

PHARMACY SERVICES MANUAL | 2011



**MEDCO
PHARMACY
SERVICES
MANUAL
2011**

The payment rates in this Agreement are confidential between the parties, except that Medco may disclose the terms of this Agreement to the extent required by rules, regulations, or by its client contracts.

Prescription claims must be submitted through the *TelePAID*[®] System only for the Eligible Person for whom the prescription is written by the Prescriber.

Any requests for an interpretation of the Pharmacy Services Manual should be submitted in writing.

Inquiries or disagreements regarding this Manual, claims processing, claims adjustments, nonpayment of claims, or professional questions should be directed to:

Medco
Pharmacy Services Department
MS B3-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417
or
www.medco.com/rph
or
Medco Pharmacy Services
Help Desk at 1 800 922-1557

For special financial issues **only**, such as: a lost payment, the need to re-create the tape or print version of the Remittance Advice, or the need to reconcile the Remittance Advice with the payment you received:

Pharmacy Services
Help Desk at 1 800 922-1557
www.medco.com/rph

To access Medco Payer Sheets:

Pharmacy Services
Help Desk at 1 800 922-1557
www.medco.com/rph

For MAC inquiries and eligibility issues, contact the **Pharmacist Resource Center**:

www.medco.com/rph

Medco's Pharmacy Services Help Desk
Medco's Pharmacy Services
Help Desk (English)
Hours of Operation

1 800 922-1557
Available 7 days a week,
24 hours a day, including holidays

Medco's Pharmacy Services
Help Desk (Spanish)
Hours of Operation
Holiday Hours of Operation

1 800 528-2671
Monday through Saturday
8:30 a.m. to 8:30 p.m., eastern time
8:30 a.m. to 4:30 p.m., eastern time
Closed Thanksgiving and Christmas Day

To access the Manual online:

www.medco.com/rph

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General Information

Medco publishes this Pharmacy Services Manual (Manual) to aid Providers in submitting claims for Medco Eligible Persons. This version of the Manual supersedes and replaces all prior versions of the Manual. The information in the Manual is confidential and proprietary to Medco.

Providers must abide by this Manual. The Manual will be deemed a part of and incorporated into the Provider's Agreement with Medco as if fully set forth therein, and the Manual will be deemed included in any reference to Provider's Agreement with Medco. Providers must comply with the terms and conditions set forth in the Provider Agreement as well as this Manual to maintain status as a network Provider in Medco's networks. Noncompliance with any of the terms of the Provider Agreement (including the terms of this Manual) is a breach of the Provider Agreement.

Any capitalized term set forth in this Manual, in the Regulatory Appendix, or in the Provider's Agreement with Medco will have the same meaning regardless of where the term is defined. Modifications by the Provider to any terms of this Manual shall not be binding upon the parties without the express written consent of Medco. The Provider should maintain a copy of this Manual, the Provider Agreement, and any contractual obligations with Medco in order to ensure compliance.

For Plan Sponsors transitioning to Medco, the reimbursement terms of network schedules may be used on the Plan Sponsor's adjudication system until such time as a transition to the *TelePAID*[®] System is complete.

A Provider's providing of Covered Services to any Eligible Person is a reaffirmation of the terms and provisions of the current Provider's Agreement with Medco as of the time the Covered Services are provided.

Medco administers many plans. Each has its own guidelines as to such things as days' supply, ingredient cost pricing, co-payment/coinsurance, drug coverage, and informational drug utilization messaging. Therefore, rely on the *TelePAID*[®] System to receive accurate information regarding the specific patient, group, prescription drug, co-payment/coinsurance, and pricing pertaining to the claim submitted. Answers to most questions about Medco can be obtained by reading this Pharmacy Services Manual.

For questions not covered in this Manual, please contact Medco at:

The Pharmacy Services Help Desk 1 800 922-1557

or write to:

Medco

Pharmacy Support

MS B3-1

100 Parsons Pond Drive

Franklin Lakes, NJ 07417

CHAPTER 1

HOW TO BECOME A MEDCO PROVIDER AND MAINTAIN PROVIDER STATUS

1.1 HOW TO GET IN TOUCH WITH MEDCO

Medco strives to ensure that its Providers receive prompt and courteous help with questions that may arise. Medco's Pharmacy Services Call Center Representatives are available 24 hours a day, 7 days a week to service Medco Providers via our toll-free phone number. Medco uses multiple call centers to service and support our Providers. In the event of natural or technological disaster, Medco's Pharmacy Services Help Desk is capable of providing uninterrupted service to our participating Provider network.

Pharmacy Services Help Desk

1 800 922-1557 (English)
24 hours a day, 365 days a year

1 800 528-2671 (Spanish)
8:30 a.m. to 4:30 p.m. ET
Closed Thanksgiving and Christmas

Or write to:

Medco
Pharmacy Support
MS B3-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

1.2 HOW TO BECOME A PROVIDER

To become a Provider, you must complete and submit an application and other documentation required by Medco, meet Medco's credentialing requirements, and be able to comply with the requirements of the Provider Agreement and Manual.

Medco will send network schedules to Provider. In order to participate in one or more networks, Provider must sign and return the applicable network schedule(s).

Provider's agreement with Medco does not constitute an agreement for Provider to participate in any or all Provider network(s). If Provider desires to participate in any network(s) and Medco agrees to such Provider's commitment to do so, the applicable payment for such network(s) will be set forth in the applicable schedules. The schedules will also set forth the geographic area, pricing, and other terms and provisions applicable to such network. Participation is effective only upon Medco's approval of all required documentation.

Medco may offer a Performance Based Network to Providers that are selected based on criteria designed to maximize managed care compliance and to control drug program expenditures. The criteria for participating in Medco's Performance Based Network is focused on administrative, professional, and financial elements that provide the framework for participating Providers to deliver managed care programs to those Sponsors willing to pay for performance. From time to time, Medco may provide quarterly updates, as well as performance enhancement support to ensure Provider's success. Medco will highlight participating Providers with the highest performance ranking in Medco cost and quality standards in directories, proposals, and client reports. If there is a discrepancy between the *TelePAID*[®] System and the actual Covered Services or rate, the *TelePAID*[®] System governs so long as it does not result in an overpayment to the Provider or member.

Where laws governing insured members require, participating Providers can request maintenance schedules from Medco. As required by applicable law, and in accordance with the applicable plan and the corresponding schedule provided to Provider, Provider may then dispense a 90 days' supply at retail.

1.3 OBTAINING AN APPLICATION

You can obtain an application from Medco by:

Writing to:

Medco
Pharmacy Administration and Contracting Unit
MS C1-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

Contacting Medco through the Web at: www.medco.com/rph

Calling the Medco Pharmacy Services Help Desk at 1 800 922-1557.

Please submit your completed application and materials to:

Medco
Pharmacy Administration and Contracting Unit
MS C1-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

1.4 INITIAL APPLICATION AND CREDENTIALING PROCESS

1.4.1 Independently Owned Pharmacies

Once you receive an application, you must complete it and return it, along with the required supporting documentation, to Medco. Medco will contact Provider if additional supporting documentation is required, or if the documentation required is not complete.

Please send the following documentation:

- A completed application.
- A photocopy of a current and valid State pharmacy license, pharmacist in charge State license, Federal tax identification number (FTIN), Federal DEA certificate (if applicable), pharmacy's NPI number, and NCPDP number.
- A photocopy of a current general and professional liability insurance certificate showing not less than \$1,000,000 per occurrence and \$3,000,000 in the aggregate per policy year of general and professional liability insurance.
- Verification that the Provider and any managing pharmacists are not currently listed on the OIG, GSA, or other state government exclusion list.

1.4.2 Pharmacy Services Administration Organizations (“PSAO”)

Providers may also delegate contracting responsibilities with Medco to one Pharmacy Services Administration Organization (“PSAO”). A Provider may be affiliated with only one PSAO for contracting purposes at any given time and Provider must report its PSAO affiliation for contracting to Medco on request.

A. If you are a Provider

- Providers are required to apply to be a Medco network Provider, as set forth above. They are also required to meet all the requirements set out in this Pharmacy Services Manual as well as any other supplements and/or additions. Failure to comply can result in losing status as a network Provider.
- If a Provider is contracted with a PSAO that maintains an agreement with Medco in accordance with applicable schedule(s), and Provider terminates its relationship with PSAO or Provider is terminated from the PSAO, Provider agrees to continue providing Covered Services to Eligible Persons in accordance with the applicable schedules for those Plan Sponsors where the applicable schedules have been implemented until the termination of the Plans' contracts with Medco.

B. If you are a PSAO

- A PSAO must certify that Providers that are affiliated with the PSAO meet Medco's requirements and the PSAO must represent that it has an ongoing policy to ensure that the Providers meet Medco's credentialing standards and abide by the Pharmacy Services Manual.

1.4 INITIAL APPLICATION AND CREDENTIALING PROCESS *(continued)*

1.4.3 Chains

Providers that have four locations or more and a common billing address are designated a chain Provider. If the Provider is considered a chain Provider by Medco, Provider's Agreement with Medco will be applicable to all Provider locations regardless of the Provider location and when the affiliated Provider is opened. Notwithstanding the foregoing, Medco may limit participation of any particular location of the chain pharmacy in the Provider's Agreement with Medco or any network.

A chain applicant may contact Medco via the toll-free Help Desk number (1 800 922-1557) to request an application. Each location must have an NCPDP/NPI number assigned to it. Once Medco receives your request, a chain and Provider application form will be mailed to you.

The completed and signed Medco application must be returned to the address below, together with a nonrefundable check payable to Medco in the amount of three hundred dollars [\$300.00] and the following documentation: Copy of DEA certificate, Federal Tax ID, State Board of Pharmacy License, a copy of a current general and professional liability insurance certificate indicating the minimum required coverage covering each location for not less than \$1,000,000 per occurrence and \$3,000,000 in the aggregate per policy year and completed Chain Contact Form. A chain Provider must also maintain adequate umbrella liability insurance coverage for its overall enterprise.

1.4.4 Application Submission

Mail all materials to:

Medco
Pharmacy Administration and Contracting Unit
MS C1-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

Upon receipt of these items, we will review your application and supporting documents and contact you with a status report. Provider's start date will be the date that Provider's application has been fully approved by Medco.

Once Provider's application is approved by Medco, we will send Provider a Provider Agreement, applicable network schedule(s) (which may include state specific schedules) and the current Pharmacy Services Manual. Schedules and Agreement will need to be reviewed by Provider, signed and sent back to Medco.

1.5 CREDENTIALING REQUIREMENTS

In order to become and remain a Provider in a Medco network, a Provider must comply with Medco's requirements. These obligations are continuing.

All Providers must comply with all applicable laws and regulations (including but not limited to all generic substitution laws) and provide all services and products in a professional manner and in compliance with the highest industry standards with care, skill, and diligence. These requirements include, but are not limited to, the following:

- Maintain in good standing all federal, state, and local licenses, permits and certificates as required by law.
- Hold a valid pharmacy license or permit as issued by the appropriate state agency in which it operates to dispense medications. Additionally, the Provider must meet all standards of operation as described in federal, state, and local laws.
- Require and verify that all personnel employed by or contracted with Provider are licensed and qualified to perform their professional duties and that they act within the scope of their licensure.
- Require and verify that Provider and all personnel employed by or contracted with Provider have not been excluded or debarred by any federal or state program. Every three months, Provider will check the applicable state and federal exclusions lists to verify that no employees or contractors are on the list. Provider must inform Medco of the fact that any entity or individual is listed on the exclusion list within 10 days. No compensation will be provided for claims for which work has been done by an excluded person or entity.
- Require and verify that any individual for whom there has been a restriction, suspension, revocation, any other disciplinary action taken, or who is on a state or federal exclusion list, does not provide any service for Medco members and inform Medco of any restrictions, suspensions, revocations or other disciplinary action taken against the Provider.
- Maintain, at its cost and expense, policies of general and professional liability insurance, including malpractice and other insurance necessary to insure Provider and its employees against any claims or claims for damages arising directly or indirectly in connection with the rendering of Covered Services and all other activities by Provider in connection with Provider's agreement with Medco, including but not limited to risks, including those associated with dispensing errors, patient counseling, and quality assurance activities.
- Section 6032 of the Deficit Reduction Act (DRA) requires Providers receiving annual Medicaid payments of five million dollars or more to educate employees, contractors and agents about federal and state fraud, false claims laws and whistleblower protections available under those laws. Compliance with Section 6032 of the DRA is a condition of receiving Medicaid payments. If the Provider receives more than five million dollars in annual Medicaid payments, it must provide training to employees, contractors and agents about the false claims laws and the whistleblower protections. Please see www.medco.com for Medco's Code of Conduct and policies concerning these issues.

1.5 CREDENTIALING REQUIREMENTS

(continued)

- Provider must dispense Covered Services to Eligible Persons in a practice setting approved by Medco. Shipping Covered Services to Eligible Persons by mail or other common carrier as a routine business practice is unapproved without the express written permission of Medco. Payments for claims involving unauthorized mail or other remote delivery carrier are subject to full recovery.

Provider must immediately give notice to Medco (1) of any issues that affect any federal, state or local license, permit or certificate, including should one be in jeopardy (e.g. Provider receives notice of any proceeding and/or investigation that may lead to loss and/or suspension of license) of, or actually loses its license(s); (2) any issues that affect its insurance, including should its insurance be in jeopardy (e.g., Provider fails to pay premium when due or received notice of cancellation) of being or be canceled, lapsed, or terminated; (3) any restriction, suspension, revocation or disciplinary action of Provider; or (4) any exclusion or debarment by any Federal or State entity of Provider or any employee that might provide service to Medco or its Plan Sponsors or members.

In the event Provider loses its license or its license is suspended or revoked; or its insurance, as required herein, is canceled, lapses, or terminates, or Provider is debarred or excluded by any Federal or State entity, Provider's Agreement with Medco will immediately terminate and Provider will no longer attempt to provide Covered Services to any Eligible Person under Provider's Agreement with Medco. Medco, in its sole discretion, will determine if Provider meets and maintains the acceptable criteria required of a participating Provider.

1.6 RE-CREDENTIALING

Medco will periodically re-credential Providers. At that time, a Provider will be required to resubmit the credentialing information to Medco in the time period specified in the re-credentialing request. Medco also re-credentials Providers as part of Medco's specific network initiatives. These initiatives include, but are not limited to, patient health programs, *TelePAID*[®] System requirements, and Provider compliance and audit programs. Provider will comply with any such programs, initiatives, and requirements.

Upon request of Medco, Provider will furnish copies of currently effective licenses, permits, certificates, registrations, or other documents held by Provider or by any pharmacist, employee, or contractor employed by the Provider. Failure to do so may result in probation, suspension, or termination from Medco networks. Medco also reserves the right, after notice to the Provider, to increase the *TelePAID*[®] system fee to a minimum \$0.30 per transaction transmitted for failure to provide requested documentation.

1.7 VERIFICATION FORMS

Provider is required to submit a completed and signed Verification Form on an annual basis within 30 days of receipt. If Provider fails to return a completed Verification Form within 30 days, Medco may charge a \$50.00 fee for each additional request Medco makes to Provider for a completed form. This amount will be deducted from claims payment. Failure to return a form may result in probation, suspension or termination from Medco networks. Medco also reserves the right, after notice to the Provider, to increase the *TelePAID*[®] system fee to a minimum \$0.30 per transaction transmitted for failure to provide a completed Verification Form.

1.8 CHANGES IN OWNERSHIP

Medco must be notified of any change in control or ownership of a Provider or any of its locations. Medco must also be notified each time a store location is opened, closed, relocated, or acquired. A Provider has 10 days after a change in ownership or store location to forward that information to Medco at:

Medco
Pharmacy Services Department
MS B3-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

If there has been a change in control or ownership, the new owner must fill out a new application and the Provider must meet the credentialing standards to participate in Medco's network. Medco, in its sole discretion, will assign the Provider Agreement and any network schedules to the new owner, require the new owner to sign a new Provider Agreement and network schedules, and/or require the new owner to use the existing Provider Agreement and/or network schedules, where applicable. Any new owner is liable for the obligations of the previous owner unless otherwise agreed to in writing by all three parties.

1.9 OTHER NETWORK CRITERIA

Provider is required to support the objectives of Sponsors whose Eligible Persons obtain Covered Services from Provider, to advance Medco programs, not to take actions against the best interest of the networks, plans, programs, and Sponsors, and to comply with disease management and other clinical drug benefit management programs administered by Medco.

1.10 LONG-TERM CARE (“LTC”) REQUIREMENTS

From time to time, Medco or a Plan Sponsor may establish specific requirements that long-term care Providers must meet in order to participate as a Medco network long-term care Provider. For Medicare Part D requirements, including additional claim submission requirements, please see the Medicare Part D section of this Manual.

1.11 HOME INFUSION PROVIDER REQUIREMENTS

From time to time, Medco or a Plan Sponsor may establish specific requirements that home infusion Providers must meet in order to participate as a Medco network home infusion Provider. For Medicare Part D requirements, please see the Medicare Part D section of this Manual.

1.12 SPECIALTY PROVIDER REQUIREMENTS

From time to time, Medco or a Plan Sponsor may establish specific requirements that Providers must meet in order to be able to dispense certain specialty products as a Medco network Provider.

CHAPTER 2.0

**CLAIMS
SUBMISSION**

2.1 THE *TelePAID*[®] SYSTEM

The *TelePAID*[®] System sets forth pricing, eligibility, and other information that governs participation in the network applicable to each Plan Sponsor and Eligible Person.

Each claim a Provider submits must contain complete and accurate information for each prescription dispensed. Provider will transmit claims to Medco with all required fields as defined by Medco using a NCPDP electronic claims standard in effect on the date of service. Claims must be submitted only for the Eligible Person for whom the prescription is written by the Prescriber.

The *TelePAID*[®] System also provides information necessary to effectively implement Medco's clinical and benefit management initiatives such as drug utilization review, prior authorization, and formulary management programs on behalf of Plan Sponsors. Provider will submit all claims through the *TelePAID*[®] System and will comply with all information communicated via the *TelePAID*[®] System or otherwise by Medco.

Provider will submit all *TelePAID*[®] System claims simultaneously with dispensing unless unusual circumstances require otherwise, in which event Provider will submit *TelePAID*[®] System claims within 90 days of the date of service. *TelePAID*[®] System claims can be reversed during the cycle in which the specific transaction adjudicated and up to 90 days after the date of service. Medco's Claim Cycle Schedule and POS cutoff dates are detailed in the Manual. Claims submitted to Medco after the applicable claims cutoff date may not be eligible for payment.

Medco will pay all Clean Claims payable by Medco in accordance with the payment rate established for the applicable plan within Medco's next regular claims cycle less the applicable co-payment/coinsurance, deductible, or other payments, such as administrative fees for certain programs, to be paid directly by the Eligible Person.

The authorization code transmitted to Provider via the *TelePAID*[®] System does not in any way limit or preclude Medco's right to review or audit claims.

Medco may make an adjustment to any claim where it is indicated that Provider received an incorrect amount for Provider services provided. Claim Adjustments should be mailed to:

Medco
Pharmacy Services Department
MS B3-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

Medco will highlight participating Pharmacies with the highest performance ranking to Medco cost and quality standards in directories, proposals, and client reports.

2.2 THE PAYER SHEET

The most current Payer Sheets can be downloaded from the Pharmacist Resource Center website at www.medco.com/rph. From the Information Menu, select "Medco Payer Sheets." Providers can also obtain current Payer Sheets by calling the Pharmacy Services Help Desk at 1 800 922-1557.

2.3 GENERAL SUBMISSION POLICIES

- Submit all claims for Covered Services for Eligible Persons via the *TelePAID*[®] System to ensure that plan design, quality, and professional practice standards are met, Sponsor's plan design and clinical management programs are offered, and DUR review and safety edits are applied.
- Over the counter ("OTC") medications submitted for reimbursement must be supported by a prescription.
- All claims must be completely and accurately submitted online in the current NCPDP HIPAA-compliant format for the Eligible Person for whom the prescription was written by the Prescriber. On January 1, 2011, Medco will start accepting claims under version D.0.
- When a multisource brand drug is dispensed, process the claim with the appropriate Dispense as Written (DAW) Code according to the DAW Code Standards Section of the Manual.
- Reinforce the use of generic and preferred brand products with Eligible Persons and Prescribers as per *TelePAID*[®] messaging.
- Inform Eligible Persons about the proper storage, dosing, utilization, side effects, potential interactions, and use of the medication dispensed within professional practice guidelines.
- Submit accurate National Provider Identification (NPI), Drug Enforcement Administration (DEA) number, State Medical Board License Number, or other Prescriber identifier on all claims in the correct NCPDP field. The preferred Prescriber identifier is the NPI number. Provider should use the NPI unless the Prescriber does not have one. For certain claims, an NPI may be required.
- Provider is required to participate in a variety of plan designs, including but not limited to those that permit access to a negotiated discount upon production of an identification card, and payment for the prescription at the point of sale.
- Provider must be available for periodic audits and abide by the Pharmacy Services Manual and online communications of plan designs via the *TelePAID*[®] System. Failure to comply may result in Medco imposing financial penalties or terminating the Provider.
- An on-site registered and licensed pharmacist experienced in third-party procedures must supervise the claims submitted by Provider.
- Basis of calculations for ingredient cost, the dispensing fee, and co-payment/coinsurance will be returned to Provider on the *TelePAID*[®] System response.

2.4 IDENTIFICATION CARDS

Medco or Medco’s designee may furnish Eligible Persons with prescription drug ID cards to be presented to a Provider or may implement alternative eligibility verification methods. Provider will not be paid for Covered Services provided to persons whose eligibility to participate in a Medco program has not been verified and communicated to Provider by the *TelePAID*® System or other applicable eligibility verification methods used by Medco. In addition, Provider will not be paid if the claim was submitted for an Eligible Person other than the person for whom the prescription was written by the Prescriber.

If the Eligible Person does not yet have an identification card, please follow the instructions on any documents the Eligible Person will provide you that will allow you to obtain the identification number for the member.

2.4.1 Information Needed to File a Claim

Eligible Person information necessary to file a claim is contained on the prescription drug ID card or can be obtained and is described as follows:

Cardholder ID — The ID format can consist of all numeric digits or alphanumeric digits. The National Council for Prescription Drug Programs (“NCPDP”) standard for this field allows up to 20 alphanumeric characters.

Group Number — Usually a 7-character field assigned by Medco. This field may, however, contain up to 15 alphanumeric characters.

Dependent coverage may include spouse and/or children. The card may be coded to indicate which family members are covered. Covered family members are identified by the following:

Relationship Codes:

- “1” Cardholder — Eligible Primary Person or Subscriber
- “2” Spouse of the Cardholder
- “3” Dependent Child
- “4” Other (requires “Clarification Eligibility Exception Code”)

Clarification Eligibility Exception Codes:

- “3” Full-time Student
- “4” Disabled Dependent
- “5” Dependent Parent
- “6” Significant Other/Dependent Adult/Domestic Partner

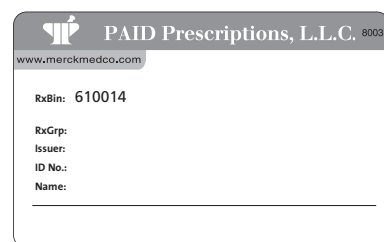
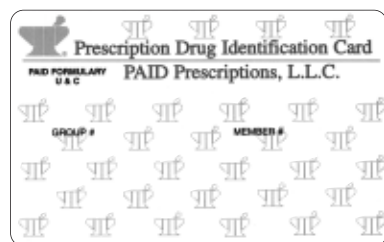
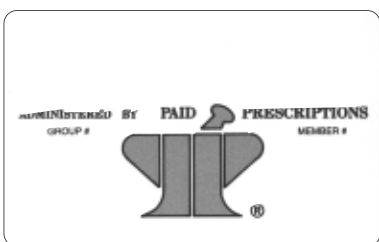
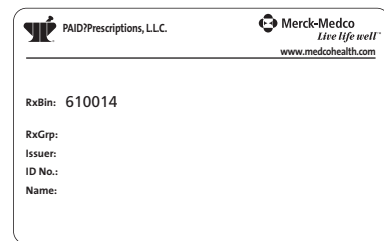
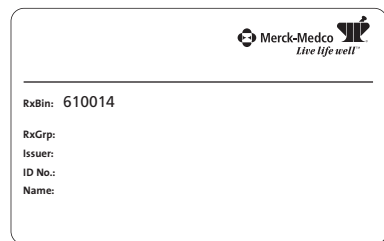
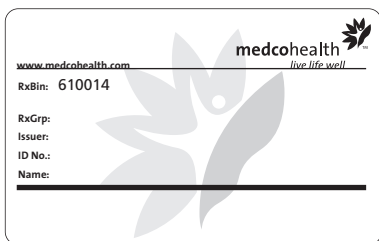
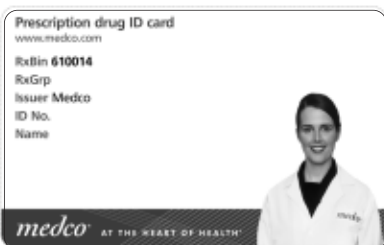
Important Note: Use of the correct Relationship Code is important. Prescription claims must be submitted to Medco only for the Eligible Person for whom the prescription is written by the Prescriber. Claims submitted for any other Eligible Person, except for the person for whom the prescription was written, are subject to audit.

2.4 IDENTIFICATION CARDS

(continued)

Eligibility of the individual patient for whom the prescription is prescribed is confirmed via the *TelePAID*® System. Some cards are valid for only the cardholder whose name is embossed on the prescription drug ID card; some cover only the member or spouse, while others cover the entire family.

2.4.2 Identification Cards



Certain clients may have a custom prescription drug ID card displaying the Medco, Medco Health, Merck-Medco, and/or PAID logos shown below. Process these cards using the *TelePAID*® System.



If the person does not have an identification card, but believes s/he is a Medco member, a Provider can verify eligibility by contacting the Pharmacy Help Desk or by following the instructions on documents that the person will provide.

2.5 REQUIRED IDENTIFICATION NUMBERS

2.5.1 National Provider Identifier

National Provider Identifier (NPI) is the required pharmacy and Prescriber identifier by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) replacing legacy identifiers (e.g., CPDP number, DEA) on all claims submitted through the *TelePAID*[®] System. The NPI is a unique 10-digit identifier assigned to healthcare providers, such as Prescribers and pharmacies, to use when submitting a HIPAA standard transaction.

2.5.2 Identifying the Prescriber

Provider is required to submit accurate information identifying the Prescriber for each claim submitted. A valid NPI number (“01”), DEA number (“12”), or state license number (“08”) is to be submitted with all claims in the Prescriber ID field. The Prescriber Identifier should be the prescribing individual’s NPI number. If NPI is not available, state license or DEA number will be accepted, as permitted. Provider will not submit the Provider’s own DEA or NPI number in this field unless the Provider is also the Prescriber. The preferred Prescriber identifier is the NPI number. Provider should use the accurate Prescriber NPI. For certain claims, an NPI may be required.

2.5.3 Identifying the Provider

Prescriptions dispensed to Eligible Persons must be from the Provider location documented in Medco’s Agreement with Provider. The NPI number (qualifier code “01”), NCPDP number (qualifier code “07”) and Medco Pharmacy account number (Pharmacy Identification number “99”) under which the claim was submitted to and adjudicated by Medco must identify the location where the pharmacist supervised dispensing of the prescription. Provider should use its correct NPI number on every claim.

2.6 NDC NUMBER AND PACKAGE SIZE

When submitting a claim, the NDC number must appear on the submitted claim as defined in the Medco Payer Sheets that are in effect on the date of service. Provider must submit the complete NDC number of the package size dispensed. Provider should dispense from the largest package size with the lowest AWP per unit.

2.7 REPACKAGER NDCs AND DOSAGE FORM

It is the Provider's obligation to submit claims using the lowest ingredient cost dosage form (i.e., tablet vs. capsule) and lowest cost package/size container available that results in the lowest reimbursement to Provider when compared to a claim that would be submitted with a different dosage form and/or package size/container. Claims submitted using a higher ingredient cost dosage form and/or package size/container that result in a higher reimbursement may be subject to audit recovery. Claims for repackaged, relabeled NDCs submitted to Medco that result in a materially higher reimbursement than claims for non-repackaged, relabeled NDCs will be subject to audit recovery. Some client plans may reimburse repackager NDCs at the same level as the manufacturer NDC.

For example:

Provider dispenses a prescription for *Prozac*[®] 20 mg capsules with substitution allowed and uses the generic tablet dosage form when allowed by law. The reimbursement to the Provider is higher than if the generic capsule dosage form was submitted. This claim will be subject to audit recovery.

Provider dispenses a prescription for *Lipitor*[®] 20-mg and uses a product from a repackager. The repackager NDC submitted has a higher ingredient cost as compared to the non-repackaged NDC, which results in payment due to the Provider for an amount that is higher than if the Provider had dispensed an NDC from a non-repackager. This claim will be subject to audit recovery.

2.8 UNBREAKABLE PACKAGES

Drugs labeled to be dispensed only in the original container or package must be dispensed in the original packaging for all Medco plans covering such drug products, as directed. All other packages, including nitroglycerin patches, are considered "breakable" and as such must be dispensed in the quantity prescribed.

2.9 PRICING SOURCES

Medco uses the most current file available from its receipt of First DataBank's daily NDDF file to update its National Drug Code ("NDC") and Average Wholesale Price ("AWP") files. If First DataBank ceases publishing or replaces AWP, or Medco decides to use another recognized pricing source or pricing benchmark other than AWP, Medco will provide notice of such change(s).

2.10 DAYS' SUPPLY

A Provider must submit an accurate days' supply on the submitted claim based on the actual metric quantity of product dispensed and/or the product manufacturer's stated content (for example the number of inhalations per canister), and the Prescriber's dosage directions. Provider must clarify ambiguous dosage directions prior to dispensing or utilize peer reviewed dispensing practice guidelines. For example, a prescription order for albuterol inhaler with instructions of "as directed" should not be assigned an arbitrary days' supply. The actual days' supply should be determined based on the manufacturers' labeled quantity, e.g., 200 metered doses per unit, divided by the number of doses prescribed.

Accurate days' supply must be correctly identified on submitted claims for all medications including prepackage medications and products that are for extended day supplies.

Some representative examples are:

Weekly Dosing Examples:

- Actonel 35mg (1 tablet = 7 day supply; 4 tablets = 28 day supply)
- Fosamax 35mg (1 tablet = 7 day supply; 4 tablets = 28 day supply)
- Catapres-TTS (1 patch = 7 day supply; 4 tablets = 28 day supply)
- Climara Patch (1 patch = 7 day supply; 4 patches = 28 day supply)

Monthly Dosing Examples:

- Actonel 75mg (2 tablets = 1 month supply)
- Actonel 150mg (1 tablet = 1 month supply)
- Boniva 150mg (1 tablet = 1 month supply)
- Nuvaring Vaginal Ring (1 ring = 28 days supply; 3 weeks on, 1 week off)
- Ortho-Evra Patch (1 patch weekly, 1 week off; 3 patches = 28 days supply)
- Zoladex 3.6mg Implant Syringe (1 syringe = 1 month supply)

Three Month Dosing Examples:

- Boniva Injectable 3mg/3ml Syringe (1 syringe = 90 day supply)
- Depo Provera 150mg/ml syringe contraceptive (1 syringe = 90 day supply)
- Estring Vaginal Ring (1 ring = 90 day supply)
- Femring Vaginal Ring (1 ring = 90 day supply)
- Zoladex 10.8mg Implant Syringe (1 syringe = 90 day supply)

Prepackage Examples:

- Multi-Vit-Flor drops 0.25mg (50ml = 50 day supply)
- Ortho-Novum 7-7-7 tablets 21 day (21 tablets is a 28 day supply)
- Seasonale (91 tablets = 91 day supply)

Provider must verify days' supply with the Eligible Person and/or Prescriber and document on the prescription. Provider must use professional judgment to ensure that the quantity and the days' supply are in accord.

2.11 QUANTITY DISPENSED

The Quantity Dispensed transmitted via the *TelePAID*[®] System for all Medco claims must reflect the exact quantity dispensed, including metric decimal amounts. Pharmacy software must conform to the then-current NCPDP Standard for the “Quantity Dispensed” field.

There are three standard billing units used to describe drug products. These billing units are “EA” (eaches), “ML” (milliliters), and “GM” (grams).

2.11.1 Products that are measured in units and not measured by weight or volume are billed as the number of “eaches” dispensed.

- Some representative “eaches” dosage forms are tablets, capsules, transdermal patches, nonfilled syringes, and reconstitutable injectable vials. These forms should be expressed as the number of units dispensed in the Quantity Dispensed field.

Example: 30 tablets dispensed
Quantity Dispensed field = 30

Example: 30 insulin syringes dispensed
Quantity Dispensed field = 30

2.11.2 Products such as solutions and injectable liquids that are measured by liquid volume are billed as the number of “milliliters” dispensed.

- Examples of representative dosage forms measured by liquid volume can include liquids, suspensions, solutions, IV solutions, irrigations, nasal sprays, oral inhalers, reconstituted noninjectable liquid dosage forms, etc., and should be expressed as the exact number of milliliters dispensed including metric decimal quantity amounts in the Quantity Dispensed field.

Example: Insulin 10 mL
2 vials dispensed (10x2)
Quantity Dispensed field = 20

Example: Ipratropium Bromide 0.02%, 2.5 mL/nebule
Report quantity dispensed in exact milliliters multiplied by the number of nebulas dispensed.
25 nebulas dispensed (2.5x25)
Quantity Dispensed field = 62.5

Exception: *Imitrex*[®] Nasal Spray 20 mg
Representative NDC 00173052300
One container dispensed
Report quantity of containers dispensed in the Quantity Dispensed field.
Quantity Dispensed field = 1

2.11 QUANTITY DISPENSED

(continued)

- Oral antibiotic suspensions, eye drops, and other noninjectable dosage forms that require reconstitution prior to dispensing and are labeled by volume should be expressed in milliliters. These products should be expressed with the exact number of milliliters, including the metric decimal quantity amounts, in the Quantity Dispensed field.

Example: Amoxicillin Suspension 150 mL (150x1)
One 150-mL bottle dispensed
Quantity Dispensed field = 150

2.11.3 Products that are measured by weight are billed as the number of “grams” dispensed and are labeled with grams on the product.

- Examples of representative products that are measured by weight can include ointments, creams, balms, bulk powders, inhalers, etc., and should be expressed as the exact number of grams dispensed including metric decimal quantity amounts in the Quantity Dispensed field.

Example: *Asmanex Twisthaler*[®] NDC 00085134103
Total grams = 0.24 grams (30 inhalations)
Quantity Dispensed field = 0.24

Example: Bethamethasone Valerate Cream 15 gm
One 15-gm tube dispensed
Quantity Dispensed field = 15

Example: Bacitracin Ophthalmic Ointment 3.5 g
One 3.5-gm tube dispensed
Quantity Dispensed field = 3.5

Example: *Androgel*[®] Gel Packet
Representative NDC 00051842530
Dispensed 30 packets containing 2.5 gm each (30 packets x 2.5 gm)
Total grams = 75
Quantity Dispensed field = 75

Exception: *Pulmicort Flexhaler*[®] 180 mcg
Representative NDC 00186091612
One container dispensed
Quantity Dispensed field = 1

2.11.4 Additional Clarification

Partially Filled Containers:

If the product is in a partially filled container, the quantity dispensed is the amount of fill volume containing the actual drug and should be expressed in milliliters.

2.11 QUANTITY DISPENSED

(continued)

Example: Dextrose 5% 250 mL in a 500-mL bottle
Quantity Dispensed field = 250

Packets:

Powder packet products such as *Questran*[®] should be expressed by number of packets dispensed.

Example: *Questran*[®]
Representative NDC 49884093665
60 packets dispensed
Quantity Dispensed field = 60

Disposable Enemas:

If enemas are labeled volumetrically, the quantity dispensed should be expressed in milliliters.

Example: *Rowasa*[®]
Representative NDC 68220002207
7 enemas dispensed
60 mL per enema (60x7)
Quantity Dispensed field = 420
If enema is not labeled volumetrically, then the quantity dispensed would be expressed as the number of units dispensed.

Antihemophilic Factor:

Quantity must be expressed by the number of international units dispensed and not the number of ampules dispensed.

Example: *Konyne*[®] HT 500
2 ampules dispensed
Quantity Dispensed field = 1,000

Combination Packages:

Drug products that are packaged with more than one drug in different dosage forms should be expressed as units of 1.

Example: *Clindareach*[®]
Representative NDC 65880050302
Package contains: pledgets, appliqués, cleansing pads, and applicator.
Quantity Dispensed field = 1

Example: *Duac CS*[®] Convenience Kit
Representative NDC 00145236701
Package contains 2 different products
Quantity Dispensed field = 1

2.11 QUANTITY DISPENSED

(continued)

Convenience Packets, Therapy Packs, and Prepackages:

Convenience packets, therapy packs, and prepackages must be billed as the number of individual tablets or capsules (units) dispensed, not the number of boxes or packages.

Example: *Chantix*[®]

Representative NDC 00069047197

Package size = 53 tablets

Quantity Dispensed field = 53

Exception: *Prevpac*[®] Patient Pack

Representative NDC 64764070201

Package size = 14 doses (each dose = 2 Prevacid 30 mg-caps, 4 amoxicillin 500-mg caps. USP, and 2 clarithromycin 500-mg tabs)

Quantity Dispensed field = 14

2.12 SALES TAX

2.12.1 Provider's Responsibility

As the owner of the drugs dispensed, Provider has sole responsibility for determining taxability, submitting the appropriate tax on the claim, collecting the applicable tax, and remitting such tax to the applicable taxing authority. Provider must specifically identify the amount of any allowable taxes on each claim submitted as a condition of payment by Medco. For those states that require sales tax on prescription drugs and other items, such as diabetes supplies, Provider should identify the percentage sales tax rate and tax basis amount used to determine the sales tax amount. If Provider believes that Medco has paid Provider the incorrect amount of tax on a claim, Provider is responsible for contacting Medco to report such incorrect payment within 30 days. Any applicable sales, use or other similarly assessed and administered tax imposed on items dispensed, or services provided hereunder will be the sole responsibility of Medco's Plan Sponsors or their members. If Medco is legally obligated to collect and remit sales, use or other similarly assessed and administered tax in a particular jurisdiction, such tax will be reflected on the applicable invoice or subsequently invoiced at such time as Medco becomes aware of such obligation.

2.12.2 Medco's Responsibility

Medco supports all state sales tax fields in accordance with the most current NCPDP electronic claims standard.

2.13 PROVIDER FEES, CARE TAXES, AND OTHER STATE FEES

In states where provider fees are charged and are reimbursable by third party payors, submit such fees in the flat tax field. For Providers in states that charge a flat tax and a provider fee, please contact the Pharmacy Help Desk for support.

2.14 PARTIAL FILLS

Medco supports all partial fill fields in accordance with the standards of NCPDP (currently version 5.1). When partially filling, a Provider should be aware of the following:

- Dispensing fees are transmitted and paid on the initial fill only.
- Collect only the amount transmitted through the *TelePAID*[®] System from the cardholder, because co-payment/coinsurance amounts differ from plan to plan.
- Sales tax, if any, is payable on all claims based on amount allowed.
- Provider has 30 days to complete a partial fill claim; after 30 days, the claim will reject.
- The associated prescription/service reference ID and dates of service are required for subsequent fills; the fill number should be identical on each fill if the prescription/service reference number is the same.
- When reversing a partial fill claim, include the dispensing status.
- Rejections will occur if the intended quantity, days' supply, patient, or product dispensed differs from the initial fill.
- All authorized refills of any prescription must bear the original prescription number.

2.15 COORDINATION OF BENEFITS (COB)

Medco supports electronic coordination of benefits (COB) and secondary claims in accordance with the standards of NCPDP (currently version 5.1). The COB segment is required when submitting secondary claims. Other coverage codes 1 through 8 are supported and will drive the claim if secondary adjudication applies. Claims denied by the primary carrier should be submitted with the NCPDP current standard (currently version 5.1) reject code identified on the COB segment. Include other coverage code when reversing a claim, because Medco can offer both primary and secondary coverage even when the same cardholder ID has both benefits. If Provider receives a reject message indicating the group does not accept secondary coverage, notify the cardholder.

Provider must submit the correct values and format the claims properly based on the NCPDP guidelines. Provider must also follow the NCPDP coverage codes.

A Provider is required to coordinate benefits for Eligible Persons and submit both primary and secondary claims as directed by the cardholder and in compliance with applicable laws and regulations.

2.16 PAYER-TO-PAYER RECONCILIATION

In instances where an adjustment to the amount paid occurs or is required, as a result of the application of applicable law and regulations, Medco will first reconcile, to the extent required, with other payer(s) if any, and then may make any necessary adjustment to the pharmacy payment.

2.17 COMPOUNDS

2.17.1 Compounds in General

A Compounded Prescription is one that meets the following criteria:

The compound consists of two or more solid, semisolid, or liquid ingredients, one of which is a Federal Legend Drug that is weighed, measured, prepared, or mixed according to the prescription order.

Reconstitution of an oral antibiotic or any other similar product is not considered a Compounded Prescription. The addition of flavorings to a commercial product is also not considered a Compounded Prescription.

The Provider is responsible for compounding preparations with approved ingredients of acceptable strength, quality, and purity, with appropriate packaging and labeling in accordance with good compounding practices, official standards, and relevant scientific information.

The Provider is responsible for documenting all Compounded Prescriptions, including but not limited to the drug's name, NDC of the package size used, manufacturer name where an NDC is not available, and metric quantity of each component used to prepare the Compounded Prescription.

Compounded Prescriptions, when covered according to the Eligible Person's plan benefit design, are Covered Services and must be submitted electronically through the *TelePAID*[®] System. Some Plan Sponsors may elect a benefit design that requires a prior authorization to be obtained for Compounded Prescription coverage.

2.17.2 Procedures for Submitting Compounded Prescription Claims Under Version 5.1

Compounded Prescriptions are required to be submitted via the *TelePAID*[®] System in accordance with the following:

1. Submit the "Compound Flag" as positive in accordance with the Pharmacy software and NCPDP Standards as defined by Medco's current Payer Sheets
2. Submit the NDC number for the highest-priced Federal Legend Drug contained in the compound (based on the extended AWP of the component).
3. Submit the quantity dispensed as the total metric quantity of the finished product.
4. Submit the Provider submitted ingredient cost for the Compounded Prescription and the Provider's U&C price.
5. Submit Eligible Person and group information as you would for any other Medco claim.
6. Collect from the Eligible Person only the applicable co-payment/coinsurance as indicated through the *TelePAID*[®] System.

2.17.3 Excluded From Reimbursement Under Version 5.1

Charges for ancillary supplies, flavoring, equipment, equipment depreciation, and/or labor are not eligible for reimbursement.

2.17 COMPOUNDS

(continued)

2.17.4 Procedures for Submitting Compounded Prescription Claims Under Version D.0

Compounded Prescriptions are required to be submitted via the *TelePAID*[®] System in accordance with the following:

1. Submit the NDC number (Product/Service ID) on the claim segment as “0” (zero) and the Product/Service ID qualifier as “00” (two zeroes) and use the compound segment to identify each individual ingredient.
2. Submit a “Compound Code” of “2” in field 406-D6 in accordance with the Pharmacy software and the NCPDP standards as defined by Medco’s current Payer Sheets for Version D.0.
3. Each individual ingredient should be represented by the NDC of the product used. The quantity of each specific ingredient, the cost of each individual ingredient, and the basis of cost determination must be submitted. The Provider may enter up to twenty-five ingredients for each Compounded Prescription claim.
4. Submit the quantity dispensed as the total metric quantity of the finished product.
5. Submit the sum of all individual ingredient costs as the Provider’s “Ingredient Cost Submitted” for the Compounded Prescription, and also submit the Provider’s U&C for the Compounded Prescription.
6. Submit the Eligible Person’s eligibility information and prescriber information as you would for any other Medco claim.
7. Collect from the Eligible Person only the applicable co-payment/coinsurance as indicated through the *TelePAID*[®] System.

2.17.5 Excluded From Reimbursement Under Version D.0

Charges for ancillary supplies, flavoring, equipment, equipment depreciation, and/or labor are not eligible for reimbursement. In addition, ingredients without NDC numbers and obsolete drugs are not eligible for reimbursement. Investigational drugs are allowed only when covered by the Plan Sponsor.

2.18 DAW CODES

When a multisource brand drug product is dispensed, process the claim with the appropriate Dispense as Written (“DAW”) Code according to the DAW Code Standards Section of this Manual.

The following NCPDP Standard DAW Codes are supported by Medco. These Codes should be part of the claim record whenever a multisource brand drug product is dispensed. Proper use of the correct DAW Code is important for payment and co-payment/coinsurance processing. Follow the *TelePAID*® System for reimbursement and co-payment/coinsurance information.

Substitution with a generic product must always be in a manner consistent with applicable laws, rules, and regulations, as well as with Sponsor’s plan benefit design.

DAW-0 No Product Selection Indicated

This is a default field value that is appropriately used for prescriptions where selection is not an issue. Examples include prescriptions written for single-source brand products and prescriptions written using the generic name and a generic product is dispensed. Plans may mandate that generic pricing be applied when **DAW-0** is submitted for multisource brand medications.

DAW-1 Substitution Not Allowed by Prescriber

This value is used when the Prescriber indicates, in a manner specified by applicable laws, rules, and regulations, that the product is to be dispensed as written. This is subject to verification by Medco at any time.

DAW-2 Substitution Allowed — Patient Requested Product Dispensed

This value is used when the Prescriber has indicated, in a manner specified by applicable laws, rules, and regulations that generic substitution is permitted and the patient requests the brand product. This situation can occur when the Prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. Patient-requested brand must be documented on the prescription and may affect patient co-payment/coinsurance.

DAW-3 Substitution Allowed — Pharmacist Selected Product Dispensed

This value is used when the Prescriber has indicated, in a manner specified by applicable laws, rules, and regulations, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the Prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. Plans mandate that generic pricing be applied when **DAW-3** is submitted for multisource brand medications.

DAW-4 Substitution Allowed — Generic Not in Stock

This value is used when the Prescriber has indicated, in a manner specified by applicable laws, rules, and regulations that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked by Provider. This situation exists due to the buying habits of the pharmacist, not because of the availability of the generic product in the marketplace. Plans mandate that generic pricing be applied when **DAW-4** is submitted for multisource brand medications.

DAW-5 Substitution Allowed — Brand Drug Dispensed as Generic

This value is used when the Prescriber has indicated, in a manner specified by applicable laws, rules, and regulations, that generic substitution is permitted and the pharmacist is utilizing the

2.18 DAW CODES

(continued)

brand product as the generic entity. Plans may mandate that generic pricing be applied when **DAW-5** is submitted.

DAW-6 Override

NCPDP – Override Code with no meaningful application by Medco. Plans mandate that generic pricing be applied when **DAW-6** is submitted.

DAW-7 Substitution Not Allowed — Brand Drug Mandated by Law

This value is used when the Prescriber has indicated, in a manner specified by applicable laws, rules, and regulations, that generic substitution is permitted, but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.

DAW-8 Substitution Allowed — Generic Drug Not Available in Marketplace

This value is used when the Prescriber has indicated, in a manner specified by applicable laws, rules, and regulations, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable. Plans mandate that brand pricing be applied when **DAW-8** is submitted for multisource brand medications.

DAW-9 Other

Reserved with no meaningful application by Medco. Plans mandate that generic pricing be applied when **DAW-9** is submitted.

Version D.0

DAW-9 – Substitution Allowed by Prescriber But Plan Requests Brand

This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the plan's formulary requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. When the Plan Sponsor supports programs that prefer brand products over generic products, submitting DAW 9 will price the claim as brand. When the Plan Sponsor does not support this benefit, and DAW 9 is submitted by the pharmacy, the claim will reject for non-supported value. The pharmacy should dispense the generic product and resubmit the claim or resubmit the claim with a different DAW code.

2.19 VACCINES

At the request of some Plan Sponsors, certain vaccine drug products and/or the administration of the vaccine drug products will be a Covered Service according to the members' specific plan benefit design. For those Plan Sponsors that cover vaccine drug product administration, Provider attests that registered pharmacists, or other healthcare professional staff, under its employ are certified, trained, and qualified to administer the covered vaccine drug products.

Provider shall submit the vaccine drug product with the administration fee claim electronically through the *TelePAID*[®] System in accordance with the current Medco Payer Sheets available at www.medco.com/rph.

When Provider dispenses and administers the vaccine drug product, Provider will transmit both the drug product and administration on the same claim submission. Provider will submit as the pharmacy's U&C, the total cost of the vaccine drug product and the administration fee. The Provider must not, under any circumstances, undermine the U&C price by inflating the U&C above the price Provider charges for the same vaccine product and administration a cash patient or customer would have paid on the same day the prescription was dispensed, inclusive of all applicable discounts.

Plan Sponsors may elect to cover just the vaccine drug product under the Eligible Person's prescription drug benefit. In that situation, the member is responsible for the administration charges. Provider may not add or represent the administration fee to the member as the co-payment. The drug product co-payment must be represented as a separate charge.

2.20 PRIOR AUTHORIZATION

2.20.1 What Is Prior Authorization?

At the request of some Plan Sponsors, certain medications or classes of medications will require additional information to be obtained to determine whether the use or the quantity above stated plan limits is covered. Prior Authorization is a feature or a program that provides prescription benefit coverage if certain circumstances are met.

2.20.2 Claim Message on Prior Authorization

The following components on the claim message indicate that a Prior Authorization is needed: A reject code of “70” with message “drug not covered” or reject code “75” with message “prior authorization required.”

After the above claim information has been received, communicate to the Eligible Person the information outlined above in “What Is Prior Authorization?”

2.20.3 Initiating Prior Authorization

A telephone number may be displayed within the help desk phone number field. The telephone number displayed will lead to Medco’s Prior Authorization unit or a Prior Authorization unit arranged by the Sponsor.

Contact the Prescriber and review the reason for the Prior Authorization. If required, the Prescriber can initiate a coverage review by contacting the toll-free number displayed on your screen.

The Provider and Eligible Person may also initiate the coverage review process by calling the toll-free number. When requested, the Prior Authorization department will fax the Prescriber a questionnaire.

If no telephone number is displayed on the claim response for a Prior Authorization, Provider should refer the Eligible Person to the toll-free number Member Services for further assistance. The Eligible Person’s Member Services number can be found on the prescription benefit card.

There may be additional actions for Provider to take. Provider is required to look in additional messages for further information.

2.20.4 Communication of Benefit Decision

Generally, the Eligible Person and Prescriber receive written confirmation of adverse benefit decisions and verbal confirmation of favorable benefit decisions.

2.21 TEMPORARY COVERAGE POLICY

In certain situations, temporary coverage is allowed for certain drugs that require prior authorization. Pharmacists receiving a Primary Reject Error Code of “Drug Not Covered” or “Prior Authorization” (NCPDP Reject Error Codes 70, 75 or 76) may be able to obtain Temporary Coverage for Eligible Persons for a limited supply of certain medications while awaiting the benefit decision. If the drug qualifies for Temporary Coverage, a Secondary Reject Error Code message will be attached to the Primary Reject Error Code (see above). The Secondary Reject Error Code of “Temp Fill of XX D/S Allowable with PA/MC Override of XXXXX.” For Medicare Groups, the message will read “Trans Supply Up to XXDS with PA/MC=11111.” (Translated: Temporary Fill of ‘XX’ Days’ Supply [Override Days’ Supply Value] Allowable with Prior Authorization/Managed Care Override of ‘XXXXX.’)*

Important Note: *If a possible DUR safety issue exists, contact the Prescriber to discuss the alert prior to processing the prescription using the Temporary Coverage Override.*

If there is no safety issue:

- *Resubmit the prescription claim for the days’ supply (D/S) provided in the reject message (unless the script was written for less).*
- *Adjust the quantity to correctly represent the reduced days’ supply. This is a critical step in processing the claim correctly and fulfilling the intent of the temporary or transition supply.*
- *If the prescription claim is for an unbreakable prepackaged item with directions for use that is greater than the allowable days’ supply, then use the smallest available package size with the days’ supply provided in the reject message.*
- *Enter the value of “01” in the NCPDP prior authorization type code field and “XXXXX” in the PA/MC field.*

Collect from the Eligible Person the indicated co-payment/coinsurance amount, if any. Provider will be reimbursed for the temporary supply of medication provided to your patient.

* “XX” will have a numeric value.

2.22 CLAIMS ADJUSTMENTS

A Provider may request an adjustment to any claim for which Provider's records indicate that a Provider received an incorrect payment. A Provider must request such adjustment for up to one year from the date of service unless applicable law allows otherwise.

2.22.1 How to Request

Adjustments can be made by phoning the Medco Pharmacy Services Help Desk, writing to Medco, or through our website. When requesting an adjustment in writing, a Provider must submit the Statement of Claims showing the original dollar amount paid and a copy of the remittance advice or if the reconciliation is via the standard electronic 835, the supportive claims detail information and authorization number. When appropriate, a Provider should include a short note and any wholesaler, manufacturer, or distributor invoices supporting the incorrect payment. Medco reserves the right to charge \$75.00 per hour for claim research fees that are associated with no change in reimbursement. Medco reserves the right to charge \$1.00 per claim for claims that are not submitted in a timely manner and require manual assistance from Medco to process.

Claim Adjustments should be mailed to:

Medco
Pharmacy Support
MS B3-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

Provider may also contact Medco through the Web at: www.medco.com/rph or by calling the Medco Pharmacy Services Help Desk at 1 800 922-1557.

2.22.2 Medco Initiated Adjustments

Medco may make an adjustment to any claim where it is indicated that Provider received an incorrect amount for Covered Services provided.

2.23 RETURN TO STOCK

All products that are not claimed by a member within 14 days of the date the claim was originally billed must be returned to stock. The claim must be reversed once the product is returned to stock. Failure to reverse such claims will result in an audit recovery and recapture of all costs involved in the reversal, including research costs.

2.24 REVERSAL OF CLAIMS

In order to reverse a claim through the *TelePAID*[®] System, a Provider is required to submit claim reversals up to 90 days after the date of service. Providers are strongly encouraged to submit the reversal as soon as possible.

If a Provider is unable to completely process a reversal online, the Provider should call the Medco Pharmacy Services Help Desk at 1 800 922-1557 for assistance. If the Provider attempts to reverse a claim after the 90-day reversal window has closed, this rejected reversal transaction will be identified and Medco will recover the amount paid to the Provider during a subsequent claims cycle. If the Provider has reason to believe it initiated the reversal in error, the Provider can forward to Medco's Pharmacy Services Help Desk a copy of the associated signature log confirming the patient received the medication billed. Medco will review this information and process an adjustment to the Provider, when appropriate. Prescription claims cannot be reversed and then reentered as a means of claims adjustment after the claims cycle has closed. Call the Pharmacy Services Help Desk for all claims adjustments. *Medco Direct*-style programs must be reversed within 3 days of the date of service.

On or after January 1, 2011, a Provider may use either Version 5.1 or Version D.0 to submit a claim reversal for a claim that was submitted in Version 5.1.

2.25 HIGH-DOLLAR CLAIMS

Claims that are over \$99,999.99 require special handling. After a claim over this amount has been entered, an adjustment will be done for the remaining dollars in the next claims cycle.

Please submit all the patient, pharmacy, and drug information as you would any other Medco claim. These claims will receive special attention and will be processed within 28 days. All high-dollar claims should be forwarded to:

Medco
Pharmacy Services/Claims Adjustment MS B3-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417
e-mail address: MedcoHDPCP@medco.com

2.26 CLAIMS THAT REQUIRE AN OVERRIDE THROUGH THE PHARMACY SERVICES HELP DESK

1. Days' Supply ("DS") submitted incorrectly on the original claim will require a Pharmacy Services override. For example, where "90 DS" was submitted incorrectly instead of the correct "30 DS," an error code of "refill-too-soon" on the subsequent refill would make it impossible to submit the claim online. A Pharmacy Services Representative, however, could override the claim. For the Pharmacy records, the software system protocol should be followed. Usually the refill would be recorded as a "cash transaction" for the sake of record keeping in the Pharmacy system.
2. In the case of covered twin dependents, when no "patient number" is found on the card, if the second twin was receiving the same medication as the first twin, a Pharmacy Services override would be required for the claim to adjudicate.
3. In the case of the same prescription filled for the second of two covered "significant others" or "two covered adults," the claim would reject as a "duplicate claim" without a Pharmacy Services override.
4. Pain medication dispensed for less than 5 days and consumed in 3 days or less will reject due to "refill-too-soon" and the "3-days'-supply limit" and will require a Pharmacy Services override.
5. A claim with both "refill-too-soon" and "maximum daily dosage" edits will require a Pharmacy Services override.

Version D.0

Up to three override codes may be submitted on a single claim. Providers will not need to obtain a Pharmacy Services override for claims with both "refill-too-soon" and "maximum daily dosage" edits.

2.27 LONG-TERM CARE BILLING REQUIREMENTS

Providers providing long-term care Covered Services to Eligible Persons must submit all claims via the *TelePAID*[®] System. The total days' supply of each individual drug, as defined by ingredient combination, strength, dosage form, and route of administration, must be billed to Medco as a one-month supply. It is Provider's responsibility to ensure that Medco is credited for any unused medications in accordance with the claims adjustment process and all applicable pharmacy laws and regulations.

Version D.0

There are three new fields that must be used by the Provider to identify the Provider that is billing the claim. The fields are (1) pharmacy services type, (2) patient residence, and (3) place of service.

2.28 HOME INFUSION BILLING REQUIREMENTS

Providers providing home infusion Covered Services to Eligible Persons must submit all claims via the *TelePAID*[®] System. Each individual drug, as defined by ingredient combination, strength, dosage form, and route of administration, must be billed to Medco no more than four (4) times during any month. It is the Provider's responsibility to ensure that Medco is credited for any unused medications in accordance with the claims adjustment process and all applicable pharmacy laws and regulations.

Version D.0

There are three new fields that must be used by the Provider to identify the Provider that is billing the claim. The fields are (1) pharmacy services type, (2) patient residence, and (3) place of service.

2.29 THIRD-PARTY SIGNATURE CLAIM LOGS

Providers must maintain a signature in the Third-Party Signature Claim Log ("Signature Log"), either electronically or on paper, for each claim submitted via the *TelePAID*[®] System, including but not limited to delivered prescriptions and Medco Direct[®] and unfunded programs.

Signature Logs must confirm on an ongoing basis to the requirements set forth in this section. Provider will obtain the signature of the Eligible Person or his/her authorized agent in the Signature Log confirming receipt of the prescription and the required certification statement for all claims submitted through the *TelePAID*[®] System. The Signature Log will be subject to audit by Medco, and Provider will not be entitled to payment for any claims not supported by a logbook signature.

Provider is required to maintain the Third-Party Signature Claim Log in a retrievable manner by date of service at the Provider for a period of 6 years from the date the prescription was dispensed, and for a period of not less than 11 years (10 years plus the contract year) for any Covered Service under Medicare. Providers that are approved to dispense prescriptions by mail or other remote carrier must maintain either a signature log or a record of shipment, including tracking numbers, where applicable, at the prescription level. When requested, Provider agrees to provide copies of signature log records to Medco.

2.29 THIRD-PARTY SIGNATURE CLAIM LOGS

(continued)

2.29.1 Requirements of a Paper Signature Log

A paper Signature Log must conform to the example set forth below.

COUNSEL (R/A)	DATE DISPENSED	RX NO.	PATIENT I.D.	THIRD PARTY PROGRAM	COUNSEL (R/A)	DATE DISPENSED	RX NO.	PATIENT I.D.	THIRD PARTY PROGRAM
Signature of Patient or Legal Representative					Signature of Patient or Legal Representative				
COUNSEL (R/A)	DATE DISPENSED	RX NO.	PATIENT I.D.	THIRD PARTY PROGRAM	COUNSEL (R/A)	DATE DISPENSED	RX NO.	PATIENT I.D.	THIRD PARTY PROGRAM
Signature of Patient or Legal Representative					Signature of Patient or Legal Representative				
COUNSEL (R/A)	DATE DISPENSED	RX NO.	PATIENT I.D.	THIRD PARTY PROGRAM	COUNSEL (R/A)	DATE DISPENSED	RX NO.	PATIENT I.D.	THIRD PARTY PROGRAM
Signature of Patient or Legal Representative					Signature of Patient or Legal Representative				

2.29.2 Requirements of an Electronic Third-Party Signature Claim Log

An Electronic Signature Log, in the format outlined in this section, is acceptable to Medco as a replacement to the traditional paper signature log.

1. Minimum Data Elements

The Electronic Signature Log must contain the following data elements for each record:

- ▶ Prescription number (7-position numeric field — left justified with zeros)
- ▶ Date of service (date field — mm/dd/yyyy)
- ▶ Co-payment charged (9-position numeric field — two positions to the right of the decimal)
- ▶ Identification of the third-party program providing prescription coverage to this patient
- ▶ Patient's first and last name (30 positions)
- ▶ Date and time the prescription was dispensed to the patient (date field mm/dd/yyyy — Time hh:mm — 24-hour time)

2.29 THIRD-PARTY SIGNATURE CLAIM LOGS

(continued)

- ▶ The certification statement text in its entirety (text)
- ▶ Dispensing Provider's NCPDP number (7-position numeric field) or dispensing Provider's NPI number (10-position numeric field)
- ▶ The unique signature of the Eligible Person or authorized agent captured at the time of dispensing that particular prescription (image format — .bmp, .gif, .tif, .jpg)
- ▶ Counseling (1 position "R" – Refused, "A" – Accepted)

Version D.0

Prescription number (12-position numeric field — left justified with zeros).

2. Format

An electronic Signature Log must conform to the example set forth below.

1) Prescription Number: 1234567	Date of Service: mm/dd/yyyy	Co-payment: \$,,\$,\$,\$
Counseling – "A"	Third-Party Program: Medco	Patient First & Last Name: XXXXX
2) Prescription Number:1234568	Date of Service: mm/dd/yyyy	Co-payment: \$,,\$,\$,\$
Counseling – "A"	Third-Party Program: Medco	Patient First & Last Name: XXXXX
3) Prescription Number:1234563	Date of Service: mm/dd/yyyy	Co-payment: \$,,\$,\$,\$
Counseling – "A"	Third-Party Program: Medco	Patient First & Last Name: XXXXX
4) Prescription Number:1234564	Date of Service: mm/dd/yyyy	Co-payment: \$,,\$,\$,\$
Counseling – "A"	Third-Party Program: Medco	Patient First & Last Name: XXXXX

Signature of Patient, Guardian, or Legal Representative, acknowledging you have read and agree to the above statements.

Signature _____

3. Retrievability

Provider agrees to maintain, in a retrievable manner, the Electronic Third-Party Signature Claim Log for a period of not less than 6 years from the date the prescription was dispensed, and for a period of not less than 11 years (10 plus the contract year) from the date any Covered Service under Medicare was dispensed. Subject to a request from Medco, either in writing, during an on-site claims review, by telephone, or as otherwise required by Medco, Provider agrees to retrieve, display, print, electronically transmit, and/or provide copies of Electronic Third-Party Signature Claim Logs to Medco. The information displayed, transmitted, or printed must be in a format that includes at least the Data Elements as outlined earlier in this section, including the unique signature of the Eligible Person or Authorized Representative, in an image format, obtained by Provider at the time of dispensing.

Provider is not entitled to payment for any prescription claim for which the Provider is unable to produce an Electronic Third-Party Signature Claim Log or for any claim in which the Electronic Third-Party Signature Log is not maintained in the required format as outlined above. Provider certifies that

2.29 THIRD-PARTY SIGNATURE CLAIM LOGS

(continued)

the prescriptions referred to in the Electronic Third-Party Signature Claim Logs were validly and lawfully dispensed to the person whose signature appears in the electronic record and that the prescriptions comply with the conditions and applicable instructions of the third-party program identified. Provider also certifies that the information covering each transaction is, to the best of Provider's knowledge, correct and that all documentation is available for audit.

The Electronic Third-Party Signature Claim Log as detailed in this section provides an alternative to participating Providers that keeps pace with advancing technology. Provider has the opportunity to replace its current Paper Third-Party Signature Claim Log with a computer-based Electronic Third- Party Signature Claim Log that meets the requirements of Medco's Sponsors as outlined above.

2.29.3 Certification Statement for Paper and Electronic Signature Logs

For each prescription transaction, the following text must be displayed, and be visible to the Eligible Person or authorized representative, directly above the area where the Eligible Person or authorized representative signs his or her name when the applicable prescription is dispensed by Provider.

Text to be displayed:

Provider:

Please have the patient, guardian, or legal representative who has received this prescription listed below read this statement and sign for the appropriate prescription.

Patient:

Your signature certifies that the information contained hereon is correct and that the person for whom the prescription was written is eligible for the benefits. You also certify that you have received the medication identified below and authorize release of all the information contained on this log and the prescription to which it corresponds to the plan administrator, the underwriter, the Sponsor, the policyholder, the insurer, the employer, and their authorized agents. You further certify that this medication is not for treatment of an on-the-job injury, and you hereby assign to this participating Provider any payment due pursuant to this transaction and authorize payment directly to this participating Provider.

State and Federal:

Your signature certifies that you received a service or item dispensed on the date listed below. You understand that payment for this service or item will be from Federal and State funds and that any false claims, statements, documents, or concealment of material facts may be prosecuted under applicable Federal and State Laws.

Worker's compensation only:

Your signature certifies that this medication is for the treatment of an on-the-job injury.

All other third-party programs:

As required by State Laws, you acknowledge receipt of an offer to counsel and have accepted or refused counseling as indicated.

2.30 E-PRESCRIBING

Prescription Origin Code is a mandatory field on submitted claims and must be populated with valid values in order for a claim to process.

Valid values for new/original prescription claims are:

- 1 – Written
- 2 – Telephone
- 3 – Electronic
- 4 – Facsimile

Valid values for refill/transfer prescription claims are:

- 0 – Not known (only valid when the transfer claim is a refill)
- 1 – Written
- 2 – Telephone
- 3 – Electronic
- 4 – Facsimile

The value 0 is an acceptable value for a refill prescription claim if the Provider cannot determine how the prescriber initially submitted the prescription.

CHAPTER 3

PROVIDER
REIMBURSEMENT

3.1 REIMBURSEMENT FORMULA

A Provider will receive payment from Medco for the goods and services provided as identified in the Provider Agreement, this Pharmacy Services Manual, and the applicable Network Schedules. The net reimbursement does not include the applicable co-pays and deductibles.

The Provider will be reimbursed for clean payable claims transmitted electronically through the *TelePAID*[®] System according to a specified bi-weekly claim cycle, except as may be required by federal or state requirements. Medco's accepted standard for claims reconciliation is the ASCX12N 835 HIPAA-compliant electronic claims reconciliation format. Paper detail and summary claims statements are considered nonstandard and, as such, they will be phased out and will not be updated.

Medco will reimburse for claims submitted for each claim cycle within 30 days from the time Medco receives the reimbursable claims. Medco will pay in accordance with applicable state and federal prompt pay requirements in accordance with the member's plan.

Providers may be paid an amount other than what was submitted as the ingredient cost, dispensing fee, or Usual and Customary Price. Provider reimbursement will be as follows:

For Covered Services, Medco will pay the lowest of:

- Average Wholesale Price (AWP) minus the applicable contracted discount plus the applicable contracted dispensing fee; OR
- The Provider's Usual and Customary Price (U&C); OR
- Maximum Allowable Cost (MAC) plus the applicable contracted dispensing fee; OR
- The Provider Submitted Ingredient Cost plus the applicable contracted dispensing fee.

There may be specific reimbursement logic that Sponsors put into place that alters the reimbursement formula set out above.

Zero Balance Logic (ZBL) may apply where allowed by Plan Sponsor.

Worker's compensation claims will be reimbursed at the lesser of:

- The above formulae; OR
- The applicable state fee schedule.

When required by a state regulation or law, Medco will reimburse worker's compensation claims at the applicable state fee schedule.

For Compounded Prescription claims submitted under Version 5.1, Medco will pay the lowest of:

- AWP of the highest-priced Federal Legend Drug in the compound minus the applicable contracted discount plus the applicable contracted dispensing fee; OR
- The Provider's Usual and Customary Price (U&C); OR
- The Provider Submitted Ingredient Cost representative of the ingredients in the compound plus the applicable contracted dispensing fee.

For Compounded Prescriptions submitted under Version 5.1, the Provider's Submitted Ingredient cost is the total AWP (metric quantity dispensed multiplied by unit AWP of each component) of the compound.

3.1 REIMBURSEMENT FORMULA

(continued)

For Compounded Prescription claims submitted under Version D.0, Provider will be reimbursed the lowest of:

- The aggregated lowest price of each ingredient in the compound, plus the contracted dispensing fee;
- The Provider's total Submitted Ingredient Cost for the compound, plus the contracted dispensing fee; OR
- The Provider's Usual and Customer Price.

To determine the lowest price for each ingredient in the compound, each NDC submitted will price using the lowest of:

- AWP minus the applicable contracted discount;
- MAC; OR
- The Provider Submitted Ingredient Cost.

3.2 ELIGIBLE PERSON COST SHARE

Provider will collect from each Eligible Person the applicable co-payment/coinsurance or other direct payment as communicated via the *TelePAID*® System or other method established by Medco.

Provider will not charge or collect from any Eligible Person any amount for Covered Services in excess of the applicable co-payment/coinsurance or other direct payment communicated by Medco. Provider acknowledges that the co-payment/coinsurance or other direct payment is an integral part of the plan design selected by the Sponsor, and Provider will not waive or discount the applicable co-payment/coinsurance or other direct payment under any circumstances.

3.3 ELEMENTS OF REIMBURSEMENT

3.3.1 Usual and Customary Price (U&C)

The lowest net cash price a cash patient or customer would have paid the day the prescription was dispensed, inclusive of all applicable discounts. U&C does not include sales tax. Please see Section 2.19 for specific rules regarding vaccines.

The Provider must not, under any circumstances, undermine U&C or compound pricing as a component of the compensation contemplated in this Agreement in any way, including but not limited to, (1) owning, operating, or affiliating with a nonparticipating Provider; or, (2) separating cash and third-party prescription business. Provider will not be allowed to participate in the Medco network if Medco determines, in its sole discretion, that Provider has taken actions to undermine U&C or compound pricing.

3.3 ELEMENTS OF REIMBURSEMENT

(continued)

3.3.2 Maximum Allowable Cost (MAC)

Medco's MAC program consists of a list or lists of drugs maintained by Medco or its Sponsors. The list(s) specify the maximum allowable ingredient cost payable for drugs on the list. Medco and/or Sponsor may review and update MAC pricing frequently and as deemed necessary to reflect changes in market pricing.

For MAC inquiries and eligibility issues, contact the Pharmacist Resource Center (www.medco.com/rph).

3.3.3 AWP

"AWP" as used herein means the current Average Wholesale Price as listed in print or electronically by First DataBank or other nationally recognized pricing source determined by Medco based on the package size dispensed.

Medco uses the most current file available from its receipt of First DataBank's daily NDDF file to update its NDC and AWP files. If First DataBank ceases publishing or replaces AWP, or Medco decides to use another recognized pricing source or pricing benchmark other than AWP, Medco will provide notice of such change(s).

3.4 FEES

3.4.1 General Fees

From time to time, Medco may require Provider to demonstrate compliance with various regulatory or Manual requirements. If Provider fails to comply with these requests, Medco reserves the right to charge up to a \$500 per day fee for each Provider location. Such fee will be deducted from claims payments to Provider.

In lieu of a daily fee, Medco reserves the right, after notice to the Provider, to increase the *TelePAID*[®] System fee to a minimum \$0.30 per transaction transmitted for failure to provide the requested documentation or remediation plan.

3.4 FEES

(continued)

3.4.2 *TelePAID*[®] System Fees

Medco may deduct from claim payments to Provider, for Provider's use of the *TelePAID*[®] System, a minimum of \$0.12 per transaction transmitted in NCPDP Standard. This amount will constitute a fee to Medco for the *TelePAID*[®] System service. This fee may be modified by Medco from time to time, upon prior notice to the Provider. For nonstandard processing of Universal Claim Forms ("UCF"), Medco reserves the right to charge up to a \$5.00 administration fee per payable claim.

Where Provider fails to comply with Medco requests, as specified throughout this Manual, Medco reserves the right to increase the *TelePAID*[®] System fee to a minimum of \$0.30 per transaction transmitted.

3.4.3 Remittance Advice Fees

Requests from Provider to receive more than one type of remittance advice per cycle or re-creation of remittance information will result in the service fees listed below:

Payment Service Type	Service Fee
Receipt of paper claims statement and electronic remittance file	\$75.00/cycle
Recreate paper claims statement	\$100.00/cycle
Recreate 835 electronic remittance output	\$100.00/media
Payment research/stop payment	\$75.00/payment

Medco reimburses participating Providers according to the claims cycle schedule included within this Manual.

3.4.4 Other Fees

Medco reserves the right to charge \$1.00 per claim for claims that are not submitted in a timely manner and require manual assistance from Medco to process.

Medco may make an adjustment to any claim where it is indicated that Provider received an incorrect amount for Provider services provided. Claim Adjustments should be mailed to:

Medco
Pharmacy Services/Claims Adjustment
MS B3-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

3.5 MEDCO CLAIMS CYCLE AND PAYMENT

The Provider will be reimbursed for Clean Claims transmitted electronically through the *TelePAID*[®] System according to the specified bi-weekly claim cycle. Medco will reimburse for claims submitted for each claim cycle within 30 days from the time Medco receives the reimbursable claims. Medco will pay in accordance with applicable state and federal prompt pay requirements in accordance with the member's plan.

Medco will provide Provider with a payment record of all claims paid. Medco's accepted standard for claims payment record is the ASC X12N 835 HIPAA-compliant electronic claims reconciliation format. Medco will not be updating paper claim statements, as that is the nonstandard format, and will be phasing out the paper detail and summary claims statements where allowed. For a data dictionary for the 835 and paper statements, please see www.medco.com/rph.

3.5 MEDCO CLAIMS CYCLE AND PAYMENT

(continued)

Medco Standard Claims Cycle Schedule 2011

Cycle	Claims Cycle	POS Cut-Off Date
1	12/25/10 - 1/7/11	Friday 01/07/11
2	1/8/11 - 1/21/11	Friday 01/21/11
3	1/22/11 - 2/4/11	Friday 02/04/11
4	2/5/11 - 2/18/11	Friday 02/18/11
5	2/19/11 - 3/4/11	Friday 03/04/11
6	3/5/11 - 3/18/11	Friday 03/18/11
7	3/19/11 - 4/1/11	Friday 04/01/11
8	4/2/11 - 4/15/11	Friday 04/15/11
9	4/16/11 - 4/29/11	Friday 04/29/11
10	4/30/11 - 5/13/11	Friday 05/13/11
11	5/14/11 - 5/27/11	Friday 05/27/11
12	5/28/11 - 6/10/11	Friday 06/10/11
13	6/11/11 - 6/24/11	Friday 06/24/11
14	6/25/11 - 7/8/11	Friday 07/08/11
15	7/9/11 - 7/22/11	Friday 07/22/11
16	7/23/11 - 8/5/11	Friday 08/05/11
17	8/6/11 - 8/19/11	Friday 08/19/11
18	8/20/11 - 9/2/11	Friday 09/02/11
19	9/3/11 - 9/16/11	Friday 09/16/11
20	9/17/11 - 9/30/11	Friday 09/30/11
21	10/1/11 - 10/14/11	Friday 10/14/11
22	10/15/11 - 10/28/11	Friday 10/28/11
23	10/29/11 - 11/11/11	Friday 11/11/11
24	11/12/11 - 11/25/11	Friday 11/25/11
25	11/26/11 - 12/9/11	Friday 12/09/11
26	12/10/11 - 12/23/11	Friday 12/23/11
27	12/24/11 - 1/6/12	Friday 01/06/12

3.5 MEDCO CLAIMS CYCLE AND PAYMENT

(continued)

Medicare Part D Claims Cycle

Medco shall provide for prompt payment of clean claims timely submitted by Provider for Covered Services furnished to Medicare Part D members within such periods as required within 14 days of receipt for claims submitted electronically, and 30 days of receipt for clean claims submitted otherwise.

Cycle	Claims Cycle	POS Cut-Off Date
1	1/1/11 - 1/7/11	Friday 01/07/11
2	1/8/11 - 1/14/11	Friday 01/14/11
3	1/15/11 - 1/21/11	Friday 01/21/11
4	1/22/11 - 1/28/11	Friday 01/28/11
5	1/29/11 - 2/4/11	Friday 02/04/11
6	2/5/11 - 2/11/11	Friday 02/11/11
7	2/12/11 - 2/18/11	Friday 02/18/11
8	2/19/11 - 2/25/11	Friday 02/25/11
9	2/26/11- 3/4/11	Friday 03/04/11
10	3/5/11 - 3/11/11	Friday 03/11/11
11	3/12/11 - 3/18/11	Friday 03/18/11
12	3/19/11 - 3/25/11	Friday 03/25/11
13	3/26/11 - 4/1/11	Friday 04/01/11
14	4/2/11 - 4/8/11	Friday 04/08/11
15	4/9/11- 4/15/11	Friday 04/15/11
16	4/16/11 - 4/22/11	Friday 04/22/11
17	4/23/11- 4/29/11	Friday 04/29/11
18	4/30/11 - 5/6/11	Friday 05/06/11
19	5/7/11- 5/13/11	Friday 05/13/11
20	5/14/11 - 5/20/11	Friday 05/20/11
21	5/21/11- 5/27/11	Friday 05/27/11
22	5/28/11 - 6/3/11	Friday 06/03/11
23	6/4/11- 6/10/11	Friday 06/10/11
24	6/11/11 - 6/17/11	Friday 06/17/11
25	6/18/11 - 6/24/11	Friday 06/24/11
26	6/25/11 - 7/1/11	Friday 07/01/11

3.5 MEDCO CLAIMS CYCLE AND PAYMENT

(continued)

Cycle	Claims Cycle	POS Cut-Off Date
27	7/2/11 - 7/8/11	Friday 07/08/11
28	7/9/11 - 7/15/11	Friday 07/15/11
29	7/16/11 - 7/22/11	Friday 07/22/11
30	7/23/11 - 7/29/11	Friday 07/29/11
31	7/30/11 - 8/5/11	Friday 08/05/11
32	8/6/11 - 8/12/11	Friday 08/12/11
33	8/13/11 - 8/19/11	Friday 08/19/11
34	8/20/11 - 8/26/11	Friday 08/26/11
35	8/27/11 - 9/2/11	Friday 09/02/11
36	9/3/11 - 9/9/11	Friday 09/09/11
37	9/10/11 - 9/16/11	Friday 09/16/11
38	9/17/11 - 9/23/11	Friday 09/23/11
39	9/24/11 - 9/30/11	Friday 09/30/11
40	10/1/11 - 10/7/11	Friday 10/07/11
41	10/8/11 - 10/14/11	Friday 10/14/11
42	10/15/11 - 10/21/11	Friday 10/21/11
43	10/22/11 - 10/28/11	Friday 10/28/11
44	10/29/11 - 11/4/11	Friday 11/04/11
45	11/5/11 - 11/11/11	Friday 11/11/11
46	11/12/11 - 11/18/11	Friday 11/18/11
47	11/19/11 - 11/25/11	Friday 11/25/11
48	11/26/11 - 12/2/11	Friday 12/02/11
49	12/3/11 - 12/9/11	Friday 12/09/11
50	12/10/11 - 12/16/11	Friday 12/16/11
51	12/17/11 - 12/23/11	Friday 12/23/11
52	12/24/11- 12/30/11	Friday 12/30/11

3.6 REIMBURSEMENT NOT RECEIVED BY A PHARMACY

Provider must notify Medco within 6 months from date of service of any valid paid claim transmitted electronically through the *TelePAID*[®] System for which Provider has not received reimbursement.

Provider agrees that any claim for unpaid reimbursement submitted to Medco after the applicable claim cut-off date will not be eligible for payment.

Payments processed by Medco that go unclaimed by the Provider for more than 1 year from the date of issuance will become the property of Medco.

Please write to the below address should Provider have questions on claim payment or lost payment:

Medco
Pharmacy Support Department
MS B3-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

CHAPTER 4

FORMULARY
INFORMATION

4.1 FORMULARIES

Sponsors often adopt a formulary as part of their overall cost-containment programs, attempting to deliver a balance between cost containment and quality of care. Medco implements a variety of formulary programs for Plan Sponsors. Medco's independent Pharmacy and Therapeutics Committee supports **Preferred Prescriptions®** and **Rx Selections™**.

In addition, Medco implements Sponsors' proprietary formulary programs. Provider is required to support all formulary programs by dispensing formulary drugs to the maximum extent possible. Provider must use best efforts to contact the Prescriber to encourage formulary compliance.

4.2 PLAN DESIGN

Plan Sponsors also adopt different plan designs as part of their overall cost-containment programs. Provider is required to participate in a variety of plan designs, including those that permit access to a negotiated discount when producing an identification card and paying for the prescription at the time of sale.

4.3 *TelePAID*® SYSTEM MESSAGING

Point-of-sale messaging is the primary vehicle for communicating formulary information to pharmacists and, thereby, to Eligible Persons. Messaging is supplemented with other communications at the discretion and direction of the Plan Sponsor. When a Provider transmits a claim consistent with the formulary, the claim adjudicates with an additional message "Formulary Rx." When a prescription is transmitted for a nonformulary drug product, the claim will either (i) reject, with MR (non formulary)," for Sponsors utilizing a "Closed Formulary"; or (ii) will adjudicate, with the message "Nonformulary Rx" in the approved message fields, for Sponsors utilizing an "Incentive or Open Formulary." Where appropriate, up to five formulary alternatives are displayed in the preferred product fields.

If a prescription is submitted for a nonformulary drug and the Prescriber has not authorized a formulary drug alternative, the Provider will inform the cardholder that the prescription is for a nonformulary drug and apply the co-payment/coinsurance, deductible, or other benefit requirement rules as transmitted via the *TelePAID*® System. In some cases, the co-payment/coinsurance for a nonformulary drug may be higher if the plan is utilizing an "Incentive or Open Formulary" program.

The Provider is expected to cooperate with, administer, and dispense in accordance with, subject to the pharmacist's professional judgment, formulary compliance programs implemented by Medco.

It is inconsistent with Medco network standards if Provider does not attempt to dispense in accordance with the formulary. Provider is required to keep a record on the original prescription of its attempt at achieving formulary compliance. Medco may recover from Provider the full amount of Provider's dispensing fees when Provider (i) fails to attempt formulary compliance or note formulary compliance efforts on the original prescription; (ii) acts contrary to formulary compliance; or (iii) causes the prescription to result in a higher cost to the Sponsor and/or the Eligible Person.

4.4 BRAND AND GENERIC DRUG STANDARDS

4.4.1 Promote the Formulary

Medco administers many plans. Each has its own guidelines as to such things as days' supply, ingredient cost pricing, co-payment/coinsurance, drug coverage, and informational drug utilization messaging. Therefore, rely on the *TelePAID*[®] System to receive accurate information regarding the specific Eligible Person, group, prescription drug, co-payment/coinsurance, and pricing pertaining to the claim submitted.

For most plans, use of generics is encouraged. In some instances, a Plan may have a preferred brand product rather than a generic. Thus, a Provider should rely on the *TelePAID*[®] System messaging to reinforce the use of generic and preferred brand products with Medco Eligible Persons and Prescribers.

If a brand drug is appropriate, a Provider should dispense preferred co-branded drug products for nonpreferred co-branded drug products where applicable, in accordance with prevailing pharmacy laws and regulations.

4.4.2 Mandatory Generic Programs

As part of Medco's managed care initiatives, Provider is required to use its best efforts in supporting Medco and its Sponsors in managing the cost and quality of Covered Services by cooperating in administering mandatory generic programs as they may from time to time be required by Plan Sponsor benefits. In practice, this means that Provider will, in accordance with the *TelePAID*[®] System messaging in all cases, dispense generic drug products for multisource brand drugs, except where prohibited by applicable laws, rules, or regulations. Where the prescription does not authorize substitution, contact the Prescriber to reinforce plan guidelines and request authorization to change to an approved generic.

Provider must maintain an adequate inventory of brand-name prescription medications and a sufficient quantity of quality, generic drugs as rated "A" by the Federal *Orange Book*.

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CHAPTER 5

PROVIDERS'
CLINICAL
OBLIGATIONS

5.1 CLINICAL MESSAGES

As noted above, a Provider is required to submit all claims for Covered Services for Eligible Persons via the *TelePAID*[®] System. This ensures that quality professional practice standards are met, Sponsor's clinical management programs are offered, and DUR review and safety edits are applied.

A Provider is required to dispense prescriptions to Eligible Persons in accordance with its pharmacist's professional judgment, quality practice standards, generic drug programs, formulary compliance, disease state management, and other clinical management programs implemented by Medco as communicated to Provider via the *TelePAID*[®] System, all applicable laws and regulations, and in accordance with Sponsor plan designs. These programs and initiatives are displayed to Provider via the *TelePAID*[®] System. The following are descriptions of the various clinical messages and opportunities displayed via the *TelePAID*[®] System:

- Drug Utilization Review (“DUR”) Messaging
- Clinical Management Programs
- Maximum Daily Dosage (“MDD”)
- Drug-to-Drug Interaction
- Refill-Too-Soon Edits
- DUR Conflict, Intervention, and Outcome Codes and Descriptions

5.2 DRUG UTILIZATION REVIEW (DUR)

Provider must display all DUR alerts to the dispensing pharmacist.

A Provider is required to operate a computer system that provides for the recording of patient drug and medical history, as allowed by law and sound pharmacy practice. Medco may require that a Provider send to Medco, via the *TelePAID*[®] System, other patient information as might be collected by the Provider, under applicable state law, such as diseases, medical conditions, nonreimbursable medications (e.g., OTCs), and allergies. This information should be compatible with DUR messaging received via the *TelePAID*[®] System when a claim is being adjudicated. Messaging includes DUR, formulary, and intervention messages transmitted via the *TelePAID*[®] System.

A Provider is required, subject to professional judgment, to act upon DUR information provided by message alerts transmitted to the Provider via the *TelePAID*[®] System. The DUR messaging may not be complete; therefore, the Provider should perform its own individual utilization review. A Provider's claims transmission system must comply fully with the current standard recognized by the NCPDP (see Glossary), which is currently version 5.1. A Provider is required to provide intervention resolution and outcome codes to Medco informing Medco of the resolution of DUR alerts and messages transmitted via the *TelePAID*[®] System. The DUR Reason for Service, Professional Service, and Result of Service codes follow at the end of this section. These codes are also available from NCPDP and systems software vendors.

THE INFORMATION PROVIDED BY THE *TELEPAID*[®] SYSTEM IS INTENDED TO SUPPLEMENT THE KNOWLEDGE OF PROVIDERS AND PRESCRIBERS. PROVIDER IS RESPONSIBLE FOR CONDUCTING ITS OWN DUR OUTSIDE OF THE *TELEPAID*[®] SYSTEM.

5.3 CLINICAL AND QUALITY MANAGEMENT PROGRAMS

Provider will comply with any special Quality Management requirements and programs established by Medco or Sponsors for participating Providers in networks. Provider will participate, as requested, in the activities and programs of and abide by the decisions of Sponsors' Quality Management and Utilization Review Committees. Provider must maintain an internal quality assurance program and will report on same to Medco upon Medco's request, along with remedial action plans.

5.4 MAXIMUM DAILY DOSAGE

If Provider receives a Maximum Daily Dosage Rejection Code message via the *TelePAID*® System when submitting a claim of "76 - Max. Dose/Day = #," the following steps need to be taken:

1. Verify that the Days' Supply and Quantity Dispensed are correct.
2. Contact the Prescriber to confirm the dosage, as needed. Document the conversation on the original prescription.
3. Document on the original prescription: (a) the reason for the override; (b) the authorization code, if applicable; (c) the name of the Medco representative, if applicable.

Once the steps are completed, enter "02" in the Submission Clarification Code Field (Submission Clarification Code), field number 420-DK, and retransmit.

Follow your Pharmacy System's Software Protocols.

Note: No default override codes are permitted on an initial inbound claims transaction.

5.5 DRUG-TO-DRUG INTERACTION

If Provider receives a DUR Reason for Service message via the *TelePAID*® System for Drug-to-Drug interactions, the following steps need to be taken:

1. Contact the Prescriber to discuss the potential "Drug-to-Drug" interaction.
2. If the Prescriber approves the prescription to be dispensed with no change after the alert, resubmit the claim using all three of the following codes:

DUR Reason for Service Code = DD (Drug-to-Drug Interaction)

DUR Professional Service Code = MO (Prescriber Consulted)

DUR Result of Service Code = 1G (Filled, with Prescriber's Approval)

Note: No default override code is permitted on an initial inbound claims transaction unless Provider has detected the Drug-to-Drug Interaction and contacted the Prescriber.

5.6 REFILL-TOO-SOON EDITS

5.6.1 Submission Clarification Codes

If Provider receives a “refill-too-soon” rejection message, the following responses are appropriate.

If the Eligible Person requests an “early refill” for no apparent reason, inform the Eligible Person of the plan limitations and let that Eligible Person know when the prescription can be refilled without a rejection.

Use the standard NCPDP override codes as follows:

Submission Clarification Codes	Definition
Value of “03” in Rx Clarification Field	Vacation supply refill
Value of “04” in Rx Clarification Field	Lost or spilled prescription
Value of “05” in Rx Clarification Field	Change to daily dosage, therapy changed by Prescriber

Note:

- ▶ If the Submission Clarification Code is entered into the Pharmacy Software system and the claim rejects a second time, inform the Eligible Person that the plan has not approved an override for one of the three conditions indicated above.
- ▶ No default override codes are permitted on an initial inbound claim transaction.
- ▶ The reason for the override must be recorded on the original prescription. If an override is applied to more than one fill for the same prescription, the reason for each override use must be documented and dated. An automatically generated override code number, generated by the Provider’s software upon override code submission, is not considered documentation.
- ▶ Document on the original prescription: a) the reason for the override; b) the Authorization Code, if applicable; c) the name of the Medco representative, if applicable.
- ▶ The Provider must use the proper Submission Clarification Code. Utilization of any Submission Clarification Code for reasons other than the intended purpose specified above will result in the identification of audit discrepancies and charge backs.
- ▶ Medco recognizes that during natural disasters and other crisis situations, some Eligible Persons may lose or leave behind their prescription medications, or medication may be damaged or destroyed. In those cases, Eligible Persons may seek an early refill from a Provider. Contact the Help Desk at 1 800 922-1557 for further information.

5.6 REFILL-TOO-SOON EDITS

(continued)

Version D.0

Providers can submit up to 3 override codes on a claim. The new standard NCPDP override codes are to be used as follows:

Submission Clarification Codes	Definition
Value of “14” in Rx Clarification Field	Long term care leave of absence
Value of “15” in Rx Clarification Field	LTC replacement
Value of “16” in Rx Clarification Field	LTC emergency box
Value of “17” in Rx Clarification Field	LTC emergency supply
Value of “18” in Rx Clarification Field	LTC patient re-admittance
Value of “19” in Rx Clarification Field	LTC split billing

Note: Certain codes will only be supported if submitted by a LTC pharmacy. New submission clarification codes may be added from time to time. Providers should refer to the NCPDP guidelines or the Medco Pharmacist Resource Center (www.medco.com/rph) for updated information.

5.6.2 Reject Codes

Consult the NCPDP Data Dictionary Version 5.1 or Version D.0 for a complete list of NCPDP reject codes for the telecommunication standard.

5.7 DUR CONFLICT, INTERVENTION, AND OUTCOME CODES AND DESCRIPTIONS

5.7.1 DUR Reason for Service Codes and Descriptions

These codes represent the NCPDP codes that identify the reasons for generating a DUR conflict.

AD: Additional Drug Needed — Optimal treatment of the patient’s condition requires the addition of a new drug to the existing therapy.

AN: Prescription Authentication — Circumstances require that the pharmacist verify the validity and/or authenticity of the prescription. The principal use is for suspected fraud.

AR: Adverse Drug Reaction — First occurrence of an adverse reaction by a patient to a drug.

AT: Additive Toxicity — Detects drugs with similar side effects that could exhibit additive toxic potential.

CD: Chronic Disease.

CH: Call Help Desk — Processor message to call help desk.

5.7 DUR CONFLICT, INTERVENTION, AND OUTCOME CODES AND DESCRIPTIONS

(continued)

5.7.1 DUR Reason for Service Codes and Descriptions (continued)

-
- CS:** Patient Complaint/Symptom — Patient presents to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment.
-
- DA:** Drug Allergy — Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question.
-
- DC:** Drug Disease (Inferred) — Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of specific medical condition may be inferred from drugs in the patient's medication history.
-
- DD:** Drug-to-Drug Interaction — Detects drug combinations in which the net pharmacological response may be different from the result expected when each drug is given separately.
-
- DF:** Drug-Food Interaction — Detects interactions between a drug and certain foods.
-
- DI:** Drug Incompatibility — Identifies physical and chemical incompatibilities between two or more drugs.
-
- DL:** Drug Lab Conflict — Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value.
-
- DM:** Apparent Drug Misuse — Pattern of drug use by a patient in a manner that is significantly different from that prescribed by the Prescriber.
-
- DS:** Tobacco Use — Conflict detects when a prescribed drug is contraindicated or might conflict with the use of tobacco products.
-
- ED:** Patient Education.
-
- ER:** Overuse (Early Refill or Refill-Too Soon) — Detects prescription refills that occur before the days' supply of the previous filling should have been exhausted.
-
- EX:** Excessive Quantity — The quantity of dosage units prescribed is excessive for dispensing at a single time.
-
- HD:** High Dose (Exceeds Maximum Daily Dose) — Detects drug doses that fall above the standard dosing range.
-
- IC:** Iatrogenic Condition — Detects possibly inappropriate use of drugs that are designed to ameliorate complications caused by another medication.
-
- ID:** Ingredient Duplication — Detects simultaneous use of drug products containing one or more identical generic chemical entities.
-

5.7 DUR CONFLICT, INTERVENTION, AND OUTCOME CODES AND DESCRIPTIONS

(continued)

5.7.1 DUR Reason for Service Codes and Descriptions (continued)

LD:	Low Dose (Under Minimum Daily Dose) — Detects drug doses that fall below the standard dosing range.
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LK:	Lock in Recipient.
------------	--------------------

LR:	Under Use — Detects prescription refills that occur after the days' supply of the previous filling should have been exhausted.
------------	--

MC:	Drug Disease (Reported/Actual) — Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the Prescriber, patient, or pharmacist.
------------	--

MN:	Insufficient Duration — Detects regimens that are shorter than the minimal limit of therapy for the drug product based on the product's common uses.
------------	--

MS:	Missing Information/Clarification — The prescription order is unclear, incomplete, or illegible with respect to essential information.
------------	--

MX:	Excessive Duration — Detects regimens that are longer than the maximal limit of therapy for the drug product based on the product's common uses.
------------	--

NA:	Drug Not Available — Drug is not currently available from any source.
------------	---

NC:	Noncovered Drug Purchase.
------------	---------------------------

ND:	New Disease/Diagnosis — Patient has a newly diagnosed condition or disease that necessitates a professional pharmacy service.
------------	---

NF:	Nonformulary Drug — Drug is not included on the formulary of the patient's pharmacy benefit plan. This code is intended to support mandatory formulary enforcement activities by pharmacists.
------------	---

NN:	Unnecessary Drug — Drug is no longer needed by the patient. This code is intended to support ongoing monitoring of established drug therapy by the pharmacist, as distinguished from "Inappropriate drug/indication," which is intended to support prospective drug utilization review of new therapy.
------------	--

NP:	New Patient Processing — Initial interview and medication history of a new patient.
------------	---

NR:	Lactation/Nursing Indication — Drug is excreted in breast milk and may represent a danger to a nursing infant.
------------	--

NS:	Insufficient Quantity — Quantity of dosage units prescribed is insufficient.
------------	--

OH:	Alcohol Conflict — Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages.
------------	---

5.7 DUR CONFLICT, INTERVENTION, AND OUTCOME CODES AND DESCRIPTIONS

(continued)

5.7.1 DUR Reason for Service Codes and Descriptions (continued)

-
- PA:** Drug Age — Detects when a prescribed drug is contraindicated based on the patient's age.
-
- PC:** Patient Question/Concern — Request for information or concern expressed by the patient with respect to his or her care.
-
- PG:** Drug Pregnancy — Detects when a prescribed drug is contraindicated for use by a pregnant woman. This information is intended to assist in weighing the therapeutic value of a drug against possible adverse effects on the fetus.
-
- PH:** Preventive Healthcare.
-
- PN:** Prescriber Consultation — Request by a Prescriber for information or a recommendation related to the care of a patient.
-
- PP:** Plan Protocol.
-
- PR:** Prior Adverse Reaction — Identifies those drugs to which the patient has previously reacted in an atypical manner.
-
- PS:** Product Selection Opportunity — An acceptable generic substitute or therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists.
-
- RE:** Suspected Environmental Risk.
-
- RF:** Health Provider Referral — Patient referred to the pharmacist by another healthcare provider.
-
- SC:** Suboptimal Compliance.
-
- SD:** Suboptimal Drug/Indication — Incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition (should not be used when a more precise code exists to describe the problem, such as Drug Interactions, Drug Allergy, Drug Disease, etc.)
-
- SE:** Side Effect — Reports possible major side effects of the prescribed drug.
-
- SF:** Suboptimal Dosage Form — Incorrect, inappropriate, or less than optimal dosage form prescribed for the patient's condition.
-
- SR:** Suboptimal Regimen — Incorrect, inappropriate, or less than optimal dosing regimen prescribed for the patient's condition.
-
- SX:** Drug Gender — Detects when a prescribed drug is contraindicated or inappropriate for use based on the patient's sex.
-

5.7 DUR CONFLICT, INTERVENTION, AND OUTCOME CODES AND DESCRIPTIONS

(continued)

5.7.1 DUR Reason for Service Codes and Descriptions (continued)

TD: Therapeutic Duplication — Detects simultaneous use of different primary generic chemical entities that have the same therapeutic effect.

TN: Laboratory Test Needed — Assessment of the patient by the pharmacist suggested that a laboratory test is needed to optimally manage therapy.

TP: Payer/Processor Question — Request by a payer or processor for information related to the care of a patient.

5.7.2 DUR Professional Service Codes and Descriptions

These codes represent the NCPDP codes that identify the intervention or action taken by a pharmacist to resolve a DUR conflict.

AS: Patient Assessment — Initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan.

CC: Coordination of Care — Case management activities of a pharmacist related to the coordination of care being delivered by multiple providers.

DE: Dosing Evaluation/Determination.

FE: Formulary Enforcement — Activities including interventions with Prescriber and patients related to the enforcement of a pharmacy benefit plan formulary.

GP: Generic Product Selection — The selection of a product chemically and therapeutically identical to that specified by the Prescriber for the purpose of achieving cost savings for the payer.

MA: Medication Administration.

MO: Prescriber Consulted — Prescriber communication related to collection of information or clarification of a specific limited problem.

MR: Medication Review — Comprehensive review and evaluation of a patient's entire medication regimen.

PO: Patient Consulted — Patient communication related to collection of information or clarification of a specific limited problem.

PE: Patient Education/Instruction — Verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management.

5.7 DUR CONFLICT, INTERVENTION, AND OUTCOME CODES AND DESCRIPTIONS

(continued)

5.7.2 DUR Professional Service Codes and Descriptions (continued)

-
- PH:** Patient Medication History — Establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile.
-
- PM:** Patient Monitoring — Evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered.
-
- PR:** Patient Referral — Referral of a patient to another healthcare provider following evaluation by the pharmacist.
-
- PT:** Perform Laboratory Test — Pharmacist performs a clinical laboratory test on a patient.
-
- RO:** Pharmacist Consulted Other Source — Communication related to collection of information or clarification of a specific limited problem via professional judgment.
-
- RT:** Recommend Laboratory Test — Pharmacist recommends the performance of a clinical laboratory test on a patient.
-
- SC:** Self-Care Consultation — Activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. Counseling a patient about the selection and use of an over-the-counter medication is probably the most common example of this type of service.
-
- SW:** Literature Search/Review — Pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.
-
- TC:** Payer/Processor Consulted — Communication by a pharmacist to a processor or payer related to the care of a patient.
-
- TH:** Therapeutic Product Interchange — The selection of a therapeutically equivalent product to that specified by the Prescriber for the purpose of achieving cost savings for the payer.

5.7.3 DUR Result of Service Codes and Descriptions

These codes represent the NCPDP codes that identify the resolution (or outcome) associated with a DUR conflict.

-
- 1A:** Filled As Is, False Positive — Identified conflict determined not to be valid.
-
- 1B:** Filled Prescription As Is — Identified conflict determined to be insignificant without contacting the Prescriber.
-
- 1C:** Filled with Different Dose.
-
- 1D:** Filled with Different Directions.
-
- 1E:** Filled with Different Drug.
-

5.7 DUR CONFLICT, INTERVENTION, AND OUTCOME CODES AND DESCRIPTIONS

(continued)

5.7.3 DUR Result of Service Codes and Descriptions (continued)

1F:	Filled with Different Quantity.
1G:	Filled with Prescriber Approval — Conflict identified was valid and potentially significant. Resolution required consultation with the Prescriber.
1H:	Brand to Generic Change — Generic drug product was substituted for the prescribed branded product.
1J:	Rx to OTC Change — An equally efficacious nonprescription drug product was dispensed in place of the prescribed product.
1K:	Filled with Different Dosage.
2A:	Prescription Not Filled.
2B:	Prescription Not Filled, Directions Clarified.
3A:	Recommendation Accepted — Prescriber accepted the recommendation made by the pharmacist.
3B:	Recommendation Not Accepted — Prescriber did not accept the recommendation made by the pharmacist.
3C:	Discontinued Drug — Prescriber authorized the discontinuance of a drug.
3D:	Regimen Changed — Prescriber authorized a change in dose or dosage regimen.
3E:	Therapy Changed — Prescriber authorized a change in medication therapy.
3F:	Therapy Changed, Cost Increase Acknowledged — Prescriber authorized a change in medication therapy recommended by the pharmacist that will increase the current cost of therapy with the goal of improving the overall healthcare outcome.
3G:	Drug Therapy Unchanged — Prescriber did not authorize a change in medication therapy.
3H:	Follow-up/Report — Verbal and/or written follow-up information was communicated from the pharmacist to the Prescriber.
3J:	Patient Referral.
3K:	Instructions Understood.
3M:	Compliance Aid Provided.
3N:	Medication Administered.

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CHAPTER 6

GENERAL INFORMATION

6.1 COMPLAINTS, GRIEVANCES, AND AUDITS

Provider will cooperate with Medco and Sponsors and comply with all applicable laws and regulations regarding complaints and grievances from Eligible Persons. Provider will comply with the complaint and grievances procedures and programs established by Medco and Plan Sponsors.

Similarly, regulatory and oversight entities and agencies may request that Medco supply documents from Providers. Provider must cooperate with Medco to supply the requested documentation in a timely manner. Because different regulatory agencies may give Medco or a Sponsor a different amount of time to respond to a request, what is “timely” may vary from request to request. The amount of time allowed to respond will be stated in the request from Medco.

Medco reserves the right to assess up to a \$100 per request fee in addition to the reversal of the claim for any claim for which documentation is not supplied.

6.2 INDEMNIFICATION

All liability arising from the provision of drugs, products, and services by Provider will be the sole responsibility of Provider. Medco and Plan Sponsors will not be liable for and Provider will indemnify, defend, and hold Medco and Plan Sponsors harmless from and against any claim, injury, damage, loss, expense (including reasonable attorney’s fees), demand, or judgment in any way resulting from any acts or omissions by Provider in the sale, compounding, dispensing, or use of any prescription drug dispensed by Provider or the providing of any other services or products by Provider. In no event and under no circumstances will Medco or Sponsors be liable to Provider for indirect or consequential damages of any nature, loss of profit, punitive damages, injury to reputation, or loss of customers or business.

6.3 PROFESSIONAL JUDGMENT

Provider is obligated to provide the Eligible Persons and Prescribers whom it serves with an adequate inventory of quality drugs. The pharmacist is by profession uniquely qualified to judge the integrity and the quality of manufactured sources. Where a prescription is written in such a manner that the Provider is provided an option with respect to brand name, manufacturing source, or package size of the drug to be supplied, Provider will supply and charge for that drug that meets official compendium specifications, if listed therein; that has the lowest ingredient cost; that in the pharmacist’s professional judgment fulfills the Prescriber’s requirements; and that meets formulary requirements.

Subject to the pharmacist’s professional judgment and availability, Provider will dispense an A-rated generic when dispensing a generic drug. Provider will (i) stock a sufficient number of drugs distributed under their generic names consistent with the prescribing habits of the Prescribers in Provider’s community, communications via the *TelePAID*[®] System, or the generic formulary of the state in which Provider is located, subject to the pharmacist’s professional judgment as to the integrity and quality of the manufacturing source, and (ii) dispense a generic drug wherever possible in accordance with applicable law or regulations.

All professional services provided by Provider must be rendered only under the direct supervision of a licensed pharmacist and each prescription must be dispensed in accordance with a lawful Prescriber’s directions, the terms and conditions contain in Provider’s Agreement with Medco, including the Manual, and/or communicated via the *TelePAID*[®] System, and applicable State and Federal laws.

6.3 PROFESSIONAL JUDGMENT

(continued)

Provider must clarify and document ambiguous dosage directions regarding utilization prior to dispensing and must not combine Prescriber-authorized refills. Provider will at all times exercise good professional judgment in the dispensing of medications and may refuse to dispense any prescription based on the dispensing pharmacist's own professional judgment.

The Provider will inform Medco Eligible Persons as to the proper storage, dosing, side effects, potential interactions, and use of the medication dispensed within professional practice guidelines.

6.4 INDEPENDENT CONTRACTORS

Medco and Provider are independent contractors engaged in the operation of their own respective businesses and Provider will not represent to anyone anything to the contrary. Neither party shall be construed to be an agent of the other.

6.5 ASSIGNMENT

Subject to the assignment requirements of the Manual, the provisions of Provider's Agreement with Medco will bind and inure to the benefit of the parties thereto and their heirs, representatives, and successors. Failure to exercise any rights arising in respect of any breach or violation of Provider's Agreement with Medco will not be a waiver of the right to exercise any rights arising in respect of any subsequent breach or violation. In the event any term or provision contained in Provider's Agreement with Medco is determined to be invalid or unenforceable, such invalidity or unenforceability will not affect the validity or enforceability of any other term, provision, or requirement contained in Provider's Agreement with Medco. Medco is the owner of the information obtained by and through the administration and processing of any prescription claim by Provider through Medco.

Provider will immediately notify Medco in the event of a change of ownership or control of the operations of Provider. Upon change of ownership, the new owner must apply for participation as a Medco Provider. Any successor to ownership or control will be responsible for all liabilities and obligations of its predecessor under Provider's Agreement with Medco, including the Provider Agreement, Manual, and the applicable pricing schedules.

Provider shall not subcontract any of the obligations of Provider's Agreement with Medco without Medco's prior written approval. Any such delegation of rights must be in accordance with the terms and conditions of Provider's Agreement with Medco.

Medco will not be bound to any of its obligations under Provider's Agreement with Medco where Provider has assigned or subcontracted its Agreement with Medco or ownership or control of the operation of Provider has changed without Medco's prior written consent, and under such circumstances Medco will have the right to terminate Provider's Agreement with Medco.

6.6 OTHER OBLIGATIONS

Provider must abide by all applicable Federal, State, and local government patient disclosure requirements concerning payment for services, including cognitive services, fees, and rebate programs. Provider must provide Covered Services in compliance with Provider's Agreement with Medco for all Eligible Persons of all Sponsors to which Provider's Agreement with Medco applies; and must not discriminate in the provision of services, including Compounded Prescriptions, with respect to any Sponsor(s) or Eligible Person(s), regardless of the Eligible Person's right to reimbursement, amount of co-payment/coinsurance, or other plan or program terms.

6.7 MEMBER HOLD HARMLESS

Provider will in no event, including but not limited to nonpayment by Medco or any Sponsors, Medco or Sponsors' insolvency, or breach of Provider's Agreement with Medco, bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an Eligible Person(s) other than Medco or the Sponsor acting on their behalf for Covered Services provided to Eligible Persons. This provision does not prohibit the collection of deductibles, co-payments/coinsurance, or charges for noncovered services.

This provision will survive the termination of Provider's Agreement with Medco regardless of the cause giving rise to termination, and will be construed to be for the benefit of the Eligible Person, and this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Eligible Person or Persons acting on their behalf.

Provider will provide Covered Services to all Eligible Persons at the applicable network rate whether or not the Eligible Person has identified himself/herself as such. Further, if Medco determines that Provider has overcharged an Eligible Person, Provider will promptly pay such overpayment to Medco or such Eligible Person, as directed upon notification by Medco.

6.8 PLAN SPONSOR HOLD HARMLESS

Provider will in no event bill, charge, or in any way seek compensation against a Sponsor.

6.9 PROVIDER WILL NOT DISCRIMINATE AGAINST ELIGIBLE PERSONS

Provider will not discriminate against Eligible Persons on the basis of race, color, national origin, gender, age, religion, marital status, health status, prescription benefit coverage, or source or amount of payment. Provider must not charge a fee to Eligible Persons as a condition for use of a participating Provider. Provider shall provide services in the same manner and in accordance with the same standards as to all other patients of Provider.

6.10 SURVIVAL OF TERMS AND CONDITIONS IN THE PROVIDER AGREEMENT AND MANUAL

Terms and conditions of Provider's Agreement with Medco, which by their nature should continue beyond the termination of Provider's Agreement with Medco, will survive the termination.

6.11 TERMINATION

Medco may limit or withdraw Provider's providing of Covered Services to any Eligible Person, group, or Sponsor's Plans regardless of the network(s) Provider participates in. Medco may at any time terminate Provider's Agreement with Medco without cause upon 30 days' prior written notice to Provider and with cause immediately.

6.12 OFFICIAL NOTICES

All notices to Medco or Provider pursuant to Provider's Agreement with Medco must be in writing and be hand-delivered or sent by first-class mail, postage prepaid, or overnight courier addressed to Medco at the address set forth below; and addressed to Provider at the street, mailing, or remit-to mailing address set forth in Provider's application or Verification Form, or such other address as may be provided by the other party in the same manner as provided for the giving of any notice.

Notwithstanding the foregoing, Medco may give notice to Provider by communication via the *TelePAID*[®] System, electronic mail, or by facsimile at the facsimile number set forth in the Provider's application or Verification Form.

All written notices will be deemed to have been received when delivered if by hand or overnight courier, or if sent by mail then on the third business day after the date such notice was mailed. Notices may be included in claims cycle mailings. All *TelePAID*[®] System or facsimile notices will be deemed received by Provider when sent by Medco.

All notices to Medco will be sent to:

Medco
Provider Network Relations Department
MS E2-6
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

6.13 MANUAL UPDATES

Medco will, upon occasion, provide updates to the Manual. Medco may provide copies of the Manual or updates to the Manual via any of the means listed above, on the Pharmacist Resource Center website, or via the United States Postal Service.

6.14 AMENDMENTS

Revisions, amendments, or modifications to Provider's Agreements with Medco will be provided by Medco from time to time. Provider will abide by the terms of Provider's Agreement with Medco, and all notices, revisions, amendments, and modifications thereto.

If Provider continues to submit claims after the effective date of any notice, revision, amendment, or modification by Medco to Provider, the notice, revision, amendment, or modification will be deemed accepted by Provider and will become part of Provider's Agreement with Medco as if Provider had given its express written consent thereto. If Provider objects to any such notice, revision, amendment, or modification, Medco reserves the right to immediately terminate Provider's Agreement with Medco.

6.15 BREACH OF AGREEMENT

It is understood that the breach by Provider of any of the terms of Provider's Agreement with Medco, including this Manual, will constitute sufficient grounds for Medco to immediately terminate Provider's Agreement with Medco.

Provider will be responsible for all Medco costs and fees that result from a Provider's noncompliance with the Manual.

6.16 GOVERNING LAW AND JURISDICTION

All disputes and matters between Provider and Medco arising out of Provider's Agreement with Medco shall be litigated before the U.S. District Court for the District of New Jersey, or, as to those lawsuits to which the Federal Court lacks subject matter jurisdiction, before a court located in Bergen County, New Jersey. The Provider's Agreement with Medco shall be governed, construed, and enforced in accordance with the laws of the State of New Jersey.

6.17 ADVERTISING

All rights in the product names, company names, trade names, logos, product packaging and designs of all Medco or Sponsor, whether or not appearing in large print or with the trademark symbol, belong exclusively to Medco or Sponsor and are protected from reproduction, imitation, dilution, or confusing or misleading uses under national and international trademark and copyright laws. The use or misuse of these trademarks or any materials is expressly prohibited without prior written consent from Medco or Sponsor, and nothing stated or implied in this Provider Services Manual confers on you any license or right under any patent or trademark of Medco or Sponsor.

Upon termination of Provider's Provider Agreement with Medco, Provider will immediately discontinue any references to being a Medco participating Provider and discontinue the use of any product names, company names, trade names, logos, product packaging and designs of Medco or Sponsor.

Provider will permit Medco to list Provider in applicable Provider directories and databases as determined by Medco for use by Eligible Persons, Sponsors, and others in locating Medco participating Providers.

6.18 CONFIDENTIALITY

6.18.1 Treat Information Pertaining to Medco, Its Plan Sponsors, and Eligible Persons as Confidential

All information pertaining to programs, Sponsors, networks, rates, marketing, Eligible Persons, procedures, methods, business practices, managed care initiatives, and solicitations by Medco, and the contents of Provider's Agreement with Medco ("Confidential Information"), are confidential and/or proprietary to Medco. Provider will use such confidential information only to the extent necessary for the purposes set forth in Provider's Agreement with Medco and will restrict disclosure of such confidential information to its employees with a need to know (and advise such employees of the obligations set forth herein), and it will not disclose confidential information to any third party without the prior written approval of Medco. Provider will maintain the confidentiality of Eligible Persons' records and personal information as required by applicable laws, rules, and regulations.

Any information contained in an 835 electronic remittance file is considered to be confidential information, as defined in this section. If Provider uses a third-party reconciler or other third-party entity for claims reconciliation, Provider must ensure that the entity abides by the confidentiality provisions as set forth herein.

6.18.2 Confidential Information Is the Property of Medco

All Confidential Information will remain the exclusive property of Medco. No right, title, or interest in the confidential information is conveyed to Provider by release of Confidential Information to it. Provider may not sell data or information that is adjudicated through the *TelePAID*[®] System. Provider will promptly notify Medco if it becomes aware of any use of the Confidential Information that is not authorized by Provider's Agreement with Medco. Provider understands that, in the event this provision is not adhered to by Provider or any of its employees, Medco will suffer irreparable damages that cannot be fully remedied by monetary damages. Accordingly, Medco will be entitled to seek and obtain injunctive relief against any such nonadherence in any court of competent jurisdiction. Medco's rights under these confidentiality requirements will not in any way be construed to limit or restrict Medco's rights to seek or obtain other damages or relief available under Provider's Agreement with Medco or applicable law.

6.18.3 Third-Party Requests for Information or Data

If a Provider receives a subpoena or third-party request for Medco information or data, the Provider will inform Medco prior to disclosing the information or data, and will give Medco an opportunity to file objections, if appropriate.

Provider will inform Medco within 14 days of the removal of prescription records from Provider's custody by an authorized Federal, State, or local agency. Upon request, a receipt provided by the agency removing the records and/or the name and phone number of the agent removing the records must be furnished to Medco's Pharmacy Audit Department.

If Medco receives a subpoena or third-party request for information about a Provider, the Provider will bear the cost of complying with the subpoena or third-party request.

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CHAPTER 7

RECORD RETENTION

7.1 REQUIRED RECORDS

You must retain all records in accordance with industry standards and applicable laws, rules, and regulations (or for 6 years, whichever is greater). Records for Medicare Part D Covered Services must be maintained for 11 years (the current contract year plus 10 years).

Your prescription and Covered Service records must include the following information:

- Patient's first and last name
- Patient's current address
- Prescriber's complete name, address, and telephone number
- Name and strength of the medication prescribed
- Quantity of medication prescribed
- Prescriber's generic substitution instructions
- Documentation of a patient's request for a multisource brand medication
- Documentation noting reason for refilling a prescription early (e.g., lost prescription, therapy change, vacation supply, etc.)
- Refill instructions
- When a prescription refill is transferred between two pharmacies, both pharmacies involved must record the transaction. The receiving pharmacy must record the identity and location of the sending pharmacy, as well as the date and prescription number of the original prescription. The sending pharmacy must record the date of transfer, the identity and location of the receiving pharmacy, and any other information required by state or federal law.
- Specific dosage directions
- Coupon or voucher for any OTC product dispensed as a Covered Service
- For compound prescriptions, the NDC, name and metric quantity of each medication used to prepare the compound
- Documentation of any changes or additions to the original prescription, including, but not limited to, revisions to the medication's strength, daily dosage, quantity of medication prescribed, refill authorization, or generic substitution instructions; including the date and name of the person at the Prescriber's office who authorized the change.
- For Medicare Part B Covered Services dispensed under a Medicare Part D plan, the patient's diagnosis must be noted on the prescription.
- For Covered Services dispensed to a patient in a Long-Term Care facility, the level of service (skilled nursing, assisted living facility, etc.) provided to the patient must be noted.
- For Medicare Part D Covered Services dispensed to a home infusion patient, the date the patient was discharged from the hospital or other acute care facility must be documented.

You must also retain the following records:

- Third-party signature claim logs
- Quality assurance plans or dispensing procedures
- Daily prescription logs
- Wholesaler, manufacturer, and distributor invoices
- Refill data documenting each time the prescription is refilled
- Documentation of any transfer of prescription stock between Provider locations

7.1 REQUIRED RECORDS

(continued)

- Electronic records
- Formulas for compound prescriptions
- Invoices or catalogs documenting acquisition costs of compound components
- Medication pricing brochures for cash customers (paper, Internet, or other format)
- Patient consent forms associated with the dispensing or administration of vaccines

7.2 SCANNED PRESCRIPTIONS

You are required to maintain a prescription record for each Covered Service you dispense. You may keep either a hard-copy prescription or a scanned image of the prescription. If you keep scanned images, you must meet the following requirements:

- The scanned image must meet all applicable pharmacy and Federal laws, rules and regulations.
- For Covered Services that are controlled substances (Schedules II, III, IV, and V) and for Covered Services dispensed to Medicare Part D eligibles, you must also retain the hard-copy paper prescriptions.
- You must scan and retain both sides of the hard-copy prescription.
- The scanned image must include any notes regarding the dispensing (i.e., overrides).
- The scanned image should be retained as a full-color document for a minimum of three (3) years after the date of service. Thereafter, the image may be retained as a black and white image. If you elect to retain the scanned image as a full-color document for only one (1) year, you must retain the image in black and white after the first year, and maintain the hard-copy prescription for a minimum of three (3) years.
- All prescription records must be retained in numerical order by prescription number.

7.3 FACSIMILE OR ELECTRONICALLY TRANSMITTED PRESCRIPTIONS

You may accept prescriptions that have been faxed or electronically transmitted if they meet all applicable laws, rules, and regulations. At the time of dispensing, you must print the facsimile or electronic record and subsequently file it with other hard-copy or scanned prescriptions. The facsimile or electronic prescription record must include the information required for hard-copy prescriptions as detailed above.

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CHAPTER 8

HOW WE AUDIT
YOU

8.1 OVERVIEW OF THE AUDIT PROCESS

All of the claims you submit to Medco are subject to audit. Medco's Pharmacy Audit Program helps to ensure that you are submitting and dispensing claims in accordance with the Manual and that you comply with program guidelines. The audit program also helps to protect against fraud, waste, and abuse.

Provider agrees that Medco's Pharmacy Audit Program is the final step in determining whether a prescription claim is entitled to reimbursement. Provider understands that it is obligated to provide specific documentation to be entitled to reimbursement for audit discrepancies. In the absence of such documentation, Provider understands it may not be entitled to reimbursement.

Provider will provide Medco, Sponsors, governmental agencies and departments, and/or their representatives or agents, during normal business hours, access to examine, audit, scan, and copy any and all records deemed by Medco, in Medco's sole discretion, necessary to determine compliance with the terms of Provider's Agreement with Medco, the *TelePAID*® System, and other Medco guidelines and requirements. Provider will, in addition to the above, provide Medco, within 30 calendar days of a request, all information requested by Medco to verify and/or substantiate Provider's compliance with Provider's Agreement with Medco. Every effort will be made to balance the burden on the Provider while balancing the need for further information.

Audits may take the form of a phone call, letter, on-site visit, or internal claims review. Provider acknowledges that HIPAA specifically permits a covered entity (i.e., a Provider) to disclose protected health information to a business associate or another covered entity for audit purposes. Specifically, as indicated in section 506(c)(4)(ii) of HIPAA, Provider must disclose protected health information to Medco "for the purpose of healthcare fraud and abuse detection or compliance."

8.2 ON-SITE AUDITS

8.2.1 Notice and Access

Medco will notify Provider, via first-class mail, in accordance with applicable rules and regulations, but no less than 14 calendar days prior to an on-site audit. However, if Medco suspects that Provider has engaged in fraudulent activities, Medco may conduct an on-site audit without advance notice. Should Provider refuse to allow the auditor to access the Provider or auditable prescription records, Medco reserves the right to recover the full amount paid or due to Provider for any claims subject to the audit, and may also terminate Provider for cause.

8.2.2 Scope

The auditor will generally review prescription records associated with claims paid to the Provider for the previous 12 to 18 months. Specific individual prescription numbers and/or masked lists of prescription files are not provided to the Provider prior to the start of the audit. We can provide you with the date and/or prescription number range so you can make the appropriate records available.

You must make available all prescriptions for the specified audit period. This includes prescriptions that are oral, telephone, and/or computer-generated, as well as prescriptions that are scanned and/or electronically transmitted (including faxed and e-prescribed prescriptions). Records must be readily accessible during Medco's audit. If records are maintained at a location other than the location being audited, you must retrieve them.

8.3 DESK AUDITS

Audits may take the form of a phone call or letter. For example, if there is a question and clarification is possible over the phone, then the question will be resolved as necessary based on the information provided. Auditing of Provider's records may also be conducted through the mail. Providers are frequently asked to furnish photocopies of specific documents in such cases.

Provider is to supply requested documentation within 30 calendar days of the request. In the event the requested documentation is not furnished within 30 days of the request, Medco is entitled to recover the full amount paid or due to Provider for the claim(s) in question.

Medco also performs a daily internal claims review. Claims that have been submitted with an improper quantity may be reversed and reprocessed with the correct quantity. When necessary, Medco will contact Provider for additional information.

8.4 GUIDELINES FOR EFFECTIVE AND EFFICIENT AUDITS

8.4.1 Records Required for Audit

During an on-site audit, you must make available all of the documents referenced in the Record Retention section of this Manual. There may be other documents required to address audit discrepancies. This additional documentation may help to establish that a prescription was valid and authorized at the time it was filled by Provider. Consideration of any additional documentation is within the sole discretion of Medco. Such additional information may include, but is not limited to, U&C pricing, dispensing patterns, or invoices.

Auditors are instructed to be fully aware of patient confidentiality practices in the pharmacy profession. Provider authorizes appropriate agencies (including, but not limited to, governmental authorities, third-party payers, Medco's agents, Sponsors, and other such entities) to release to Medco information deemed by Medco to be necessary to determine Provider's compliance with Provider's Agreement with Medco and other Medco guidelines and requirements.

Providers that maintain scanned prescriptions must provide Medco field auditors with free access to a terminal not being used for the Provider's day-to-day operations to review the scanned images associated with the prescriptions to be audited. The terminal must have the capability to focus and zoom the scanned image, as necessary. Provider agrees to print and provide Medco with copies of the scanned prescriptions associated with Covered Services dispensed. The system in use must clearly identify claims which have been reversed, returned to the patient or otherwise not dispensed, preferably by deleting the image from the record.

In the event an operator is assigned to assist the auditor with the review of the scanned prescriptions, such operator must be dedicated to the task and be available during the entire audit. In the event a scanned image is unavailable due to system failure or other reasons, the claim will be identified as a Prescription Not on File and be subject to audit recovery.

Provider must provide access to invoices during the audit. Medco may request that Provider provide authorization to the wholesaler, manufacturer, or distributor to release corresponding drug purchase summaries to Medco to facilitate the purchase verification process. Failure to provide sufficient invoices or authorization to obtain drug purchase summaries will cause the claim in question to be identified as Insufficient Invoice and be subject to audit recovery.

8.4.2 What to Expect During the Audit

Upon receiving notification of a scheduled audit, if any of the dates are inconvenient, Provider must contact the auditor identified in the letter, as soon as possible or within 3 business days of receipt of the letter, at 1 800 523-6389, extension 7292, to request a specific alternative appointment. Although we will make every effort to accommodate reasonable scheduling requests, the sooner we are contacted, the more likely we will be able to accommodate Provider's request. Audits will take place during normal business hours.

8.4 GUIDELINES FOR EFFECTIVE AND EFFICIENT AUDITS

(continued)

In most cases, the auditor can work independently and with minimal interaction with Provider until the conclusion of the on-site audit. The auditor does not need a large work area; however, an uncluttered area with a hard writing surface will allow the auditor to work more efficiently. Ideally, this area should not be located in a busy area, and should be located so as to allow the auditor to have easy access to the prescription records that are part of the review. However, the auditor should be able to observe the operation of the Provider. If the Provider has to work with the auditor, the Provider should ensure that there is sufficient staffing on the day of the audit so that the auditor can work effectively without waiting for information while the staff attends to other matters. If the Provider has to retrieve records required during the audit, Provider must allow the auditor the opportunity to observe the record retrieval process.

8.4.3 How to Make Your Audit More Efficient

To minimize your exposure during an audit, Provider should review and comply with the following guidelines and suggestions:

- **DAW Code Submission**

All claims must be submitted with the accurate DAW indicator in accordance with current NCPDP Standards. If the Eligible Person requests that a brand be dispensed, the claim must be submitted with a DAW 2 code, even if the Prescriber agrees to change the prescription to require that the brand drug be dispensed. In all cases, Provider must document the Eligible Person's request for the brand on the original prescription. Computer systems that default to DAW 1 or that cannot handle all DAW codes will result in discrepancies. Provider must document on all prescriptions (original, telephone, fax, or electronic) submitted for payment with DAW 1 (Prescriber DAW) at the time of dispensing that the Prescriber prevented substitution.

- **Coverage Exclusions**

Certain categories of Covered Services, such as investigational drugs and therapeutic devices, are typically excluded from coverage by Medco plans. In all cases, Provider should follow the messages received from the *TelePAID*[®] System when submitting claims to determine if the Covered Service is covered under the Eligible Person's plan. Refills dispensed more than one year from the date of the Prescriber's original order date are also excluded from coverage.

- **Paper Prescription**

The Provider must document as much information as possible on the paper prescription regarding the filling of the prescription at the time the prescription is dispensed, including, but not limited to, the patient's full name, address and telephone number. The patient's complete address and telephone number can be recorded as part of the Provider's patient profile computer system, so long as the system is accessible to the auditor. During the audit, it will be difficult to remember the circumstances regarding a particular prescription, so it is important to include as much detail as possible on the paper prescription. In addition, the notation on the prescription may eliminate a question or may even identify the audit discrepancy.

8.4 GUIDELINES FOR EFFECTIVE AND EFFICIENT AUDITS

(continued)

- **Return to Stock Discrepancies**

If Provider attempts to reverse a POS claim after the reversal window has closed, this rejected reversal transaction will be identified and Medco will recover the amount paid to Provider during a subsequent claims cycle. If Provider has reason to believe it initiated the reversal in error, Provider can forward to Medco's Pharmacy Services Help Desk a copy of the associated signature log confirming the patient received the medication billed. Medco will review this information and process an adjustment to Provider, when appropriate.

- **Provider Number**

Provider agrees to process all claims with the unique Medco provider identification number of the dispensing Provider. Prescription claims submitted with a Medco Provider number other than the number assigned by Medco to the dispensing Provider may be subject to full recovery or recovery of the dispensing fee.

- **NPI Number**

Provider agrees to process all claims with the accurate NPI number of the dispensing Provider. Prescription claims submitted without an NPI number or with an inaccurate NPI number may be subject to full recovery or recovery of the dispensing fee.

- **Compounds**

Provider must provide the auditor with copies of all formulas or recipes used to prepare compound prescriptions, especially where the ingredients are not listed by the Prescriber on the paper prescription. Medco reserves the right to validate pricing for all compound components with First DataBank, Medispan, Red Book, or other nationally recognized pricing sources.

- **Prescription Splitting**

Prescription splitting is a common discrepancy identified during the audit process. For this discrepancy, the Provider reduces the amount dispensed from the quantity authorized by the Prescriber and allowed under the applicable plan. As a result, the Eligible Person is caused to pay extra co-payments and Provider receives additional dispensing fees.

Prescription Example:

90 Procardia XL® 90 mg

1 tablet daily

2 refills authorized

Applicable plan maximum is a 90-day supply.

Under this example, the proper quantity to dispense is 90 tablets. Provider would be splitting the prescription if the quantity dispensed were reduced to a 30-day supply. Improper dispensing such as this would result in the Eligible Person paying two additional co-payments and the Provider receiving two extra dispensing fees.

8.4 GUIDELINES FOR EFFECTIVE AND EFFICIENT AUDITS

(continued)

Authorized refills cannot be combined with the initial quantity written by the Prescriber in order to increase the quantity of the medication dispensed.

Prescription Example:

30 Procardia XL® 90 mg

1 tablet daily

2 refills authorized

Applicable plan maximum is a 90-day supply.

The proper quantity to dispense in this example is 30 tablets.

8.5 REPORTING

Medco will, when it deems necessary, report its examination/audit findings to appropriate governmental bodies, claims processors and payers, regulatory agencies, professional review and audit reporting organizations, Sponsors, and other such entities.

8.6 AUDIT DISCREPANCIES

8.6.1 Discrepancy Determination

All audit discrepancies uncovered by Medco (including those resulting from mail or desk audits) will result in full or partial charge backs to Provider in the amount that Provider improperly received from Medco. Each audited Provider has the opportunity to review and respond to noted discrepancies.

8.6.2 Audit Charges

In the event any audit of Provider's records evidences any payments to Provider to which Provider was not entitled under Provider's Agreement with Medco, Medco may, in addition to any other remedies available to it or the Sponsors, withhold all funds at issue pending the final resolution of said payments and/or discrepancies pursuant to Provider's Agreement with Medco, subject to all applicable laws and regulations. If the unentitled payments are between ten thousand dollars (\$10,000) and nineteen thousand nine hundred ninety-nine dollars and ninety-nine cents (\$19,999.99), then Provider will be required to reimburse Medco ten percent (10%) of the audit recoupment. In addition, if the unentitled payments exceed twenty thousand dollars (\$20,000.00), then Provider will be required to reimburse Medco 25% of the audit recoupment.

Additionally, any Provider placed on probationary status or reinstated into the Medco participating Provider network will be required to pay Medco's reasonable audit costs related to such Provider's probation or reinstatement and a reinstatement fee set by Medco, as applicable.

8.6 AUDIT DISCREPANCIES

(continued)

8.6.3 Discrepancy Type Legend

In addition to this Pharmacy Services Manual, explanations of discrepancies, recovery amounts, and documentation required to address certain discrepancies may be found on the back of or included with each Discrepancy Evaluation Report.

Discrepancy Type	Discrepancy Description	Discrepancy Definition
CF	Prescription Not on File	There was no hard-copy prescription on file at the Provider that corresponded to the claim billed. Regeneration of hard copy prescriptions from electronically stored information at the time of the audit does not constitute hard copy.
CQ	Cut Quantity	The quantity dispensed by the Provider was reduced from the amount authorized by the Prescriber and allowed under the applicable Medco Plan.
DG	Dispensed Generic / Billed Brand	The Provider dispensed the generic medication to the patient while billing for the more expensive brand-name product.
DGR	Dispensed Greater Than Prescribed	The quantity dispensed exceeded the amount authorized by the Prescriber.
DUP	Duplicate Claim	The claim in question was billed more than once but only one fill was dispensed.
EPL	Exceeds Plan Limits	The quantity of medication dispensed by the Provider exceeded the amount allowed under the applicable Medco plan.
IDR	Invalid Prescriber	The physician identified as the Prescriber is ineligible to practice medicine and/or cannot prescribe due to sanctions and/or any other limitations or qualifications of the Prescriber, including but not limited to any (i) medications or (ii) certain medications or (iii) classes of medications.
IDS	Invalid Day's Supply/Tiered Copay	Based on the quantity dispensed and the prescribed daily dosage, the Provider submitted an inaccurate days' supply, resulting in an incorrect co-payment.
IDX	Invalid Diagnosis	An invalid diagnosis submitted for claim in question.
IPI	Inaccurate Prescriber Identifier Submitted	The Provider's electronic claims submission included a DEA, NPI, license number, or other Prescriber identifier that does not belong to the Prescriber.

8.6 AUDIT DISCREPANCIES

(continued)

Discrepancy Type	Discrepancy Description	Discrepancy Definition
IRX	Invalid Prescription	The prescription on file at Provider is not a valid prescription (i.e., prescription not signed by the Prescriber; filled/refilled outside of Federal, State or plan guidelines; information missing from the prescription; controlled substance prescription with an invalid or missing Prescriber's DEA number).
IMD	Ineligible Member/Dependent	The claim was billed for an individual who is not the eligible member, spouse, dependent child, or other dependent (i.e., full-time student, disabled dependent, dependent parent, significant other/dependent adult/domestic partner).
MCI	Prescriber Cannot Be Identified	Based on the information provided by the Provider, the Prescriber could not be identified. Proper identification of the Prescriber includes the Prescriber's first name or first initial, last name, telephone number, and address.
MCP	Prescriber Contests Authorizing Prescription	The Prescriber contests authorizing the prescription.
MS	Missing Signature	There was no signature log on file at the Provider corresponding to the claim billed.
NPC	Incorrect Provider Identifier	The unique Provider identifier submitted on the claim does not correspond to the dispensing Provider.
NRD	No Response to Desk Audit Request	The Provider did not provide the information requested pursuant to a desk audit.
NRR	No Record of Refill	The Provider had no record of a refill being dispensed on the date billed.
OBQ	Overbilled Quantity	The Provider submitted the claim with a metric quantity in excess of the quantity actually dispensed.
OC	Overpriced Compound	Overpriced Compounded Prescription.
OD	Overqualified Dispensing	The prescription as written by the Prescriber allowed for generic substitution; however, the Provider dispensed and billed for the brand-name medication.
OIC	Overbilled Ingredient Cost	The Provider submits the claim with inaccurate claims information, which results in an incorrect ingredient cost reimbursement to the Provider.
OTH	Other	Other discrepancy types.

8.6 AUDIT DISCREPANCIES

(continued)

Discrepancy Type	Discrepancy Description	Discrepancy Definition
PCR	Patient Contests Receipt	The patient contests receiving the prescription claim reimbursed under his member ID number.
PND	Patient Name Different	The first or last name of the patient identified on the prescription differs from the name under which the claim was billed.
POD	Package Size Overqualified Dispensing	The Provider submitted the claim with the NDC of a smaller package size than product ordered or dispensed or submitted and dispensed a package smaller when not mandated by the Prescriber and when the larger, appropriate package size was available in the marketplace.
ROY	Refill > 1 Year Old From Date Authorized	The Provider dispensed a refill more than 1 year from the date that the particular prescription was originally written or otherwise authorized.
RST	Return to Stock	All or part of the claim in question was not picked up by the patient and returned to the Provider's stock.
RTS	Refill Too Soon	A prescription is inappropriately refilled earlier than allowed under the applicable plan design. The Provider inappropriately utilizes the refill-too-soon override and/or does not properly document an appropriate reason for the early refill, or Provider submitted an understated days' supply.
SHR	Shared Prescription	Claim submitted for a quantity to be shared by two or more patients, instead of separate prescriptions for each patient. Other patients sharing the prescription order for the patient may or may not be covered persons.
UM	Unauthorized Mail Prescription	The Covered Service was not personally picked up by the patient or received through a local delivery service. This definition encompasses mail and other remote delivery carriers. Claim for a Covered Service was not authorized as a mail-service prescription.
UR	Unauthorized Refill	The Provider exceeded the Prescriber's refill authorization.
XDB	Incorrect Drug Billed	The medication billed by the Provider differs entirely from the medication identified on the Prescriber's prescription order.

8.6 AUDIT DISCREPANCIES

(continued)

8.6.4 Types of Discrepancies

There are certain types of audit discrepancies that can be addressed with specific documentation. These discrepancies include the following:

Discrepancy Type	Discrepancy Description	Recovery Amount	Documentation Required to Address Discrepancy
CF	Prescription Not on File	Net Amount Paid	Covering Original Prescription or Prescriber Statement
INV	Insufficient Invoice	Net Amount Paid	Invoice or Wholesaler Statement
IPI	Inaccurate Prescriber Identifier Submitted	Net Amount Paid	Covering Original Prescription or Prescriber Statement
MCI	Prescriber Cannot Be Identified	Net Amount Paid	Covering Original Prescription or Prescriber Statement
MCP	Prescriber Contests Authorizing Prescription	Net Amount Paid	Covering Original Prescription or Prescriber Statement
MS	Missing Signature	Net Amount Paid	Patient Statement
NRD	No Response to Desk Audit Request	Net Amount Paid	Pharmacy Provides Requested Document
NRR	No Record of Refill (noncomputerized pharmacy)	Net Amount Paid	Patient Statement
PCR	Patient Contests Receipt	Net Amount Paid	Patient Statement
RST	Return to Stock	Net Amount Paid	Corresponding Signature Log
UR	Unauthorized Refill	Net Amount Paid	Covering Original Prescription or Prescriber Statement

8.6 AUDIT DISCREPANCIES

(continued)

When providing documentation to address a discrepancy, Provider should adhere to the following guidelines:

- Photocopies of documentation are not acceptable. All information should be submitted via Certified Mail, Federal Express, UPS, or other certified carrier. Documentation submitted for review should be received by the finalization date indicated on the accompanying letter.
- All patient and Prescriber statements must: (1) include the address and telephone number of the patient or Prescriber, respectively; (2) clearly reference the medication(s), date(s) of service, and patient(s) in question; and (3) explain why the initial contact was contested. Statements from Prescriber must be on the Prescriber's own letterhead or covering prescription.
- A covering original prescription is a type of Prescriber statement and is an original piece of documentation obtained after the original prescription on file at the Provider was filled. This subsequent piece of information, written on a prescription pad, is obtained from the Prescriber who originally authorized the prescription at issue after the prescription has been filled, in order to verify that the prescription filled was authentic and authorized by that Prescriber.
- A covering original prescription is not the original prescription on file at the Provider, but rather, is documentation received subsequent to the original prescription on file in order to substantiate the original prescription on file at the Provider. A covering original prescription must be from the same Prescriber who allegedly authorized the prescription when it was first filled, and must: (1) include the complete address and telephone number of the Prescriber, and (2) clearly reference the medication(s) at issue, date(s) of service for each medication (which includes each and every refill), and patient(s) in question.

8.6 AUDIT DISCREPANCIES

(continued)

For other types of discrepancies, there is no specific piece of documentation that can address or offset the discrepancy. However, if Provider believes that any of these discrepancies have been identified in error, Provider should contact the in-house auditor assigned to the audit. These discrepancies include the following:

Discrepancy Type	Discrepancy Description	Recovery Amount
CQ	Cut Quantity	Excess Dispensing Fee
DG	Dispensed Generic / Billed Brand	Difference Between the Billed and Correct Ingredient Costs
DGR	Dispensed Greater Than Prescribed	Difference Between the Billed and Correct Ingredient Costs
DUP	Duplicate Claim	Net Amount Paid
EPL	Exceeds Plan Limits	Difference Between the Billed and Correct Ingredient Costs
IDR	Invalid Prescriber	Net Amount Paid
IDS	Invalid Day's Supply / Tiered Copay	Difference in Co-Payment Amounts
IDX	Invalid Diagnosis	Net Amount Paid
IRX	Invalid Prescription	Net Amount Paid
IMD	Ineligible Member / Dependent	Net Amount Paid
NPC	Incorrect Provider Identifier	Dispensing Fee or Net Amount Paid
NRR	No Record of Refill (Computerized Pharmacy)	Net Amount Paid
OBQ	Overbilled Quantity	Difference Between the Billed and Correct Ingredient Costs
OC	Overpriced Compound	Difference Between the Billed and Correct Ingredient Costs
OD	Overqualified Dispensing	Difference Between the Billed and Correct Ingredient Costs
OIC	Overbilled Ingredient Cost	Difference Between the Billed and Correct Ingredient Costs
OTH	Other	Net Amount Paid

8.6 AUDIT DISCREPANCIES

(continued)

Discrepancy Type	Discrepancy Description	Recovery Amount
PND	Patient Name Different	Net Amount Paid
POD	Package Size Overqualified Dispensing	Difference Between the Billed and Correct Ingredient Costs
ROY	Refill > 1 Year Old From Date Authorized	Net Amount Paid
RTS	Refill Too Soon	Net Amount Paid
SHR	Shared Prescription	Difference Between the Billed and Correct Ingredient Costs
UM	Unauthorized Mail Prescription	Net Amount Paid
XDB	Incorrect Drug Billed	Difference Between the Billed and Correct Ingredient Costs

8.7 DISPUTE RESOLUTION

Inquiries regarding audits may be submitted via mail, telephone, or e-mail to the following:

Medco
 Director, Pharmacy Audit Department
 MS E1-MS 1
 100 Parsons Pond Drive
 Franklin Lakes, NJ 07417
 PharmacyAudit@medco.com
 1 201 269-7292

8.8 POTENTIALLY FRAUDULENT PRESCRIPTION REFERRALS

According to government estimates, healthcare fraud may represent 5 percent of the healthcare dollar. Together, Medco and Provider can coordinate efforts to provide an effective prescription benefit while also helping to deter fraudulent claims. Provider will notify Medco if Provider has reason to believe potentially fraudulent prescriptions or inappropriate claims activity, such as the following, is occurring:

- An Eligible Person is presenting a prescription not written by the Prescriber identified.
- An Eligible Person is presenting a forged or altered prescription, calling in their own prescriptions, or may be over-utilizing prescriptions.
- Claim rejects based on a claim submitted by another Provider without explanation by Eligible Person.
- Medication is inconsistent with practice or specialty of Prescriber.

Fraudulent “original” prescriptions involve many types of medications (antibiotics, antifungals, antivirals, cardiac, cholesterol lowering, etc.), not just controlled substances. Medco has also seen an increase in the number of prescriptions (e.g., *Stadol*[®]) inappropriately telephoned to pharmacies by patients posing as Prescribers. Provider must know their patient and Prescriber. Provider should verify the prescription with the Prescriber and the identity of the patient before dispensing. Prescriptions not authorized by a Prescriber are not valid prescriptions and are subject to recovery from the Provider.

When information is identified, the information and associated documentation should be forwarded to the address below. Each referral should identify the Eligible Person (member ID number), Prescriber (DEA or NPI number, if possible), Provider (NCPDP, NPI, Medco Provider number) and the fraudulent prescriptions or inappropriate claims activity. Information regarding Eligible Persons, Pharmacies, and/or Prescribers can be forwarded to the Audit Department at the following address and telephone number:

Medco
Director, Pharmacy Audit Department
MS-E1-MS 1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417
1 201 269-7292

Medco reserves the right to suspend payment from Provider without notice under certain circumstances, such as receipt of reliable information or evidence of probable fraud.

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CHAPTER 9

FREQUENTLY
ASKED
QUESTIONS

Q: Can medications that require Prior Authorization be dispensed when Medco's Prior Authorization Desk is unavailable?

A: Medco does have a Temporary Coverage Policy. For such a circumstance, see Temporary Coverage Policy Section of this Manual for details.

Q: When I enroll in a specific Medco network, am I obligated to accept all programs for all Eligible Persons using that network?

A: When you sign a network pricing schedule, you are obligated to accept all programs for all Eligible Persons using the network in which you are enrolled. Termination from a network can be accomplished by writing to Medco, Network Management Department, 100 Parsons Pond Drive, Franklin Lakes, NJ 07417.

Q: Does the TelePAID® System support fractional quantities of ophthalmic products and metered dose inhalers?

A: Yes. Fractional quantities of medications must be sent through the TelePAID® System for proper claims adjudication. For example, the 3.5-g tube of Bacitracin Ophthalmic Ointment must be reported in the "Quantity Dispensed" field as 3.5, not 4.

Q: What is the MDD for *Imitrex*® 50 mg oral tablets?

A: The MDD for *Imitrex*® 50 mg oral tablets is considered to be 1.07 tablets per day. Stated another way: 32 tablets per 30 days; 96 tablets per 90 days.

Q: What days' supply should be used for *Premarin*® 0.625 mg, No. 75, Sig: One tablet daily for days 1 to 25?

A: The proper days' supply in this case is 90, not 75.

Q: What should I do if I don't receive my bi-weekly payment from Medco?

A: Call the Medco Pharmacy Services Help Desk at 1 800 922-1557.

Q: Whom do I call if I have a compounding or DUR question that only a pharmacist can answer?

A: Call the Medco Pharmacy Services Help Desk at 1 800 922-1557.

Q: How do I report the correct days' supply (DS) on a prescription for four tablets of a drug with the directions of 1 tablet per week?

A: The DS should be reported as 28 days.

Q: How do I contact Medco if I have a grievance regarding service Medco has provided?

A: You must submit your grievance in writing to:

Medco
Attn: Provider Grievances MS B3-1
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

GLOSSARY

Average Wholesale Price:

“AWP” as used herein means the current Average Wholesale Price as listed in print or electronically by First DataBank or other nationally recognized pricing source determined by Medco based on the package size dispensed. If First DataBank ceases publishing or replaces AWP, or Medco decides to use another recognized pricing source or pricing benchmark other than AWP, Medco will provide notice of such change(s).

Clean Claim:

A Clean Claim is a claim for payment for a healthcare service that has no defect or impropriety. A defect or impropriety shall include lack of required sustaining documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

Compounded Prescription:

A Compounded Prescription is a compound that consists of two or more solid, semi-solid, or liquid ingredients, one of which is a Federal Legend Drug that is weighed, measured, prepared, or mixed according to the prescription order. Reconstitution of an oral antibiotic or any other similar product is not considered a compound prescription. The addition of flavorings to a commercial product is also not considered a compound prescription.

Covered Services:

The providing of prescription drugs, services, over the counter (“OTC”) products and other medical products and services covered by Plan Sponsors.

Eligible Person:

An Eligible Person refers to a person who is enrolled with a Sponsor.

NCPDP Standard:

TelePAID® System claims are submitted to Medco in accord with the standard Version 5.1 or the then-current standard version as established by the:

National Council for Prescription Drug Programs, Inc.
9240 East Raintree Drive
Scottsdale, Arizona 85260
Phone Number: 1 480 477-1000
Fax Number: 1 480 767-1042

Plan Sponsor or Sponsor:

An entity such as an employer, health plan, managed Medicaid entity, Medicare Part D sponsor, or other entity that has contracted with Medco for prescription drug management services and/or workers compensation services.

Prescriber:

A licensed practitioner with the legal authority to initiate a prescription drug order in the course of professional practice for an Eligible Person. Prescribers generally refer to licensed physicians, podiatrists, and physician extenders but may include other practitioners as well. Coverage of prescription drugs and other medical products and services may vary by type of Prescriber, Plan Sponsors’ plan designs, and applicable state law.

Provider:

Provider and Pharmacy are used interchangeably in Manual and the Provider Agreement and Schedules. A Provider or Pharmacy is an entity licensed to dispense Covered Services and contracted with Medco to provide Covered Services.

GLOSSARY

(continued)

Secure Fax Number:

A Secure Fax Number is defined as a Provider fax number that is secure enough to receive confidential patient information and is not available to the general public nor to any nonprofessional Provider staff.

TelePAID® System:

TelePAID® is the online claims submission and processing system used for the adjudication of all Medco claims for Eligible Persons. *TelePAID*® System claims are submitted only for the Eligible Person for whom the prescription is intended.

Usual and Customary Price (“U&C”):

The lowest net cash price a cash patient or customer would have paid the day the prescription was dispensed, inclusive of all applicable discounts. For information about vaccines, see Section 2.19.

Zero Balance Logic (“ZBL”):

When Zero Balance Logic (ZBL) applies, the Provider will receive as reimbursement the lower of (1) Eligible Person’s co-payment or (2) the dispensing Provider’s U&C price.

SECTION 10

**REGULATORY
APPENDIX**

REGULATORY APPENDIX

Many states require that Providers comply with certain statutes and regulations when providing Covered Services to Eligible Persons in that state. The following Regulatory Appendix, which is attached hereto and made a part of this Pharmacy Services Manual, contains various regulations, requirements, and laws (“Requirements”) that may apply to the arrangement between Medco, Provider, and/or Sponsor and the provision of applicable Covered Services by Provider.

Generally, the Requirements are applicable to Covered Services for Sponsors that are insurance companies, HMO(s), and governmental agencies and are usually not applicable to Sponsors that have self-funded plans. Provider is required to comply with all applicable Requirements. By providing Covered Services to an individual subject to any of these Requirements, this Provider Agreement is modified as set forth in the applicable state-specific provision. In the event that there is a conflict between a provision in this Manual and a provision in the Regulatory Appendix, the provision in the Regulatory Appendix shall control. This Regulatory Appendix may be amended to reflect any changes to the applicable law(s).

ALABAMA REQUIREMENTS

1. Any provision of this Manual that is in conflict with the requirements of Alabama Code 1975 § 27-21A-3 is unenforceable.
2. Provider hereby agrees that in no event, including but not limited to, nonpayment, Medco insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person, or persons other than Medco acting on behalf of the Eligible Person for services provided pursuant to this Agreement. This provision shall not prohibit collection of copayments, deductibles, and coinsurances on Medco's behalf made in accordance with the terms of the Agreement between Medco and Plan Sponsors.
3. Provider further agrees that (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Medco's subscriber, and that (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and an Eligible Person, or persons on his or her behalf.
4. Provider may not change, amend, or waive any provision of this Agreement without prior written consent of Medco. Any attempts to change, amend, or waive this Agreement are void.

ALASKA REQUIREMENTS

1. In the event of a dispute between Provider and Medco, a fair, prompt, and mutual dispute resolution process shall be used consisting of the following:
 - 1.1. The parties shall hold an initial meeting at which Provider and Medco are present or represented by individuals with authority regarding the matters in dispute; the meeting shall be held within 10 working days after Medco receives written notice of the dispute or gives written notice to Provider, unless the parties otherwise agree in writing to a different schedule;
 - 1.2. If, within 30 days following the initial meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to the parties and who is not regularly under contract to or employed by either of the parties; each party shall bear its proportionate share of the cost of mediation, including the mediator fees;
 - 1.3. If, after a period of 60 days following commencement of mediation, the parties are unable to resolve the dispute, either party may seek other relief allowed by law.
 - 1.4. The parties agree to negotiate in good faith at the initial meeting and in mediation.
2. Provider shall not be penalized or Provider's Agreement terminated by Medco because the Provider acts as an advocate for an Eligible Person in seeking appropriate, medically necessary healthcare services;
3. Pharmacy shall be free to communicate openly with a covered person about all appropriate diagnostic testing and treatment options; and
4. In the event the Provider Agreement is terminated, Provider shall continue to provide Pharmacy Services to Eligible Persons who are pregnant or being actively treated by Provider on the date of termination of the Pharmacy Agreement, and the Pharmacy Agreement shall remain in force with respect to the continuing treatment. The Eligible Person shall be treated for the purposes of benefit determination or claim payment as if Pharmacy was still under contract with Medco. However, treatment is required to continue only while the applicable Plan remains in effect and: (1) for the period that is the longest of (A) the end of the current plan year; (B) up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment; or (C) through completion of postpartum care, if the Eligible Person is pregnant on the date of termination; or (2) until the end of the medically necessary treatment for the condition, disease, illness, or injury if the person has a terminal condition, disease, illness, or injury; in this paragraph, "terminal" means a life expectancy of less than one year. The requirements of this section do not apply to medical care services covered by Medicaid.
5. Discretionary termination by either party must apply equitably to both parties.

ARIZONA REQUIREMENTS

1. Provider will provide services to Eligible Persons at the same rates and subject to the same terms and conditions established in this Agreement for the duration of the period after Sponsor is declared insolvent, until the earliest of the following:
 - A. The duration of the agreed-upon period under the Eligible Person's healthcare plan or for 60 days from the date insolvency is declared, whichever is longer.
 - B. A notification from Sponsor or Medco or a determination by the court that Sponsor cannot provide adequate assurance it will be able to pay Provider's claims for Covered Services that were rendered after Sponsor is declared insolvent.
 - C. A determination by the court that Sponsor is unable to pay Provider claims for Covered Services that were rendered after Sponsor is declared insolvent.
 - D. A determination by the court that continuation of this Agreement would constitute undue hardship to the Provider.
 - E. A determination by the court that Sponsor has satisfied its obligations to all Eligible Persons under its healthcare plans.

ARKANSAS REQUIREMENTS

In the event that Medco fails to pay for health care services as set forth in this Agreement, the Eligible Person shall not be liable to the Provider for any sums owed by Medco.

CALIFORNIA REQUIREMENTS

1. If requested to do so, Provider shall continue to provide Covered Services to Eligible Persons with special circumstances following termination of this Agreement for any reason, other than quality of care or fraud, until alternate arrangements for such care can be made by Medco or Sponsor. This provision shall survive termination of this Agreement.
2. Provider shall display in a prominent place a notice informing Eligible Persons how to contact Sponsor, file a complaint with Sponsor, obtain assistance from the Department, and seek an independent medical review.
 - 2.1. The notice shall be displayed in English and in any individually identifiable language that is spoken in the home by ten percent (10%) or more of the households in the U.S. Postal Service ZIP code in which the reception or waiting area is located, according to the US Census Bureau's Census 2000 Summary File 3, Quick Table–P16 for the appropriate ZIP code, which is incorporated by reference.
 - 2.2. The notice shall be in a form prescribed, provided and translated by the Department for posting.
 - 2.3. The notice and translations can be found at www.dmhc.ca.gov and are available for downloading and printing. In the alternative, hard copies of the notice and translations may be obtained by submitting a written request to the Department of Managed Health Care, Attn: Waiting Room Notices, 980–9th Street, Suite 500, Sacramento, CA 95814.
3. Provider shall comply with all applicable laws, regulations, and Medco policies pertaining to language assistance for all Eligible Person encounters whether in person, in writing or on the telephone.
4. Provider will have 45 days to approve material changes to the Manual. Provider should assume that every new version of the Manual contains material changes. If Provider does not contact Medco in writing, Provider will have been deemed to accept changes to the Manual. This section does not apply to changes made as a result of a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization that requires a shorter time frame for compliance.
5. Provider will have fifteen (15) days' advance notice prior to changes in a Sponsor's quality improvement or utilization management programs or procedures of Sponsor or Medco. This section does not apply to changes if the change is necessary to comply with a state or federal law or regulation or any accreditation requirements of a private sector accreditation organization.

COLORADO REQUIREMENTS

1. Provider shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of HMO.
2. This Agreement shall not be terminated by Medco because Provider expresses disagreement with HMO's decision to deny or limit benefits to an Eligible Person or because a Provider discusses with a current, former, or prospective Eligible Person any aspect of such Person's medical condition, any proposed treatments or treatment alternatives, whether covered by the HMO or not, policy provisions of HMO, or Provider's personal recommendations regarding selection of an HMO based on the Provider's personal knowledge of the health needs of such Persons.
3. In the event that this Agreement is terminated by Medco without cause and Medco has not provided 60 days' prior written notice to Eligible Persons of this termination, Provider shall continue to provide Covered Services to Eligible Persons for 60 days after termination of this Agreement.
4. A material change to a contract shall occur only if Medco provides in writing to Provider the proposed change and gives ninety (90) days' notice before the effective date of the change. The writing shall be conspicuously entitled "notice of material change to contract." Provider may object in writing to the material change within fifteen (15) days and has the right to terminate the contract upon written notice of termination provided to Medco not later than sixty (60) days before the effective date of the material change. If Provider does not object, the change will become effective.
5. If a material change is the addition of a new category of coverage and the health care provider objects, the addition shall not be effective as to the health care provider, and the objection shall not be a basis upon which the person or entity may terminate the contract.
6. Notwithstanding the above, the Agreement may be modified by operation of law as required by any applicable state or federal law or regulation, and Medco may disclose this change by any reasonable means.
7. Provider can decline to provide services to new Eligible Persons upon sixty (60) days' notice. The Provider's notice shall state the reason or reasons for this action. For the purposes of this subsection (7), "new Eligible Persons" means those patients who have not received services from the Provider in the immediately preceding three (3) years. An Eligible Person shall not become a "new Eligible Person" solely by changing coverage from one Plan Sponsor to another Plan Sponsor.
8. The Agreement between a Provider and Medco shall be terminated if a federal law enforcement agency ceases the operations of the pharmacist or pharmacy due to alleged or actual criminal activity.
9. Medco and Provider shall provide at least sixty (60) days' written notice to each other before terminating the Agreement without cause. The carrier shall make a good faith effort to provide written notice of termination within fifteen (15) working days after receipt of or issuance of a notice of termination to all Eligible Persons that are patients seen on a regular basis by the Provider whose contract is terminating, regardless of whether the termination was for or without cause.
10. Medco shall not penalize a Provider because a participating Provider, in good faith, reports to state or federal authorities any act or practice by Medco or Sponsor that jeopardizes patient health or welfare, or because the participating Provider discusses the financial incentives or financial arrangements between the Provider and the managed care plan.

CONNECTICUT REQUIREMENTS

1. Provider and Medco must both provide at least sixty (60) days' advance written notice to terminate the Agreement. The notice provision shall not apply: (1) when lack of such notice is necessary for the health or safety of the Eligible Persons, (2) when Provider has entered into a contract with Medco that is found to be based on fraud or material misrepresentation; or (3) when Provider engages in any fraudulent activity related to the terms of the Agreement with Medco.
2. No managed care organization shall take or threaten to take any action against any Provider in retaliation for such Provider's assistance to an enrollee under the provisions of subsection (e) of section 38a-226c or section 38a-478n.

DELAWARE REQUIREMENTS

1. Except in cases where termination was due to unsafe healthcare practices that compromise the health or safety of Eligible Persons, Medco agrees to assure continued coverage of services at the contract price by a terminated Provider for up to 120 calendar days in cases where it is medically necessary for the Eligible Person to continue treatment with the terminated Provider. In cases of the pregnancy of an Eligible Person, medical necessity shall be deemed to have been demonstrated and coverage shall continue to completion of postpartum care.
2. Provider agrees that in no event, including but not limited to nonpayment by Medco or Sponsor, insolvency of Medco or Sponsor, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person or a person (other than Medco or Sponsor) acting on behalf of the Eligible Person for services provided pursuant to this Agreement. This Agreement does not prohibit the Provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Eligible Persons.
3. In the event of Medco's insolvency or other cessation of operations, Provider agrees to provide Covered Services to Eligible Persons through the period for which a premium has been paid to Sponsor on behalf of an Eligible Person or until an Eligible Person's discharge from an inpatient facility, whichever time is greater. Provider agrees to provide Covered Services to Eligible Persons confined in an inpatient facility on the date of insolvency or other cessation of operations until their continued confinement in an inpatient facility is no longer medically necessary.
4. These contract provisions shall be construed in favor of the Eligible Person, shall survive the termination of the Provider Agreement regardless of the reason for termination, including the insolvency of Medco or Sponsor, and shall supersede any oral or written contrary agreement between Provider and an Eligible Person or his or her representative to the extent that such agreement is inconsistent with this section.

FLORIDA REQUIREMENTS

HMO

1. Provider must give sixty (60) days' advance written notice to Medco and the Florida Department of Insurance before canceling the contract with Medco for any reason.
2. Nonpayment for goods or services rendered by the Provider to Medco is not a valid reason for avoiding the 60-day advance notice of cancellation.
3. Medco will provide sixty (60) days' advance written notice to the Pharmacy and the Florida Department of Insurance before canceling, without cause, this Agreement, except in a case in which an Eligible Person's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.
4. Upon receipt by Medco of a 60-day cancellation notice, Medco may, if requested by the Provider, terminate this Agreement in less than sixty (60) days if Medco is not financially impaired or insolvent.
5. In the event this Agreement is terminated for any reason other than for cause, Provider shall continue to provide services to Eligible Persons undergoing active treatment when medically necessary, through completion of treatment of the condition for which the Eligible Person was receiving care at the time of the termination, until the Eligible Person selects another treating Pharmacy, or during the next open enrollment period offered by Sponsor, whichever is longer, but not longer than 6 months after termination of this Agreement. Provider shall continue to provide services to an Eligible Person who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, until completion of postpartum care. This provision does not prevent Provider from refusing to continue to provide care to an Eligible Person who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this provision, Provider shall continue to be bound by the terms of the Agreement. Changes made within 30 days before termination of this Agreement are effective only if agreed to by both parties.
6. Pharmacy shall comply with all applicable aspects of the Hernandez Settlement Agreement ("HSA"). An HSA situation arises when an Eligible Person who is a Medicaid recipient attempts to fill a prescription at a participating pharmacy location and is unable to receive his/her prescription as a result of:
 - (1) An unreasonable delay in filling the prescription;
 - (2) A denial of the prescription;
 - (3) The reduction of a prescribed good or service; and/or
 - (4) The termination of a prescription
7. Pharmacy shall post signs in both English and Spanish in a conspicuous location advising Eligible Persons who are Medicaid recipients that if reimbursement for Covered Drugs is initially rejected, Pharmacy shall provide written information, including pamphlets in English and Spanish, that will inform them the reason the claim reimbursement was rejected and what the Eligible Person can do about it.
8. Pharmacy shall provide notice to Eligible Persons who are Medicaid recipients whose claim reimbursement is rejected. Notice shall consist of either a printed copy of the computer screen stating the reason for rejection or by writing the reason for claim reimbursement rejection and the date of rejection on the pamphlet, required in Section 1 above, which will be given to the Eligible Person.

FLORIDA REQUIREMENTS

(continued)

9. Pharmacy that fails any aspect of the HSA survey agrees to undergo mandatory training within six (6) months and then be reevaluated within one (1) month of the HSA training to ensure that Pharmacy is in compliance with the HSA.
10. This Agreement shall be canceled upon issuance of an order by the Office of Insurance Regulations pursuant to this section.
11. Consumer Assistance Notice. In compliance with Florida law, Pharmacy shall post a prominently displayed and clearly noticeable consumer assistance notice in Pharmacy's reception area which states the addresses and toll-free telephone numbers of the Florida Agency for Health Care Administration ("AHCA"), the Subscriber Assistance Program ("SAP"), and the Florida Department of Financial Services/Office of Insurance Regulation ("OIR") and states that the address and toll-free number of Medco's grievance department shall be provided upon request. An example notice is attached as Consumer Assistance Notice Appendix.

GEORGIA REQUIREMENTS

1. An Eligible Person shall be held harmless for provider utilization review decisions over which he or she has no control.

HAWAII REQUIREMENTS

1. Provider shall not be prohibited from discussing treatment or nontreatment options with Eligible Persons that may not reflect Sponsor's position or may not be covered by Sponsor.
2. Provider shall not be prohibited, or otherwise restricted, from acting within the lawful scope of practice, from advising or advocating on behalf of an Eligible Person for the Eligible Person's health status, medical care, or treatment or nontreatment options, including any alternative treatments that might be self-administered.
3. Provider shall not be prohibited, or otherwise restricted, from advocating on behalf of the Eligible Person to obtain necessary healthcare services in any grievance system or utilization review process, or individual authorization process.
4. Provider shall provide for continuity of treatment in the event a Provider's participation terminates during the course of a member's treatment by that Provider.
5. Provider will comply with Sponsor's cultural competency plan.
6. Provider shall seek prior approval from the Department of Human Services – Med-QUEST Division for any marketing materials developed and distributed by Provider relating to the programs. Materials shall be forwarded to Sponsor for submission to the Department of Human Services – Med-QUEST Division for review and approval prior to distribution.
7. Sponsor and the Department of Human Services – Med-QUEST Division, or their respective designee, will have the right to inspect, evaluate, and audit any pertinent books, financial records, medical records, documents, papers, and records of the Provider involving financial transactions related to this Agreement and for the monitoring of quality of care being rendered with/without the specific consent of the member. Provider shall provide medical records or access to medical records by Sponsor and the Department of Human Services – Med-QUEST Division, or its designee, within sixty (60) days of a request. Refusal to provide medical records or access to medical records or inability to produce the medical records to support the claim/encounter shall result in recovery of payment.
8. Provider certifies that all Billing Form data submitted shall be accurate and complete.
9. To the extent that Provider's Agreement allows notice of termination of fewer than sixty (60) days, Provider will give at least 60 days' advance notice of termination of a Schedule or the Agreement.

IDAHO REQUIREMENTS

1. Medco shall not refuse to contract with or compensate for covered services an otherwise eligible Provider solely because the Provider has in good faith communicated with one (1) or more current, former, or prospective Eligible Person(s) regarding the provisions, terms or requirements of the organization's products as they relate to the needs of the Provider's patients.
2. Medco will not terminate a Provider practicing in conformity with community standards for advocating for an Eligible Person based solely on the advocacy.

ILLINOIS REQUIREMENTS

1. Provider shall provide at least sixty (60) days' notice for termination with cause, and at least ninety (90) days' notice for termination without cause. Upon receipt of such notice, Medco shall notify Eligible Persons within thirty (30) days after the termination and the proper steps to be taken for selecting a new Provider. In the event the Provider violates the agreement and does not give a notice of termination in the appropriate timeframe, Medco must provide immediate notice to the Eligible Persons.
2. Medco must give at least sixty (60) days' notice of nonrenewal or termination of a Provider to the Pharmacy and to the Eligible Persons served by the Provider. The notice shall include a name and address to which an Eligible Persons or Provider may direct comments and concerns regarding the nonrenewal or termination. Immediate written notice may be provided without sixty (60) days' notice when a Provider's license has been disciplined by a State licensing board. The notice shall inform the Eligible Persons of the availability of transitional services and that the Eligible Persons must request transitional services within thirty (30) days from receipt of this notice.
3. Provider will give at least fifteen (15) days' advance notice to Medco of cancellation of Provider's professional liability insurance.

INDIANA REQUIREMENTS

1. Provider, at the request of Medco, will continue to treat an Eligible Person for up to sixty (60) days following the termination of Provider's Agreement with Medco. In the case of an Eligible Person in her third trimester of pregnancy, Provider will continue to treat the Eligible Person throughout the term of the pregnancy. The Eligible Person will not be liable to the Provider for any amounts owed for Covered Services other than any deductibles or co-payment amounts specified in the certificate of coverage or other contract between Eligible Person and Sponsor. In the event the terminated Provider is authorized to continue to treat the Eligible Person, Provider shall continue to be paid at the previously contracted rate and terms for services provided to the Eligible Person.

IOWA REQUIREMENTS

1. Provider shall not be penalized for discussing treatment options with Eligible Persons, irrespective of Sponsor's position on the treatment options, or from advocating on behalf of Eligible Persons within the utilization review or grievance processes established by Sponsor or a person contracting with Sponsor.
2. Medco shall not penalize Provider because Provider, in good faith, reports to State or Federal authorities any act or practice by Sponsor that, in the opinion of the Provider, jeopardizes Eligible Person's health or welfare.
3. Termination of contract shall require no less than sixty (60) days' prior written notice by either party who wishes to terminate the contract.

KANSAS REQUIREMENTS

HMO

1. If there is Medicaid coverage for Pharmacy Services provided to Eligible Persons, the Medicaid coverage shall be the source of last resort of any payment to Provider.
2. In the event of insolvency of Medco or Sponsor, Provider shall continue to provide Covered Services to Eligible Persons for the duration of the period after Medco or Sponsor's insolvency for which premium payment has been made.
3. In the event Provider's participation in the plan is terminated for any reason, care to Eligible Persons shall continue for a period up to ninety (90) days by a Provider who is terminated from a network in those cases where the continuation of such care is medically necessary and in accordance with the dictates of medical prudence and where the Eligible Person has special circumstances such as a disability, a life-threatening illness, or is in the third trimester of pregnancy. The Eligible Person will not be liable to the Provider for any amounts owed for Covered Services other than any deductibles or co-payment amounts specified in the certificate of coverage or other contract between the Eligible Person and Sponsor. In the event the terminated Provider is authorized to continue treating the Eligible Person, Provider shall continue to be paid at the previously contracted rate and terms for services provided to the Eligible Person.
4. Medco and Sponsor shall not prohibit or restrict any Provider from discussing with or disclosing to any Eligible Person any medically appropriate health care information that such Provider deems appropriate regarding the nature of treatment options, the risks or alternatives thereto, the process used or the decision made by Sponsor to approve or deny health care services, the availability of alternate therapies, consultations, or tests, or from advocating on behalf of the Eligible Person the utilization review or grievance processes established by Sponsor.

KENTUCKY REQUIREMENTS

1. If requested to do so, Provider shall continue to provide Covered Services to Eligible Persons with special circumstances following termination of this Agreement for any reason, other than quality of care or fraud, until alternate arrangements for such care can be made by Medco or Sponsor. This provision shall survive termination of this Agreement.
2. If Provider enters into any subcontract agreement with another Provider to provide their services to the Eligible Persons, or dependent of the Eligible Persons, where the subcontracted Provider will bill Medco or Eligible Persons directly for the subcontracted services, the subcontract agreement must meet all requirements of applicable Kentucky law. All such subcontract agreements shall be filed with the commissioner.
3. Provider shall not be penalized, or this Agreement terminated, because Provider discusses medically necessary or appropriate care with an Eligible Person or another person on behalf of an Eligible Person.
4. Provider may not be prohibited by Medco or Sponsor from discussing all treatment options with the Eligible Person.
5. Other information determined by Provider to be in the best interests of the Eligible Person may be disclosed by Provider to the Eligible Persons or to another person on behalf of an Eligible Person.
6. Provider shall not be penalized for discussing financial incentives and financial arrangements between Provider and Medco with an Eligible Person.

LOUISIANA REQUIREMENTS

Medco Health LLC processes insured claims in the State of Louisiana.

1. Provider participating in Louisiana can submit prescription claims for reimbursement for a period of 1 (one) year from the claim's date of service.

MAINE REQUIREMENTS

1. In the case of Medco's insolvency, the Agreement and relevant Schedules may be assigned to Sponsors utilizing the schedules.
2. In the event of insolvency of Medco or Sponsor, Provider shall continue to provide Covered Services to Eligible Persons for the duration of the period after Medco or Sponsor's insolvency for which premium payment has been made for an Eligible Person.
3. After the initial six month period of participation by the Provider, Provider may terminate the Agreement upon ninety (90) days' notice.

MARYLAND REQUIREMENTS

1. Provider shall not differentiate nor discriminate in the treatment of Eligible Persons as to the quality of services rendered on the basis of membership with Medco, source or amount of payment, race, sex, age, color, religion, national origin, handicap, or health status. The rights of Eligible Persons shall be observed, protected, and promoted. Prescription services shall be rendered to Eligible Persons in the same manner, in accordance with the same standard, and with the same time availability as offered to all other patients of Provider.
2. Provider agrees that in no event, including, but not limited to, nonpayment by Medco, Medco's insolvency, or breach of this Agreement, shall Provider, or its subcontractors, bill, charge, or collect a deposit from, seek compensation, remuneration, reimbursement, or payment from, or have recourse against, Eligible Persons for Covered Services, where applicable. Provider further agrees that this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination, and shall be construed to be for the benefit of the applicable Eligible Person.
3. If Medco terminates its agreement with Provider, Medco shall notify Provider at least 90 days before the date of termination if the termination is for a reason unrelated to fraud, patient abuse, incompetency or loss of licensure status.
4. If Provider terminates its agreement with Medco, Provider shall continue for at least 90 days after the date of notice of termination to furnish Covered Services to Eligible Persons for whom the Provider was responsible for the delivery of Covered Services before notice of termination.
5. Provider will submit *TelePAID*[®] Systems claims within 180 days of the date of service. After 90 days, please contact Medco Pharmacy Services Help Desk.
6. This Agreement, and all matters or disputes relating hereto, shall be governed by the laws of the State of Maryland without regard to choice of law provisions.
7. This Maryland Requirements page shall control to the extent of any inconsistency between this Maryland Requirements page and any other provision in this Pharmacy Services Manual.
8. For Coventry Health Care of Delaware, Inc. – products licensed by the State of Maryland, the following definition of experimental services applies:

Experimental Services (including Experimental Drugs): Services or drugs that are not recognized as efficacious as that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. “Experimental Services” do not include Controlled Clinical Trials.
9. Providers have 90 working days after receiving a denial of a claim to appeal that denial. Appeals should be sent to the address set out on page i of the Manual.
10. Medco may only retroactively deny reimbursement during the 6-month period after the date that Medco paid Provider except as provided in the audit section of the Manual for fraudulently and improperly submitted claims. When Medco retroactively denies reimbursement to a health care provider, Medco shall be required to provide the health care provider with a written statement specifying the basis for the retroactive denial. If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denial claim.

MARYLAND REQUIREMENTS

(continued)

11. Amendments to the Agreement will become effective at the earlier of 30 days after notice, or upon the Provider's acceptance of the terms.
12. Medco will not schedule an onsite audit to begin during the first five (5) calendar days of a month unless request by the pharmacy.
13. Medco will not recoup any setoff of any moneys for an overpayment or a denial of a claim until 30 working days after the date the final audit report has been delivered to Provider. Medco shall remit any money due to a Provider as a result of an underpayment of a claim within 30 working days after the final audit report has been delivered to Provider. Notwithstanding the preceding sentences, Medco may withhold future payments before the date the final audit report has been delivered to the Provider if the identified discrepancies for all disputed claims in the preliminary report for an individual audit exceed \$25,000 or the Provider is suspected of fraud.
14. If a health care service for a patient has been preauthorized or approved by Medco or the insurer, the insurer may not deny reimbursement to a health care provider for preauthorized or approval service delivered to that patient unless:
 - 1) The information submitted to the insurer regarding the services to be delivered to the patient was fraudulent or intentionally misrepresentative;
 - 2) Critical information requested by the insurer regarding the service to be delivered to the patient was omitted such that the insurer's determination would have been different had it known the critical information;
 - 3) A planned course of treatment for the patient that was approved by the insurer was not substantially followed by the health care provider; or
 - 4) On the date the preauthorized or approved service was delivered:
 - I. The patient was not covered by the insurer
 - II. The insurer maintained an automated eligibility verification system that was available to the contracting provider by telephone or via the Internet; and
 - III. According to the verification system, the patient was not covered by the insurer.

MASSACHUSETTS REQUIREMENTS

1. If requested to do so, Provider shall continue to provide Covered Services to Eligible Persons with special circumstances following termination of this Agreement for any reason, other than quality of care or fraud, until alternate arrangements for such care can be made by Medco or Sponsor. This provision shall survive termination of this Agreement.
2. Neither party to this Agreement may terminate the Agreement without cause. Prior to termination of this Agreement by Medco for cause, Medco shall provide Provider with written notice of the reason(s) for termination.
3. Medco and Sponsor shall not terminate this Agreement or withhold compensation due to Provider for Covered Services solely because Provider has in good faith communicated with or advocated on behalf of one or more of Provider's prospective, current, or former patients regarding the provision, terms, or requirements of Sponsor's health benefit plans as they relate to the needs of such patients or regarding the method by which Provider is compensated for services provided under this Agreement. Nothing herein shall be construed to allow Provider to disclose confidential specific compensation terms of its Agreement and Schedules with Medco.
4. Provider is not required to indemnify Medco or Sponsor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges, incurred in connection with any claim or action brought against Medco or Sponsor based on Medco or Sponsor's management decisions, utilization review provisions, or other policies, guidelines, or actions.
5. This Agreement may not contain any incentive plan that includes a specific payment made to a Provider as an inducement to reduce, delay, or limit specific, medically necessary services covered by the healthcare contract.
 - a. Provider shall not profit from provisions of covered services that are not medically necessary or medically appropriate.
 - b. Medco or Sponsor shall not profit from denial or withholding of Covered Services that are medically necessary or medically appropriate.
6. Medco shall notify Provider in writing of modifications in payments, modifications in Covered Services, or modification in procedures, documents, or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of Provider and the effective date of the modifications. The notice shall be provided sixty (60) days before the effective date of such modification unless such other date for notice is mutually agreed upon between Medco and Provider.
7. Provider shall not bill Eligible Persons for nonpayment by Medco or Sponsor amounts owed under the contract due to insolvency. This requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.
8. Utilization review is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures, or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

MASSACHUSETTS REQUIREMENTS

(continued)

9. Provider shall not be denied participation or refused compensation for Covered Services solely because such Provider has in good faith:
 - 9.1. Communicated with or advocated on behalf of one or more of his prospective, current, or former patients regarding the provisions, terms, or requirements of Medco or Sponsor's health benefit plans as they relate to the needs of Provider's patients; or
 - 9.2. Communicated with one or more of his prospective, current, or former patients with respect to the method by which Provider is compensated by Medco for services provided to the patient.
10. Pharmacies shall comply with Medco's requirements for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services.
11. Provider agrees that in no event, including but not limited to nonpayment by Medco or Sponsor of amounts due Provider under this Agreement, insolvency of Medco or Sponsor, or any breach of this Agreement by Medco or Sponsor, shall Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, an Eligible Person or persons acting on behalf of an Eligible Person other than Medco, the Sponsor, the employer or the group health maintenance contract holder for services provided pursuant to this contract except for the payment of applicable co-payment, co-insurance or deductibles for services covered by Sponsor. The requirements of this provision shall survive any termination of this contract for services rendered prior to the termination, regardless of the cause of such termination. Sponsors, Eligible Persons, or any person acting on the Eligible Person's behalf, other than the health maintenance organization, and the employer or group health maintenance contract-holder shall be third-party beneficiaries of this clause. This provision supersedes any oral or written agreement hereafter entered into between Provider and an Eligible Person or persons acting on the member's behalf, other than the health maintenance organization, and the employer or group health maintenance contract holder.
12. Provider is not required to indemnify Medco or Sponsors for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against Sponsor based on the Sponsor's management decisions, utilization review provisions or other policies, guidelines or actions.
13. Medco will provide a written statement to Provider of the reason or reasons for such Provider's involuntary disenrollment.

MICHIGAN REQUIREMENTS

1. Reimbursement.

Provider agrees to look solely to HMO for payment for pharmacy services provided to HMO Eligible Persons except to the extent the collection of co-payment may be required.

2. Utilization Management, Quality Improvement, and Other HMO or Medco Programs.

Provider shall cooperate with all credentialing and recredentialing processes and all utilization management, quality improvement, peer review, member grievance, on-site review, or other similar programs that Medco or HMO may have in place.

3. Member Protection Provision.

This provision supersedes and replaces all other payment provisions when an HMO is the payer, when required by a specific payer other than an HMO, or when required pursuant to applicable statutes and regulations:

In no event, including but not limited to, nonpayment by payer, including HMO, for Provider services rendered to Eligible Persons by Provider, insolvency of Medco or HMO, or breach by HMO or Medco of any term or condition of their agreements, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against any Eligible Person or persons acting on behalf of the Eligible Person for Provider services eligible for reimbursement under the agreement; provided, however, that Provider may collect from the Eligible Person expenses or charges for services not covered under the Eligible Person's benefit contract.

Provider agrees not to maintain any action at law or in equity against an Eligible Person to collect sums that are owed to Provider for Provider services, even in the event that the HMO or Medco fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this agreement.

The provisions of this section shall (1) apply to all pharmacy services rendered while this agreement is in force; (2) with respect to pharmacy services rendered while this agreement is in force, survive the termination of this agreement regardless of the cause of termination; (3) be construed to be for the benefit of the Eligible Persons; and (4) supersede any oral or written agreement, existing or subsequently entered into, between Pharmacy and an Eligible Person or person acting on an Eligible Person's behalf, that requires the Eligible Person to pay for such pharmacy services.

4. Laws, Regulations, and Licenses.

Provider shall maintain all Federal, State, and local licenses, certifications, and permits, without material restriction, that are required to provide healthcare services according to the laws of the jurisdiction in which pharmacy services are provided, and shall comply with all applicable statutes and regulations. Provider shall also require that all healthcare professionals employed by or under contract with Provider to render pharmacy services to Eligible Persons comply with this provision.

5. Government and Accrediting Agency Access to Records.

Provider agrees that the Federal, State, and local government, or accrediting agencies, including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall to the extent permitted and/or required by law have immediate and complete access to, and Provider shall release, all information and records or copies of such within the possession of Provider, Medco, or HMO that are pertinent to Eligible Persons if such access is necessary to comply with accreditation standards, statutes, or regulations applicable to HMO or Medco.

MINNESOTA REQUIREMENTS

1. If Provider's Agreement allows for less than 120 days' advance written notice of termination, and Provider terminates this Agreement without cause, Provider shall give Medco 120 days' advance notice of termination.
2. Any amendment or change in the terms of this Agreement must be disclosed to Provider at least forty-five (45) days prior to the effective date of the proposed change, with the exception of amendments required of Medco by law or governmental regulatory authority, when notice shall be given to Provider when the requirement is made known to Medco.
3. This Agreement shall not contain or require unilateral terms regarding indemnification or arbitration. Notwithstanding any prohibitions in this section, this Agreement between Medco and a Provider may be unilaterally terminated by either party in accordance with the terms of this Agreement.
4. Medco may not terminate or fail to renew this Agreement without cause unless Medco has given Provider a written notice of the termination or nonrenewal one hundred and twenty (120) days before the effective date.
5. Provider shall comply with The Minnesota Uniform Companion Guide for NCPDP Uniform Pharmacy Claim Submission and Response Transaction which was promulgated as a rule pursuant to Minnesota Statutes, §62J.61. Requirements include, but are not limited to, the submission of prescriber's NPI on retail claims, and the submission of prescriber NPI and name on Worker's Compensation claims.
6. Medco will not take retaliatory action against a Provider solely on the grounds that the Provider disseminated accurate information regarding coverage of benefits or accurate benefit limitations of an Eligible Person's contract or accurate interpreted provisions of the Provider's Agreement that limit the prescribing, providing, or ordering of care.
7. Provider agrees not to bill, charge, collect a deposit from, seek remuneration from, or have any recourse against an Eligible Person or Persons acting on their behalf for services provided under this Agreement. This provision applies to but is not limited to the following events: (1) nonpayment by Medco and/or Sponsor; or (2) breach of this Agreement. This provision does not prohibit the Provider from collecting co-payments or fees for uncovered services.

This provision survives the termination of this Agreement for authorized services provided before this Agreement terminates, regardless of the reason for termination. This provision is for the benefit of Eligible Persons. This provision does not apply to services provided after this Agreement terminates.

This provision supersedes any contrary oral or written agreement existing now or entered into in the future between the Provider and an Eligible Person or Persons acting on their behalf regarding liability for payment for services not provided under this Agreement.

MISSISSIPPI REQUIREMENTS

1. If the Agreement provides that Provider may terminate the Agreement or Schedule with less than sixty (60) days' advance written notice, Provider will give at least sixty (60) days' advance written notice of termination.

MISSOURI REQUIREMENTS

1. In the event of Medco's or Plan Sponsor's insolvency or other cessation of operations, Covered Services to Eligible Persons shall continue through the period for which a premium has been paid to Sponsor on behalf of the Eligible Person or until the Eligible Person's discharge from an inpatient facility, whichever time is greater.
2. This provision shall be construed in favor of the Eligible Person, survive the termination of the Agreement regardless of the reason for termination, including the insolvency of Medco, supersede any oral or written contrary Agreement between Provider and an Eligible Person or the representative of Eligible Person if the contrary Agreement is inconsistent with the hold harmless and continuation of Covered Services provisions. This provision is applicable to, and binding upon, all individuals with whom Provider may subcontract to provide Covered Services to Eligible Persons.
3. Provider must furnish covered benefits to all Eligible Persons without regard to the Eligible Person's enrollment in the plan as a private purchaser of the plan or as a participant in a publicly financed program of healthcare services.
4. At least sixty (60) days' written notice must be provided to the other party before terminating the Agreement without cause. The written notice shall include an explanation of why the Agreement is being terminated. Medco shall provide written notice within thirty (30) working days of receipt or issuance of a notice of termination to all Eligible Persons who are providing Covered Services to Eligible Persons on a regular basis by the Provider whose Agreement is terminating, irrespective of whether the termination was for or without cause. Within fifteen (15) working days of the date that the Provider either gives or receives notice of termination, the Provider shall supply Medco with a list of those patients of the Provider that are administered by Medco.
5. Provider's Agreement cannot be terminated unless Medco provides a written explanation of the reasons for the proposed termination and an opportunity for a review or hearing. This paragraph shall not apply in cases involving imminent harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency.
 - 5.1. The notice of the proposed termination shall include:
 - 5.1.1. The reasons for the proposed action;
 - 5.1.2. Notice that the Provider has the right to request a hearing or review, at the Provider's discretion, before a panel appointed by Medco;
 - 5.1.3. A time limit of not less than thirty (30) days within which Provider may request a hearing; and
 - 5.1.4. A time limit for a hearing date which shall be held within thirty (30) days after the date of receipt of a request for a hearing.
 - 5.2. The hearing panel shall comprise at least three persons appointed by Medco. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the Provider under review. The hearing panel may consist of more than three persons, provided however that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel.
 - 5.3. The hearing panel shall render a decision on the proposed action within fifteen (15) days after a hearing. Such decision shall include reinstatement of Provider by Medco, provisional reinstatement subject to conditions set forth by Medco or termination of Provider. Such decision shall be provided in writing to Provider.

MISSOURI REQUIREMENTS

(continued)

- 5.4. A decision by the hearing panel to terminate Provider shall be effective not less than thirty (30) days after the receipt by Provider of the hearing panel's decision.
- 5.5. In no event shall termination be effective earlier than sixty (60) days from the receipt of the notice of termination.
6. Either party may exercise a right of nonrenewal at the expiration of the Agreement period set forth therein or upon sixty (60) days' notice to the other party; provided, however, that any nonrenewal shall not constitute a termination for purposes of this section.
7. Upon termination from the network, Provider shall continue to provide care to enrollees for a period of up to ninety (90) days where the continuation of care is medically necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness. In such instances, the Eligible Person shall not be liable to Provider for any amounts owed for Covered Services other than deductibles or co-payment amounts. In the event the terminated Provider is authorized to continue treating the Eligible Person pursuant to this paragraph, Medco shall have an obligation to pay the terminated Provider at the previously contracted rate for services provided to the Eligible Person.
8. Neither Sponsor nor Medco shall restrict Provider from disclosing to any Eligible Person any information that Provider deems appropriate regarding the nature of treatment, risks, or alternatives thereto; the availability of other therapy, consultation, or test; the decision of any Sponsor to authorize or deny services; or the process that any Sponsor or any person contracting with such Sponsor uses, or proposes to use, authorize or deny healthcare services or benefits.
9. Provider agrees that the Federal, State, and local government and any of their authorized representatives shall, to the extent permitted and/or required by law, have immediate and complete access to all information and records in the possession of Provider, Medco, or HMO that are pertinent to Eligible Persons if such access is necessary to comply with any statutes or regulations applicable to HMO or Medco.
10. Provider shall have thirty (30) days to review the Agreement prior to its execution thereof.
11. Medco shall not penalize a Provider because the Provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that may jeopardize patient health or welfare.

MONTANA REQUIREMENTS

1. If Medco or Sponsor becomes insolvent or otherwise ceases operations, covered benefits to Eligible Persons will continue through the end of the period for which a premium has been paid to the Sponsor on behalf of the Eligible Person, but not to exceed thirty (30) days.
2. This Agreement may not be terminated by either party prior to the expiration of its term except for just cause. For purposes of this subsection, “just cause” means reasonable grounds for termination based on a failure to satisfactorily perform contract obligations or other legitimate business reason.
3. Medco and Provider shall provide at least sixty (60) days’ written notice to each other before terminating this Agreement without cause.
4. Provider shall furnish covered services to all Eligible Persons without regard to the Eligible Person’s enrollment in the plan as a private purchaser or as a participant in a publicly financed program of healthcare services. This requirement does not apply to circumstances in which the Provider should not render services arising from any lack of training, experience, or skill or because of a restriction on the Provider’s license.
5. Medco and Sponsor will not prohibit a participating Provider from discussing a treatment option with an Eligible Person or from advocating on behalf of an Eligible Person within the utilization review or grievance processes established by Sponsor or Medco.
6. Medco and Sponsor will not penalize a participating Provider because the Provider, in good faith, reports to state or federal authorities an act or practice by the Sponsor that may adversely affect patient health or welfare.

NEBRASKA REQUIREMENTS

1. If a Provider's Agreement allows for termination with less than sixty (60) days' advance written notice, a Provider shall provide at least sixty (60) days' advance written notice prior to termination.

NEVADA REQUIREMENTS

1. Medco will provide Provider with thirty (30) days' advance written notice of modifications to the Agreement. If Provider does not object in writing within thirty (30) days, the modification becomes effective.
2. The insured may continue to obtain medical treatment for the medical condition from the provider of health care pursuant to this section, if:
 - (a) The insured is actively undergoing a medically necessary course of treatment; and
 - (b) The provider of health care and the insured agree that the continuity of care is desirable.
3. The provider of health care is entitled to receive reimbursement from the insurer for the medical treatment the provider of health care provides to the insured pursuant to this section, if the provider of health care agrees:
 - (1) To provide medical treatment under the terms of the contract between the provider of health care and the insurer with regard to the insured, including, without limitation, the rates of payment for providing medical service, as those terms existed before the termination of the contract between the provider of health care and the insurer; and
 - (2) Not to seek payment from the insured for any medical service provided by the provider of health care that the provider of health care could not have received from the insured were the provider of health care still under contract with the insurer.
4. The coverage required by subsection 2 must be provided until the later of:
 - (a) 120 days after the date the contract is terminated; or
 - (b) If the medical condition is pregnancy, the 45th day after:
 - (1) The date of delivery; or
 - (2) If the pregnancy does not end in delivery, the date of the end of the pregnancy
5. The requirements of this section do not apply to a provider of health care if:
 - (a) The provider of health care was under contract with the insurer and the insurer terminated that contract because of the medical incompetence or professional misconduct of the provider of health care; and
 - (b) The insurer did not enter into another contract with the provider of health care after the contract was terminated pursuant to paragraph (a).
6. Medco and Sponsor may not restrict or interfere with any communication between Provider and an Eligible Person regarding any information that Provider determines is relevant to the health care of the Eligible Person.
7. Medco shall not terminate a contract with, demote, refuse to contract with or refuse to compensate a Provider solely because the Provider, in good faith: (1) advocates in private or in public on behalf of an Eligible Person; (2) assists an Eligible Person in seeking reconsideration of a decision by Medco or Sponsor to deny coverage for a health care service; or (3) reports a violation of law to an appropriate authority.

NEW HAMPSHIRE REQUIREMENTS

1. Medco may not remove Provider from its network or refuse to renew Provider with its network for participating in an Eligible Person's internal grievance procedure or external review.
2. Medco shall give Provider sixty (60) days' advance notice of the effective date of a material change in the applicable fee schedule.
3. In the event that the Agreement is terminated for any reason other than unprofessional behavior, Eligible Persons shall have continued access to Provider. The continued access to Provider shall be made available for sixty (60) days from the date of termination of the contract and shall be provided and paid for in accordance with the terms and conditions of the Eligible Person's health benefit plan and the prior Agreement between Medco and Provider.
4. No managed health care plan may: (1) adopt a gag rule or practice that prohibits Provider from discussing a treatment option with an Eligible Person even if the Sponsor does not approve of the option; (2) include in any of its contracts with Providers any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary services to an Eligible Person; or (3) require a Provider to violate any recognized fiduciary duty of his profession or place his license in jeopardy.
5. Medco shall explain in writing the rationale for its proposed termination of a Provider and deliver reasonable advance written notice to the Provider prior to the proposed effective date of the termination. The timing of the advance written notice will vary depending upon the reason for the termination.
6. A managed health care plan shall adopt and implement a fair hearing plan that permits a health care provider to dispute the existence of adequate cause to terminate the provider's participation with the plan to the extent that the relationship is terminated for cause and shall include in each provider contract a dispute resolution mechanism.

NEW JERSEY HMO REQUIREMENTS

Provider agrees that Covered Services provided to Eligible Persons who are members of a New Jersey licensed Health Maintenance Organization that has contracted with Medco to provide pharmacy services (each, an “HMO”) shall be subject to the following additional terms and conditions:

1. No Penalty for Acting as Advocate.

Provider may not be terminated as a Medco participating Provider or penalized solely because of its filing a complaint or appeal as permitted by applicable law or regulation.

2. Co-payments/Coinsurance.

Provider will bill and collect from Eligible Persons only co-payment/coinsurance, and deductibles, if any, provided for under the applicable plan covering such Eligible Person(s) and set forth on the Eligible Person’s Member ID card, communicated to Provider via the *TelePAID*® System, or of which Provider is otherwise notified by Medco as being in effect. Nothing in the foregoing sentence will preclude Provider from billing an Eligible Person for non-Covered Services. Except as provided for with respect to such co-payments/coinsurance and deductibles, or any fees for non-Covered Services, Provider will not hold any Eligible Person financially responsible for Covered Services, whether or not Provider believes that the compensation received from Medco is adequate. Provider will accept payment from Medco as provided herein as payment in full by Medco and HMO for all Covered Services rendered to Eligible Persons pursuant to Provider’s Agreement with Medco. Provider will not balance-bill Eligible Persons. Provider will not maintain, and will not cause any agents, trustees, or assignees of Provider to maintain, any action at law or in equity against an Eligible Person to collect sums that are owed by Medco under the terms of Provider’s Agreement with Medco, even if Medco fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of Provider’s Agreement with Medco. This section will survive termination of Provider’s Agreement with Medco, regardless of the cause of termination. Provider will bill to, and collect directly from, Eligible Persons all co-payments/coinsurance and deductible payments relating to Covered Services.

3. Nondiscrimination.

Provider shall not differentiate or discriminate in the treatment of Eligible Persons as to the quality of services rendered on the basis of membership with HMO. Prescription services shall be rendered to such Eligible Persons in the same manner, in accordance with the same standard, and with the availability as provided to all other patients of Provider.

4. Quality Assurance and Utilization Review Programs.

Provider will be bound by and comply with the HMO Quality Assurance and Utilization Review Programs (the “Programs”) as may be implemented and modified from time to time by HMO, upon written notice from Medco or HMO to Provider. Provider will cooperate and participate with Medco and HMO in the operation of the Programs, including, without limitation, the development of any applicable treatment plans, credentialing, and external audits.

5. Patient Records.

Provider will maintain records for each Eligible Person as dictated by generally accepted pharmaceutical practice and as may be necessary to comply with applicable law. Provider will maintain the confidentiality of such records as provided in Provider’s Agreement with Medco. Provider will provide Medco and HMO or either of their respective designees reasonable access during regular business hours to such records, for the period required by applicable law and anytime

NEW JERSEY HMO REQUIREMENTS

(continued)

thereafter that such access is required in connection with the provision of Covered Services to an Eligible Person. Each of Medco and HMO will have access at reasonable times upon demand to all books, records, and papers of Provider relating to the Covered Services provided to Eligible Persons, to the cost thereof and to payments received by Provider directly from Eligible Persons (or from others on their behalf). The obligations set forth in this paragraph shall survive the termination of Provider's Agreement with Medco.

6. No Obligation to Violate Rules.

Nothing in Provider's Agreement with Medco (including these New Jersey HMO Requirements) shall be interpreted to impose obligations or responsibilities on Provider to violate the statutes or rules governing licensure of Provider.

7. Privity of Contract.

Provider acknowledges and agrees that HMO shall be deemed to have privity of contract with Provider with respect to Provider's Agreement with Medco, such that HMO shall have standing to enforce Provider's Agreement with Medco in the absence of enforcement of such Agreement by Medco.

8. General.

Any provision required to be in Provider's Agreement with Medco by N.J.A.C. 8:38-15.2 or 15.3 will be binding upon Medco, HMO, and Provider, whether or not specifically provided for herein.

9. Termination Due Process.

If a Provider's participation is terminated other than at the end of a term, Medco will give the Provider ninety (90) days' advance written notice. The Provider may request a written statement of reasons for the termination. Medco will follow the procedures as required by law for conducting a hearing within thirty (30) days of the Provider's request. If the Provider requests a hearing, the Provider's participation will not be deemed an abrogation of its rights. Provider is entitled to ninety (90) days' notice and a hearing; however, if the Provider's participation is terminated due to a determination that the Provider has engaged in fraud, breached this agreement, or represents an imminent danger to a patient(s) or the public health, safety, and welfare, as determined by Medco, the Provider will not be entitled to such a hearing.

10. Post Termination Continuation of Services.

Provider shall continue to provide Covered Services in accordance with the terms of this Agreement to Eligible Persons in special circumstances, who are in the care of Provider and for whom HMO is the insurer, on termination of this Agreement for up to four (4) months or longer in accordance with applicable law or until alternate arrangements can be made by Medco or HMO. If this Agreement is terminated as a result of a determination that Provider has engaged in fraud, breached this Agreement, or presented an imminent danger to the patient or the public health, safety, and welfare, as determined by Medco, the Provider will not be permitted to continue to provide services after termination.

11. Prohibited Grounds for Termination.

No Provider shall be terminated or penalized solely for acting as an advocate for the Eligible Person in seeking appropriate medically necessary healthcare services. No Provider may be penalized for discussing medically necessary or appropriate care with Eligible Persons.

NEW JERSEY HMO REQUIREMENTS

(continued)

12. Conformity of Law.

Medco shall amend this Agreement to bring any provision that conflicts with applicable law into compliance with applicable law.

13. Appeals.

To the extent that applicable law provides that a dispute between Provider and Medco may be reviewed pursuant to applicable State or Federal external review proceedings, the dispute, if brought to such proceedings, shall be resolved pursuant to applicable law governing such proceedings.

14. Change to Agreement.

Medco shall provide thirty (30) days' notice to Provider of material changes to this Manual. Each new version of the Manual may contain material changes.

15. Applicability to Other Members.

The provisions of this Regulatory Appendix shall also apply to members insured through carriers' managed care plans as required by applicable New Jersey law and regulation.

16. Nonliability.

Nothing in this Agreement will be construed to require Provider to indemnify Medco and/or Sponsor for any tort liability resulting from acts or omissions of Medco and/or Sponsor.

17. Provider shall have the right to communicate openly with an Eligible Person about all diagnostic testing and treatment options.

NEW MEXICO REQUIREMENTS

1. A Sponsor may not: (1) adopt a gag rule or practice that prohibits a Provider from discussing a treatment option with an Eligible Person even if the Sponsor does not approve of the option; (2) include in any of its contracts with Providers any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary services to an Eligible Person; or (3) require a Provider to violate any recognized fiduciary duty of his or her profession or place his or her license in jeopardy.
2. Medco will, prior to terminating a Provider, supply a written rationale for the termination and deliver reasonable advance written notice to Provider prior to the proposed effective date of the termination. The timing of the advance written notice will vary depending upon the reason for the termination.
3. A managed health care plan shall adopt and implement a fair hearing plan that permits a health care provider to dispute the existence of adequate cause to terminate the provider's participation with the plan to the extent that the relationship is terminated for cause and shall include in each provider contract a dispute resolution mechanism.

NEW YORK REQUIREMENTS

Medco Health New York Independent Practice Association, L.L.C., will perform all those services that are required under New York State Public Health Law and/or regulations to be performed by an independent practice association. Medco Health L.L.C., shall perform other services for purposes of applicable New York laws and regulations.

In addition, Provider agrees that Covered Services provided to Eligible Persons who are members of a New York licensed health maintenance organization that has contracted with Medco to provide pharmacy services (each, an “HMO”) shall be subject to the following terms and conditions only in respect to pharmacy services provided to Eligible Persons of such New York HMOs.

Notwithstanding any other provision of this Agreement, contract, or amendment (hereinafter “the Agreement” or “this Agreement”) the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

A. Definitions For Purposes Of This Appendix

“Managed Care Organization” or “MCO” shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

“Independent Practice Association” or “IPA” shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such healthcare providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. “IPA” may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

“Provider” shall mean physicians, dentists, nurses, pharmacists and other healthcare professionals, pharmacies, hospitals and other entities engaged in the delivery of healthcare services which are licensed and/or certified as required by applicable Federal and State law.

B. General Terms And Conditions

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.
2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least thirty (30) days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive healthcare services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such

NEW YORK REQUIREMENTS

(continued)

material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.
4. The provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the provider at least thirty (30) days in advance of implementation, including but not limited to:
 - quality improvement/management;
 - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
 - member grievances; and
 - provider credentialing.
5. The provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.
6. If the provider is a primary care practitioner, the provider agrees to provide for twenty-four (24) hour coverage and back-up coverage when the provider is unavailable. The provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.
7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA's own acts or omissions, by indemnification or otherwise, to a provider.
8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) and Chapter 551 of the Laws of 2006, and all amendments thereto.
9. To the extent the MCO enrolls individuals covered by the Medical Assistance and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:
 - a. The MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider's or IPA's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;

NEW YORK REQUIREMENTS

(continued)

- b. The Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA's performance; and
 - c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.
 - d. The MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility.
 - e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
10. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.
11. The provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply with the HIV confidentiality requirements of Article 27-F of the Public Health Law.

C. Payment; Risk Arrangements

1. **Enrollee Nonliability.** Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long-term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting co-payments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that provider shall have advised the

NEW YORK REQUIREMENTS

(continued)

enrollee in writing that the service is uncovered and of the enrollee's liability therefor prior to providing the service. Where the provider has not been given a list of services covered by the MCO, and/or provider is uncertain as to whether a service is covered, the provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the provider or paid directly to enrollees by third-party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.
3. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

D. Records; Access

1. Pursuant to appropriate consent/authorization by the enrollee, the provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, provider claims processing and payment. The provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The provider shall provide copies of such records to DOH at no cost. The provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.
2. When such records pertain to Medicaid or Family Health Plus reimbursable services the provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.
3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years

NEW YORK REQUIREMENTS

(continued)

after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the provider agrees to obtain consent from the enrollee if the enrollee has not previously signed a consent for disclosure of medical records.

E. Termination and Transition

1. Termination or nonrenewal of an agreement between an MCO and an IPA, institutional network provider, or medical group provider that serves five percent or more of the enrolled population in a county, or the termination or nonrenewal of an agreement between an IPA and an institutional provider or medical group provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination, by the MCO may be effected on less than 45 days notice provided the MCO demonstrates to DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.
2. If this Agreement is between the MCO and a healthcare professional, the MCO shall provide to such healthcare professional a written explanation of the reasons for the proposed contract termination, other than nonrenewal, and an opportunity for a review as required by state law. The MCO shall provide the healthcare professional 60 days notice of its decision to not renew this Agreement.
3. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA's provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA's providers agree, that the IPA providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for one hundred eighty (180) days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.
4. Continuation of Treatment. The provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the

NEW YORK REQUIREMENTS

(continued)

confinement or course of treatment was commenced during the paid premium period. For purposes of this clause, the term “provider” shall include the IPA and the IPA’s contracted providers if this Agreement is between the MCO and an IPA. This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the provider is providing healthcare services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the provider has been terminated or suspended from the Medicaid Program.
6. In the event of termination of this Agreement, the provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

F. Arbitration

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

G. IPA-Specific Provisions

1. Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA’s analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.

NORTH CAROLINA REQUIREMENTS

1. If this Agreement terminates as a result of insolvency of a North Carolina licensed Health Maintenance Organization, Provider shall continue to provide Covered Services to all Eligible Persons for the period for which premium has been paid.
2. This Agreement (including the Manual and any amendments hereto) constitutes the complete and sole contract between the parties and supersedes any and all prior or contemporaneous oral or written communications not expressly contained herein.
3. Provider shall maintain licensure and credentials sufficient to meet Sponsors' credentialing requirements that have been adopted from Medco.
4. Provider shall cooperate with Eligible Persons in member grievance procedures.
5. Provider shall comply with Medco's sanctions program which has been approved and adopted by Sponsor.
6. Sponsor shall allow Provider reasonable time, at least fourteen (14) days, to comply with changes in benefit exclusions, administration and Utilization Review requirements, credentialing and Quality Management programs, and provider sanction policies communicated to Provider via mail, e-mail, or fax. Point-of-sale ("POS") messaging electronically transmitted via the *TelePAID*[®] System shall be effective immediately, in real time, as the claim is being adjudicated.
7. Provider shall be listed in provider directories produced by Medco for Sponsor or provider directories produced by applicable Sponsor and distributed to its Eligible Persons.
8. Provider shall maintain records relating to the services provided by Provider to Eligible Person in accordance with applicable laws, industry standards, and the standards set by Medco on behalf of the applicable Sponsor. Provider shall provide copies of records relating to services provided by Provider to Eligible Persons to the applicable Sponsor in accordance with all applicable confidentiality laws and regulations regarding such records and to the North Carolina Department of Insurance in conjunction with its regulation of Sponsor.
9. Provider shall maintain the confidentiality of Eligible Persons' medical records, personal information, and other health records as required by State and Federal laws.
10. In the event of termination of this Agreement or insolvency of the Sponsor or Medco, Provider agrees upon request to cooperate with the orderly transfer of administrative duties and Eligible Person's records.
11. Provider understands and agrees that its obligation to comply with the Utilization Review programs, credentialing, Quality Management programs, and provider sanctions programs of Medco and/or Sponsor shall not override the professional or ethical responsibility of Provider nor interfere with Provider's ability to provide information or assistance to Eligible Persons.
12. In the event of termination of this Agreement or Medco's or Sponsor's insolvency, Provider agrees to continue providing ongoing care until alternate arrangements for such care can be made by Medco or Sponsor. "Ongoing care" means the Provider will dispense medications to Eligible Persons and charge the Eligible Persons the Provider's Usual and Customary amount. The Eligible Person will submit claims to Medco or the Sponsor for reimbursement processing.
13. Provider shall not be obligated to pay interest to Medco for adjustments on overpayments made to Provider and Medco shall not be obligated to pay interest to participating Provider for adjustments on underpayments made to Provider.

NORTH CAROLINA REQUIREMENTS

(continued)

14. Drug Utilization Review (“DUR”) is performed by the pharmacist to determine a prescription’s suitability with consideration to the health and drug history submitted by the patient, drug-to-drug interactions, drug contraindications, and appropriate standards of practice.
15. Provider shall inform the Eligible Person when a particular drug is not covered by the Plan Sponsor and that the Eligible Person would be responsible for payment of that drug.
16. Medco will be obligated to inform and provide applicable prescription plan design and other information to Provider as required by 11 NCAC 20.0202(15)(b).
17. Medco shall provide Provider with not less than fourteen (14) days’ prior written notice of a change in control, delegation, transfer, or assignment of the core duties under this contract.
18. Provider will not assign, delegate, or transfer Provider’s duties and obligations under the contract without Medco’s prior written consent.
19. Notwithstanding the provisions in Section 2.1 of the Manual, Provider will submit *TelePAID*[®] Systems claims within 180 days of the date of service. Claims submitted to Medco after the applicable claims cutoff date will not be eligible for payment, unless Medco has agreed to waive this provision due to circumstances that limited Provider’s ability to submit a claim.
20. Medco shall provide a copy of the Pharmacy Services Manual to all Providers annually and prior to (i) the execution of a new Provider Contract, or (ii) amending an existing Provider Contract. The Pharmacy Services Manual may be provided to the Provider in hard copy, CD, or other electronic format, and may also be provided by posting the Pharmacy Services Manual on Medco’s website.
21. For North Carolina insured business, the Pharmacy Services Manual shall not conflict with or override any term of the Provider Contract, including fee schedules. In the event of a conflict between the Pharmacy Services Manual and the Provider Contract, the Provider Contract shall govern.
22. Provider shall perform its obligations under the Provider Contract in compliance with all applicable North Carolina statutory and regulatory requirements.
23. The Provider shall not bill any Eligible Person for Covered Services, except for specified copayments, and applicable deductibles. This provision shall prohibit a Provider and Eligible Person from agreeing to continue non-Covered Services at the Eligible Person’s own expense, as long as the Provider has notified the Eligible Person in advance that the carrier may not cover or continue to cover specific services and the Eligible Person chooses to receive the service.
24. This Agreement is governed by North Carolina law.
25. Medco shall send any proposed amendment (each, a “Proposed Amendment”) to the notice contact set forth in the Provider Agreement. The Provider should supply both a name and a title as the contact, as required by North Carolina law. The Proposed Amendment shall be dated, labeled “Amendment,” and signed by Medco. The Proposed Amendment shall be effective on the later of (i) the date on which Medco receives an executed copy of the Proposed Amendment from the Provider or (ii) sixty (60) days from the date on which the Provider receives the Proposed Amendment; provided, however, that the Provider does not object to the Proposed Amendment in writing within such sixty-day period. In the event the Provider objects to the Proposed Amendment in writing within such sixty-day period, the Proposed Amendment shall not take effect and Medco may terminate the Provider Agreement by providing written notice at least sixty (60) days prior to the date of such termination.

NORTH CAROLINA REQUIREMENTS

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- 26.** All notices required under the Provider Agreement shall be provided and deemed delivered as follows: (i) first-class postage prepaid, United States mail, and deemed delivered five (5) business days following the date the notice is mailed; (ii) hand delivered and deemed delivered on the date of actual delivery; (iii) certified or registered mail, return receipt requested, and deemed delivered on the date of return receipt; or (iv) through a commercial courier service and deemed delivered on the date of delivery. All notices to Medco required under the Provider Agreement will be sent to the contact and address set forth on page i of the Pharmacy Services Manual. All notices to Provider required under the Provider Agreement will be sent to the contact and address set forth in the Provider Agreement or as updated on the annual verification form returned by the Provider. The Provider should supply both a name and a title as the contact, as required by North Carolina law.

NORTH DAKOTA REQUIREMENTS

1. To the extent either party has the ability under the Agreement or Schedules to terminate without cause with less than sixty (60) days' advance written notice, the party must provide at least sixty (60) days' advance written notice of the termination without cause.
2. Medco and Sponsor may not penalize a Provider because Provider, in good faith, reports to state or federal authorities any act or practice by Medco or Sponsor that jeopardizes patient health or welfare.
3. Medco and Sponsor may not restrict or interfere with any medical communication and may not take any of the following actions against Provider solely on the basis of a medical communication:
 - (1) Refusal to contract with Provider;
 - (2) Termination of or refusal to renew a contract with Provider;
 - (3) Refusal to refer patients to or allow others to refer patients to Provider; or
 - (4) Refusal to compensate Provider for Covered Services that are medically necessary.
4. Provider shall not indemnify Medco or Sponsor for Medco's or Sponsor's willful misconduct or breach of contract. Indemnification as set forth in Section 6.2 is not waived.
5. Medco and Sponsor will not take any of the following actions against Provider in retaliation for the Provider's good faith advocacy on behalf of an Eligible Person: (1) refusal to contract with Provider; (2) termination of or refusal to renew a contract with Provider; (3) refusal to refer patients to or allow others to refer patients to the health care provider; or (4) refusal to compensate Provider for Covered Services that are medically necessary.

OHIO REQUIREMENTS

1. Provider agrees that in no event, including but not limited to nonpayment by Medco or Sponsor, insolvency of Medco or Sponsor, or breach of this agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, an Eligible Person, or person acting on behalf of an Eligible Person, for Covered Services. This does not prohibit Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to Eligible Persons, nor from any recourse against Medco or its successor.
2. Provider must continue to provide Covered Services to Eligible Persons in the event of Medco's or Sponsor's insolvency or discontinuance of operations as needed to complete any medically necessary procedures commenced but unfinished at the time of insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all Covered Services that constitute medically necessary follow-up care for that procedure. This provision shall survive the termination of the Agreement with respect to services covered and provided under the Agreement during the time the Agreement was in effect, regardless of the reason for the termination, including the insolvency of Medco or Sponsor.
3. Provider shall observe, protect, and promote the rights of Eligible Persons as patients.

OREGON REQUIREMENTS

1. Medco and Sponsor shall limit the right of Provider to contract with an Eligible Person for payment of services not within the scope of the Covered Services. Advance notice shall be given to the Eligible Person that the services to be provided are not Covered Services.

PENNSYLVANIA IDS REQUIREMENTS

In compliance with the requirements applicable to “Integrated Delivery Systems” (“IDS”), set forth in 28 PA. Code § 9.724 (Plan-IDS Contracts) and § 9.725 (IDS-Provider Contracts):

1. Provider acknowledges and agrees that nothing contained in this Agreement limits:
 - 1.1. The authority of Sponsor to ensure Provider’s participation in and compliance with Sponsor’s quality assurance, utilization management, Member complaint and grievance systems, and procedures or limits.
 - 1.2. The authority of the Pennsylvania Department of Health or the Pennsylvania Department of Public Welfare to monitor the effectiveness of Sponsor’s system and procedures or the extent to which Sponsor adequately monitors any function delegated to Medco, or to require Sponsor to take prompt corrective action regarding quality of care or Member grievances and complaints.
 - 1.3. Sponsor’s authority to sanction or terminate Provider, in the event that Provider is found to be providing inadequate or poor quality care or failing to comply with plan systems, standards, or procedures as agreed to by Medco.
2. Provider acknowledges and agrees further that:
 - 2.1. Any delegation by Sponsor to Medco for performance of quality assurance, utilization management, credentialing, provider relations, and other medical management systems shall be subject to Sponsor’s oversight and monitoring of Medco’s performance. Provider must meet the minimum credentialing standards established by Sponsor and approved by the Commonwealth of Pennsylvania. Sponsor retains the authority to accept, reject, or terminate Provider.
 - 2.2. Sponsor, upon failure of Medco to properly implement and administer the systems, or to take prompt corrective action after identifying quality, Member satisfaction, or other problems, may terminate its contract with Medco, and that, as a result of the termination, Provider’s participation in Sponsor’s network may also be terminated.
 - 2.3. Data Reporting Requirements: Provider agrees that it shall report data as required by the Pennsylvania Department of Health and the Pennsylvania Department of Public Welfare. Medco agrees that it shall notify Provider of data-reporting requirements.

PENNSYLVANIA MEDICAID REGULATORY REQUIREMENTS

1. Member Grievances and Complaints.

Provider shall immediately refer to Sponsor any Member grievances or complaints of which it becomes aware. Provider shall cooperate with and participate in Sponsor's Member Grievance Procedures and Complaint Procedures as directed by Sponsor, and shall abide by the decisions of Sponsor's Grievance Committee and Complaint Committee. Provider shall comply with Medicare grievance and appeals procedures for Medicare Members as set forth in Sponsor's Provider Manual and as required by CMS.

2. Insurance.

Provider shall secure and maintain a policy of general liability with minimum coverage limits of \$1 million per occurrence/\$3 million aggregate. Provider shall provide Certificates of Insurance evidencing Provider's insurance coverage to Medco upon request.

3. Member Hold Harmless.

- 3.1. Provider agrees that in no event, including but not limited to, nonpayment by Medco or Sponsor, the insolvency of Sponsor or Medco, or breach of this Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Members, the Commonwealth of Pennsylvania or persons other than Sponsor or Medco for services provided under the Provider Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on Sponsor's behalf made in accordance with the terms of an enrollment agreement between Sponsor and Members. (Medicaid Members are not liable for any supplemental charges or co-payments.)
- 3.2. Provider further agrees that (a) this hold-harmless provision shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Sponsor's Members, and (b) this hold-harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and a Member or persons acting on their behalf.
- 3.3. No modification, addition, or deletion to the provisions of this section shall be given effect unless it has first been approved by the Pennsylvania Departments of Health and Public Welfare.

4. Quality Management.

Provider agrees to cooperate with and abide by Sponsor's Quality Management Program, which includes Sponsor's quality assurance and utilization review policies and procedures. All such programs and policies referred to in this section, or any other section of this Addendum, are limited to those required by the Commonwealth of Pennsylvania and/or those requiring approval by the Commonwealth.

PENNSYLVANIA MEDICAID REGULATORY REQUIREMENTS

(continued)

5. No Termination for Member Advocacy or Filing Grievance on Member's Behalf.

Neither Medco nor Sponsor may sanction, terminate, or fail to renew the agreement with Provider solely because:

- 5.1. Provider advocated for medically necessary and appropriate healthcare services on behalf of a Member as determined by reputable providers practicing within the legal standard of care;
- 5.2. Provider filed a Grievance on behalf of and with the written consent of a Member, or helped a Member to file a grievance;
- 5.3. Provider protested a Sponsor or Sponsor decision, policy, or practice Provider believed interfered with its ability to provide medically necessary and appropriate healthcare; or
- 5.4. Provider took another action specifically permitted under 40 P.S. §§ 991.2113, 991.2121, and 991.2171.

6. Federal and State Funds.

Provider acknowledges that payments to it with respect to Members who are eligible for Medical Assistance are derived from Federal and State funds and that Provider may be held civilly and/or criminally liable to both Sponsor and the Pennsylvania Department of Public Welfare in the event of false claims, nonperformance, misrepresentation, fraud, or abuse for services provided to Medical Assistance recipients (including Sponsor's Members who are Medical Assistance recipients).

7. No Interference with Professional Judgment.

- 7.1. Neither Sponsor nor Medco shall prohibit or restrict Provider from, nor penalize Provider for, discussing:
 - a. Medically necessary and appropriate care with or on behalf of a Member, government healthcare officials, or the Pennsylvania Department of Public Welfare, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternative therapies, consultations, or tests;
 - b. The process Sponsor or Medco uses or proposes to use to deny payment for a healthcare service; or
 - c. The decision of any managed care plan to deny payment for a healthcare service.

PENNSYLVANIA MEDICAID REGULATORY REQUIREMENTS

(continued)

- 7.2. This Agreement may not be terminated because Provider: (i) advocates for medically necessary and appropriate healthcare as determined by reputable providers practicing within the legal standard of care; (ii) files a grievance on behalf of a Member pursuant to the procedures set forth in the Insurance Pharmacy Law of 1921, as amended by Article XXI of Act 68 of 1998 (P.L. 464, No. 68) and its applicable regulations, 28 PA. Code Chapter 9; (iii) protests a decision, policy, or practice that Provider reasonably believes interferes with Provider's ability to provide medically necessary and appropriate healthcare; or (iv) objects to the provision of or refuses to provide or refer a healthcare service on moral or religious grounds, provided that Provider makes adequate information available to Members and prospective Members.
- 7.3. Provider is specifically permitted to have such discussions on behalf of the Member with the Department of Public Welfare and other healthcare officials, provided that the Member consents to such discussions.

8. Records.

- 8.1. Provider shall maintain records of the claims information for seven (7) years after the dispensing date or until all then pending audits or inspection activities as described in this section are completed. Such records shall be in a format and media deemed appropriate by Medco and approved by Sponsor. Each party may audit, review, and duplicate such records, and any other records the parties have regarding the claims information made in connection with this Agreement ("Records") by providing reasonable prior written notice to the party holding the applicable Records. Such review and duplication shall occur during regular business hours at the place of business of the holder of the Records, and shall be subject to all applicable laws regarding the confidentiality of such Records. The party requesting duplication of Records shall pay the party holding such Records its reasonable duplicating costs.
- 8.2. Provider shall adhere to the applicable requirements of 42 CFR Subsection 434.6, including but not limited to those regarding maintaining an appropriate record system for services provided hereunder and safeguarding information concerning Covered Members in accordance with applicable federal statutes and regulations governing Medical Assistance programs.
- 8.3. The Pennsylvania Departments of Health, Insurance, and Public Welfare, and any external quality review organization approved by the Departments of Health or Public Welfare, shall be provided access to records of Provider for the purpose of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with Pennsylvania laws and the Department of Public Welfare's contract with Sponsor. The records shall only be accessible to Departmental employees or agents with direct responsibilities for the enumerated activities.

9. Inspection.

The Pennsylvania Departments of Health, Insurance, and Public Welfare, and the United States Department of Health and Human Services, may evaluate, through inspection or other means, the quality, appropriateness, and timeliness of service performed hereunder.

PENNSYLVANIA MEDICAID REGULATORY REQUIREMENTS

(continued)

10. Program Integrity; Fraud and Abuse.

Provider shall comply with all policies and procedures as developed and amended from time to time for the detection and prevention of fraud and abuse committed by providers, employees, or Members, and to ensure program integrity in the Pennsylvania Medical Assistance program. Such compliance may include, but not be limited to, the submission of statistical and narrative reports regarding fraud and abuse detection activities, referral or information of suspected or confirmed fraud or abuse to Sponsor, and Sponsor shall immediately notify the Pennsylvania Departments of Health and Public Welfare, as appropriate, regarding such suspected or confirmed fraud or abuse. Medco will immediately terminate any Provider precluded from participation in Medicaid, as it concerns such Provider's participation in a Sponsor Medicaid Program, and shall make no payments to such Provider after the effective preclusion date.

11. Hold Harmless for Health Plan/Provider Dispute.

In the event that any dispute arises between Provider and Medco, Provider and Medco hereby agree to indemnify and hold harmless the Pennsylvania Department of Public Welfare and Members from any legal or financial liability arising out of or in connection with any such dispute.

12. Non-Discrimination.

Provider shall not discriminate in the hiring of its employees on the basis of sex, marital status, age, disability, race, color, religion, or any other basis prohibited by law. Furthermore, Provider shall not discriminate or differentiate in the provision of services hereunder on the basis of sex, marital status, age, disability, race, color, religion, sexual orientation, health status, the fact that a Member is a Medicaid or Medicare beneficiary, or any other basis prohibited by law.

13. ADA Compliance.

Pursuant to federal regulation promulgated under the authority of the Americans with Disabilities Act, as amended, Provider understands and agrees that no individual with a disability shall, on the basis of the disability, be excluded from participation in this Agreement or from activities provided for under this Agreement.

14. Commonwealth Hold Harmless.

Provider agrees to hold harmless the Commonwealth of Pennsylvania, all Commonwealth officers and employees, and all Members in the event of nonpayment by Sponsor to Medco or Medco to Provider. Provider shall further indemnify and hold harmless the Commonwealth and its agents, officers, and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs, and expenses that may in any manner accrue against the Commonwealth or their agents, officers, or employees through the intentional conduct or negligent acts or omissions of Provider, its agents, officers, or employees in connection with Provider's performance of services hereunder.

15. Record Retention.

Provider shall retain the source records for its data reports for a minimum of seven (7) years and shall develop and maintain written policies and procedures for the storing of these records.

PENNSYLVANIA MEDICAID REGULATORY REQUIREMENTS

(continued)

16. Definitions.

In providing services under the Agreement, the following terms shall have the meanings set forth below:

- 16.1. “Emergency” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.
- 16.2. “Medically Necessary” shall have the meaning set forth in Health Plans’ contract with the Pennsylvania Department of Public Welfare, namely: A service or benefit is “medically necessary” if it is compensable under the Pennsylvania Medical Assistance Program and if it meets any one of the following standards: (a) the service or benefit shall, or is reasonably expected to, prevent the onset of an illness, condition, or disability; (b) the service or benefit shall, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (c) the service or benefit shall assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age. The determination as to whether a service or benefit is medically necessary shall be based on the determination of a qualified and trained medical professional that takes into account information provided by the Member, the Member’s family, and other medical professionals.

17. Submission of Encounter Data.

Provider shall submit claims electronically at the point of service.

18. Continuation of Services.

Provider agrees in the event of Medco’s or Sponsor’s insolvency or other cessation of operations that Provider shall continue to provide benefits to Members through the period for which the premium has been paid.

19. Notice of Change in Circumstances.

Provider shall notify Medco immediately of any change in circumstances that would adversely affect Provider’s ability to render services under this Agreement, including, but not limited, to: (i) suspension or loss of license, certification, or accreditation; (ii) the imposition of sanctions under a Federal or State healthcare program; (iii) the indictment, arrest, or conviction of a felony or any criminal charge of Provider; (iv) the loss or reduction of liability coverage or professional malpractice coverage; (v) the filing of a malpractice or other negligence based claim by a Member against Provider; or (viii) Provider becoming insolvent or voluntarily or involuntarily filing for bankruptcy, the assignment for the benefit of creditors, the appointment of a receiver, or similar relief.

PENNSYLVANIA MEDICAID REGULATORY REQUIREMENTS

(continued)

20. Severability.

If any provision in the Agreement is deemed to be illegal or unenforceable, or any court of competent jurisdiction restricts or limits the applicability of any provision in the Agreement, the Agreement shall be interpreted as if the provision in question has been stricken or so restricted or limited, but shall not affect the other provisions of the Agreement.

21. Fee-For-Service Window.

Medco and Provider agree that Provider shall provide services to a Plan Member enrolled in the Medical Assistance program during the period that the Member is covered under the Medicaid fee-for-service program prior to the effective date of his or her enrollment in the Sponsor's managed care program.

22. Confidentiality of and Access to Records.

Provider agrees to maintain Sponsor's Members' records confidential in accordance with 40 P.S. 991.2131 and to comply with all Federal and State laws and regulations regarding the confidentiality of patient records. The Pennsylvania Departments of Health, Insurance, and, when necessary, Department of Public Welfare, shall have access to records for purposes of quality assurance, investigation of complaints and grievances, enforcement, or other compliance activities under the 40 P.S. 991.2101 through 991.2193, as amended, 28 PA. Code Chapter 9, and all other laws of the Commonwealth of Pennsylvania. Such records shall be accessible only to those Pennsylvania Department of Health employees or agents with direct responsibility for the activities mentioned in the previous sentence.

23. Adherence to Laws.

Provider to adhere to all State and Federal laws and regulations to which it is subject.

24. Policies and Procedures.

Provider agrees to comply with any material changes, including but not limited to amendments, repeals, and additions, to the Sponsor Provider Manual. Such material changes shall be binding upon Provider thirty (30) days after Provider's receipt of written notice thereof, unless circumstances require an earlier effective date. If any applicable laws or regulations are enacted, amended, promulgated, repealed, or revised, whether or not retroactively, that affect any of the rights, duties, or obligations of the parties under the Agreement, including, without limitation, those concerning the eligibility of Members and the provision of Covered Prescription Drug Services, the Agreement shall be deemed amended effective as of the date such laws or regulations become or became effective.

25. Termination.

Medco agrees that, notwithstanding any provision to the contrary, neither Medco nor Provider is permitted to terminate the Provider Agreement, without cause, without at least sixty (60) days' prior written notice.

PENNSYLVANIA INSURANCE

1. An Eligible Person may continue an ongoing course of treatment, at the option of the Eligible Person, for up to sixty (60) days from the date the Eligible Person is notified by Sponsor of the termination or pending termination of Provider at the same rate and terms as under the Agreement.
2. If Medco terminates Provider's Agreement for cause, including breach of contract, fraud, criminal activity or posing a danger to an Eligible Person or the health, safety or welfare of the public as determined by Medco or Sponsor, Medco and Sponsor shall not be responsible for Covered Services provided to the Eligible Person following the date of termination.
3. Provider shall keep Eligible Person records confidential in accordance with section 2131 of the act (40 P.S. § 991.2131) and all applicable State and Federal laws and regulations.
4. Provider shall allow the Insurance Department, and, when necessary, the Department of Public Welfare, access to records for the purpose of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with the laws of the Commonwealth. However, only employees and agents with direct responsibilities will have access to the records. This section does not limit Medco's ability to access records pursuant to the Manual and this Agreement.
5. To the extent that the Agreement or Schedules allow Medco or Provider to terminate the Agreement or a Schedule without cause, Medco and Provider must give sixty (60) days' advance written notice of termination without cause.
6. Medco will provide thirty (30) days' advance written notice of changes to the Agreement or Schedules unless the change is required by law or regulation. Each version of the Manual will contain changes.
7. To the extent that the Agreement or Schedules allow Provider to terminate the Agreement or a Schedule that covers Eligible Persons covered by a HMO, Provider must give sixty (60) days' advance written notice.

RHODE ISLAND REQUIREMENTS

HMO

1. Provider agrees that no Eligible Person shall be liable for charges for Covered Services, except for amounts due for co-payments.
2. Notwithstanding anything to the contrary in the Agreement, Medco shall not terminate the contract “without cause”; provided however, “cause” shall include the lack of need due to economic considerations.

SOUTH CAROLINA REQUIREMENTS

1. Nothing in this Agreement shall limit the ability of the Provider to discuss with an Eligible Person, the treatment options available to them, risks associated with treatments, utilization management decisions, and recommended course of treatment.
2. Each party to a managed care participating provider agreement is responsible for the legal consequences and costs of his own acts or omissions, or both, and is not responsible for the acts or omissions, or both, of the other party.

SOUTH DAKOTA REQUIREMENTS

1. Medco and Sponsor will not prohibit or penalize a Provider from discussing treatment options with Eligible Persons irrespective of Medco's or Sponsor's position on the treatment options, from advocating on behalf of Eligible Persons within the utilization review or grievance processes established by Sponsor or from, in good faith, reporting to the state or federal authorities any act or practice by Medco or Sponsor that jeopardizes patient health or welfare.
2. To the extent that the Agreement or a Schedule allows Medco or Provider to terminate the Agreement without cause with less than sixty (60) days' advance written notice, Medco and Provider shall provide at least sixty (60) days' advance written notice before terminating the Agreement or Schedule without cause. If Provider is terminated or terminates the contract without cause, upon request by Provider or Eligible Person and upon agreement by Provider to follow all applicable network requirements and accept contracted reimbursement rates, Medco shall permit the Eligible Person to continue an ongoing course of treatment for ninety (90) days following the effective date of the Agreement or Schedule termination. In the event an Eligible Person that has entered a second trimester of pregnancy at the time of the termination as specified in this section, the continuation of network coverage through Provider shall extend to the provision of postpartum care directly related to the delivery.

TENNESSEE REQUIREMENTS

1. DEFINITIONS. As used in this section:

- (A) (1) “Clean claim” means a claim received by a health insurance entity for adjudication that requires no further information, adjustment or alteration by the provider of the services in order to be processed and paid by the health insurer. A claim is clean if it has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this section;
- (2) “Clean claim” does not include a duplicate claim;
- (3) “Clean claim” does not include any claim submitted more than ninety (90) days after the date of service; and
- (4) “Clean claim” includes resubmitted paper claims with previously identified deficiencies corrected;
- (B) “Duplicate claim” means an original claim and its duplicate, when the duplicate is filed within thirty (30) days of the original claim;
- (C) “Health insurance coverage” means benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any policy, certificate or agreement offered by a health insurance entity; provided, that health insurance coverage does not include policies or certificates covering only accident, credit, disability income, long-term care, hospital indemnity, medicare supplement as defined in § 1882(g)(1) of the Social Security Act, codified in 42 U.S.C. § 1395ss(g)(1), specified disease, other limited benefit health insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- (D) “Health insurance entity” means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including, but not limited to, an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation;
- (E) “Pay” means that the health insurance entity shall either send the provider cash or a cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health insurance entity. Payment shall occur on the date when the cash, cash equivalent or notice of credit is mailed or otherwise sent to the provider; and
- (F) “Submitted” means that the provider either mails or otherwise sends a claim to the health insurance entity. Submission shall occur on the date the claim is mailed or otherwise sent to the health insurance entity.

TENNESSEE REQUIREMENTS

(continued)

2. Medco shall pay the total amount of a clean claim within thirty (30) days after the date of receipt for a paper claim, and within twenty-one (21) days after the date of receipt for an electronic claim. If only a portion of the claim is clean, Medco shall pay the part of the claim that is not in dispute and notify the Provider in writing why the remaining portion will not be paid. If the claim is not clean, Medco shall notify the Provider in writing and provide the reasons why the claim is not clean and will not be paid, and will also explain what additional documentation and information is required to adjudicate the claim as clean. If Medco fails to comply with this provision, Medco shall pay one percent (1%) interest per month, accruing from the day after the payment was due, on the amount of the clean claim that remains unpaid.
3. If a Provider provides substantiating documentation or information, Medco shall not deny a paper claim upon resubmission based upon a lack of such information.
4. Medco shall timely provide all contracted Providers with the information necessary to properly submit a claim.

TEXAS REQUIREMENTS

1. Termination of this Agreement, except for reason of competence or professional behavior, shall not release Medco from the obligation to reimburse Provider for Covered Services provided in special circumstances post-termination to Eligible Persons at less than the agreed-upon rate. This obligation shall not extend beyond the 90th day after the effective date of the termination.
2. Medco shall provide written notification of termination of this Agreement to Provider at least 90 days prior to the effective date of termination, except if termination is related to (i) imminent harm to Eligible Person's health; (ii) action against Provider's license to practice or loss of insurance or reduction in insurance by Provider; or (iii) fraud, in which case Provider's termination by Medco may be immediate.
3. Prior to termination of this Agreement, Medco will give Provider a written explanation of the reason(s) for termination and Provider may request and receive a review of the proposed termination by an advisory review panel. Such review shall not be provided in cases where termination is related to the provisions set forth in Section 2 above.
4. In the event of termination of this Agreement, Medco shall provide reasonable advance notice of the impending termination of Provider to Eligible Persons receiving Covered Services at Provider except in cases where termination is immediate and notice by Medco to such Eligible Persons shall be immediate.
5. Provider shall post a notice to Eligible Persons on the process for resolving complaints with Medco or the Sponsor. Such notice shall include the Texas Department of Insurance's toll-free telephone number for filing complaints.
6. Nothing in this Agreement will be construed to require Provider to indemnify Medco and/or Sponsor for any tort liability resulting from acts or omissions of Medco and/or Sponsor.
7. Neither Medco or Sponsor may engage in retaliatory action, including refusal to renew or termination of this Agreement, against Provider because Provider has, on behalf of an Eligible Person, reasonably filed a complaint against Medco or appealed a decision of Medco.

UTAH REQUIREMENTS

1. If Medco or Sponsor become insolvent, Provider will continue to provide services to Eligible Persons until the earlier of: (1) ninety (90) days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or (2) the date the term of the contract ends.
2. During the time period set out in section 1, Provider agrees to accept reduced fees and shall: (1) accept the reduced payment as payment in full, and (2) relinquish any right to collect additional amounts from any Eligible Person. Medco may not reduce a fee to less than 75% of the regular fee set forth in Schedule and the Eligible Person shall continue to pay the same copayments, deductibles, and other payments for the Covered Services.
3. Provider may not collect or attempt to collect from any Eligible Person sums owed by Medco and may not bill or maintain any action at law against an enrollee to collect sums owed by Medco or Sponsor or the amount of the regular fee reduction.
4. Any dispute under Sections 1-3 shall be subject to binding arbitration by a jointly selected arbitrator to be held in Bergen County, New Jersey. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared.
5. Medco shall not penalize a Provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.
6. If Medco permits another private entity with which it does not share common ownership or control to use or otherwise lease one or more of its networks, Medco will ensure that the leasing entity pays Providers in accordance with the Schedule(s) that is leased.

VIRGINIA REQUIREMENTS

1. Provider shall provide sixty (60) days' advance notice to Medco of termination of this Agreement.
2. In the event of insolvency of Sponsor, Provider shall continue to provide Covered Services to Eligible Persons for the duration of the period for which premium payment has been made.
3. Medco shall not terminate this Agreement nor otherwise penalize Provider solely because of Provider's invoking of Provider's right under this Agreement or applicable law or regulation.
4. Medco shall, within 30 days after receipt of a claim, request electronically or in writing from Provider the information and documentation that Medco reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, Medco shall make the payment of the claim in compliance with this section. Medco shall not refuse to pay a claim for healthcare services rendered pursuant to this Agreement which are covered benefits if Medco fails timely to notify or attempt to notify Provider of the matters identified above unless such failure was caused in material part by the Provider submitting the claims; however, nothing herein shall preclude Medco from imposing a retroactive denial of payment of such a claim unless such retroactive denial of payment of the claim would violate subdivision 4 of this subsection. Nothing in this subsection shall require Medco to pay a claim which is not a clean claim.
5. In the event that Medco is required to pay interest as a result of any issue or claim arising under this Agreement or under any other applicable law, Medco shall pay such interest, if not sooner paid or required to be paid, at the time of payment of any underlying claim or within sixty (60) days thereafter, without necessity of demand.
6. Medco shall pay a claim if Medco has previously authorized the healthcare service, unless:
 - a. The documentation for the claim provided by the Provider or Eligible Person submitting the claim clearly fails to support the claim as originally authorized; or
 - b. Medco's refusal is because (i) another payer is responsible for the payment, (ii) the Provider or Eligible Person has already been paid for the healthcare services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to Medco by the Provider, Eligible Person, or other person not related to Medco, or (iv) the Eligible Person receiving the healthcare services was not eligible to receive them on the date of service and Medco did not know, and with the exercise of reasonable care could not have known, of the Eligible Person's eligibility status.
7. Claims adjudicated by Medco shall not be retroactively denied unless Medco has provided thirty (30) days' notice to Provider the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because Provider was already paid for such services rendered or the services were not rendered by Provider, or (iii) the claim was not submitted in accordance with the lesser of twelve (12) months or the time frames set forth herein.

VIRGINIA REQUIREMENTS

(continued)

8. Notwithstanding subdivision 7 of this subsection, with respect to Provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, Medco shall not impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless Medco specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.
9. No Amendment to this Agreement applicable to Provider shall be effective as to the Provider, unless the Provider has been provided with the applicable portion of the proposed Amendment at least sixty (60) calendar days before the effective date and the Provider has failed to notify Medco within thirty (30) calendar days of receipt of the documentation of the Provider's intention to terminate this Agreement at the earliest date thereafter permitted under this Agreement.

WASHINGTON REQUIREMENTS

1. Provider hereby agrees that in no event, including but not limited to nonpayment by Sponsor, Sponsor's insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an Eligible Person or person acting on their behalf, other than Sponsor, for services provided pursuant to this Agreement. This provision shall not prohibit collection of deductibles, co-payments, coinsurance, and/or noncovered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Eligible Persons in accordance with the terms of the Eligible Person's plan.
2. Provider agrees, in the event of Sponsor's insolvency, to continue to provide the services promised in this Agreement to Eligible Persons of Sponsor for the duration of the period for which premiums on behalf of the Eligible Person were paid to Sponsor.
3. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Eligible Person's plan.
4. Provider may not bill the Eligible Person for Covered Services (except for deductibles, co-payments, or coinsurance) where Sponsor denies payment because Provider has failed to comply with the terms or conditions of this Agreement.
5. Provider further agrees (i) that the provisions of Sections 1, 2, 3, and 4 of this Section shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Sponsor's Eligible Persons, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Eligible Persons or persons acting on their behalf.
6. If Provider contracts with other providers or facilities who agree to provide Covered Services to Eligible Persons of Sponsor with the expectation of receiving payment directly or indirectly from Sponsor, such providers or facilities must agree to abide by the provision of 1, 2, 3, 4, and 5 of this Section.
7. If Provider willfully collects or attempts to collect an amount from an Eligible Person knowing that collection to be in violation of this Agreement, it shall constitute a class C felony under RCW 48.80.030(5).
8. Provider shall be given reasonable notice of not less than sixty (60) days of material changes that affect Provider and that affect healthcare service delivery unless changes to Federal or State law or regulation make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity provisions of this Agreement, Provider may terminate this Agreement without penalty if Provider does not agree with the changes. No change to this Agreement may be made retroactive without the express consent of Provider.
9. This Agreement may not require alternative dispute resolution to the exclusion of judicial remedies; however, alternative dispute resolution may be required prior to judicial remedies.
10. If Medco fails to pay claims within the standard established under applicable Washington law, Medco shall pay interest on undenied and unpaid claims more than sixty-one (61) days old. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by Provider or instances where Medco has not been granted reasonable access to information under Provider's control.

WASHINGTON REQUIREMENTS

(continued)

11. Provider shall have not less than thirty (30) days after the action giving rise to a dispute to complain and initiate the dispute resolution process. In the event Medco fails to acknowledge any such complaint within thirty (30) days of receipt, the Provider may proceed as if the request has been rejected. In the case of billing disputes, a decision must be rendered within sixty (60) days of the complaint.
12. In the case of a billing audit or dispute, Provider is entitled to Medco documentation relating to the claims at issue.
13. Provider shall not discriminate in the treatment of Eligible Persons rendered on the basis of enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of healthcare services. This requirement does not apply to circumstances when where Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.
14. Medco shall provide at least sixty (60) days' written notice to Provider before terminating this Agreement without cause.
15. Provider's Agreement with Medco shall be governed, construed, and enforced in accordance with the laws of the State of Washington.
16. In the event of any conflict between the terms of this Addendum and the Provider Agreement, the terms of this Addendum shall control.

WEST VIRGINIA REQUIREMENTS

HMO

1. If the Agreement or Schedule allows Provider to terminate without cause with less than sixty (60) days' advance written notice, Provider shall provide at least sixty (60) days' advance written notice.
2. Medco or Sponsor may waive the sixty (60) day notice requirement for a Provider if Medco and Sponsor are not financially impaired or insolvent.
3. Provider has twenty (20) business days after receiving an amendment to the Provider Agreement or Schedule to provide written notice of Provider's intent to terminate the Agreement or Schedule (as applicable) as soon as allowed under the Agreement or Schedule. The amendment will not take effect in the time prior to termination.

WISCONSIN REQUIREMENTS

1. Except as provided in Paragraph 2, in the event the Provider Agreement is terminated, Provider shall continue to provide Covered Services to Eligible Persons who are undergoing a course of treatment with a Provider, and the Provider Agreement shall remain in force with respect to the continuing treatment. Treatment is required to continue only for the period that is the shortest of (A) through completion of the course of treatment; (B) for 90 days after the Provider's participation in the plan terminates, or (C) for women in their second or third trimester of pregnancy, until the completion of post-partum care for the mother and the infant. However, in no event is coverage required to extend beyond the end of the plan year (for Eligible Persons enrolled in a plan with no open enrollment period) or until the end of the plan year for which it was represented that Provider was, or would be, a participating provider (for Eligible Persons enrolled in a plan with an open enrollment period).
2. The coverage required under this section need not be provided or may be discontinued if Medco or Sponsor terminates Provider's Agreement for misconduct on the part of the Provider.

WYOMING REQUIREMENTS

HMO

1. If the Agreement or Schedule allows Provider to terminate without cause with less than sixty (60) days' advance written notice, Provider shall provide at least sixty (60) days' advance written notice.

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SECTION 11

**MEDICARE
PART D**

11.1 MEDICARE PRESCRIPTION DRUG ID CARDS

Eligibility of the individual patient for whom the prescription is prescribed is confirmed via the *TelePAID*[®] System. Below are samples of the Medicare Prescription Plan ID cards used for primary coverage:

Medco Medicare Prescription Plan[®](PDP)

RxBin 610014
 RxPcn MEDDPRIME
 RxGrp
 Issuer 80840
 ID No.
 Name

MedicareRx
Prescription Drug Coverage

Medco Medicare Prescription Plan[®]

RxBin 610014
 RxPcn MEDDPRIME
 RxGrp
 Issuer 80840
 ID No.
 Name

MedicareRx
Prescription Drug Coverage

Medco Medicare Prescription Plan[™]

RxBin 610014
 RxPcn MEDDPRIME
 RxGrp
 Issuer 80840
 ID No.
 Name

MedicareRx
Prescription Drug Coverage
 CMS_S5660<PBP>

MEDCO YOURx PLAN[™]

RxBin 610014
 RxPcn MEDDPRIME
 RxGrp
 Issuer 80840
 ID No.
 Name

MedicareRx
Prescription Drug Coverage
 CMS_S5660 <PBP>

Below are samples of the Medco's Medicare Prescription Plan ID cards used for secondary coverage or coordination of benefits (COB):

RxBin **610031**
 RxPCN MEDDCOPAY
 RxGrp
 Issuer MEDCO
 ID No.
 Name

www.medco.com *medco*[®]

RxBin **610031**
 RxPCN MEDDCOBSEG
 RxGrp
 Issuer MEDCO
 ID No.
 Name

www.medco.com *medco*[®]

Note: The Rx Bin number for secondary claims using the COB segment or co-pay only option is 610031.

11.2 MEDICARE PART D ADDENDUM PROVIDER NETWORK REQUIREMENTS

Effective on the effective date of Provider's participation in the Medco Medicare Provider network, the following provisions are added to, and made a part of, the Agreement currently in force between Provider and Medco. The terms of this Addendum apply to services provided by Provider, to Eligible Persons, as a network Provider in one or more of Medco's Medicare Part D Prescription Drug Benefit Program Provider networks ("Covered Services"). Provider's Participating Provider Agreement with Medco includes participation in the Medicare Part D prescription drug benefit programs administered by Medco utilizing all schedules in effect. Provider's decision not to participate in this Agreement will not modify that Provider's current contractual relationship with Medco. To the degree any provisions in the Agreement conflict with this Addendum, the provision of this Addendum shall prevail. The terms of this Addendum will remain in effect until the termination of the Agreement currently in force between Provider and Medco.

1. Provider agrees to render Covered Services to Eligible Persons. Provider agrees to participate as a network Provider in one or more of Medco's Medicare Part D Provider networks under the terms and conditions agreed to by the parties. Any activities or services performed by Provider in connection with a Medicare Part D plan Sponsor's Medicare Part D plan will be consistent and comply with the Sponsor's contractual obligations as a Medicare Part D plan Sponsor. 42 CFR § 423.505(i)(3)(iii).
2. Provider agrees to participate in and provide Covered Services to Medicare Part D eligible members, including amendment to Provider's Participating Provider Agreement to participate in the Medicare Part D prescription drug benefit programs administered by Medco utilizing all Schedules in effect.
3. Provider will comply with all applicable Federal and State laws and regulations and Centers for Medicare & Medicaid Services ("CMS") instructions. Long-Term Care (LTC) Pharmacies shall comply with performance and service criteria as established by CMS for Long-Term Care Pharmacies and as set forth in the "Long-Term Care Provider Performance and Service Criteria Addendum," available upon request. 42 CFR § 423.505(i)(4)(iv).
4. In the event that Provider delegates any activity or responsibility related to Covered Services to subcontractor(s), the subcontractor(s) will be subject to the terms and conditions set forth in this Addendum. Provider will ensure that its agreements with such subcontractor(s), if any, provide that the subcontractor(s) will comply with all of the terms and conditions set forth in this Addendum. 42 CFR § 423.505(i)(3) and (4). Notwithstanding the provisions of this Section 4, Provider shall not delegate services under the Medco Agreement, unless it receives written permission from Medco.
5. Payments under this Addendum from Medco to Provider are made, in whole or in part, from Federal funds, and subject Provider to all laws applicable to the individuals or entities who receive Federal funds, including the False Claims Act (32 USC 3729, et. seq.), the Anti-Kickback Statute (section 1128B (b) of the Social Security Act), Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973. 42 CFR § 505(i)(4)(iv).
6. Provider will comply with State and Federal privacy and security requirements, including the confidentiality and security provisions stated in the Medicare Part D regulations at 42 CFR § 423.136.
7. Provider will comply with minimum standards for pharmacy practice as established by the States. 42 CFR § 423.153(c)(1).

11.2 MEDICARE PART D ADDENDUM PHARMACY NETWORK REQUIREMENTS

(continued)

8. Provider will maintain, for the current contract period and ten (10) prior years, all books, contracts, medical records, patient care documentation, and other records of Provider relating to Covered Services, in their original format for the greater of three (3) years or the period required by State law and allow those records to be transferred to an electronic format that replicated the original prescription for the remaining seven (7) years of the 10-year record retention requirement. 42 CFR § 423.505(d) CMS Application (Records Retention).
9. Provider will give the U.S. Department of Health and Human Service (HHS) and U.S. Comptroller General, and their authorized designees, the right to inspect, evaluate and audit all books, contracts, medical records, patient care documentation, and other records relating to Medicare Part D covered services during the term of the Agreement and for a period of 10 years following termination or expiration of the Agreement for any reason, or until completion of any audit, whichever is later. This provision shall survive termination of the Agreement. Provider agrees that CMS or its designees may have direct access to Provider's books, contracts, records, including medical records and documentation relating to the Medicare Part D program, on Provider's premises. 42 CFR § 423.505(i)(2)(ii).
10. If CMS or Medco or a Medicare Part D Sponsor client contracted with Medco determines that Pharmacy has not performed satisfactorily under this Agreement, CMS or Medco or Plan Sponsor may revoke any of the activities or reporting responsibilities delegated to Pharmacy by this Agreement. 42 CFR § 423.505(i)(4)(ii).
11. Medco and Medicare Part D Sponsor will monitor the performance of Provider on an ongoing basis, including, but not limited to, ongoing audits performed by, or on behalf of, Medco, which assesses whether Provider is in compliance with all Medicare Part D provisions. 42 CFR § 423.505(i)(4)(iii). Provider will give Medco the right to inspect, evaluate, and audit all books, contracts, medical records, patient care documentation, and other records, and Provider shall cooperate with Medco and Medicare Part D Sponsor as necessary to support Medco's and Medicare Part D Sponsor's monitoring strategy. 42 CFR § 423.505(i)(2) and CMS Prescription Drug Benefit Manual, Chapter 9 at 41—Medicare Part D Program to Control Fraud, Waste & Abuse. If Provider refuses to provide documentation as requested by Medco to demonstrate compliance with this Manual and CMS's directives, Medco reserves the right to assess up to a \$500 a day fee per Provider location or increase the *TelePAID*® transaction fee to a minimum of \$0.30 per transaction until the requirement has been met.
12. Provider will ensure that Eligible Persons are not held liable for fees that are the responsibility of Medco. Provider agrees that in no event, including but not limited to nonpayment by Medco's insolvency, or breach of Provider's Agreement with Medco, shall Provider or its subcontractors bill, charge, or collect a deposit from, seek compensation, remuneration, reimbursement, or payment from, or have recourse against, Eligible Persons for Covered Services provided pursuant to Provider's Agreement with Medco. This provision shall not prohibit the collection of coinsurance, co-payments, or deductibles or charges for non-Covered Services, where applicable. Provider further agrees that this provision shall survive the termination of Provider's Agreement with Medco regardless of the cause giving rise to termination and shall be construed to be for the benefit of the applicable Eligible Person(s). 42 CFR § 423.505(i)(3)(i). In addition, Provider understands and agrees that applicable dual eligible (Medicare/Medicaid) Members will not be responsible for any plan cost sharing for Medicare D services.

11.2 MEDICARE PART D ADDENDUM PHARMACY NETWORK REQUIREMENTS

(continued)

13. Applicable to Long-Term Care Provider only. Provider shall fully disclose to Medco in a format acceptable to Medco any and all discounts and rebate arrangements, access/performance rebates of other price concessions with or any other direct or indirect remuneration from drug manufacturers or other parties when such remuneration is designed to or likely to directly or indirectly influence or impact utilization of Medicare Part D drugs. Such disclosure shall detail the source of the funds, the purpose, and the specific dollar amounts paid to the pharmacy from the manufacturer for these purposes.
14. In the Long-Term Care setting when the Eligible Person is not the person presenting the prescription order directly to the pharmacist or the Provider staff, Provider shall comply with the following CMS requirement. When there is an issue with the requested prescription order, the physician or other prescriber may prescribe a different medication or request for an exception through the Medicare Part D exception process: (i) If Provider is offsite of the LTC facility, Provider must send (fax or deliver) the “Medicare Prescription Coverage and your Rights” notice to the location in the LTC facility designated to accept such notice; (ii) If Provider is on-site at the LTC facility, Provider must deliver the notice to the location that the LTC facility designated to accept the notice. Provider should indicate to the LTC facility staff that they are responsible for providing the Eligible Person (or his/her appointed representative) and his/her treating physician with the notice and for placing a copy of the notice in the Eligible Person’s file at the LTC facility. CMS Manual, Chapter 18, Section 40.3.1.
15. Provider will submit claims for Eligible Persons through the *TelePAID*[®] System, Medco’s real-time claims adjudication system. 42 CFR § 423.505(b)(17). In the event that Provider submits claims data on behalf of Medco, Provider, in addition to Medco, will certify to CMS regarding the accuracy, completeness, and truthfulness of the data and acknowledge that the claims data submitted on behalf of Medco will be used for the purposes of obtaining Federal reimbursement. CMS Prescription Drug Benefit Manual, Chapter 9 — Medicare Part D Program to Control Fraud, Waste & Abuse.
16. As communicated through the *TelePAID*[®] System, Provider will provide Eligible Persons with access to negotiated pricing and charge Eligible Persons the correct cost-sharing amount, including that which applies to individuals qualifying for low income subsidy as indicated through the *TelePAID*[®] System. 42 CFR § 423.104(g)(1).
17. Provider will review any drug utilization and other messages as communicated through the *TelePAID*[®] System and use professional judgment as to whether any clinical action is required. 42 CFR § 423.153(c)(2).
18. Provider agrees to cooperate with all quality assurance activities designed to reduce medication errors and adverse drug interactions as required by CMS or Medco including, but not limited to, establishing an internal medication error identification and reduction system. 42 CFR § 423.1-53(c)(4).
19. Provider agrees to comply and cooperate with Medco’s policies and procedures including policies, procedures, reporting, corrective actions, and training and education that support its compliance and fraud and abuse program. 42 CFR § 423.504. Provider agrees to provide Medco, on request, with copies of Provider’s corrective actions and compliance training attestation and compliance training module, and training attendance log, related to the Part D benefit. CMS Prescription Drug Benefit Manual Chapter 9 at 42–Part D Program to Control Fraud Waste & Abuse. Provider agrees to have in place and provide fraud, waste and abuse training to all employees who are directly or indirectly involved in the administration of Medicare benefits. If Provider refuses to provide

11.2 MEDICARE PART D ADDENDUM PHARMACY NETWORK REQUIREMENTS

(continued)

documentation as requested by Medco to demonstrate compliance with this Manual and CMS' directives, Medco reserves the right to assess up to a \$500 a day fee per Provider location or increase the *TelePAID*[®] transaction fee to a minimum of \$0.30 per transaction until the requirement has been met.

20. Provider agrees to: (1) train employees annually; (2) train new employees within thirty (30) days of date of hire; (3) track employee attendance; and (4) provide copies of training materials and attendance logs upon request.
21. Provider shall not employ or contract for the provisions of Covered Services with any individual or entity excluded from participation in the Medicare and Medicaid program under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person currently is employed by or under contract with Provider relating to the furnishing of Covered Services. Provider shall review the Office of Inspector General and General Services Administration exclusion files and verify on quarterly basis, or as often as required by CMS guidelines, that the persons it employs for Covered Services are in good standing. 42 CFR § 423.752(a)(6); CMS Fraud, Waste, and Abuse Guidelines. Each year during the term of this Addendum, or as often as required by CMS, Provider shall provide a written attestation to Medco confirming Provider's compliance and Provider's subcontractors' compliance with the requirements of this paragraph. Provider shall immediately disclose to Medco any debarment, exclusion or other event that makes its employees or subcontractor(s) ineligible to perform work related to federal healthcare programs.
22. Provider may not distribute printed information comparing the benefits of different Medicare Part D plans unless Provider accepts and displays materials from all Medicare Part D plan Sponsors with which Provider contracts. 42 CFR § 423.2668(k).
23. Provider will post or distribute notices instructing Eligible Persons to contact their Medicare Part D plan to obtain a coverage determination or request an exception if the Eligible Person disagrees with the information provided by the Provider. To satisfy this requirement, Provider must use the form notice attached to this Addendum and may not deviate from the content of this notice. This notice may be distributed to Eligible Persons or conspicuously posted at the provider. Posted notices must be large enough to be easily read by the target audience. 42 CFR § 423.562(a)(3).
24. Provider has an obligation to report compliance concerns and suspected or actual misconduct related to the Medicare Part D program. Provider may report fraud, waste, and abuse anonymously to Medco's confidential Medicare Fraud, Waste, and Abuse Hotline 1 800 303-9373, which is available 24 hours a day, seven days a week. Provider filing a report should not fear reprisal of any sort whatsoever. Provider is protected from retaliation for complaints under False Claims Act, as well as by other applicable Federal and State antiretaliation protections. 31 U.S.C. § 3730(h).
25. Provider will cooperate and comply with all CMS and Medco requirements regarding the processing of Eligible Person coverage determinations, grievances and appeals, including the obligation to provide information (including medical record and other pertinent information) to Medco within the time frame reasonably requested for such purpose. A copy of a representative sample of the Medicare Part D grievance and appeals procedures may be found on the Pharmacist Resource Center website at www.medco.com/rph.
26. Provider shall submit a report in writing to Medco within thirty (30) calendar days of Provider's knowledge of any and all civil judgments and other adjudicated actions or decisions against the Provider related to the delivery of any healthcare item or service (regardless of whether the civil

11.2 MEDICARE PART D ADDENDUM PHARMACY NETWORK REQUIREMENTS

(continued)

judgment or other adjudicated action or decision is the subject of a pending appeal). CMS Prescription Drug Benefit Manual, Chapter 9–Medicare Part D Program to Control Fraud, Waste & Abuse.

27. Provider shall not deny, limit, or condition coverage or the furnishing of healthcare services or benefits to Eligible Persons based on health factors, such as medical condition (including mental as well as physical illness), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. 42 CFR § 423.505(b) (3).
28. Medco’s Medicare Prescription Drug Plan and Medicare Part D Sponsor clients retain ultimate responsibility to comply with the terms of its CMS contract. 42 CFR § 423.5 05(i).
29. Provider shall comply with applicable CMS Medicare Part D vaccine administration requirements, as amended from time to time by regulatory agencies. 42CFR 423.100; CMS Medicare Part D Vaccine Administration Guidance.
30. The administration of the Medicare Part D program may require Provider’s participation in the secondary payment process, including but not limited to the coordination of benefit process and cooperate in the reprocessing of certain claims to ensure correction of enrollee eligibility and total reimbursements to Provider in accordance with network contract/schedules. Medicare Part D Sponsors are responsible for reimbursing or collecting amounts from Eligible Persons that result from the reprocessing of these claims. 42 CFR 423.464; CMS Medicare Part D Manual.
31. Provider shall be in compliance with all NPI and NCPDP standards and requirements applicable to Medicare Part D claims, as amended by regulatory agencies from time to time. 45 CFR Part 162.
32. Provider shall ensure professional services and ancillary supplies necessary for home infusion are in place before dispensing home infusion drugs to Eligible Persons in his/her place of residence. 42 CFR § 423.120(a) (4). Participating Home Infusion Provider may be required to attest to having complied with these CMS Home Infusion standards, and provide the attestation to Medco or its agent upon request.

Participating Home Infusion Provider, at a minimum, hereby agrees to:
 - (i) provide delivery of home-infused drugs in a form that can be administered in a clinically appropriate fashion;
 - (ii) provide 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; and,
 - (iv) provide delivery of home infusion drugs within 24 hours of discharge from an acute care setting, or later if so prescribed.
33. In accordance with CMS guidelines, payments made for Eligible Persons cost-sharing by any entity – including safety net provider – that has an obligation to pay for covered Medicare Part D drugs on behalf of Medicare Part D enrollees, or which voluntarily elects to use public funds for that purpose, will not count toward that beneficiary’s True Out-of-Pocket costs (TrOOP) expenditures. Provider shall let Medco know of the Eligible Person, if any and the claim(s) for which the cost sharing or co-payment is waived, so that Medco may delete those amounts from the Eligible Person’s TrOOP as required under the Medicare Part D program.

11.2 MEDICARE PART D ADDENDUM PHARMACY NETWORK REQUIREMENTS

(continued)

34. In accordance with the CMS March 30, 2009 “Issuance of the 2010 Call Letter” guidance, Medicare Part D prescription drug benefit plans and Sponsors were to exclude from Part D coverage NDCs not properly listed with the FDA (the Non-Matched List). NDCs that are not listed are effectively not eligible for reimbursement under Medicare Part D Plans. A complete listing can be found at:
http://www.cms.hhs.gov/PrescriptionDrugCovContra/03_RxContracting_FormularyGuidance.asp
42 CFR Part 422
35. This Amendment shall be automatically amended to conform to the requirements of applicable law, regulations, and CMS instructions.
36. LTC Providers only: LTC Providers shall have at least thirty (30) days and no more than ninety (90) days (i.e., up to 90 days) to submit claims to Medco for payment of Medicare Part D claims.
37. Provider may submit a claim to Medco after dispensing to member, if the claim meets other Part D requirements (e.g., for a formulary drug used for a medically accepted indication) and in a manner that provides sufficient detail to implement the calculation of TrOOP expenditures (e.g., via a single claim, Point-of-Sale transaction, and in HIPAA compliant format NCPDP 5.1 or D.0, as appropriate).
38. Medco shall provide for prompt pay of clean claims timely submitted by eligible Providers for Covered Services furnished to Medicare Part D members within such periods as required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and applicable regulations, within fourteen (14) days of receipt for claims submitted electronically, and thirty (30) days of receipt for clean claims submitted otherwise. A claim is deemed to be clean unless the Part D plan sponsor notifies the party submitting the claim of any defect or impropriety within ten (10) days following receipt of additional information. This section shall supersede any other provision to the contrary in this Manual, for Medicare Part D claims. 42 §§ CFR 423.505 and 423.520.
39. If applicable, Medco shall update any prescription drug pricing standard for reimbursement of network Providers that is based on the cost of a drug used by a Medicare Part D Sponsor and not less frequently thereafter than once every seven (7) days, to accurately reflect the market price of acquiring the drug, consistent with 42 CFR § 423.505(b)(21). 42 CFR § 423.505(h).
40. LTC Provider understands and agrees that billing the Medicare Part D program for drugs covered by Medicare Part A is prohibited. LTC Provider shall retrospectively review beneficiaries’ Part A eligibility with its contracted LTC facilities, reverse ineligible Part D claims, and refund beneficiaries who inappropriately paid Part D cost-sharing, as applicable. Medco audits shall include the review of potentially ineligible Part D payments for drugs covered by Medicare Part A and Medco shall retain the right to alert the applicable CMS account manager of improprieties. CMS Memorandum, November 25, 2008; CMS Prescription Drug Benefit Manual, Ch. 6, Sec. 20.2. Provider, if requested by Medco, shall obtain and provide documentation to demonstrate that claims were properly billed to the Medicare Part D program rather than being covered by Medicare Part A. Medco reserves the right to charge up to a \$100 a day fee per location for Providers who fail to provide the requested documentation.
41. “AWP” as used herein mean the current Average Wholesale Price as listed in print or electronically by First DataBank based upon the package size dispensed. If First DataBank ceases publishing or replaces AWP, or Medco decides to use another recognized pricing source or pricing benchmark other than AWP, Medco will provide ten (10) days’ notice of such change(s).

11.2 MEDICARE PART D ADDENDUM PHARMACY NETWORK REQUIREMENTS

(continued)

42. Providers, particularly long-term care (LTC) Providers, are required to work with the LTC facilities in which Eligible Members reside to identify any Medicare enrollees who have elected hospice and ensure hospice drugs are not billed to Part D Plan Sponsors.

43. LONG TERM CARE PROVIDER PERFORMANCE AND SERVICE CRITERIA

A. Comprehensive Inventory and Inventory Capacity — Provider must provide a comprehensive inventory of Medco's, Medco's Sponsors and Employer Sponsors' formulary drugs commonly used in the long term care setting. In addition, Provider must provide a secured area for physical storage of drugs, with necessary added security as required by federal and state law for controlled substances. This is not to be interpreted that the Provider will have inventory or security measures outside of the normal business setting.

B. Pharmacy Operations and Prescription Orders — Provider must provide the services of a dispensing pharmacist to meet the requirements of pharmacy practice for dispensing prescription drugs to LTC residents, including but not limited to the performance of drug utilization review ("DUR"). In addition, the Provider must conduct DUR to routinely screen for allergies and drug interactions, to identify potential adverse drug reactions, to identify inappropriate drug usage in the LTC population, and to promote cost effective therapy in the LTC setting. The Provider must also be equipped with pharmacy software and systems sufficient to meet the needs of prescription drug ordering and distribution to an LTC facility. Further, the Provider must provide written copies of the Provider's pharmacy procedures manual and said manual must be available at each LTC facility nurses' unit. Provider is also required to provide ongoing in-service training to assure that LTC facility staff is proficient in the Provider's processes for ordering and receiving of medications. Provider must be responsible for return and/or disposal of unused medications following discontinuance, transfer, discharge, or death as permitted by State Boards of Pharmacy. Controlled substances and out of date substances must be disposed of within State and Federal guidelines.

C. Special Packaging — Provider must have the capacity to provide specific drugs in Unit of Use Packaging, Bingo Cards, Cassettes, Unit Dose or other special packaging commonly required by LTC facilities. Provider must have access to, or arrangements with, a vendor to furnish supplies and equipment including but not limited to labels, auxiliary labels, and packing machines for furnishing drugs in such special packaging required by the LTC setting.

D. IV Medications — Provider must have the capacity to provide IV medications to the LTC resident as ordered by a qualified medical professional. Provider must have access to specialized facilities for the preparation of IV prescriptions (clean room). Additionally, Provider must have access to or arrangements with a vendor to furnish special equipment and supplies as well as IV trained pharmacists and technicians as required to safely provide IV medications.

E. Compounding/Alternative Forms of Drug Composition — Provider must be capable of providing specialized drug delivery formulations as required for some LTC residents. Specifically, residents unable to swallow or ingest medications through normal routes may require tablets split or crushed or provided in suspensions or gel forms, to facilitate effective drug delivery.

F. Pharmacist On-call Service — Provider must provide on-call, 24 hours a day, 7 days a week service with a qualified pharmacist available for handling calls after hours and to provide medication dispensing available for emergencies, holidays and after hours of normal operations.

11.2 MEDICARE PART D ADDENDUM PHARMACY NETWORK REQUIREMENTS

(continued)

G. Delivery Service — Provider must provide for delivery of medications to the LTC facility up to seven (7) days each week (up to three (3) times per day) and in-between regularly scheduled visits. Emergency delivery service must be available 24 hours a day, 7 days a week. Specific delivery arrangements will be determined through an agreement between the Provider and the LTC facility. Provider must provide safe and secure exchange systems for delivery of medication to the LTC facility. In addition, Provider must provide medication cassettes, or other standard delivery systems, that may be exchanged on a routine basis for automatic restocking. The Provider delivery of medication to carts is a part of routine “dispensing.”

H. Emergency Boxes — Provider must provide an “emergency” supply of medications as required by the facility in compliance with State requirements.

I. Emergency Log Books — Provider must provide a system for logging and charging medication used from emergency/first dose stock. Further, the Provider must maintain a comprehensive record of a resident’s medication order and drug administration.

J. Miscellaneous Reports, Forms and Prescription Ordering Supplies — Provider must provide reports, forms and prescription ordering supplies necessary for the delivery of quality Provider care in the LTC setting. Such reports, forms and prescription ordering supplies may include, but will not necessarily be limited to, pharmacy order forms, monthly management reports to assist the LTC facility in managing orders, medication administration records, treatment administration records, interim order forms for new prescription orders, and boxes/folders for order storage and reconciliation in the facility.

44. Formulary Transition Supply

All Part D Plans are required by CMS to provide a transition supply to Part D Eligible Persons. The intent is to provide immediate short term coverage for new Part D enrollees in order to continue ongoing therapies. It is imperative that Provider review *TelePAID*[®] messaging to ensure that Eligible Persons receive the appropriate transition supply. It is also imperative that Provider ensure that the Days’ Supply and the quantity dispensed are correct. Failure to provide transition supply, as directed by the *TelePAID*[®] messaging and the Eligible Person may result in a fee of \$50 per claim.

45. Patient Location Codes

To ensure proper reimbursement and ensure that the Sponsor provides the correct benefit to an Eligible Person, it is important that the Provider submit accurate patient location codes. Patient location codes must be entered as per the Payor Sheets in order to ensure appropriate adjudication of the claim. Home infusion and long term care claims must meet the CMS qualifications in order to submit the patient location codes. Failure to submit patient location codes may result in a fee of \$50 per claim.

For Version D.0, there are three new fields that must be used by the Provider to identify the Provider that is billing the claim. The fields are (1) pharmacy services type, (2) patient residence, and (3) place of service.

46. Coordination of Benefits

It is imperative that Provider ensure that it has accurate information for beneficiaries and that it appropriately coordinate an Eligible Person’s benefit.

11.3 BEST AVAILABLE EVIDENCE (BAE) AND LOW INCOME SUBSIDY (LIS) POLICY

Best Available Evidence (BAE) Policy

In accordance with CMS regulations, the best available evidence policy will be invoked when the Low Income Subsidy (LIS) information in CMS's systems for Medicare Part D enrollees does not appear to be correct and when:

- a. Medicare Part D enrollee or participating Provider has evidence from the SSA, a state Medicaid agency that supports a more favorable LIS status for the enrollee or
- b. Medicare Part D enrollee claims to be subsidy eligible based on the full or partial dual eligible and cannot provide appropriate documentation.

Verify BAE contact information

Provider must contact Medco Provider Help Desk at 1 800 922-1557 to validate whether:

- a. Member is enrolled under a Health Plan where Medco provides PBM services – Medco Client is the Part D Sponsor
- b. Member is enrolled under Medco PDP plan, employer group plan sponsored by Medco – Medco is the Part D Sponsor

Steps to take when BAE discrepancy is believed to exist – Medco client is the Part D Sponsor

- a. Help Desk representative will provide the pharmacist with the BAE contact information for the Health Plan.
- b. A Health Plan will advise the pharmacist what steps the pharmacist should take in order for the client to update LIS information in Medco system.

Steps to take when BAE discrepancy is believed to exist – Medco is the Part D Sponsor

When BAE discrepancy is believed to exist, Provider must provide Medco with the following:

- a. Supportive documentation, if available (see below for details)
- b. If member has more or less than three (3) days of medication remaining
 - a. If member has 3 or more days of medication remaining, indicate “Non-Immediate BAE Assistance Needed”
 - b. If member has less than 3 days of medication remaining, indicate “Immediate BAE Assistance Needed”
- c. Member's Name (First, Last)
- d. Member's ID Number
- e. Member's Medicare Number (Health Insurance Claim Number – HICN)
- f. All documentation must include Provider's name, NPI number, NCPDP number, and a name of a Provider contact person and his/her telephone number or e-mail address to facilitate a return response.

11.3 BEST AVAILABLE EVIDENCE (BAE) AND LOW INCOME SUBSIDY (LIS) POLICY

(continued)

Provider may send all required documentation and information via: Fax to: 1 570 614-0268

Mail to: Medco
P.O. Box 4558
Scranton, PA 18505

Documentation: Any one of the following will be considered to be valid documentation:

For Dual Eligible:

- A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date during a month after June of the previous calendar year;
- A copy of a State document that confirms active Medicaid status during a month after June of the previous calendar year;
- A print-out from the State electronic enrollment file showing Medicaid status during a month after June of the previous calendar year;
- A screen print from the State's Medicaid systems showing Medicaid status during a month after June of the previous calendar year;
- Other documentation provided by the State showing Medicaid status during a month after June of the previous calendar year; or,
- A letter from SSA showing the individual receives SSI; or
- An Important Information letter from SSA confirming that the beneficiary is “. . . automatically eligible for extra help”

For Institutionalized Individuals:

- A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
- A copy of State document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
- A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year

Note: The documents listed above are valid for the purpose of establishing the correct LIS cost-sharing level and effective date for individuals who should be deemed eligible for LIS.

- For individuals who are not deemed eligible, but who apply and are found LIS eligible, a copy of the SSA award letter.

11.3 BEST AVAILABLE EVIDENCE (BAE) AND LOW INCOME SUBSIDY (LIS) POLICY

(continued)

LTC Providers Only: From time to time, the Low Income Subsidy (LIS) eligibility information in CMS's systems for Medicare Part D enrollees may be updated retrospectively. When this occurs, LTC Provider's attestation of noncollection of co-payments for Medicare Part D LIS enrollees who are either members of the Medco PDP or members of a plan administered by Medco on behalf of a Part D sponsor will be required. Failure of LTC Provider to attest to this noncollection of co-payments may result in Medco holding reimbursements of these cost-sharing amounts.

11.4 REIMBURSEMENT OF COST-SHARING AMOUNTS FOR LONG TERM CARE PHARMACIES

Long Term Care (LTC) pharmacies generally do not collect cost sharing amounts from known institutionalized dual eligible beneficiaries of Medicare Part D plans or their responsible parties. LTC pharmacies may seek reimbursement for any cost-sharing amounts not collected from LIS-Eligible enrollees either prospectively or retrospectively.

Prospective LTC Attestation Process

To participate in the Prospective LTC attestation process, the Provider must sign an annual attestation agreeing to defer collection of the cost sharing amounts for LIS beneficiaries on a go forward basis. If the Provider makes a claim adjustment due to retroactive eligibility subsidy-level changes, the LTC Provider will automatically receive the cost sharing amount. If the LTC Provider subsequently discovers that the cost-sharing amount has been improperly collected from a LIS beneficiary or his or her responsible party, the Provider must return the cost-sharing amount to the eligible party.

To participate in the Prospective LTC attestation process, Provider should call the Provider Services Help Desk or write to:

Medco
Attn: Retiree Solutions, LTC-ADJ
225 Summit Avenue
Montvale, NJ 07645

Retrospective LTC Attestation Process

The Retrospective attestation process will apply to LTC pharmacies that do not opt into the Prospective process. Each LTC Provider will receive a quarterly Retrospective Attestation Package at the end of each quarter. The package will detail the previous quarter's cost-sharing adjustments for LIS beneficiaries that may not have been collected by the LTC Provider. Provider must review all cost sharing amounts and claim detail. Within thirty (30) days of receipt of the report, the LTC Provider must submit a report to Medco, detailing which beneficiaries are entitled to payment. Failure to submit a response will result in cost sharing amounts being deferred to the beneficiaries.

11.5 LONG TERM CARE PHARMACY LEVEL OF CARE CHANGES

Medicare claims that reject for Refill Too Soon with an additional message “IF LEVEL OF CARE CHANGE CALL PHARM HELP DESK” will require authorization from the Help Desk. This message is seen on Medicare claims where the member is eligible for a transition supply if the member has exited from an LTC facility/hospital/skilled nursing facility/psychiatric hospital or changed from hospice care to Medicare Part A and Medicare Part B benefits. When the message is presented via the *TelePAID*[®] System and the member had one of these events in the last ninety (90) days, Provider must call the Pharmacy Help Desk for authorization to override the claim.

- Note: The override that is supplied cannot be re-used without calling the Pharmacy Help Desk each time you believe a member qualifies for a transition fill. A member only qualifies for one transition fill per Level of Care change.

When an authorized override has been obtained, Provider must note the override on the original prescription. The notations must contain the reason for the override and, where applicable, the name of the Medco representative that authorized the override and the authorization claim number. If Provider fails to document an appropriate reason for the override, the claim will be subject to audit recovery.

MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

You **have the right to request a coverage determination and get a written explanation** from your Medicare drug plan if:

- Your prescriber or pharmacist tells you that your Medicare drug plan will not cover a prescription drug in the amount or form prescribed; or
- You are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription drug.

You **also have the right to ask** your Medicare drug plan **for an exception** (a special type of coverage determination) **and get a written explanation** from your Medicare drug plan if:

- You believe you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- You believe a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- You believe you should get a drug you need at a lower cost-sharing amount.

What you need to do:

- Contact your Medicare drug plan to ask for a coverage determination, including an exception request.
- Refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE to find out how to contact your drug plan.
- When you contact your Medicare drug plan, be ready to tell them:
 1. The prescription drug(s) that you believe you need. Include the dose and strength, if known.
 2. The name of the Provider or prescriber who told you that the prescription drug(s) is not covered.
 3. The date you were told that the prescription drug(s) is not covered.

The Medicare drug plan's written explanation will give you the specific reasons why the prescription drug is not covered and will explain how to request an appeal if you disagree with the drug plan's decision.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. The time required to complete this information collection is estimated to average one minute per response, including the time to select the preprinted form, and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form No. CMS-10147 (10/31/2011)

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