Pennsylvania
Department of Health

SPECIAL PHARMACEUTICAL BENEFITS PROGRAM 1 (SPBP 1)

PHARMACY PROVIDER MANUAL

Version 1.3

September, 2024

Revision History

Document Version	Date	Name	Comments
0.1	Various	A. Brewer R. Flage J. Haines	Subject matter expert review
0.2	1/2022	B. Silsley	Reformatted
0.2	1/2022	A. Brewer J. Haines	Review
0.3	1/2022	B. Silsley	Formatting changes per Department request
0.3	2/2022	J. Weiss	Auditor review
0.4	2/2022	B. Silsley	Updated footers, incorporated auditor feedback, prepare for final review
0.5	6/2022	S. Kane	Final QA review
0.5	7/2022	J. Haines	Revised and approved by the Department of Health
1.0	7/2022	B. Silsley	Final version created
1.1	7/2024	B. Silsley	Annual review Updated for new branding
1.2	9/2024	J. Haines	Revised manual
1.3	9/2024	J. Haines	Updated fonts, accessibility, table of contents; Final version created

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Definitions

Average wholesale price (AWP)	The cost of a dispensed drug based upon the price published in a national drug pricing system in current use by the Department as the average wholesale price of a prescription drug. The terms average wholesale price and average wholesale cost are synonymous.
Confidential information	Information that is not available to the public upon request, including, but not limited to the claimant's medical information, as well as information disclosure which would give an unfair, unethical, or illegal advantage to another desiring to contract with the Commonwealth of Pennsylvania.
Department	The Department of Health
Federal upper limit (FUL)	The price of a drug based on the maximum amount Medicaid can reimburse for certain multi source drugs as established by the Centers for Medicare and Medicaid Services.
Formulary	The Pennsylvania Department of Health's Special Pharmaceutical Benefits Program 1 HIV/AIDS Covered Drug List is available at www.health.pa.gov/spbp.
Medical history	A medical record established and maintained on each SPBP 1 cardholder served by the provider. This record must include, as a minimum, the following cardholder information as obtained from the cardholder or equivalent information as approved by the Department: • Name • SPBP 1 identification card number • Medication allergies and other allergies • Current medication utilization • Indication of all medical disorders known to the cardholder • Separate entries for each prescription medication
Principal place of business	A location where an enrolled provider can and will conduct all business directly related to this dispensing of services under the SPBP 1.
Program	The agency, in this case the Pennsylvania Department of Aging and its subcontractor, authorized by the Department of Health to enter into Provider Agreements with providers to provide services to SPBP 1 claimants.
Unit	The measured quantity of a prescription drug to be used such as a single tablet or capsule. Oral liquids, aerosols and ointments are exempt.
Usual and customary charge (U&C)	The provider's charge to the cash-paying public for a prescription drug, in a specific strength and quantity, or a service rendered within a specific calendar month. Discounts or coupons offered to the cash-paying public

	shall be considered to be offered to the Department as well. Discounts applied to cardholders or coupons presented by the cardholder shall be accepted by the provider and credited to the SPBP 1 payment.
Wholesale acquisition cost (WAC)	The manufacturer's reported list price of a drug when sold to a wholesaler as published in a national drug pricing system in current use by the Department. The WAC price does not include any additional discounts, rebates, or other price reductions offered on a specific drug purchase.
340B drugs	Brand and generic drugs purchased under Section 340B of the Public Health Service Act of 1992 (340B) including sub-ceiling purchases authorized by 340B and those made through the 340B Prime Vendor Program.

1.0 Overview of the Special Pharmaceutical Benefits Program 1 (SPBP 1)

Purpose

To provide a consolidated summary of policies relating to the Special Pharmaceutical Benefits Program 1 (SPBP 1).

Scope

This manual is applicable to all enrolled providers who can dispense drugs to eligible SPBP 1 cardholders.

Background

The SPBP 1 covers the cost of certain drugs used for the treatment of individuals with low and moderate incomes who are living with HIV. The program originated in 1987 as the result of a federal public health services grant to pay for the drug Retrovir® (AZT). Since 1987, the services covered by the program have expanded significantly. Currently, the program covers drugs used in treating HIV/AIDS and related conditions. The SPBP 1 enrollment applications and the SPBP 1 covered drugs can be found at: www.health.pa.gov/spbp.

To participate in the SPBP 1, providers located in Pennsylvania must be enrolled in the Pennsylvania Medicaid program and the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program. Those Providers permitted by SPBP to enroll, and whose place of business is in a contiguous state, e.g., Ohio, New York, etc., shall maintain active enrollment in the Pennsylvania Medicaid Program. Mail order Providers permitted by SPBP to enroll, and whose place of business is not in Pennsylvania, or a contiguous state shall maintain active enrollment in the Medicaid Program in their state.

This manual provides a consolidated summary of the most significant provider policies and procedures relating to the SPBP 1.

To participate in SPBP 1, all claims are to be submitted using the SPBP 1 point-of-sale electronic claim submission process. Providers must enroll and sign a provider agreement with the Program to do SPBP 1 claims processing.

2.0 Cardholder Information

Applications

Applications are available on SPBP's website at: www.health.pa.gov/spbp.

For more information about enrollment or to request an application from SPBP 1 call 1-800-922-9384 or send an email to SPBP@pa.gov.

The SPBP 1 Card

Enrolled providers shall examine a cardholder's SPBP 1 card on each occasion pharmaceuticals are dispensed. It is the provider's responsibility to establish the identity of the cardholder and to verify the eligibility dates on the card presented. Claims submitted for persons who are not approved cardholders on the date the prescription is dispensed will not be paid.

- **SPBP 1 Identification Number:** The cardholder's unique SPBP 1 number. This nine-character alphanumeric field must be entered on all SPBP 1 claims. The first three characters are always SP1.
- **The SPBP Cardholder's Name:** The services dispensed must be for the cardholder whose name appears on the card.
- **Begin Date:** The start of the coverage period for this cardholder. Claims will not be honored prior to the date imprinted on this card.
- **End Date:** The end of the coverage period for this cardholder. Claims will not be honored beyond the date imprinted on this card.

Coverage periods are in up to yearly increments. All SPBP 1 cardholders must complete a re-enrollment form every year.

3.0 Provider Enrollment

To receive payment through the SPBP 1 automated claims processing system for services covered by the SPBP 1, a provider must sign a provider agreement with the SPBP 1. By signing the SPBP 1 Provider Agreement, the Provider:

- Agrees to participate in the SPBP 1, and in the course of such participation to comply with all federal and Pennsylvania laws generally and specifically governing participation in the SPBP including, but not be limited to, the Ryan White HIV/AIDS Treatment Extension Act of 2009 (42 U.S.C.A. § 300ff-21, et seq.) and Section 340B of the Public Health Service Act of 1992 (42 U.S.C. § 256B). The Provider agrees to be knowledgeable of and to comply with applicable rules and regulations promulgated under such laws and any amendments thereto.
- Agrees to maintain the confidentiality of medical records of individuals served by the Provider and shall also abide by all appropriate confidentiality laws and regulations including, but not be limited to, the Confidentiality of HIV-Related Information Act 1990-48, 35 P.S. sections 7601et seq. As required by 45 C.F.R. Parts 160 and 164, the Provider agrees to comply with the privacy and security standards provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and its regulations. As required by 45 C.F.R. Section 162.410, the Provider agrees to comply with the National Provider System, the Provider agrees it shall possess a National Provider Identifier (NPI) Number obtained from the National Plan and Provider Enumeration System (NPPES). The Provider further agrees that any information received will not be disclosed to third parties without appropriate authorization.

Assignment of provider numbers

A prospective SPBP 1 provider must apply for, be enrolled in and agree to certain conditions of participation before payment can be made for pharmaceuticals furnished to SPBP 1 cardholders. The provider identification number for pharmacies is the provider’s National Provider Identifier (NPI).

Conditions of participation

- **Provider agreements:** Providers must file a formal participation agreement with the SPBP 1. The provider agrees to all terms and conditions of the Program’s Online Claims Adjudication System and Electronic Funds Transfer. Provider agreements are specific to the enrolled provider and may not be transferred.
- **Licensure:** The provider must be licensed by the appropriate State and Federal authority and have their principal place of business in the Commonwealth of Pennsylvania unless otherwise authorized by the SPBP 1.

- **Records:** The provider must agree to keep any records necessary to disclose the extent of SPBP 1 services the provider furnishes to cardholders. On request, the provider must furnish authorized Commonwealth of Pennsylvania officials or their authorized agents, within 7 business days, any information maintained under the requirements of the preceding sentence, and any information regarding payments claimed by the provider for furnishing services under the SPBP 1. All records must be retained for a minimum of four calendar years.

General payment policy

Payments will be made for enrolled SPBP 1 participants only.

No payment will be made if alternative payments are available through another public agency, other insurance or health program resulting in the SPBP 1 cardholder having no copayments.

Individuals must be enrolled in SPBP 1 before services are provided in order for payment to be warranted.

To be compensable, prescriptions that have been written or verbally ordered by a licensed prescriber shall contain:

- The name and address of the patient on each page of the record.
- The name of the licensed prescriber.
- Prescriptions must contain the name, strength, and quantity of the medication. *Using As Directed* is not acceptable.
- Prescriptions must contain directions for use.
- Number of refills, if any.
- The DEA number of the licensed prescriber, when controlled substances have been prescribed.
- The professional license number (NPI#) of the licensed prescriber.
- The date the prescription was written or verbally ordered.
- Fax prescriptions must contain header information: the name and phone from prescriber's office.

The Provider agrees to identify brand and generic drugs purchased under Section 340B of the Public Health Service Act of 1992 (340B) including sub-ceiling purchases authorized by 340B and those made through the 340B Prime Vendor Program by submitting the Value 20 in the National Council for Prescription Drug Programs (NCPDP) Submission Clarification Code Field (420-DK) and enter the Actual Acquisition Cost (AAC) in the NCPDP Ingredient Cost Field (409-D9) and the Value 08 (340B/Disproportionate Share Pricing/Public Health Service) in the NCPDP Basis of Cost Determination

Field (423-DN). If the Provider determines retrospectively that a non-340B claim previously billed and paid has been subsequently converted to a 340B claim, the Provider further agrees to reverse the original non-340B claim and resubmit the claim as a 340B claim in accordance with this paragraph.

For payment to be made for filling altered prescriptions, the pharmacy shall certify in writing on the prescription or annotated in the computer (provided time stamped) that the licensed prescriber made the change. Changes in the nature or brand of a medication, the strength of a medication, directions, or quantity dispensed are acceptable only if the consent of the prescriber was obtained before dispensing. The written explanation of the pharmacy on the prescription must state that this was done and give the reasons for the change.

Limitations on payment

Under no circumstances shall the provider be paid an amount that exceeds the usual and customary charge to the self-paying public. A payment shall be the lower of either the provider's charge to the self-paying public or the maximum limits established by the SPBP 1 Provider Agreement.

Non-compensable services

Payment will not be made for prescription drugs or nutritional supplements not covered by the SPBP 1 formulary.

Method of payment

Payment for covered pharmaceuticals will be consistent with policies established by SPBP 1 and identified both in this manual and agreed upon in the SPBP 1 Provider Agreement.

Rate of provider reimbursement

Providers are required to bill SPBP 1 at the usual and customary charge for the services dispensed. The retail price must appear on the label or on the accompanying receipt.

Usual and customary charge is defined as an enrolled provider's charge to the cash-paying public for a prescription drug, in a specific strength and quantity, or a service rendered within a specific calendar month. Discounts or coupons offered to the cash-paying public shall be considered to be offered to the Department as well. Discounts applied to cardholders or coupons presented by the cardholder shall be accepted by the provider and credited to the SPBP 1 payment.

The Department will pay a provider for a compensable product as follows:

1. For non-340B Brand drugs, payment will be based on the lower of:
    a. (WAC + 7%) + a dispensing fee of $4.00

       OR

    b. (AWP minus 14%) + a dispensing fee of $4.00

OR

c. U&C

2. For 340B Brand drugs, payment will be based on the lower of:

   a. (WAC minus 49%) + a dispensing fee of $12.00

      OR

   b. U&C

3. For non-340B Generic drugs, payment will be based on the lower of:

   a. (WAC + 66%) + a dispensing fee of $4.00

      OR

   b. (AWP minus 25%) + a dispensing fee of $4.00

      OR

   c. FUL + a dispensing fee of $4.00

      OR

   d. U&C

4. For 340B Generic drugs, payment will be based on the lower of:

   a. (WAC minus 49%) + a dispensing fee of $12.00

      OR

   b. FUL + a dispensing fee of $12.00

      OR

   c. U&C

Payment: The provider must agree to accept the amount paid by SPBP 1 as payment in full.

Third party liability

In the event third party drug coverage exists, the provider must seek reimbursement from the cardholder's private or public drug plan(s) prior to billing SPBP 1. If other drug coverage exists for a cardholder and payment is made by the other payer(s) on an approved claim, the SPBP will pay the final other payer patient responsibility amount and no additional dispensing fee if the drug is covered on the SPBP 1 formulary and the claim is approved.

Freedom of choice

Cardholders are permitted to select approved providers from whom they receive services.

Professional responsibility

The provider assumes professional responsibility for providing services to eligible cardholders in the SPBP 1. She/he may refuse to provide any service which appears to be improperly executed or which, in her/his professional judgment, is unsafe.

Change in ownership

A change of ownership includes a sale, a change in corporate structure or controlling interest in the provider's business, the addition of a partner or other corporate reorganization. When a change of ownership is to take place in a provider that has, until that time, been an enrolled provider of the SPBP 1, the following applies to avoid unnecessary interruption in the participation of the provider and to the SPBP 1 cardholders who use the provider.

As early as possible, before the change of ownership occurs, the prospective provider shall notify the Program that a change of ownership will be occurring.

Immediately upon receipt of its (business/professional) license number, the prospective provider shall notify the Program that the license has been issued.

Upon notification of the new owner's license number, the Program or its authorized agent will execute the provider agreement and enroll the new owner in the SPBP 1.

The effective date of the new owner's provider agreement shall be the date of issuance of the license number by the appropriate State agency, unless the Department is reviewing the change of ownership. If the Department is reviewing the change of ownership, the Department will determine the effective date of the new owner's provider agreement. The Program will notify the new owner that a review of the change in ownership is occurring, and that the Department will not pay the provider for service rendered prior to the date of a valid and fully executed provider agreement. During the period of review, the provider may service cardholders with the understanding that reimbursement under the SPBP 1 may subsequently be disallowed if the Department determines that the provider will not be enrolled or that disenrollment of the provider is warranted. If the provider number (NPI#) is going to be transferred, it is up to either party to be responsible for submitting requested records for an audit and make any payments for discrepancies.

SPBP 1 Provider Agreements are specific to the enrolled provider and are non-transferable. Providers are reminded that they must comply with all Commonwealth of Pennsylvania laws and regulations regarding proper notification as well as the contractual obligations as set forth in the SPBP 1 Provider Agreement. In the event of an audit involving the same NPI number as the previous owner, the program is not responsible for contacting the previous owner for recoupments. The recoupments are tied to the NPI number used to adjudicate the claims.

4.0 Claims Processing

General Information

Providers are responsible for the timely submission of claims. In accordance with the provider agreement, claims are to be submitted at the time of presentation of the prescription and prior to the dispensing of the medication. In no case will original point-of-sale claim submissions be accepted beyond 180 days from the date the prescription is dispensed. Providers wishing to correct errors or make adjustments are to do so within 180 days of the date of dispensing using the point-of-sale system. The Department reserves the right to refuse payment of claims submitted more than 180 days after the date the provider dispensed the prescription drugs covered by the claim.

A cardholder's prescription must be presented or be on file for SPBP 1 services to be rendered. Each time SPBP 1 services are rendered, the provider should verify that the cardholder is eligible by examining the SPBP 1 card.

The claim submission process for SPBP 1 is an on-line, real-time system. All SPBP 1 providers must submit claims using this real-time system. The on-line system is available 7am – 10pm, seven days a week, 365 days of the year except for required maintenance and/or upgrades. Paper claims are not accepted by SPBP 1.

With the Program's on-line claims processing system, providers must maintain a signature log. It is the responsibility of providers to ensure that the logs are current. The Program acknowledges that a cardholder's pharmaceuticals may be received by an agent presenting the cardholder's SPBP 1 card. In such cases, the representative must identify their relationship to the cardholder. Providers having claims that cannot be verified on the date the prescription was dispensed by a clear and accurate signature log will have any such claims disallowed in an audit.

Online access

Providers can access the on-line system either through following the program's on-line submission specifications, available upon request, or by contacting a software vendor.

Providers utilizing computer vendors to maintain the pharmacy's computer system should contact their vendor to have software installed using the program's specifications.

Providers utilizing a software vendor can have their existing system modified to process SPBP 1 claims using the program's specifications.

Providers may contact Provider Services at 800-835-4080 to obtain a listing of software vendors currently supplying services to other SPBP 1 Providers.

The Provider agrees to use software that supports the number of COB iterations identified in the NCPDP version currently in use by the Program. Providers unable to meet this requirement and who encounter a cardholder enrolled in multiple prescription programs shall either dispense the medication at the

lowest copay available by the plans or assist in the transfer of the prescription to another provider whose software meets this requirement.

Providers or their software vendors must have their software certified with the Program and receive a certification number prior to submitting claims. Providers who have enrolled in the Program but have not completed their software certification and elect to accept SPBP 1 claims during the interim may not bill cardholders for any claims subsequently denied.

Adjustments

Adjustments are to be submitted by the provider using the on-line system. Providers must submit a rebill to adjust a claim. If a provider bills SPBP 1 through a computer vendor and the vendor's program does not permit the rebill of the transaction, the provider must submit an electronic reversal and then submit the corrected claim as an original claim. If the provider determines retrospectively that a non-340B claim previously billed and paid has been subsequently converted to a 340B claim, the provider must reverse the original non-340B claim and resubmit the claim as an original 340B claim in accordance with the SPBP 1 Provider Agreement.

Claims submitted with other insurance

<u>If the provider receives reimbursement from another insurance company:</u>

The SPBP 1 will process the claim. Approved claims will have the amount of the Other Payer Patient Responsibility Amount identified by the Primary reimbursed. The copay due from the SPBP 1 cardholder will be $0.00.

Usual & Customary Charge/ Gross Amount Due Submitted	$480.00
Cardholder's primary insurance pays ($260.00 is entered in Other Payer Amount Paid field)	$260.00
Other Payer Patient Responsibility Amount	$45.00

The Program will return the co-pay amount ($0) to be collected from the cardholder; the Program will pay the provider $45.00.

<u>Other Insurance denies the claim:</u>

Claims denied by the primary with a correctable reason entered, such as, but not limited to: Missing/invalid (M/I) prescriber ID, M/I gender Code, M/I NPI, M/I cardholder ID, etc. will be rejected.

Claims rejected by the primary payer and submitted with a non-correctable NCPDP error may be paid, i.e., "Filled after coverage terminated" NCPDP error 69. Drugs rejected by the primary for NCPDP error

70 “Product/Service not covered”, NCPDP 75 “Prior Authorization Required”, etc. may be accepted by SPBP 1 if the drug is on the SPBP 1 formulary.

For those products needing a prior authorization by the primary, it is expected that the provider will adhere to the primary plan’s policy in seeking a prior authorization. If the primary rejects the claim NCPDP Error 79, “Refill Too Soon,” the claim will also be denied by SPBP 1.

It is expected that the provider will adhere to the primary plan’s policy in seeking the early refill. If the primary grants the early refill, SPBP 1 will also pay the claim for medications that are reimbursable by SPBP 1.

Claims denied by the primary plan, but accepted by SPBP 1, are subject to SPBP 1 edits.

Other Insurance accepts and processes claim:

No amount is returned in the Other Payer Amount paid field (i.e., cardholder is in deductible). The Other Payer Responsibility Amount is returned.

Usual & Customary Charge/ Gross Amount Due Submitted	$480.00

Amount the cardholder’s primary insurance pays is “0”; the provider receives a “paid claim” response.

Other Payer Amount Paid	$0.00
Other Payer Patient Responsibility Amount	$325.00
Amount billed to SPBP 1	$325.00

The Program will return the co-pay amount ($0) to be collected from the cardholder; the Program will pay the provider the $325.00.

Covered Medication

The current SPBP 1 drug formulary is available at: www.health.pa.gov/spbp.

Reimbursement is in accordance with provisions contained within the SPBP 1 Provider Agreement.

General SPBP formulary coverage guidelines:

1. The formulary includes coverage of antiretroviral drugs
2. The formulary includes selected brand name, generic, and over-the-counter (OTC) non-antiretroviral drugs, biologics, and devices
3. The formulary includes selected nutrients and nutritional agents

4. Formulary coverage for Group 1 and 2 is limited to drugs, biologics, and devices approved by the Food and Drug Administration (FDA)

5. Formulary exclusions include but are not limited to the following:

   a. Drugs prescribed for the symptomatic relief of cough and colds

   b. Drugs when used to promote fertility

   c. Drugs when used for cosmetic purposes or hair growth

   d. Placebos

   e. Non-legend soaps, cleansing agents, dentifrices, mouthwashes, douche solutions, ear wax removal agents, deodorants, liniments, antiseptics, irrigants, emollients, and other personal care and medicine chest items

   f. Non-legend aqueous saline solutions for use other than for intravenous administration

   g. Non-legend water preparations, such as distilled water, water for injection, and identical, similar, or related products

   h. DESI drugs

   i. Agents when used for the treatment of sexual or erectile dysfunction

6. All drugs (Rx and OTC) on the formulary require a written prescription from a licensed medical provider

Criteria for claims reimbursement

SPBP 1 copayment - SPBP 1 cardholders are not required to pay a copay amount for each service. Rebates and kickbacks to SPBP 1 cardholders are prohibited. Coupons and/or discounts are applicable to the amount billed to the Program.

Payment for services dispensed shall be limited to those whose size is consistent with the medical needs of the cardholder and does not exceed a 34-day supply or 100 units (tablets or capsules), whichever is greater. All other forms (creams, ointments, etc.) limited to a 34-day supply. If primary pays (OCC2), up to a 90-day supply is allowed.

The SPBP 1 is considered the “Payer of Last Resort”. Pharmacies and dispensing providers must ask the cardholder about other drug coverage and, if applicable, submit the claim to the other payer(s) prior to submitting the claim to the SPBP.

SPBP 1 cardholders having primary insurance are to follow the primary plans quantity and days’ supply rules. SPBP 1 will accept these claims as the secondary payer. Claims denied by a primary payer are subject to SPBP 1 rules.

Refills will be covered up to and including 11 refills within 12 months from the original date of the prescription. Claims submitted for more than 11 refills or after 12 months from the original date of the prescription will have any such claims denied in the on-line claims system or disallowed in an audit.

Prescriber's license number

The prescriber's NPI (National Provider Identifier) number must be included with claim submission data. Additionally, no payments will be made for drugs dispensed in response to a prescription or order issued by a prescriber who has been precluded or excluded from the Medicare Program, Medicaid Program, or the PACE Program. A DEA (Drug Enforcement Agency) number submitted in lieu of an NPI will be accepted on secondary or tertiary claims when a primary payer requires the prescriber's DEA.

SPBP 1 benefits are not available to cover the costs of filling services ordered or written by prescribers who are not licensed by the Commonwealth of Pennsylvania unless the provider complies with the following rules:

- At the time of dispensing, the provider shall determine that a prescriber not licensed by the Commonwealth of Pennsylvania to practice has a valid license to practice in the state in which the prescription was written.
- The provider shall submit upon request to the Program the name, address, telephone number, and appropriate out-of-state prescriber license number.

Failure by the provider to comply with these rules constitutes grounds for denial of reimbursement under the SPBP and termination of the provider agreement.

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

- Non Matched Prescriber ID (NCPDP Error Code = 56)
- Prescriber is Not Covered (NCPDP Error Code = 71)

Mandatory Dispensing of Multisource Drugs (Generic Substitution)

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

When a pharmacist receives a prescription for a SPBP 1 cardholder it must be treated in the following manner:

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

- The pharmacist shall fill the prescription with the least expensive generic in the pharmacy. (For audit purposes, the brand name and the manufacturer must be noted on the prescription.)
- The selection of a drug product shall not be more expensive than the brand or trade name originally written by the prescriber.
- Subsequent refills shall be filled in compliance with Section 22.55(e) from Title 28 (Health and Safety) of the Pennsylvania Code which states: Prescription refills, where permitted by the practitioner, shall be completed using the identical product (same distributor and manufacturer) as dispensed on the original, unless the person presenting the prescription and the practitioner authorize, in advance, a different manufacturer's generic equivalent product. Advance authorization is not required in an emergency, but the physician shall be notified by the pharmacist as soon as possible thereafter.
- Multisource brand name products with an A-rated generic available will not be reimbursed unless the prescriber has specified Brand Medically Necessary on the prescription.
- Only the products contained on the SPBP 1 Formulary will be considered for reimbursement.

Negated Prescriptions

If claims have been submitted to SPBP 1 and paid for, and the prescriptions have not been dispensed to the SPBP 1 cardholder, providers are to submit an on-line reversal no later than 30 days beyond the date of dispensing/submission. Auditors may interpret the failure to void such claims as an attempt to defraud the Program.

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

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

For those providers requesting either gross negative adjustments or sending in payments for claims paid by the Program more than one (1) year from the date of service, an administrative fee will also be assessed. The Program will base this fee on the estimated rate of interest earned while the Program’s money was retained in the provider’s account or $100.00, whichever is greater. This administrative fee will also appear on the remittance advice of the cycle in which the negative adjustment was entered or the check processed.

Manufacturers' rebate

SPBP 1 shall not reimburse for any covered prescription drug without the manufacturer entering into a rebate agreement with the U.S. Department of Health and Human Services as designated in Section

340B of the Public Health Service Act of 1992 (42 U.S.C. § 256B). The SPBP 1 does allow an exception to the 340B rebate agreement requirement for products that are considered diabetic supplies, vaccines, vitamins, minerals, and nutritional supplements since the manufacturers of these types of products are generally not required to provide rebates under the 340B program.

5.0 Drug Utilization Review

When a provider authorized to provide prescription services to SPBP 1 cardholders observes any irregularities in prescriptions, dosages, medication history, prescriber utilization, cardholder name, SPBP 1 identification card number, or other similar kinds of irregularities, the provider shall discontinue prescription services.

Whenever a provider suspects the submission of a false or fraudulent prescription order or false or fraudulent information for prescription services, the provider shall notify the SPBP 1 of the cardholder's name, SPBP 1 identification card number, the name of the prescriber of any prescriptions related to the false or fraudulent prescription, and any additional pertinent details related to the false or fraudulent order or prescription services.

6.0 Electronic funds transfer (EFT)

Reimbursement

The SPBP 1 pays claims electronically through the Automated Clearing House (ACH) by using an Electronic Funds Transfer (EFT) system. To comply with EFT, which is addressed in your Provider Enrollment Application, you must complete the EFT section. In accordance with the SPBP 1 Provider Agreement, providers are responsible for using a financial institution that accepts electronic funds transfers.

The process for the Electronic Funds Transfer is as follows: Each week the Department issues a an ACH transaction for deposit into Prime Therapeutics bank account. When Prime Therapeutics is notified by the bank that the funds are deposited into their account (in approximately two business days), the Electronic Funds Transfer will be released into the provider accounts.

Once a provider is accepted into the Program, a minimum of four weeks will be necessary to process and test each provider's EFT data. Providers may receive remittance advices through either the Web R/A or FTP process but will not have the money transferred until EFT data is successfully tested through the clearing house account and the provider's identified bank.

Providers deciding to change accounts must update their EFT Authorization using the online application at https://papaceportal.lh.primetherapeutics.com. Providers are urged to maintain both the old and new account temporarily to avoid interruption of payment. Upon successful testing of the new account's EFT data, the provider will be notified thereby enabling them to close the old account at their convenience.

7.0 Remittance Advice

General information

Each electronic funds transfer generates a Remittance Advice Report (R/A). This document shows the status of each claim accepted by the SPBP 1 and gives a detailed breakdown of payment.

Although the SPBP 1 R/A is reported separately, the format, types, and explanations of information presented (with the exception of the cardholder's name) is identical to that provided in the PACE Remittance Advice.

Those providers receiving their R/A via FTP must use the received electronic media for reconciliation. The R/A is the acknowledged report for identification of all paid claims. Providers not receiving their R/A via FTP are directed to use the Medicare Remit Easy Print (MREP) software that enables providers to view and print the Health Insurance Portability and Accountability Act (HIPAA) compliant 835 (remittance advice). This software, is available for free, can be used to access and print remittance advice information, including special reports, from the HIPAA 835. This software is described on the Centers for Medicare and Medicaid Services (CMS) website at: www.cms.gov (www.cms.gov/data-research/cms-information-technology/access-cms-data-application/medicare-remit-easy-print). Although the Easy Print web-based product was designed for Medicare use, a user guide is available for providers using Easy Print to reconcile the SPBP 1 R/A.

Uses of the remittance advice

The Remittance Advice is the provider's record of all transactions made on the SPBP 1 claims for a cycle and should be reconciled with in-house records upon receipt and filed for future reference.

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

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

Providers who do not use the R/A for reconciliation but request the Program to do provider-billing profiles to verify R/A information will be billed for such extraordinary services.

8.0 Pharmacy Audits

General information

This section identifies some relevant portions of the Pennsylvania Code and provider agreement governing the SPBP 1. This is not intended to be all-inclusive. Providers are advised that violations of the Pennsylvania Code or SPBP 1 Provider Agreement may constitute civil and criminal conduct subject to civil and criminal penalties.

Pharmacy audits are conducted by an experienced provider of professional independent pharmacy audits. Findings of these initial audits may indicate that a comprehensive Recovery Audit or further investigation be done by the Department.

The purpose of these pharmacy audits is to ensure the provider is adhering to federal and state laws, program policies, as well as the SPBP 1 Provider Agreement. Providers are reminded that Section II of the SPBP 1 Provider Agreement states:

It shall be unlawful for any person to submit a false or fraudulent claim or application; to aid or abet another in the submission of a false or fraudulent claim or application; to receive benefits or reimbursement under a private, state or federal program for assistance and claim or receive duplicative benefits hereunder; to solicit, receive, offer or pay any kickback, bribe or rebate, in cash or in-kind, from or to any person in connection with furnishing of services under this Agreement; or to otherwise violate any provision of this Agreement. Any person who commits a prohibited act may be charged with a criminal offense, pursuant to the provision of Title 18 of the Pennsylvania Consolidated Statutes (relating to Crimes and Offenses).

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

- Submits false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled under SPBP 1.
- Submits a claim for dispensing only part of an amount which is less than the maximum limit of the Program except when the provider can document that insufficient inventory prevented the dispensing of the Program limit and that no additional dispensing fee was charged for dispensing the remainder at a later time (i.e., a partial fill).
- Submits false information to obtain authorization to dispense prescription drugs, supplies or provide services under SPBP 1.
- Solicits, receives, offers or pays remuneration, including a kick-back, bribe or rebate, directly or indirectly in cash or in kind, from or to a person in connection with the dispensing of prescription drugs, supplies, or services or referral of cardholders.
- Submits a duplicate claim for which the provider has already received or claimed reimbursement from any source.

- Submits a claim that was not dispensed by the provider at the provider's principal place of business or was not dispensed to a cardholder.
- Submits a claim that is not documented in the prescribed manner. See 49 Pa. Code Chapters 16-18 (relating to State Board of Medicine-general provisions; State Board of Medicine-medical doctors; and State Board of Medicine-practitioners other than doctors) and 49 Pa. Code § 27.78 (relating to standards of practice).
- Submits a claim, order, or prescription, which is of little or no benefit to the cardholder, is below accepted treatment standards, or is not medically necessary.
- Submits a claim that misrepresents the description of the service rendered, the date-of-service, the identity of the cardholder, the identity of the prescriber, or the identity of the actual provider.
- Submits a claim under SPBP 1 at a cost that is greater than the provider's usual charge to the general public.
- Enters into an agreement, combination, or conspiracy to obtain or aid another in obtaining from the Department payment to which the provider or other person is not entitled.
- Submits a claim for a cardholder outside the Commonwealth of Pennsylvania except as provided in the SPBP 1 Provider Agreement.

Maintenance of records

As required in the SPBP 1 Provider Agreement, the Program will not pay for claims when the following documentation cannot be presented, and the lack of this documentation may constitute grounds for terminating a provider agreement:

An enrolled provider shall retain original hardcopy records for four calendar years at the principal place of business. An original hardcopy record is one of the following:

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

Original hardcopy prescriptions or orders that are not handwritten by the prescriber shall bear the date and the handwritten signature or the handwritten initials of the dispensing provider.

In addition to the original hardcopy records, the provider shall maintain a daily hardcopy record of filled and refilled prescriptions. The daily hardcopy record shall identify the prescriber who ordered the service, the patient for whom the service is intended, the strength and dosage of the medication, the number assigned to the prescription and the date of dispensing. The daily hardcopy record shall bear the handwritten signature or the handwritten initials of the pharmacist who filled or refilled the

prescription. The data, which supports the daily hardcopy record, may be maintained by a manual system or by an electronic data processing system that meets the requirements in this paragraph.

The provider shall assure that the system prevents improper access to, and manipulation or alteration of, stored records.

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

The system shall provide retrieval of information regarding the original dispensing and the refilling of prescriptions, supplies or procedures.

A provider using a computerized system shall sign or initial the original hardcopy prescription or order at the time of the first dispensing and the initials of the provider shall be entered into the computer record.

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

- The initials of the provider who dispensed the refill shall be entered at the time of dispensing.
- One of the following:
  - The system shall be capable of displaying a record of refills each day on a daily hardcopy printout of refills done that day and the dated signature of each provider whose initials appear on the printout shall be affixed, on a daily basis, to the daily hardcopy printout to certify that it is a complete and accurate record.
  - Documentation of the required refill information at the time of dispensing shall be reduced to a hardcopy record that contains the information required by this paragraph. The handwritten signature or the handwritten initials of the dispensing provider shall be affixed on a daily basis to the hardcopy record to certify that it is a true, complete and accurate record.
  - Documentation of the required refill information at the time of dispensing shall be reduced to a dispensing log which contains the record number which leads directly to the hardcopy record of information under this paragraph in the provider's principal place of business; the signature of the SPBP 1 cardholder; and the date the service was refilled. The handwritten signature or the handwritten initials of the dispensing provider shall be affixed on a daily basis to the provider's dispensing log to certify that it is a true, complete and accurate record.
  - A provider that employs a computerized system shall have an auxiliary procedure that shall be used for documentation of all new and refilled services dispensed during system downtime. The auxiliary procedure shall provide for the entry into the computer of data collected during the downtime and the provider shall ensure that the maximum number of refills authorized on the original order has not been exceeded.

- Only the provider or personnel authorized by and under the direct supervision of, the dispensing provider may enter data into the computerized system. A person authorized to enter data into the computerized system shall be readily identifiable as being accountable for the entering of the specific data which that person entered.

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

Records of SPBP 1 cardholders shall be readily available for review, copying or photographing by authorized Commonwealth of Pennsylvania officials or their authorized agents. "Readily available" means that the records shall be maintained in a reasonable and retrievable manner at the provider's principal place of business.

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

Access to records

Enrolled providers shall agree to provide reasonable access to records necessary to comply with the provisions for Program review set forth in the SPBP 1 Provider Agreement.

Confidential information

The Provider shall maintain all patient records as specified in the Provider Agreement.

9.0 Inquiries

Payment and pharmacy inquiries

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

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

Special Pharmaceutical Benefits Program
Provider Services Department
PO Box 8809
Harrisburg, PA 17105
Provider Services Phone Number: 1-800-835-4080

Cardholder services inquiries

Inquiries from cardholders or case managers regarding general program information, cardholder application status, or cardholder eligibility requirements should be directed to SPBP 1 at 1-800-922-9384.