Provider Portal
Supplemental Policies, Procedures and Regulations

Prepared by:
Envision Pharmaceutical Services, Inc.
(800) 361-4542

This document contains detailed explanations of certain conditions of participation in the EnvisionRxOptions pharmacy network. Procedures are outlined for the electronic submission of pharmacy claims. Also contained are helpful contact numbers, payment terms, answers to common questions and our pricing and reimbursement process.
Proprietary and Confidential
The information contained in this document is privileged and confidential property of EnvisionRxOptions. This document cannot be reproduced or transmitted in any form without the written approval of EnvisionRxOptions. If you are not the intended recipient, or have received this communication in error, please notify EnvisionRxOptions immediately and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and security of information, including the HIPAA Privacy guidelines.

The information contained herein is for informational, evaluative, or educational purposes only and is not legal, regulatory compliance, health/medical, or financial advice. The financial information or projections contained herein are an estimate for evaluative purposes only and not a statement of any future financial performance or results.

Advertising Requests
Pharmacy Providers are expressly denied any rights to use the EnvisionRxOptions name, likeness, logo or other forms of advertisement without prior, written consent from EnvisionRxOptions. This applies to all advertisements that reference EnvisionRxOptions in any way regardless of the advertising medium. To request permission, submit a copy of the advertisement if printed medium or script, if radio, TV, or cable, via fax to Provider Relations at 330-486-4801. In the request, the Pharmacy Provider must include the Pharmacy contact name and telephone number, reason for the advertisement, duration and market(s) where the advertisement will be placed. Approval or denial by EnvisionRxOptions will be communicated in writing to the requesting Pharmacy once internal review is completed. Note that any advertising designed to waive or discount Participant cost share (copayments, coinsurances or deductibles) will automatically not be approved.

Capitalized Terms
All capitalized terms used herein shall have the same meanings as those ascribed to the corresponding term in the Agreement, unless otherwise indicated. The term “Member” shall include Medicare Part D Members.
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GENERAL INFORMATION

EnvisionRxOptions is a national Pharmacy Benefit Manager (PBM) that was created to bring clarity and transparency to the PBM industry. EnvisionRxOptions is a full disclosure, 100% pass-through PBM. EnvisionRxOptions does not spread networks and passes 100% of the benefit of all provider contract negotiations directly to the Member.

This Provider Portal of our Policies, Procedures and Regulations is designed to offer you, our Participating Pharmacy Providers, with important information regarding our program requirements and our operational procedures. Participating Pharmacy providers that sign our Participating Pharmacy Agreement (PPA) are contractually bound to comply with the terms of these Policies, Procedures and Regulations.

As a Participating Pharmacy provider, you will receive a fully signed PPA. If your Pharmacy has not received its copy of the PPA, or if you have any questions regarding the PPA, please call our Pharmacy Help Desk at 800-361-4542 (TTY Users may call 711). All Pharmacies are expected to adhere to the PPA terms. Failure to comply could result in the termination of your PPA by EnvisionRxOptions.

EnvisionRxOptions credentials potential Pharmacy providers prior to their acceptance in any EnvisionRxOptions network. EnvisionRxOptions monitors the credentials of its providers in accordance with EnvisionRxOptions’ policies, acceptable industry standards and/or as mandated by law. Pharmacy providers must respond promptly to provide EnvisionRxOptions with any requested documentation necessary to in order to maintain its participation status.

Any updates to your Pharmacy’s mailing or location address, telephone number, payment addresses etc., must be emailed to pharmacy@rxoptions.net or faxed to 330-486-4801. Please allow 15 business days for your update to become effective. In addition to notifying us of these changes your Pharmacy must notify NCPDP at 480-477-1000.

EnvisionRxOptions reserves the right to update this document from time to time. The latest copy of the Provider Portal can be found at www.envisionrx.com under “I am a Pharmacy” tab.

CONTACT INFORMATION

EnvisionRxOptions’ Pharmacy Help Desk is open 24 hours per day, seven days per week – including holidays. For questions or other information regarding EnvisionRxOptions, please contact the Pharmacy Help Desk at: 800 361-4542 (TTY Users may call 711).

OTHER IMPORTANT PHONE NUMBERS

<table>
<thead>
<tr>
<th>Department</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Fraud Waste &amp; Abuse</td>
<td>(866) 417-3069</td>
</tr>
<tr>
<td>Dispute Resolution</td>
<td>(800) 361-4542</td>
</tr>
<tr>
<td>Coverage Determinations</td>
<td>(800) 361-4542</td>
</tr>
</tbody>
</table>
NETWORK APPLICATION AND CREDENTIALING GUIDELINES

APPLYING FOR PARTICIPATION
To apply to become a participating Pharmacy, the applicant can fill out the online new participating Pharmacy orientation application at http://www.envisionrx.com/pharmacies/pharmenroll.aspx or call the Pharmacy Help Desk at 800-361-4542 (TTY Users may call 711). Once this initial contact is made, EnvisionRxOptions will initiate the enrollment process. Please allow up to 45 business days to process credentials in order to add your Pharmacy to the EnvisionRxOptions network(s).

CREDENTIALING GUIDELINES
EnvisionRxOptions initially credentials and continually monitors the credentials of all Participating Pharmacy Providers prior to, and after, inclusion in EnvisionRxOptions’ networks. Providers are required to meet various conditions of participation as set forth by EnvisionRxOptions and to adhere to governmental regulations and standards, as applicable. The Credentialing process includes a review of the following:

1. Independent Pharmacy/Dispensing Providers must have
   - Current DEA
   - Current State License
   - Current Professional Liability Insurance at required levels
   - No sanctions per the Office of Inspector General, Health and Human Services (HHS)
   - No sanctions per any Office of Medicaid Inspector General in any state
   - No sanctions per the System for Award Management (SAM) and Medicare Exclusion Databases (MED)
   - Clear Pharmacy Board Orders
   - Additional information as determined by EnvisionRxOptions

2. 5 year look-back period of Credentials
   - Chain/PSAO Pharmacy
   - Signed and dated “Pharmacy Chain Credentialing Verification” form
   - If PSAO does not attest, each Pharmacy will be recognized as an Independent Pharmacy and will adhere to the same credentialing standards as an Independent (see above for Independent Credentialing Standards)

EnvisionRxOptions uses primary-source verification during its review of the Pharmacy license and DEA registration.

Quarterly Provider Credentialing Audits
EnvisionRxOptions audits the credentials of its participating providers on a quarterly basis. We may contact your Pharmacy to request proof of insurance coverage or additional copies of your Pharmacy’s other credentials. The required documents will need to be faxed or emailed the same business day of the request, unless another timeframe is noted in your Participating Pharmacy Agreement with EnvisionRxOptions.

If your Pharmacy is contacted during an EnvisionRxOptions quarterly credentialing check, we thank you for your anticipated cooperation in gathering and submitting the credentialing information we may require.
NETWORK PHARMACY CONTRACTING
EnvisionRxOptions shall enter into a Participating Pharmacy Agreement, or addendum to a current PPA when contracting with a new chain, PSAO, or independent Pharmacy to become a participating Pharmacy in the EnvisionRxOptions network, or when renegotiating an existing contract (e.g. changes in fee schedules or contracting provisions) with a current participating Pharmacy. In addition, Participating Pharmacy Agreements entered into with Medicare Network Pharmacies shall comply with all CMS requirements and instructions.

NON-PREFERRED VS. PREFERRED STATUS
Providers who currently have “preferred” status with a Medicare Part D plan in the EnvisionRxOptions network may lose that status if they join a PSAO that does not have a “preferred” status in its contract with EnvisionRxOptions.

90 DAY TERMINATION POLICY
All Independent Pharmacies must provide EnvisionRxOptions with ninety (90) days’ notice before terminating their contract agreement with EnvisionRxOptions. Providers who currently have a “preferred” status with a Medicare Part D plan in the EnvisionRxOptions network may lose that status if they join a PSAO that does not have a “preferred” status in its contract with EnvisionRxOptions.

PROVIDER AND MEMBER SERVICE STANDARDS

NON-DISCRIMINATION CLAUSE
EnvisionRxOptions’ participating Pharmacy providers shall not discriminate against Members with respect to a person’s age, gender, race, disability, ethnic group, national origin, or making a distinction in favor of or against, a person or thing based on the group, class or category to which that person or thing belongs rather than on individual merit. Additionally, providers shall not discriminate against Members as it related to health care such as accepting only Members from within a product line based upon high reimbursement rate and excludes other Members within that same product line based upon lower reimbursement rate.

PROVIDER NETWORK - ACCESSIBILITY
EnvisionRxOptions participating Pharmacy providers shall ensure that Members receive equal treatment, access, and rights without regard to race, color, national origin or Limited English Proficiency (LEP). Providers shall provide or arrange language assistance (i.e. interpreters and/or language appropriate written materials) to person with limited English proficiency (LEP). All pharmacies in Envision networks must be compliant with applicable access standards related to the Americans with Disabilities Act of 1990 (or its successor).

PHARMACY COMMUNICATION
All participating Pharmacies within the EnvisionRxOptions network shall have a standard format method for receiving communications for continuing participation requirements, notifications of network activities, and/or federal and state mandates. Pharmacies will be notified of any communications via email, fax, or standard mail (USPS).

QUALITY ASSURANCE
Your Pharmacy agrees to use commercially reasonable efforts to promptly respond to, resolve, and remedy any problems that may arise and to cooperate with Network in investigating and
resolving any complaints from Members. Your Pharmacy agrees to use best efforts to immediately respond to, resolve, and remedy all Members’ clinical grievances presented by the Network within five (5) business days and to restore goodwill to Members to Network’s and Plan Sponsors’ or Program Sponsors’ satisfaction. Your Pharmacy will exercise professional judgment in the provision of Covered Drugs to Members, and will counsel Members on their drug therapy as may be indicated. In addition, your Pharmacy will refrain from making disparaging comments to Members about Network, Plan Sponsors or Program Sponsors. Your Pharmacy will educate its pharmacists and other employees who have contact with the Members on this topic.

NETWORK PHARMACY COMPLAINT PROCESS
Complaints about Pharmacy services and/or disparaging comments received for any participating Pharmacy contracted within EnvisionRxOptions network(s) are handled by the EnvisionRxOptions’ Provider Relations department. Provider Relations will collaborate as needed with other departments within EnvisionRxOptions to resolve the issue(s) as quickly as possible. As per the Pharmacy Participating Agreement, a Pharmacy is prohibited from making disparaging comments related to EnvisionRxOptions and/or its Affiliates or Plan Sponsors to any Members.

INVESTIGATIONS BY GOVERNMENT AGENCIES
EnvisionRxOptions reserves the right to immediately temporarily suspend its agreement with your Pharmacy upon becoming aware that your Pharmacy has been investigated, within the past five years, or is currently under investigation by a Federal or State governmental agency or regulatory body. Pharmacy may submit a written appeal of the termination to EnvisionRxOptions to the address provided in the Agreement notice within 14 days of receipt of such notice. The written appeal submitted by the Pharmacy must include supporting documents to EnvisionRxOptions for review in order to be considered for reinstatement into the Network.

If a Pharmacy is being investigated for any reason, EnvisionRxOptions reserves the right to suspend the Pharmacy, until the investigation is complete. Once the investigation is completed, the Pharmacy will either be reinstated or terminated from participating in EnvisionRxOptions networks. For any claims processed by the Pharmacy that are determined as invalid or ineligible claims, if applicable, the entire claim cost can be recouped by Network, including any dispensing fee(s), except as otherwise directed by law.

EXCLUDED PARTIES
The Pharmacy is required to check the HHS OIG List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM) Excluded Parties Lists System prior to the hiring (and monthly thereafter) of any new employee, temporary employee, volunteer, consultant, governing body member, or subcontractor, to ensure that it does not employ or contract with a person or entity who is excluded from participating in any federal program. If any person or entity employed by or under contract with the Pharmacy is found on the OIG LEIE or SAM lists, the Pharmacy must immediately notify Network and refund Network any reimbursements made to the Pharmacy for any Claims submitted to Network by the excluded person or entity within ten (10) business days.

In addition, EnvisionRxOptions will monitor and suspend a Pharmacy from participation in its network if the Pharmacy has been identified or under review for engaging in any behavior or practice that:

1. Poses a significant risk to the health, welfare, or safety of any Members; or
2. Promotes or commits fraud, waste, or abuse; or
3. Commits an act, omission or material breach that is contrary to the criteria set forth in the Participating Pharmacy Agreement and the Provider Portal.

If a Pharmacy breaches the Participating Pharmacy Agreement, the Pharmacy may be suspended and/or terminated from the EnvisionRxOptions network.

**FRAUD, WASTE AND ABUSE TRAINING**

CMS requires all participating Pharmacies to conduct both General Compliance and Fraud, Waste and Abuse training for their personnel (employees and contracted staff and vendors) who are engaged in the delivery of Medicare services. This training must be provided within ninety (90) days of contracting with EnvisionRxOptions and annually thereafter. The Pharmacy must be able to demonstrate that its employees have satisfied these training requirements and must retain proof of such training for ten (10) years. Examples of proof of training may include copies of sign-in sheets, employee attestations and electronic certifications from the employees taking and completing the training. Upon reasonable request by EnvisionRxOptions, your Pharmacy must be willing to offer written attestation to its compliance of this section.

**PROCESSING A CLAIM**

**BIN NUMBER AND PCN INFORMATION**

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>BIN#</th>
<th>PCN*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part D**</td>
<td>012312</td>
<td>PARTD</td>
</tr>
<tr>
<td>Commercial</td>
<td>009893</td>
<td>ROIRX</td>
</tr>
<tr>
<td>FamilyWize</td>
<td>610194</td>
<td>FW</td>
</tr>
<tr>
<td>Costco Employees</td>
<td>015342</td>
<td>COSTEMP</td>
</tr>
<tr>
<td>Envision Medical Solutions</td>
<td>610272</td>
<td>ROIRX</td>
</tr>
<tr>
<td>Tri-County Schools Insurance Group</td>
<td>013477</td>
<td>ROIRX</td>
</tr>
<tr>
<td>NYPD</td>
<td>009893</td>
<td>AE02</td>
</tr>
<tr>
<td>Delta Care</td>
<td>016473</td>
<td>N/A</td>
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<tr>
<td>Careington</td>
<td>610303</td>
<td>AE02</td>
</tr>
<tr>
<td>Cogent Works</td>
<td>017134</td>
<td>ROIRX</td>
</tr>
<tr>
<td>ProCURE Pharmaceutical Services</td>
<td>017241</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*PCN must be entered with all capital letters

**See Medicare Part D section for more information regarding Part D Bin Requirements**

**ELECTRONIC CLAIMS TRANSMISSIONS REQUIREMENT**

Pharmacy shall, within three (3) days of compounding or dispensing a Covered Drug to a Member, submit online to Network via Network’s System, a Claim for payment in NCPDP format. Pharmacy shall bill Network using the 11 digit National Drug Code (NDC) number for the drug dispensed. Pharmacy must submit as part of the pricing information submitted for each prescription, its usual and customary price (U&C) and submitted ingredient cost. Network shall not be liable for any transmission charges for Claims data.

Along with such Claim, Pharmacy shall submit to Network or its designated processor the following information: (i) The Member’s name; (ii) identification number; (iii) group number (for Members under a group plan contract); (iv) service date; (v) Pharmacy NCPDP or NPI number with service provider qualifier; (vi) prescription number; (vii) NDC number; (viii) quantity dispensed; (ix) prescribed days’ supply; (x) prescribing practitioner’s DEA or NPI number and prescribing provider qualifier, and Pharmacy acknowledges and agrees the prescribing practitioner’s NPI must be submitted for all Medicare Claims; (xi) Average Wholesale Price
(AWP), Wholesale Acquisition Cost (WAC), or such other pricing methodology as has been adopted by the industry; (xii) dispensing fee as described in the Plan Sheets attached to this Agreement; and (xiii) copayments, deductibles or coinsurance collected from Members.

EnvisionRxOptions requires all participating Pharmacy providers to be Health Insurance Portability and Accountability Act (HIPAA) compliant with all electronic claim transactions utilizing the NCPDP version D.0 Telecommunication Standard format.

EnvisionRxOptions recognizes “Dispense As Written” (DAW) Codes 0, 1, 2, 3, 4, 5, 7 only. While a DAW code is not required to be transmitted on the claim, the DAW field drives reimbursement of the prescription and the Members copayment. This field must be filled correctly; the DAW data entered by the Pharmacy may be subject to retrospective review.

1. **Online System Down-Time Transmission Procedures**
   In the event a party’s claims adjudication system (as referenced in the Participating Pharmacy Agreement as the Network and/or Pharmacy “System”) is unavailable, your Pharmacy should attempt to resubmit the claim not later than 30 days of the date the prescription was filled. “System” means the real-time on-line electronic claims system used by the Parties to access and relay information including, amounts collectible from Beneficiaries, amounts payable under this Agreement, and certain operational policies and procedures as established by PBM.

2. **Claims Reversals and Claim Adjustments**
   If your Pharmacy needs to resubmit a claim previously processed through the System, the original claim must first be reversed prior to the claim resubmission. Reversals must be made within 60 days from the date your Pharmacy ran the claim through the System. Once a reversal is submitted and accepted, an adjusted claim may be transmitted. For prescriptions billed to EnvisionRxOptions that are not picked up by the Member, EnvisionRxOptions encourages Pharmacies to reverse the claim via the System within 14 days from the date the prescription was filled. EnvisionRxOptions reserves the right to audit for prescriptions that were not picked up by the Member to ensure appropriate claim reversals. Your Pharmacy may need to contact your Online systems software system documentation or vendor information about how to submit a claim reversal.

If your Pharmacy was unable to reverse claims over 60 days from the date of service via the System, you should contact the Pharmacy Help Desk at 800-361-4542 (TTY Users may call 711).

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**Reimbursement and MAC**

Your Pharmacy will be reimbursed for Covered Services based on the lesser of your Pharmacy's Usual and Customary (U&C), Maximum Allowable Cost (MAC) or Ingredient Cost (IC) plus a Dispensing Fee, less the Member's cost share responsibility (copayment, coinsurance or deductible). Ingredient cost is based on Medi-Span's Average Wholesale Price (AWP) as reflected in the System at the time prescription was filled, minus a discount as specified in the Participating Pharmacy Agreement and/or Rate Sheet. EnvisionRxOptions reserves the right to change the AWP source to an industry accepted publication.
COMPOUND PRESCRIPTIONS

COMPOUND PRESCRIPTION DEFINITION
“Compound Prescription” means a prescription for medication which would require the dispensing pharmacist to produce an extemporaneously produced mixture containing at least one Covered Drug that is a Federal Legend drug, the end product of which is not available in an equivalent commercial form. A prescription will not be considered a Compound Prescription if the medication is reconstituted or if the only ingredient added to the prescription medication is water, alcohol or a sodium chloride solution. Compound Prescription means any Claim in which a Compound Drug is adjudicated.

COMPOUND PRESCRIPTION CLAIM SUBMISSION
Compound prescription claims should be submitted by entering compounding indicator “2” and listing all the NDC’s ingredients in the compound, the quantity used for each NDC and the submitted ingredient cost for each NDC. Your Pharmacy will be reimbursed for compound prescriptions based on covered ingredients. Your Pharmacy will not be reimbursed for the non-covered ingredients (e.g. water, alcohol, or sodium chloride solution). Your Pharmacy will be reimbursed the lesser of the Pharmacy’s U&C or Ingredient Cost plus a Dispensing Fee, minus the Members cost-share (copayment, coinsurance or deductible). Ingredient cost is based on Medi-Span’s Average Wholesale Prices (AWPs) as reflected in the System at the time the prescription was filled, minus the discount reflected in the Participating Pharmacy Agreement and/or Rate Sheet.

Reject 8G: Product/Service ID (407-D7) Must Be A Single Zero "0" For Compounds will be sent back to the pharmacy for the following: If a value other than "0" is submitted in the Product/Service ID field (407-D7)

Reject 8Z: Product/Service ID Qualifier Value Not Supported will be sent back to the pharmacy for the following: If a value other than "00" is submitted in the Product/Service ID Qualifier Field (436-E1)

COST SHARE (COPAYMENTS, COINSURANCE, AND DEDUCTIBLES)
EnvisionRxOptions will deduct the Members cost-share (copayments, coinsurances, and deductibles) from your reimbursement. Your Pharmacy must collect the full amount of the Member’s cost-share as determined by the EnvisionRxOptions Network System. Copayments, coinsurances or deductibles are not eligible to be discounted or excused/ waived at any time by your Pharmacy. And you may not collect copayments, coinsurances and deductibles that exceed your Pharmacy’s U&C.

ALL LINES OF BUSINESS

INITIATED PRESCRIPTIONS
Pharmacy shall not deliver Covered Drugs to a Member without the Member’s consent prior to each delivery. Additionally, Pharmacy agrees that it will not bill for reimbursement for Members' Covered Drug prescriptions until and unless the Member has received such prescriptions.
IDENTIFICATION CARDS

All information to process a claim is included on the Member ID card. The Pharmacy is required to process the claim using the Member information unless the Member expressly requests that a claim not be submitted to the insurer. Please note: the Member ID is normally a unique number that may contain alpha characters. EnvisionRxOptions also utilizes a relationship designation which may or may not be printed on the card.

The card normally contains the following information when issued by EnvisionRxOptions:

1. The Member’s name on the card with a Member ID consisting of up to 15 characters which may be alpha numeric but will not contain Member’s Social Security Number.
2. The family Member card will either list the Member’s full name with no dependents or the Member’s last name with dependents. The relationship code for the dependents may or may not be listed on the card. The Member cardholder will have 01 as the person code and spouses will have 02 and other dependents may be listed by first name on the card and use the person codes 03, 04 etc., respectively.
3. On the back of the card, there is a toll-free number which clearly identifies how to reach our Pharmacy Help Desk. The Pharmacy Help Desk is staffed 24 hours a day and 7 days a week, 365 days a year–including holidays.

Be certain to verify the ID number on the Member’s EnvisionRxOptions prescription card before transmitting a claim in order to avoid a rejection, subsequent adjustment, or the processing of the claim improperly under another Member’s eligibility.

In order to process a Pharmacy claim, the entire Member number including the two digit person code must be submitted for each claim. After processing the claim, the Member must pay the co-payment or coinsurance for any drug covered under the Member’s Pharmacy prescription plan.

Sample Cards:

Front Side of Commercial Card

Back Side of Commercial Card

Front Side of Medicare Part D Card

Back Side of Medicare Part D Card
EDITS

FRAUD WASTE AND ABUSE EDITS
EnvisionRxOptions’ clients may choose to apply edits for Fraud, Waste and Abuse purposes. These edits typically fall under 2 categories:

1. Max Quantity Limits – maximum quantity of medication that can be dispensed over a specific period of time at the applicable copayment, coinsurance, or deductible.
2. Max Dollar limits – maximum amount of money that an insurance company (or self-insured company) will pay for claims within a specific time period.

Both of these edits are designed to confirm that the Pharmacy is dispensing the appropriate dose/quantity based on the prescriber’s directions. Below is the reject messaging that you will receive at the Pharmacy:
   Reject 76: Plan limitations exceeded – MH
   Reject 76: Potential FWA please call 1-866-417-3069

If you receive one of these messages on a rejected claim, please contact the Pharmacy Help Desk at 800-361-4542 or the number listed on the rejected claim messaging (TTY Users may call 711). You will be asked to confirm the drug name, dosage form, strength and directions from the prescriber and then an override may be placed in the system for the claim to be resubmitted.

DRUG UTILIZATION REVIEW (DUR) EDITS
EnvisionRxOptions clients have the ability to reject claims based on Medi-Span DUR edits in the following categories: Therapeutic Duplication, Drug-Drug Interaction, Ingredient Duplication, Drug Age Precaution, and High Dose. The client may select soft or hard rejections to be applied to these DUR edits. When a hard rejection occurs, the only way to override the claim is to contact the Pharmacy Help Desk at 800-361-4542 or the number listed on the rejected claim messaging (TTY Users may call 711).

Claims will reject in the following manner when a Client has selected a soft rejection edit:

Drug-Drug Interaction: Reject 88:
- Use DD, MO/MR, 1B/1G. For >1 alert use 00000000003

Dose Check-High Dose Interaction: Reject 88:
- Use HD, DE/MO/MR, 1B/1G. For >1 alert use 00000000003

Drug-Age Interaction: Reject 88:
- Use PA, MO/MR, 1B/1G. For >1 alert use 00000000003

Drug-Sex Interaction: Reject 88:
When a Client selects a soft rejection the rejection may be overridden in one of 2 methods:

**Method 1:**
The Pharmacy populates the following fields with NCPDP standard service codes to override the DUR reject:

1. Professional Service Code NCPDP field = 44Ø-E5.

<table>
<thead>
<tr>
<th>DUR Conflict Code</th>
<th>Description</th>
<th>Prof Service Code</th>
<th>Reason Service Code</th>
<th>Result of Service Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>TD</td>
<td>Therapeutic Duplication</td>
<td>MR</td>
<td>TD</td>
<td>1B</td>
</tr>
<tr>
<td>DD</td>
<td>Drug-Drug Interaction</td>
<td>MR</td>
<td>DD</td>
<td>1B</td>
</tr>
<tr>
<td>ID</td>
<td>Ingredient Duplication</td>
<td>MR</td>
<td>ID</td>
<td>1B</td>
</tr>
<tr>
<td>PA</td>
<td>Drug Age Precaution</td>
<td>MR</td>
<td>PA</td>
<td>1B</td>
</tr>
<tr>
<td>HD</td>
<td>High Dose</td>
<td>MR</td>
<td>HD</td>
<td>1B</td>
</tr>
</tbody>
</table>

The DUR conflict code should be the deciding factor on which combination of service codes submitted to override the rejection.

**Method 2:**
In certain circumstances, when there are multiple DUR edits on a claim, Pharmacies will be able to submit a prior authorization code consisting of 00000000003 (10 zeros and then the number 3) at Point Of Sale.

**COORDINATION OF BENEFITS (COB)**
Coordination of Benefits is a provision used to establish the order which health insurance plans pay claims when more than one plan exists. In cases where there is other coverage involved, the following will apply to the claim submission:

1. Accepted Values:
   - 00 – Not specified
   - 01 – No other coverage identified
   - 02 – Other coverage exists, payment collected
   - 03 – Other coverage exists, this claim not covered
   - 04 – Other coverage exists, payment not collected
   - 08 – Claim is billing for copay

2. When the COB field (308-C8) is populated, the Pharmacy must submit the appropriate values in:
   - 431-DV: OPA*required for Government COB Processing only
   - 430-DU: Gross Amount Due (OPPRA)
   - 352-NQ: PRA (OPPRA)
MEDICARE PART D

The Medicare Part D program has some unique requirements. Below is a summary of each requirement.

MEDICARE COVERAGE GAP DISCOUNT PROGRAM

The Affordable Care Act includes provisions to close the Medicare Part D prescription drug coverage gap (also known as the “donut hole”) to make prescription drugs more affordable for people with Medicare. The first step in closing the coverage gap was the mailing of the one-time $250 rebate check to most people who reached the coverage gap in 2010. The second step to closing the coverage gap began January 1, 2011.

Effective January 2011, people with Medicare who have Part D coverage, but do not receive extra help (the low-income subsidy), will receive a 50% discount under the Medicare Coverage Gap Discount Program on “applicable” drugs at the Point Of Sale and a 7% increase in coverage for all other covered Part D drugs (e.g., generic drugs and supplies associated with the delivery of insulin) while they are in the coverage gap. Over the next 10 years, prescription drug coverage will continue to increase for all covered drugs in the coverage gap so the amount people pay during the gap will continue to decrease until it reaches 25% in 2020.

WHAT ARE “APPLICABLE” DRUGS?

Applicable drugs are Part D prescription drugs approved under new drug applications (NDAs) or licensed under biologics license applications (BLAs). These are generally covered brand-name Part D drugs including insulin and Part D vaccines. Applicable drugs also include Part D prescription drugs that are commonly considered generic drugs, but actually have been FDA approved under NDAs. These drugs must be covered by a signed discount agreement to be covered under Part D. Beginning in 2011, only those applicable drugs that are covered under a signed manufacturer discount agreement with the Centers for Medicare & Medicaid Services (CMS) will be covered under Part D.

All other covered Part D drugs (e.g. generic drugs approved under abbreviated new drug applications (ANDAs) and supplies associated with the delivery of insulin) may continue to be covered by Part D plans irrespective of a signed manufacturer agreement. In addition, to be considered an applicable drug, drugs approved under ANDAs, BLAs and NDAs must all be properly listed with the FDA to process under Medicare Part D guidelines.

HOW WILL THE MEDICARE COVERAGE GAP DISCOUNT PROGRAM WORK?

Drug manufacturers must sign agreements with CMS to participate in the Medicare Coverage Gap Discount Program. The agreement specifies that all of the manufacturers’ applicable BLA and NDA drugs will automatically be discounted by 50% at the Point Of Sale for non LIS Members’ coverage gap claims starting on January 1, 2011. The discount doesn’t include the cost of the dispensing fee. The full cost of the drug will count as out-of-pocket spending for the purposes of reaching catastrophic coverage.

Example: Mrs. Anderson reaches the coverage gap. She goes to her Pharmacy to fill a prescription for an applicable drug. The price for the drug is $60 and the dispensing fee is $2. Once the 50% discount is applied, the cost of the drug is $30. The $2 dispensing fee is added to
the $30 discounted amount. Mrs. Anderson will pay $32 for the prescription, but the entire $62 (both what Mrs. Anderson and the manufacturer pay) will be counted as out-of-pocket spending and will help Mrs. Anderson reach the end of the coverage gap.

If a drug manufacturer doesn’t sign a discount agreement with CMS, its applicable drugs won’t be covered under Part D, and Part D sponsors won’t be allowed to grant an exception or provide a transition fill for such drugs. People may still buy the drug at its full price, but the cost won’t count towards the progression through the coverage gap. Medicare Part D plans will review coverage gap claims to determine the person’s eligibility and if the drugs are eligible for the discount.

**HOW WILL MY PHARMACY KNOW WHICH MANUFACTURERS HAVE SIGNED A COVERAGE GAP DISCOUNT PROGRAM AGREEMENT WITH CMS?**

CMS publishes a listing of companies that have signed an agreement along with the associated five-digit labeler codes on its Web site. The listing of labeler codes and manufacturers can be found at [www.cms.gov/PrescriptionDrugCovGenIn](http://www.cms.gov/PrescriptionDrugCovGenIn). Select “Part D Information for Pharmaceutical Manufacturers.”

**MEDICARE AUDIT AND RECORD RETENTION REQUIREMENTS**

Pharmacies and their downstream contracted entities must comply with Medicare laws, and, regulations and CMS instructions and guidelines. CMS requires that records be maintained for a period of 10 years from the final date of the contract between CMS and the Plan Sponsor or the date of audit completion, whichever is later. The Pharmacy agrees to make its books and other records available in accordance with section 42 CFR 423.505(e)(2) and 42 CFR 423.505(i)(2), which generally states that CMS may inspect, evaluate and audit any books, contracts, records, including medical records and documentation related to CMS’s contract with the Plan Sponsors. In addition, the Pharmacy is responsible for notifying EnvisionRxOptions of Pharmacy closures, acquisitions and mergers. Once EnvisionRxOptions has been notified of a Pharmacy closure, acquisition or merger, an attestation will be sent to the Pharmacy to attest to the status of the prescription records.

**REJECTIONS**

Pharmacies will receive rejections for claims on drugs with the following rejection message if they are not properly listed with the FDA (ANDA, BLA, NDA drugs) or they are properly listed with the FDA but they are not contracted with CMS for participation in the Coverage Gap Discount Program (BLA/NDA drugs):

1. **Reject 70-PM excludes:** NDC not FDA listed (ANDA drugs) or Not CMS contracted (BLA/NDA drugs). Based on guidance from CMS, EnvisionRxOptions utilizes the FDA’s Comprehensive NDC Structured Product Labeling Data Element File (NSDE) to determine if a drug is considered a valid Part D drug eligible for coverage under the Medicare Part D Program. There are three (3) steps in determining if a drug is eligible for coverage under Medicare Part D:

   - Determine if the Drug Product is Approved by the FDA. In order to verify the approval status of drug products, verification at the NDC level of all NDCs must be confirmed. This is done through matching the specific NDC against the FDA’s NSDE file.
2. Determine if the Drug Product is licensed under an ANDA, NDA or BLA

- CMS issued guidance on May 21, 2010 in a memo regarding administration of the coverage gap discount program. Additional guidance was issued during the CMS Part C & D User Conference Call held on November 3, 2010. Specifically, drugs that have been approved by the FDA under a New Drug Application (NDA) or Biological License Application (BLA) are considered applicable drugs for the coverage gap discount program. All other Part D drugs (drugs approved under an ANDA, compounds, syringes, and other medical supplies associated with the delivery of insulin) are eligible for coverage under Medicare Part D.

- If the drug product is licensed under an ANDA (these are typically generic products) or is one of the other non-applicable drug products (i.e. insulin syringes), the product is eligible for coverage under Medicare Part D. If the drug product is licensed under an NDA or BLA, step 3 is followed.

3. Determine if the Drug Product is Made by a Manufacturer who has a Signed Agreement with CMS to provide the 50% Coverage Gap Discount

- All manufacturers of applicable drugs must have signed agreements with CMS in order to be considered covered Part D drugs. If the manufacturers did not sign agreements with CMS to provide the coverage gap discount, those drugs are NOT eligible for coverage under any phase of the Medicare Part D benefit. CMS maintains a list of manufacturers that have signed agreements and their applicable labeler codes. This list is then used to verify that drugs properly listed in the FDA NDC Directory with an application type of NDA or BLA is a drug product that is made by a participating manufacturer and therefore considered a valid Part D Drug if the Drug is on the Part D Plan’s Formulary.

If the drug product is licensed under an NDA or BLA but the manufacturer is not considered a participating manufacturer, then the drug product is not eligible for coverage under Medicare Part D and the reject message stated above will be received by the Pharmacy.

4. Reject 70-PM excludes; NDC not FDA listed (ANDA drugs) or Not CMS contracted BLA/NDA drugs

It is our recommendation to try to fill the prescription with another NDC for the product. Oftentimes, an alternative manufacturer is listed appropriately in the FDA’s NSDE file. If a prescription is filled with an NDC properly listed in the FDA’s NSDE file the claim will pay. Please contact our Pharmacy Help Desk at the number provided in the rejected claim messaging, if assistance is needed in identifying an NDC that properly listed with the FDA (TTY Users may call 711).

If you are filling for a brand medication and receive this rejection message, it is our recommendation that you contact the physician for a generic alternative or a branded alternative produced by a participating manufacturer.¹

¹ Resources/Further Information: FDA NDC Directory http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm
PART D UNIQUE BIN REQUIREMENTS

Effective January 1, 2012, CMS required claims for the Medicare Part D program be submitted through a unique BIN/PCN combination. This is to ensure that (1) Pharmacies can routinely identify situations in which they are billing a Part D claim and (2) that payers secondary to Part D can properly coordinate benefits on Part D claims. EnvisionRxOptions has a dedicated BIN/PCN for Medicare Part D claims 012312/PARTD. In the event a claim is submitted for medications that are eligible for Medicare Part B coverage for MA-PD Plan Sponsors, Pharmacies will receive the following reject message:

Reject 01: FORCEREJCODE: 01 Invalid BIN. Medicare Part B Drugs must be submitted to BIN/PCN: 009893 / ROIRX

Claims should then be re-submitted using the same Member identification number to the 009893 BIN.  

TRANSITION REQUIREMENTS

Medicare Part D requires that a transition process be maintained with respect to: (1) the transition of new Members into prescription drug plans following the annual coordinated election period; (2) the transition of newly eligible Medicare Members from other coverage into a Part D plan; (3) the transition of individuals who switch from one Part D plan to another after the start of the contract year; (4) new Members residing in Long Term Care (LTC) facility; (5) current Members affected by negative formulary changes from one contract year to the next; (6) Members who request an exception but there is a failure to issue a timely decision on the request by the end of the transition period; (7) Members who remain in the same plan for the new plan year and are on a drug that was the result of an exception that was granted in the previous plan year; (8) current Member experiencing a level of care change; (9) current Members entering the LTC setting from other care settings; and (10) current Members in a LTC setting requiring an emergency supply of a non-formulary drug.

Transition process requirements will be applicable to both non-formulary drugs and drugs on the formulary with utilization management edits, meaning both: (1) Part D covered drugs that are not on the applicable Plan Sponsor formulary, and (2) Part D covered drugs that are on the applicable Plan Sponsor formulary but require prior authorization or step therapy under Plan Sponsor's utilization management rules.

The EnvisionRxOptions Online System will automatically provide up to a temporary 30 day fill in the retail setting (unless the Member presents a prescription written for less than 30 days, in which case EnvisionRxOptions will allow multiple fills to provide up to a total of 30 days of


FDA NDC Directory FAQs http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm
FDA Orange Book http://www.fda.gov/cder/ob/default.htm
FDA Orange Book FAQs http://www.accessdata.fda.gov/scripts/cder/ob/faqlink.cfm
medication) anytime within the first 90 days of the Member’s enrollment in a plan, beginning on the Member’s effective date of coverage with the Plan Sponsor.

To the extent that a Member is outside his or her 90-day transition period, EnvisionRxOptions will still provide an emergency supply of Part D covered non-formulary medications (including Part D covered drugs that are on a Plan Sponsor’s formulary that would otherwise require prior authorization or step therapy under Plan Sponsor’s utilization management rules). This will occur on a case by case basis, when it has been identified that the Member’s exception request or appeal has not been completed by the end of the transition period. Pharmacies should contact the EnvisionRxOptions Pharmacy Help Desk at the number listed on the rejected claim messaging to obtain emergency transition fills in the retail setting (TTY Users may call 711).

In the Long Term Care (LTC) setting, EnvisionRxOptions Online System will automatically provide up to a 98 day supply of medications eligible for transition fills (unless the Member presents with a prescription written for less than 31 days), with multiple refills as necessary, during the first 90 days of a beneficiary’s enrollment in a plan, beginning on the Member’s effective date of coverage. Pharmacy Network providers are required to place a service location code of 0 or 1 on the claim and a patient residence code of 03 for NCPDP D.0 submissions in order for the automatic LTC transition process to work correctly. Members in assisted living facilities will be able to obtain up to a 31 day transition fill (instead of 30) when Pharmacy Network Providers submit a patient residence code of 4 on a NCPDP D.0 claim.

In the LTC setting, after the 90 day transition period has expired, EnvisionRxOptions will still provide a 31 day emergency supply of Part D covered non-formulary medications, as well as Part D covered drugs that are on a Plan Sponsor’s formulary that would otherwise require prior authorization or step therapy under a Plan Sponsor’s utilization management rules (unless the Member presents with a prescription written for less than 31 days), while an exception or prior authorization is requested or when it has been identified that the Member’s exception request or appeal has not been completed by the end of the transition period. Pharmacies should contact the Pharmacy Help Desk at the number provided in the rejected claim messaging to obtain an emergency transition fill (TTY Users may call 711).

For Members being admitted to or discharged from a LTC facility, early refill edits will not be used to limit appropriate and necessary access to their Part D benefit, and such Members are allowed to access a refill upon admission or discharge.

In the event a prescription is for a pack size that due to dosing requirements exceeds the 30 day transition fill rule (i.e. eye drops or insulin) and the pack size cannot be broken to provide only the 30 day supply, Pharmacies should contact the Pharmacy Help Desk at the number provided in the rejected claim messaging to obtain a manual transition override (TTY Users may call 711).³

³ Resources/Further Information:
Reminder of the Part D Transition Policy
Final 2007 Transition Guidance
MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS – REVISED GUIDANCE
FOR DISTRIBUTION OF STANDARDIZED PHARMACY NOTICE (CMS-10147)

As required by CMS guidelines, Medicare Part D network Pharmacies (including mail-order and specialty Pharmacies) are required to distribute a written copy of the standardized Pharmacy Notice when the Member’s prescription cannot be covered (“filled”) under the Medicare Part D benefit and the issue cannot be resolved at Point Of Sale. The Pharmacy notice instructs Members about their right to contact their Part D plan to request a coverage determination, including an exception. This is a standardized Pharmacy Notice, the content of which may not be altered. The OMB control number must be displayed in the upper right corner of the notice. The fields for the Member’s name and the drug and prescription number are optional and may be populated by the Pharmacy. A logo is not required but Pharmacies may place their logo in the space above the optional fields for the Member’s name and the drug and prescription number. The Pharmacy Help Desk can be contacted at 800-361-4542 with questions, or if the required attestation has not been returned to EnvisionRxOptions (TTY Users may call 711).

Printing the Pharmacy Notice on prescription label stock or an integrated prescription receipt is permitted, so long as the Pharmacy notice is provided to the Member in at least 12-point font. Electronic distribution of the Pharmacy notice is permitted if the Member or the Member’s appointed representative has provided an e-mail address or fax number and has indicated a preference for that method of communication.

Mail-Order Pharmacies
If a prescription cannot be covered (“filled”) under the Medicare Part D program as described above, the mail-order Pharmacy must distribute the standardized Pharmacy Notice to the Member. The mail-order Pharmacy has the option of working with the plan and the prescriber to resolve the matter and provide the needed medication or an appropriate substitute. If the matter cannot be resolved and the Pharmacy cannot fill the prescription, the Pharmacy notice must be provided to the Member via the Member’s preferred method of communication (fax, email, or first class mail) as expeditiously as the Member’s health condition requires, but no later than 72 hours from the Pharmacy’s receipt of the original transaction response indicating the claim is not covered by Medicare Part D.

Home Infusion Pharmacies
If a prescription cannot be covered (“filled”) under the Medicare Part D program as described above, the Home Infusion Pharmacy must distribute the standardized Pharmacy notice to the Member either electronically, by fax, in-person, or by first class mail. The Home Infusion Pharmacy has the option of working with the plan and the prescriber to resolve the matter and provide the needed medication or an appropriate substitute. If the Pharmacy cannot fill the prescription, the Pharmacy notice must be provided to the Member expeditiously as the Member’s health condition requires. However, no later than 72 hours from the Pharmacy’s receipt of the original transaction response indicating the claim is not covered by Medicare Part D. For Members brought on service by the Home Infusion Pharmacy, the Pharmacy can also choose to deliver the Pharmacy notice in person with delivery of Home Infusion drugs or through an infusion nurse if the next scheduled visit is within 72 hours of the receipt of the transaction code indicating the claim cannot be covered by Medicare Part D.

NPPES Registration
Pharmacy must maintain the CMS required specialty registration and identification as a home infusion provider through National Plan & Provider Enumeration System (NPPES). Failure to maintain such self-reported registration and identification may result in reimbursement withholds
or reductions and/or recovery of paid claims amounts by Network on behalf of its Plan Sponsors, unless or until all Pharmacy primary and additional specialty(ies) registration requirements have been met.

NOTE: Network reserves the right to audit claims and related documentation of Pharmacy on behalf of its Plan Sponsors to ensure compliance with the Participating Pharmacy Agreement as a home infusion pharmacy.

Pharmacies Serving Long-Term-Care Facilities
Given the uniqueness of the long-term-care (LTC) setting, there is typically no point of sale encounter between the Pharmacy and the Member (LTC resident) and, therefore, no practical means for the Pharmacy to provide the Pharmacy Notice directly to the Member. In most instances where there is an issue with the prescription, CMS expects that the Pharmacist will contact the prescriber or an appropriate staff person at the LTC facility to resolve the matter. This will ensure the Member receives the needed medication or an appropriate substitute, obviating the need to deliver the Pharmacy notice. If the Pharmacy must fax or otherwise deliver the Pharmacy notice to the Member, the Member’s representative, prescriber or an appropriate staff person at the LTC facility must receive the Pharmacy Notice expeditiously as the Member’s health condition requires. However, no later than 72 hours from the Pharmacy’s receipt of the original transaction response indicating the claim is not covered by Part D.

NOTE: If the Member is a self-pay resident, and the Pharmacy cannot fill the prescription under the Part D benefit, the Pharmacy must, upon receipt of the transaction response, fax, or otherwise deliver the Pharmacy notice to the Member, the Member’s representative, prescriber or an appropriate staff person at the LTC facility. After distribution of the Pharmacy notice, the LTC Pharmacy should continue to work with prescriber or facility to resolve the matter and ensure the resident receives the needed medication or an appropriate substitute.  

EnvisionRxOptions will provide network Pharmacies a primary Reject Code for the following reasons:
1. Reject 70: Non Formulary Medications
2. Reject 75: Prior Authorization or Step Therapy Required
3. Reject 9G: Quantity Dispensed Exceeds Maximum Allowed

In addition, EnvisionRxOptions will transmit a secondary Reject Code 569. Per NCPDP, this rejection code is defined as: “Provide Beneficiary with CMS Notice of Appeal Rights”. This secondary reject code will tell Pharmacies that Pharmacy Notice is required to be distributed to the Member. The Pharmacy Help Desk can be contacted at the number listed on the rejected claim messaging (TTY Users may call 711).

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4 Resources/Additional Information: NCPDP website 
http://www.NCPDP.org/
Medicare Prescription Drug Coverage and Your Rights
The Notice of Appeal Reject Code will not be returned in circumstances where transition coverage would not apply, such as:

1. The claim does not contain all necessary data elements for adjudication
2. The drug in question is an Over-the-Counter (OTC) medication that is not covered by a Plan Sponsor
3. The prescription is written by a sanctioned provider who has been excluded from participation in the Medicare Program
4. The drug is not listed on the participating CMS Manufacturer Labeler Code List
5. The drug is not listed on the Food and Drug Administration (FDA) Electronic List-NDC Structured Product Labeling Data Elements File (NSDE)
6. The claim rejects for a refill too soon/early refill edit
7. The drug in question is not covered by the Part D plan benefit, but is covered by a co-administered insured benefit managed by a single processor. In this scenario, the Pharmacy submits a single claim transaction for the drug and drug is covered by the co-administered insured benefit after being rejected by Part D and processed in accordance with the benefits offered by the Supplemental payer.
8. The drug is excluded from coverage under Medicare Part D (i.e. drugs used for cosmetic purposes, drugs used for weight loss or gain, drugs used to promote fertility, drugs used for the symptomatic relief of cough & cold symptoms, prescription vitamins or mineral products except for prenatal vitamins or fluoride preparations, or drugs used to treat erectile dysfunction)
9. The drug requires a Medicare Part B vs. Medicare Part D Determination

Additional copies of the Medicare Prescription Drug Coverage and Your Right Standardized Pharmacy notice are available from the EnvisionRxOptions Provider Relations department as well as the CMS website.5

**HOSPICE MEDICATIONS**

CMS requires that Part D Plan Sponsors ensure that Part D does not pay for drugs and biologics that may be covered under the Medicare Part A per-diem payment to a hospice program. As specified in Section 1861(dd) of the Social Security Act and in Federal regulations at 42 CFR 418, the hospice provider is responsible for covering all drugs or biologics for the palliation and management of the terminal and related conditions.

Please note CMS’ position is stated in the 1983 Hospice Final Rule, which implemented the hospice benefit.

CMS interpreted related conditions broadly, and wrote that hospices are required to cover virtually all the palliative care needed by terminally ill patients (48 FR 56010). Drugs for the palliation and management of the terminal illness and related conditions are the responsibility of the hospice, and as CMS has noted in rulemaking, at the end of life, most conditions are related.

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5 **Resources/Additional Information:**
Medicare Prescription Drug Coverage and Your Rights
Thus, when a sponsor receives a transaction reply report (TRR) showing a Member has elected hospice, the sponsor must have controls in place to comply with this requirement. Plan Sponsors are encouraged to place beneficiary-level PA requirements on four categories of prescription drugs, including: analgesics, antinauseants (antiemetics), laxatives, and antianxiety drugs.

Effective 09/01/2013, and monthly thereafter, EnvisionRxOptions will be implementing Member level prior authorization for the above four categories of medications for all Members who have elected Hospice coverage as identified via Medicare eligibility data.

Your Pharmacy may start seeing rejections on drugs previously covered under the Part D benefit. Reject messaging will state: “Per Medicare enrollment – member in hospice. Please bill hospice provider. If Member is no longer on hospice please call 866-250-2005.”

In addition, once the edits are in place for current Members EnvisionRxOptions will be notifying all Pharmacies with prior claims for these Members’ to ask that the claims to be reversed and billed to the hospice provider. EnvisionRxOptions will send the Hospice provider contact information to the Pharmacy if we have it available.  

**PRESCRIBER VERIFICATION**

CMS guidance specifies that the NPI is intended to uniquely identify a health care provider in standard transactions, such as health care claims. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use NPIs in standard transactions by the specified compliance dates. The NPI is the only health care provider identifier that Covered Entities may use to identify health care providers.

Per CMS final rule (77 FR 54664), beginning May 6, 2013, Type I (Individual) NPIs are to be submitted on claims. As per this requirement, any Type 2 (Organizational) NPI submitted by the Pharmacy will be rejected at point of sale with a force Reject Code 619. EnvisionRxOptions will only accept claims for a valid Type I Prescriber NPI.

EnvisionRxOptions subscribes to a service that maintains Prescriber NPI and DEA numbers, as well as the scope of practice with respect to authority to prescribe controlled substances. This database is updated bi-weekly. During the electronic submissions, if the prescriber is not found within the database or has an expired or invalid DEA or NPI, the claim will reject.

CMS will allow rejections on these claims as long as they can be resolved at Point Of Sale. If your Pharmacy receives a reject 619 (Rejection 619: Prescriber Type 1 NPI Required; Effective 5.6.2013 A valid Individual Prescriber NPI is required on all claims. Organizational NPIs no longer permitted), please take the following steps to attempt to obtain a paid claim.

- Verify that the correct prescriber NPI/DEA number has been entered on the claim
  - If previously submitted an incorrect NPI/DEA number, correct the number and resubmit the claim

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• If still receiving a reject, please verify that the NPI/DEA submitted does not belong to an organization. If so, correct the number and resubmit the claim.

If Pharmacy submitted the correct prescriber NPI/DEA number on the claim and the NPI is not a Type II
• Verify that the physician name is spelled correctly
• Verify you have the physician address and phone number entered correctly

Please contact the EnvisionRxOptions Pharmacy Help Desk at 800-361-4542, if you have questions or require additional assistance. (TTY users may call 711). 7

LONG TERM CARE PHARMACY (LTC)
If the Pharmacy is located in, or has a contract with, a LTC facility, and the Member is in a LTC facility, the Pharmacy has up to 90 days from the date of dispensing to submit a claim for reimbursement.

SHORT CYCLE DISPENSING
Pursuant to CMS 42 CFR 423.154, beginning January 1, 2013 and thereafter, to the extent that Long Term Care (LTC) Pharmacies dispenses Oral Solid Brands to Members residing in Long Term Care Facilities, LTC Pharmacy shall dispense only Short Cycle Drug Doses of an Oral Solid Brand, regardless if the Oral Solid Brand is written for an amount exceeding a 14 day supply by a prescriber.

“Oral Solid Brand” or “Oral Solid Brand Name Maintenance Covered Product” means a brand name prescription drug that is a prescription product as defined in CMS 42 CFR 423.4. Excluded from the definition of Oral Solid Brand name prescription drugs as defined at CMS 42 CFR 423.154(b) include prescription drugs such as, but not limited to, solid oral doses of antibiotics and solid oral doses of prescription drugs that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging (e.g., oral contraceptives).

Your Pharmacy may receive rejections on drugs you believe are generic. Below is an excerpt from the Medicare Prescription Drug Benefit Manual which explains when Medicare considers a drug a generic medication under the Medicare Part D program.

“(f)or a purpose of Part D, what determines whether a drug is a generic drug is the type of application on file for that product with the Food and Drug Administration (FDA). If a drug product approval is based upon an abbreviated new drug application (ANDA), that drug is therefore a generic drug.” (42 CFR 423.4)

If your Pharmacy has received a claim rejection and would like to verify drug application type on file with the FDA, please reference http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm or at:
http://www.fda.gov/ForIndustry/DataStandards/StructuredProductLabeling/ucm240580.htm

7 Resources/Additional Information:
CMS Memo-Prescriber Identifier Reporting
As set forth in the CMS requirement, announced changes to the Drug Data Processing System (DDPS) for the purpose of using prescription drug event (PDE) data as a vehicle for meeting the regulatory reporting requirements described at 42 CFR 423.154(a)(2). Health care providers, such as a hospital, must require certain non-covered individual health care providers who are prescribers to obtain and disclose a NPI. The compliance date for the new NPI requirement is May 6, 2013. Sponsors must report only a Type 1 (individual) NPI on the PDE record.

As instructed, beginning February 28, 2013 CMS will revise the PDE detail record layout to include Pharmacy Service Type (147-U7), Patient Residence (384-4X), and Submission Clarification Code (420-DK). Below are the fields’ Definition and Values effective November 2012. For those claims where the Patient Residence is 03—Nursing Facility, the Submission Clarification Code (SCC), if applicable, must also be valid.

<table>
<thead>
<tr>
<th>FIELD NAME</th>
<th>DEFINITION / VALUES</th>
</tr>
</thead>
</table>
| Pharmacy Service Type           | The type of service being performed by a Pharmacy when different contractual terms exist between a payer and the Pharmacy, or when benefits are based upon the type of service performed.  
01 – Community/Retail Pharmacy Services  
02 – Compounding Pharmacy Services  
03 – Home Infusion Therapy Provider Services  
04 – Institutional Pharmacy Services  
05 – Long Term Care Pharmacy Services  
06 – Mail Order Pharmacy Services  
07 – Managed Care Organization Pharmacy Services  
08 – Specialty Care Pharmacy Services  
99 – Other |
| Patient Residence               | Code identifying the patient’s place of residence.  
00 – Not specified, other patient residence not identified below  
01 – Home Community/Retail Pharmacy Services  
03 – Nursing Facility  
04 – Assisted Living Facility  
06 – Group Home  
09 – Intermediate Care Facility/Mentally  
11 - Hospice |
| Submission Clarification Code   | Code indicating they the pharmacist is clarifying the submission.  
16 – Long Term Care (LTC) emergency box or automated dispensing machine  
21 – LTC dispensing, 14 days or less not applicable  
22 – LTC dispensing, 7 day supply  
23 – LTC dispensing, 4 days  
24 – LTC dispensing, 3 day  
25 – LTC dispensing, 2 day  
26 – LTC dispensing, 1 days  
27 – LTC dispensing, 4 day, then 3 day supply  
28 – LTC dispensing, 2 day, then 3 day supply  
29 – LTC dispensing, daily during the week then multiple days for weekend  
30 – LTC dispensing, per shift  
31 – LTC dispensing, per med pass |
2014 REQUIREMENTS FOR CODING PATIENT RESIDENCE AND PHARMACY SERVICE TYPE ON CLAIM TRANSACTIONS

On June 20, 2013, CMS released a memo regarding the 2014 Requirements for Patient Residence and Pharmacy Service Type on claims transactions. Beginning in 2014, CMS will require a valid Patient Residence and Pharmacy Service Type on all Medicare Part D claims. All retail and mail order pharmacies must include a valid Patient Residence code on all Part D claims transactions. If the patient residence is unknown, the Pharmacy may default to a Patient Residence of 1 (Home). Long Term Care, Home Infusion, and Specialty Pharmacies should be able to reliably report on all claims since they deliver to the Member residence.

In the event a transaction has a missing or invalid code, the claim may be rejected at point-of-sale.

Valid Patient Residence Codes as of 7/17/2013 include:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not specified other patient residence not identified below</td>
</tr>
<tr>
<td>1</td>
<td>Home</td>
</tr>
<tr>
<td>3</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>4</td>
<td>Assisted Living Facility</td>
</tr>
<tr>
<td>6</td>
<td>Group Home</td>
</tr>
<tr>
<td>9</td>
<td>Intermediate Care Facility/Mentally Retarded</td>
</tr>
<tr>
<td>11</td>
<td>Hospice</td>
</tr>
</tbody>
</table>

All Pharmacies are expected to know the appropriate (i.e., non-default) Pharmacy service code to include on all Part D claims.

Valid Pharmacy Service Type Codes as of 7/17/13 include:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Community/Retail Pharmacy Services</td>
</tr>
<tr>
<td>2</td>
<td>Compounding Pharmacy Services</td>
</tr>
<tr>
<td>3</td>
<td>Home Infusion Therapy Provider Services</td>
</tr>
<tr>
<td>4</td>
<td>Institutional Pharmacy Services</td>
</tr>
<tr>
<td>5</td>
<td>Long Term Care Pharmacy Services</td>
</tr>
<tr>
<td>6</td>
<td>Mail Order Pharmacy Services</td>
</tr>
<tr>
<td>7</td>
<td>Managed Care Organization Pharmacy Services</td>
</tr>
<tr>
<td>8</td>
<td>Specialty Care Pharmacy Services</td>
</tr>
</tbody>
</table>

*Network reserves the right to audit claims on behalf of its Plan Sponsors. Failure by pharmacy to submit claims with proper submission codes may result in reimbursement withholds or reductions and/or recovery of paid claims amounts, unless or until all correct submission code requirements have been met.

Resources/Additional Information:
CMS Memorandum on 2014 Requirements for Coding Patient Residence and Pharmacy Service Type on Claims dated June 20, 2013, available at www.envisionrx.com
2014 DAILY COST SHARING REQUIREMENTS

Beginning, January 1, 2014, certain prescriptions that are dispensed by a participating Pharmacy for less than a 30 days’ supply may have an applicable daily cost-sharing rate attached in accordance with 42 C.F.R. § 423.153(b)(4)(i). This requirement provides Part D Members, in consultation with their prescribers, the option of shorter days’ supplies of initial fills of new prescriptions without the disincentive of the Member paying a full month’s co-payment or coinsurance. Prescribers are expected to be particularly supportive of this prescribing option when the prescription is for a drug that has significant side effects, is frequently poorly tolerated, and when less than a month’s supply of the prescription is clinically appropriate.

In addition, it would allow the Member the ability to synchronize their prescriptions in consultation with their pharmacists without having to pay a full month’s cost sharing when less than a month’s supply of medication(s) is dispensed during the synchronization process until all medications are on the same thirty or more days refill schedule. CMS intends to include language in future Medicare & You and Part D Evidence of Coverage (EOC) documents on the availability of daily cost sharing rates, and on how beneficiaries should consider taking advantage of them. Also, it should be noted that daily cost sharing requirements does not address how Pharmacy dispensing fees are to be negotiated, calculated or paid. There is no necessary connection between daily cost sharing amounts charged to beneficiaries and how dispensing fees are paid to Pharmacies.

ADDITIONAL MEDICARE PART D REQUIREMENTS

1. True Out Of Pocket (“TrOOP”)
   Your Pharmacy must process TrOOP expenses as required by CMS. Pricing information will be communicated back to the Pharmacy via the Online System.

2. Cost Sharing
   Your Pharmacy must charge and apply the correct Member cost share amount, including that which applies to the Members qualifying for the low-income subsidy. Cost share amounts will be communicated back to the Pharmacy via the Online System. Your Pharmacy must also, if expressly requested by the Part D Member, agree to not submit the claim to the Payer.

3. Pricing Differential
   Your Pharmacy must inform Medicare Part D Members at the Point Of Sale (or at the Point Of Delivery) of the lowest priced, generically equivalent drug if one exists for the Member’s prescription, as well as an associated differential in price. (Member’s copayments are often based on whether a generic, preferred brand or non-preferred brand is dispensed.) Prescription drug costs can best be managed through the following actions:

   - Generic Drug Substitution – Dispense FDA-approved generic equivalent drugs whenever possible and in accordance with Federal and State laws. Contact the

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9 Resources/Additional Information:
CMS Memorandum on 2014 Requirements for Coding Patient Residence and Pharmacy Service Type on Claims dated June 20, 2013, available at www.envisionrx.com
prescriber if necessary in order to dispense a generic equivalent drug. Certain
drugs with documented dosing problems should not be dispensed generically
unless requested by the prescriber.

- **Prescription Drug List Compliance** – If a generic equivalent drug cannot be
substituted, contact the prescriber to determine if a drug from the Prescription
Drug List can be dispensed as an alternative. Claims messaging will usually
contained the preferred drug alternative.

- **Prescriber “Dispense as Written” Prescription (DAW1)** – If a prescription
specifies “Dispense As Written,” Pharmacy should contact the prescriber to
determine if a generic equivalent or drug from the Prescription Drug List can be
dispensed as an alternative.

4. **Compliance**

Your Pharmacy is required to fill prescriptions, provide reporting, and provide all
services required to support the Medicare Prescription Drug Benefit Program, and to
abide by all applicable federal and state laws and regulations, as well as CMS
instructions.

5. **Home Infusion Pharmacies**

“All Home Infusion pharmacies shall, at a minimum, meet the following
requirements:

(i) Are capable of delivering home-infused drugs in a form that can be
administered in a clinically appropriate fashion.

(ii) Are capable of providing infusible Part D drugs for both short-term acute
care and long-term chronic care therapies.

(iii) Ensure that the professional services and ancillary supplies necessary for
home infusion therapy are in place before dispensing Part D home infusion
drugs.

(iv) Provide delivery of home infusion drugs within 24 hours of discharge from
an acute care setting, or later if so prescribed.

in accordance with CMS § 423.120 Access to Covered Part D Drugs. “

6. **e-Prescribing**

If the Pharmacy transmits and/or receives prescription and prescription related
information using electronic media for Part D covered drugs for Part D eligible
individuals, Pharmacy must comply with all e-prescribing standards, using current
NCPDP standards.

7. **Minimum Standards**

Your Pharmacy is required to comply with the applicable minimum standards for
Pharmacy practice as established by the state in which the Pharmacy is located.
8. Payment of Clean Claims
In accordance with 42 CFR 423.520, your Pharmacy will be reimbursed within 14 days of submission date for all clean claims submitted via the Online System, and within 30 days for other claims (e.g. rejected or disputed claims etc.).

RETAIL VACCINE

The purpose of the EnvisionRxOptions retail Pharmacy vaccine program is to provide a complete range of vaccines that may be appropriately administered in the retail Pharmacy setting. The fee schedule is priced at the Generic Product Indicator (GPI) level, allowing Pharmacies the flexibility to purchase various NDCs within that GPI. Since some NDCs are added on a seasonal basis under the existing GPI, such as flu vaccines, Pharmacies may be able to make better purchasing decisions. The language in the Vaccine Program addendum allows EnvisionRxOptions to adjust pricing or the vaccine contents should market trends change. For instance, at the beginning of a season, the Centers for Disease Control and Prevention (CDC) may not call for an H1N1 vaccine; however, later in the season the CDC may change this determination. Our addendum would allow us to make that change.

Pricing for these vaccines were carefully compared to other national and regional payors’ pricing as well as that of a major national vaccine distributor. The fee schedule is based on an average discount of AWP within the applicable GPI. In addition to each ingredient cost reimbursement, Pharmacies are also paid a vaccine medication administration fee.

In addition to seasonal flu vaccines, the EnvisionRxOptions Retail Pharmacy Vaccine Program now includes scores of other vaccines such as Hepatitis A & B, Human Papillomavirus, Pneumococcal, Meningococcal, Diphtheria, Tetanus, Measles, Mumps and Rubella, Polio, Chicken Pox, Shingles, Yellow Fever, Rabies and Typhoid.

In order to receive a vaccine under this Program, Members should present their Pharmacy ID card to the pharmacist. The BIN/PCN will be the same as any other Commercial, Medicare or Medicaid claim. The Pharmacy is contractually obligated to collect any applicable copays or cost sharing. Please note that not all EnvisionRxOptions Plan Sponsors participate in this program.

State laws may vary regarding administration of some vaccines at a retail setting or by a pharmacist. You are required to know and comply with your state’s regulations regarding the administration of vaccines by your Pharmacy.

RETAIL VACCINE PROCESSING INSTRUCTIONS
In order for your Pharmacy to be reimbursed correctly, please submit claims as you would normally with the NDC code. You must enter “Dose (ml)” from your Attachment A-Reimbursement in the “Metric Decimal or Quantity Dispensed” field which appears as FIELD # 442-E7 on your Payer Sheet.

You must submit “MA” in the “Pro Svc Code, Professional Service Code” field which appears as FIELD # 440-E5 on your Payer Sheet. The administration fee of $15.00 must go in the “Incent Amt Sub, Incentive Amount Submitted” field which appears as FIELD # 438-E3 on your Payer Sheet.
PRICING AND REIMBURSEMENT

The Pharmacy Help Desk is open for questions regarding payment and pricing 24 hours a day, 7 days a week, 365 days a year. If you feel that you have not been properly reimbursed for a prescription drug, please call the Pharmacy Help Desk at 800-361-4542 to speak with a customer representative (TTY users may call 711). Please provide your Pharmacy’s NCPDP number, prescription number, date of service, NDC number of the drug, quantity dispensed and the amount due your Pharmacy. The representative will log the details and forward the disputed claim over to the Pharmacy Disputes team for review and follow up. If you are not satisfied with the response by the Pharmacy Disputes team, the Pharmacy may appeal the decision by contacting the Pharmacy Help Desk and requesting to speak to the Pharmacy Disputes supervisor who will address the claim and reply within 72 hours.

Please be advised that if your Pharmacy submits a claim to EnvisionRxOptions, even if your Pharmacy is not currently contracted at the time of service, for a program, your acceptance for reimbursement constitutes acceptance of the rates for that program.

EnvisionRxOptions contracts for rebates and provides the discount price that is to be compared with your usual and customary price. The lower of the two prices is sent back to the Pharmacy as the amount to be paid to the pharmacy.

In the event that EnvisionRxOptions determines that your Pharmacy was overpaid or underpaid for a prescription, the adjusted amount will be applied to your next reimbursement cycle. Your Pharmacy must continue to dispense prescriptions to Members in good faith during and subsequent to any pricing and reimbursement. Your Pharmacy must refrain from making disparaging comments to Members about EnvisionRxOptions or about Member’s health care plan or program.

STATE SPECIFIC PROVISIONS

NEW HAMPSHIRE - MEDICAID LINE OF BUSINESS

Participating Pharmacies must comply with the following provisions in connection with the New Hampshire Medicaid Care Management Program. Said provisions are subject to DHHS’ approval and revisions.

Pharmacy’s Licensure and Enrollment. Pharmacy represents and agrees that it is licensed and/or certified in accordance with the laws of the State of New Hampshire, and Pharmacy is not excluded from participation in federal health care programs or under sanction or exclusion from participation in the New Hampshire state Medicaid program. Pharmacy further represents and agrees that it is enrolled as a New Hampshire Medicaid provider. Pharmacy agrees to notify Network immediately should Pharmacy be excluded from participation in federal health care programs or be sanctioned or excluded from the New Hampshire state Medicaid program.
I. Pharmacy’s Acceptance of – and Compliance with – all eligibility and reporting requirements. Pharmacy represents and agrees that it is in compliance with all federal and state eligibility criteria, reporting requirements, and any other applicable rules and regulations related to the New Hampshire state Medicaid program.

II. Pharmacy’s Acceptance of – and Compliance with – Federal and State Statutes and Regulations. Pursuant to 42 CFR 438.6, 42 CFR 438.100(a)(2) and 42 CFR 438.100(d), Pharmacy agrees to adhere to all applicable federal and state laws, including the following without limitation:

A. Pharmacy shall ensure that at a minimum, conflict of interest safeguards equal to federal safeguards (as set forth at 41 USC 423, section 27) are in place (as set forth in Social Security Act, Section 1923(d)(3)).

B. Pharmacy shall comply with the following Federal and State Medicaid Statutes, Regulations, and Policies:

i. Medicare: Title XVIII of the Social Security Act, as amended; 42 U.S.C.A. §1395 et seq.

ii. Related rules: Title 42 Chapter IV

iii. Medicaid: Title XIX of the Social Security Act, as amended; 42 U.S.C.A. §1396 et seq. (specific to managed care: §§ 1902(a)(4), 1903(m), 1905(t), and 1932 of the Social Security Act)

iv. Related rules: Title 42 Chapter IV (specific to managed care: 42 CFR § 438; see also 431 and 435)

v. Children’s Health Insurance Program (CHIP): Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397; Regulations promulgated thereunder: 42 CFR 457

vi. Patient Protection and Affordable Care Act of 2010

vii. Health Care and Education Reconciliation Act of 2010, amending the Patient Protection and Affordable Care Act

viii. American Recovery and Reinvestment Act

ix. 42 CFR 435; XX-YY, Chapter ZZ of New Hampshire Department of Health and Human Services’ (“DHHS”) Eligibility Manual, NH Laws (RSAs), Regulations, State Plan

C. Pharmacy shall meet Medicare certification and be in good standing. Pharmacy represents that it is not, and does not employ or contract, directly or indirectly, with:

i. Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 or 1128A of the SSA for the provision of health care, utilization review, medical social work, or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

ii. Any entity for the provision of such services (directly or indirectly) through an excluded individual or entity;
iii. Any individual or entity excluded from Medicaid or New Hampshire participation by DHHS;

iv. Any individual or entity discharged or suspended from doing business with the State of New Hampshire;

v. Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act; or

vi. Any providers or subcontractors excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

D. Pharmacy shall comply with the Civil Rights Act of 1964 (42 U.S.C. § 2000d), Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the regulations (45 C.F.R. Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.

E. Pharmacy shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing Services, Pharmacy will not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid beneficiaries who are qualified disabled individuals covered by the provisions of the ADA. A "qualified individual with a disability" defined pursuant to 42 U.S.C. § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (42 U.S.C. § 12131).

F. In connection with ensuring non-discrimination in enrollment, Pharmacy agrees:

i. To not discriminate against eligible Medicaid recipients because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

ii. To not discriminate against eligible persons or eligible Medicaid recipients on the basis of their health or mental health history, health or mental health status, their need for health care services, the insurance reimbursement amount based on the eligible person’s actuarial class, or pre-existing medical/health conditions.

G. Pursuant to 42 CFR 438.100(c), Pharmacy agrees that each eligible Medicaid recipient is free to exercise his/her rights, and an eligible Medicaid recipient’s exercise of those rights shall not adversely affect the way Pharmacy treats the eligible Medicaid recipient.
H. Pursuant to 42 CFR 438.206(c)(1)(ii), Pharmacy agrees to offer to eligible Medicaid recipients hours of operation that are no less than the hours of operation offered to commercial and FFS patients.

I. Pursuant to 42 CFR 438.106(c), 42 CFR 438.6(1), 42 CFR 438.230 and 42 CFR 438.204(a) and Section 1932(b)(6) of the Social Security Act, Pharmacy agrees that it may not bill any eligible Medicaid recipient any amount greater than would be owed if Pharmacy provided the services directly to the eligible Medicaid recipient, and the eligible Medicaid recipient was without any Medicaid or insurance coverage.

J. Pharmacy shall comply with the terms of the Federal False Claims Act, as set forth at 31 U.S.C. §§ 3729 to 3733, and with the New Hampshire False Claims Act, as set forth at N.H. Rev. Stat. Ann §§ 167:61b to e (and as each may be amended from time to time), including the whistleblower protections afforded by such laws.

K. Pharmacy shall comply with the Health Insurance Portability & Accountability Act of 1996 (as governed by 45 C.F.R. Section 164.504(e)), which will be provided on request from Pharmacy.

III. Pharmacy’s Acceptance of – and Compliance With – Terms Required by DHHS Medicaid Contract. Pharmacy acknowledges that Boston Medical Center Health Plan, Inc. (“BMCHP” or “Client”), doing business as Well Sense Health Plan in New Hampshire, has entered into a government agency contract with DHHS to manage and arrange for the provision of covered services to New Hampshire Medicaid enrollees (“DHHS Medicaid Contract”); that the term “BMCHP Medicaid Care Management Program” shall mean the Medicaid managed care program offered by BMCHP to New Hampshire Medicaid enrollees pursuant to the DHHS Medicaid Contract; that the DHHS Medicaid Contract contains provisions applicable to participating providers, including pharmacies; and that pharmacy agrees to comply with the terms and conditions of the DHHS Medicaid Contract applicable to pharmacies, including without limitation the requirements reflected in the following:

A. Pharmacy agrees to submit and transmit all claims information to Network, as directed by Network, so as to satisfy the terms of the DHHS Medicaid Contract.

B. Subject to applicable rules regarding patient confidentiality, Pharmacy shall, within the time required by Network and/or BMCHP, provide Network and/or BMCHP with copies of specified Members’ pharmacy and other relevant records to enable Network and/or BMCHP to meet legal or contractually-imposed requirements, including without limitation, for purposes of resolving Member appeals and grievances. Pharmacy acknowledges that, because of substantial fines and penalties imposed under applicable laws and contracts, timely provision of records under this section is a material obligation of Pharmacy.

C. Network, its designee, or DHHS may conduct an audit pursuant to the DHHS Medicaid Contract or as required by DHHS. Pharmacy shall cooperate with and extend all reasonable and necessary support to Network, its designee, and/or DHHS to facilitate any review or audit.

D. To enable Network and Client to create and update Client’s Provider Directory and post accurately all DHHS required information concerning pharmacy network providers on a website accessible to participants who are eligible and enrolled in the BMCHP Medicaid Care Management Program (“Members”), Pharmacy agrees to provide Network, in writing, with the following information within twenty four (24) hours of any change to said information: (a) Pharmacy name; (b) Pharmacy location; (c) Pharmacy telephone number(s); (d) Pharmacy office hours; (e) whether Pharmacy
offers non-English languages, and if so, which languages are offered; (f) if Pharmacy is not accepting new patients; or (g) any change in restrictions to Members’ freedom of choice.

E. Pharmacy agrees to accept a Member’s Medicaid ID Card as proof of enrollment until Member receives a BMCHP’s Medicaid Care Management Program ID card.

F. Pharmacy agrees that, in no event, including without limitation, nonpayment by Network or Network’s insolvency, shall Pharmacy bill, charge, collect a deposit from, seek payment from, maintain any action at law or in equity or have any other recourse against a Member for items provided pursuant to BMCHP Medicaid Care Management Program. This provision does not prohibit Pharmacy from collecting from Members (i) Copayments or Deductibles consistent with BMCHP Medicaid Care Management Program; or (ii) charges for items not covered under BMCHP Medicaid Care Management Program delivered on a fee-for-service basis to Members who are informed in advance of the cost and agree in writing to accept payment responsibility for such non-covered items.

G. Pharmacy agrees to submit to any periodic credentialing recertification processes by which Client and/or Network periodically review, approve and recertify the credentials of Pharmacy pursuant to NCQA requirements and any comparable requirements defined by DHHS.

H. Pharmacy shall be responsive to the linguistic, cultural and other unique needs of any minority, homeless person, disabled individuals or other special populations that comprise BMCHP’s membership, including the capacity to communicate with Members in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or deaf blind.

I. Pharmacy agrees to participate in a pharmacy satisfaction survey, approved by DHHS and administered by a third party, should Pharmacy be identified as a participant for said survey.

J. Pharmacy agrees to cooperate fully with Client’s Quality Assessment and Performance Improvement (“QAPI”) Program, as developed and approved by DHHS.

K. Pharmacy agrees to indemnify and hold harmless Network and Client should any damages or liquidated damages be paid by either entity as a result of Pharmacy’s non-compliance or failure to satisfy any applicable federal or state law.

L. Pharmacy will not release and make public statements or press releases concerning the BMCHP Medicaid Care Management Program without the prior consent of BMCHP and DHHS.

M. Pharmacy also agrees to respond to a BMCHP disability survey, should it be asked to do so, that is developed by the State of New Hampshire, the attestation of which shall be kept on file by BMCHP and shall be available for inspection by the DHHS.

N. Pharmacy agrees to abide by the BMCHP’s written Fraud and Abuse policies and initiatives made available to Pharmacy, and if found to be not compliant with policies and initiatives, shall implement corrective actions as agreed to between the parties. Pharmacy shall further cooperate fully with any federal or state agency conducting Fraud and Abuse investigations concerning Members. Full cooperation includes, but is not limited to, timely exchange of information and strategies for addressing Fraud and Abuse, as well as allowing prompt direct access to information, free copies of documents and other available information related to Fraud and Abuse or other violations of government-sponsored health care programs. Pharmacy shall maintain the confidentiality of any such investigation.
For pharmacies in the state of Virginia, Network will:

1. Update, not less frequently than once every seven days, the maximum allowable cost list, unless there has been no change to the maximum allowable cost of any drug on the list since the last update;

2. Verify, not less frequently than once every seven days, that the drugs on the maximum allowable cost list are available to participating pharmacy providers from at least one regional or national pharmacy wholesaler and that the amount for each drug is not obsolete and promptly revise the maximum allowable cost if necessary to comply with this provision;

3. Provide a process for each participating pharmacy provider to readily access the maximum allowable cost list specific to that provider; and

4. Prohibit the intermediary or carrier from terminating or failing to renew its contractual relationship with a participating pharmacy provider for invoking its rights under any contractual provision required by this section.

Pharmacy may appeal, or request an investigation, and resolution of disputes regarding maximum allowable cost drug pricing that includes:

1. A time period of fourteen days from the date of initial claim adjudication for the participating pharmacy provider to file its appeal;

2. A requirement that the appeal be investigated and resolved within fourteen days of its initiation by the participating pharmacy provider;

3. A telephone number at which the participating pharmacy provider may contact the carrier or its intermediary to speak to a person responsible for processing appeals;

4. A requirement that a carrier or its intermediary, if an appeal is denied, provide (i) a reason for the denial, and (ii) the national drug code of the drug under appeal which the carrier or its intermediary contends may be purchased by the participating pharmacy provider for an amount that is equal to or less than the maximum allowable cost; and

5. A requirement that a carrier or its intermediary, if an appeal is successful, update the maximum allowable cost for the drug under appeal within five days of the determination of the appeal.
WHERE TO GET HELP

The Pharmacy Help Desk is available 24 hours a day, 7 days a week, 365 days per year including holidays at: 800-361-4542 (TTY Users may call 711). The Pharmacy Help Desk is available to assist with billing/payment inquiries, claims and formulary questions, disputes and appeals, member/plan benefits, member eligibility, Pharmacy network issues, and prior authorizations. If a Pharmacy has suggestions for how the network can better serve our members, they can also contact the Pharmacy Help Desk as well.

- If a Member has a general or clinical question or a dispute regarding a claim, please refer them to our Customer Service number located on the reverse side of their membership card.

- If your Pharmacy has a question regarding an accounting issue such as payments, EFT set up etc. email EnvisionRxOptions to pharmacypayables@rxoptions.net

- If your Pharmacy has a question regarding MAC drug pricing, email EnvisionRxOptions to macdisputes@rxoptions.net

Members in the program should be directed to call the number on the back of their cards (TTY Users may call 711).
ACRONYMS

ANDA Abbreviated New Drug Application
AWP Average Wholesale Price
BLA Biologics License Application
CFR Code of Federal Regulations
CMS The Center for Medicare and Medicaid Services
COB Coordination of Benefits
DAW Dispense as Written
DDPS Drug Data Processing System
DEA Drug Enforcement Administration
DUR Drug Utilization Review
FDA Food and Drug Administration
FWA Fraud, Waste and Abuse
HHS Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996
IC Ingredient Cost
LEP Limited English Proficiency
LTC Long Term Care
MAC Maximum Allowable Cost
NCPDP National Council for Prescription Drug Programs
NDA New Drug Application
NDC National Drug Code
NPI National Provider Identifier
NSDE NDC Structured Product Labeling Data Element
OIG Office of Inspector General
OPA Other Payer Amount
OPPRA Other Payer-Patient Responsibility Amount
OTC Over-the-Counter
PBM Pharmacy Benefit Manager
PDEs Prescription Drug Events
POS Point Of Sale
PPA Participating Provider Agreement
PRA Patient Responsibility Amount
PSAO Pharmacy Services Administration Organization
TrOOP True Out Of Pocket
U&C Usual and Customary
USPS United States Postal Services