and be approved by DHS. Upon successful enrollment, the provider will receive a Provider Enrollment Letter (PRV-9008-R). (Refer to Section 6.3 for information on the Provider Enrollment Letter).

Provider enrollment forms can be found on the DHS website at:

<http://www.dhs.state.pa.us/provider/promise/enrollmentinformation/index.htm>

NOTE: You can also use the following telephone numbers:

CATEGORY	TELEPHONE NUMBER	HOURS OF OPERATION
Application Requests (Inpatient and Outpatient)	(717) 772-6456 (Messages only)	24 hours/day 7 days/week

Applications In-Process (Inpatient and Outpatient)	(717) 772-6140	Monday – Friday 8:30 a.m. – 12:00 noon 1:00 p.m. – 3:30 p.m.
Long Term Care Provider Enrollment Applications	(717) 772-2571	Monday – Friday 8:30 a.m. – 5:00 p.m.

6.1.2.2 EPEAP

Through the electronic Provider Enrollment Automation Project (ePEAP) providers with Internet access can review and request changes to their provider information via the Internet. Providers are required to register and create a 4-digit password in order to use ePEAP. Please go to:

http://www.dpw.state.pa.us/cs/groups/webcontent/documents/manual/s_001933.pdf

and follow the directions to use ePEAP.

Current limitations to ePEAP are:

- This website cannot be used to enroll a new provider or to re-enroll a provider. It is to be used by currently enrolled providers to request changes to their provider information.
- Certain provider types are not able to use ePEAP at this time. Refer to this Medical Assistance Bulletin for the complete list:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_004253.pdf

6.1.3 PA PROMIS^e™ Provider Identification

PA PROMIS^e™ provides the ability to enroll providers in various programs and record their demographic, certification and rate information. PA PROMIS^e™ maintains a single unique number to identify a provider. PA PROMIS^e™ supports the ability to uniquely identify locations, provider types, specialties, authorization/certification/licensing information for services and other required data within the unique provider identification number.

DHS initiated a Master Provider Index (MPI) in conjunction with PA PROMIS^e™. MPI is a central repository of provider profiles and demographic information that registers and identifies providers uniquely within DHS. Under MPI and PA PROMIS^e™, a provider is considered a unique legal entity and can be either a business or an individual provider doing business with DHS. Additionally, providers can be assigned only one MPI provider

identification number for a given Federal Employee Identification Number (FEIN) or Social Security Number.

Each enrolled PA PROMIS^e™ provider will be assigned a 9-digit MPI provider identification number. In addition, each provider will be assigned one or more 4-digit service locations that identify the physical address where service is provided, the provider type and at least one specialty.

NOTE: When submitting claims to DHS, providers must use their 9-digit provider identification number and the appropriate 4-digit service location as the unique provider identification for the claim.

6.1.4 Hearing Aid Dispensing Certification

In accordance with the policy direction set forth in MA Bulletin 01-07-07 et al., “Provider Specialty 220 (Hearing Aid Dispenser) Requirement and Updated MA Program Fee Schedule for Hearing Aid Supplies,” providers who dispense hearing aid supplies must submit yearly updated proof of Department of Health (DOH) certification. Upon annual renewal of the DOH certification, a copy of the renewed certification must be submitted to MA Provider Enrollment to ensure an active status of Provider Specialty 220 (Hearing Aid Dispenser) on your enrollment files. Please refer to the instructions as outlined in the Procedure section of MA Bulletin 01-07-07 et al. for adding Provider Specialty 220 to your provider file and for instruction on submitting the required DOH annual certification renewals. Effective August 1, 2007, failure to submit proof of DOH certification and yearly renewals will result in claim denials and inability to bill for hearing aid supplies.

6.2 Provider Enrollment Letter

* CURRENT DATE) (PROVIDER NAME)
(STREET ADDRESS 1)
(STREET ADDRESS 2)
(CITY/STATE/ZIP)

Provider ID / Service Location: XXXXXXXXXXX XXXX Dear Provider:
Your contract as a medical provider under programs administered by the Pennsylvania Department of Human Services has been approved.

Your program and expiration dates are listed below. Prior to expiration, you will receive a notification to extend your contract.

As an approved provider, you may submit claims for reimbursement under the medical programs within the scope of coverage of your services for eligible individuals.

The nine (09) digit identification provider number, and four (04) digit service location listed above have been assigned to you for billing purposes. In order to assure prompt reimbursement, it is imperative that these numbers be shown on each claim.

P.O. Box 8194
Harrisburg, PA 17105-8194

EMC submissions

- Modem - Modem transmissions must be submitted using the new 492 record layout.
- Tape - Tapes received must be submitted using the new 492 record layout.
- Diskette - Diskettes received must be submitted using the new 128 record layout.

6.4 Claim Forms Through PA PROMIS^eTM

The provider will use their provider ID number and password to log into PROMIS^eTM and will be able to perform the following functions:

- Review messages and informational notices from DHS that are displayed upon log on to the secure web site. Once read, the message can be marked "read" and will no longer appear on the initial window.
- Maintain passwords and, if authorized, can create and manage user accounts for others in their organizations.
- Review the status of claims submitted to DHS for payment and can review specific Error Status Codes (ESC) and HIPAA Adjustment Reason Codes for rejected claims.
- Submit claims directly for payment or adjustments for services and prescriptions.
- Pharmacy claims are automatically reviewed for ProDUR (Prospective Drug Utilization Review) alerts and overrides at the time of entry and corrections can be made before final submission.
- Assuming successful completion of a claim submission, the total allowed amount of the claim, plus any adjustment information, will be displayed to the submitting provider. Although this response will be available upon submission, the claim will be held in a "Suspend" status for later processing. This prompt response to the claim submission will significantly reduce the time required for providers to submit properly completed claims and allow faster processing.
- Review information for specific procedures, drugs and diagnoses.
- Check pricing and eligibility limitation information.
- Verify the eligibility status of recipients. Inquiries can be made by Recipient ID/Card Issue Number, SSN/Date of Birth, or Recipient Name/Date of Birth combinations.
- Review and download records of payments (remittance advice) from DHS for the past two years.

- The provider can search for, download, and print an Adobe Acrobat (.PDF) copy of their original paper remittance advice.
- Download or review provider handbooks, billing guides, fee schedules, MA bulletins, etc., from the DHS website.

All claims, regardless of media, are translated into a common file structure for PA PROMIS^e™ that allows them to be communicated in a common format between different computer systems. Electronic Fee-for-Service claims and adjustments are accepted in the HIPAA-compliant 837 Professional (X12 837 4010) format.

PA PROMIS^e™ supports the input of claims through multiple media, including:

- Diskette
- CD
- Tape
- Bulletin Board via PC modem dial up
- Internet

6.5 Recipient Signatures

Providers must obtain applicable recipient signatures either on the claim form or on the MA Encounter Form (MA 91). The purpose of the recipient's signature is to certify that the recipient received the service and that the person listed on the PA ACCESS Card is the individual who received the services provided.

A parent, legal guardian, relative, or friend may sign his or her own name on behalf of the recipient. The provider or an employee of the provider does not qualify as an agent of the recipient; however, children who reside in the custody of a County children and youth agency may have a representative or legal custodian sign the claim form or the MA 91 for the child.

The following situations do not require that the provider obtain the recipient's signature:

- When billing for inpatient hospital, short procedure unit, ambulatory surgical center, nursing home, and emergency room services.
- When billing for services which are paid in part by another third party resource, such as Medicare, Blue Cross, or Blue Shield.
- When billing for services provided to a recipient who is unable to sign because of a physical condition such as palsy.
- When resubmitting a rejected claim form.

- When billing on computer-generated claims. In this instance, you must obtain the recipient's signature on the Encounter Form (MA 91).

6.6 Record Keeping and Onsite Access

Providers must retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA recipients and that meet the criteria established in regulations.

For more information, please refer to Chapter 1101.51(e) at:

<http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html>

7 PRIOR AUTHORIZATION

The Prior Authorization process and 1150 Administrative Waiver (Program Exception) process are automated systems that enable providers to obtain prior approval for reimbursement of specific MA biologicals and items, and those services or items not listed on the MA Program Fee Schedule.

7.1 Prior Authorization in PA PROMIS^eTM

Prior authorization is required for those services and items so designated in the MA Program Fee Schedule with the prior authorization (PA) indicator.

The automated system ensures that a decision must be rendered on the prior authorization request within **21 days** of receipt of the Outpatient Service Authorization Request Form (MA 97), or the request is automatically approved.

7.2 Prior Authorization of Drugs

The purpose of this section is to remind pharmacists enrolled in the MA Program that DHS requires prior authorization on certain drugs and for certain recipients. Claims will be rejected unless the prescriber receives prior authorization from DHS and the pharmacist uses the prior authorization number to bill DHS.

In general, the following situations require prior authorization. Also included are the toll-free numbers that prescribers can call to obtain prior authorization. Providers should refer to regulations at 55 Pa. Code Chapter 1121, MA bulletins, and Remittance Advice (RA) Alerts for further details.

7.2.1 Prior Authorization of Multi-source Brand Name Drugs

DHS requires prior authorization on those multi-source brand name drugs that have “A” rated generics available as a condition for payment through the MA Program.

DHS will issue a 10-digit prior authorization number to the prescriber if prior authorization is granted. The prescriber must include this 10-digit number on the prescription, in addition to the handwritten phrase “**Brand Medically Necessary**” or “**Brand Necessary**” as required by the Generic Equivalent Drug Law. The “Brand Medically Necessary” notation on the prescription does not serve as adequate justification to pay for the brand name drug through the MA Program. The pharmacy must include the prior authorization number in order to have the claim paid.

Prescriptions for multi-source brand name drugs requiring prior authorization having the notation “Brand Medically Necessary” with no prior authorization number cannot be substituted with a generic. Therefore, if this occurs, the recipient will have to pay the entire cost of the prescription since the brand name drug is no longer compensable under the MA Program.

In addition, since all brand name products on the DHS list are noncompensable unless prior authorization is granted, recipient who request the brand name produce dispensed instead of the generic without approval must also pay the entire prescription price from their own resources. **Under no circumstances should the pharmacy bill DHS for the generic and accept partial payment from the recipient for the difference between the brand name price and the generic price.**

Each prior authorization number issued will authorize coverage for the original prescription and its refills (a maximum of five refills within a six-month period). All original prescriptions and their subsequent refills will require a new prior authorization number. Therefore, the prescriber must request an approval each time a new prescription is written for a drug on the DHS list. Pharmacies will be required to include the prior authorization number assigned to that prescription when the initial claim and all subsequent refills are submitted for payment. If the prior authorization number is omitted from the submission or is incorrect, the claim will reject.

Pharmacies may accept telephone orders for prescriptions requiring prior authorization, if the prescriber conveys the prior authorization number and the “Brand Medically Necessary” phrase to the pharmacist.

However, the prescriber is required to send a properly written prescription containing the prior authorization number and the handwritten “Brand Medically Necessary” phrase to the pharmacy within 15 days. Since the pharmacy is primarily held accountable for the maintenance of the required records for each MA prescription, the option to accept “Brand Medically Necessary” prescriptions by telephone will rest with the pharmacist.

Pharmacies may also transfer copies to or from another pharmacy for “Brand Medically Necessary” prescriptions if requested by the recipient. Both pharmacies involved should apply the same mandates for transferring “Brand Medically Necessary” prescriptions as described in the Pharmacy Act pertaining to transferring prescriptions. The prior authorization number assigned to the original prescription is needed to submit the claim for the transferred prescription. Therefore, it must be included with the transfer. The pharmacy receiving the copy should be certain to reference the name and prescription number of the pharmacy giving the copy, and vice versa.

DHS will not reject claims for an Over-The-Counter brand name drug subject to a State Maximum Allowable Cost (MAC). Instead, DHS will process the claim and determine the payment rate by using the State MAC for the ingredient cost if the pharmacy is willing to accept the DHS payment. However, DHS will require prior authorization to override any State MAC price and pay the full ingredient cost.

Emergency Situations

Pharmacies may dispense an emergency supply of the brand name product without prior authorization if the prescriber writes “**Emergency**” on the prescription. This will indicate that the prescriber was unable to contact the Prior Authorization Unit because DHS was closed due to a holiday, the weekend, or after hours.

In these situations, DHS will permit the prescriber to write for **NO MORE THAN A 5-DAY SUPPLY** of the brand name product. If the prescriber indicates an “Emergency” situation and the quantity prescribed exceeds a 5-day supply, the pharmacist may reduce the quantity to the required amount. Prior authorization will be required for any subsequent quantities of the drug dispensed.

In an emergency situation, if the pharmacist is unable to contact the prescriber to renew an expired prescription, the pharmacist is permitted to dispense up to a 5-day supply of the brand name drug without prior authorization.

Refills are not permitted if the claim was originally filled as an emergency.

7.2.2 Prior Authorization of Anti-ulcer Drugs

DHS requires prescribers to request prior authorization to prescribe certain anti-ulcer drugs in certain situations. Those situations that require prior authorization are:

- A continuation of treatment at the acute dosage level or any dosage level higher than the maintenance dosage level in excess of 90 days for any condition. Concurrent use with another anti-ulcer drug at any dosage level.
- A change from one anti-ulcer drug to another during the 90-day acute stage.
- New prescriptions issued for continued use at the acute dosage level. Prior authorization will NOT be required for:
 - Prescriptions written for the initial 90 days at the acute dosage level during any 9 consecutive months.
 - Prescriptions written for the maintenance dosage level at any time.

7.2.3 Prior Authorization of Viagra and Other Drugs for Erectile Dysfunctions

All drugs indicated for the treatment of Erectile Dysfunction require prior authorization.

DHS has established criteria to approve prescriptions for Viagra and similar products and has placed limits on all prescriptions for Viagra. In order to receive approval for Viagra and similar drugs under the Fee-for-Service delivery system, the prescriber must certify to all of the following:

1. The patient must be a male 19 years old or over.
2. The patient must have a stated diagnosis of Erectile Dysfunction.
3. Any patient being prescribed Viagra must not be concurrently or intermittently using organic nitrates in any form.
4. The patient must have had a medical evaluation (physical and history) within one year of the request.

DHS will issue prior authorization if the prescriber can document all of the criteria listed above and will require the prescriber to maintain this documentation in the individual's patient medical file. The prescriber must be able to provide this documentation to DHS in writing upon request.

Viagra will be subject to the following limitations:

- There will be no refills authorized on any prescription for Viagra or other drugs indicated for the treatment of Erectile Dysfunction. Subsequent prescriptions will require a new prescription and a new prior authorization request and approval.
- Quantities of Viagra are limited to four total tablets per month (30 days), regardless of the strength.
- Since there is no instance for the immediate need of Viagra or any other drug used in the treatment of Erectile Dysfunction, there will be NO emergency supplies authorized. "Immediate need" has been defined by the Centers for Medicare and Medicaid Services (CMS) as, "a situation where the lack of a certain drug would involve immediate and severe consequences, continuation of immediate and severe consequences, or pose an immediate threat to the patient's life."
- All prescriptions for Viagra and other similar drugs will be subject to copayment unless exempted by Federal or State Law.

7.2.4 Prior Authorization of COX-2 Drugs

Non-steroidal anti-inflammatory drugs (NSAIDs) are United States Food and Drug Administration (FDA) indicated for a variety of rheumatic and other conditions. COX-2 selective NSAIDs (for example, Celebrex, Vioxx, and Bextra) and non-selective NSAIDs are equally effective of acute pain, osteoarthritis and inflammatory musculoskeletal conditions and offer no advantage regarding renal or cardiovascular effects. COX-2 selective NSAIDs appear to offer the greatest advantage in patients at high risk of serious gastrointestinal (GI) complications. COX-2 NSAIDs reduce the likelihood of GI ulcerations seen on endoscopy and serious adverse GI events when compared with non-selective NSAIDs. Age, anti-coagulant and NSAID use represent indirect risk factors for causing serious adverse GI events. Because of their comparable efficacy and tolerability, non-selective NSAIDs should be the initial course of treatment except for individuals at high risk for the development of GI, and certain other complications.

To assure that COX-2 selective NSAIDs are prescribed only when medically necessary, DHS requires prior authorization for prescriptions of COX-2 selective NSAIDs dispensed, including refills that meet any of the following conditions:

- The recipient is taking another NSAID.
- The prescribed dosage is higher than the dosage recommended by the FDA.
- The recipient is under 70 years of age and is not taking an anticoagulant.

Prescriptions for COX-2 selective NSAIDs that do not meet any of the listed conditions will not require prior authorization. However, any early refills for COX-2 selective NSAIDs will require prior authorization regardless of the conditions.

7.2.5 Prior Authorization of Sustained / Controlled Release Oxycodone / OxyContin®

An alert from the Federal Department of Health and Human Services (DHHS), Office of the Inspector General (OIG), advised state Medicaid programs that they are vulnerable to payment of illegally acquired OxyContin® prescriptions. According to the Federal OIG and other law enforcement agencies, OxyContin® has been increasingly abused in geographical areas where the drug, when covered as a prescription benefit, provides an alternative to heroin. Individuals who inappropriately use this medication for non-medical purposes are vulnerable to dependency, addiction, or even death.

Conversely, DHS understands and appreciates OxyContin®'s effectiveness in controlling moderate to severe chronic pain. Various consumer groups and professional medical organizations have urged DHS to refrain from imposing limitations or implementing prior authorization of this drug. DHS, however, cannot ignore identified instances of abuse and diversion being billed to the MA Program. Accordingly, DHS has selected a threshold for prior authorization that attempts to identify situations above the typical dosing intervals and number of strengths used concurrently. It is understood that there are valid reasons to prescribe at the levels that will require prior authorization, but there is also evidence of abuse at these levels.

DHS requires prior authorization of all prescriptions for OxyContin® that meet either or both of the conditions identified below. These conditions apply only to prescriptions covered under the Fee-for-Service delivery system.

- Prescriptions that exceed doses of greater than three tablets per day of any single strength of OxyContin®.
- Prescriptions for more than two different strengths of OxyContin® that are taken concurrently.

Prior authorization requests will be accepted from the ***prescriber only***. Prescriptions that do not meet either of the above conditions will NOT require prior authorization.

In order to receive approval for the quantities or strengths of OxyContin® that require prior authorization, the prescriber will need to provide information that will explain the need for the medication at the prescribed dosage or quantity. DHS will apply the established clinical medical necessity criteria during the review of the prior authorization request.

There will be NO emergency supplies authorized for OxyContin® while a prior authorization request is pending. Alternative medications may be used if pain relief needs are immediate. Additionally, early refills, i.e., dispensing an OxyContin® prescription when more than 25% of an earlier dispensed supply remains, will not be approved and prior authorization will not be granted for any exceptions.

7.2.6 Procedure for Requesting Prior Authorization of Drugs

1. The prescriber must obtain prior authorization by calling the appropriate toll-free number and write the 10-digit prior authorization number on the front of the prescription.
2. The pharmacy must include the prior authorization in the designated prior authorization number field when submitting a claim for a drug requiring prior authorization.
3. DHS will reject any claim if the prior authorization process is not followed for circumstances requiring prior authorization.

For questions, please call the appropriate toll-free number for your provider type. Pharmacies that receive claim rejections may call 1-800-932-0938 for assistance.

7.2.7 List of Drugs Requiring Prior Authorization

The following details prescription drugs that require prior authorization:

NOTE: These tables will be updated periodically as necessary.

Product	NDC
A/T/S Sol 2%	00039-0016-60
Actifed Tab	00501-2018-12124, 48
Albalon Oph Sol	11980-0154-15
Aldactazide Tab	25/25 00025-1011-31, 55
Aldactone Tab 25 mg	00025-1001-31, 51, 55
Anafranil Cap 25 mg	00078-0316-05, 06
Anafranil Cap 50 mg	00078-0317-05, 06
Anafranil Cap 75 mg	00078-0318-05
Anaprox Tab 275 mg	00004-6201-01
Anaprox-DS Tab 550 mg	00004-6200-01, 14
Ansaid Tab 100 mg	00009-0305-03, 30
Antivert Tab 12.5 mg	00049-2100-66, 82
Antivert Tab 25 mg	00049-2110-66, 82

Product	NDC
Anusol HC Cr 2.5%	61570-0313-11
Apresoline Tabs 10 mg	00083-0037-30
Artane Tab 2 mg	00005-4434-23, 34
Artane Tab 5 mg	00005-4436-23
Atarax Syr. (10 mg/15 ml)	00049-5590-93
Ativan Tab 1 mg	00008-0064-02, 03, 05, 07
Ativan Tab 2 mg	00008-0065-02, 03, 05, 07
Ativan Tab 0.5 mg	00008-0081-02103, 05
Atrovent Sol for Inh. 0.02% 2.5 ml	00597-0080-62 (8/22/03)
Axid Tab 150 mg	65726-0144-15, 35, 75, 86, 90, 96
	00002-3144-01, 03, 33, 60, 81, 82
Axid Tab 300 reg	65726-0145-10
	00002-0145-10
Azulfidine 500 reg Tabs	00013-0101-01, 11, 20
A/T/S Sol 2%	00039-0016-60
Bactrire DS Tab	00004-0117-01, 04, 14
Bactrire Oral Susp (pediatric)	00004-1033-28
Bactrire Tab 400 reg/80 reg	00004-0050-01
Bentyl Cap 10 reg	00068-0120-61
Bentyl Tab 20 reg	00068-0123-61
Betagan Oph Sol 0.5%	11980-0252-20, 21, 25, 60, 65,
Betagan Oph Sol 0.25%	11980-0469-20
Bleph-10 Oph Oint	00023-0311-04
Bleph-10 Oph Sol	11980-0011-15

Product	NDC
Bumex Tab 0.5 reg	0004-0125-01, 11, 14
Bumex Tab 1 reg	00004-0121-01, 11, 14
Bumex Tab 2 mg	00004-0162-01, 11
Buspar Tab 5 reg	00087-0818-41, 44
Buspar Tab 10 mg	00087-0819-41, 43, 44
Buspar Tab 15 reg	00087-0822-32, 33, 34
Calan Tab 40 mg	00025-1771-31
Calan Tab 80 reg	00025-1851-31, 51, 52
Calan Tab 120 mg	00025-1861-31, 52
Calan SR Tab 180 mg	00025-1911-31, 34
Capoten Tab 12.5 mg	00003-0450-54, 51, 75
Capoten Tab 25 mg	00003-0452-50, 51, 75
Capoten Tab 50 mg	00003-0482-50, 51, 75
Capoten Tab 100 mg	00003-0485-50
Capozide 25/25	00003-0349-50
Capozide 25/15	00003-0338-50
Capozide 50/25	00003-0390-50
Carafate Tab 1 Gm (AUL)	00088-1712-55, 47, 49, 53, 25
Carbex Tab 5 mg	63481-0408-60
Cardene Cap 20 mg	00004-0183-01
Cardene Cap 30 mg	00004-0184-01, 14
Cardizem Tab 120 mg	00088~1792-47
Cardizem Tab 30 mg	00088-1771-47, 55, 90
Cardizem Tab 60 mg	00088-1772-47, 55

Product	NDC
Cardizem Tab 90 mg	00088-1791-47
Cardura Tab 1 mg	00049-2750-41, 66
Cardura Tab 2 mg	00049-2760-41, 66
Cardura Tab 4 mg	00049-2770-41, 66
Cardura Tab 8 mg	00049-2780-41, 66
Cataflam Tab 50 mg	00028-0151-01, 61
Catapres Tab 0.1 mg	00597-0006-01, 10, 61
Catapres Tab 0.2 mg	00597-0007-01, 10, 61
Catapres Tab 0.3 mg	00597-0011-01
Ceclor Cap 250 mg	00002-3061-33, 02, 15
Ceclor Cap 500 mg	00002-3062-02, 15
Ceclor Susp 125 mg	00002-5057-18, 68
Ceclor Susp 187 mg	00002-5130-48
Ceclor Susp 250 mg	00002-5058-18, 68
Ceclor Susp 375 mg	00002-5132-48
Cephulac Syr 10gm/15ml	00068-0413-16, 39, 64
Cetamide Oph Oint 10%	00065-0526-35
Chlor-Trimeton Tab 4 mg	00085-0080-06, 08, 01, 02, 09
Chronulac Syr 10GM/15ml	00068-0409-08, 32
Cleocin Cap 150 mg	00009-0225-01, 02, 03
Cleocin T Topical Solution 1%	00009-3116-01, 02
Clinoril Tab 150 mg	00006-0941-68
Clinoril Tab 200 mg	00006-0942-68
Cogentin Tab 0.5 mg	00006-0021-68

Product	NDC
Cogentin Tab 1 mg	00006-0635-68
Cogentin Tab 2 mg	00006-0060-68
Compazine Tab 5 mg	00007-3366-20, 21
Compazine Tab 10 mg	00007-3367-20, 21
Cordarone Tab 200 mg	00008-4188-04, 06
Corgard Tab 20 mg	00003-0232-50
Corgard Tab 40 mg	00003-0207-50, 76
Corgard Tab 120 mg	00003-0208-50
Crolom Oph Susp 4%	24208-0300-10
Darvocet-N 100 Tab	00002-0363-02, 03, 33, 43, 46
Daypro Tab 600 mg	00025-1381-31, 34, 51
Demerol tab 50 mg	00024-0335-04, 02, 06
Demerol Tab 100 mg	00024-0337-04, 06
Depade Tab 50 mg	00406-0092-01, 03
Depakene 250 mg/5ml Syrup	00074-5682-16
Depakene Cap 250 mg	00074-5681-13, 11
Desyre1 Tab 100 mg	00087-0776-41, 43
Desyre1 Tab 150 mg	00087-0778-43, 44
Desyre1 Tab 50 mg	00087-0775-41, 42, 43
Diabinese Tab lob mg	00069-3930-66
Diabinese Tab 250 mg	00069-3940-66, 41, 71, 82
Diamox Tab 125 mg	57706-0754-23
Diamox Tab 250 mg	57706-0755-23
Diprosone Cr 0.05%	00085-0853-02, 03

Product	NDC
Diprosone Lot 0.05%	00085-0028-06
Ditropan Tab 5 mg	17314-9200-01, 02, 03
Do1obid Tab 500 mg	00006-0697-61
Dyazide Cap 37.5/25	00007-3650-21, 22, 30
Duricef Cap 500 mg	00087-0784-46
Dynacin Cap 50 mg	99207-0497-10, 05
Dynacin Cap 100 mg	99207-0498-50, 05
EC-Naprosyn Tab 500 mg	00004-6416-01
Econopred Plus Oph Susp	00998-0637-05, 10
Elavil Tab 100 mg	00310-0043-10
Elavil Tab 10 mg	00310-0040-10, 34
Elavil Tab 25 mg	00310-0045-34, 39, 50
Elavil Tab 50 mg	00310-0041-10, 34, 39
Elavil Tab 75 mg	00310-0042-10
Eryderm Sol 2%	00074-2698-02
Erymax/ Top Sol 2%	00023-0540-02
Estrace Tab 0.5 mg	00087-0021-41
Estrace Tab 1 mg	00087-0755-01, 48
Estrace Tab 2 reg	00087-0756-01, 48
Etrafon Forte Tab 4-25	00085-0720-04, 08
Etrafon Tab 2-10	00085-0287-04, 08
Etrafon Tab 2-25	00085-0598-04, 08
Feldene Cap 10 reg	00663-3220-66
	00069-3220-66

Product	NDC
Feldene Cap 20 reg	00663-3230-66, 41, 73
	00069-3230-73
Flagyl Tab 250 mg	00025-1831-50, 31
Flagyl Tab 500 reg	00025-1821-50, 31, 51
Flexeril Tab 10 mg	00006-0931-68, 28
FML 0.1% Oph Susp	11980-0211-05, 10, 15
Garamycin Oph Sol.	00085-0899-05
Glucotrol Tab 5 mg	00049-4110-66, 41, 73
Glucotrol Tab 10 reg	00049-4120-66, 41, 73
Halcion Tab 0.125 mg	00009-0010-11, 32, 38
Haldol Conc 2mg/ml	00045-0250-04
Hycodan Syrup	63481-0234-16
Hygroton Tab 25 mg	00075-0022-00
Hygroton Tab 50 mg	00075-0020-00
Hytrin Cap 1 mg	00074-3805-11, 13
Hytrin Cap 2 mg	00074-3806-11, 13 I
Hytrin Cap 5 mg	00074-3807-11, 13
Hytrin Cap 10 mg	00074-3808-11, 13
Imodium Cap 2 mg	50458-0400-10
Imdur Tab SA 60 mg	00085-4110-01, 03
Inderal Tab 10 mg	00046-0421-81, 95, 99
Inderal Tab 20 mg	00046-0422-81, 95, 99
Inderal Tab 40 mg	00046-0424-81, 95, 99
Inderal Tab 80 mg	00046-0428-81, 95

Product	NDC
Inderide-40/25 Tab	00046-0484-81, 91
Inderide-80/25 Tab	00046-0488-81
ISMO Tab 20 mg	00008-0771-01, 02
Isoptin SR Tab 180 mg	00044-1825-02, 12
Isordi1 Tab 5 mg	00008-4152-01, 02, 03, 05
Isordi1 Tab 10 mg	00008-4153-01, 02, 03
Isordi1 Tab 20 mg	00008-4154-01, 02, 05
Isordi1 Tab SL 2.5 mg	00008-4139-01, 03, 05
Isordi1 Tab SL 5.0 mg	00008-4126-07, 01, 03
Keflex Cap 250 mg	00777-0869-20, 02
Keflex Cap 500 mg	00777-0871-20, 02
Kenalog Cream 0.1%	00003-0506-49
Klonopin Tab 0.5 mg	00004-0068-01
Klonopin Tab 1 mg	00004-0058-01, 50
Klonopin Tab 2 mg	00004-0098-01
Lasix Tab 20 mg	00039-0067-10, 11, 50, 70
Lasix Tab 40 mg	00039-0060-11, 13, 50, 70
Lasix Tab 80 mg	00039-0066-05, 11, 50
Lidex Gel 0.5%	99207-0507-13, 14, 17
Lidex Cr 0.05%	99207-0511-13, 17
Lidex Sol 0.05%	99207-0517-46
Lioresal Tab 10 mg	00028-0023-01, 61
Lioresal Tab 20 mg	00028-0033-01, 61
Lodine Cap 200 mg	00046-0738-81, 99

Product	NDC
Lodine Tab 400 mg	00046-0761-81, 99
Lodine Tab 500 mg	00046-0787-81
Lomotil Tab	00025-0061-31, 34, 51, 52, 55
Loniten Tab 2.5 mg	00009-0121-01
Loniten Tab 10 mg	00009-0137-01
Keflex Cap 250 mg	00777-0869-20, 02
Keflex Cap 500 mg	00777-0871-20, 02
Kenalog Cream 0.1%	00003-0506-49
Klonopin Tab 0.5 mg	00004-0068-01
Klonopin Tab 1 mg	00004-0058-01, 50
Klonopin Tab 2 mg	00004-0098-01
Lasix Tab 20 mg	00039-0067-10, 11, 50, 70
Lasix Tab 40 mg	00039-0060-11, 13, 50, 70
Lasix Tab 80 mg	00039-0066-05, 11, 50
Lidex Gel 0.5%	99207-0507-13, 14, 17
Lidex Cr 0.05%	99207-0511-13, 17
Lidex Sol 0.05%	99207-0517-46
Lioresal Tab 10 mg	00028-0023-01, 61
Lioresal Tab 20 mg	00028-0033-01, 61
Lodine Cap 200 mg	00046-0738-81, 99
Lodine Tab 400 mg	00046-0761-81, 99
Lodine Tab 500 mg	00046-0787-81
Lomotil Tab	00025-0061-31, 34, 51, 52, 55
Loniten Tab 2.5 mg	00009-0121-01

Product	NDC
Loniten Tab 10 mg	00009-0137-01
Mellaril Tab 100 reg	00078-0005-05, 06, 09
Mellaril Tab 25 reg	00078-0003-05, 06, 09
Mellaril Tab 50 mg	00078-0004-05, 06, 09
Mevacor Tab 10 reg	00006-0730-61
Mevacor Tab 20 reg	00006-0731-28, 61, 82, 94
Mexitil Cap 200 reg	00597-0067-01
Minipress Cap 1 reg	00069-4310-71
Minipress Cap 5 reg	00069-4380-71
Minocin Cap 50 reg	00005-5343-23, 27
Minocin Cap 100 reg	00005-5344-18, 27
Moduretic Tab 50 reg/5 reg	00006-0917-68
Monistat 7 Vag Supp 100 reg	00062-5427-01, 05, 36
Lortab 10/500	50474-0910-01, 50, 60
LozoY Tab 1.25 mg	00075-0700-00, 99
Lozol Tab 2.5 mg	0075-0082-00, 62, 99
Maxitrol Oph Oint.	00065-0631-36
Maxivate Cream 0.05%	00072-9410-45
Maxivate Lotion 0.05%	00072-9490-60
Maxzide 50/75 Tab	62794-0460-01,05
Maxzide Tab 25 mg	62794-0464-05, 88
Mellaril Tab 100 reg	00078-0005-05, 06, 09
Medrol Tab 4 mg	00009-0056-03, 04, 05
Megace Tab 20 reg	00015-0595-01

Product	NDC
Megace Tab 40 reg	00015-0596-41, 45, 46
Mellaril Tab 10 reg	00078-0002-05, 06, 09
Mellaril Tab 100 reg	00078-0005-05, 06, 09
Mellaril Tab 25 reg	00078-0003-05, 06, 09
Mellaril Tab 50 mg	00078-0004-05, 06, 09
Mevacor Tab 10 reg	00006-0730-61
Mevacor Tab 20 reg	00006-0731-28, 61, 82, 94
Mexiti1 Cap 200 reg	00597-0067-01
Minipress Cap 1 reg	00069-4310-71
Minipress Cap 5 reg	00069-4380-71
Minocin Cap 50 reg	00005-5343-23, 27
Minocin Cap 100 reg	00005-5344-18, 27
Moduretic Tab 50 reg/5 reg	00006-0917-68
Monistat 7 Vag Supp 100 reg	00062-5427-01, 05, 36
Motrin Tab 400 mg	00009-7385-01, 02, 03, 04
Motrin Tab 600 mg	00009-7386-01, 02, 03, 04, 05
Motrin Tab 800 mg	00009-7387-01, 02, 03, 04, 05
Mucomyst Sol 20%	00087-0570-02, 03
Mycolog II Cr.	00003-0566-30, 65, 60
Mycolog II Oint	00003-0466-30, 60, 65
Mycostatin Cr.	00003-0579-31
Mycostatin Oral Susp.	00003-0588-60,10
Mydriacyl Oph Sol 0.5%	00998-0354-15
Mydriacyl Oph Sol 1%	00998-0355-15

Product	NDC
Mysoline Tab 250 mg	59075-0691-10, 11, 81
	66490-0691-10
Naprosyn Tab 375 mg	00004-6311-01, 14
	18393-0273-62
Naprosyn EC Tab 500 mg	00004-6416-01
Navane Cap 1 mg	00049-5710-66
Navane Cap 10 mg	00049-5740-66, 82
Navane Cap 2 mg	00049-5720-66,82
Navane Cap 5 mg	00049-5730-66
Neosporin Oph Sol.	61570-0045-10
Neptazane Tab 25 mg	57706-0756-23
Neptazane Tab 50 mg	57706-0757-23
Nizoral Tab 200 mg	50458-0220-10
Norflex Tab 100 mg	00089-0221-10,50
Normodyne Tab 100 mg	00085-0244-04, 05, 07, 08
Norrnodine Tab 200 mg	00085-0752-04, 05, 07, 08
Norrnodine Tab 300 mg	00085-0438-03, 05, 06
Nutracort Lot. 1% 120 ml	00064-2200-04
Ocufen Oph Sol 0.03%	11980-0801-03
Ocupress Oph Sol drops 1%	58768-0001-01, 02, 04
	59148-0001-01, 02, 04
Ogen Tab 0.625 mg (0.75 Tab)	00009-3772-01,17
Ogen Tab 1.25 mg (1.5 Tab)	00009-3773-01
Ogen Tab 2.5 mg tab (3 Tab)	00009-3774-01

Product	NDC
Orudis Cap 50 mg	00008-4181-01
Orudis Cap 75 mg	00008-4187-01, 02, 04
Pamelor Cap 10 reg	00078-0086-05, 06
Pamelor Cap 25 reg	00078-0087-05, 06, 08
Pamelor Cap 50 mg	00078-0078-05, 06
Pamelor Cap 75 mg	00078-0079-05
Penecort Cream 2.5% 30 gm	00023-0550-30
Pepcid Tab 20 mg (AUL)	00006-0963-28, 31, 58, 82, 94
Pepcid Tab 40 mg (AUL)	00006-0964-28, 31, 58, 82, 94
Pepcid AC Gelcaps 10 mg	16837-0856-60,28
Pepcid Complete Chew Tabs	16837-0888-54,75,28
Percocet Tab	63481-0623-70, 75, 85
Peridex Liquid 0.12%	51284-0620-22
Periogard Oral Rinse 0.12%	00126-0271-16
Perretil Tab 2.5 mg	00085-0442-04
Permitil Tab 5 reg	00085-0550-04
Permitil Tab 10 rmg	00085-0316-05
Phenergan Syr (6.25rng/5rnl)	00008-0549-01, 02, 03
Plaquenil Tab 200 mg	00024-1562-10
Polytrirn Oph Sol	00023-7824-10
Pred Forte Oph Sol"r1%	11980-0180-05, 10
Prelone Syrup	00451-1500-08, 16
Prinivil Tab 2.5 rng r	00006-0015-31, 28, 58
Prinivil Tab 5 mg	00006-0019-28, 54, 58, 72

Product	NDC
Prinivil Tab 10 mg	00006-0106-28, 31, 54, 58, 82, 87, 94, 72
Prinivil Tab 20 mg	00006-0207-28, 31, 54, 58, 72, 87, 94
Prinivil Tab 40 mg	00006-0237-58
Prinzide Tab 10/12.5 mg	00006-0145-58
Prinzide Tab 20/12.5 mg	00006-0140-31, 58
Prinzide Tab 20/25 mg	00006-0142-31, 58
	00451-1500-08, 16
Procardia Cap 20 mg	00069-2610-66, 41, 72
Prolixin Tab 1 mg	00003-0863-50
Prolixin Tab 10 mg	00003-0956-50
Prolixin Tab 2.5 mg	00003-0864-50
Prolixin Tab 5 mg	00003-0877-50
Propine Oph Sol 0.1%	00023-9208-05
ProSom Tab 1 mg	00074-3735-13
ProSom Tab 2 mg	00074-3736-13
Proventil Inhaler 17 grn	00085-0614-02,03
Proventil Syr 2mg/5ml	00085-0315-02
Proventil Sol Inh 0.5%	00085-0208-02
Provera Tab 2.5 mg	00009-0064-04, 06, 12
Provera Tab 5 mg	00009-0286-03, 42
Provera Tab 10 mg	00009-0050-11, 09, 02
Prozac Tab 10 mg	00002-4006-02,30
Prozac Cap 10 mg	00777-3104-01, 02, 07, 81, 82
Prozac Cap 20 mg	00777-3105-01, 02, 33, 07, 30, 81, 82

Product	NDC
Prozac Cap 40 mg	00777-3107-30
Prozac 20 mg/5ml sol.	00777-5120-58
Questran Powder 378grn	00087-0580-05
Questran Packets (4gm)	00087-0580-11 00015-0580-11
Questran Light Powder (4 grn/pack)	00087-0589-03
Reglan Oral Sol 5 mg/ml	00031-6706-25
Reglan Tab 5 mg	00031-6705-63
Reglan Tab 10 mg	00031-6701-63,70
Restoril Cap 15 mg	00078-0098-05, 06, 08
Restoril Cap 30 mg	00078-0099-05, 06, 08
Revia Tab 50 mg	00056-0011-30, 70, 22, 50
Robaxin Tab 500 mg	00031-7429-63, 70
Sectral Cap 200 mg	00008-4177-01,04
Sectral Cap 400 mg	00008-4179-01
Selsun Shampoo (2.5%)	00074-2660-04
Septra Tab 400/80 mg	61570-0052-01
Septra DS Tab	00173-0852-55
	61570-0053-01, 52, 05, 20
Septra Oral Susp	00173-0854-96; 61570-0050-11, 16
	00173-0855-96; 61570-0051-16
Serax Cap 10 mg	00008-0051-02, 03
Serax Cap 15 mg	00008-0006-02, 04
Serax Cap 30 reg	00008-0052-02, 04 and 63857-0329-10
Sinequan Oral Conc	00049-5100-47

Product	NDC
Sinequan Cap 10 mg	00049-5340-66, 82
Sinequan Cap 100 mg	00049-5380-66
Sinequan Cap 25 mg	00049-5350-66, 94
Sinequan Cap 50 mg	00049-5360-94, 66
Sinequan Cap 75 mg	00049-5390-66
Slow-K Tab (8reeq)	57267-0165-40, 65
	00078-0320-05, 09
Sodium Sulamyd Oph Oint 10%	00085-0066-03
Sodium Sulamyd Oph Sol 10%	00085-0946-06
Soma Compound Tab	00037-2103-01, 03, 85
Soma Tab 350 mg	00037-2001-01, 03, 85
Sorbitrate Tab 10 mg	00310-0780-10, 39, 50
Sorbitrate Tab 20 mg	00310-0820-10, 39
Sorbitrate Tab 5 mg	00310-0770-10,50
Stelazine Tab 5 mg	00108-4906-20
Symmetrel Syr 50 mg/5 ml	63481-0205-16
Synalar Sol 0.01%	99207-0506-46
Tagamet Tab 200 mg (AUL)	00108-5012-20
Tagamet Tabs 300 mg (AUL)	00108-5013-20, 21, 25
Tagamet Tabs 400 ms (AUL)	00108-5026-18, 25
Tagamet Tabs 80b mg (AUL)	00108-5027-13, 21, 25, 76
Temovate Cream 0.5%	00173-0375-01, 02, 72
	51479-0375-01, 02, 72, 73
Tenex Tab 1 mg	00031-8901-63, 70

Product	NDC
Tenex Tab 2 mg	00031-8903-63
Tenoretic Tab 100 mg/25 mg	00310-0117-10
Tenoretic Tab 50 mg/25 mg	00310-0115-10
Tenormin Tab 100 mg	00310-0101-10, 39
Tenormin Tab 50 mg	00310-0105-10, 39, 34
Tenormin Tab 25 mg	00310-0107-10
Tessalon Pearls Cap 100 mg	00456-0688-01, 02
Theo-Dur Tab 100 mg	00085-0487-01, 05, 10, 50
Theo-Dur Tab 200 mg	00085-0933-01, 05, 10, 50
Thiothixene Cap 10mg	17236-0468-10
Ticlid Tab 250 mg	00004-0018-23, 14, 22
Timoptic Oph Sol 0.25%	00006-3366-03, 10, 12
Timoptic Oph Sol 0.5%	00006-3367-03, 10, 12
Tobrex Oph Sol 0.3%	00065-0643-05
Tofranil Tab 10 mg	00028-0032-01
Tofranil Tab 25 mg	00028-0140-01
Tofranil Tab 50 mg	00028-0136-01
Tolinase Tab 250 mg	00009-0114-05, 04
Toradol Tab 10 mg	00004-0273-01
Trental Tab 400 mg SA	00039-0078-10, 11
Triavil Tab10-2	59417-04:01-71
Triavil Tab 25-2	59417-0402-71
Triavil Tab 25-4	59417-0404-71
Tridesilon Cream 0.05% 60 Gm.	45820-0420-37 (8/22/03)

Product	NDC
	00026-5561-62
Tridesilon Oint 0.05%	00026-5591-61, 62
	45802-0425-35, 37
Trilafon Tab 2 mg	00085-0705-04
Trilafon Tab 4 mg	00085-0940-05
Trilafon Tab 8 mg	00085-0313-05
Trilafon Tab 16 mg	00085-0077-05
T-Stat Top Sol 2%	00072-8300-60
Tylenol w/Codeine Tab #2	00045-0511-73
Tylenol w/Codeine Tab #3	00045-0513-60, 72, 73, 70
Tylenol w/Codeine Tab #4	00045-0515-70, 73, 60
Tylox Cap	00045-0526-60, 79
Ultram Tab 50 mg	00045-0659-10, 60, 70
Vasotec 2.5 mg	00006-0014-28, , 68, 82, 87,
	64455-0140-10, 11, 90
Vasotec 5 mg	00006-0712-28, 68, 82, 87, 94
	64455-0141-10, 90
Vasotec 10 mg	00006-0713-28, 68, 82, 87, 94
	64455-0142-10, 90 8/22/03
Vasotec 20 mg	00006-0714-28, 68, 82, 94
	64455-0143-10, 90
Vectrin Cap 50 mg	00047-0687-24
Vectrin Cap 100 mg Cap	00047-0688-19
Ventolin Inhaler 17 Gm	00173-0321-88, 98

Product	NDC
Ventolin Inhaler sol (5mg/20ml)	00173-0385-58
Ventolin Liq 2 mg/5 ml	00173-0351-54
Vibramycin Cap 50 reg	00069-0940-50
Vibramycin Cap 100 mg	00069-0950-50, 73
Vibra-Tab 100 reg	00069-0990-50
Vicodin ES Tab 7.5/750	00044-0728-02, 03, 41
Vicodin HP Tab 10/660	00044-0725-02, 03
Vicodin Tab 5 mg/500 reg	00044-0727-02, 03, 41
Visken Tab 5 mg	00078-0111-05
Visken Tab 10 mg	00078-0073-05
Vistaril Cap 100 mg	00069-5430-66, 73
Vistaril Cap 25 mg	00069-5410-66
Vistaril Cap 50 mg	00069-5420-66
Toltaren Tab 50 mg	00028-0262-01, 10, 60, 61
Toltaren Tab 75 mg	00028-0264-01,10,60,61
Wygesic Tab	00008-0085-01, 02
Xanax Tab 0.25 mg	00009-0029-01, 02, 46, 14
Xanax Tab 0.5 mg	00009-0055-01, 03, 15, 46
Xanax Tab 1 mg	00009-0090-01, 04, 13
Xanax Tab 2 mg	00009-0094-01
Xylocaine Viscous Sol 2%	00186-0360-01
Zanaflex Tab 2 mg	59075-0592-15
Zanaflex Tab 4 mg	59075-0594-15
Zantac Tab 150 mg (AUL)	00173-0344-14, 12, 42

Product	NDC
Zantac Tab 300 mg (AUL)	00173-0393-47, 06, 40
Zestoretic Tab 10/12.5 mg	00310-0141-10
Zestoretic Tab 20/12.5 mg	00310-0142-10
Zestoretic Tab 20/25 mg	00310-0145-10
Zestril Tab 2.5 mg	00310-0135-10
Zestril Tab 5 mg	00310-0130-10, 34, 39
Zestril Tab 10 mg	00310-0131-10, 34, 35, 73
Zestril Tab 20 mg	00310-0132-10, 34, 35, 73
Zestril Tab 30 mg	00310-0133-10
Zestril Tab 40 mg	00310-0134-10
Ziac Tab 2.5/6.25 mg	00005-3238-23
Ziac Tab 5/6.25 mg	00005-3234-23
Ziac Tab 10/6.25 mg	00005-3235-38
Zovirax Cap 200 mg	00173-0991-55, 56
Zovirax Cap 400 mg	00173-0949-55
Zovirax Cap 800 mg	00173-0945-55, 56
Zyloprim Tab 100 mg	65483-0991-10
Zyloprim Tab 300 mg	00173-0998-55, 70
	65483-0993-10, 50
Zovirax Cap 200 mg	00173-0991-55, 56

7.2.7.1 NDC NUMBERS AND MAINTENANCE DOSES FOR ANTI-ULCER DRUGS Rev. July 2002

ANY DAILY DOSE THAT EXCEEDS THE MAINTENANCE DOSE LISTED BELOW WILL REQUIRE PRIOR AUTHORIZATION AFTER 90 DAYS CONTINUED USE.

#2 NDC NUMBERS AND MAINTENANCE DOSES FOR ANTI-ULCER DRUGS Rev. July 2002:

ANY DAILY DOSE THAT EXCEEDS THE MAINTENANCE DOSE LISTED BELOW WILL REQUIRE PRIOR AUTHORIZATION AFTER 90 DAYS CONTINUED USE.

Drug Name	NDC	Maintenance Dose
AXID PULVULE 150 mg	00002-3144-0101/03/33/60/81/8265726 - 0144-15/35/75/86/90/96	1 capsule
AXID PULVULE 300 mg	00002-3145-3065726-0145-10	0
AXID AR tablet 75 mg	00573-2400-10/20/30/40/45	2 tablets
NIZATIDINE Cap 150 mg	22222-2222-22	1 tablet
NIZATIDINE Cap 300 mg	22222-2222-22	0
PEPCID Oral suspension 40 mg/5ml*	00006-3538-92	2.5 ml
PEPCID tablet 20 mg*	00006-0963-28/31/58/72/82/87/94	1 tablet
PEPCID AC tablet 10 mg*.(OTC)	16837-0872-02/06/09/12/18/28/30/31/33/50/51/52/60/90	2 tablets
PEPCID AC Chew Tab 10 mg (OTC)	16837-0873-06/30/61	2 tablets
PEPCID Complete Chew Tab 10 mg (OTC)	16837-0888-03/05/11/15/25/28/5054/7516837-0291-03/05/25/28/50/52	2 tablets
PEPCID AC GELCAPS 10 mg (OTC)	16837-0856-06/28/30/60/61/90	2 capsules
PEPCID RPD tablet 20 mg*	00006-3553-28/31/48	1 tablet
PEPCID RPD tablet 40	00006-3554-31/48	1/2 tablet

Drug Name	NDC	Maintenance Dose
mg*		
PEPCID tablet 40 mg *	00006-0964- 28/31/58/72/82/87/94	1/2 tablet
FAMOTIDINE (PEPCID)	22222-2222-22	
TAGAMET HB tablet200 mg* (OTC)	00766-5016- 06/12/18/30/50/70	1 tablet
TAGAMET HB liquid200mg/20ml (OTC)	00766-5015-12	40 ml
TAGAMET liquid 300mg/5ml *	00108-5014-10/48	5 ml
TAGAMET tablet 200 mg *	00108-5012-20	2 tablets
TAGAMET tablet 300 mg *	00108-5013-20/21/25	1 tablet
TAGAMET tablet 400 mg *	00108-5026-18/25	1 tablet
TAGAMET tablet 800 mg *	00108-5027-13/21/25/76	1/2 tablet
CIMETADINE (Tagamet)	CIMETADINE (Tagamet)	CIMETADINE (Tagamet)
ZANTAC granules	ZANTAC granules	ZANTAC granules
ZANTAC tablet 75 mg*	ZANTAC tablet 75 mg*	ZANTAC tablet 75 mg*
ZANTAC tablet 150 mg *	ZANTAC tablet 150 mg *	ZANTAC tablet 150 mg *
ZANTAC tablet 300 mg *	ZANTAC tablet 300 mg *	ZANTAC tablet 300 mg *
ZANTAC syrup 15mg/ml*	ZANTAC syrup 15mg/ml*	ZANTAC syrup 15mg/ml*
ZANTAC tablet 150 mg EFFERDOSE*	ZANTAC tablet 150 mg EFFERDOSE*	ZANTAC tablet 150 mg EFFERDOSE*
RANTIDINE (Zantac)	RANTIDINE (Zantac)	RANTIDINE (Zantac)

* REQUIRES PRIOR AUTHORIZATION FOR BRAND NAME DRUG

7.2.7.2 COX-2 Drugs requiring Prior Authorization

NDC Numbers and Maximum Daily Dose on COX-2 Inhibitors:

Drug Name	NDC	Maximum Daily Dose
Celebrex:		
Celebrex cap 100mg (42001) -	00025-1520-31/34/51	2 tabs
Celebrex cap 200mg (42002) -	00025-1525-31/34/51	2 tabs
Vioxx:		
Vioxx tab 12.5mg (93181) -	00006-0074-28/31/68/80/82	1 tab
Vioxx tab 25mg (93161) -	00006-0110-28/31/68/80/82	1 tab
Vioxx tab 50mg (42222) -	00006-0114-28/31/68/74/81	5 tabs/month
Vioxx Susp 12.5mg/5ml (93191) -	00006-3784-64	1 unit (5ml)
Vioxx Susp 25mg/5ml (93351) -	00006-3785-64	1 unit (5ml)
Bextra:		
Bextra tab 10mg (15475) -	00025-1975-31/34/51	1 tab
Bextra tab 20m (15481) -	00025-1980-31/34/51	1 tab

7.2.7.3 Oxycontin Drugs and NDC's requiring Prior Authorization

Oxycontin 10mg (Oxycodone HCL)	59011-0100-10,25
Oxycontin 20mg (Oxycodone HCL)	59011-0103-10,25
Oxycontin 40mg (Oxycodone HCL)	59011-0105-10,25 Oxycontin
80mg (Oxycodone HCL)	59011-0107-10,25 Oxycontin

120mg (Oxycodone HCL)	59011-0109-10,25 -(no longer available)
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7.2.7.4 Erectile Dysfunction Drugs requiring Prior Authorization

Viagra:

NDCs	
25 mg tablet	00069-4200-30
50 mg tablet	00069-4210-30,66
100 mg tablet	00069-4220-30,66

Muse ("Alprostadil"): Urethral Suppository (Pellet):

NDCs	Carton	Pouch
125 micrograms	62541-0110-06	62541-0110-01
250 micrograms	62541-0120-06	62541-0120-01
500 micrograms	62541-0130-06	62541-0130-01
1000 micrograms	62541-0140-06	62541-0140-01

Caverject ("Alprostadil"): For Intracavernous use

NDCs	
5 microgram vials with diluent's syringe	00009-7212-03
10 microgram vials with diluent's syringe	00009-3778-08
10 microgram system	00009-3778-13
10 microgram/mi kit	00009-7655-02
20 microgram vials with diluent's syringe	00009-3701-01
20 microgram system	00009-3701-13
40 mcg/2ml kit	00009-7650-02
20mcg/ml kit	00009-7654-02
Impulse Kit 10 mcg	00009-5181-01

Impulse Kit 20 mcg	00009-5182-01
NDC's of vials only, no diluent's syringe	
10 microgram vial	00009-3778-04,05
20 microgram vial	00009-3701-05,08
40 microgram vial	00009-7686-01,04
EDEX	
10 microgram vial	00091-1010-06
20 microgram vial	00091-1020-06
40 microgram vial	00091-1040-06
10 microgram kit	00091-1010-44; 00091-1410-44
20 microgram kit	00091-1020-44; 00091-1420-44
40 microgram kit	00091-1040-44; 00091-1440-44
10 microgram starter pack	00091-1110-11
20 microgram starter pack	00091-1120-11
40 microgram starter pack	00091-1140-11
10 microgram refill pack	00091-1027-22
20 microgram refill pack	00091-1029-22
40 microgram refill pack	00091-1032-22

7.2.8 Steps for Payment

1. Be certain the prescriber included the prior authorization number and the “Brand Medically Necessary” notation on the prescription.
2. Prepare the claim in electronic format. Enter the prior authorization number in the Prior Authorization Field (NCPDP PA/MC Field). Since this field is also used to indicate “pregnancy” or “copay not collected” you must use the following to indicate pregnancy, copy not collected, and/or prior authorization:

- If the recipient is not pregnant, copay is collected and prior authorization is required, enter the value “1” in the first position of the PA/MC field and the 10-digit prior authorization number in positions 2 through 11.
 - If the recipient is pregnant and prior authorization is required, enter the value “8” in the first position of the PA/MC field and the 10-digit prior authorization number in positions 2 through 11.
 - If the copay is applicable but not collected from the recipient and prior authorization is required, enter “4” in the first position of the PA/MC field and the 10-digit prior authorization number in positions 2 through 11.
 - If the recipient is pregnant and no prior authorization is required, enter “8” in the first position of the PA/MC field and leave positions 2 through 11 blank or zero filled.
 - If copy is applicable but not collected from the recipient and no prior authorization is required, enter “4” in the first position of the PA/MC field and leave positions 2 through 11 blank or zero filled.
3. The “DAW” field is used for information purposes only. DHS does not use this field as the override indicator for a State MAC drug. You must enter the prior authorization number issued to the prescriber to override a State MAC.
 4. If the claim submitted involves a State OTC drug which the pharmacy will accept payment at the State MAC rate, submit the claim without the prior authorization number. The claim will be processed using the State MAC rate.
 5. To indicate an EMERGENCY SITUATION, enter “03” in the Level of Service Field. DHS will reject EMERGENCY claims without prior authorization if the quantity exceeds a 5 day supply.
 6. Transmit the claim to DHS electronically.

7.2.8.1 Anti-ulcer Drugs

1. If there is no prior authorization number on the prescription form, submit the claim as you would any other claim. If prior authorization is not required, the claim will be adjudicated as a normal submission. If prior authorization is required, you will get a message indicating prior authorization is required.
2. If prior authorization is required and there is no prior authorization number on the prescription, contact the prescriber. The prescriber may either call DHS for prior authorization or reduce the dosage to the maintenance dosage level. **DO NOT CALL DHS. ONLY PRESCRIBERS ARE PERMITTED TO CALL FOR PRIOR AUTHORIZATION.**
3. If prior authorization is required and there is a prior authorization number on the prescription, prepare the electronic claim by entering the prior authorization

number in the Prior Authorization Field (NCPDP PA/MC Field). Since this field is also used to indicate “pregnancy” or “copay not collected”, you must use the following to indicate pregnancy and/or prior authorization:

- If the recipient is not pregnant, copay is collected and prior authorization is required, enter the value “1” in the first position of the PA/MC field and the 10-digit prior authorization number in positions 2 through 11.
 - If the recipient is pregnant and prior authorization is required, enter the value “8” in the first position of the PA/MC field and the 10-digit prior authorization number in positions 2 through 11.
 - If copay is applicable but not collected from the patient and prior authorization is required, enter “4” in the first position of the PA/MC field and the 10-digit prior authorization number in positions 2 through 11.
 - If the recipient is pregnant and no prior authorization is required, enter “8” in the first position of the PA/MC field and leave positions 2 through 11 blank or zero filled.
 - If copay is required but not collected from the recipient and no prior authorization is required, enter “4” in the first position of the PA/MC field and leave positions 2 through 11 blank or zero filled.
4. Each time you submit a claim for an anti-ulcer drug during the first 90 days of treatment at the acute dosage level, DHS will send you one of three messages:
- The number of days remaining in the initial 90-day acute treatment period. You may wish to notify the prescriber or the patient when prior authorization will be required for a continuation of treatment at this level.
 - The number of days a refill quantity may extend past the 90 days. You may NOT override this alert. You should tell the prescriber that prior authorization will be needed for continued treatment at this level. In the meantime, you may reduce the quantity to an amount that is within the 90-day limit. The prescriber may also instruct you to reduce the quantity and change the directions to the maintenance level.
 - Whether two or more of these products were prescribed or are being taken at the same time. If the same prescriber is involved, the prescriber must be notified to request prior authorization for both drugs. If more than one prescriber is involved, you should notify each to determine the appropriate course of action.
5. Any claim involving any new prescription or any refill for anti-ulcer drugs submitted before 75 percent of the days supply of the previous claim has passed will be rejected. **YOU WILL NOT BE PERMITTED TO OVERRIDE THIS “EARLY REFILL” ALERT.**

7.2.8.2 Viagra and Other Drugs for Erectile Dysfunction

1. Be certain the prescriber included the prior authorization number on the front of the prescription.
These drugs will not be covered unless DHS has issued a prior authorization for that prescription only. **DO NOT CALL THE PRIOR AUTHORIZATION UNIT FOR APPROVAL TO FILL THE PRESCRIPTION. ONLY PRESCRIBERS ARE PERMITTED TO CALL FOR PRIOR AUTHORIZATION.**
2. Prepare the electronic claim by entering the prior authorization number in the Prior Authorization Field (NCPDP PA/MC Field).
3. Transmit the electronic claim to DHS.
4. Remember that DHS will NOT cover emergency supplies of Viagra or any other drug product indicated for Erectile Dysfunction. If you dispense any interim quantities of these drugs without prior authorization, you do so at your own risk.
5. For patient prescribed Viagra, if you detect a drug-drug interaction for organic nitrates in any form or if you know the recipient is on nitrates, call the prescriber immediately to determine what subsequent steps you should take.

7.2.8.3 COX-2 Drugs

Thresholds for Prior Authorization Prescriptions for COX-2 selective NSAIDs, including refills that meet any of the following conditions must be prior authorized:

1. The recipient is taking another NSAID.
The on-line claims adjudication system will verify the recipient has a record of a recent prescription for an NSAID (i.e., more than 25% of an earlier dispensed supply remains).
2. The prescribed dosage is higher than the dosage recommended by the FDA.
The on-line claims adjudication system will calculate the daily dose (quantity divided by days' supply) to determine if it is higher than the FDA-recommended dosage.
3. The recipient is under 70 years of age and is not taking an anticoagulant.
The on-line claims adjudication system will verify the age of the recipient and if a recipient has a record of a recent prescription (within the past 60 days) for an anticoagulant.

If the on-line adjudication system indicates that a prior authorization is required and the prescription or the refill has not been prior authorized, the pharmacist should notify the recipient or the prescriber that the prescription now requires prior authorization.

Emergency Supplies

DHS will allow the pharmacist to dispense an emergency supply of the medication without prior authorization if, in the professional judgment of the pharmacist, the recipient has an immediate need for the medication such as, the recipient cannot take any other alternative medication for pain relief during the time the prior authorization is being obtained. In emergency situations, the pharmacist may dispense a five-day supply of the COX-2 selective NSAID without prior authorization, unless the pharmacist determines that taking the COX-2 selective NSAID, either alone or along with other medication(s) that the recipient may be taking, would jeopardize the health and safety of the recipient.

Early Refills

Early refills of COX-2 selective NSAIDs (i.e., when more than 25% of an earlier-dispensed supply remains) will be permitted only under extraordinary circumstances where the need for the early refill is caused by circumstances demonstrated to be beyond the control of the recipient. If the recipient needs an early refill and extraordinary circumstances were demonstrated, a special prior authorization will be required. This applies regardless of whether the initial prescription was already prior authorized or the initial prescription was exempt from prior authorization. In either case, the pharmacist should notify the prescriber that the early refill requires prior authorization and instruct the prescriber to call the MA Program for a special prior authorization for the early refill. If the prescriber cannot be reached immediately or the prescriber cannot reach the MA Program and there is an immediate need for the medication in the professional judgment of the pharmacist, the pharmacist may dispense an emergency supply of the medication, as described under “Emergency Supplies” above.

Initiating the Prior Authorization Request

- Who May Initiate the Request?

The prescriber must request the prior authorization. A condensed version of the procedures for initiating the request is included in this handbook to assist pharmacists in guiding non- participating or out-of-state prescribers on the procedures for requesting prior authorization. Pharmacists may also refer prescribers to the DHS website:

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/pharmacyservices/pharmacypriorauthorizationgeneralrequirements/index.htm>

Prior Authorization Procedures.

- Where and When to Call

The MA Fee-for-Service Program Prior Authorization Unit accepts requests for prior authorization at 1-800-379-3309 between 8:00 A.M. and 4:00 P.M., Monday through Friday.

THE PHARMACY SHOULD NOT CONTACT THE PRIOR AUTHORIZATION UNIT FOR APPROVAL TO FILL THE PRESCRIPTION. THIS TELEPHONE NUMBER IS RESERVED FOR PRESCRIBERS ONLY.

Information and Supporting Documentation That Must Be Available for the Prior Authorization Review. The information required at the time prior authorization is requested includes the following:

- Name and ACCESS care number of the recipient;
- Prescriber's license number;
- Specifics of the prescription (i.e., drug, strength, quantity, directions, days supply);
- Clinical information to support the medical necessity for a prescription for a COX-2 selective NSAID, as described in the "Review of Documentation for Medical Necessity" section below.

Documentation Supporting the Need for a Prescription for a COX-2 Selective NSAID

The clinical information provided during the course of the review must also be verifiable within the patient's medical record. Upon retrospective review, DHS may seek restitution for the payment of the prescription and any applicable restitution penalties from the prescriber if the medical record does not support the medical necessity for the prescription. (Refer to [55 Pa. Code, Chapter 1101, §1101.83\(b\)](#))

Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a COX-2 selective NSAID, the determination of whether the requested prescription is medically necessary will take into account the following:

- Whether the recipient has a documented history of one or more of the following conditions:
 - Signs and symptoms of osteoarthritis;
 - Signs and symptoms of rheumatoid arthritis;
 - Acute pain;
 - Primary dysmenorrhea;
 - Familial adenomatous polyposis (FAP) (for Celebrex only);
 - Any other inflammatory disease (for example, Gout, Psoriatic arthritis);

AND

- Whether a COX-2 selective NSAID is the most appropriate option as documented by one or more of the following:
 - The recipient is 70 years of age or older;
 - The recipient is taking an anticoagulant;
 - The recipient is taking a corticosteroid;
 - The recipient has a history of intolerance or therapeutic failure of at least two non-selective NSAIDs such as ibuprofen, naproxen, diclofenac, etodolac, indomethacin and sulindac;
 - The recipient has a risk for treatment with non-selective NSAIDs such as peptic ulcer disease, NSAID-related ulceration, clinically significant gastrointestinal bleeding, coagulation defect, oral/injectible glucocorticoids, or erosive esophagitis;

AND

- Whether the recipient is not taking any other selective or non-selective NSAID except low dose aspirin;

AND

- Whether the prescribed dosage is consistent with FDA recommendations based on the individual's age and medical condition.

Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical review criteria listed above to assess the medical necessity of the request for a prescription for a COX-2 selective NSAID. If the answer to each of the questions is “YES,” the reviewer will prior authorize the prescription. If the answer to any of the questions is “NO,” the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such requests for service may be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

Long Term Therapy

DHS will consider requests to authorize multiple refills for a recipient when, in the professional judgment of the reviewer, treatment for the condition is expected to be ongoing. Multiple refills will not exceed five refills or six months.

Timeframe of Review

DHS will respond to requests for prior authorization within 24-hours of receiving all information reasonably necessary to make a decision.

Prior Authorization Number

If DHS prior authorizes the request, a 10-digit prior authorization number will be issued. This number should be written on the prescription and in the medical record in the event that the prescriber needs to later refer to the number for the patient or pharmacy.

Denials

If the request for a COX-2 selective NSAID is denied or approved other than as requested, the recipient has the right to appeal DHS's decision. The recipient has 30 days from the date of the prior authorization notice to submit the appeal in writing to the address listed on the notice. If the recipient has been receiving the services that are being reduced, changed, or denied and an appeal is hand-delivered or postmarked within 10 days of the date of the notice, the services will continue until a decision is made on the appeal.

Dispensing Considerations

The pharmacist should call the prescriber to alert him/her that the prescription now requires prior authorization if a prescription for a COX-2 selective NSAID is presented without a prior authorization number and the on-line adjudication system indicates that prior authorization is required.

The prescriber should not ask the pharmacist to call for the prior authorization number. Prior authorization numbers will be provided only to the prescriber.

THE PHARMACY SHOULD NOT CONTACT THE PRIOR AUTHORIZATION UNIT FOR APPROVAL TO FILL THE PRESCRIPTION. THE UNIT WILL ACCEPT REQUESTS ONLY FROM THE PRESCRIBER.

Procedures to Submit Pharmacy Claims

Using the on-line claims adjudication system prior authorization field (NCPDP PA/MC Field), place the value "1" in the first position and the 10-digit prior authorization number in positions 2 through 11. Transmit the electronic claim to DHS. The prior authorization number is unique and specific to the prescription authorized and will be verified for validity.

When submitting a claim for an emergency supply of a COX-2 selective NSAID, place the value "03" in the Level of Service Field. DHS will reject emergency claims if the emergency supply quantity exceeds a 5-day supply.

7.2.8.4 Sustained Controlled Release Oxycodone/OxyContin®

Thresholds for Prior Authorization

DHS requires prior authorization on prescriptions for OxyContin® that meet either or both of the following conditions:

- Prescriptions that exceed doses of greater than three tablets per day of any single strength of OxyContin®.

The number of tablets per day is determined by the prescriber within the prescribed directions for use. Directions for use are required on all MA prescriptions. However, upon dispensing the medication, the pharmacist plays a key role in transmitting accurate information to DHS. The pharmacist enters the “days’ supply” which in turn drives the automated system alerts for prior authorization. The tablets per day value is system calculated by dividing the quantity dispensed by the days supply. Pharmacists need to appreciate the need for entering accurate information within the days’ supply field as this element is key to an accurate alert for prior authorization for OxyContin®. A shortening of the days’ supply to avoid a later early refill alert can inaccurately increase the calculated tablets per day and trigger a prior authorization that may not be necessary.

- Prescriptions for more than two different strengths of OxyContin® that are taken concurrently.

Regardless of whether the third, or any subsequent strength is actually taken concurrently, the on-line claims adjudication system may recognize the medication as being taken concurrently depending on the amount of time elapsing between prescriptions. Accordingly, where the prescriber is aware that a third, or additional strengths are prescribed within the same timeframe that the earlier strengths would have covered, the prescribers have been alerted to request prior authorization.

NOTE: It is possible for a prescriber to prescribe up to six tablets per day of OxyContin® (i.e., three tablets for each of up to two strengths without prior authorization).

Emergency Supplies

DHS does not consider a delay in the receipt of OxyContin® to present a life-threatening emergency and, therefore, will NOT cover emergency supplies of OxyContin® pending approval of a request for prior authorization. Temporary alternative methods of pain relief may be necessary.

Early Fills

Additionally, early fills (i.e., dispensing an OxyContin® prescription when more than 25% of an earlier dispensed supply remains) will not be approved and prior authorization will not be granted for any exceptions.

Initiating the Prior Authorization Request

- Who May Initiate the Request?

The prescriber must request prior authorization. A condensed version of the procedures for initiating the request are included here for the pharmacy’s information,

as pharmacists are often placed in the position of guiding non-participating or out-of-state prescribers. Pharmacists can also refer prescribers to DHS's website:

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/pharmacyservices/pharmacypriorauthorizationgeneralrequirements/index.htm>

Procedures on Prior Authorization

- Where and When to Call

Prior authorization requests will be accepted by the MA Fee-for-Service Program Prior Authorization Unit at **1-800-558-2660** between the hours of 8:00 A.M. and 4:00 P.M., Monday through Friday.

THE PHARMACY SHOULD NOT CONTACT THE PRIOR AUTHORIZATION UNIT FOR APPROVAL TO FILL THE PRESCRIPTION. THIS TELEPHONE NUMBER IS RESERVED FOR PRESCRIBERS ONLY.

Review Process

- Use of Medical Necessity Review Criteria
DHS nurse reviewers will accept the prior authorization request and apply review criteria to assess the medical necessity of the drug and the dosage level. DHS utilized an independent panel of experts to develop the criteria. (Refer to the "Medical Necessity Review Criteria for Controlled Release Oxycodone/OxyContin®" below)
- Timeliness of Review
DHS will respond to prior authorization review requests within 24-hours.
- Approval/Prior Authorization Number

If DHS approves the request, a 10-digit prior authorization number will be issued. This number should be documented on the prescription and within the recipient's medical record in the event that the prescriber needs to reference the number for the recipient/pharmacy.

- Long Term Therapy
DHS will consider requests to authorize multiple prescriptions for a recipient during the prior authorization review when, in the professional judgment of the reviewer, the condition producing the pain reasonably can be expected to continue for longer than 30 days. The reviewer will approve multiple prescriptions consistent with the expected duration of the pain/therapy, but not to exceed six prescriptions or six months. When multiple prescriptions are approved during a review, both the prescriber and the recipient will receive written confirmation of the prior authorization numbers and related prescription information.

NOTE: Authorization for multiple months does not waive the requirement for original prescriptions for each month approved.

- Peer Review

If the criteria are not met, the prior authorization request will be referred to the physician review level for a determination.

Dispensing Considerations

The on-line claims adjudication system can assist in the monitoring of the requirements for controlled release Oxycodone/OxyContin®. The on-line system may detect a need for prior authorization not previously known to the prescriber. For example, if a recipient is receiving prescriptions from multiple prescribers unknown to each other and the system detects multiple strengths or an excessive tablet supply, prior authorization will be required. The pharmacist should contact the prescriber to alert him/her that the prescription has tripped the threshold level and prior authorization is now required.

THE PHARMACY SHOULD NOT CONTACT THE PRIOR AUTHORIZATION UNIT FOR APPROVAL TO FILL THE PRESCRIPTION. THIS TELEPHONE NUMBER IS RESERVED FOR PRESCRIBERS ONLY.

Pharmacy Billing Procedures

Using the on-line claims adjudication system prior authorization field (NCPDP PA/MC Field), place the value “1” in the first position and the 10-digit prior authorization number in positions 2 through 11. Transmit the electronic claim to DHS. The prior authorization number is unique and specific to the prescription authorized and will be verified for validity.

Medical Necessity Review Criteria for Controlled Release Oxycodone/OxyContin®

- Brand Name
OxyContin®
- Generic Name
Controlled Release Oxycodone
- Oral Tablet Strengths/Generic Codes
10mg/16282
20mg/16283
40mg/16284
80mg/16286
160mg/92459
FDA Indication

The controlled release oral form of Oxycodone/OxyContin® is indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time. OxyContin®

is not intended for use as a PRN (“as needed”) analgesic or for acute, short-term pain relief.

- **Criteria Elements**

All three of the following medical necessity criteria elements must be met in the professional judgment of the reviewer, for verification of medical necessity and approval of prior authorization at a non-physician review level. Situations not meeting one or more of the following criteria will be considered on a case-by-case basis by a physician reviewer to determine the medical necessity.

- There is a documented history of pain that includes all of the following:
 - Pain arises from a chronic condition; **AND**
 - Pain is moderate to severe in nature; **AND**
 - Pain is sustained and persistent rather than brief and intermittent; **AND**
 - Pain interferes with the activities of daily living (ADL), such as work, mobility, sleep, eating, personal hygiene and social functioning.
- A narcotic pain reliever is the most appropriate treatment option as documented by one or more of the following elements:
 - * Pain is inadequately controlled by non-narcotic pain relievers, including non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen (APAP), and aspirin (ASA); **OR**
 - * Recipient exhibits contraindications to non-narcotic pain relievers, such as allergy, drug-disease interaction, drug-drug interaction, history of adverse reaction; **OR**
 - * There is documentation regarding an earlier episode of the same pain etiology and nature where management with non-narcotic medication was inadequate; **OR**
 - * The pain is so severe that it would be appropriate to initiate pain management with opioids such as pain resulting from metastatic disease or severe orthopedic trauma.
- The proposed dosage is the minimum effective dosage. For doses and dosing intervals that exceed the FDA-approved starting dose of 10mg every 12 hours, there is documentation demonstrating an appropriate upward titration of OxyContin® or an appropriate conversion from other opioid-containing medications.

- **Expert Panel Review and Approval**

These criteria have been reviewed and approved by an independent panel of experts including multiple physician specialties, pharmacists and a consumer representative. The physician specialties represented included anesthesiology,

addiction medicine, hematology, oncology, pain management and family practice. Additionally, the panel included pharmacists from the University of Maryland, School of Pharmacy's Center on Drugs and Public Policy and staff from the Pennsylvania Medical Society's Center for Professional Drug Education.

- Literature References

References included, but were not limited to:

Jacox A, Carr DB, Payne E, et al. Management of cancer pain. Clinical practice guideline no. 9, AHCPR Publication No. 94-0592. Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Public Health Service. Rockville, MD. 1994.

Model guidelines for the use of controlled substances for the treatment of pain. Federation of State Medical Boards of the United States, Inc. May 2, 1998.

Purdue Pharma LP. Product Information: OxyContin®. July 2001.

7.3 Medical Supplies and Durable Medical Equipment (DME) Requiring Prior Authorization

Services and items requiring prior authorization are identified in the MA Program Fee Schedule with the prior authorization (PA) indicator. Prior authorization is also required when a single item costing *under* \$100 per item is requested in quantities totaling *more* than \$100.

Prior authorization is required after **three months** of rental on **any** item.

7.3.1 Procedures for Obtaining Prior Authorization for Medical Supplies and DME

When an MA beneficiary has the need for an item(s) requiring prior authorization, the **prescribing practitioner** must complete **two** copies of a prescription. The original prescription must be given to the beneficiary. The **prescriber** completes the prior authorization section of the Medical Services/Supplies Prior Authorization Request Form (MA 97).

The **prescriber** submits the completed MA 97 with a copy of the beneficiary's prescription in the envelope (ENV 320) provided by DHS.

For medical supplies and DME which require prior authorization, send the completed MA 97 and prescription to:

Department of Human Services
Outpatient PA/1150 Waiver Services
P.O. Box 8188
Harrisburg, PA 17105-8188

DHS will either approve or deny the request and notify accordingly the **prescriber** and the beneficiary by means of the Prior Authorization Notice (MA 328).

NOTE: AN APPROVED PRIOR AUTHORIZATION REQUEST MEANS ONLY THAT THE SERVICE WAS DETERMINED MEDICALLY NECESSARY, BUT IT DOES NOT GUARANTEE THE BENEFICIARY'S MA ELIGIBILITY. IT IS THE RESPONSIBILITY OF THE PROVIDER, AS WELL AS THE PRESCRIBER, TO VERIFY THE BENEFICIARY'S ELIGIBILITY THROUGH THE ELIGIBILITY VERIFICATION SYSTEM (EVS), NOT ONLY ON THE DATE THE SERVICE IS REQUESTED, BUT ALSO ON THE DATE THE SERVICE IS PERFORMED/PROVIDED.

7.3.1.1 Prior Authorization and Program Exception Review of Hyperbaric Oxygen Therapy in Full Body Chamber

- I. General Requirements for Prior Authorization and Program Exception Requests for Hyperbaric Oxygen Therapy in a Full Body Chamber
 - A. Hyperbaric Oxygen Therapy services in a Full Body Chamber That Requires Prior Authorization
 - B. Hyperbaric Oxygen Therapy Services in a Full Body Chamber That Require a Program Exception
 - C. Emergency Services
 - D. Retrospective Reviews
- II. Procedures for Requesting Prior Authorization or a Program Exception for Hyperbaric Oxygen Therapy Services in a Full Body Chamber
 - A. Initiating the Prior Authorization or Program Exception Request
 - B. Information and Supporting Documentation that Must Be Available for the Prior Authorization or Program Exception Review
 - C. Documentation Supporting the Need for a Service That Requires Prior Authorization or a Program Exception
 - D. Review of Documentation for Medical Necessity
 - E. Clinical Review Processes
 - F. Timeframe of Review
 - G. Notification of Decision
 - H. Denials
 - I. Prior Authorization or Program Exception Number
- III. Procedures to Submit Claims
 - A. Submission of Claims
 - B. Claims for Emergency Room Services
- I. GENERAL REQUIREMENTS FOR PRIOR AUTHORIZATION AND PROGRAM EXCEPTION REQUESTS FOR HYPERBARIC OXYGEN THERAPY SERVICES IN A FULL BODY CHAMBER**
 - A. Hyperbaric Oxygen Therapy Services in a Full Body Chamber That Require Prior Authorization
 1. Hyperbaric oxygen therapy services provided in a full body chamber in the hospital outpatient setting.

2. Hyperbaric oxygen therapy services provided in a full body chamber on an outpatient basis to a Medical Assistance (MA) beneficiary who is admitted to an inpatient facility.

B. Hyperbaric Oxygen Therapy Services in a Full Body Chamber That Require a Program Exception (1150 Waiver)

1. A request for hyperbaric oxygen therapy services in a full body chamber that exceeds the MA Program Fee Schedule limit of 4 units per day.

C. Emergency Services

Retrospective authorization or program exception is required for hyperbaric oxygen therapy services in a full body chamber that is provided in the hospital outpatient setting on an emergency basis. The request must be submitted within thirty (30) days of the date of service, following the procedure in Section II. If it is determined that the service was not provided to treat an emergency medical condition or was not found to be medically necessary, as set forth in Department regulations and program bulletins, the prior authorization or program exception request will be denied.

D. Retrospective Reviews

Retroactive MA Eligibility

A prescriber may request authorization for outpatient hospital claims for hyperbaric oxygen therapy services in a full body chamber provided to individuals who are determined to be eligible for MA retroactively (“late pickups”). The request must be submitted within thirty (30) days of the date the provider receives notice of the eligibility determination, following the procedure in Section II. If it is determined that the service was not medically necessary, the authorization request will be denied.

Individuals with Third Party Resources

For those individuals with Third Party Resources, including Medicare and private insurance, the Department will not require PA or PE approval of hyperbaric oxygen therapy services prior to the service being performed. In these instances, the rendering provider will submit its claim for cost sharing to the MA Program in the usual manner as set forth in the CMS 1500 Billing Guide for PROMIS^e™. If the Third Party Resource denies payment for the hyperbaric oxygen therapy service or pays less than the MA Program fee, the prescriber may request retrospective approval from the Department within 30 days of the date of the Third Party Resource Explanation of Benefits (EOB).

II. PROCEDURE FOR REQUESTING PRIOR AUTHORIZATION OR A PROGRAM EXCEPTION FOR HYPERBARIC OXYGEN THERAPY SERVICES IN A FULL BODY CHAMBER

A. Initiating the Prior Authorization or Program Exception Request

1. Who May Initiate the Request

The prescribing practitioner must request prior authorization or a program exception.

2. How to Initiate the Request

The Department accepts prior authorization requests for prior authorization by telephone at 1-800-537-8862, choose Option 1, then choose Option 3, and then choose Option 2, between 7:30 a.m. - 12 p.m. and 1:00 p.m. - 4:00 p.m. Monday through Friday.

B. Information and Supporting Documentation that Must Be Available for the Prior Authorization Review

The information required at the time prior authorization is requested includes the following:

1. Prescribing practitioner's name, address, and office telephone number, or prescribing practitioner's Medical Assistance Identification (MAID) number and National Provider Identifier (NPI) number/taxonomy/zip code
2. Rendering provider's or facility's MAID number and NPI number/taxonomy/zip code
3. Beneficiary's name and Medical Assistance Identification number
4. Procedure code of the requested service
5. Diagnosis and ICD-9 or ICD-10, as applicable, diagnosis code
6. Clinical information to support the medical necessity for the requested service, including:
 - a. Symptoms and their duration
 - b. Physical examination findings
 - c. Corresponding laboratory and/or imaging reports
 - d. Treatments the beneficiary has received
 - e. Reason the service is being requested
 - f. Specialist reports or evaluations
 - g. Clinical notes

C. Documentation Supporting the Need for a Service that Requires Prior Authorization or a Program Exception

The clinical information provided during the course of the prior authorization or program exception review must be verifiable within the patient's medical record. Upon retrospective review, the Department may seek restitution for the payment of the service and any applicable restitution penalties from the prescriber if the medical record does not support the medical necessity for the service. See 55 Pa.Code § 1101.83(b).

D. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of hyperbaric oxygen therapy services in a full body chamber (HBOT), the determination of whether the requested service is medically necessary will take into account whether the beneficiary:

1. Has a diagnosis of Type I or Type II Diabetes.

AND

2. Chronic, severe, or gangrenous diabetic lower extremity wound(s) that is (are) a Wagner grade 3 or higher.

AND

3. The wound(s) have no documented measurable improvement in the last 30 days of standard wound therapy.

OR

4. Has compromised skin grafts or flaps (not for the primary management of wounds) and the graft or flap has no documented measurable improvement of the wound(s) in the last 30 days of standard wound therapy.

OR

5. Has a diagnosis of active radionecrosis (osteoradionecrosis, myoradionecrosis, brain radionecrosis, and other soft tissue radiation necrosis).

OR

6. Has a diagnosis of radiation proctitis.

OR

7. Is undergoing dental surgery of a radiated jaw and requires prophylactic pre- and post-treatment.

OR

8. Has a diagnosis of idiopathic sudden deafness, acoustic trauma or noise-induced hearing loss within the past 3 months.

OR

9. Chronic refractory osteomyelitis that has been unresponsive to conventional medical and surgical management.

E. Clinical Review Process

Prior authorization nurse reviewers will review the request for prior authorization and apply the clinical guidelines in Section D. above, to assess the medical necessity of the requested service. If the nurse reviewer determines that the requested service meets the medical necessity guidelines, then the nurse reviewer will approve the request. If the nurse reviewer determines that the guidelines are not met, then the request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization or a program exception may be approved when, in the professional judgment of the physician reviewer, the service is medically necessary to meet the medical needs of the beneficiary.

F. Timeframe for Review

The Department will make a decision on the prior authorization request within two (2) business days of receiving all information reasonably needed to make a decision regarding the medical necessity of the services. A decision may be made during the call if sufficient information is provided at that time. If additional information is requested and not received by the 15th day of the date of initial request, the request will be denied for lack of sufficient information.

The Department will make a decision on a program exception request based on the regulations set forth at 55 Pa.Code § 1150.63 within 21 days of receiving the request for a beneficiary less than 21 years of age.

G. Notification of Decision

The Department will issue a written notice of the decision to the beneficiary, the prescribing provider and the rendering provider (if applicable).

NOTE: An approved prior authorization or program exception request means only that the service has been determined to be medically necessary. It does not address the beneficiary's eligibility for the service on the date of service. It is the responsibility of the rendering provider to verify the beneficiary's eligibility through the Eligibility Verification System (EVS) on the date the service is provided.

H. Denials

If a prior authorization or program exception request is denied or approved other than as requested, the beneficiary has the right to appeal the Department's decision. The beneficiary has thirty (30) days from the date on the prior authorization notice to submit an appeal in writing to the address listed on the notice.

I. Prior Authorization or Program Exception Number

If the prior authorization or program exception request is approved, the Department will issue a prior authorization or program exception

number, which is valid for the time period not to exceed a maximum of thirty (30) calendar days.

J. Duration of Approvals

A prior authorization or program exception approval is valid for a maximum of thirty (30) calendar days.

K. Subsequent Approvals

If the treatment period exceeds thirty (30) calendar days, the provider must contact the Department by telephone at 1-800-537-8862 to request reevaluation and update the prior authorization or program exception every thirty (30) days.

III. PROCEDURES TO SUBMIT CLAIMS

A. Submission of Claims

Follow the instructions for submitting a claim for approved hyperbaric oxygen therapy under pressure found in the General Hospitals (including Outpatient Hospital Clinic, Emergency Room, Hospital Short Procedure Unit (SPU), and Outpatient Rehabilitation Hospital providers) billing guide on the Department's website at the following address:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/s_001877.pdf

Follow the instructions for submitting a claim for approved hyperbaric oxygen therapy under pressure as a program exception found in the Claims Submission Instructions for Services Approved via the 1150 Administrative Waiver on the Department's website at the following address:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/s_001859.pdf

Providers who are unable to access the billing guide online may obtain a hard copy by calling 1-800-537-8862, prompt 4.

Follow the instructions for submitting an internet claim for approved hyperbaric oxygen therapy under pressure found in the PROMIS^e™ Provider Internet User Manual on the Department's website at the following address:

<http://promise.dpw.state.pa.us/promisehelp/manuals/promiseproviderinternetusermanual.pdf>

B. Claims for Emergency Room Services

When hyperbaric oxygen therapy under pressure is provided as part of an emergency room treatment where the beneficiary is admitted directly to the inpatient setting from the emergency room, the service must be included on the inpatient invoice rather than being billed as an outpatient claim.

7.3.2 Exceptions

In the event that a beneficiary is in immediate need of a service or item requiring prior authorization, and the situation **is an emergency**, the prescriber may indicate that the prescription be filled by the provider before submitting the MA 97. The prescriber must still complete and submit the MA 97 for review. This request will be examined in the same manner as an initial request for prior authorization.

If DHS determines that the beneficiary's circumstances did not constitute an emergency situation and the MA 97 is denied, the **provider will not be compensated** for the service or item provided.

7.3.3 Steps for Payment

When the **provider** is presented with the recipient's prescription, the **provider** fills the prescription and completes an invoice in accordance with existing instructions for completion of the CMS-1500 Claim Form.

Upon completion, the **provider** submits the original invoice to DHS for processing, while retaining a file copy. The **provider** should submit the CMS-1500 to the regular address for claim submission:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8194
Harrisburg, PA 17105-8194

7.4 1150 Administrative Waiver (Program Exception)

The Department may, under extraordinary circumstances, pay for an item which is not on the MA Program Fee Schedule through the PE process. See 55 Pa.Code §1150.63(b). In addition, providers may request a PE when seeking an exception to the rate for an item on the MA Program Fee Schedule or when seeking to provide an item in a quantity that exceeds the limits on the MA Program Fee Schedule.

In order to assist the Department in establishing a price for an item that is not on the MA Program fee schedule, or to evaluate a request for a PE seeking an exception to the established rate, PE requests must include documentation, more fully described below, of the Manufacturer's Suggested Retail Price (MSRP) and the adjusted acquisition cost.

The MSRP is the price at which the manufacturer recommends retailers sell their product(s).

The adjusted acquisition cost is the actual cost of an item, after discounts and rebates, to the medical supplier/manufacturer. It does not include the following costs:

- Delivery or shipping costs (including postage and handling)
- Labor costs (including assembly, repair or fitting)
- Operating expenses (including insurance costs)

PE requests to exceed the quantity limits will be approved if determined medically necessary by the Department and will be paid at the established MA Program fee schedule rate and, therefore, are not subject to the documentation requirements set forth in subsection 7.4.2 below.

7.4.1 Procedures for Obtaining an 1150 Administrative Waiver

When a MA beneficiary is in need of an item requiring a PE, the physician prescriber completes two copies of a prescription detailing all components of the item prescribed for the MA beneficiary. One prescription is given to the MA beneficiary to provide to the medical supplier. The submitting physician prescriber completes the 1150 Waiver (Program Exception) section of the Outpatient Services Authorization Request (MA 97) form in accordance with form directions and places a check mark in block number 2 on the form, which identifies the request as an 1150 Waiver (Program Exception) request.

The physician prescriber or medical supplier (on behalf of the physician prescriber) submits the completed MA 97 form, with a copy of the MA beneficiary's prescription, documentation supporting medical necessity, and information required to determine pricing, in the envelope (ENV K-320) provided by the Department to the appropriate address listed on the cover sheet of the MA 97 form. The nationally recognized procedure code for the service or item for the Program Exception request must be reflected on the MA-97 Form. If the service or item being requested does not have a nationally recognized code, then a thorough description of the service or item being requested must be provided. Medical justification must be provided for the item or limit expansion being requested and the request must include a reason why the item or limit on the MA Program Fee Schedule is not adequate. The provider places an additional copy of the prescription in the recipient's medical file kept in the provider's office.

Once the Program Exception request is received, the Department will approve, approve other than requested, or deny the request. Notification of the Department's decision will be sent to the physician prescriber and the MA beneficiary by means of a Notice of Decision.

Please note: An approved 1150 Administrative Waiver/PE request means only that the service or item was determined medically necessary; it does not guarantee the beneficiary's eligibility. It is the responsibility of the prescriber, as well as the provider, to verify the beneficiary's eligibility through the eligibility verification system (EVS); not only on the date the service or item is requested, but also on the date the service or item is performed or provided.

7.4.2 Documentation Requirements for 1150 Administrative Waiver Requests for Durable Medical Equipment and Medical Supplies

Providers must include documentation of the adjusted acquisition cost and the MSRP with PE requests.

- Providers that have already purchased the item must submit an invoice for the item with the PE request.

- Providers that have not purchased the item, but have received a cost quote from the manufacturer, must submit the cost quote with the PE request.
- If the PE request is being submitted by a medical supplier that is not the manufacturer, the documentation should be submitted on the letterhead of the manufacturer or distributor from whom the medical supplier ordered the item.
- If the PE request is being submitted by a manufacturer, the documentation should be submitted on its own letterhead with a statement that it is the manufacturer.
- If the PE request is being submitted by a distributor, the distributor should submit the documentation on the letterhead of the company from which the requested item was acquired.

This information, along with the information provided to establish medical necessity, must be provided in order for the Department to process PE requests for DME, medical supplies, prosthetics and orthotics.

All invoices for PE requests to the Department must be unaltered, fully legible, on the medical supplier, manufacturer, or distributor letterhead, and must include the following:

1. The supplier/manufacturer/distributor letterhead must include the following:
 - Supplier/manufacturer/distributor name
 - Complete address
 - Customer Service telephone number
 - Customer Service fax number
2. Complete "Invoice to" information
3. Complete "Ship To" information which includes name of the beneficiary/supplier receiving the item, street address, city, state and zip code
4. The date of the invoice
5. The invoice number
6. Product name
7. Serial number (if applicable)
8. Product model number
9. Item number
10. Full item description
11. The unit of measure and quantity of defined unit (examples: pair= 2, set= 3, case= 35, box= 10, and package= 60)
12. The MSRP per unit of measure
13. The adjusted acquisition cost per unit of measure for each item purchased, including any and all other discount(s), rebates, refunds or other price-reducing allowances (e.g. full payment terms)
14. Sales tax, shipping, handling, delivery, postage, insurance costs, labor costs, operating expenses and any other charges imposed shall be individually identified

Acceptable documentation for all cost quotes for PE requests to the Department must be unaltered, fully legible, on the medical supplier, manufacturer, or distributor letterhead from which the item(s) are being ordered and must include the following:

1. The supplier/manufacturer/distributor letterhead must include the following:
 - Supplier/manufacturer/distributor name
 - Complete address
 - Customer Service telephone number

- Customer Service fax number
2. Complete “Quote To” information
 3. Complete “Ship To” information which includes the name of the supplier receiving the item, street address, city, state and zip code
 4. The date of the quote
 5. The date the quote expires
 6. Quote number
 7. Product name
 8. Serial number (if applicable)
 9. Product model number
 10. Item number
 11. Full item description
 12. The unit of measure and quantity of defined unit (e.g. pair = 2, set = 3, case = 35, box = 10 & package = 60)
 13. The MSRP per unit of measure
 14. The adjusted acquisition cost per unit of measure for each item purchased, including any and all other discount(s), rebates, refunds or other price-reducing allowances (e.g. full payment terms)
 15. Sales tax, shipping, handling, delivery, postage, insurance costs, labor costs, operating expenses and any other charges imposed shall be individually identified
 16. Customer number
 17. Applicable national procedure code(s)

For all PE requests approved based upon a cost quote, providers must submit the final paid invoice depicting the above (1–17) information to the Department at the following address within 30 days after the item is purchased:

Commonwealth of Pennsylvania
 Department of Human Services
 Office of Medical Assistance Programs
 Bureau of Fiscal Management
 Division of Hospital and Outpatient Rate Setting
 Commonwealth Tower, 6th Floor
 P.O. Box 2675
 Harrisburg, Pennsylvania 17105

The MSRP may be incorporated into the document that contains the invoice or cost quote. All MSRPs, invoices or cost quotes submitted to the Department as required documentation in association with a PE request must be personally signed (including printed name) and dated by an authorized representative of the medical supplier, manufacturer or distributor.

7.4.3 Exceptions

In the event that a beneficiary is in immediate need of a service or item requiring an 1150 Administrative Waiver, and the situation is an emergency, the prescriber may indicate that the prescription be filled by the provider before submitting the MA 97. The prescriber must still complete and submit the MA 97 for regular review. This request will be examined in the same manner as an initial request for an 1150 Administrative Waiver.

If DHS determines that the beneficiary's circumstances did not constitute an emergency situation and the MA 97 is denied, the provider will not be compensated for the service or item dispensed.

7.4.4 Steps for Payment

When the provider is presented with the beneficiary's prescription, the provider fills the prescription and completes a claim form in accordance with existing instructions for completion of the CMS-1500 Claim Form. Upon completion, the provider submits the original claim form to DPW for processing. (The provider should make a copy of the claim form for his/her file.) The provider should submit the CMS-1500 to the regular address for claim submission:

Department of Public Welfare
Office of Medical Assistance Programs
P.O. Box 8194
Harrisburg, PA 17105-8194

7.5 Benefit Limit Exception for a Drug Prescription

Effective January 1, 1993, DHS implemented a benefit limit of six prescriptions per month for GA eligible recipients, 21 years of age and older.

Effective August 10, 2005, DHS established criteria and a process to grant an exception to the benefit limit of six prescriptions/refills per month.

Effective January 3, 2012, DHS established a benefit package limit of six prescriptions per month for categorically needy adult MA eligible recipients, 21 years of age and older, as well as criteria and a process to grant an exception to the benefit limit. The criteria and exception process for GA eligible adult recipients are revised to meet the same criteria and process established for categorically needy MA adults. This pharmacy benefit package limit change does not apply to MA recipients who are under 21 years of age, are pregnant, including the postpartum period, or reside in a nursing facility or an intermediate care facility. When the pharmacist determines that the MA recipient is pregnant or resides in a nursing facility or intermediate care facility, the pharmacist should enter the appropriate pregnancy indicator or patient residence code as specified in the Pennsylvania PROMIS^e™ – NCPDP Version D.0 Desk Reference Guide for PROMIS^e™. This will ensure that the claim is not denied as exceeding the benefit limit. Pharmacists may refer to the Pennsylvania PROMIS^e™ – NCPDP Version D.0 Desk Reference Guide for PROMIS^e™ at:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/p_002931.pdf

7.5.1 Criteria for a Benefit Limit Exception

An exception to the numerical limit on prescription for drugs will be granted when:

- DHS determines the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the recipient; or

- DHS determines the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the recipient; or
- DHS determines that granting a specific exception is a cost effective alternative for the MA Program; or,
- DHS determines that granting an exception is necessary in order to comply with Federal law.

7.5.2 Automatic Approval of a Benefit Limit Exception

An exception to the limit of six prescriptions for drugs may be granted automatically at the point of sale pharmacy when a claim is submitted for payment by the MA Program, the six prescription limit is exceeded, and the prescription is for a drug in one of the classes listed below, and, if applicable, that the recipient's claim history record shows the specific diagnosis or condition listed below:

- Antianginal medications.
- Antiarrhythmic medications.
- Anticoagulant/Antiplatelet medications.
- Anticonvulsant medications, when there is a paid claim for the same drug, in the past 90 days, or a paid claim* with a diagnosis of seizure or bipolar diagnosis, in the past 365 days.
- Antidepressant medications, when there is a paid claim*, in past 180 days, with a diagnosis of depression.
- Antiemetics, when there is claim in past 90 days for a cancer medication or a paid claim* with a diagnosis of cancer, or pancreatitis, in the past 180 days.
- Antihypertensive medications, when there is a paid claim*, in the past 365 days, with diagnosis of angina, coronary artery disease (CAD), myocardial infarction (MI), **cerebrovascular** stroke (CVS), chronic renal insufficiency (CRI), chronic renal failure (CRF), diabetes mellitus (DM), hypertension (HTN), or glaucoma.
- Antiinfective medications, when there is a paid claim, in the past 90 days, for immunosuppressant, cancer or multiple sclerosis medications or a paid claim*, in the past 180 days, with a diagnosis of HIV, cancer, transplant, sickle cell anemia or diabetes.
- Antiparkinsons medications.
- Antipsychotic medications.
- Asthma and chronic obstructive pulmonary disease (COPD) medications.

- Cancer medications.
- Diabetes medications.
- Enzyme deficiency agents.
- Family planning agents.
- Glaucoma medications.
- Hemophilia agents.
- Hepatitis medications.
- HIV/AIDS medications.
- Immune deficiency agents.
- Immunosuppressants.
- Mood stabilizers.
- Multiple sclerosis medications.
- Narcotics, when there is a paid claim*, in the past 180 days, with a diagnosis of cancer or sickle cell anemia.
- Opiate dependency agents.
- Oral steroids.
- Proton pump inhibitors, when there is a paid claim*, in past 180 days, with a diagnosis of gastrointestinal (GI) bleed, Barrett's esophagitis or Zollinger Ellison.
- Pulmonary hypertension medications.
- Thyroid medications.
- Triptans.

**Paid Claim = professional, inpatient, outpatient or long term care claim paid by the MA Program for the recipient.*

7.5.3 Request for a Benefit Limit Exception

- The prescriber may request a benefit limit exception (BLE) when the recipient meets the numerical limit of six prescriptions for that calendar month, an exception is not granted automatically at the pharmacy, and the prescriber determines that the recipient meets the criteria for an exception.

- Pharmacists may dispense up to a 5-day emergency supply of a prescribed medication without a BLE approval, if, in the professional judgment of the pharmacist, the recipient has an immediate need for the medication and not supplying the medication would result in serious impairment to a recipient's health. A prescription for a pharmacy item dispensed as an emergency supply does not count toward the six prescriptions per month limit.
- The prescriber requests approval for a BLE by faxing the Pharmacy Benefit Limit Exception Request Form to MA Pharmacy Services at 1-866-327-0191; or, if the prescriber does not have access to a fax machine, by calling MA Pharmacy Services at 1-800-537-8862. The following information is required from the prescriber:
 - Recipient name, address, date of birth, and ACCESS card ID number.
 - The prescriber's name, specialty, National Provider Number (NPI), state medical license number, address, telephone and fax numbers.
 - Information about the drug that is being requested including the drug name, strength, quantity, directions, day supply, and anticipated duration of the regimen.
 - Copies of documentation from the recipient's medical record supporting the criterion for the benefit limit exception.
 - ICD-9-CM Diagnosis Code(s) or diagnosis.
- The DHS medical reviewer determines whether the request should be approved or denied. A determination is made within 24 to 72 hours, once DHS receives all of the required medical documentation.
- DHS will notify the prescribing provider by return fax or telephone indicating whether the request for an exception to the pharmacy benefit limit is approved or denied.
- DHS will also send a written Notice of Decision to the prescribing provider and the recipient.
- Only the recipient has the right to appeal the denial.
- If the BLE request is approved, the prescriber obtains an authorization number for the approval and includes that number on the prescription.
- When a PA for a drug is indicated for a reason other than a BLE, such as for an excessive quantity, a clinical review, or medical necessity for a non-preferred drug, the prescribing provider must also obtain approval from DHS that specifically addresses all PA requirements.

8 REMITTANCE ADVICE

The Remittance Advice (RA) Statement explains the actions taken and the status of claims and claim adjustments processed by DHS during a daily cycle. The processing date on the RA statement is the computer processing date for the cycle. Checks corresponding to each cycle are mailed separately by the Treasury Department.

The first page of the RA is used as a mailing label and contains the “Address” where the RA is being sent. This is followed by the “Detail” page(s) that list all of the invoices processed during the PA PROMIS[™] daily cycle. The next page is a “Summary” of activity from the detail page(s). Finally, the last page(s) is the Explanation of Edits Set This Cycle page(s).

8.1 Remittance Advice Address Page

The RA Address Page contains the address where the RA Statement is to be mailed and is used as a mailing label.

Providers may also find a Remittance Advice (RA) Alert on this page.

8.2 Remittance Advice Detail Page

The detail pages of the RA statement contain information about the invoices and claim adjustments processed during the daily cycle.

Claim form information contained on the detail pages is arranged alphabetically by recipient last name. If there is more than one provider *service location code*, claims will be returned on separate RA Statements as determined by each service location.

8.3 Remittance Advice Summary Page

This page contains information summarizing all action taken on your claims during the daily cycle.

8.4 PA PROMIS[™] “Explanation of Edits Set this Cycle” Page

The Explanation of Edits Set this Cycle is always the last page(s) of the RA Statement. This page contains a list of the Explanation Codes or Comments that appear on the RA Detail page(s) for this daily cycle. To the right of each Explanation Code is the description of the code.

8.5 Invoice Reconciliation Method for Pharmacies Submitting the CMS-1500 Claim Form for Medical Supplies/Durable Medical Equipment (DME)

The daily RA statement reconciles submitted invoices with MA claims processing activities. By itself, the RA statement will not serve as an accounts receivable report because:

- Suspended claims will be processed in more than one daily computer run. Therefore, the difference between claims processed over a certain time period and the paid/rejected claims during the same period may not equal outstanding submitted invoices.
- The amount billed by the provider indicates the usual and customary charges and will ordinarily not equal the MA paid-in-full amount for services as determined by the MA Program Fee Schedule

To determine the “accounts receivable”, you should develop a “reconciliation” system. As an example, some providers use the following method:

- Step 1. Your copy of invoices that were submitted to DHS is placed in a "submitted" or "suspended" file. They are filed by date of submission to DHS. Within each submission date batch, the file copies are in alphabetical order by the recipient's last name.
- If you have arranged with DHS to use different service locations or payees, then you should have a separate submitted invoice file for each service location or payee. Your RA statement will be organized first by service location, then by recipient name in alphabetical order.
- It is very important that you enter your own reference number (i.e., patient account number) or patient's name in Block 26 (Patient's Account Number) of the CMS-1500 to comply with your own filing system. The information entered into this box is listed in the first column of the RA statement. This information can be used to identify the patient on claims whenever the name of the recipient does not appear on the RA statement. If DHS cannot identify the patient due to an inaccurate recipient number, a blank space will appear on the RA Statement where the recipient's name usually appears. When this situation occurs, the information entered on the invoice in Block 26 of the CMS-1500, will enable you to identify the patient and keep your own records up to date.
- Step 2. Each additional batch of invoices that is submitted is added to the back of the submitted/suspended file so that the oldest file copies are in the front and the most recent are in the back.
- Step 3. Each time you receive an RA statement from DHS, the "submitted file" is compared to the RA statement.
- If an invoice has been approved and "paid", that invoice is removed from the submitted file and placed with the provider's permanent financial records.

- If there was an overpayment or underpayment, a claim adjustment is submitted. The file copy of the claim adjustment is added to the submitted file.
- If an invoice has been identified as "denied", the file copy of that invoice is removed from the submitted file.
 - If the denied invoice is one that DHS should not pay, (for example, the recipient is ineligible or the service is not covered), then the invoice is placed in your permanent record.
 - If the denied invoice is one you believe DHS should pay, then prepare and submit a new invoice with the correct information. Correct information may be found in the provider's records or secured from the recipient. If the Explanation Code indicates that it is a recipient eligibility related problem, access EVS to verify recipient eligibility. For all other problems, contact DHS. The provider copy of the resubmitted invoice is added to the resubmitted file as a regular invoice under the new date of submission.

Step 4. All file copies of submitted claims that are identified on the RA statement as suspended are left in your submitted file for comparison with future RA statements.

Step 5. If an invoice does not appear on an RA Statement as approved, denied, or suspended within 45 - 50 days after submission, resubmit the claim immediately. If you have Internet access, go to the PA PROMIS^e™ Internet site at: <http://promise.dhs.state.pa.us/> to check the status of the claim or contact the Provider Inquiry Unit and request claim status. In most cases, invoices will appear on an RA Statement 25-35 calendar days after submission. This reconciliation system will not only make it easier to reconcile your submitted claims with DHS's processing actions, but it will give you a quick indicator of the number of outstanding claims. It will also give you an approximate age (by submission date) of the outstanding claims.

9 HIPAA REQUIREMENTS

This section includes how the Health Insurance Portability and Accountability Act (HIPAA) requirements were implemented and applied in the PA PROMIS^e™ Program. This section also describes how providers can become certified to submit HIPAA transactions and code sets. Additionally, the handbook will provide information on how the HIPAA security rules will protect private information in the PA PROMIS^e™ Program.

9.1 Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) became public law on August 21, 1996. It is a federal bi-partisan law based on the Kennedy-Kassebaum bill. The Department of Health and Human Services assigned the Centers for Medicare & Medicaid Services (CMS) the task of implementing HIPAA. The primary goal of the law was to make it easier for people to keep health insurance, and help the industry control administrative costs.

HIPAA is divided into five Titles or sections. Title I is Portability and has been fully implemented. Portability allows individuals to carry their health insurance from one job to another so that they do not have a lapse in coverage. It also restricts health plans from imposing pre-existing condition limitations on individuals who switch from one health plan to another.

Title II is called Administrative Simplification. Title II is designed to:

- Reduce health care fraud and abuse;
- Guarantee security and privacy of health information;
- Enforce standards for health information and transactions; and
- Reduce the cost of healthcare by standardizing the way the industry communicates information. Titles III, IV, and V have not yet been defined.

The main benefit of HIPAA is standardization. HIPAA requires the adoption of industry-wide standards for administrative health care transactions; national code sets; and privacy protections. Standards have also been developed for unique identifiers for providers, health plans and employers; security measures; and electronic signatures.

9.1.1 Administrative Simplification

The goal of administrative simplification is to reduce health care administrative costs and promote quality and continuity of care by facilitating electronic data interchange (EDI). HIPAA establishes standards for 10 electronic health care transactions, national code sets, and unique identifiers for providers, health plans, employers, and individuals. It also establishes standards for ensuring the security of electronic health care transactions.

Although industry use of EDI is growing, health care transactions are transported and processed in various file structures and record layouts.

It is important to remember two things:

1. HIPAA does not require providers to submit claims or receive remittance advice statements electronically.
2. It also does not directly address paper claims.

9.1.2 Transactions Adopted

837 Professional	NCPDP 5.1 Claim	270 Eligibility Request
837 Institutional Inpatient	NCPDP 5.1 Reversal	271 Eligibility Response
837 Institution Nursing Home	NCPDP 5.1 Eligibility	
837 Dental	NCPDP 1.1 Batch	
835 Remittance Advice		

9.1.3 Code Sets Adopted

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD- 9-CM)	Diagnoses (all services) and Inpatient Hospital Procedures
National Drug Codes (NDC)	Drugs, Biologicals
Current Dental Terminology, fourth edition (CDT-4)	Dental Services
Current Procedural Terminology, fourth edition (CPT-4)	Physician and all other services
CPT-4 – Healthcare Common Procedural Coding System (HCPCS) Level II	Medical equipment, injectible drugs, transportation services, and other services not found in CPT-4
CMS Health Care Claim Adjustment Reason Codes and Remittance Advice Remark Codes	

9.1.4 Software Options Available

Providers have four options for selecting software used to submit HIPAA-ready transactions to Pennsylvania Medical Assistance.

- Request Provider Electronic Solutions (PES) software (provided free-of-charge).
- Purchase certified HIPAA software from your vendor of choice.
- Program your own system software.
- Use a clearinghouse that uses HIPAA certified software.

All providers planning to submit HIPAA-ready claims, regardless of the origin of their software, need to register and be certified by HPE, DHS's claims processing contractor, prior to submitting their first claim. To register, please go to <https://promise.dpw.state.pa.us/ePROM/ProviderSoftware/softwareCertificationForm.asp> and complete the registration form. If you do not have Internet access, please call 717-975-6085, and leave your name and telephone number. A certification expert will contact you to complete the registration process.

9.1.5 HIPAA Claim Transaction Certification

For HIPAA-compliant transactions to be submitted, there is a certification process that involves registration and testing. When you register for certification, you must indicate the type of transactions you will be sending/receiving.

It is vital that you complete the certification process and become certified to exchange HIPAA transactions. Without certification, your files will not be accepted and your claims will not be processed.

Certification does not insure that claims will be paid.

9.1.5.1 Provider Electronic Solutions Software

If you are looking for a way to send and receive HIPAA-ready electronic transactions and determine recipient eligibility, consider the Provider Electronic Solutions software. You can submit the following transaction types:

- EVS transactions (interactive and batch)
- Professional Claims (837P)
- Dental Claims (837D)
- Institutional Claims (837I)
- Long Term Care Claims (837I)
- Electronic Remittance Advice (835)
- Pharmacy Claims, Eligibility, and Extended Reversals (NCPDP 5.1)

NOTE: For more information on Provider Electronic Solutions software click on <http://promise.dpw.state.pa.us/ePROM/ ProviderSoftware/softwareDownloadMain.asp>

Follow the directions to download the software.

NOTE: This software is available to you free-of-charge, and runs on Microsoft Windows operating systems on IBM compatible computers.

9.1.5.2 PA PROMIS^e™ Internet Providers

Providers who submit claim transactions directly through the PA PROMIS^e™ Internet Application do *not* require certification because this application is built to be HIPAA compliant. However, you are required to be an active provider in PA PROMIS^e™. You will also need a valid log on ID and a username and password to access PA PROMIS^e™.

9.1.5.3 Software Vendors/Developers

Clearinghouses, software vendors and developers distributing software to providers are required to certify through HPE. Upon successful certification, each vendor/developer will be assigned a Terminal ID. The software vendor/developer will provide this number to their users when distributing software. Providers who submit claims through a clearinghouse are covered under the clearinghouse's certification.

837/835 submitters:

- Clearinghouses and providers/submitters directly interacting electronically with the HPE clearinghouse must certify (this also includes providers using certified software purchased from a vendor).
- Providers submitting claims through a clearinghouse are covered under the clearinghouse's certification.

NCPDP 5.1 vendors:

- Software vendors and developers distributing software to providers must certify.
- Vendors of interactive software are also required to certify with Emdeon Business Services.

NCPDP 5.1 interactive submitters:

- Submitters using certified software are covered under the software vendor's certification

- Interactive submitters using certified vendor software will not be required to obtain an HPE HIPAA clearinghouse ID but will be required to register with Emdeon Business Services.

NCPDP 1.1 batch submitters:

- Submitters using certified software are covered under the software vendor's certification.
- Each provider who submits batch transactions using certified vendor software is responsible for obtaining an HPE HIPAA clearinghouse ID that grants access to the HPE clearinghouse system.

270/271 vendors:

- Software vendors and developers distributing software to providers must certify.

270/271 interactive submitters:

- Submitters using certified software are covered under the software vendor's certification

270/271 batch submitters:

- Submitters using certified software are covered under the software vendor's certification.
- Each submitter is responsible for obtaining an HPE HIPAA clearinghouse ID that grants access to the HPE clearinghouse system.

278 Prior Authorization:

- Submitters using certified software are covered under the software vendor's certification.
- Each submitter is responsible for obtaining an HPE HIPAA clearinghouse ID that grants access to the HPE clearinghouse system.

Register for PROMIS^e™ certification by visiting the DHS website:

<http://promise.dpw.state.pa.us/ePROM/ProviderSoftware/softwareDownloadMain.asp>

Click on the "PROMIS^e™ Certification Registration Form" link. After you complete and electronically submit the registration form, an HPE representative will contact you to explain the certification process. If you do not have Internet access or need help completing the PROMIS^e™ Certification Registration Form, call the HPE Provider Service Center's toll-free telephone line at 1-800-248-2152 (Harrisburg area residents may call 717-975-4100).

9.2 HIPAA Privacy

The HIPAA Privacy Rule became effective on April 14, 2001 and was amended on August 14, 2002. It creates national standards to protect medical records and other protected health information (PHI) and sets a minimum standard of safeguards of PHI.

The regulations impact covered entities that are health care plans, health care clearinghouses and health care providers. Most covered entities, except for small health plans, must comply with the requirements by April 14, 2003. DHS performs functions as a health care plan and health care provider. Any entity having access to PHI must do an analysis to determine whether it is a covered entity and, as such, subject to the HIPAA Privacy Regulations.

9.2.1 Requirements

Generally, the HIPAA Privacy Rule prohibits disclosure of PHI except in accordance with the regulations. All organizations, which have access to PHI must do an analysis to determine whether or not it is a covered entity. The regulations define and limit the circumstances under which covered entities may use or disclose PHI to others.

Permissible uses under the rules include three categories:

1. Use and disclosure for treatment, payment and healthcare operations;
2. Use and disclosure with individual authorization; and
3. Use and disclosure without authorization for specified purposes.

The HIPAA Privacy Regulations require Covered Entities to:

- Appoint a privacy officer charged with creating a comprehensive Privacy Policy.
- Develop minimum necessary policies.
- Amend Business Associate contracts.
- Develop accounting of disclosures capability.
- Develop procedures to request alternative means of communication.
- Develop procedures to request restricted use of PHI.
- Develop complaint procedures.
- Develop amendment request procedures.
- Develop individual access procedures.
- Develop an anti-retaliation policy.
- Train the workforce.

- Develop and disseminate the Privacy Notice.

9.2.2 Business Associate Relationships

As a covered entity, DHS must have safeguards in place when it shares information with its Business Associates. A Business Associate is defined by the HIPAA Privacy Regulation as a person or entity, not employed by the covered entity, who performs a function for the covered entity that requires it to use, disclose, create or receive PHI. The covered entity may disclose PHI to a Business Associate if it receives satisfactory assurances that the Business Associate will appropriately safeguard the information in accordance with the HIPAA requirements. These assurances are memorialized in a Business Associate Agreement that may or may not be part of a current contract or other agreement. The Business Associate language must establish permitted and required uses and disclosures and must require Business Associates to:

- Appropriately, safeguard PHI.
- Report any misuse of PHI.
- Secure satisfactory assurances from any subcontractor.
- Grant individuals access to and the ability to amend their PHI.
- Make available an accounting of disclosures.
- Release applicable records to the covered entity and the Secretary of Health and Human Services.
- Upon termination of the Business Associate relationship, return or destroy PHI.

DHS's Business Associates include, but are not limited to Counties, Managed Care Organizations, Children and Youth Agency Contractors, and certain Contractors/Grantees. DHS's agreements with its Business Associates must be amended (or otherwise modified) to include the Business Associate language required for HIPAA compliance. DHS will discontinue sharing information and/or discontinue a relationship with a Business Associate who fails to comply with the Business Associate language.

9.2.3 Notice of Privacy Practice

A covered entity must provide its consumers with a plain language notice of individual rights with respect to PHI maintained by the covered entity. Beginning April 15, 2003, health care providers must provide the notice to all individuals on their first day of service, and must post the notice at the provider's delivery site, if applicable. Except in an emergency treatment situation, a provider must make a good faith effort to obtain a written acknowledgement of receipt of the notice. Health plans must provide the notice to each individual enrolled in the plan as of April 14, 2003, and to each new enrollee thereafter at the time of enrollment, and within sixty days of any material revision to the notice. A covered entity with a web site must post its notice on the web site. A covered

entity must document compliance with the notice requirements and must keep a copy of notices issued.

The specific elements of the notice include:

- Header: “This notice describes how medical information about you may be used and how you can get access to this information. Please review it carefully.”
- A description, including at least one example, of the types of uses and disclosures the covered entity may make for treatment, payment or health care operations.
- A description of each of the other purposes for which the covered entity is required or permitted to use or disclose individually identifiable health information without consent or authorization.
- If appropriate, a statement that the covered entity will contact the individual to provide information about health-related benefits or services.
- A statement of the individual’s rights under the privacy regulations.
- A statement of the covered entity’s duties under the privacy regulations.
- A statement informing individuals how they may complain about alleged violations of the privacy regulations.

9.2.4 Employee Training and Privacy Officer

Providers must train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed.

9.2.5 Consent and Authorization

9.2.5.1 Consent

The HIPAA Privacy Regulations permit (not require) a covered entity to obtain a consent from a patient to use and disclose PHI for treatment, payment and health care operations. DHS will be obtaining consent for treatment, payment, and health care operations from its clients, where practicable.

9.2.5.2 Authorization

The HIPAA Privacy Regulations make a clear distinction between consents and authorizations. Consents are used only for disclosures related to treatment, payment and health care operations. The covered entity is required to have an authorization from an individual for any disclosure that is not for treatment, payment, or health care operations or exempted under the regulations. An authorization must clearly and specifically describe the information that may be disclosed, provide the name of the person or entity authorized to make the disclosure and to whom the information may

be disclosed. An authorization must also contain an expiration date or event, a statement that the authorization may be revoked in writing, a statement that the information may be subject to redisclosure and be signed and dated.

9.2.6 Enforcement

DHS is not responsible for the enforcement of the HIPAA privacy requirements. This responsibility lies with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). The enforcement activities of OCR will involve:

- Conducting compliance review;
- Providing technical assistance to covered entities to assist them in achieving compliance with technical assistance;
- Responding to questions and providing guidance;
- Investigating complaints; and, when necessary,
- Seeking civil monetary penalties and making referrals for criminal prosecution

9.3 HIPAA Security Rule

The HIPAA Security Rule sets guidelines for the protection of private information. Security is the policies, procedures, technical services, and mechanisms used to protect electronic information. It mandates computer systems, facility, and user security safeguards. These safeguards are intended to minimize unauthorized disclosures and lost data.

9.4 Penalties for Noncompliance

The penalties outlined for the two rules released to date are as follows:

Penalties for the Transactions and Code Sets are aimed at the health plans, billing services and providers who submit claims electronically. They are:

- \$100 per violation (defined as each claim element) Maximum of \$25,000 per year.

Privacy affects all covered entities, such as health plans, billing services, providers and business associates who receive and use protected health information. The penalties for wrongful disclosures are:

- Up to \$250,000 AND 10 years in prison.

For more information on penalties, please go to <http://www.hhs.gov/ocr/privacy/>

10Appendix A – Billing Guides

This section contains the Billing Guide for the NCPDP 5.1/Pharmacy Billing Provider Handbook. Please contact the Department of Human Services for more information.

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/s_001919.pdf

11Appendix B - Bulletins

This section contains the link to Bulletins for the NCPDP 5.1/Pharmacy Billing Provider Handbook.

<http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>

12Appendix C – Provider Internet User Manual

This section contains the link to the Internet User Manual for Providers for the NCPDP
5.1/Pharmacy Billing Provider Handbook.

http://www.dpw.state.pa.us/cs/groups/public/documents/manual/s_002302.pdf

13Appendix D – Special Forms

This section contains the Special Forms for the NCPDP 5.1/Pharmacy Billing Provider Handbook. Please note that these forms are created and updated by the Department of Public Welfare. Please contact them with any questions concerning these forms or any forms you may think should be listed here.

<http://www.dhs.state.pa.us/dhsassets/maforms/index.htm>

14Appendix E – Glossary

This section contains a link to the list of Terminology/Description of Services (glossary) that is included in the NCPDP 5.1/Pharmacy Billing Provider Handbook. Please use this glossary to find a word or phrase that you may not understand. Please contact the Department of Human Services with any questions concerning this list or any word or phrase you may think should be listed here.

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/medicalassistanceprogramsdictionary/index.htm>