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DIVISION OF TENNCARE PHARMACY PROVIDER MANUAL

FOR

TENNCARE

COVERKIDS

COVERRX

AUGUST 1, 2025
OPTUM RX

REVISION HISTORY

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 4, 2019	New document	Optum Rx
2.0	Policies and procedures as of May 1, 2020	Updates to TennCare Professional Dispensing Fees	Optum Rx
3.0	Policies and procedures as of January 1, 2021	CoverKids Program Addition	Optum Rx
4.1	Policies and procedures as of 9/1/2021	Update to TennCare LTSSPDF/Reimbursement	Optum Rx
4.2	Policies and procedures as of 9/1/2021	Add TennCare 90-day supply processing	Optum Rx
4.3	Policies and procedures as of 8/1/2021	Update Emergency Protocols	Optum Rx
4.4	Policies and procedures as of 9/1/2021	CoverKids and CoverRx Reimbursement appeals process	Optum Rx
5.1	Policies and procedures as of 11/20/2022	Remove TennCare compound script limit	Optum Rx
5.2	Policies and procedures as of 11/20/2022	CoverKids and CoverRx Professional Dispensing Fees	Optum Rx
5.3	Policies and procedures as of 11/20/2022	Added 340B Pricing Strategy	Optum Rx
5.5	Policies and procedures as of 11/20/2022	Updated Attestation list language to not counting against script limit	Optum Rx
5.5	Policies and procedures as of 11/20/2022	Updated Provider information section with Optum Network information	Optum Rx
5.6	Pricing vendor change	Addition of new pricing vendor Mercer	Optum Rx
5.7	Nondiscrimination policy 6/5/2023	Addition of Nondiscrimination policy	T. Olson
5.8	9/20/2023 PDF updates	11/1/23 Update TennCare dispensing fees	Optum Rx
5.9	9/20/2023 Survey updates	Reduced PDF for survey non-responders	Optum Rx
6.0	9/20/23 Table update	Removed Table 2.4 and updated Table 3.8	Optum Rx
6.1	08/01/24 Websites and diaper updates	Updated Optum Rx/TennCare website links, links to Mercer websites, addition diaper program information.	Optum Rx
7.0	08/01/25 Script Limit updates	Updated information to reflect removal of monthly script limit for generic drugs.	Optum Rx
7.0	Medicaid Drug Rebate Program (MDRP) updates	Added information around Medicaid Drug Rebate Program (MDRP) and claims	Optum Rx
7.0	Updates to Excluded Products	Removed exclusion of products	Optum Rx

SUMMARY OF CHANGES

Revision	Page number
Inserted language to allow 90-day supply billing for a specific list of medications as listed at https://welcome.optumrx.com/tenncare/landing h	13
Addition of additional explanation around the Emergency fill protocol	38
Removed $4 MAC List from pricing for CoverRx	25
Inserted language to coincide with professional dispensing fee restrictions for LTSS pharmacies to one dispensing fee per 26-day calendar days	22
Inserted Professional Dispensing Fee changes being implemented on May 1, 2020, and modified existing fees to be effective through April 30, 2020.	23-24
Addition of CoverKids program information	7,8, 12, 49, 50
Addition of CoverKids claims reimbursement appeals process	50
Addition of CoverRx claims reimbursement appeals process	25
Removed important note under Compound Claims	18
Change in TennCare Professional Dispensing Fee Language	21
Change in CoverRx Reimbursement Language	25
Updated member-initiated PA telephone number	8
Change in CoverKids Reimbursement Language	49
Change in TennCare Reimbursement Language	21
Change in TennCare pricing vendor from MSLC to Mercer	23
Added nondiscrimination policy	50
Added return to stock requirement	48
PDF updates	20-25, 49-50
Survey Non-responder PDF updates	21-22
Removed Table 2.4	18
Updated Table 3.8	24
Updated link to Optum Rx TennCare website	3, 8-10, 12, 14-15, 17,19, 21, 29, 32, 34-35, 37, 46
Updated link to Optum Rx CoverKids website	8, 48
TennCare Diaper Benefit Program	14, 23-15, 28, 33, 35, 51
Monthly Prescription Limit Changes	14-15, 19, 36-37, 40-41
Updates to Excluded Products	33, 40
Added information about Medicaid Drug Rebate Program	33

1. Table of Contents

1. INTRODUCTION

This manual provides claims submission guidelines for the Division of TennCare pharmacy program. TennCare is the State of Tennessee's Medicaid program. TennCare provides prescription coverage for mostly low-income pregnant women, parents or caretakers of a minor child, children, and individuals who are elderly or have a disability. CoverRx is a State of Tennessee funded prescription drug program designed to help Tennesseans who have no pharmacy coverage but have a need for medication. CoverKids is a Children's Health Insurance Program (CHIP) that provides prescription coverage for eligible children ages 18 & younger and for eligible pregnant women. Important TennCare, CoverRx and CoverKids coverage and reimbursement policies are available in this manual.

1.1 PHARMACY BENEFITS ADMINISTRATOR (PBA)

Optum Rx assumed pharmacy benefits management responsibilities for the Division of TennCare (hereafter known as "TennCare") for the State Medicaid and CoverRx program on January 1, 2020. Optum Rx assumed pharmacy benefits management responsibilities for CoverKids CHIP program on January 2, 2021.

1.2 PBA CONTACT INFORMATION

Contact	Telephone Number(s)	Mail, Email, & Web Address	Comments
Optum Rx	P: 866-434-5520	https://welcome.optumrx.com/tenncare/landing	PBM Information
TennCare Pharmacy Program		https://www.tn.gov/tenncare/members-applicants/pharmacy.html	Tennessee Medicaid Program information
CoverRx Pharmacy Program	P: 800-424-5815 F: 800-424-5766	https://www.tn.gov/tenncare/coverrx/ https://new.optumrx.com/coverrx	CoverRx Pharmacy Program information
CoverKids Pharmacy Program	P: 844-568-2179 F: 844-403-1029	https://welcome.optumrx.com/coverkids/landing	CoverKids Pharmacy Program information
CoverKids Program		https://www.tn.gov/coverkids	CoverKids Program
Optum Rx Pharmacy Support Center 24/7/365	P: 866-434-5520		Pharmacy calls for: • ProDUR Questions • Non-clinical PA and early refills • Questions regarding Payer Specifications, etc.
Optum Rx Manual Claims Processing		Optum Rx P.O. Box 29044 Hot Springs, AR 71903	For Manual Claims Processing
Optum Rx Clinical Call Center (PA) 24/7/365	P: 866-434-5524 F: 866-434-5523		Prescriber calls for Prior Authorization requests and questions
Optum Rx Member Call Center 24/7/365	P: 888-816-1680		
Optum Rx Web Support Call Center 7am-7pm Monday-Friday	P: 800-241-8276		Pharmacy calls for: • Assistance with UAC, Web RA, and Web PA • Password management • Navigation
Optum Rx Provider Relations 8am-4:30pm Monday-Friday	P: 480-365-5227		
Optum Rx Provider Education 8 am-4:30 pm Monday-Friday		TNRxEducation@optum.com	PARF forms and Program Requirements
TennCare Fraud and Abuse Hotline 24/7/365	P: 800-433-3982	https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html	
TennCare Solutions (Member Appeals) 24/7/365	P: 800-878-3192 F: 888-345-5575		
Member Initiated Prior Authorization 24/7/365	P: 888-816-1680		

2. PHARMACY BILLING POLICY AND PROCEDURES

2.1 PROGRAM SETUP

Claim Format

The POS will accept pharmacy transactions in the National Council for Prescription Drug Programs (NCPDP) standardized version D.0; lower versions will not be accepted. The POS transaction is submitted by the pharmacy through their switching vendor and adjudicated by Optum Rx using online, real-time claim editing, including the posting of Prospective Drug Utilization Review (pro-DUR) alerts, occurs within seconds. Responses to the provider are based on the submitted information and historical paid claim information. For claim-formatting information, providers should review the TennCare D.0 Payer Specification document online at the OptumRx TennCare website.

The format for electronic media is NCPDP Batch v1.2. Batch claims will only be accepted from providers managed by the State of Tennessee's Department of Health. Optum Rx will accept member submitted receipts and member submitted receipts from the TennCare Appeals Unit for manual entry into the system.

All arrangements with switching companies and software vendors should be handled directly by the provider with their preferred vendor.

Point-of-Sale (POS) NCPDP Version D.0

As part of claims processing, Optum Rx uses an online POS system to provide submitters with real-time online information regarding:

- Client eligibility
- Drug coverage
- Dispensing limits
- Pricing
- Payment information
- ProDUR

The POS system is used in conjunction with a pharmacy's in-house operating system. While there are a variety of different pharmacy operating systems, the information contained in this manual specifies only the response messages related to the interactions with the Optum Rx online system and not the technical operation of a pharmacy's in-house- specific system. Pharmacies should check with their software vendors to ensure their system is able to process as per the payer specifications listed on the Payer Specifications sheet.

Supported POS Transaction Types

- Optum Rx uses the following NCPDP Version D.0 transaction types. A pharmacy's ability to use these transaction types depends on its software. At a minimum, pharmacies should have the capability to submit original claims (B1), reversals (B2),

and re-bills (B3). Other transactions listed in Table 2.1 – NCPDP Version D.0 Transaction Types Supported are also supported. Original Claims Adjudication (B1) – This transaction captures and processes the claim and returns the dollar amount allowed under the program's reimbursement formula. The B1 transaction is the prevalent transaction used by pharmacies.

- Claims Reversal (B2) – This transaction is used by a pharmacy to cancel a claim that was previously processed. To submit a reversal, a pharmacy must void a claim that has received a PAID status and select the REVERSAL (Void) option in its computer system.
- Claims Re-Bill (B3) – This transaction is used by the pharmacy to adjust and resubmit a claim that has received a PAID status. A "claim re-bill" voids the original claim and resubmits the claim within a single transaction. The B3 claim is identical in format to the B1 claim with the only difference being that the Transaction Code (NCPDP Field 1Ø3-A3) is equal to B3.
- The following fields must match the original paid claim for a successful transmission of a B2 (Reversal) or B3 (Re-bill):
    - Service Provider ID – NPI Number
    - Prescription Number
    - Date of Service (Date Filled)
    - National Drug Code (NDC)

Table 2.1—NCPDP Version D.0 Transaction Types Supported

NCPDP D.0 Transaction Code	Transaction Name
B1	Billing
B2	Reversal
B3	Re-bill
E1	Eligibility Inquiry

Required Data Elements

A software vendor needs Optum Rx's payer specifications to set up a pharmacy's computer system to allow access to the required fields and to process claims. The Optum Rx Claims Processing system has program-specific field requirements (e.g., Mandatory, Situational, and Not Required). Table 2.1.1 – Definitions of Field Requirements Indicators Used in Payer Specifications lists abbreviations that are used throughout the payer specifications to depict field requirements.

Table 2.1.1—Definitions of Field Requirements Indicators Used in Payer Specifications

Code	Description
M	MANDATORY Designated as MANDATORY in accordance with the NCPDP Telecommunication Implementation Guide Version D.0. The fields must be sent if the segment is required for the transaction.
R	REQUIRED Fields with this designation according to this program's specifications must be sent if the segment is required for the transaction.
RW	QUALIFED REQUIREMENT "Required when" the situations designated have qualifications for usages ("Required if x," "Not required if y").

Claims are not processed without all the required (or mandatory) data elements.

Required (or mandatory) fields may or may not be used in the adjudication process. Also, fields not required at this time may be required at a future date.

Claims are edited for valid format and valid values on fields that are not required.
If data are submitted in fields not required for processing as indicated by the payer specifications, the data are subjected to valid format/valid value checks. Failure to pass those checks result in claim denials.

- Required Segments – The transaction types implemented by Optum Rx Medicaid Administration have NCPDP-defined request formats or segments. Table 2.1.2 – Segments Supported for B1, B2, and B3 Transaction Types lists NCPDP segments used.

Table 2.1.2—Segments Supported for B1, B2, and B3 Transaction Types

Segment	B1	B2	B3
Header	M	M	M
Patient	S	S	S
Insurance	M	S	M
Claim	M	M	M
Pharmacy Provider	S	N	S
Prescriber	M	S	M
COB/Other Payments	S	N	S
Worker's Comp	N	N	N
DUR/PPS	S	S	S
Pricing	M	S	M
Coupon	S	N	S
Compound	S	N	S
Prior Authorizations	S	N	S
Clinical	S	N	S
Facility	S	N	S

M = Mandatory S = Situational N = Not Used

- Payer Specifications – A list of transaction types and their field requirements is available at the OptumRx TennCare website. These specifications list B1 and B3 transaction types with their segments, fields, field requirement indicators (mandatory, situational, optional), and values supported by Optum Rx.
- Program Setup – Table 2.1.3 – Important Required Values for Program Set Up lists required values unique to TennCare programs.

Table 2.1.3—Important Required Values for Program Set Up

Fields	Description	Comments
BIN #	ØØ1553	
Processor Control #	TennCare: TNM CoverRx: CVRX CoverKids: CKDS	
Group		Not Required
Provider ID #	NPI	10 bytes (numeric)
Cardholder ID #	Optum Rx Health Services Patient ID Social Security Number	12 bytes (numeric) 9 bytes (numeric)
Prescriber ID #	NPI Number	10 bytes (numeric) An algorithm validation will be performed to verify NPI is valid.
Product Code	National Drug Code (NDC)	11 digits

Member Claims

Optum Rx supports the processing of manual claims receipts sent to the Manual Claims Department from the TennCare appeals unit and the member. These appeal claims are for new and existing members who were eligible to receive pharmacy services at the time services were rendered. The steps performed by Optum Rx will take place within 21 calendar days of receipt provided sufficient information to process is present on the member appeals claim receipt.

The appeals unit and the member can email or mail the member appeals claim receipt(s) and supporting documentation to Optum Rx:

Optum Rx
Attn: Manual Claims Department
P.O. Box 29044
Hot Springs, AR 71903
tnmappealsrph@optum.com

2.2 PROGRAM SPECIFICATIONS

Timely Filing Limits

Most pharmacies that utilize the POS system submit their claims at the time of dispensing the drugs. However, there may be mitigating reasons that require a claim to be submitted retroactively.

- For all original claims and adjustments, the timely filing limit is 365 days from the date of service (DOS).
- For reversal transactions, the filing limit is unlimited.
- Claims that exceed the prescribed timely filing limit will deny and return NCPDP Error Code– 81 “Timely Filing Exceeded.”
- Requests for overrides on claims and adjustments billed past the timely filing limits of 366 days or more, the pharmacy must contact TennCare for consideration. Providers

should contact the TennCare Provider Operations line Monday–Friday, 8:00 a.m. – 4:30 p.m., CT at 1-800-852-2683.

Mandatory Generic Requirements

- TennCare is a mandatory generic program.
- Multi-source brand products submitted with a DAW code of '1' require a prior authorization to bypass the MAC/FUL pricing.

Branded Drugs Classified as Generics

- Exceptions to the mandatory generic policy exist where TennCare prefers a brand product over a generic.
- Generic copays ($1.50) are applied to these products.
- Also, these TennCare mandated brands do not count toward the two brand monthly limit.
- For a current detailed listing of these drugs, please see the Branded Drugs Classified as Generics list on the OptumRx TennCare website.

Dispensing Limits/Claim Restrictions

For current detailed information specifically regarding dispensing limitations and/or claim restrictions, refer to the OptumRx TennCare website.

Days Supply

The standard days supply maximum is 31 days per prescription with the following exceptions:

- OTC Products up to 100-day supply depending on package size (see Section 7.4—Covered OTC Products)
- Long-Term Care (LTC) up to a 35-day supply
- Drug is on 90 Day Supply Drug List (see list at https://welcome.optumrx.com/tenncare/landing)
- The following drug agents will allow up to a 35-day supply:
  - Lamictal Starter Kit
  - Xarelto, with an ICD-10 code for hip or knee replacement
- The following drug agent(s) will allow up to a 42-day supply:
  - Cimzia Starter Kit
- The following drug agent(s) will allow up to a 56-day supply:
  - Stelara
- The following drug agents will allow up to a 91-day supply:
  - Femring
  - Estring
  - Fluphenazine decanoate injection
  - Haloperidol decanoate injection
  - Medroxyprogesterone 150 mg/mL
  - Medroxyprogesterone 104 mg/0.65 mL

  - Seasonique/Seasonale and generics
  - Insulins*
- The following products will allow up to a 60-day supply:
  - See Covered Diapers/Training Pants UPC list
- *For insulin products, TennCare allows up to a 91-day supply because insulin doses and regimens are individualized, and in many cases, a single bottle will not cover the entire 31 day timeframe. TennCare still covers only the least costly amount of the drug necessary to meet the prescriber's prescription. Please adhere to the following when dispensing insulin in quantities greater than a 31-day supply (35 days for LTC patients):
  - Hard copy prescriptions must always state the dose being used. TennCare does not pay for prescriptions with sigs stating, "as directed."
  - If one 10 mL vial of insulin or one box of insulin pens lasts longer than 31 days, please transmit the box for a single vial or single box of pens and submit the actual number of days supply greater than 31 days.
  - If one 10 mL vial of insulin or box of insulin pens will not last the enrollee 31 days, the pharmacy may dispense only the quantity sufficient to last the minimum days over 31 days.
    - For example, if one vial lasts 12 days, dispense 3 vials to last 36 days, but not 4 vials to last 48 days.

Quantity Limits

There are no minimum quantity limits. For current detailed information specific to these dispensing limits, refer to the OptumRx TennCare website.

Minimum/Maximum Age Limits

For current detailed information specific to these limitations, refer to the OptumRx TennCare website.

Refills

- DEA Class = Ø: Original plus up to 99 refills within 366 days from original Date Rx Written
- DEA Class = 2: No refills
- DEA Class = 3-5: Original plus 5 refills within 183 days from original Date Rx Written

Rx/Month

TennCare Medicaid adults (defined as 21 years or older) who are not in an institution or Home and Community Based Services (HCBS) waiver are subject to a monthly prescription limit (see Section 8.7– Prescription Limits).

The prescription limit for TennCare is two (2) brand name prescriptions per calendar month(see Section 8.8 – Exceeding Prescriptions Limits for approved exceptions).

CoverRx adults (defined as 18–64 years old) have a prescription limit of five prescriptions per calendar month. Refer to the CoverRx Covered Drug list for exceptions to the monthly five prescription limit.

2.3 COORDINATION OF BENEFITS (COB)

Overview

Coordination of benefits is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments, and thus, prevention of duplicate payments.

Third-party liability (TPL) refers to:

- An insurance plan or carrier
- A program
- A commercial carrier

The plan or carrier can be:

- An individual
- A group
- Employer-related
- Self-insured
- A self-funded plan

The program can be Medicare, which has liability for all or part of an enrollee's medical or pharmacy coverage.

The terms third-party liability and other insurance are used interchangeably to mean any source other than Medicaid that has a financial obligation for health care coverage.

COB Process

TennCare is always the payer of last resort. If a member has Third-Party Liability (TPL), the claim must first be submitted to the other payers first.

If a claim is submitted for a member with existing TPL the pharmacy will receive a reject with NCPDP reject code 41 – "Submit Bill to Other Processor Or Primary Payer" as well as a supplemental message that includes any billing information we have for the primary payer, such as phone number, BIN, PCN, Group ID, and member ID. The Optum Rx COB process does require a match to the member's primary payer's Other Payer ID and submission of the Other Payer Date.

- Online COB (cost avoidance) is required. COB edits will be applied when TPL exists for the enrollee and claim date of service (DOS).
- COB processing requires that the Other Payer Amount Paid, Other Payer ID, Other Payer Date, and Other Payer Patient Responsibility be submitted on the claim to

TennCare. Pharmacy providers are asked to submit the TPL carrier code when coordinating claims for payment with a primary payer.

- System returns Other Payer details in "COB Response Segment" (items returned are subject to information received on the recipients COB records):
  - Other Payer Coverage Type
  - Other Payer ID Qualifier
  - Other Payer ID
  - Other Payer Processor Control Number
  - Other Payer Cardholder ID
  - Other Payer Group ID
  - Other Payer Person Code
  - Other Payer Help Desk Phone Number
  - Other Payer Patient Relationship Code
  - Other Payer Benefit Effective Date
  - Other Payer Benefit Termination Date

Reimbursement will be calculated to pay the lesser of the Medicaid allowed amount or the Other Payer Patient Responsibility as reported by the primary carrier, less the third-party payment.

- Medicaid copayments will also be deducted for participants subject to Medicaid copay. In some cases, this may result in the claim billed to Medicaid being paid at $0.00.
- Note: Optum Rx will not send a negative amount in the Amount Paid field if the TPL and copayment are greater than the Medicaid allowable.
- Copay Only Claims, Other Coverage Code = 8, are not allowed.

Refer to the Payer Specification document on the OptumRx TennCare website for specific requirements of the program.

The following are values and claim dispositions based on pharmacist submission of the standard NCPDP TPL codes. Where applicable, it has been noted which Other Coverage Code (NCPDP field 3Ø8-C8) should be used based on the error codes received from the primary.

Table 2.2—TPL Codes

NCPDP Field #3Ø8-C8	When to Use	Submission Requirements/Responses

Ø – Not Specified	OCC Ø is allowed; submit when member does not have TPL.	Claim will reject with a 41 error if member record has TPL. Additional fields in the NCPDP COB segment should not be submitted with this OCC. Claim should be submitted to TPL and then resubmitted with proper OCC and COB required fields.
1 – No Other Coverage	OCC 1 is allowed; this code can be used when the pharmacy cannot determine the valid TPL identity.	Additional fields in the NCPDP COB segment should not be submitted with this OCC. Claim should be submitted to TPL and then resubmitted to TennCare with proper OCC and COB required fields. Verify TPL information provided.
2 – Exists Payment Collected	OCC 2 is used when any positive amount of money is collected from another payer. Submit the amount collected from the primary payer (TPL), along with the date the claim was adjudicated to the primary payer (TPL) in order to override the TPL denial.	Paid claim and completed COB segment inclusive of the following fields: • Other Payer Amount Paid (431-DV) that is > $0 • Other Payer Amount Paid Qualifier (342-HC) must be a valid value • Other Payer-Patient Responsibility Amount Submitted (352-NQ) if ≥ $0 • Other Payer Date (443-E8) that is complaint with timely filing. • Other Payer ID (34Ø-7C) that is valid • Other Payer ID Qualifier (339-6C) that is valid • Claims submitted without required COB fields will reject with NCPDP code 13 or other specific reject codes.
3 – Exists Claim Not Covered	OCC 3 is used when the TennCare beneficiary has TPL, but the particular drug is not covered by the specific plan(s).	Requires submission of: • Other Payer Date (443-E8) • Other Payer ID (34Ø-7C) • Other Payer ID Qualifier (339-6C) And the reject code generated after billing the other insurer(s) in the "Other Payer Reject Code (472-6E)." Claim will only pay if the following Other Payer Reject Codes are submitted: 6Ø, 61, 63, 65, 66, 67, 68, 69, 7Ø, 3Y. Claims submitted without required COB fields will reject with NCPDPD code 13 or other specific reject codes.
4 – Exists Payment Not Collected	OCC 4 is used when a patient's TPL is active, but there is no payment collected from the primary insurer (i.e., the beneficiary has not met their primary payer's deductible obligation, plan capitation, etc.). OCC 4 should also be used if the total cost of the claim is less than the patient's TPL copay requirement and the primary insurance plan made no payment.	Paid claim; also requires submission of: • Other Payer Amount Paid (431-DV) = $0 • Other Payer Amount Paid Qualifier (342-HC) • Other Payer-Patient Responsibility Amount Submitted (352-NQ) if ≥ $0 • Other Payer Date (443-E8) that is valid • Other Payer ID (34Ø-7C) that is valid • Other Payer ID Qualifier (339-6C) Claims submitted without required COB fields will reject with NCPDP code 13 or other specific reject codes.
8 – Claim Billing for a Copay	OCC 8 is not accepted.	

2.4 COMPOUND CLAIMS

All compounds must be submitted using the NCPDP version D.0 standard multi-ingredient compound functionality. Therefore, all ingredients must be identified; their units must be indicated; and the ingredient cost for each ingredient must be submitted on the claim. At least one item in the compound must be a covered drug. If an excluded or non-PDL agent is included in the compound, the claim will reject for "invalid compound." The pharmacy may place an "8" in the Submission Clarification Code (NCPDP Field 42Ø-DK) and resubmit the claim; however, be advised that any component of a compound requiring a PA will necessitate an approval prior to receiving payment from the TennCare Pharmacy Program.

Important Notes:

- The Claim Segment Product ID (i.e., National Drug Code (NDC)) is defined as a mandatory field and, therefore, must be submitted for all claims, including multi-ingredient compounds.
- A non-blank space value is expected in the Claim Segment Product ID field for field validation. The pharmacy submits a single zero in this field for a multi- ingredient compound. For compound segment transactions, the claim is rejected if a single zero is not submitted as the Product ID.
- A Submission Clarification Code value of "8" only allows a claim to continue processing if at least one ingredient is covered. Non-covered ingredients will process with the submission clarification code; but only covered ingredients are eligible for reimbursement.
- The Compound Type (NCPDP Field 996-G1) is required to be submitted on all compound claims. If this field is not submitted, the claim will reject.
- Pharmacies must transmit the same NDC numbers that are being used to dispense the medication.
- Compounds that contain an antibiotic must also contain another active ingredient. For example, an antibiotic suspension plus flavoring, or an injectable antibiotic plus a fluid will not be covered as a compound.
- Coverage of Active Pharmaceutical Ingredients (APIs)
    - An API is defined by 21 C.F.R. § 207.3(a)(4) as a bulk drug substance that "is represented for use in a drug and that, when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient or a finished dosage form of the drug." APIs may be included in extemporaneously compounded prescriptions and may serve as the active drug component in a compounded formulation.
    - As of January 1, 2011, coverage of APIs is limited to select ingredients found to be cost-effective to TennCare. A list of APIs identified as being cost effective for the State can be found at the OptumRx TennCare website.
    - APIs are only payable when submitted as an ingredient in a compound. If they are submitted as a non-compound claim, the claim will deny.

- If total cost is not equal to the sum of the ingredients' cost, the claim will deny.
- Multiple instances of an NDC within a compound will not be allowed.
- Duplicate edits are applied regardless of the compound status of the claim.
- The pharmacy provider will use DUR/PPS Level of Effort (NCPDP Field 474-8E) to enter the appropriate value based on the preparation time of the compound. See Table 3.8 for Professional Dispensing Fees.

2.5 REQUIRED FIELDS FOR SUBMITTING MULTI-INGREDIENT COMPOUNDS

On Claim Segment:

- Enter Compound Code (NCPDP Field 4Ø6-D6) of "2."
- Enter Product Code/NDC (NCPDP Field 4Ø7-D7) as "Ø" on the claim segment to identify the claim as a multi-ingredient compound.
- Enter Product/Service ID Qualifier (NCPDP Field 436-E1) as "ØØ" to identify the product as a multi-ingredient compound.
- Enter Quantity Dispensed (NCPDP Field 442-E7) of entire product.
- Enter Gross Amount Due (NCPDP Field 43Ø-DU) for entire product.
- Submission Clarification Code (NCPDP Field 42Ø-DK) = Value "8" will only be permitted for POS (not valid for paper claims) and should be used only for compounds.
- DUR/PPS Level of Effort (NCPDP Field 474-8E). Enter the appropriate value based on the preparation time of the compound to determine the appropriate Professional Dispensing Fee.

On Compound Segment:

- Compound Dosage Form Description Code (NCPDP Field 45Ø-EF)
- Compound Dispensing Unit Form Indicator (NCPCP Field 451-EG)
- Compound Route of Administration (NCPCP Field 452-EH)
- Compound Ingredient Component Count (NCPCP Field 447-EC) (Maximum of 25) for Each Line Item
- Compound Product ID Qualifier (NCPCP Field 488-RE) of "ØØ"
- Compound Product ID (NCPDP Field 489-TE)
- Compound Ingredient Quantity (NCPDP Field 448-ED)
- Compound Ingredient Cost (NCPDP Field 449-EE)

2.6 PARTIAL FILLS

In those cases where a provider does not dispense the full amount per the prescriber's directions because of a drug shortage, the pharmacy provider should submit the claim as a partial fill and indicate as such on the claim transaction.

- Standard NCPDP fields required for partial fills will be supported and required.
- The Professional Dispensing Fee will be paid on the initial fill.
- The copayment, if applicable, will be collected on the initial fill.

Refer to the TennCare D.0 Payer Specification document on the OptumRx/TennCare website specific requirements of the program.

2.7 PARTIAL FILLS FOR CONTROLLED SUBSTANCES

Claims submitted for partial fills of Controlled Substances may be paid if:

- The partial fill is requested by the patient or the practitioner who wrote the prescription.
- The total quantity dispensed through partial fills does not exceed the total quantity prescribed for the original prescription.

Additionally, the pharmacist must retain the original prescription at the pharmacy where the prescription was first presented, and the partial fill dispensed.

Any subsequent fill must occur at the pharmacy that initially dispensed the partial fill and must be filled within six (6) months from issuance of the original prescription.

Pharmacies will be able to indicate an incremental fill of controlled substances using NCPDP submission clarification codes (SCC) as follows:

Submission Clarification Code (SCC)	Description	Comments
47	Initial fill	Full copay, if applicable Full dispensing fee Included in member's monthly prescription limit
48	Incremental fill	$0 copay Full dispensing fee Not included in member's monthly prescription limit
10	Completion fill	$0 copay Full dispensing fee Not included in member's monthly prescription limit

2.8 CLAIMS PROCESSING EDITS/REJECTS

After an online claim submission is made by a pharmacy, the POS system returns a message to indicate the outcome of the processing. If the claim passes all edits, a PAID message is returned with the allowed reimbursement amount. A claim that fails an edit and is REJECTED (or DENIED) also returns with an NCPDP rejection code and message. Refer to POS Reject Codes and Messages for a list of POS rejection codes and messages.

A duplicate disposition occurs when there is an attempt to submit a claim that has already gone through the adjudication process with either some or all of the previous claim's information. An exact match on the following fields results in a duplicate disposition:

- Same Patient/Member
- Same Service Provider ID
- Same Date of Service
- Same Product/Service ID
- Same Prescription/Service Reference Number

- Same Fill Number

In situations where there are matches on some of the above data elements, Optum Rx returns an NCPDP Error Code 83 – "Duplicate Paid Claim" to indicate a possible suspected duplicate.

There are situations where the provider sends the transaction request and Optum Rx receives the request and processes the transaction. Then, due to communication problems or interruptions, the response is not received by the provider. In these cases, the provider should resubmit the transaction request. Optum Rx responds with the same information as the first response, but the transaction response is marked as duplicate.

3. PHARMACY REIMBURSEMENT

3.1 OVERVIEW

Pharmacy claim reimbursement follows CMS guidelines and is based on AAAC, which is calculated by surveys that are conducted by TennCare's vendor. Participation in the survey process is mandatory for pharmacies in Optum's TennCare Provider network, as stated in the provider contract.

Dispensing fees are now referred to as Professional Dispensing Fees (PDF) which is equal to the average cost of dispensing a prescription by network providers in the State of Tennessee. This fee is calculated by TennCare's vendor and participation in this survey is mandatory for pharmacies in Optum's TennCare Provider network, as stated in the provider contract.

Pharmacies who fail to submit a "complete" response to 3 cost of dispensing and/or AAAC surveys will be subject to a reduced PDF of $5.00 on all prescription claims, with the exception of specialty medications and compounded products. A "complete" survey is defined as a good faith effort to submit all relevant invoices and/or to provide relevant, useable answers to at least 80% of the survey questions. To incentivize pharmacies to complete the cost of dispensing survey, TennCare will reset their non-response count to zero whenever a pharmacy submits a complete and timely cost of dispensing survey.

Additional information regarding TennCare's non-responder's policy can be found at the TennCare Policies website.

3.2 TENNCARE REIMBURSEMENT

Network Pharmacy Reimbursement Schedule

Pricing strategy for **Ambulatory – Low Volume network pharmacies** will be:

- The lesser of:
  - Federal Upper Limit (FUL) + Professional Dispensing Fee (PDF); or
  - Average Actual Acquisition Cost (AAAC) + PDF (if no FUL, or if AAAC is less than FUL); or

  - National Average Drug Acquisition Cost (NADAC) + PDF (if no AAAC or if NADAC is less than AAAC); or
  - Usual and Customary (U&C)
- If there is no FUL, AAAC, or NADAC, price at the lesser of:
  - Wholesale Acquisition Cost (WAC) – 3% + PDF for Brands or WAC – 6% + for Generics; or
  - U&C

Pricing strategy for **Ambulatory – High Volume network pharmacies** will be:

- The lesser of:
  - FUL + Professional Dispensing Fee (PDF); or
  - AAAC + PDF (if no FUL, or if AAAC is less than FUL); or
  - NADAC + PDF (if no AAAC or if NADAC is less than AAAC); or
  - U&C
- If there is no FUL, AAAC, or NADAC, price at the lesser of:
  - WAC – 3% + PDF for Brands or WAC – 6% + PDF for Generics; or
  - U&C

Pricing strategy for **LTC network pharmacies** will be:

- The lesser of:
  - FUL + Professional Dispensing Fee (PDF); or
  - AAAC + PDF (if no FUL, or if AAAC is less than FUL); or
  - NADAC + PDF (if no AAAC or if NADAC is less than AAAC); or
- If there is no FUL, AAAC, or NADAC price at WAC – 3% + PDF for Brands or WAC – 6% + PDF for Generics.
- Pharmacies will only be allowed a single PDF per GPI per calendar month per member per accumulated 26-day supply **select products excluded**

Pricing strategy for **Specialty network pharmacies** will be:

- The lesser of:
  - AAAC + PDF; or
  - NADAC + PDF (if no AAAC or if NADAC is less than AAAC)
- If there is no AAAC or NADAC, price at WAC – 3% + PDF for Brands or WAC – 6% + PDF for Generics

Pricing strategy for 340B claims from **340B pharmacies** will be:

- The lesser of:
  - 340B ceiling price + Professional Dispensing Fee (PDF); or
  - 340B Covered Entities' Acquisition Cost + PDF; or
  - U&C

Pricing strategy for non-340B claims from **340B pharmacies** will be:

- The lesser of:
  - FUL + Professional Dispensing Fee (PDF); or
  - AAAC + PDF (if no FUL, or if AAAC is less than FUL); or
  - NADAC + PDF (if no AAAC or if NADAC is less than AAAC); or
  - U&C
- If there is no FUL, AAAC, or NADAC, price at the lesser of:
  - WAC – 3% + PDF for Brands or WAC – 6% + PDF for Generics; or
  - U&C

For claims for diapers/training pants for TennCare members under 2 years old, the pricing strategy for **all pharmacies** will be:

- MAC + sales tax (calculated on MAC price) + Admin Fee
  - Note: PDF is not paid on diaper/training pants claims.

Compounds

Each individual ingredient is priced as above plus the applicable Professional Dispensing Fee based on Level of Effort.

Average Actual Acquisition Cost (AAAC)

The Centers for Medicare & Medicaid (CMS) Outpatient Drug Final Rule (81 FR5170) mandates that states adopt an ingredient reimbursement methodology based on the actual prices paid by providers to acquire drugs. TennCare conducted a TN Average Actual Acquisition Cost (AAAC) survey to establish the new ingredient cost reimbursement methodology. More information on the AAAC survey results and reimbursement methodology can be found at https://tn.mercerrxpassage.us/

When pharmacies find that their cost has increased, but there has not been a change in the AAAC for that product, or if a 340B covered entity pharmacy finds an issue with an estimated 340B ceiling price, pharmacies should not contact Optum Rx, but instead pharmacies may submit an Rate Review to TennCare's vendor at the following link: https://tn.mercerrxpassage.us/

3.3 TENNCARE PROFESSIONAL DISPENSING FEE

TennCare will provide the professional dispensing fees (PDF) included below to participating pharmacies:

- Ambulatory Pharmacies
  - Low Volume: prescription volume between 0–64,999 prescriptions/year: $13.16
  - High Volume: prescription volume greater than 65,000 prescriptions/year: $9.02
- Long-Term Care Pharmacies: $13.16

- 340B Pharmacies:
  - $16.92 for claims submitted as 340B claims
  - $13.16 for claims submitted as non-340B claims
- Specialty Pharmacies: $13.16
- Specialty drugs (regardless of pharmacy type): $52.46
- Blood Factor Products: $172.69 for all provider types
- Diapers/Training Pants: not applicable
- Compounds: up to $25.00; antibiotics are not authorized for this amount and pay the standard Professional Dispensing Fee.
  - The pharmacy provider will use DUR/PPS Level of Effort (NCPDP Field 474-8E) to enter the appropriate value based on the preparation time of the compound. The values for this field and resulting Professional Dispensing Fees (compounding fees) are as follows:

Table 3.8—Compound Claims—Professional Dispensing Fees (Effective 11/1/2023)

High Volume Ambulatory, Non-responder, or Dispensary Pharmacies		
Value	Preparation Time	Professional Dispensing Fee (PDF)
11	0-15 minutes	$10.00
12	16-30 minutes	$15.00
13	31+ minutes	$25.00

Low Volume Ambulatory, Specialty, LTC, or Non-340B claims from 340B Pharmacies		
Value	Preparation Time	Professional Dispensing Fee (PDF)
11	0-15 minutes	$13.16
12	16-30 minutes	$15.00
13	31+ minutes	$25.00

340B Claims from 340B Pharmacies		
Value	Preparation Time	Professional Dispensing Fee (PDF)
11	0-15 minutes	$16.92
12	16-30 minutes	$16.92
13	31+ minutes	$25.00

3.4 TENNCARE PHARMACY COPAYMENT

TennCare Medicaid children (defined as less than 21) are not subject to copays. TennCare Medicaid adults (defined as 21 or older) who have a pharmacy benefit and who are not LTC residents or HCBS waiver recipients are subject to copays. Exceptions include:

- Pregnant women
- People receiving hospice care
- TennCare Standard Children at or above 100 percent of the federal poverty level (based on Copay Indicator)

Note: Pregnant women and people receiving hospice care need to self-declare at the pharmacy to be exempt from the copay. The pharmacy may override the copay for a pregnant recipient by submitting a "2" in the Pregnancy Indicator field (NCPDP Field 335-2C). The pharmacy may override the copay for a recipient in hospice care by submitting an "11" in the Patient Residence field (NCPDP Field 384-4X).

- Brand name medications have $3.00 copay per prescription.
- Generic name medications have $1.50 copay per prescription.
- Family planning drugs are not subject to the copay.
- Diapers and training pants are not subject to the copay.
- The TennCare Pharmacy System determines the copay based on the above eligibility rules.
- Enrollees cannot be denied services for failure to pay copay.
- A claim for a multi-ingredient compound receives the brand copay.

3.5 COVERRX REIMBURSEMENT

CoverRx pharmacy claim reimbursement for products dispensed to CoverRx members follows lesser of methodology of the following:

- The pharmacy's usual and customary charge to the general public; or
- Average Wholesale Price (AWP) - 15% + PDF; or
- Maximum Allowable Cost (MAC) + PDF; or
- The FUL for certain multiple source drugs as established and published by CMS + PDF
- Professional Dispensing Fees for pharmacy providers deemed a Low Volume pharmacy for TennCare will be $13.16. All other providers will receive a PDF of $2.50 for brands and $3.00 for generics.

Pharmacy providers may request a claim reimbursement review by submitting a fully completed Claim Reimbursement Review Form[1] to Optum Rx within seven (7) business days of the paid claim's adjudication date.

- The pharmacy must include an original invoice for the NDC being appealed.
- The NDC reflected on the invoice submitted must match the NDC submitted on the pharmacy claim and Claim Reimbursement Review Form.
- The date reflected on the invoice must coincide with the date of service on the Claim Reimbursement Review Form and pharmacy claim submitted.
- The appeal will be denied if it lacks requisite information or is inaccurate or ambiguous.

Within seven (7) days, Optum Rx will provide a written response indicating the outcome. If a claim reimbursement adjustment is not warranted, Optum Rx will provide alternatives within the

[1] OptumRx MAC Reimbursement Review Form

response (when possible) that demonstrate product availability below the current reimbursement rate.

3.6 COVERRX COPAYMENT

CoverRx members are charged a $3.00 copay for generics at a retail pharmacy for a 30-day supply, and a $5.00 copay for brands at a retail pharmacy for a 30-day supply, generics at a retail pharmacy for over a 30-day supply, and a 90-day mail order supply.

4. PROVIDER INFORMATION

The Tennessee Pharmacy Provider Network consists of pharmacies that have been registered by TennCare, and have received a Tennessee Medicaid ID.

Enrollment into the Tennessee Pharmacy Provider Network requires the provider to first register with TennCare on the Provider Registration site.

Pharmacies must also have a network agreement with Optum Rx. Please contact Optum Rx at Independent.contracting@optum.com.

5. SPECIAL PARTICIPANT CONDITIONS

5.1 MEDICARE PRESCRIPTION DRUG COVERAGE

Adult members with TennCare coverage and Medicare are not eligible for Pharmacy benefits through TennCare. Pharmacy claims should be submitted through their Medicare Part D plan.

Children with TennCare and Medicare coverage are eligible for TennCare Pharmacy benefits as secondary coverage. The primary coverage should always be their Medicare Part D plan.

5.2 LOCK-IN

Enrollees may be locked into a designated pharmacy. Claims submitted for these individuals will deny NCPDP Error Code M2 – “Recipient Locked In” with an additional supplemental message when the claim is submitted by an unauthorized pharmacy. In the event of an emergency, contact the Optum Rx Pharmacy Support Center for override consideration.

Specific enrollees may also be subject to Prior Authorization requirements for all controlled substances. Controlled substance claims submitted for these individuals will deny NCPDP Error Code – “3N—M/I Prior Authorized Number Assigned” with a supplemental message that states “PA Required for each Controlled Substance Fill.” The prescribing physician is required to contact the Optum Rx Clinical Call Center for PA consideration.

5.3 HOSPICE AND LONG-TERM SERVICES AND SUPPORTS (LTSS) RECIPIENTS

Hospice Recipients

- Hospice patients are identified by the submission of the Patient Residence field (NCPDP Field 38404x) = 11.
- Hospice patients must be self-declared at the pharmacy.
- Hospice patients are exempt from copay.

Long-Term Services and Supports (LTSS) Recipients

- TennCare allows up to a 35-day supply per fill for LTSS claims.
- Drugs that are generally included as floor stock (prescription drugs or devices not labeled for a specific patient and maintained at a nursing station, floor stock delivery system or other hospital department, located outside the pharmacy, for the purpose of administration to a patient of the facility) are not covered if the patient is a resident in a LTSS facility.
- PA, PDL, and ProDUR edits (as described for retail) apply unless specifically noted otherwise. (No copay, no Rx limit)
- Community and home based may have some limits apply (determined by the member's benefit package).
- LTSS determination is made strictly on eligibility requirements and is not necessarily based on the location where a patient resides. TennCare makes LTSS eligibility determinations based on pre-admission evaluation information provided by the facility.
- Patients who reside in assisted living facilities are not considered as LTSS patients.

5.4 NEWBORN PRESCRIPTION CLAIMS

Submit the claim under the parent's Optum Rx ID number, date of birth, last name, and first name with the word "baby" at the end of the first name. If the parent is not covered, the newborn will not have coverage until added.

Note: If the Claim rejects for over the monthly prescription limit, contact the Optum Rx Pharmacy Support Center Help Desk.

Providers are encouraged to submit the Patient Relationship Code field (NCPDP Field 3Ø6-C6) with a code of '3' on newborn claims.

For claims for diapers for newborns, submit as above along with Prior Authorization Type Code field (NCPDP Field 461-EU) '8' and Prior Authorization Number Submitted field (NCPDP Field 462-EV) '55555555555' (eleven 5s). This override code will work for two claims for diapers for newborns without their own Optum Rx ID number. For additional claims, such as for multiples (twins, triplets, etc.), please contact Optum Rx Pharmacy Support Center Help Desk.

5.5 VOLUNTARY DISMISSAL OF PATIENT BY PHARMACY

In the event a TennCare Pharmacy Provider determines that he/she cannot establish and/or maintain a professional relationship with a TennCare enrollee or an enrollee's representative and will no longer provide TennCare pharmacy services for either individual, that decision is to be reported directly to the Bureau of TennCare. It is to be reported within 24 hours of the occurrence. In the event of the date of determination occurring on a weekend (Saturday or Sunday) or a State/Federal holiday, the determination is to be reported on the next business day.

5.6 340B CLAIMS

340B pharmacies will be required to identify 340B claims by submitting the Submission Clarification Code (42Ø-DK) of 20 and a Basis of Cost Determination (423-DN) of 08 "Disproportionate Share Pricing." It is also required that 340B pharmacies submit their Actual Acquisition Cost for 340B claims in the Ingredient Cost Submitted field (4Ø9-D9) and their normal Usual and Customary rate in the Usual and Customary Charge field (426- DQ). Specifics are also listed at the OptumRx TennCare website.

Non-340B claims should be billed at the regular rate and not include the values required above.

6. PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR)

6.1 OVERVIEW

ProDUR encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of Optum Rx assists in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing assists the pharmacists to ensure that their patients receive the appropriate medications.

Because the Optum Rx ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. Optum Rx recognizes that the pharmacists use their education and professional judgments in all aspects of dispensing.

6.2 DRUG UTILIZATION REVIEW (DUR) EDITS

The following ProDUR edits will deny for TennCare:

- Early Refill (ER)
  - Non-Controlled Products Early Refill Tolerance: 85%
  - For non-controlled products, the system will automatically check for an increase in dose and when an increase in dosage is detected, the system will not deny the current claim for early refill.
  - Controlled Products Early Refill Tolerance: 95%

    - The Call Center may assist in overriding this reject if one of the following circumstances exist:
        - Dosage/therapy change has occurred.
        - Patient is no longer taking the original dosage.
        - Dosage time/frequency change has occurred.
        - Two strengths of the same drug are used to make a strength of that medication not currently manufactured.
- Therapeutic Duplication (TD)
    - ProDUR edits involving: Narcotic Analgesics, Sedative Hypnotics, Benzodiazepines, or Skeletal Muscle Relaxants require a telephone call to the Clinical Call Center to obtain an override.
- Drug-to-Drug Interactions (DD)
    - Minimum/maximum daily dosing (LD, HD) High Dose HD only: tolerance at 100%
- Drug-to-Gender (SX)
    - Severity level 1 interaction will deny and require a call to the Pharmacy Support Center for override consideration. Severity level 2 interactions will return ProDUR message.
- Drug-to-Pregnancy Precautions (PG)
- Drug-to-Geriatric Precautions (PA)
- Drug-to-Pediatric Precautions (PA)

6.3 PRO-DUR OVERRIDES

The following are the NCPDP interactive Professional Service, Result of Service, Reason for Service, and Submission Clarification Codes. These codes may be used to override ProDUR denials at the POS.

Problem/Conflict Type: The following override codes may be used by providers in any condition where a provider-level override is allowed for ProDUR denials.

Table 6.3.1—ProDUR Overrides

Professional Service Codes Allowed for Submission	All codes are allowed for all conflict types.
Professional Service Code/Description	Select one: • M0/Prescriber Consulted • P0/Patient Consulted • RO/Physician Consulted, Other
Result of Service Codes Allowed for Submission	All codes are allowed for all conflict types.
Result of Service Code/Description	Select one: • 1A/filled as is, false positive • 1B/filled prescription as is • 1C/filled, with different dose • 1D/filled, different direction • 1E/filled, with different drug • 1F/filled, different quantity • 1G/filled, prescriber approved
Reason for Service Code	• ER (only for non-controlled and only for increase in dose) • DD • TD • SX • PA (drug-age)
Submission Clarification Code/Description (Listed only as reference, not required on claims)	Select one: • 02/other override • 03/vacation supply • 04/lost prescription • 05/therapy change • 06/starter dose • 07/medically necessary

All ProDUR alert messages appear at the end of the claims adjudication transmission. Alerts appear in the following format:

Table 6.3.2—ProDUR Alert Format

Format	Field Definitions
Reason for Service	Up to three characters. Code transmitted to pharmacy when a conflict is detected (e.g., ER, HD, TD, DD).
Severity Index Code	One character. Code indicates how critical a given conflict is.
Other Pharmacy Indicator	One character. Indicates if the dispensing provider also dispensed the first drug in question. • 1 = your pharmacy • 3 = other pharmacy
Previous Date of Fill	Eight characters. Indicates previous fill date of conflicting drug in YYYY/MM/DD format.
Quantity of Previous Fill	Five characters. Indicates quantity of conflicting drug previously dispensed.
Database Indicator	One character. Indicates source of ProDUR message. 1 = MediSpan 4 = processor developed
Other Prescriber	One character. Indicates the prescriber of conflicting prescription. • 0 = no value • 1 = same prescriber • 2 = other prescriber

6.4 PPS CONFLICT COES FOR PATIENTS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY (I/DD)

Patients with an intellectual or developmental disability (I/DD) who are receiving 4 or more agents from the following PDL classes will deny for Prior Authorization required with the message: “Multiple Psychotropics Alert: RPh Review Required.”

- Agents for Opiate Detoxification
- Anti-Anxiety Agents
- Antidepressants: SSRIs
- Antidepressants: SSRI/SRM
- Antidepressants: SNRIs
- Antidepressants: New Generation
- Antidepressants: MAOIs
- Antidepressants: Tricyclics
- Antipsychotics: Typicals
- Antipsychotics: Atypicals
- Atypical Antipsychotic/SSRI Combinations
- Sedative Hypnotics

Pharmacists, with the appropriate information and documentation (if needed to complete the review), will be able to re-submit the denied claims using the Professional Pharmacy Service (PPS) codes in the following table. This process should assist to expedite the denial clarification and successful adjudication while maintaining safe and effective therapy for all claims impacted by this Prospective Drug Utilization Review edit.

Table 6.4—Professional Pharmacy Service (PPS) Codes

Response Field	Response Codes	
Intervention Code	AS	Patient Assessment
	CC	Coordination of Care
	MØ	Prescriber consulted
	MA	Medication Administration
	MP	Patient will be monitored
	MR	Medication Review
	PØ	Patient consulted
	PH	Patient Medication History
	PM	Patient Monitoring
	RØ	Pharmacist consulted other source
	SW	Literature search/review
	TH	Therapeutic Product Interchange
Outcome Code	1A	Filled As Is, False Positive
	1B	Filled Prescription As Is
	1C	Filled, With Different Dose
	1D	Filled, With Different Directions
	1E	Filled, With Different Drug
	1F	Filled, Different Quantity
	1G	Filled, With Prescriber Approval
	2A	Prescription Not Filled

7. PREFERRED DRUG LIST AND PRIOR AUTHORIZATION REQUIREMENTS

7.1 PREFERRED DRUG LIST (PDL)

All claims are interrogated against the Preferred Drug List (PDL), benefit requirements, and DUR criteria. A complete listing of PA criteria, step therapy requirements, quantity limits, and duration of therapy edits can be found on the OptumRx TennCare website.

All claims are interrogated for compliance with state and federal requirements.

Prescriptions must be dispensed pursuant to the orders of a physician or legally authorized prescriber. Any subsequent refills may be dispensed not more than one year from the date the prescription was written (or earlier whenever legally dictated).

CIIs may not be refilled; a new prescription is required for each fill.

Controlled drugs other than CIIs may be refilled, pursuant to the order of a physician or legally authorized prescriber, up to five refills or six months, whichever comes first.

Non-controlled drugs may be refilled, pursuant to the order of a physician or legally authorized prescriber, up to one year.

7.2 COVERED DRUGS

All active rebateable drugs are covered unless otherwise noted on the Drug Exclusion or other limited drug coverage list.

Excluded Products:

- DESI/IRS/LTE drugs are not covered.
- Agents when used for anorexia, weight loss, or weight gain, except for weight loss drugs prescribed for treatment of obesity
- Agents when used to promote fertility.
- Agents when used for cosmetic purposes or hair growth.
- Most agents when used for the symptomatic relief of cough and colds.
- Prescription vitamins and mineral products, except prenatal vitamins, renal vitamins, and fluoride preparations.
- Most non-prescription drugs (see Section 7.4—Covered OTC Products)
- Prescription drugs and compound agents produced by a manufacturer that is not participating in the Medicaid Drug Rebate program (i.e., non-rebateable products).
- Agents when used for the treatment of sexual or erectile dysfunction.
- Dummy NDCs are not allowed. Generic UPCs are allowed for diaper products.
- Non-self-administered drugs must be billed through the medical benefit, with some exceptions.

Claims for excluded products will deny and return the following NCPDP Error Code(s):

- NCPDP Error Code – 70 “Drug not covered” returned on claims submitted for the adult population (defined as 21 or older).
- NCPDP Error Code – 75 “PA Required” returned on claims submitted for children (defined as under 21).
- NCPDP Error Code – “AC—Product Does Not Offer Federal Rebate, Not Cov’d. Please Try Alternate NDC or Refer to PDL.”

Medicaid Drug Rebate Program (MDRP)

The Medicaid Drug Rebate Program (MDRP) is a program that includes Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and participating drug manufacturers that helps to offset the Federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients. The program requires a drug manufacturer to enter, and have in effect, a National Drug Rebate Agreement (NDRA) with the Secretary of the Department of Health and Human Services (HHS) in exchange for state Medicaid coverage of most of the manufacturer’s drugs.

A complete list of manufacturers by labeler code (the first five digits of the NDC) that have entered into a rebate agreement with the federal government is available on the Optum Rx/TennCare website. The TennCare Active Labelers list is posted under the “Program Information” section. To ensure that the appropriate manufacture is invoiced for rebates due to the State, pharmacy providers must accurately bill NDCs dispensed.

Claims for products from non-participating manufacturers will reject at POS with the following message: “AC—Product Does Not Offer Federal Rebate, Not Cov’d. Please Try Alternate NDC or Refer to PDL.”

Providers are encouraged to inform their patients who are prescribed a non-rebateable product that switching to a covered product will decrease delays in receiving their medications. Some manufacturers that do not participate in the MDRP allow patients receiving Medicaid benefits to qualify for their Patient Assistance Programs (PAPs). Providers can assist members with applying to applicable manufacturer Patient Assistance Programs (PAPs) or submit prior authorization requests for members needing these medications.

7.3 LONG-TERM CARE (LTC) PER DIEM

TennCare has identified drugs that are not covered for LTC members through the pharmacy benefit, as these drugs are covered in the LTC “per diem” reimbursement and are the responsibility of the LTC to provide:

- Antacids (facility must provide at least one of the following):
  - Aluminum/Magnesium Hydroxide Suspension (Maalox®)
  - Concentrated Aluminum/Magnesium Hydroxide Suspension (Maalox TC®)
  - Aluminum/Magnesium Hydroxide + Simethicone Suspension (Mylanta®, Gelusil®)
  - Concentrated Aluminum/Magnesium Hydroxide + Simethicone Suspension (Gelusil II®, Mylanta II®)
- Antidiarrheals (facility must provide at least one of the following):
  - Bismuth Subsalicylate Suspension (Pepto-Bismol®)
- Laxatives and Stool Softeners (facility must provide at least two of the following):
  - Docusate sodium 100 mg capsules (Colace®, DOSS®, Dulcolax®)
  - Milk of Magnesia (MOM)
  - Mineral oil
  - Bisacodyl 5 mg tablets (Dulcolax®)
  - Milk of magnesia with cascara sagrada
- Cough and Cold:
  - Guaifenesin syrup (Robitussin®)
- Internal Analgesics (facility must provide all of the following):
  - Acetaminophen 325 mg tablets (Tylenol®)
  - Aspirin 325 mg tablets
  - Acetaminophen 650 mg suppositories or aspirin 650 mg suppositories
  - Acetaminophen 160 mg/5 ml suspension
- Topicals (facility must provide all of the following):
  - Isopropyl alcohol 70%
  - Hydrogen peroxide 3%
  - Neomycin/Polymyxin/Bacitracin topical ointment (Neosporin®)
  - Povidone-Iodine solution (Betadine®)
  - Lemon and glycerin swabs

- Topical skin moisturizing lotion
- Mouthwash

7.4 COVERED OTC PRODUCTS

TennCare has certain OTC items that are covered. These items must be dispensed pursuant to the order of a physician or legally authorized prescriber. Full lists are available at the OptumRx TennCare website.

- TennCare will provide OTC coverage for full, unopened packages only.
  - Some products are only available in package sizes that will last longer than TennCare's current plan limitations. Pharmacies are to enter the correct days supply for the claim, and for those products with unavoidable larger package sizes, the current days supply limitation of 31-days will not be enforced (e.g., 100-count multivitamin to be taken once daily should be submitted as 100-day supply).
  - Optum Rx strongly encourages pharmacies to review your current products that you submit to TennCare routinely, and if not on the published list, ensure that you stock the covered NDC's.
- Per guidance from CMS, TennCare will provide OTC coverage for products that are submitted with the pharmacy's Usual and Customary (U&C) over-the-counter price. The U&C price that is submitted must be the price that anyone not shopping for prescriptions pays in your pharmacy or store for these items.
  - For example, if a 4oz. bottle of guaifenesin syrup sells on your over-the-counter shelves in your store or pharmacy for $3.59, the claim must be submitted with $3.59 as your U&C price.
- Prior authorization will be required for products with package quantities higher than a normal course of therapy and for products priced significantly higher than other products in the same category.

Diapers/Training Pants

Beginning August 7, 2024, TennCare and CoverKids will cover up to 100 diapers per month (max of 200 diapers per 60 days) for members under two years of age.

- Pharmacies can submit full package quantities up to the limit to a member's pharmacy benefit.
  - Multiple packages can be submitted up to the 200 diaper per claim limit.
- Days supply should be calculated using 3.3333 diapers per day. Example: a package of 96 diapers should be processed as a 29-day supply.
  - Diapers can be refilled at the 85% refill threshold.
- Pharmacies can choose to utilize the Diaper Request Form posted on the TennCare Diaper website to aid in collecting member information, product selection, and attestation from the parent/guardian to prevent fraud, waste, and abuse of the program. The form is not required.
- Pharmacies are required to collect proof of receipt at point-of-sale.

- Pharmacies should utilize the pharmacy or pharmacist's NPI in the Prescriber Field (NCPDP Field Number 411-DB) along with Submission Clarification Code = 42 (NCPDP Field Number 420-DK). Origin code should be 5-Pharmacy (NCPDP Field Number 419-DJ).
- Pharmacies in Tennessee will need to submit sales tax on diaper claims. Pharmacies in other states should follow their state laws around sales tax. Information about submission of sales tax is in the Diaper Billing Guide.
- Covered Diaper UPCs will be posted on the TennCare Diaper Benefit website at: http://www.tn.gov/tenncare/diapers.
    - Pharmacies may purchase diapers/training pants from any wholesaler or retailer but should maintain invoices and/or receipts for audit purposes for the length of time listed in the Network Agreement.
    - Pharmacies may utilize the Generic Diaper UPCs to dispense non-covered diaper products to members. More information about Generic Diaper UPCs and the Generic Diaper UPC list can be found on the TennCare Diaper Benefit website.
    - Current MAC rates for diapers may also be found on the website.
- Pharmacies may submit rate inquires to TennCare's pricing vendor, Mercer, via their website: https://tn.mercerrxpassage.us/ .

For a billing guide, optional diaper request form, Frequently Asked Questions, and Covered Product list, please visit the TennCare Diaper Benefit program website: https://tn.gov/tenncare/diapers

7.5 INJECTABLE DRUGS

If an injectable product is not listed on the Covered Injectable Drugs list at the OptumRx TennCare website and not otherwise included, the injectable product will deny and will need to be billed to the patient's respective Managed Care Organization (MCO). MCO contact information can be found at Managed Care Organizations (tn.gov).

NCPDP Reject Code 816 – "Bill Patient MCO/Medical Plan" or "Service Not Covered, Obtain Via Clinic" is returned on claims submitted for the adult population (defined as 21 or older).

7.6 PRESCRIPTION LIMITS

TennCare Medicaid adults, (defined as 21 or older) who are not in an institution or Home and Community Based Services (HCBS) waiver, are subject to a monthly prescription limit.

Exception: As noted above, non-pregnant Medically Needy adult enrollees who are not in an institution or HCBS waiver have no pharmacy benefit.

- As of August 1, 2025, the affected enrollees are limited to two brand prescriptions and/or refills each calendar month. The monthly limit for generic prescriptions has been removed.
- The POS system also enables the pharmacist to determine when a claim is denied because of the prescription limit. The rejection is an NCPDP Error Code of 76 "Plan Limitations Exceeded" with a supplemental message of "Rx limits exceeded, max 2 brands/month."
- Pharmacies may bill enrollees for prescriptions over the prescription limit; however, the pharmacy should attempt to process the prescription and receive the "over the limit" denial before billing the patient.

- In rare circumstances, the TennCare PDL may list only brand name drugs as preferred agents in a drug class in which generic drugs are available. In such cases, the preferred brands are treated like generics in that they do not count toward the two brands per month limit, and they do not carry the brand copay. A list of these products can be found on the OptumRx TennCare website under "Brand as Generic List."

7.7 EXCEEDING PRESCRIPTION LIMITS

There are two ways a TennCare enrollee who is subject to prescription limits can receive prescriptions over and above the monthly limit, (i.e., more than two brand name prescriptions per month):

- Auto-Exemption & Attestation Drug List: a select list of drugs and products exempt from monthly script limit.
  - TennCare has developed a list of medications called the Auto-Exemption & Attestation Drug List that do not count towards the monthly prescription limit.
  - The Auto-Exemption & Attestation List is applicable only to enrollees who have pharmacy coverage. Enrollees without pharmacy coverage may not obtain drugs on this list.
  - The pharmacy POS recognizes the Auto-Exemption & Attestation Drug List products and ensures that they are not counted towards the limit.
  - See Table 7.7.1 for medication categories included on the Auto-Exemption List. Table 7.7.2 shows medication categories included on the Attestation List.
  - The Auto-Exemption & Attestation List can be found on the Optum Rx TennCare website.
- Dose-Titration Override: select drugs (listed in Table 7.7.3) and/or drug classes the pharmacy provider is allowed to process a second claim for within 21 days of the initial claim.

Table 7.7.1—Auto-Exemption List

Auto-Exemption List*		
Antineoplastics	Dialysis Medications	Long-Acting Antipsychotics
Antiparkinsonian Agents	Flu Vaccines (injectable only)	Miscellaneous
Antitubercular Agents	Hematopoietic Agents	Prenatal Vitamins
Antivirals	Hepatitis C Agents	Respiratory Agents (generics only)
Cardiovascular Oral Agents (generic only)	Inhaled Antibiotics	Smoking Cessation Agents
Clotting Factors	Immunosuppressives	Supplies—Diabetes & Asthma
Contraceptives	Insulins	Total Parenteral Nutrition (TPN)
Diabetes Oral Agents (generic only)	Iron Preparations	Transplant Agents

Table 7.7.2—Categories Included on Prescriber Attestation List

Categories Included on Prescriber Attestation List*		
Antianginals	Antivirals	Otics
Antiarrhythmics	Cardiac Glycosides	Pancreatic Enzymes
Antibiotics	Diuretics	Parkinson's Agents

Anticoagulants	Hyperkalemia Agents	Pheochromocytoma Agents
Anticonvulsants	Hypotensives	Potassium Supplements (Rx only)
Antidepressants	Immune Globulins	Pulmonary Arterial Hypertension Agents
Antiemetics	Multiple Sclerosis Agents	Respiratory Agents
Antifungals	Nitroglycerin preparations	Rheumatoid Arthritis Agents
Antiparasitics	Ophthalmic preparations	Thyroid Hormones
Antiplatelets	Oral Steroids	Vasodilators
Antipsychotics	Oral Thrombopoietic Agents	Vasopressors

Full list available at: https://welcome.optumrx.com/tenncare/landing

*Note: the above lists may not be all inclusive and are subject to change.

Table 7.7.3—Dose Titration List

Dose Titration List*		
Drug Class	Drug Name	Submission Clarification Code (SCC)
Anticoagulants	warfarin, Jantoven®	2
Anticonvulsants	all anticonvulsants	2
Atypical Antipsychotics (*see below for clozapine products)	all agents	2
Immune Globulin	Hizentra™	2
Low Molecular Weight Heparins	Arixtra®, Fragmin®, Lovenox®, and Innohep®	2
Oral Oncology Agents	All agents except methotrexate, mercaptopurine, hydroxyurea, leucovorin, mesna, and thalidomide.	2
Selective Norepinephrine Reuptake Inhibitors (SNRIs)	all agents	2
Selective Serotonin Reuptake Inhibitors (SSRIs)	all agents	2
Thrombopoietin Agonists	Promacta®	2
Thyroid Hormones	levothyroxine	2
Xanthines	theophylline	2
Atypical Antipsychotics (clozapine products)	clozapine, clozapine ODT, Clozaril®, FazaClo® ODT, and Versacloz®	6
Miscellaneous Agents	Subutex®, Suboxone®, Zubsolv®, Bunavail®, and buprenorphine	6

Full list available at: https://welcome.optumrx.com/tenncare/landing

*Note: the above lists may not be all inclusive and are subject to change

7.8 PRIOR AUTHORIZATIONS (PA)

Diagnosis Override PAs

Prior Authorization requirements can be bypassed for certain medications when specific medical conditions exist. Those specific medications and diagnoses are available at the OptumRx TennCare website.

Prescribers are encouraged to include the applicable diagnosis code on the prescription for submission on the electronic pharmacy claim.

The incoming claim should include a Diagnosis Code Qualifier (field 492-WE) of "01," indicating ICD-10, as well as the appropriate Diagnosis Code (field 424-DØ).

Clinical PAs

The Optum Rx Clinical Call Center will receive PA requests for products that have clinical edits for the TennCare program. PA request(s) are made by the prescriber or the prescriber's agent. Requests may be initiated by telephone, fax, or Web PA. The member may also initiate a PA request by contacting the Member PA line. The Clinical Call Center will send a fax to the member's prescriber, requesting the required information needed to issue a PA. This is only done after the Clinical Call Center determines that 24 hours have elapsed since the claim for the requested medication was submitted and denied and no PA has been initiated and/or issued.

When a clinical PA request is denied, the Optum Rx Clinical Center will produce and mail a denial letter to the beneficiary and notify the prescriber on the denial per fax.

Pharmacist Responsibilities for PARFS

Participation in the TennCare pharmacy program requires pharmacists to adhere to the specific process when unresolved point-of sale denials are encountered. Denials for non-preferred medications, step therapy, therapeutic duplication, and quantity limits are subject to the following requirements of the CMS Appeals and Grievances guidelines.

- The pharmacist must attempt to contact the prescriber and/or Optum Rx Clinical Support Call Center at 1-866-434-5524 to resolve the denial.
- If the pharmacist is unable to resolve the denial and dispense the prescription in full, the pharmacist must complete and give the patient the Prior Authorization Required Form (PARF).
- The PARF explains why the patient is not receiving the prescribed medication or full amount, and how a patient may help initiate the prior approval process.
- If the pharmacist contacts the prescriber and he or she indicates that a prior authorization will be initiated (but has not yet been obtained), the pharmacist should provide the patient with the PARF.
- If the pharmacist is unsuccessful in reaching the prescriber and resolving the matter, the pharmacist should consider providing an emergency three-day supply of the medication in accordance with the procedures listed in the section below.
- Regardless of whether the patient receives an emergency supply, a PARF must be provided whenever the prescribed medication or the quantity ordered is not received.
- A copy of the PARF is also available online at the or by calling 1-866-434-5524.

Emergency Protocols

The TennCare Pharmacy Program requires pharmacists to adhere to specific procedures when unresolved POS denials are encountered. Denials for non-preferred medications, step therapy, therapeutic duplication, and quantity limits are subject to the following CMS Appeals and Grievances guidelines: The pharmacist must attempt to contact the prescriber and/or Optum Rx Pharmacy Support Center to resolve the denial. If the pharmacist is unsuccessful in reaching the

prescriber and resolving the matter, the pharmacist should consider providing an emergency three-day supply of the medication.

Note: An emergency situation is a situation that, in the judgment of the dispensing pharmacist, involves an immediate threat of severe adverse consequences to the enrollee, or the continuation of immediate and severe adverse consequences to the enrollee, if an outpatient drug is not dispensed when a prescription is submitted.
Pharmacies may **NOT** dispense a 3-day Emergency Supply for prescriptions when:

- A member has reached a benefit limit (days supply limit, quantity limit, monthly prescription limit, etc.), OR
- The prescribed drug is excluded from TennCare coverage. Plan exclusions include:
  - DESI/IRS/LETE drugs are not covered.
  - Agents when used for anorexia, weight loss, or weight gain, except for weight loss drugs prescribed for treatment of obesity
  - Agents when used to promote fertility.
  - Agents when used for cosmetic purposes or hair growth.
  - Cough and cold products not found on TennCare's Covered OTC Product List (see Section 7.4—Covered OTC Products)
  - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations, and others found on TennCare's Covered OTC Product List (see Section 7.4—Covered OTC Products)
  - Nonprescription drugs not found on TennCare's Covered OTC Product List (see Section 7.4) Covered OTC Products
  - Prescription drugs and compounded agents produced by a manufacturer that is not participating in the Medicaid Drug Rebate program (i.e., non-rebateable products).
  - Agents when used for the treatment of sexual or erectile dysfunction.
  - Dummy NDCs are not allowed.
  - Non-self-administered drugs must be billed through the medical benefit, with some exceptions.

Claims for excluded products will deny and return the following NCPDP Error Code(s):

- NCPDP Error Code –70 "Drug Not Covered" returned on claims submitted fort the adult population (defined as 21 or older).

Emergency Supply Override Process

- Claim denied for non-preferred or requiring PA.
- The pharmacist should determine if an immediate threat of severe adverse consequences exists should the patient not receive an emergency supply.
- In the pharmacist's judgement, if the dispensing of an emergency supply is warranted, determine the appropriate amount for a three-day supply. For unbreakable packages, the full package can be dispensed.

- Resubmit the adjusted claim to Optum Rx, including both a Prior Authorization Type Code (NCPDP Field 461-EU) of "8" and Prior Authorization Number (NCPDP Field 462-EV) of "88888888888" (eleven 8s) to override the POS denial.
    - The enrollee is not charged a copay for the emergency supply.
    - The emergency supply DOES count toward the monthly prescription limit if the prescription is for a brand name product.
    - Only one emergency supply is provided per drug, per member per year.
    - TennCare will not pay for the remainder of the original prescription at any pharmacy unless the prescriber has received a PA. If the prescriber obtains a PA or changes the drug to an alternative not requiring a PA in the same month, the remainder of the prescription and/or substitute prescription does not count toward the monthly brand limit.
    - To exempt the remainder of the prescription from the prescription limit once a PA is obtained, or to exempt the replacement prescription from counting toward the monthly brand prescription limit, the value of "5" must be submitted in the Submission Clarification Code (NCPDP Field 42Ø-DK) on the incoming claim within 14 days of the initial prescription.

Pharmacy Override Summary

TABLE 7.8—Pharmacy Override Summary

Override Type	Override NCPDP Field	Code
Emergency 3-Day Supply of Non-PDL Product (Exempt from copay)	Prior Authorization Type Code (461-EU)	8
	Prior Authorization Number (462-EV)	Eleven 8s
Filling the remainder of an emergency 3-day supply after a PA is obtained or the drug is changed to a formulary agent (within 14 days) for the 2 fills to count as one prescription. Copay applies.	Submission Clarification Code (SCC) (42Ø-DK)	5
Hospice Patient (exempt from copay)	Patient Residence Field (384-4X)	11
Pregnant Patient (exempt from copay)	Pregnancy Indicator Field (335-2C)	2
Titration Dose Override	Submission Clarification Code (SCC) (42Ø-DK)	2
Titration Dose/Fill Override *Process the 2nd, 3rd, 4th, or 5th Rx for the same drug with the override code to avoid the subsequent Rx counting as another Rx against the limit.	Submission Clarification Code (SCC) (42Ø-DK)	6

7.9 COVERRX COVERED DRUG LIST

CoverRx covers more than 200 generic medications, insulin, diabetic supplies, and mental health drugs. CoverRx also provides discounts on most, but not all, non-covered drugs. Refer to the CoverRx Drug Covered List for a complete list of covered drugs.

8. AUDIT AND PROGRAM INTEGRITY

8.1 OVERVIEW

To ensure the safety of its enrollees and monitor pharmacy services provided by the TennCare Pharmacy Program, Optum Rx will maintain a comprehensive Program Integrity Plan including policies and procedures to address the prevention of fraud, waste, and abuse (FWA). Our process is designed to identify fraud, waste, and abuse as well as inappropriate billings. Our comprehensive program integrity plan includes desktop and on-site audits, verification of benefits letters, retrospective claim audits, reporting and analytics, clinical review, as well as more in-depth investigational audits when warranted. In addition, Optum Rx will educate its pharmacy provider network on the correct way to bill claims and incorporate findings into our system to prevent and detect future occurrences.

Optum Rx cooperates with oversight agencies, including but not limited to, TennCare's Office of Program Integrity, the Tennessee Bureau of Investigation, Medicaid Fraud Control Division (TBI MFCD), and the State of Tennessee's Office of the Inspector General (OIG).

Optum Rx promptly refers any information or allegation concerning possible unethical or improper business practices by providers within the Optum Rx network to TennCare OPI and TBI MFCD.

8.2 FWA DEFINITIONS

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care It also includes Member practices that result in unnecessary cost to the Medicaid program.

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law.

Waste: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Member Fraud: If a Provider suspects a Member of ID fraud, drug-seeking behavior, or any other fraudulent behavior, it should be reported to Optum Rx or TennCare.

8.3 RIGHT TO INSPECTION BY GOVERNMENT ENTITIES

Provide that TennCare, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCD, and DOJ, as well as any authorized state or federal agency or entity, shall have the right to evaluate through inspection, evaluation, review, or request, whether announced or unannounced, or other means any records pertinent to the Agreement, including, but not limited to,

- Medical records,

- Billing records,
- Financial records, and/or any records related to services rendered, quality, appropriateness, and timeliness of services; and/or
- Any records relevant to an administrative, civil, and/or criminal investigation and/or prosecution.

When performed or requested, the evaluation, inspection, review, or request, shall be performed with the immediate cooperation of the Pharmacy. Upon request, the Pharmacy shall assist in such reviews, including the provision of complete copies of medical records. Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not bar disclosure of protected health information (PHI) to health oversight agencies, including but not limited to, OIG, TBI MFCD, Department of Health and Human Services (DHHS) OIG and Department of Justice (DOJ), so long as these agencies operate in compliance with applicable regulations. Provide that any authorized state or federal agency or entity, including, but not limited to, TennCare, OIG, TBI MFCD, DHHS OIG, DOJ, and the Office of the Comptroller of the Treasury may use these records and information for administrative, civil, or criminal investigations and prosecutions within the limitations set forth under HIPAA and Health Information Technology for Economic and Clinical Health (HITECH). Said records are to be provided by the provider at no cost to the requesting agency.

8.4 MONTHLY SCREENING REQUIREMENTS AND EXCLUSION FROM PARTICIPATION IN GOVERNMENT HEALTHCARE PROGRAMS

For the purpose of the Exclusion and Screening Requirements, the following definitions shall apply:

- "Exclusion Lists" means the US DHHS's OIG's List of Excluded Individuals/Entities, the General Services Administration's List of Parties Excluded from Federal Programs, and the TennCare Terminated Provider List.
- "Ineligible Persons" means any individual or entity who:
    - Is, as of the date of such Exclusion Lists are accessed by the Provider, excluded, debarred, suspended, or otherwise ineligible to participate in Federal healthcare programs, or in Federal procurement or non-procurement programs; OR
    - Has been convicted of a criminal offense that falls within the ambit of 42U.S.C. §1320(a)-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

The Pharmacy shall immediately notify the PBA Project Director should any pharmacist employed by the Pharmacy be sanctioned by the Federal OIG, the DHHS, or the Centers for Medicare & Medicaid Services (CMS). No pharmacists who have been excluded from participation in any government health care programs (Medicare, Medicaid, or other state or federal government health care programs) shall be permitted to participate in the TennCare program unless they can document that Federal OIG, CMS, or DHHS has fully reinstated them as a participating provider. The Pharmacy shall immediately notify the PBA if it has been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or is otherwise not in good standing with the TennCare Program. Failure to notify the PBA shall constitute a material breach of the Agreement. Failure to provide the PBA with this information may also be cause for termination of the Pharmacy from participation in the TennCare program, and

recoupment of any and all reimbursements made to the Pharmacy during the time period such excluded provider was providing Pharmaceutical Services to TennCare enrollees.

The Pharmacy shall screen its employees, owners, officers, and managing agents and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and are not employing or contracting with an individual or entity that has been excluded. The Pharmacy shall be required to immediately report to the PBA an exclusion information discovered. The Pharmacy shall be informed that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare enrollees.

8.5 COMPLIANCE WITH LEGAL REGULATIONS

Both the PBA and the Pharmacy agree to recognize and abide by all state and federal laws, rules, regulations, and guidelines applicable. The Agreement incorporates by reference the scope of the services provided or anticipated to be provided by the Agreement, including, but not limited to, the Tennessee State Plan, 42 CFR § 431.107, 42 CFR 455 subpart B, TCA §53-10-304, and TennCare rules.

8.6 INCORPORATION BY REFERENCE OF FEDERAL AND STATE LAW/REGULATION

By reference, the Agreement incorporates all applicable federal and state laws and regulations, and any applicable court orders or consent decrees; all revisions of such laws or regulations court orders or consent decrees shall automatically be incorporated into the Agreement as they become effective.

The Pharmacy shall be compliant with Section 6032 of the Deficit Reduction Act of 2005 (DRA) with regard to policy development, employee training, and whistle blower protection related to The False Claims Act, 31 USCA § 3729-3733, et seq.

8.7 HIPAA COMPLIANCE

In accordance with the HIPAA regulations, the Pharmacy shall at a minimum comply with the following requirements:

- As a party to this Agreement, the Pharmacy hereby acknowledges its designation as a covered entity under the HIPAA regulations.
- The Pharmacy shall comply with the transactions and code set, privacy, and security regulations of HIPAA. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations.
- The Pharmacy shall transmit/receive from/to its provider, subcontractors, clearinghouses, and PBA all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by the PBA so long as the PBA's direction does not conflict with the law.
- The Pharmacy shall agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security, and all subsequent HIPAA standards, that it shall be in breach of the Agreement and shall then take all reasonable

steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between the PBA and the Pharmacy and between the Pharmacy and its providers and/or subcontractors to a halt, if for any reason the Pharmacy cannot meet the requirements of this Section, the PBA may terminate this Agreement in accordance with Section 10.2.

- PHI data exchanged between the Pharmacy and the PBA is intended to be used only for the purposes of health care operations, payment, and oversight and its related functions. All PHI not transmitted for the purposes of health care operations and its related functions, or for purposes allowed under the HIPAA regulations shall be de-identified to protect the individual enrollee's PHI under the privacy act.
- Disclosures of PHI from the Pharmacy to the PBA shall be restricted as specified in the HIPAA regulations and shall be permitted for the purposes of health care operation, payment, and oversight; obtaining premium bids for providing health coverage; and modifying, amending, or terminating the group health plan. Disclosures to the PBA from the Pharmacy shall be as permitted and/or required under the law.
- The Pharmacy shall report to PBA within 48 hours of becoming aware of any use or disclosure of PHI in violation of the Agreement by the Pharmacy, its officers, directors, employees, subcontractors, or agents or by a third-party to which the Pharmacy disclosed PHI.
- The Pharmacy shall specify in its agreements with any agent or subcontractor of the Pharmacy that shall have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms, and conditions that apply to the Pharmacy pursuant to this Section.
- The Pharmacy shall make available to TennCare enrollees the right to amend their PHI in accordance with the HIPAA regulations. The Pharmacy shall also make information available to enrollees, educating them of their rights and necessary steps in this regard in their Notice of Privacy Practices.
- The Pharmacy shall make an enrollee's PHI accessible to TennCare immediately upon request by TennCare.
- The Pharmacy shall make available to the PBA within 10 days of notice by the PBA to the Pharmacy, such information as in the Pharmacy's possession, and is required for the PBA to make the accounting of disclosures required by 45 CFR § 164.528. At a minimum, the Pharmacy shall provide the PBA with the following information:
    - The date of disclosure;
    - The name of the entity or person who received the HIPAA PHI, and if known, the address of such entity or person;
    - A brief description of the PHI disclosed; and
    - A brief statement of the purpose of such disclosure that includes an explanation of the basis for such disclosure.
- In the event that the request for an accounting of disclosures is submitted directly to the Pharmacy, the Pharmacy shall within two days forward such request to PBA. It shall be the PBA's responsibility to prepare and deliver any such accounting requested. Additionally, the Pharmacy shall institute an appropriate record keeping process and procedures and policies

to enable the Pharmacy to comply with the requirements of this Section; l) The Pharmacy shall make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the Secretary of DHHS for the purposes of determining compliance with the HIPAA regulations upon request;

- The Pharmacy shall create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which Pharmacy acknowledges and promises to perform, including, but not limited to, the following obligations and actions:
    - Safeguards – The Pharmacy agrees to use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that the Pharmacy creates, receives, maintains, or transmits on behalf of PBA and/or TennCare.
    - Pharmacy's Agents – The Pharmacy agrees to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of PBA and/or TennCare agrees to use reasonable and appropriate safeguards to protect the PHI.
    - Notification of Security Incident – The Pharmacy agrees to report to the PBA within 48 hours of becoming aware of any use or disclosure of TennCare enrollee PHI or of any security incident of which the Pharmacy becomes aware.
- The Pharmacy shall implement all appropriate administrative, technical, and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of the Agreement, including, but not limited to, confidentiality requirements in 45 CFR parts 160 and 164;
- The Pharmacy shall set up appropriate mechanisms to ensure minimum necessary access of its staff to PHI;
- The Pharmacy shall create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; enrollees' rights to amend, access, request restrictions; and the right to file a complaint;
- The Pharmacy shall provide an appropriate level of training to its staff and enrollees regarding HIPAA related policies, procedures, enrollee rights, and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter;
- The Pharmacy shall be allowed to use and receive PHI from the PBA and/or TennCare where necessary for the management and administration of the Agreement and to carry out business operations;
- The Pharmacy shall be permitted to use and disclose PHI for the Pharmacy's own legal responsibilities;
- The Pharmacy shall adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by Pharmacy employees and other persons performing work for said Pharmacy to have only minimum necessary access to personally identifiable data within their organization;
- The Pharmacy shall continue to protect PHI relating to individuals who are deceased;
- The Pharmacy must make available PHI in accordance with 45 CFR § 164.524; and

- The Pharmacy must make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526.
- In accordance with HIPAA regulations, Pharmacy shall adhere, at a minimum, to the following guidelines:
    - The Pharmacy shall make its individually identifiable health information available to enrollees for amendment and access as specified and restricted under the HIPAA regulations;
    - The Pharmacy shall adopt and implement policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding plan administration and oversight;
    - The Pharmacy shall adopt a mechanism for resolving any issues of non-compliance as required by law; and
    - The Pharmacy shall establish similar HIPAA trading partner and business associate agreements with its subcontractors, trading partners, and business associates

8.8 TAMPER RESISTANT PRESCRIPTION REQUIREMENTS

All prescriptions for TennCare patients must be written using tamper-resistant pads/paper, with the limited exceptions outlined below:

- Prescriptions sent to the pharmacy electronically (either by e-prescribe or by fax).
- Prescriptions communicated to the pharmacy by telephone.
- Drugs administered in nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

TennCare Enrollees should receive a “Tamper-Resistant Denial Notice” when a non-compliant tamper resistant prescription cannot be resolved at the point-of-sale and the prescription is unable to be dispensed. This notice may be obtained from the Optum Rx TennCare website under Enrollee Forms.

Prescriptions are required to have a minimum of one feature from each of the three CMS categories listed below:

1. Industry-recognized feature(s) designed to prevent unauthorized copying.

Feature	Description
“Void” or “Illegal” pantograph	The word “Void” appears when the prescription is photocopied. Due to the word “Void” on faxed prescriptions, this feature requires the pharmacy to document if the prescription was faxed.
Watermarking	Special paper containing “watermarking.”

2. Industry-recognized feature(s) designed to prevent erasure or modification written by the prescriber.

Feature	Description
Quantity check-off boxes with Refill Indicator (circle or check number of refills or "NR")	In addition to the written quantity on the prescription, quantities are indicated in ranges. It is recommended that ranges be 25s with the highest being "151 and over." The range box corresponding to the quantity prescribed MUST be checked for the prescription to be valid. Indicates the number of refills on the prescription. Refill number must be used to be a valid prescription. Document if the prescription was faxed.
Uniform non-white background color	Background that consists of a solid color or consistent pattern that has been printed onto the paper. This will inhibit a forger from physically erasing written or printed information on a prescription form. If someone tries to erase or copy, the consistent background color will look altered and show the color.

3. Industry-recognized feature(s) designed to prevent use of counterfeit prescription forms.

Feature	Description
Security features and descriptions listed on prescriptions. (This feature is required on all TennCare tamper-resistant pads/paper after 10/1/2008.)	Complete list of the security features on the prescription paper for compliance purposes.
Heat sensing imprint	By touching the imprint or design, the imprint will disappear.

**Be advised that all prescriptions paid for by TennCare must follow these State/Federal regulations.

8.9 SIGNATURE LOG REQUIRMENTS

Documentation of receipt of prescriptions is required by TennCare for each prescription dispensed to a TennCare Member. Documentation must include at a minimum the prescription number, member name, date filled, date received, and a signature of the person receiving the prescription (i.e., the member, member's representative, or a representative of the facility in which the patient resides). When prescriptions have been mailed, shipped, or delivered, Company shall require a signature confirmation documenting proof of receipt.

The signature logs are required for the auditor to review if requested. If the auditor requests further review of a signature log on an audit due to a missing signature log or if further investigation is needed, only an original signed statement from the member, member's representative, or a representative of the facility in which the patient resides, verifying receipt of the medication and the

date it was received, can be provided to auditor within the time allotted. The statement must include member contact information.

8.10 RETURN TO STOCK

All prescriptions must be reversed and returned to stock within (10) business days of dispensing if not delivered to or picked-up by the patient.

8.11 REPORTING OF SUSPECTED FRAUD/ABUSE

In accordance with the Tennessee state plan, TennCare rules, and *Optum Rx PBA Participating Pharmacy Agreement for Ambulatory and Long-Term Care Providers* Section 10, subsections 10.14 (A) Reporting; 10.14(B) Cooperation; 10.14(C) Internal Controls; and 10.14(D) False Claims Act Certification; the Pharmacy shall report any suspicion or knowledge of fraud and/or abuse, including, but not limited to:

- False or fraudulent filings of claims; and
- The acceptance or failure to return monies allowed or paid on claims known to be false, incorrect, inaccurate, or fraudulent.

The Pharmacy shall report all confirmed or suspected fraud and abuse to the appropriate agency as follows:

- Suspected fraud and abuse in the administration of the program shall be reported to the TBI MFCD, TennCare OPI, and/or the OIG;
- All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCD, TennCare OPI; and,
- All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG.
- The Pharmacy shall use the Fraud Investigation Form (PBA Participating Pharmacy Agreement for Ambulatory and Long-Term Care Providers Attachment (C), or such other form as may be deemed satisfactory by the agency to which the report is to be made.

In addition, you may report TennCare Fraud or Abuse by any of the following methods:
Tennessee OIG

  - Go to: https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html
  - Complete the form online form
    - Click the appropriate tab above to complete either form for TennCare Recipient Fraud or Abuse or TennCare Provider Fraud or Abuse.
  - Download and submit the Report TennCare Recipient Fraud OR Report
  - TennCare Provider Fraud forms
  - Call the Fraud Toll Free Hotline at 1-800-433-3982
  - Call the Tennessee OIG at 1-615-687-7200
- TennCare
  - Email the TennCare Program Integrity Unit (PIU) at ProgramIntegrity.TennCare@tn.gov.
  - Call the Toll-Free TennCare Provider Toll Free Fraud Hotline at 1-833-687-9611
- TBI, MFCD

- Call the TBI MFCD Toll-Free Hotline at 1-800-433-5454
- Email the Tennessee Bureau of Investigations at tipstotbi@tbi.tn.gov.

- Contact the US DHHS OIG:
  - Call: 1-800-447-8477
  - Email: HHSTips@oig.hhs.gov
  - Mail the address below:

Office of Inspector General
U.S. Department of Health & Human Services
ATTN: OIG HOTLINE OPERATIONS PO Box 23489
Washington, DC 20026

Pursuant to TCA § 71-5-2603(d), the Pharmacy shall be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to OIG or TBI MFCD, as appropriate.

9. COVERKIDS

9.1 COVERKIDS FORMULARY

CoverKids is utilizing the Optum Rx Select Formulary with Comprehensive Utilization Management which includes hundreds of medications. The comprehensive formulary may be found at https://welcome.optumrx.com/coverkids/forms.

- Prior authorizations may be submitted via phone, fax, or via the website at https://welcome.optumrx.com/coverkids/landing by selecting the CoverMyMeds link Phone: 844-568-2179
- Fax: 844-403-1029

9.2 COVERKIDS REIMBURSEMENT

Network Pharmacy Reimbursement Schedule

- CoverKids pharmacy claim reimbursement[1] for products dispensed to CoverKids members follows lesser of methodology of the following:
  - The pharmacy's usual and customary charge to the general public; or
  - The contracted Average Wholesale Price (AWP) discount plus a professional dispensing fee (PDF), if any; or
  - The Maximum Allowable Cost (MAC) price plus PDF, if any.
- Under the Pass-Through Pricing Model, CoverKids shall pay the actual retail pharmacy rates paid by Optum Rx which are estimated to be the annual aggregate, effective rates set forth below:
- CoverKids shall pay the actual retail pharmacy rates paid by Optum Rx:
  - Retail 30 Brand: AWP minus 18.50%, plus a $0.50 PDF. Low Volume pharmacies will receive a $13.16 PDF.
  - Retail 30 Generic: AWP minus 84.00%, plus a $0.50 PDF. Low Volume pharmacies will receive a $13.16 PDF.

- Retail 90 Brand: AWP minus 22.00%, plus a $0.50 PDF. Low Volume pharmacies will receive a $13.16 PDF.
- Retail 90 Generic: AWP minus 86.00%, plus a $0.50 PDF. Low Volume pharmacies will receive a $13.16 PDF.
- Mail Service Brand: AWP minus 22.00%, plus a $0.00 dispensing fee.
- Mail Service Generic: AWP minus 86.00%, plus a $0.00 dispensing fee.
- Specialty Drugs (Open Network): AWP minus 17.50%, plus a $0.00 dispensing fee.
- Diapers/Training pants: MAC price + sales tax (calculated on MAC price) + Admin fee
  - PDF is not paid on diaper/training pants claims

- Pharmacy providers may request a claim reimbursement review by submitting a fully completed Claim Reimbursement Review Form[2] to Optum Rx within seven (7) business days of the paid claim's adjudication date.
  - The pharmacy must include an original invoice for the NDC being appealed.
  - The NDC reflected on the invoice submitted must match the NDC submitted on the pharmacy claim and Claim Reimbursement Review Form.
  - The date reflected on the invoice must coincide with the date of service on the Claim Reimbursement Review Form and pharmacy claim submitted.
  - The appeal will be denied if it lacks requisite information or is inaccurate or ambiguous.
- Within seven (7) business days, Optum Rx will provide a written response indicating the outcome. If a claim reimbursement adjustment is not warranted, Optum Rx will provide alternatives within the response (when possible) that demonstrate product availability below the current reimbursement rate.

9.3 COVERKIDS COPAYMENT

CoverKids members are charged at $0.00, $1.00, $3.00, $5.00, $20.00, or $40.00 copay depending on the member's benefit plan, drug tier, and whether or not the member has met an out-of-pocket maximum amount.

10. NON-DISCRIMINATION COMPLAINCE REQUIREMENTS

10.1 NON-DISCRIMINATION

TennCare members should receive culturally competent care that is free from discrimination due to a person's race, color, national origin, language, sex, age, religion, disability, or any status protected by federal or state civil rights laws, in TennCare or Optum Rx. Discrimination can take the following forms:

- Not letting a person take part in the same things as other people.
- A patient not getting the help they needed to fill a prescription.
- A patient not getting the care they needed during a health care encounter.

Under the disability nondiscrimination laws, qualified individuals with disabilities must be provided with an equal opportunity to participate in a program, service, or activity. This means a patient may need a

[2] OptumRx MAC Reimbursement Review Form

mitigating measure like a reasonable accommodation or auxiliary aids and services during a service encounter. You can learn more about Titles II and III of the ADA, Section 1557 of the Patient Protection and Affordable Care Act, and Section 504 of the Rehabilitation Act of 1973 at:

- http://www.ada.gov and
- Civil Rights for Providers of Health Care and Human Services | HHS.gov

Members are to be provided with proper accommodations for any disabilities. In determining what types of auxiliary aids and services are necessary, you shall give primary consideration to the requests of individuals with disabilities in accordance with 28 C.F.R. § 35.160 and 28 C.F.R. § 36.303. In order to be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability. If an individual requests an auxiliary aid or service that you can demonstrate would result in a fundamental alteration in the nature of its services or result in an undue financial and administrative burden, you do not have to provide the requested auxiliary aid or service to the individual. However, if available, you shall provide the individual with another form of an auxiliary aid or service that would achieve effective communication with the individual and not result in a fundamental alteration in the nature of your services or result in an undue financial and administrative burden.

The nondiscrimination laws require effective communication with individuals. This means that a provider must provide translation or interpretation services needed to effectively communicate with a Limited English Proficiency (LEP) individual or an auxiliary aid or service to effectively communicate with an individual with a disability. The National Institute of Minority Health and Health Disparities created a *Language Access Portal* (LAP). The LAP contains information, in multiple languages, for six disease areas (cancer, diabetes, cardiovascular disease, and more) where major health disparities have been identified in non-English speaking populations. To learn more: https://www.nimhd.nih.gov/programs/edu-training/language-access/index.html

You are responsible for ensuring that patients have a full understanding of their prescription treatment guidelines, regardless of their cultural background, which includes the person's preferred language, literacy level, or disability status. To ensure that all members receive appropriate access to their pharmacy benefits, you are expected to comply with federal and state requirements regarding cultural and linguistic services.

It is not permissible to:

- Turn a member away.
- Limit an individual's participation or access to services because of cultural or communication barriers.
- Subject individuals to unreasonable delays due to cultural and language barriers
- Provide a lower quality level of service to individuals who are LEP, individuals with low literacy levels, individuals with disabilities, or individuals with different cultural backgrounds.

You must have written procedures for the provision of free language and communication assistance services, like interpretation and translation services for any member who needs such services,

including but not limited to, members with LEP. Optum Rx provides free language and communication assistance services to members during direct contacts with Optum Rx staff. Optum Rx does not reimburse for language and communication assistance services offered to TennCare members in your pharmacy setting. You are responsible for offering these services without charge to the member. This is a requirement under the federal civil rights regulations, which applies to any provider that accepts TennCare funds.

Health literacy also plays an important role in effective communication and culturally competent care. The U.S. Department of Health and Human Services has health literacy and communication tools and resources at:

- Health Literacy | health.gov, and
- Consumer Health Content on MyHealthfinder | health.gov

You can learn more about civil rights compliance and cultural competency and find resources like trainings, toolkits, forms, policies, and notices at:

- https://www.tn.gov/tenncare/providers/programs-and-facilities/civil-rights-information.html, and
- https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

10.2 DISCRIMINATION COMPLAINTS

When a program or entity receives federal funding, beneficiaries, like TennCare members, and participants, like providers, in that program have the right to receive services or participate in that program free from discrimination because of their race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law. By law, no one can retaliate against a person for making a complaint.

Information on how to file a complaint and the TennCare real-time and PDF discrimination complaint forms can be found at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html. Complaints can also be filed by calling TennCare Connect at 855-259-0701 or by mailing completed complaint forms to:

TennCare, Office of Civil Rights Compliance
310 Great Circle Rd, Floor 3W
Nashville, TN 37243

Optum Rx Civil Rights Coordinator
11000 Optum Circle
Eden Prairie, MN 55344
Email: Optum_Civil_Rights@Optum.com

Providers are required to assist members with obtaining discrimination complaint forms and assistance from Optum Rx's Nondiscrimination Compliance Officer for TennCare:

10.3 CULTURAL COMPETENCY

We shall ensure that all TennCare members receive equitable and effective treatment in a culturally and linguistically appropriate manner. You are expected to be culturally sensitive to the diverse population you serve by effectively and appropriately providing services to people of all races, cultures, religions, ethnic backgrounds, education, and medical status in a manner that recognizes values, affirms and respects the worth of each individual member, and protects and preserves the dignity of each.

Everyone has the right to receive culturally and linguistically appropriate services (CLAS). The care delivered needs to be respectful of the person's beliefs, practices and unique needs for each and every member. For more information, including national standards and training, we encourage you to visit thinkculturalhealth.hhs.gov.

What is cultural competency?

Culture refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people. It impacts the care given to members because it describes:

- Concepts of health, healing
- How illness, disease, and their causes are perceived
- The behaviors of patients who are seeking health care
- Attitudes toward health care providers

It also defines health care expectations such as:

- Who provides treatment
- What is considered a health problem
- What type of treatment
- Where care is sought
- How symptoms are expressed
- How rights and protections are understood

And why is it important?
Cultural competency is one the main ingredients in closing the disparities gap in health care. It’s the way patients and providers can come together and talk about health concerns without cultural differences hindering the conversation but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

Cultural competence emphasizes the idea of effectively operating in different cultural contexts and altering practices to reach different cultural groups. Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

A cultural competency program can help you respectfully and sensitively address the needs of your patients who have been marginalized because of their race, gender, sex, age, and other protected statuses. There are many cultural influences that impact the delivery of health care services. Some cultural preferences to remember include the following:

- Do patients feel that their privacy is respected?
- Are they the health care decision maker?
- Does the patient's belief in botanical treatments and healers contradict standard medical practices and does it impact their decisions?
- What type of language skills and preferences does the patient use in their interactions?

Because health care is a cultural construct based in beliefs about the nature of disease and the human body, cultural issues are central in the delivery of health services.

Culture impacts every health care encounter. By understanding these influences and by communicating clearly at each visit you fulfill the opportunity to build rapport, help improve adherence and safety.