Ohio Administrative Code

Rule 5160-9-06 Pharmacy services: billing and recordkeeping requirements.

Effective: February 16, 2024

(A) The pharmacy claims submitted to the Ohio department of medicaid (ODM) or its designee, the pharmacy point-of-sale vendor, must reflect the actual national drug code (NDC) on the container from which the product was dispensed.

(B) All records of prescriptions must comply with federal and state regulations and be retained by the provider for a period of six years from the date of payment of the claim and if an audit is initiated during this time, records must be retained until the audit is resolved.

(C) For a pharmacy claim to be eligible for payment by ODM, any prescription executed in written (and non-electronic) format must be executed on a tamper-resistant form.

(1) To be considered tamper resistant, a prescription form must contain all of the following three characteristics:

(a) One or more features designed to prevent unauthorized copying of a completed or blank prescription form;

(b) One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and

(c) One or more features designed to prevent the use of counterfeit prescription forms.

(2) The tamper-resistant requirement applies to all written prescriptions presented at the pharmacy when ODM pays any part of the claim, including when ODM is not the primary payer, in accordance with paragraphs (F) and (G) of this rule.

(3) The tamper-resistant requirement does not apply in the following situations:

(a) Prescriptions transmitted to the pharmacy via an electronic prescription transmission system, facsimile device, or telephone, in accordance with rules promulgated by the state board of pharmacy in agency 4729 of the Administrative Code;

(b) Orders for medications administered in a provider setting and billed by the administering provider in accordance with paragraph (H) of rule 5160-9-03 of the Administrative Code; or

(c) Orders for medications administered in a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID), if the order is written in the recipient's medical record and given by medical staff directly to the pharmacy. The prescription is considered tamper resistant if the recipient does not have opportunity to handle the written order.

(4) If a written prescription that is not tamper resistant is presented at the pharmacy, the pharmacy may fill the prescription on an emergency basis and obtain a compliant tamper-resistant replacement from the prescriber within seventy-two hours of dispensing.

(a) A tamper-resistant replacement may be obtained via any of the following methods:

(i) Telephone verification from the prescriber or prescriber's staff, documented on the prescription with the name of the person at the prescriber's office verifying the prescription, date of verification, and identification of the pharmacist or pharmacy staff member requesting verification;

(ii) Obtaining a copy of the prescription from the prescriber via facsimile device;

(iii) Obtaining an electronic prescription from the prescriber; or

(iv) Obtaining a replacement written prescription from the prescriber on a tamper-resistant form.

(b) The replacement tamper-resistant prescription shall be filed with the original, non-tamper-resistant prescription.

(c) The dispensing pharmacist shall use professional judgment to define an emergency situation.

(5) When it is determined that a recipient is retroactively eligible, and the recipient's original or refill prescription was filled during a period when the recipient is retroactively eligible, the pharmacy must ensure that the original prescription was tamper resistant before billing the pharmacy claim to ODM.

(a) If the prescription meets the provisions of paragraph (C)(3) of this rule, the tamper-resistant requirement does not apply.

(b) If the original prescription was not tamper resistant, the pharmacy may obtain a tamper-resistant replacement as described in paragraphs (C)(4)(a) and (C)(4)(b) of this rule.

(D) Claims for drugs purchased through the 340B drug discount program as defined in section 340B(a)(4) of the "Public Health Service Act," 42 U.S.C. 256b(a)(4) (as in effect as of January 7, 2011) are submitted with the provider's actual acquisition cost plus cost of dispensing, and use the codes described in billing instructions issued by ODM or its designee.

(E) Voids and reversals

(1) Return to stock

(a) When recipients fail to pick up their prescriptions, pharmacies must reverse the claim submitted to ODM as soon as possible and not later than fourteen days after preparation.

(b) When prescriptions were dispensed to a resident of a NF or ICF/IID and there is an unutilized portion of a legally redispensable drug remaining, the drug must either be:

(i) Destroyed; or

(ii) Returned to the pharmacy to be redispensed and the product cost, not including the dispensing fee, must be credited to ODM by voiding or reversing the original claim and submitting a new claim for the utilized amount plus dispensing fee.

(2) Voids, reversals, and replacement claims for other reasons

(a) Original claims should be submitted within three hundred sixty-five days of the date of service. Claims may be reversed, voided, or replaced (i.e., re-billed) at any time within the first three hundred sixty-five days after the date of service.

(b) Claims may be reversed, voided, or replaced beyond three hundred sixty-five days after the date of service in the following circumstances:

(i) Adjudicated paid claims may be reversed and replaced (i.e., re-billed) beyond three hundred sixty-five days after the date of service if the adjudication date of the replacement claim is within ninety days after the date of original claim payment.

(ii) Adjudicated denied claims may be replaced (i.e., re-billed) beyond three hundred sixty-five days after the date of service if the adjudication date of the replacement claim is within ninety days after the date of adjudication of an original denied claim.

(iii) Adjudicated paid claims may be reversed or voided beyond three hundred sixty-five days after the date of service if the adjudication date of the reversal or void is within five hundred forty-five days after the date of original claim payment.

(F) Third party liability

(1) In accordance with rules 5160-1-17.2 and 5160-1-08 of the Administrative Code, ODM is the payer of last resort.

(2) The provider's claim shall include the following indicators for each third-party payer as described in billing instructions issued by ODM or its designee.

(a) A payer identification code;

(b) Whether the claim was approved or denied, and if denied the reason for the denial;

(c) All amounts paid by third-party payers; and

(d) The recipient 's responsibility amount assigned by each payer.

(G) Medicare part B-covered services

Drugs covered by medicare part B for dually eligible recipients will first be billed by the provider to medicare. When appropriate, ODM pays the medicare part B cost sharing in accordance with rules 5160-1-05 to 5160-1-05.3 of the Administrative Code. Cost sharing for medicare part B services should not be billed in a pharmacy claim format and should be billed in accordance with the billing instructions issued by ODM for professional claims billed secondary to medicare part B or medicare part C.

(H) Medicare part D-covered services

Drugs that are covered or are eligible to be covered by medicare part D for dually eligible recipients are not covered by medicaid. Medicaid does not pay medicare cost sharing for medicare part D services.

(I) Provider types described in rule 5160-9-01 of the Administrative Code are required to submit a complete response to the cost of dispensing survey conducted according to section 5164.752 of the Revised Code.

(1) A complete response to the cost of dispensing survey includes supplying complete information about the terminal distributor for, at the least, all of the following categories:

(a) Demographics;

(b) Number of prescriptions dispensed annually, broken out by medicaid fee-for-service and other payers, and including a total volume for the location;

(c) Sales and cost of goods sold;

(d) Direct expenses;

(e) Overhead expenses; and

(f) Certification that the person submitting the survey believes the information to be true, correct, and complete.

(2) Providers that do not submit a complete response to the cost of dispensing survey may be paid a lower professional dispensing fee (PDF) in accordance with rule 5160-9-05 of the Administrative Code.

(3) Newly-enrolled providers are assigned to the dispensing fee described in rule 5160-9-05 of the Administrative Code.

(a) If the provider received the new provider number due to a change in ownership, the department uses the number of prescriptions reported by the previous ownership to determine the PDF.

(b) In a situation other than a change of ownership, a provider is newly enrolled if the date of approval for an application to enroll as a provider, or the date of approval of a specialty pharmacy designation, is less than ninety days prior to the distribution of the most recently conducted cost of dispensing survey then the date of approval is not the effective date of the provider agreement or specialty designation when the effective date is made retroactive by ODM.

(4) If a provider experiences a change in prescription volume during the first nine months following the implementation of a PDF category significant enough that it would result in the provider falling into a different PDF category, the provider may submit a written request with supporting documentation to ODM, no later than the thirtieth day of April of the first year, requesting assignment to a different category. If the supporting documentation justifies an adjustment, ODM will assign a new PDF category effective the first day of July for the second year.