PHARMACEUTICAL ASSISTANCE CONTRACT FOR THE ELDERLY (PACE)

PHARMACY PROVIDER MANUAL

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1.0 Overview

Purpose

This manual provides a consolidated summary of policies relating to the Pharmaceutical Assistance Contract for the Elderly (PACE) program.

Scope

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

Background

The Pharmaceutical Assistance Contract for the Elderly (PACE) Program

The PACE/PACENET prescription assistance program offers low-cost prescription medication to qualified residents age 65 and older. PACE covers all medications requiring a prescription in the Commonwealth, as well as insulin, insulin syringes and insulin needles, unless a manufacturer does not participate in the Manufacturers' Rebate Program. PACE does not cover experimental medications, medications for hair loss or wrinkles or over-the-counter (OTC) medications that can be purchased without a prescription.

The PACE Program began on July 1, 1984. Income eligibility expanded several times, and the legislation of 1996 created a new program, PACENET (Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier).

Financed with Pennsylvania state lottery funds, PACE Program daily operations are administered by Prime Therapeutics State Government Solutions LLC, following the guidelines of and reporting to the Pennsylvania Department of Aging (PDA).

The PACE Program is regulated by the Pennsylvania Code (https://www.pacodeandbulletin.gov), which can also be viewed on the Commonwealth of Pennsylvania portal (https://papaceportal.lh.primetherapeutics.com).

The Clearinghouse

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

2.0 Cardholder Information

General Claimant Eligibility Policy

Applicants must complete an enrollment application. PACE cardholders are auto-enrolled on an annual basis.

PACE/PACENET eligibility criteria:

- **Income limits*:** A cardholder must meet income guidelines established by the program. Additionally, if the person is currently qualified for prescription benefits under Medical Assistance, they are not eligible for PACE.
- **Residence:** A cardholder must have lived in the Commonwealth of Pennsylvania for at least 90 consecutive days preceding the date of application to the Department of Aging.
- **Age:** A cardholder must be 65 years of age or older to participate in the PACE Program. A cardholder may submit a completed PACE application 30 days prior to their 65th birthday to assist in the timely determination of eligibility.

*Income limits are subject to change. Refer to PACECARES (https://pacecares.primetherapeutics.com) for current income limits.

Other Prescription Drug Insurance Coverage

The PACE Program is designed to be the payor of last resort. Although Medical Assistance participants receiving pharmacy benefits are ineligible, other prescription drug insurance coverage is acceptable. PACE and PACENET applicants must identify on their enrollment application any/all companies with whom they have prescription insurance coverage. In instances in which the provider is unable to bill the other carrier or is unable to ascertain the existence or extent of other benefits, the PACE Program will bill the cardholder's insurance company for the benefits paid on their behalf.

Monthly Deductible

Cardholders eligible for the PACENET program must satisfy a monthly deductible. This deductible is established each year based on the Medicare Part D premium benchmark as established annually by the Centers for Medicare & Medicaid Services (CMS).

Providers are to transmit all prescription claims for which the PACENET cardholder is paying. PACENET will accumulate the monies spent and notify the provider in the response of the amount the cardholder is to pay.

Providers are notified of annual benchmark changes via email and/or fax. These bulletins are also available on the **Pharmacists** tab of the Commonwealth of Pennsylvania web portal (https://papaceportal.lh. primetherapeutics.com).

PACENET Premiums

The maximum premium collected in a month is one-month premium. Premium payment is due only when medications are billed for that month. If no medications are billed, that month's premium does not rollover. Any remaining premium does not rollover to the next month and cardholder costs will not exceed the monthly premium plus any copay due. If the cardholder does not have any scripts filled, the premium does not rollover to the next month.

Copayment

Eligible PACE cardholders are required to pay the following copay once the applicable deductible has been met:

	GENERIC	BRAND
PACE	$6.00	$9.00
PACENET	$8.00	$15.00

Copay amounts may be reduced by the Program if the Program's calculated reimbursement is less than the applicable copay.

Cardholders who insist on an A-Rated multiple source product in lieu of an available generic when a Medical Exception has not been granted will be responsible for the entire usual and customary (U&C) price of the prescription.

Providers are notified of changes in the copayment amount via email and/or fax. These bulletins are also available on the Commonwealth of Pennsylvania web portal (https://papaceportal.lh.primetherapeutics.com) under the **Pharmacists** tab.

Applications

Applications can be completed online or downloaded (English or Spanish) from PACECARES (https://pacecares.primetherapeutics.com) and mailed or faxed. Applications can also be taken over the phone.

For more information about enrollment or to request an application from PACE call 1-800-225-7223 or send an email to papace@primetherapeutics.com.

Instructions for completing and submitting an application are attached to the form.

The PACE Card

Enrolled providers are required to request a cardholder's PACE/PACENET card each time a script is dispensed. PACENET cards are identified through the inclusion of the word **NET**. It is the provider's responsibility to establish the identity of the cardholder and verify the eligibility date on the card presented. Claims submitted for individuals who are not approved cardholders on the date the prescription is dispensed will not be paid.

The following information on the card should be examined:

- **ID number:** The cardholder's unique PACE/PACENET ID number is a randomly generated nine-character identifier. The ID format is: four numbers, one letter and four numbers. The letters L, I and O are NOT used.
- **Name:** Name of the individual determined to be eligible for benefits under the PACE Program. The drugs dispensed must be for the cardholder whose name appears on the card.
- **Authorized Signature:** Signature of the eligible cardholder.

All cardholders are automatically re-enrolled after an annual review of income matches received by state and federal agency files. The Program does not require a renewal application from the cardholder. Cardholders may be moved between PACE and PACENET programs based on income guidelines during this auto-enrollment process, or they may be cancelled from the program, if over income.

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

Instructions and information for PACE/PACENET cardholders can be obtained by calling Cardholder Services using the toll-free number on the back of the card (1-800-225-7223).

Explanation of Benefits Statement

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

Freedom of Choice

Cardholders are free to choose a provider that works best for them, as long as the pharmacy is a participating provider with both PACE and the cardholder’s part D plan in order to get the most for the cardholder’s benefit.

3.0 Provider Information

Provider Enrollment

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

PACE/PACENET providers serving older Pennsylvanians in the retail and mail order environment must be located within the Commonwealth. Medicare Part D mail order providers may reside outside of the Commonwealth if they are the primary preferred mail order provider for a Medicare Part D plan. Although the Program's providers are overwhelmingly pharmacies, PACE/PACENET also enrolls dispensing physicians and Certified Registered Nurse Practitioners (CRNPs) into the Program. Dispensing physicians and CRNPs are subject to the same terms and conditions as pharmacy providers with two notable exceptions:

- Dispensing physicians and CRNPs do not receive a dispensing fee.
- Dispensing physicians and CRNPs enrolling in PACE must enroll themselves, not their practice.

Conditions of Participation

Provider Agreements

Providers must file formal participation agreements with the Department of Aging. The provider agrees to all terms and conditions of the Program's point-of-sale system and Electronic Funds Transfer (EFT). An agreement is presented for each program in which the provider is enrolling for electronic signature. Additionally, providers receive a copy of the agreements when approved for participation.

An enrolled provider may be required to sign a new agreement upon any changes in legislation and/or pricing which would require a change to the existing language in the agreement.

Provider agreements are specific to the enrolled provider and may not be transferred.

Providers are enrolled either as a walk-in provider or mail order provider. The exception to this is retail pharmacies who are dually enrolled as long-term care pharmacies.

Pharmacies enrolling as a mail order provider must complete the Pennsylvania Pharmaceutical Assistance Contract For The Elderly Supplemental Mail Order Enrollment Form And Agreement.

Mail order pharmacies that are the primary preferred mail order for a Medicare Part D plan may reside outside of the Commonwealth. Pharmacies meeting this criterion must complete the Pennsylvania Pharmaceutical Assistance Contract For The Elderly and the Pennsylvania Pharmaceutical Assistance Contract For The Elderly Needs Enhancement Tier Coordination of Benefits with Medicare Part D Plans or MA-PD Plans agreements.

These agreements detail the unique features required of the mail order provider environment.

Licensure

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

primary preferred mail order provider. Mail Order Part D pharmacies must be currently licensed by the state in which they reside.

Records

The provider must agree to keep any records necessary to disclose the extent of PACE services the provider furnishes to cardholders. On request, the provider must furnish authorized Commonwealth officials or their authorized agents, within seven business days, any information maintained under these requirements and any information regarding payments claimed by the provider for furnishing services under the PACE Program. All records must be retained for a minimum of four calendar years.

PACENET

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

Conditions of Mail Order Participation

Pharmacies enrolled as mail order providers are subject to all eligibility criteria of walk-in (conventional retail) providers.

The following conditions are unique to providers furnishing services through mail, shipping companies or online pharmacy web portals.

- Mail order providers may not charge PACE cardholders additional fees above the required co-payment and deductible/monthly premium, if applicable, for any mail order or delivery service.
- Mail order providers must have, or take steps to develop, a systematic mail order operation, to include the submission of all PACE claims using an online point-of-sale system.
- Providers providing mail order services ***Shall Not*** request PACE cardholders to send a PACE identification card through the mail.
- Mail Order providers are responsible for developing or maintaining a system of control which offers assurance to the Department that cardholder identity and cardholder receipt of the ordered prescription drugs are verified. Providers will only be reimbursed for online claims of active, approved cardholders.
- Enrolled providers offering mail order prescription service shall have or establish and maintain a medication history on all PACE/PACENET cardholders provided with these services.

Other Provisions for Prescription Services by Mail

- Provider shall provide PACE cardholders with order forms and clear instructions for submitting mail orders. These forms must include, at a minimum, the cardholder's signature (or legally designated representative), address, telephone number (where applicable) and PACE/PACENET identification number.
- Each initial mail order prescription must be accompanied by a valid prescription as written by the licensed prescriber.

- If mail order prescription drugs cannot be delivered by mail, the provider shall notify the cardholder and the prescriber by telephone or mail within two working days of the receipt of the mail order and return the written prescription(s) to the cardholder. The exception to this notification is when the provider believes a prescription is not authentic. The provider shall verify the authenticity of the prescription with the prescriber. If the provider feels the prescription is fraudulent, they shall refuse to fill the prescription. The prescription is not returned to the cardholder; it is sent to the Department along with the cardholder's name, address and PACE identification number.
- Providers of prescription services by mail may not accept initial prescription for PACE Program benefits by telephone unless the provider obtains the name, address, telephone number, state license number, NPI and DEA number of the prescriber and verifies that this information is correct, and that the prescription originated from the prescriber.
  - Refill prescription orders may be accepted by telephone.
- ***No Prescription Drugs Dispensed By Mail Shall Be Mailed To An Address Outside The Commonwealth***. Packages used for the dispensing of prescription drugs by mail shall bear the words ***Do Not Forward*** on the face which bears the cardholder's Pennsylvania address.
- Mail Order providers whose internal procedures dictate that the medication is dispensed prior to billing cannot bill the cardholder if the claim is denied.
- A prescription drug delivered by first-class mail or equivalent shall be accompanied, at a minimum, by the following:
  - Clear instructions to the cardholder explaining the procedures and policies for requesting prescriptions by mail.
  - Information regarding the use and storage of the prescription drug, as appropriate.
- When a provider observes any irregularities in prescriptions, dosages, medication history, prescriber utilization, mailing address, cardholder name or PACE identification card number or other similar kinds of irregularities, the provider shall make an immediate comparison of signatures in the cardholder's file.
- The provider shall discontinue prescription services by mail to any cardholder who fails to submit all due cardholder payments or is suspected of submitting a false or fraudulent prescription order or false or fraudulent information.
- Whenever a provider of prescription services by mail discontinues services, the provider shall notify the Department of the cardholder's name and PACE identification card number and the name of the prescriber of any prescriptions related to the reasons for the provider's decision to discontinue services.
- Cardholders or medical personnel must have access to a registered pharmacist in the event of drug concerns or emergency situations. This access may include either the acceptance of collect phone calls or the establishment of a toll-free number. The mail order provider shall issue clear instructions to the cardholder regarding the access phone number and its appropriate use.

Rate of Provider Reimbursement

Providers are required to bill PACE at the usual charge for the drugs dispensed. The retail price must appear on the label or on the accompanying receipt.

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

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 PACE provider agreement.

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

PROVIDER REIMBURSEMENT FOR PACE

Non-340B	Payment will be based on the lower of the following amount: • National Average Drug Acquisition Cost (NADAC) + a professional dispensing fee of $10.49 per prescription minus the copayment and deductible (if applicable for PACENET) OR • The Usual and Customary (U&C) price minus the copayment and deductible (if applicable for PACENET) • **If NADAC IS NOT FOUND**—(Wholesale Acquisition Cost (WAC) +3.2%) + a professional dispensing fee of $10.49 per prescription minus the copayment and deductible (if applicable for PACENET) OR • The Usual and Customary (U&C) price minus the copayment and deductible (if applicable for PACENET)
340B Brand	Payment will be based on the lower of: • (WAC minus 49%) + a professional dispensing fee of $10.49 per prescription minus the copayment and deductible (if applicable for PACENET) OR • The U&C price minus the copayment and deductible (if applicable for PACENET)
340B Generic	Payment will be based on the lower of: • (WAC minus 49%) + a professional dispensing fee of $10.49 per prescription and the minus the copayment and deductible (if applicable for PACENET) OR • Federal Upper Limits (FUL) + a professional dispensing fee of $10.49 per prescription minus the copayment and deductible (if applicable for PACENET) OR • The U&C price minus the copayment and deductible (if applicable for PACENET)

PROVIDER REIMBURSEMENT FOR PA PAP CLEARINGHOUSE

Non-340B	Payment will be based on the lower of the following amount: • National Average Drug Acquisition Cost (NADAC) + a professional dispensing fee of $10.49 per prescription minus the copayment OR • The Usual and Customary (U&C) price and the subtraction of the copayment • **If NADAC IS NOT FOUND**—(Wholesale Acquisition Cost (WAC) +3.2%) + a professional dispensing fee of $10.49 per prescription minus the copayment OR • The Usual and Customary (U&C) price minus the copayment
340B Brand	Payment will be based on the lower of: • (WAC minus 49%) + a professional dispensing fee of $10.49 per prescription minus the copayment OR • The U&C charge minus the copayment
340B Generic	Payment will be based on the lower of: • (WAC minus 49%) + a professional dispensing fee of $10.49 per prescription minus the copayment OR • Federal Upper Limits (FUL) + a professional dispensing fee of $10.49 per prescription minus the copayment OR • The U&C charge minus of the copayment

Note: Dispensing physicians and CRNPs do not receive a dispensing fee.

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

Third Party Liability/Other Coverage

If third party insurance(s) exists, the provider must first seek reimbursement from the cardholder's other insurance company.

Note: Instances may occur in which the cardholder failed to inform a provider of another insurance carrier which is subsequently identified to the Program. In those cases, the existence of the other carrier will be returned as part of the *NCPDP Error 41, Other Coverage Exists* claim response. Providers may have to bill more than one other insurance before billing PACE.

Professional Responsibility

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

Change in Ownership

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

The provider is notified that they will be temporarily terminated even if the new provider has Power of Attorney from the previous owner (PACE does not acknowledge POA). Once the new application is approved, coverage will be retroactive. The provider will be directed to the Commonwealth of Pennsylvania Web Portal (http://papaceportal.lh.primetherapeutics.com) once the termination is completed so that they can submit a new application. The provider will receive written instructions for enrolling in the PACE/PACENET programs.

When a change in *controlling interest* is to take place in a pharmacy which has, until that time, been an enrolled provider of the PACE Program, the Provider will be sent a letter with instructions on updating the controlling interest information in the Commonwealth of Pennsylvania Web Portal (https://papaceportal.lh.primetherapeutics.com). This process prevents interruption in the participation of the pharmacy and the PACE/PACENET cardholders who use the pharmacy.

NOTE: Detailed instructions for adding and modifying enrollment information is documented in the *Pharmaceutical Assistance Contract for the Elderly (PACE)/Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier (PACENET) Web Provider Enrollment/Provider Management User Guide* on the Commonwealth of Pennsylvania web portal (https://papaceportal.lh.primetherapeutics.com).

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 point of sale and prior to dispensing the medication. Providers can only make adjustments to claims within 90 days of the dispense date, using the point-of-sale system. After 90 days, the system will reject the claim, and a claims exception form must be submitted to the PACE Program. However, the Program reserves the right to refuse payment of claims submitted more than 90 days after the dispense date.

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

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

> **Note:** Providers can submit claims for consideration outside of the normal processing timeframe. See Exception Processing for more information.

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 individual presenting the cardholder’s PACE/PACENET card. In such cases, the representative must identify his or her relationship to the cardholder. Providers having claims that cannot be verified on the date the prescription was dispensed by a clear and accurate signature log will have any such claims disallowed in an audit.

PACE Claims Formats

Claims must conform to the current NCPDP D.0 Payer Specifications for successful online processing. These specifications can be found on the Commonwealth of Pennsylvania Web Portal (https://papaceportal.lh.primetherapeutics.com).

Online Access

Providers can access the web claims submission online system either through following the program’s payer specifications on the Commonwealth of Pennsylvania Web Portal (https://papaceportal.lh.primetherapeutics.com), or by contacting a software vendor. Providers can contact PACE Provider Services at 800-835-4080 to obtain a listing of software vendors currently supplying services to other PACE providers.

Providers using computer vendors to maintain the pharmacy's computer system should contact the vendor to have software installed using the PACE Program’s specifications.

Providers using a software vendor can have the existing system modified to process PACE claims using the Program’s specifications.

Providers agree 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 PACE claims during the interim may not bill cardholders for any claims subsequently denied.

Adjustments

Adjustments are to be submitted by the Provider using the online system. Providers must submit a rebill to adjust a claim. If a provider bills PACE 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.

Exception Processing

Providers use the exception process to request payment for claims that are outside of the Program's online processing limits of 90 days for PACE. Providers must use the Universal Claim Form to submit a paper claim in this situation.

Providers must contact PACE Provider Services at 1-800-835-4080 to request an Exception Processing form for claims that are outside the Department's online 90-day processing limits.

The representative receiving the call records the required information, including the representatives name, date of request, requestor's name, pharmacy name and NPI, contact email and phone number, Cardholder name, Cardholder ID, Date of Service and medication name/dosage. If the request is from a chain Provider, the specific store information is recorded.

The Provider must complete and return a (UCF) and provide a letter of justification to support the request to the address provided in the letter.

Documents are received at Prime and are sent to the Provider Services Supervisor for review. If the forms are incomplete and do not provide sufficient information to support the exception request, the request cannot be completed. Providers will be asked to resubmit the forms with the required documentation so that the request can be reviewed, and a decision can be made.

Providers are responsible for obtaining copyrighted UCF forms from NCPDP's vendor, CommuniForm LLC, by going to https://www.ncpdp.org/Universal-Claim-Forms and following the link or by phone at 877-817-3979, fax 866-308-2036.

Common data elements are listed on the back of the form to assist Providers with filling out the form. In addition, the D.0 Specifications for PACE, CRDP, SPBP, PA PAP, Naloxone and all Ancillary Programs found on the [Commonwealth of Pennsylvania Web Portal](https://papaceportal.lh.primetherapeutics.com) (https://papaceportal.lh.primetherapeutics.com) provide instructions specific to the Program for each field as needed.

The client (PDA), patient representatives (POAs) and cardholders can also request exception processing.

Claims Submitted with Other Insurance

If the Provider receives reimbursement from another insurance company:

If the provider is billing the Program for the Patient Responsibility (the primary plan's Patient Paid Amount or co-pay), the amount billed to the other carrier is included in the **Other Payer Amount Paid** field. The other applicable fields (e.g., "OTHER PAYER DATE") are to be completed as described below.

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

Note: The Program will return the co-pay amount to be collected from the cardholder; the Program will pay the provider $20.00 minus any applicable premium and copay.

Other Insurance is a discount plan:

Provider is billing the primary insurance plan's co-pay only. If the provider is billing the Program for the primary insurance plan's co-pay, the provider should enter the other program's co-pay amount in the **Patient Paid Amount** field.

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

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

Compound Drug Submission

Refer to the current NCPDP D.0 Payer Specifications for submission requirements for compound drug claims. These specifications can be found on the **Pharmacists** tab of the Commonwealth of Pennsylvania Web Portal (https://papaceportal.lh.primetherapeutics.com).

Criteria for Claims Reimbursement

All eligible PACE/PACENET cardholders who receive prescription drug services are required to pay the full co-pay amount for each prescription, unless the cost of the drug is lower than the co-pay. Providers must be aware that PACE and PACENET have different co-payments.

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

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

- Is consistent with the medical needs of the cardholder: and
- Does not exceed a 30-day supply or 100 units (tablets or capsules), whichever is less when PACE is the primary payor; exceptions include items such as insulin and eye drops which allow for longer days supplies due to the bottle sizes, or
- Does not exceed a 15-day supply and may not be renewed beyond 15 days (in the case of acute therapies), or
- Is the maximum dosage (in the case of a chronic maintenance drug) covered under the Act, except in those cases where a prescriber is utilizing a test dosage; or.
- Is in compliance with CMS mandated short cycle dispensing.

PACE is considered the “Payor of Last Resort”. Pharmacies and dispensing providers must ask the enrollee about other drug coverage and, if applicable, submit the claim to that payor prior to submitting the claim to PACE.

Refills will be covered up to and including 11 refills or a 12-month supply, whichever occurs first from the original filling of the prescription. The exception is for acute conditions where no refills are covered beyond 15 days total supply or when refills are prohibited by law.

Prescriber's License Number

The prescriber's NPI must be included with claim submission data. Additionally, no payments will be made for drugs dispensed in response to a prescription issued by a prescriber who has been precluded or excluded from the Medicare Program or the Medical Assistance Program.

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

- At the time of dispensing, the pharmacist shall determine that a physician not licensed by the Commonwealth to practice has a valid license to practice in the District of Columbia or one of the following states: Delaware, Maryland, New Jersey, New York, Ohio, Virginia or West Virginia.
- The pharmacist shall submit the name, address, telephone number and appropriate out-of-state physician license number to PDA upon request.
- Failure by the provider to comply with these requirements constitutes grounds for denial of reimbursement under the PACE Program and termination of the provider agreement.
- Prescriptions for PACE cardholders issued by physicians possessing valid licenses in the states cited above may be submitted to the PACE Program by entering the prescriber's NPI.

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

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

Physician Assistants

The Pennsylvania State Board of Medicine permits physician assistants (PAs) to perform certain clinical procedures, including the limited prescribing of legend drugs. PACE will reimburse prescriptions written by PAs in accordance with the Board's regulations. Providers are encouraged to obtain copies of these regulations from the State Board of Medicine (www.dos.pa.gov) to ensure compliance in the dispensing of medications. This information is also available online (www.pacode com), Title 49, Professional and Vocational Standards.

Certified Registered Nurse Practitioner

The Pennsylvania State Board of Medicine and the State Board of Nursing permit certified registered nurse practitioners (CRNPs) to prescribe and dispense a drug relevant to the area of practice of the CRNP. PACE will reimburse prescriptions written by CRNPs in accordance with the Boards' regulations. Providers are encouraged to obtain copies of these regulations from the State Board of Medicine (www.dos.pa.gov) to ensure compliance in the dispensing of medications. This information is also available online (www.pacode com), Title 49, Professional and Vocational Standards.

Optometrists

Section 4.1 of the Optometric Practice and Licensure Act permits the prescribing of certain medications (http://www.dos.pa.gov) by optometrists. The Program has not installed edits to deny claims for pharmaceuticals not appearing on this list. Providers are advised, therefore, that during a PACE audit, any pharmaceuticals prescribed by an optometrist and paid by the Program that do not appear on the list will be disallowed.

Dentists

Claims containing a dentist's license number in the prescriber license number field and submitted for pharmaceuticals **other than antibiotics, analgesics, non-steroidals or fluoride preparations** will reject with NCPDP Error 88, accompanied by the DUR response "CH". To receive an override for pharmaceuticals not in these categories, providers must call PACE Provider Services at 800-835-4080 to confirm that the prescription was ordered by the dentist identified on the claim. Either provider confirmation or correction of the prescriber number will result in continued processing of the claim.

Generic Substitution

The Generic Equivalent Act (https://www.pacodeandbulletin.gov) requires providers to substitute a generic drug for a trade name product in the absence of a prescription that specifically prohibits substitution.

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

- If an A-rated generic therapeutically equivalent drug is available for dispensing to a claimant, the provider will dispense the A-rated generic therapeutically equivalent drug.
- The pharmacist will fill the prescription with the least expensive generic in the pharmacy. For audit purposes, the brand name and the manufacturer dispensed to the patient must be documented.

Providers will not be reimbursed for brand name products except in the following circumstances:

- There is no A-rated generic therapeutically equivalent drug on the market. This does not apply to the lack of availability in the providing pharmacy.
- An A-rated generic therapeutically equivalent drug is deemed by the Department, in consultation with the Utilization Review Committee, to have a narrow therapeutic index.
- The Department of Health had determined that a drug shall not be recognized as an A-rated generic therapeutically equivalent drug.
- The brand name drug is less expensive to the Program.

Negated Prescriptions

Claims submitted to PACE for prescriptions not received by the cardholder violate the Rules and Regulations governing the PACE Program.

If claims have been submitted to PACE and paid, and the prescriptions have not been dispensed to the cardholder, providers are to submit an online 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 using the online system.

For those providers sending in lists, remittance advices or other documentation requesting that the Program 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 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

PACE and PACENET Programs shall not reimburse for prescription drugs unless the manufacturer has a fully executed rebate agreement as designated in Section 340B of the Public Health Service Act of 1992 (42 U.S.C. § 256B). The PACE Program does allow an exception to the 340B rebate agreement requirement for products that are considered diabetic supplies, vaccines, prescription vitamins and 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

Introduction

The PACE Program maintains and continually enhances a therapeutic drug utilization review (TDUR) program to monitor and correct, where necessary, misutilization and inappropriate prescribing and dispensing as well as a Prospective Drug Utilization Review (ProDUR) program performed prior to dispensing to help pharmacists ensure that their patients receive appropriate medications.

Retrospective Drug Utilization Review of Prescription Drug History

Retrospective Drug Utilization Review is performed on drug classes where it has been determined that additional monitoring is needed for patient safety and efficacy of a medication. This includes opioids, sedative hypnotics, benzodiazepines, skeletal muscle relaxants and combinations of these medications, as well as vaccines that are to be administered on a schedule. Other medications may be added or removed as approved by the Pharmaceutical Assistance Advisory Board (PAAB) or PACE Technical Advisory Committee (TAC) meetings based upon their interactions with other drugs and conditions frequently found in the PACE Program's population.

A clinical team reviews these therapies prescribed to cardholders for clinical appropriateness and optimization of therapy. In addition to the PACE claim history, access to data from the Pennsylvania Prescription Drug Monitoring Program (PDMP), Health Information Exchange platforms and medical records submitted from the prescriber's office provides critical information about prescriptions obtained through sources other than PACE. This retrospective review may prompt actions by the reviewers, such as:

- letters to prescribers
- communications with prescribers regarding concerns with medication(s) in question
- requesting from the prescriber an etiology of the condition requiring the use of prescribed medication over alternatives
- receiving patient/prescriber opioid use agreements and pain consult results
- referrals to the High Dose Opioid/Polypharmacy (HDO-P) Program, an outreach and telehealth education program for cardholders using opioid medications at high doses (MME>120) or in combination with other central nervous system depressants. The HDO-P Program is conducted by the University of Pennsylvania's Behavioral Health Laboratory on behalf of PACE. Using a collaborative care model, the program provides cardholders and their prescribers with support for opioid therapy optimization and dosage tapering.

Prospective Drug Utilization Review

PACE's prospective drug utilization review system screens incoming prescriptions to help ensure that drugs are used appropriately. Prospective Drug Utilization Review (ProDUR) criteria address issues such as dosages which exceed levels generally accepted as safe and effective initial, acute or maintenance therapy; duplicate therapies; duration of treatment without re-evaluation of the cardholder by the prescriber; and drug-to-drug interactions. These reviews are done online prior to reimbursement authorization by PACE.

ProDUR Criteria

The PACE ProDUR criteria has its foundation in the retrospective TDUR criteria file. This criteria base was created by a national working group, convened by the Geriatric Pharmacy Institute within the Philadelphia College of Pharmacy and Science and the Center on Drugs and Public Policy within the University of Maryland, and funded by the Centers for Medicare & Medicaid Services (CMS). Current ProDUR criteria uses the following drug compendia for reimbursement determinations:

- Official product labeling
- Clinical Pharmacology (https://www.clinicalkey.com)
- MICROMEDEX (https://www.micromedexsolutions.com)

The following types of criteria reviews are performed on claims submitted for reimbursement.

Note: In conducting a review of drug usage patterns, the following assumptions are made:

- All entries from the provider (pharmacy) are accurate.
- Drugs dispensed or administered on a routine basis are consumed by the patient.
- Medication is correctly consumed by or administered to the patient as originally ordered by the physician.

Initial Dose	For a first prescription of a given drug, the prescribed daily dose of medication exceeds PACE's safety threshold for initial use.
Maximum Dose	The prescribed daily dose of medication exceeds PACE's safety threshold for non-initial use.
Quantity Limit	The quantity of units prescribed (e.g., pill, tablets) within a specified time interval exceeds PACE's safety limit.
Duration of Therapy	The total duration of time for which the cardholder has continuously used the medication exceeds PACE's safety limit.
Duplicate Therapy	Two or more drugs with the same therapeutic effect have been prescribed concurrently, and the combination is duplicative rather than synergistic.
Drug-Drug	Two or more drugs for which concurrent use is contraindicated have been prescribed.
Diagnosis Required	PACE reviews diagnostic information provided by the prescriber to ensure that the drug that has been prescribed is safe and effective for the intended use, based on FDA and compendia support guidelines.
Step Therapy	For some conditions, accepted clinical guidelines recommend that certain medications should be used as the first line of treatment. Other medications I the step therapy protocol may be substituted or added later, if needed.
Medical Exception	Some medications require additional clinical review by PACE pharmacists to ensure that the prescribed medication is appropriate.

Advisory Committees

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

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

The Program is continually reviewing and evaluating data referencing the proper use of pharmaceuticals.

In addition, the Pharmaceutical Assistance Advisory Board (PAAB) was established to help ensure the continuing efficiency and effectiveness of the PACE Program. The board is required to meet at least two times a year. Meetings are open to the public and are virtual via Microsoft Teams.

Medical Exceptions

Any DUR rejection may receive a Medical Exception under certain cardholder-specific conditions. Providers should contact the Provider Help Desk (800-835-4080) to ascertain if the cardholder is eligible for a medical exception when a claim denies at the point of sale.

All decisions regarding medical exceptions are made by a staff pharmacist, nurse or certified pharmacy technician. Guidelines are documented for reference and consultation is requested as needed. The UR Analyst will review the mailed or faxed Medical Exception requests and will make a determination for reimbursement. The analyst completes the medical exception process by entering all pertinent information into the prior authorization (PA) management system. Any appeals are reviewed by a nurse or pharmacist.

The UR Analyst provides direction to Provider Services as to how to resolve a situation with the pharmacist or physician when a claim rejects at the point of sale.

Medical exception requests can be mailed or faxed to:

PACE
Utilization Review
4000 Crums Mill Road
Suite 303
Harrisburg, PA 17112
Fax Number: 888-656-0372

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

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

6.0 Electronic Funds Transfer

Reimbursement

The PACE Program pays claims electronically through the Automated Clearing House (ACH) using an Electronic Funds Transfer (EFT) system. To comply with EFT, Providers must complete the EFT tab in the Commonwealth of Pennsylvania web portal (https://papaceportal.lh.primetherapeutics.com) when completing an enrollment application. In accordance with the Provider Agreement, providers are responsible for using a financial institution that accepts electronic funds transfers.

The process for the EFT is as follows: Each week the Department issues an ACH transaction for deposit into Prime's bank account. When Prime is notified by the bank that the funds are deposited into their account, the EFT 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 clearinghouse account and the provider's identified bank.

Providers who change accounts must update their EFT Authorization using the Commonwealth of Pennsylvania web portal (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 EFT generates a Remittance Advice (R/A) Report. This document gives a detailed breakdown of payment.

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 them to view and print Health Insurance Portability and Accountability Act (HIPAA) compliant 835 (remittance advice) reports. This software is available for free and can be used to access and print remittance advice information, including special reports, from the HIPPAA 835. This software is described on the CMS website (https://www.cms.gov) for more information as well as download instructions and a user guide.

Uses of the Remittance Advice

The R/A is the provider's record of all transactions made on PACE claims for a cycle and should be reconciled with in-house records upon receipt and filed for future reference.

Always refer to the R/A when questions arise about a particular claim. If the R/A cannot resolve questions on claim payments, follow the proper procedure for submitting inquiries as outlined in Inquiries.

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

8.0 Pharmacy Audits

General Information

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 the audit is to ensure that the provider is adhering with state and federal laws, as required by the program policies (https://www.pacodeandbulletin.gov), as well as contractual obligations specified in the Provider Agreement and this Pharmacy Provider Manual.

A provider who violates their agreement may be liable for a civil penalty for each violation. If the same Provider collects three or more civil penalties the Provider will be ineligible to participate in the Program for a period of one year. If the Provider collects more than three civil penalties the Provider may be determined to be permanently ineligible to participate in the Program. Prohibited Acts and Criminal Penalties are detailed in the Provider Agreement.

The PACE-PACENET Program Regulations can be accessed on the Commonwealth of Pennsylvania Web Portal (https://papaceportal.lh.primetherapeutics.com > **Pharmacists** > **Documents**). Paragraph 22.82 of the regulations defines what constitutes false or fraudulent claims by providers.

The PACE Program Provider Audit Principles And Practices on the Commonwealth of Pennsylvania Web Portal (https://papaceportal.lh.primetherapeutics.com) provides additional information on the audit process.

Maintenance of Prescription Records

As required under paragraph 22.11 (f) (13) of the regulations, the Program will not pay for claims when the 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 prescriptions for four years at the principal place of business. An original hardcopy prescription 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 pharmacist by hand, typewriter, computer or other mechanical or electronic means.

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

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

- The provider shall ensure that the system prevents improper access to, and manipulation or alteration of, stored records. The Department may develop provider instructions for safeguarding of stored records. If the Department does develop provider instructions, they will be distributed to providers as technical assistance to facilitate the provider's compliance with this subparagraph.
- Arrangements shall be made which ensure completeness and continuity of prescription records if the relationship between a pharmacy and a supplier of data processing services terminates.
- The system shall provide retrieval of information regarding the original dispensing and the refilling of prescriptions.
- A provider using a computerized system shall sign or initial the original hardcopy prescription at the time of the first dispensing and the initials of the pharmacist shall be entered into the computer record of the dispensed prescription.
- The introduction of prescription refill records into the system shall meet the following criteria:
  - The initials of the pharmacist 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 prescriptions refilled each day on a daily hardcopy printout of prescriptions refilled that day and the dated Signature of each pharmacist whose initials appear on the printout shall be affixed, on a daily basis, to the daily hardcopy printout to certify that it is a complete and accurate record.
    - Documentation of the required refill information at the time of dispensing shall be reduced to a hardcopy record of the prescription that contains the information required by this paragraph. The handwritten signature or the handwritten initials of the dispensing pharmacist shall be affixed on a daily basis to the hardcopy record to certify that it is a true, complete and accurate record
    - Documentation of the required refill information at the time of dispensing shall be reduced to a pharmacy dispensing log which contains the prescription number which leads directly to the hardcopy record of in formation under this paragraph in the provider's principal place of business; the signature of the PACE cardholder; and the date the prescript ion was refilled. The handwritten signature or the handwritten initials of the dispensing pharmacist shall be affixed on a daily basis to the pharmacy dispensing log to certify that it is a true, complete and accurate record.
- A pharmacy that employs a computerized system shall have an auxiliary procedure that shall be used for documentation of all new and refilled prescriptions dispensed during system downtime. The auxiliary procedure shall provide for the entry into the computer of data collected during the downtime, and the pharmacist shall ensure that the maximum number of refills authorized on the original prescription has not been exceeded.
- Only personnel authorized by, and under the direct supervision of, the dispensing pharmacist may enter prescription data into the computerized system. A person authorized to enter data into the computerized system shall be readily identifiable as being accountable for the entering of the specific data which that person entered.

- A change of a prescription order shall be documented on the original hardcopy prescription. Changes in the nature of a medication, the brand or manufacturer of a medication, the strength of a medication, or directions for its use are acceptable only if the consent of the prescriber was obtained before dispensing. The written explanation of the pharmacy on the prescription shall state that this was done and give the reasons for the change.
- Prescription records of PACE cardholders shall be readily available for review, copying or photographing by authorized Commonwealth officials or their authorized agents. *Readily available* means that the records shall be maintained in a reasonable and retrievable manner at the provider's principal place of business.

Maintenance of Other Records

Other records necessary to disclose the full nature and extent of prescription drugs, both covered and not covered by the PACE Program, which were dispensed by a provider shall be retained for four years and shall be available for review and copying by authorized Commonwealth officials or their authorized agents within seven 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 provider agreement.

Confidential Information

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

9.0 Inquiries

General Inquiries

Providers should contact PACE Provider Services at 1-800-835-4080.

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

Payment Inquiries

Inquiries regarding payments must include the R/A payment date and the provider's NPI number. This information appears on the R/A.

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

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

Provider Services Department
Post Office Box 8809
Harrisburg, PA 17105
Telephone Toll-free: 1-800-835-4080
Email: PacePS@primetherapeutics.com

Cardholder Services Inquiries

Inquiries from cardholders regarding cardholder application status or cardholder eligibility requirements should be directed to the Cardholder Services toll-free number: 1-800-225-7223.