POLICY AND PROCEDURE	
Title: Pharmacy Claims	
Primary policy owner: Pharmacy	**Policy #:** PH49
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☐Behavioral Health & Social Services (BH/SS) 3) ☐ Benefits Administration (BA) 4) ☐ Case Management (CM) 5) ☒ Claims (CLMS) 6) ☐ Community Marketplace & Member Engagement (MAR) 7) ☐ Compliance (CMP/HPA) 8) ☐ Configuration (CFG) 9) ☐ Provider Contracting (CONT) 10) ☐ Cultural & Linguistics (CL) 11) ☐ Customer Service (CS)	12) ☐ Facilities (FAC) 13) ☐ Finance (FIN) 14) ☐ Human Resources (HR) 15) ☐ Information Technology / Core Systems (IT) 16) ☒ Pharmacy (PH) 17) ☐ Provider Networks (PRO) 18) ☐ QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☐ Utilization Management (UM) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☐ Medical Management (MM)
Product Type: ☐Medi-Cal ☒D-SNP	**Supersedes Policy Number:** *NA*

I. PURPOSE

To ensure Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") is in compliance with all contractual requirements, applicable federal and state laws, and regulations for responding, preventing, reviewing, and investigating all reported and identified non-

compliance. Health Plan Workforce and Delegates adjudicate pharmacy claims at the Point-of-Sale (POS) in compliance with federal and state regulations and other program requirements.

II. POLICY

A. Health Plan must, through its Pharmacy Benefits Manager (PBM), adjudicate, and process retail pharmacy claims using Health Insurance Portability and Accountability Act (HIPAA) compliant transactions and must comply with applicable National Council for Prescription Drug Programs (NCPDP) standards.

B. Part D pharmacy claims must adjudicate and process in real time and must meet minimum Center for Medicare and Medicaid Services (CMS) guidelines related to response times, error rates, and system availability.

C. The following verifications must happen before a claim is paid to ensure accuracy of the claim processing:

1. Eligibility: The Plan number, Group number and member's ID numbers submitted on the claim must match the data provided to CMS via the 4Rx file.
2. Pharmacy Network status: The dispensing pharmacy must be verified as participating in the pharmacy network.
3. Prescriber Status: the prescriber must have a valid, active NPI and must not be on the Office of Inspector General (OIG) Exclusion or CMS Preclusion lists.
4. Drug Status: The National Drug Code (NDC) for the claim submitted must be valid and must be covered on Health Plan formulary.
5. Exceptions: B versus D determination and transition rules must apply. (See BvD Policy).
6. CMS Inflation Reduction Act (IRA) rules must apply for vaccines and insulin products.
7. The correct member's cost must be calculated based on member's benefit stage.

D. Coordination of benefit rules must apply (see PH34 Coordination of Benefits (COB), True-Up and Financial Information Reporting (FIR) Policy).

Low Income Subsidy (LIS) Claims

A. Full subsidy eligible individuals must be entitled to the following:
    1. Elimination of the annual deductible.
    2. Reduction in cost-sharing for all covered Part D drugs covered below the out-of-pocket limit.
    3. Copayment amounts not to exceed the copayment amounts specified in § 423.104(d)(5)(A).
    4. No cost sharing for full-benefit dual-eligible individuals who are institutionalized.
    5. The following must apply to Low Income Cost Share (LICS)amounts:
        a. LICS only applies to covered Part D drugs.
        b. When cost sharing for a non-low-income subsidy (LIS) enrollee under the plan is less than the statutory maximum LICS, the LIS beneficiary pays the lesser amount.
    6. The PBM must have processes in place to adhere to CMS required 45-day timeframe for over/underpayment and must detect changes in LIS level to re-process appropriate claims.

Hospice Claims

A. The PBM must have systems in place to identify in its adjudicating system, members that are flagged by CMS as being in hospice care.
    1. The PBM must adjudicate under Part D only drugs used for treatment of a condition that is unrelated to the terminal condition of the individual.
    2. The following 4 categories of drugs must be hospice "always" drugs and must reject at the POS.
        a. Analgesics.
        b. Antiemetics.
        c. Laxatives.
        d. Antianxiety medications.

Long Term Care Claims

A. Prescription drugs to Long-Term Care (LTC) facilities (skilled nursing facilities/nursing homes) available in brand-name solid oral doses must be dispensed in no greater than 14-day increments.
B. Certain solid oral branded medications must be excluded from the requirement, such as antibiotics, that are for short-term treatment of an acute infection and drugs that are required by the FDA to be dispensed in their original container (unbreakable packages).
C. Claims for compounded medications must be processed according to CMS rules on Part D compounds.
D. Concurrent Drug Utilization Review (cDUR) checks and pharmacists' overrides must be completed to ensure safe dispensing at the POS (See DUR Policy).
E. Appropriate reports must be generated to ensure:
    1. Accuracy of the claims.
    2. Prescription Drug Events (PDE) file generation.
    3. Level of service.

III. PROCEDURE

Claims Adjudication

A. Health Plan delegates the processing of the pharmacy claims to the PBM.
B. Health Plan uses national drug databases to ensure correct Part D adjudication both for ongoing drug and price updates. The 2 databases the PBM uses are First Data Bank and Medi-Span.
C. Health Plan sets up the benefit, annually, with the PBM including formulary design and benefit design by the 3rd quarter of the year preceding the benefit year.
D. In the 4th quarter of the year preceding the benefit year, the PBM conducts claims testing to ensure that the test claims are processing based on the formulary and pharmacy benefit structure approved by CMS, including LICS (cost sharing subsidy claims).
    1. The testing validation process encompasses different scenarios.
    2. The PBM provides part D claim test scenarios for Health Plan's review and input.
    3. Health Plan, if needed, requests additional scenarios for thorough testing.

4. Health Plan reviews and signs off on the testing claims prior to the beginning of the calendar year.

E. Health Plan shall provides the PBM daily eligibility files to ensure correct coding of the members' benefits in the PBM's adjudication system.
F. The PBM follows all Part D claim adjudication requirements set forth by CMS including, but not limited to, those listed in the Policy section of this document.
G. The PBM's pharmacy help desk provides assistance to the pharmacies calling for questions about claim adjudications and overrides.
H. The PBM provides Health Plan daily reports showing:
    1. Daily paid claims.
    2. Daily rejected claims.
    3. Daily reversed claims.
    4. Daily transition claims.
I. The PBM provides Health Plan monthly reports to ensure that real-time, online claims processing system is operating according to CMS standards and Performance Guarantees are met with the PBM.
    1. Ninety-nine percent (99%) of eligibility files will be loaded without error.
    2. Ninety-nine percent (99%) or greater of eligibility files will be loaded within twenty-four (24) hours of receipt.
    3. PDE acceptance rate will be ninety-nine point five (99.5%) or greater.
    4. Ninety-eight (98%) of pharmacy network additions will occur within fifteen (15) Business Days of the date after which the contract has been received and validated as complete and all credentialing, including onsite observation visit, has been completed and approved.
    5. Eighty percent (80%) of calls answered within thirty (30) seconds or less for caller to reach a live person.
    6. Eligible Member call abandonment rate will be 2.5% or less.
    7. Average hold time not to exceed two (2) minutes.
    8. Overpayments and underpayments are resolved within 45 days either by recoupment or reimbursement.

J. Health Plan reviews these reports to ensure accuracy. Specifically, Health Plan reviews the daily rejected reports according to CMS requirements (see PH35 Daily Reject Review Policy).

LIS Claims

A. The PBM processes the claims for members with LIS according to the data provided by Health Plan in its eligibility files.
B. The PBM's claim processing system calculates the amount the member has to pay – also referred to as LICS.
C. The PBM adheres to CMS required 45-day timeframe for overpayment/underpayment. Automatic detection of retroactive changes for LIS members requiring reprocessing shall be identified immediately. Once identified, the PBM runs the reprocessing of the claims and provides regular reports to Health Plan for verification.
D. Health Plan reviews LICS claims copayments to ensure that the correct amounts are calculated and that the lesser of logic applies for medications costing less than the LICS claims amounts.
E. Health Plan reviews LIS retrospective adjudication reports regularly to ensure that reimbursements/recoupments are correct and issued in a timely manner.

Hospice Claims

A. The PBM flags the members enrolled in hospice care, identified by Health Plan as having hospice attribute. Claims that may be covered under hospice care are rejected at the point of sale with the following code: A3: "This Product May Be Covered Under Hospice – Medicare A"
B. Health Plan ensures the appropriate adjudication of hospice claims by checking the daily reject report and validating the date the member was identified as a hospice patient.
C. The PBM produces a monthly Hospice Claims Report that Health Plan uses to identify claims that may have paid inappropriately under the Part D benefit. This may occur when:
    1. A hospice attribute to a member's profile is added after the PBM has already processed the claim as Part D.
    2. The drug is not in one of the four categories identified by CMS but is related to the beneficiary's terminal illness or related conditions.

D. Health Plan uses the Hospice Claims Report to determine if a claim paid inappropriately under the Part D benefit, in which case Health Plan works directly with the hospice facility to coordinate repayment.

LTC Claims

A. When a pharmacy submits a patient residence code that indicates the member is in an LTC facility, the PBM claim adjudication system determines if the claim qualifies as short-cycle dispensing using the following process:
    1. Validation of the pharmacy service type.
    2. Validation that the claim submitted is for a Part D drug, that is brand, solid, oral dosage form and does not fall within any of the exception products (i.e., antibiotics), and that it is not dispensed in an unbreakable package.
B. Health Plan conducts daily review of rejected claims and regular review of paid claims to ensure that the LTC short cycle dispensing is appropriately implemented.

Record Keeping

A. The PBM and Health Plan maintain all books, documents, papers and/or records relating to Medicare members for up to ten (10) years from the final date of Health Plan's contract period or ten (10) years from the date of any audit, if later. Health Plan permits CMS, the U.S. Department of Health and Human Services (HHS), and the Comptroller General, or their designees, the right to inspect any pertinent information related to the contract during the contract term, for up to ten (10) years from the final date of the contract period, and in certain instances described in the Medicare Advantage regulation(s), periods in excess of ten (10) years, as appropriate, (ten (10) years from the date of any audit, if later).

IV. ATTACHMENT(S)

A. Glossary of Terms Link

V. REFERENCES

A. 42 CFR § 423.104 - Requirements related to qualified prescription drug coverage.

B. Social Security Act in section 1861(dd) and Federal regulations in 42 CFR §418.106 and §418.202(f)
C. 42 CFR § 423.782 - Cost-sharing subsidy
D. Elimination of annual deductible amount: § 423.104(d)(1).
E. Applicable copayment for LIS Claims: § 423.104(d)(5)(A)
F. Medicare Prescription Drug Benefit Manual, Chapter 5: Benefits and Beneficiary Protections, Section 20 and Section 30.
G. Medicare Prescription Drug Manual (MPDM), Chapter 13: Premium and Cost-Sharing Subsidies for Low-Income Individuals, Section 60 and Section 70
H. Health Plan Policy PH34: Coordination of Benefits (COB), True-Up and Financial Information Reporting (FIR)
I. Health Plan Policy PH35: Daily Reject Review
J. Health Plan Policy PH37: Drug Utilization Review
K. Health Plan Policy PH43: Outpatient Drugs Part B Versus Part D
L. State Medicaid Agency Contract (SMAC)
M. Health Plan Contract with Centers for Medicare & Medicaid Services (CMS)

VI. REVISION HISTORY

Version*	Revision Summary	Date
001		
002		
003		
004		
Initial Effective Date: 09/24/2025		
Published Date:09/29/2025		

VII. Committee Review and Approval To Be Completed by Compliance

Committee Name	Version	Date
Compliance Committee	001	09/24/2025

• Privacy & Security Oversight Committee		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review Committee		
Quality Improvement Health Equity Committee (QIHEC)		
• Quality Operations Committee		
• Grievance Committee		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare Services (DHCS)			
Department of Managed Care (DMHC)			

IX. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy