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DIVISION OF TENNCARE PHARMACY PROVIDER MANUAL

FOR

TennCare

CoverKids

CoverRx

November 1, 2023
OPTUMRX

REVISION HISTORY

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 4, 2019	New document	OptumRx
2.0	Policies and procedures as of May 1, 2020	Updates to TennCare Professional Dispensing Fees	OptumRx
3.0	Policies and procedures as of January 1, 2021	CoverKids Program Addition	OptumRx
4.1	Policies and procedures as of 9/1/2021	Update to TennCare LTC PDF/Reimbursement	OptumRx
4.2	Policies and procedures as of 9/1/2021	Add TennCare 90-day supply processing	OptumRx
4.3	Policies and procedures as of 8/1/2021	Update Emergency Protocols	OptumRx
4.4	Policies and procedures as of 9/1/2021	CoverKids and CoverRx Reimbursement appeals process	OptumRx
5.1	Policies and procedures as of 11/20/2022	Remove TennCare compound script limit	OptumRx
5.2	Policies and procedures as of 11/20/2022	CoverKids an CoverRx Professional Dispensing Fees	OptumRx
5.3	Policies and procedures as of 11/20/2022	Added 340B Pricing Strategy	OptumRx
5.5	Policies and procedures as of 11/20/2022	Updated Attestation list language to not counting against script limit	OptumRx
5.5	Policies and procedures as of 11/20/2022	Updated Provider information section with Optum Network information	OptumRx
5.6	Pricing vendor change	Addition of new pricing vendor Mercer	OptumRx
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	OptumRx
5.9	9/20/2023 Survey updates	Reduced PDF for survey non-responders	OptumRx
6.0	9/20/23 Table update	Removed Table 2.4 and updated Table 3.8	OptumRx

SUMMARY OF CHANGES

Revision	Page number
Inserted language to allow 90-day supply billing for a specific list of medications as listed at www.optumrx.com/tenncare	13
Addition of additional explanation around the Emergency fill protocol	39
Removed \$4 MAC List from pricing for CoverRx	26
Inserted language to coincide with professional dispensing fee restrictions for LTC 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.	22-23
Addition of CoverKids program information	2, 5, 6, 12 & 48
Addition of CoverKids claims reimbursement appeals process	49 - 50
Addition of CoverRx claims reimbursement appeals process	25
Removed important note under Compound Claims	19
Change in TennCare Professional Dispensing Fee Language	24-25
Change in CoverRx Reimbursement Language	27
Updated member-initiated PA telephone number	7
Change in CoverKids Reimbursement Language	54
Change in TennCare Reimbursement Language	23
Change in TennCare pricing vendor from MSLC to Mercer	24
Added nondiscrimination policy	57
Added return to stock requirement	49
PDF updates	20, 25, 26, 53
Survey Non-responder PDF updates	23
Removed Table 2.4	20
Updated Table 3.8	27

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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)

OptumRx 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. OptumRx assumed pharmacy benefits management responsibilities for CoverKids CHIP program on January 2, 2021.

1.2 PBA CONTACT INFORMATION

Contact	Telephone Number(s)	Mail, Email, and Web Address
OptumRx	866-434-5520	https://www.optumrx.com/tenncare
TennCare Pharmacy Program		Pharmacy (tn.gov)
CoverRx Pharmacy Program	P: 800-424-5815 F: 800-424-5766	https://www.tn.gov/tenncare/coverrx
CoverKids Pharmacy Program	P: 844-568-2179 F: 844-403-1029	https://www.optumrx.com/coverkids
CoverKids Program		https://www.tn.gov/coverkids
OptumRx Pharmacy Support Center 24/7/365	866-434-5520	
OptumRx Manual Claims Processing		OptumRx P.O. Box 29044 Hot Springs, AR 71903



Contact	Telephone Number(s)	Mail, Email, and Web Address
OptumRx Clinical Call Center (PA) 24/7/365	866-434-5524	
OptumRx Member Call Center 24/7/365	888-816-1680	
OptumRx Web Support Call Center 7:00 a.m. – 7:00 p.m. Monday–Friday	800-241-8276	
OptumRx Provider Relations 8:00 a.m. – 4:30 p.m. Monday–Friday	480-365-5227	
OptumRx Provider Education 8:00 a.m. – 4:30 p.m. Monday–Friday		tnmprovider@optum.com
TennCare Fraud And Abuse Hotline 24/7/365	800-433-3982	https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html
TennCare Solutions (Member Appeals) 24/7/365	800-878-3192	
Member Initiated Prior Authorization 24/7/365	888-816-1680	
Family Assistance Services Center 7:00 a.m. – 5:30 p.m. Monday–Friday	866-311-4287	
FTP	800-924-6741	



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 OptumRx 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. OptumRx will accept member submitted receipts and member submitted receipts from the TC 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 – NCPDP VERSION D.0

As part of claims processing, OptumRx 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 OptumRx 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 in Section 10.0 – Appendix A – Payer Specifications of this manual.

SUPPORTED POS TRANSACTION TYPES

OptumRx 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 103-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 OptumRx’s payer specifications to set up a pharmacy’s computer system to allow access to the required fields and to process claims. The OptumRx 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.



Code	Description
RW	QUALIFIED REQUIREMENT “Required when” the situations designated have qualifications for usage (“Required if x,” “Not required if y”).

Claims are not processed without all of 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 OptumRx 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 OptumRx.

- 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 #	OptumRx 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

OptumRx supports the processing of manual claims receipts sent to our 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 OptumRx 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 OptumRx:

OptumRx
Attn: Manual Claims Department
P.O. Box 29044
Hot Springs, AR 71903
tnmprovider@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.
- Enrollees are charged the generic co-pay of \$1.50 for TennCare.
- 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 depending in package size (see Section 8.5 – Covered OTC Products)
- Long-term care (LTC) up to a 35-day supply
- 90-Day supply drug list (see list at www.optumrx.com/tenncare)
- 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 Agents will allow up to a 42-day supply:
 - Cimzia Starter Kits
- The following Drug Agent 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 104mg/0.65ml
 - Seasonique/Seasonale
 - Insulins*

*For insulin products, we allow 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 doctor'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 10ml vial of insulin or one box of insulin pens lasts greater than 31 days, please transmit the claim for a single vial or box of pens and submit the actual number of days' supply greater than 31 days.
- If one 10ml vial of insulin or one box of insulin pens will not last the enrollee 31 days, pharmacy may dispense only the quantity sufficient to last the minimum days over 31.
 - 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 = Ø: Original plus up to 99 refills within 366 days from original Date Rx Written
- DEA = 2: No refills
- DEA = 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 five prescriptions per calendar month, of which no more than two can be brand name drugs (see Section 8.8 – Exceeding Prescriptions Limits for approved exceptions).

CoverRx adults (defined as 18 – 64 years old) has a prescription limit of five prescriptions per calendar month.

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 OptumRx COB process does require a match 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 co-payments will also be deducted for participants subject to Medicaid co-pay. In some cases, this may result in the claim billed to Medicaid being paid at \$0.00.

Note: OptumRx will not send a negative amount in the Amount Paid field if the TPL and co-payment are greater than the Medicaid allowable.

- Co-pay 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.

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 308-C8) should be used based on the error codes received from the primary.

Table 2.2 – TPL Codes

NCPDP Field #308-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.

NCPDP Field #308-C8	When to Use	Submission Requirements/Responses
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.	<p>Paid claim and completed COB segment inclusive of the following fields:</p> <ul style="list-style-type: none"> • 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 compliant with timely filing. • Other Payer ID (340-7C) that is valid • Other Payer ID Qualifier (339-6C) that is valid <p>Claims submitted without required COB fields will reject with NCPDP code 13 or other specific reject codes</p>
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).	<p>Requires submission of:</p> <ul style="list-style-type: none"> • Other Payer Date (443-E8) • Other Payer ID (340-7C) • Other Payer ID Qualifier (339-6C) <p>And the reject code generated after billing the other insurer(s) in the "Other Payer Reject Code (472-6E). Claim will pay only if the following Other Payer Reject codes are submitted: 60, 61, 63, 65, 66, 67, 68, 69, 70, 3Y</p> <p>Claims submitted without required COB fields will reject with NCPDP code 13 or other specific reject codes</p>
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 co-pay requirement and the primary insurance plan made no payment.	<p>Paid claim; also requires submission of:</p> <ul style="list-style-type: none"> • Other Payer Amount Paid (431-DV) that = \$0 • Other Payer Amount Paid Qualifier (342-HC) • Other Payer-Patient Responsibility Amount Submitted (352-NQ) this is > or = \$0 • Other Payer Date (443-E8) that is valid • Other Payer ID (340-7C) that is valid • Other Payer ID Qualifier (339-6C) <p>Claims submitted without required COB fields will reject with NCPDP code 13 or other specific reject codes</p>
8 – Claim Billing for a Co-pay	OCC 8 is not accepted	



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.
- Monthly script limits are applied to compound claims, with the following exceptions:
 - Monthly brand script limits (2 scripts/month) will not be applied if medication is found on Prescriber Attestation or Auto-exempt list. Compounds with at least one brand ingredient will be counted towards the brand script limit unless the ingredient is on the Prescriber Attestation or Auto-exempt list.
 - Monthly total script limits (5 scripts/month) will not be applied if medication is found on Prescriber Attestation or Auto-exempt list.
- 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 406-D6) of “2.”
- Enter Product Code/NDC (NCPDP Field 407-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 430-DU) for entire product.
- Submission Clarification Code (NCPDP Field 420-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 450-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 co-payment, if applicable, will be collected on the initial fill

Refer to the TennCare D.0 Payer Specification document on the [OptumRx TennCare website](#) for 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	Description	Comments
47	Initial fill	Full copay, if applicable Full dispensing fee Included in member's monthly prescription script limit
48	Incremental fill	\$0 copay Full dispensing fee Not included in member's monthly prescription script limit
10	Completion fill	\$0 copay Full dispensing fee Not included in member's monthly prescription script 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 Section 10.0 – Appendix A – 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 claims 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, OptumRx 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 OptumRx 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. OptumRx 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% + PDF 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

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 <http://ghscapps.mercer.com/tenncarepharmacy/>

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 OptumRx, but instead pharmacies may submit an Rate Review to TennCare's vendor at the following link: <http://ghscapps.mercer.com/tenncarepharmacy/>

3.3 TENNCARE PROFESSIONAL DISPENSING FEE

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

- Ambulatory Pharmacies
 - Prescription volume between 0–64,999 prescriptions/year: \$13.16
 - 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

Compound: up to \$25.00; antibiotics are not authorized for this amount and pays 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
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
11	0-15 minutes	\$13.16
12	16-30 minutes	\$15.00
13	31+ minutes	\$25.00

340B Pharmacies for 340B claims

Value	Preparation Time	Professional Dispensing Fee
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 co-pays. 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 co-pays. 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 co-pay. The pharmacy may override the co-pay for a pregnant recipient by submitting a “2” in the Pregnancy Indicator field (NCPDP Field 335-2C). The pharmacy may override the co-pay 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 co-pay per prescription
- Generic name medications have \$1.50 co-pay per prescription
- Family planning drugs are not subject to the co-pay
- The TennCare Pharmacy System determines the co-pay based on the above eligibility rules
- Enrollees cannot be denied services for failure to pay co-pay
- A claim for a multi-ingredient compound receives the brand co-pay

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) minus 15% plus professional dispensing fee (PDF); or
- Maximum Allowable Cost (MAC) plus PDF; or
- The FUL for certain multiple source drugs as established and published by CMS plus a 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 generic

Pharmacy providers may request a claim reimbursement review by submitting a fully completed [Claim Reimbursement Review Form](#)¹ to OptumRx 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.

¹ OptumRx MAC Reimbursement Review Form

- The date reflected on the invoice must coincide with the date of service on the 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, OptumRx will provide a written response indicating the outcome. If a claim reimbursement adjustment is not warranted, OptumRx will provide alternatives within the response (when possible) that demonstrate product availability below the current reimbursement rate.

3.6 COVERRX COPAYMENT

CoverRx members are charged a \$3.00 co-pay for generic at a retail pharmacy for a 30-day supply, and a \$5.00 co-pay for brand at a retail pharmacy for a 30-day supply, generic 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 OptumRx. Please contact OptumRx 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 OptumRx 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 OptumRx Pharmacy Support Center for PA consideration.

5.3 HOSPICE AND LONG-TERM CARE (LTC) RECIPIENTS

HOSPICE RECIPIENTS

- Hospice patients are identified by the submission of the Patient Residence field (NCPDP Field 384-4X) = 11
- Hospice patients must be self-declared at the pharmacy.
- Exempt from Co-Pay

LONG-TERM CARE RECIPIENTS

- TennCare allows up to a 35-day supply per fill for LTC 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 LTC facility.

- PA, PDL, and ProDUR edits (as described for retail) apply unless specifically noted otherwise. (No co-pay, no Rx limit)
- Community and home based may have some limits apply (determined by the member's benefit package)
- LTC determination is made strictly on eligibility requirements and is not necessarily based on the location where a patient resides. TennCare makes LTC eligibility determinations based on pre-admission evaluation information provided by the facility.
- Patients who reside in assisted living facilities are not considered as LTC patients.

5.4 NEWBORN PRESCRIPTION CLAIMS

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

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

Providers are encouraged to submit the Patient Relationship Code field (NCPDP Field 306-C6) with a code of '3' on newborn claims.

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 (420-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 (409-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 (PRO-DUR)

6.1 OVERVIEW

ProDUR encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of OptumRx 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 OptumRx ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. OptumRx 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 exists:
 - 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 strength of that medication not currently manufactured.
- Therapeutic Duplication
 - ProDUR edits involving: Narcotic Analgesics, Sedative Hypnotics, Benzodiazepines, or Skeletal Muscle Relaxants require a telephone call to the Pharmacy Support 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)

6.3 PRODUR 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	Professional Service Code/Description	Result of Service Codes Allowed for Submission	Result of Service Code/Description	Reason for Service Code	Submission Clarification Code/Description (Listed as reference only, not required on claims)
All codes are allowed for all conflict types.	Select one: <ul style="list-style-type: none"> ○ M0/Prescriber Consulted ○ P0/Patient Consulted ○ RO/Physician Consulted Other 	All codes are allowed for all conflict types	Select one: <ul style="list-style-type: none"> ○ 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 	<ul style="list-style-type: none"> ○ ER (Only for Non-controlled and only for Increase in Dose) ○ DD ○ TD ○ SX ○ PA (Drug-Age) 	Select one: <ul style="list-style-type: none"> ○ 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. <ul style="list-style-type: none"> ○ 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. <ul style="list-style-type: none"> ○ 1 = MediSpan ○ 4 = Processor Developed

Format	Field Definitions
Other Prescriber	One character. Indicates the prescriber of conflicting prescription. <ul style="list-style-type: none"> ○ 0 = No Value ○ 1 = Same Prescriber ○ 2 = Other Prescriber

6.4 PPS CONFLICT CODES 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 Combination
- 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 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 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
	R0	Pharmacist consulted other source
	SW	Literature Search/Review
	TH	Therapeutic Product Interchange

Response Field	Response Codes	
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

Response Field	Response Codes	
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).

CII's may not be refilled; a new prescription is required for each fill.

Controlled drugs other than CII's 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
- Agents when used to promote fertility
- Agents when used for cosmetic purposes or hair growth
- Most agents used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Most nonprescription drugs (see Section 8.5 – 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.
- 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)

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)

- Kaolin/Pectin Suspension (Kaopectate®)
- Kaolin/Pectin with Belladonna Alkaloids Suspension (Donnagel®)
- Bismuth Subsalicylate Suspension (Pepto-Bismol®)

Laxatives and Stool Softeners (Facility must provide at least two of the following)

- Docusate Sodium 100mg capsules (Colace®, DOSS®, Docusate)
- Milk of Magnesia (MOM)
- Mineral Oil
- Bisacodyl 5mg tablets (Dulcolax®)
- Milk of Magnesia with Cascara Sagrada

Cough and Cold

- Guaifenesin Syrup (Robitussin®)

Internal Analgesics (Facility must provide all of the following)

- Acetaminophen 325mg Tablets (Tylenol®)
- Aspirin 325mg Compressed Tablets (Tylenol®)
- Acetaminophen 650mg Suppositories or Aspirin 650mg Suppositories

- Acetaminophen 160mg/5ml Elixir

Topicals (Facility must provide all of the following)

- Isopropyl Alcohol 70%
- Hydrogen Peroxide 10%
- Neomycin/Polymyxin/Bacitracin Topical Ointment (Neosporin®, Mycitracin®)
- 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)
 - OptumRx 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.

7.5 INJECTABLE DRUGS

If an injectable product is not listed on the Covered injectables list at the [OptumRx TennCare website and](#) not otherwise included, the injectable product will deny and will need to be billed to the patients respective MCO. MCO contact information can be found at [Managed Care Organizations \(tn.gov\)](#)

NCPDP Error Code R6 – "Product/Service Not Appropriate for This Location" 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.

- Every calendar month, the affected enrollees are limited to five prescriptions and/or refills, of which no more than two can be brand names.
- 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, “Monthly limit of 5 scripts exceeded,” or “Monthly limit of 2 brand scripts exceeded.”

- Pharmacies may bill enrollees for prescriptions over the prescription limit; however, the pharmacy should ALWAYS 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, but count towards the monthly limit, and they do not carry the brand co-pay.

7.7 EXCEEDING PRESCRIPTION LIMITS

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

- Auto-Exemption list: A select list of drug products exempt from monthly script limit.
- Dose Titration Override: Select drugs and/or drug classes the pharmacy provider is allowed to process a second claim for within 21 days of the initial claim.
- Prescriber Attestation List: A select list of drug products exempt from monthly script limit.

1. Auto-Exemption List

- TennCare has developed a list of medications called the Auto-Exemption List that do not count towards the monthly prescription limit.
- The Auto-Exemption List is applicable only to persons who have pharmacy coverage. Persons without pharmacy coverage may not obtain drugs on this list.
- The pharmacy POS recognizes Auto-Exemption List drugs and ensures that they are not counted toward the limit.

The Auto-Exemption List includes medications in the following categories:

Table 7.7.1 Auto-Exemption List

Auto-Exemption List*		
Antineoplastics	Dialysis Medications	Long-acting Antipsychotics
Antiparkinsonian Agent	Flu Vaccine (injectables 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

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Table 7.7.2 Dose Titration List

Dose Titration List		
Drug class	Drug name	Submission Clarification Code
Anticoagulants	warfarin, Jantoven®, Coumadin®	2
Anticonvulsants	all anticonvulsants	2
Atypical Antipsychotics (see below for clozapine, Clozaril®, and FazaClo®)	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)	clozapine, clozapine ODT, Clozaril®, FazaClo® ODT, and Versacloz®	6
Miscellaneous Agents	Subutex®, Suboxone®, Zubsolv®, Bunavail®, and buprenorphine	6

Full list
available
at:

https://www.optumrx.com/oe_tennCare/landing

Prescriber Attestation List

- TennCare has developed a list of medications called the Attestation List that do not count towards the monthly prescription limit.
- The Auto-Exemption List is applicable only to persons who have pharmacy coverage. Persons without pharmacy coverage may not obtain drugs on this list.
- The pharmacy POS recognizes Auto-Exemption List drugs and ensures that they are not counted toward the limit.

Table 7.7.3 – 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://www.optumrx.com/oe_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 written for 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 OptumRx Clinical Call Center will receive PA requests for products that have clinical edits for the TennCare program. PA request(s) are made by the prescribing physician or the prescribing physician'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 OptumRx 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 OptumRx 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 [OptumRx TennCare website](#) 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 OptumRx 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/LTE drugs are not covered.
 - Agents when used for anorexia, weight loss, or weight gain
 - 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 8.5 –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 8.5 – Covered OTC Products)
 - Nonprescription drugs not found on TennCare's Covered OTC Product List (see Section 8.5) 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.
 - 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)

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 judgment, 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 OptumRx, including both a Prior Authorization Type Code (NCPDP Field 461-EU) of “8” and Prior Authorization Number (NCPDP Field 462-EV) of “8888888888” to override the POS denial.
 - The enrollee is not charged a co-pay for the emergency supply.
 - The emergency supply DOES count toward the monthly prescription limit.
 - Only one emergency supply is provided per drug per member per year.
 - Recipients are not permitted to receive, nor will TennCare 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 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 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 Co-pay)	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) in order for the 2 fills to count as one prescription. Co-pay applies.	Submission clarification Code (42Ø-DK)	5
Hospice Patient (Exempt from Co-pay)	Patient Residence Field (384-4X)	11
Pregnant Patient (Exempt from Co-pay)	Pregnancy Indicator Field (335-2C)	2
Titration Dose Override	Submission clarification Code (42Ø-DK)	2
Titration Dose/Fill Override *Process the 2 nd , 3 rd , 4 th , 5 th Rx for the same drug with the override code to avoid the subsequent Rx counting as another prescription against the limit.	Submission Clarification Code (42Ø-DK)	6

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, OptumRx 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, OptumRx 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.

OptumRx 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).

OptumRx promptly refers any information or allegation concerning possible unethical or improper business practices by providers within the OptumRx 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 OptumRx 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, 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 HEALTH CARE 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 (located at <https://oig.hhs.gov/exclusions/index.asp>), the General Services Administration’s List of Parties Excluded from Federal Programs (located at <https://www.sam.gov/SAM/>), and the TennCare Terminated Provider List (<https://www.tn.gov/tenncare/fraud-and-abuse/program-integrity.html>).
- “Ineligible Persons” means any individual or entity who:
 - Is, as of the date such Exclusion Lists are accessed by the Provider, excluded, debarred, suspended, or otherwise ineligible to participate in Federal health care programs, or in Federal procurement or non- procurement programs; OR
 - Has been convicted of a criminal offense that falls within the ambit of 42 U.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; access to records; 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)

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- Prescriptions communicated to the pharmacy by telephone
- Drugs administered in nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

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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 [OptumRx TennCare website](#).

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 25’s 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.

Feature	Description
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 REQUIREMENTS

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 *OptumRx 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 OptumRx Select Formulary with Comprehensive Utilization Management which includes hundreds of medications. The comprehensive formulary may be found at www.optumrx.com/coverkids/formulary

- Prior Authorizations
 - Prior authorizations may be submitted via phone, fax or via the website at <https://www.optumrx.com/coverkids> by selecting the Covermymed link.
Phone: 844-568-2179
Fax: 844-403-1029

9.2 COVERKIDS REIMBURSEMENT

NETWORK PHARMACY REIMBURSEMENT SCHEDULE

- CoverKids pharmacy claim reimbursement¹ 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 OptumRx which are estimated to be the annual aggregate, effective rates set forth below:
- CoverKids shall pay the actual retail pharmacy rates paid by OptumRx:
 - Retail 30 Brand: AWP minus 18.50%, plus a \$0.50 PDF. Low Volume pharmacies will receive an \$13.16 PDF.
 - Retail 30 Generic: AWP minus 84.00%, plus a \$0.50 PDF. Low Volume pharmacies will receive an \$13.16 PDF.
 - Retail 90 Brand: AWP minus 22.00%, plus a \$0.50 PDF. Low Volume pharmacies will receive an \$13.16 PDF.
 - Retail 90 Generic: AWP minus 86.00%, plus a \$0.50 PDF. Low Volume pharmacies will receive an \$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.
- Pharmacy providers may request a claim reimbursement review by submitting a fully completed [Claim Reimbursement Review Form²](#) to OptumRx 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.

² OptumRx MAC 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, OptumRx will provide a written response indicating the outcome. If a claim reimbursement adjustment is not warranted, OptumRx 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 a \$0.00, \$1.00, \$3.00, \$5.00, \$20.00 or \$40.00 co-pay depending on the member's benefit plan, drug tier, and whether or not the member has met an out-of-pocket maximum amount.

10 Nondiscrimination Compliance 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 OptumRx. 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 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:

- www.ada.gov, and
- [Civil Rights for Providers of Health Care and Human Services | HHS.gov](https://www.hhs.gov/civil-rights/providers)

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. OptumRx provides free language and communication assistance services to members during direct contacts with OptumRx staff. OptumRx 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](https://www.health.gov/health-literacy), and
- [Consumer Health Content on MyHealthfinder | health.gov](https://www.health.gov/consumer-health-content-on-myhealthfinder)

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. 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

OptumRx 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 OptumRx'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

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.