

Chapter 22

Pharmacy Services

The purpose of this chapter is to explain PrimeWest Health pharmacy policies and procedures. PrimeWest Health utilizes Prime Therapeutics (Prime) as its pharmacy claims processor.

PrimeWest Health Contact Information

If you need additional information, please contact:

PrimeWest Health
2209 Jefferson St, Ste 101
Alexandria MN 56308

For general member questions, call **1-866-431-0802** (toll free).

PrimeWest Health website: www.primewest.org

Visit the PrimeWest Health website for the following information:

1. **PrimePointers** (providers) and **PrimeLines** (member) newsletters
2. Announcements
3. Requests and inquiries
4. Member services
5. Contact information
6. Exception request forms
7. Formulary information
8. Additional policies and procedures

Prime Therapeutics, LLC Help Center Contact information

Prime Therapeutics, LLC (Prime)
Mail Route PWEST
PO Box 64812
Saint Paul, MN 55164

1-800-821-4795 (toll free)

The Prime Therapeutics, LLC (Prime) Contact Center has staff to assist pharmacies with processing questions or problems. Representatives are available 7 a.m. – 11 p.m., Monday through Friday, and 7:30 a.m. – 6 p.m., Saturday and Sunday. Representatives are also available on-call for emergency situations. Please follow the prompts if calling after business hours.

Federal Anti-Fraud Statutes

Pharmacies cannot use pharmaceutical manufacturers' coupons, discounts, or similar promotions in order to attract prescription business from Medical Assistance recipients. Federal anti-fraud and abuse provisions prohibit certain types of business transactions or arrangements, per Section 231(h) of the Health Insurance Portability and Accountability Act (HIPAA) and the Office of Inspector General Special Fraud Alert, 59 Fed. Reg. 242; 1994. See [Requirements for Providers](#), Chapter 1 for details.

How to Determine Drug Coverage

[Visit our website for drug coverage determinations.](#)

Please choose the appropriate formulary, as they differ between coverage groups. Questions regarding coverage of a particular medication can be directed to the [formularies](#) listed on the PrimeWest Health website or by calling Prime’s help desk at **1-800-821-4795** (toll free).

Labeler Codes

Each listed drug product is assigned a unique 11-digit, 3-segment number, known as the National Drug Code (NDC). The first segment (5 digits) identifies the manufacturer or labeler of the drug, the second segment (4 digits) identifies the drug, and the third segment (2 digits) identifies the package size. Minnesota Health Care Programs (MHCP) requires the 11-digit 5-4-2- format for billing or reporting a NDC. Use the [NDC Format Conversion](#) chart to convert a 10-digit NDC to an 11-digit NDC.

Tamper-Resistant Prescription Blanks

The [Appropriations Act of 2007](#) states that payment will not be made for prescriptions in non-electronic form for Medical Assistance (MA)-covered outpatient drugs unless the prescription was executed on a tamper resistant prescription blank. This law does not affect E-prescribed, faxed or prescriptions phoned in to the pharmacy by the prescriber.

Effective October 1, 2008, handwritten prescriptions must be executed on a tamper resistant prescription blank with at least one characteristics from all three categories as outlined in the [February 2008 NCPDP letter to Medicaid](#).

To help pharmacists to identify tamper resistant prescriptions and check for tampering, MHCP recommends tamper resistant prescription blanks display preprinted text identifying the tamper resistant features.

The “serial number” in Category 3 is not acceptable as a valid tamper resistant feature. MHCP does not track serial numbers. A unique number on a prescription generated by an automated medical record does not satisfy the tamper resistant requirements in any category.

Best practices information is available in the [July 2008 NCPDP letter to Medicaid](#).

General Claim Information

Processor Control Number

Prime requires a separate processor control number for each carrier. A bank identification number (BIN) is also required when adjudicating claims through the online system. Use the following codes for all PrimeWest Health members:

Plan Type	BIN	PCN
PMAP (Medicaid)	610455	PWEST
MSHO* Part D Claims	610455	MPDPW
MSHO & SNBC** Part B Claims	610455	PWEST
SNBC Part D Claims	610455	MPDPH

*PrimeWest Health’s name for this program is PrimeWest Senior Health Complete (HMO SNP)

**PrimeWest health’s name for this program is Prime Health Complete (HMO SNP)/(SNBC)

NDC (National Drug Code)

The NDC number used on the claim shall be the NDC number from the pharmacy's in-stock package size from which the prescription product was dispensed.

Effective March 15, 2011, providers will be required to submit an NDC with all Not Otherwise Specified (NOS) J Healthcare Common Procedure Coding System (HCPCS) codes. NOS J HCPCS code services billed over \$100 will be subject to evaluation and may require authorization for further processing.

Please use the individual field available on the 837 claim format to enter the NDC code when submitting your claim.

Days Supply

The pharmacy should submit the number of consecutive day's supply the prescription product will last. Future refills may be rejected if the days supply is submitted inaccurately. For prescription products that cannot be broken (e.g., inhalers topical creams, eye drops, over-the-counter [OTC] products), where the *smallest unit available* exceeds the benefit plan for the member, the pharmacy should submit the maximum days supply allowed under the member's benefit. *Example:* Member's benefit allows a 34-day supply. One inhaler will last 40 days. The pharmacy should bill the inhaler as a 34-day supply. In situations where one unit does not maximize the member's benefit (e.g., inhalers), the pharmacy should only submit the quantity that falls within the benefit. *Example:* Member's benefit allows a 34-day supply. One inhaler will last 28 days. The member should receive one inhaler.

Plan Type	Day Supply
PMAP (Medicaid)	34 days
MSHO (Medicare B & D)	31 days
SNBC (Medicare B & D)	31 days

Dispensed Package Size

When a pharmacy submits a claim for a prescription drug service provided by the pharmacy, the pharmacy must submit the NDC number for the original package size from which the prescription drug service was dispensed. *For example,* if a drug is purchased in a 5,000-count bottle and repackaged in 100-count bottles prior to dispensing, the NDC for a 5,000-count bottle must be used. In this case, using the NDC for a 100-count bottle is not permitted. Many drugs distributed by repackagers are not covered by PrimeWest Health. A pharmacy may not dispense a repackager's drug and then bill PrimeWest Health using the original manufacturer's NDC. Prescriptions may not be separated and dispensed by doses. If separate packaging is required, the pharmacy must use a duplicate label. *For example,* a dose required in school or adult care center should not be dispensed as a separate prescription.

Benefit Plan

Existing benefits may change without prior notice to the pharmacy. The claim adjudication system will provide the pharmacy with current benefit information. Brief explanations of common benefit designs are listed in the following sections. If you have questions about any benefit limitation, please call the Prime Pharmacy Help Center at **1-800-821-4795** (toll free).

Non-Covered Services

When a claim is submitted for a non-covered drug, the pharmacy will receive NCPDP reject code 70, “Product/service not covered.”

Generic Mandate

Pharmacies are required to substitute a generic equivalent or lower priced medication and inform the member of the substitution under applicable Minnesota State Pharmacy Laws. If the member objects to the substitution, the following codes may be tried. Use of these codes does not guarantee that the formulary exception process can be avoided.

1. DAW 1 Override

This allows the prescribing provider to request that the brand name product be dispensed instead of an equivalent generic without passing an ancillary charge to the member. The claim must be submitted with a DAW of 1 to override the pricing and to provide payment for the brand name product. If DAW 1 is used in processing a claim, the written prescription must contain documentation of the “Dispense as Written” order from the prescribing provider. If the prescription is telephoned in, the pharmacist must manually write on the written prescription document “Dispense as Written.” (A formulary exception must be submitted to Prime for review to see if it meets criteria on an individual basis. [Visit the PrimeWest Health website for the authorization forms.](#))

2. DAW 2 Override

Use this if the member requests a brand name product instead of an equivalent generic without paying an ancillary charge. The pharmacy should indicate on the prescription that the member requested the brand and submit the claim using a DAW of 2.

Online Claim Submission

The "E3" initiative is a set of electronic data interchange (EDI) requirements designed to fulfill the requirements of MN Stat. sec 62J.536. Starting with submission dates on or after July 15, 2009, all professional and institutional claims must be submitted electronically in order to comply with the Statute. These include all claims currently processed by PrimeWest Health, including 837P (professional), 837I (institutional), 837D (dental), pharmacy claims, and crossover claims, which include payment information from other insurance carriers via the coordination of benefits (COB) process. For more information on billing, please see EDI requirements in [Billing Policy](#), Chapter 4.

The pharmacy is required to submit all claims online to Prime for all prescription drug services provided to a member, including situations where:

1. The copay equals the pharmacy payment
2. The pharmacy payment is less than the copay

The pharmacy must submit claims online using the format designated by Prime. The pharmacy has 90 days from the date of service to submit a claim online. The pharmacy is required to submit the Usual and Customary Charge (U&C) on each claim processed through the online adjudication system. If the claim is older than 90 days, the pharmacy must submit a paper claim to Prime. Claims exceeding 180 days may not be eligible for reimbursement.

Online Availability

The online system is available for claims processing 24 hours a day, 365 days a year.

In the rare event that the Prime claim system is unavailable, or if a problem occurs at the switch company, the pharmacy should provide the member with enough medication until the claim can be adjudicated online.

Claim Reversal

The pharmacy has 10 days from the date of service to reverse a claim. Any prescription that has not been delivered or received by a member must be reversed through the POS claim adjudication system within 10 days from date of service.

Coordination of Benefits (COB)

COB capabilities are now available on a limited basis. Please call PrimeWest Health Utilization Management at **1-866-431-0803** (toll free) for assistance in processing secondary claims. Keep in mind that all secondary claims submitted to PrimeWest Health must be on our formulary lists in order to be processed for payment. Non-formulary items will deny at POS for secondary claims unless a Prior Authorization has been received.

Claim Formats

1. POS claims must be submitted in the current NCPDP version as specified by Prime.
2. A Universal Claim Form (UCF) can be submitted for paper submissions

A Prime payer specification sheet can be found at www.primetherapeutics.com for a complete list of required and/or situational processing requirements.

Copay Charge

The copay is the amount specified by PrimeWest Health that the member is required to pay to the pharmacy for prescription drug services. Prime passes back the appropriate copay to be collected from the member when the claim is adjudicated through the online system.

1. The pharmacy will only collect the copay adjudicated back from Prime on the claim. No additional costs will be requested for services.
2. If the member cannot pay the copay, service may not be denied at that time. Services cannot be withheld or refused if the member is unable to pay the copay or has other debts unpaid. Please refer to [42 CFR 447.53](#) for additional details.
3. Minnesota Senior Health Options (MSHO) Special Needs BasicCare (SNBC) members entering a Long-term Care (LTC) facility will be responsible for any copays on their prescriptions for at least the remainder of that month, sometimes longer. For stays in the LTC facility anticipated to be less than a month, copays would still apply and be the responsibility of the member until enrollment is updated to reflect institutional status.

Eligible Providers, Prescribers, Recipients

Eligible Dispensing Providers

1. A pharmacy that is licensed by the Minnesota Board of Pharmacy
2. A pharmacy enrolled into the Prime network of pharmacies
3. An out-of-network pharmacy, licensed by a state board of pharmacy, that applies for retroactive enrollment
4. The pharmacy must maintain a clean professional environment in accordance with all state pharmacy laws

5. The pharmacy must maintain all license requirements established by the Board of Pharmacy in its jurisdiction
6. A physician located in a local trade area where there is no PrimeWest Health-enrolled pharmacy;
 - a. The physician, to be eligible for payment, must personally dispense the prescribed drug according to applicable Minnesota statutes, and must adhere to the labeling requirements of the Minnesota Board of Pharmacy
7. A physician or nurse practitioner employed by or under contract with a community health board for communicable disease control.

Eligible Prescribers

A physician, osteopath, dentist, podiatrist, nurse practitioner, mental health certified nurse specialist, optometrist, physician assistant, or other health care professional licensed to prescribe drugs under Minnesota Statute or, the laws of another state or Canada may prescribe drugs within the scope of his/her profession. Pharmacists may prescribe over-the-counter (OTC) medications to PrimeWest Health members.

Provider Identifier

In accordance with State and Federal regulations, National Provider Identifiers (NPI) of the pharmacy and practitioners must be transmitted with all claims. Failure to use the pharmacy's NPI will result in a denied claim. If reasonable efforts to obtain and send the NPI of the prescriber are tried, the pharmacy can use other identifiers in accordance with their current pharmacy benefits management (PBM) agreement. A pharmacy can use the Drug Enforcement Agency (DEA) number as identification for the prescribing provider. If the provider's DEA number is also unavailable, the pharmacy may substitute its own DEA number in its place.

Pharmacist Prescribing - OTC Medications

The following policies apply to pharmacists prescribing OTC medications:

1. OTC medication must be medically necessary, and the recipient must not need a referral to another health care professional
2. Drug therapy must be reviewed for potential adverse interactions
3. Drug counseling must be consistent with MN Rules part [6800.0910](#)
4. Keep on file a prescription as defined in MS [151.01](#), subd. 16. As with all other MA and Prescription Drug Plan (PDP) prescriptions, the prescription must be kept on file for the term applicable to Federal and State requirements. For the purposes of providing OTC drugs to recipients, the pharmacist is the prescriber who must sign the prescription. Prescriptions may be refilled for up to 12 months as specified in MN Rules part [6800.3510](#).
5. Prescription must be dispensed in accordance with all relevant sections of MS [151](#) and MN Rules part [6800](#)
6. The pharmacy's DEA number should be used in conjunction with the evaluating pharmacist when sending through claims. Individual pharmacists will not be enrolled as providers.
7. For the original fill, document on the prescription information regarding medical necessity, drug therapy reviews, and drug counseling. For refills, document in the recipient's profile any updated information regarding medical necessity, drug therapy reviews, and drug counseling.
8. The pharmacist is required to have the recipient sign for receipt of the prescription whenever possible
9. OTC drug products must be billed at the shelf price of the pharmacy. If a pharmacy is not accessible to, or frequented by the general public, or if the OTC drug is not on display for sale to the general public, then the usual and customary charge for the OTC drug will be the actual acquisition cost of the product plus a reasonable mark-up based on the actual acquisition cost. The Prime maximum allowable cost (MAC) list will supersede any submitted OTC drug prices.
10. The smallest quantity of OTC medication must be selected to fulfill the member's needs for the 31/34 day

supply. In the event an OTC product contains greater than the 31/34 day supply, it is acceptable to dispense the entire, unopened container and submit a day's supply of 31/34 to allow the claim to be paid. Efforts should be taken by the pharmacy to document this and stock the smallest container size available to achieve the month's supply.

Eligible Recipients

Member Eligibility

A member's eligibility can be verified through the claim adjudication system or by calling the Prime Pharmacy Help Desk **1-800-821-4795** (toll free). Under no circumstances should a member, whose eligibility has been verified, be denied a prescription drug service (subject to pharmacist's professional judgment) or be asked to pay more than the transmitted copay.

Eligibility Verification

1. Access recipient eligibility information by using the PrimeWest Health Web Portal, Provider Contact Center, or the automated Minnesota Department of Human Services (DHS) Eligibility Verification System (which includes a telephone service and a web portal within MN-ITS).
2. Verify member eligibility through:
 - a. [PrimeWest Health Web Portal](#). Prior registration is required using the [Web Portal Registration Form](#).
 - b. PrimeWest Health Provider Contact Center: **1-866-431-0802** (toll free)
 - c. [DHS MN-ITS web portal](#)
 - d. DHS EVS Line: **1-651-431-2700** or **1-800-657-3613** (toll free)
 - e. [Emdeon](#): **1-866-369-8805** (toll free)

Standard Eligibility Format

The eligibility format used by the majority of PrimeWest Health members includes the following elements:

1. Member identification (ID) number
2. Date of birth
3. Gender status
4. Prescriber identifier (DEA #)

The pharmacy can require a person to produce a member ID card or other photo ID prior to providing a prescription drug service. The ID card does not ensure a member's eligibility. If a member does not have a member ID card/valid photo ID and the pharmacy is unsure of eligibility, call Prime's Pharmacy Help Desk or use of the MN-ITS system to verify eligibility on the date of service to obtain accurate member information prior to processing a claim. The member's Medical Assistance number is the same as his/her PrimeWest Health ID number.

Responsibility of Pharmacy

All pharmacy claims for medications are processed by Prime. Pharmacies should follow their policies and procedures for proper submission of claims. In addition to Prime's requirements, PrimeWest Health requires the following:

1. Provide prescription drug services to all members in accordance with the standard of practice of the communities in which the pharmacy provides services. Service should be provided without regard to race, religion, sex, color, national origin, age, or physical or mental health status, upon the written or verbal prescription order or refill from a prescribing provider

2. Submit all claims online to Prime for adjudication within 90 days from the date the prescription is dispensed
3. Submit no more than the Usual and Customary Charge (U&C) for all claims for prescription drug services
4. Submit the NDC from the original package size from which the prescription drug was dispensed
5. Comply with the Drug Formulary unless otherwise directed by the prescribing provider to dispense the prescription “Brand Necessary,” “DAW,” etc.
6. Collect all applicable copays from the member at time of service unless other arrangements have been made. If the member is unable to pay the copay, the pharmacy may not refuse service at that time. Future prescriptions may be denied if it is the pharmacy’s policy to not allow delinquent accounts. Under no circumstances shall the pharmacy collect or attempt to collect additional fees for prescription drug services provided.
7. Contacting the member’s prescriber in cases of claims rejection related to Utilization Management policies or non-formulary status is strongly recommended
8. Notification of members *prior* to dispensing of any rejected medications claims for any reason, especially those members residing in LTC facilities, of the potential of non-coverage is expected of all pharmacies serving PrimeWest Health members

Summary of Pharmacy Requirements while Filling Prescriptions

1. Verify “**AS DIRECTED**” prescription orders by contacting the prescribing provider to verify directions. This allows the pharmacy to provide an accurate days supply on the claim. If the prescribing provider is unavailable, the pharmacy should ask the member how he/she was instructed to take the prescription drug. A pharmacy audit of files with inaccurate or unjustified quantities or direction may result in recoupment of payments.
2. Maintain a signature log that contains the signature of the member or designee, indicating receipt of the prescription drug. Mailed or delivered prescriptions should be noted on the signature log with the date of delivery. An electronic transaction log may be used in lieu of a signature log

Limitations on Pharmacy Services

1. A prescribed drug must be dispensed in the quantity specified on the prescription unless the pharmacy is using unit dose dispensing or the specified quantity is not available in the pharmacy when the prescription is dispensed. Only one dispensing fee is allowed for dispensing the quantity specified on the prescription.
 - a. OTC drugs must be dispensed in the manufacturer’s original, unopened container and can be dispensed in greater than 31/34-day supplies, if necessary, to meet that requirement. If dispensing under this provision, the smallest commercially made form must be used.
 - b. Inhalers or unit of use medications that cannot be dispensed in partial quantities are acceptable to dispense at the maximum monthly supply. If dispensing under this provision, the smallest commercially-made form must be used.
2. Except as noted above, an initial or refill prescription for a maintenance drug must be dispensed in not less than the maximum monthly supply, unless the pharmacy is using unit dose dispensing or the drug is clozapine, the dispensing fee is limited to one per month, and no additional dispensing fee will be paid until that quantity is used by the recipient.
3. Except as described below or unless the drug is clozapine, the dispensing fee billed by or paid to a particular pharmacy or dispensing physician for a maintenance drug is limited to the fee per maximum monthly supply.
4. More than one dispensing fee per calendar month for a maintenance drug for a recipient is allowed if the record kept by the pharmacist or dispensing physician documents that there is a significant chance of over dosage by the recipient if a larger quantity of drug is dispensed, and if the pharmacist or dispensing physician writes of this reason on the prescription.
5. Refill prescriptions must be authorized and approved by the prescriber as consistent with accepted pharmacy practice. Refills must be documented in the prescription file and initialed by the pharmacist who refills the prescription.

6. OTC medications must be dispensed in the manufacturer’s unopened container. Any OTC drug available in packaging designed for OTC sale to the public must be dispensed in that original packaging.

Unit Dose Dispensing

Providers specially enrolled with Prime as a unit dose dispenser can receive a unit dose dispensing fee. To obtain a Provider Agreement Addendum, contact:

Prime Therapeutics, Inc.
PO Box 64812
Saint Paul, MN 55164

1-800-821-4795 (toll free)

1. Unit dose packaging procedures and fees apply only to legend drugs. OTC products must be dispensed in their original containers.
2. Dispensing fees for legend drugs dispensed in unit dose packaging may not be billed or paid for more often than once per calendar month or cycle, whichever results in the lesser number of dispensing fees, regardless of the type of unit dose system used by the pharmacy or the number of times during the month that the pharmacy dispenses the drug. If the member’s prescription drug service is dispensed in small increments during the calendar month, the pharmacy must keep a written record of each dispensing act showing the date, NDC, and quantity of the drug dispensed. The pharmacy may only bill one dispensing fee.
3. Only one dispensing fee per calendar month must be billed or paid for each maintenance legend drug, regardless of the type of unit dose system used by the pharmacy or the number of times during the month that the pharmacy dispenses the drug.
4. The date of service reported on the claim must be the actual date the entire quantity was dispensed. For prescription drug service dispensed in unit dose containers, the last dispensing date of the calendar month or calendar cycle must be used as the date of service transmitted via POS.
5. **LTC Therapy Claim Identifier** – The pharmacy must submit the NCPDP field with a value of 03 to identify the prescription drug service as a nursing home therapy drug, with a value of 05 to identify the prescription drug service as a rest home therapy drug to access the terms and conditions of the Prime Medicare Long Term Care Network.

Returning Unused Unit Dose Package Drugs

Drugs dispensed in unit dose packaging must be returned to a pharmacy as specified below when the recipient no longer uses the drug. A provider of pharmacy services using a unit dose system must comply with MN Rules part [6800.2700](#).

1. An LTC facility must return unused drugs dispensed in unit dose packaging to the provider that dispensed the drugs.
2. The provider that receives the returned drugs must rebill Prime for the actual amount of medication used on the electronic claim system.
3. If the pharmacy is unable to reprocess the claim on the electronic claim system, a check may be sent. An estimation of the approved medication amount minus any applicable dispensing fees should be calculated. This is a reimbursement method of last resort. **Checks must be made payable to “Prime Therapeutics LLC” and be mailed to:**

Prime Therapeutics LLC.
PO Box 64812
Saint Paul, MN 55164

Compound Drugs

“Compound Prescription” means a prescription where two or more medications are mixed together. One of these drugs must be a Federal Legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound prescription if it is reconstituted or if only water, alcohol, or sodium chloride solutions are added to the active ingredient. Compound drugs are reimbursed based on the average wholesale price (AWP) of all the ingredients and total quantity of the compound being dispensed. Preparation time is not used in the calculation of reimbursement for compound drugs. Compounds are driven by the compound code the pharmacist enters into the system. Once the claim is determined to be a compound, it will adjudicate off of how Prime has set up and the price/patient pay schedules. Regardless of if it's submitted via through a pharmacy or paper claim, Prime will pay the claim on the most expensive ingredient submitted. As far as fees go, Prime does not pay a higher dispensing fee for compounds other than those fees and rates agreed upon between Prime and its network pharmacy when they do contracting. Generally, compounds are set up to pay on the same rate scale as brands. Compound drugs can be submitted through the online adjudication system using the following guidelines:

1. The Compound drug must contain at least one Federal legend ingredient. A Federal legend drug by law is one that can be obtained only by prescription and bears the label “Caution, Federal Law prohibits dispensing without a prescription,” or “Rx Only.”
2. All legend products contained in the compound must have a valid NDC number
3. The NDC number of the most expensive legend ingredient must be submitted on the claim
4. The quantity of the entire compound should be submitted
5. The AWP for the entire compound’s combined ingredients should be submitted
6. The pharmacy should flag the claim as a compound drug in its system prior to adjudication
7. Bioequivalent compounds of a manufactured product are not covered
8. Sustained-release and extended-release compounds are not covered
9. Syringes cannot be billed as a compound

Accurate Quantity

The quantity dispensed must be entered exactly as written. Quantities should be submitted as metric quantity (including decimal points). The pharmacy must enter the exact quantity, no rounding up or down on claims.

OTC Products

Price will not exceed shelf price for customer purchase.

Solutions Prescriptions

Solutions such as saline for nebulizers, intravenous solutions (IV), irrigation solutions, and diluents are to be billed under medical supply items.

General Insulin Benefits

A valid prescription must be on file for any insulin dispensed to a member.

Insulin should be dispensed within the days supply limits set by PrimeWest Health.

Insulin Supplies

Unless indicated by the POS system, insulin syringes and needles are generally a covered benefit. For MSHO/SNBC members these, are considered Part D covered items and should be sent to that specific BIN & PCN listed above.

A valid prescription is required for insulin syringes and needles that are dispensed to a member.

Complaints and Appeals

Please contact the PrimeWest Health Complaint, Appeals, and Grievance Coordinator at **1-866-431-0801** (toll free) for full information regarding complaints and Appeals.

Utilization Management Programs for PMAP & MSHO

Administrative Determinations

MAC List

Multiple manufacturers of a given drug product create competition in the marketplace resulting in decreased acquisition costs. Typically, generic drugs are introduced at costs ranging from 20 to 50 percent lower than those of the original brand name product. A number of elements support the idea of a MAC program rather than a specific percentage discount for reimbursement of multi-source products.

1. Generic drugs are sold to pharmacies over a very wide discount range off AWP, whereas brand drugs are typically sold at a very narrow discount off AWP. Thus, a single discount percent off AWP does not fit all generics.
2. A MAC program can select a reimbursement price that will cover most generics, but not the brand version. Reimbursement lower than the brand acquisition is a strong driver to generic dispensing.
3. A MAC program can selectively pick generic drug products that meet pre-determined criteria relating to clinical, marketing, and cost considerations.

PrimeWest Health has adopted the Prime's MAC program, which includes a list of multi-source drugs that are reimbursed at an upper limit per unit price. Highly utilized products are reviewed quarterly. However, individual products can be adjusted on an as-needed basis. If availability of a drug becomes limited, the MAC will be temporarily suspended or the drug may be permanently removed from the MAC list. The drug may be re-added when market sources confirm adequate supply and distribution. For a copy of the Prime MAC list, please contact them per your pharmacy provider agreement.

Generic Drugs

Information about Generic Drugs

Health professionals and consumers can be assured that the FDA-approved generic drugs on the MAC list meet the same rigid standards as the brand-name drugs. To gain FDA approval, a generic drug must:

1. Contain the same active ingredients as the brand name drug
2. Be identical in strength, dosage form, and route of administration
3. Have the same labeling
4. Be bioequivalent to the referenced brand
5. Meet the same batch requirements for identity, strength purity, and quality

6. Be manufactured under the same strict standards of the FDA’s good manufacturing practice regulations required for brand name products

Generic Drug Standards

1. The provider must dispense a generic drug whenever permitted and in accordance with applicable laws.
2. The pharmacy must contact the prescriber to encourage a change to a generic substitute when the prescription contains a “dispense as written” signature for a multi-source brand name medication.
3. The pharmacy must stock a sufficient amount of drugs under their generic name coinciding with the habits of local prescribers, the PrimeWest Health formulary(s) as indicated by the claims system response and other correspondence, or the generic formulary of the State in which the provider resides

Vacation Supply & Lost medications for PMAP, MSHO, and SNBC Members

A pharmacy may obtain prior authorization for a dosage change or vacation request by calling the Prime Help Desk at **800-821-4795** (toll free). The following are situations that would be covered under this provision:

Process for Handling “Refill-Too-Soon” Override and Authorization Requests

PrimeWest Health follows the DHS MHCP Manual, Chapter 22, *Pharmacy*.

Criteria

1. Recipients will be allowed only one override in 12 months for lost, stolen, damaged, or destroyed medications.
2. Recipients will be allowed only one vacation supply override per 12 months.
3. Vacation overrides will be allowed only after 50 percent of the last submitted days supply has passed (e.g., if the last submitted days supply was 34, a vacation override will not be granted until at least 17 days have passed since the last fill).
4. A leave of absence override maybe allowed in certain circumstances. The intent is that an authorization may be granted for a recipient who lives in an LTC facility and receives a pass to leave the facility for a weekend or other short stay away from the facility. Authorization will not be granted for regularly scheduled absences such as for work and school supplies.
5. If the member increased the dose without prescriber consent, no override will be granted.

Pharmacy Non-Controlled Substance Overrides

Override/authorization is granted in the following circumstances	
Circumstance	Action
Member does not reside in an LTC facility such as a nursing home or ICF/MR and one of the following occurred with the medication: <ul style="list-style-type: none"> • Lost • Stolen • Damaged • Destroyed 	Authorization is granted once every 12 months
Prescriber increased the dose of the medication	Verify with the prescriber and document that the dose was increased

Pharmacy entered the wrong days supply on the first fill	Reverse the claim and rebill
Change in living arrangement such as the member was admitted to or discharged from a nursing home	Verify and document the change in living arrangement
The facility kept the medications that were taken from the member and the member was discharged/released from a: <ul style="list-style-type: none"> • Hospital • Correctional facility • Detoxification center 	Verify and document the discharge/release from the facility
Member enters a detoxification facility for the purpose detoxification only	Authorization will be granted for only the exact amount needed for the detoxification stay. The detoxification facility must order, pick up, and maintain control of the medication.
Member must travel and will not return before the next anticipated prescription fill date	A vacation/travel override will only be allowed after 50% of the last supply’s days have passed. Authorization is granted once every 12 months. The maximum allowed override is a 34-day supply.
Recipient requires a refill override to allow a medication supply at camp.	Authorization is granted. The maximum allowed override is a 34-day supply.

Override/authorization is <i>not</i> granted in the following circumstances	
Circumstance	Action
Member resides in an LTC facility such as a nursing home or ICF/MR and medication was: <ul style="list-style-type: none"> • Lost • Stolen • Damaged • Destroyed 	The facility must replace the medication at its own cost
Member increased the dose of the medication	Authorization will not be granted
Member received authorization once within the last 12 months because one of the following occurred with the medication: <ul style="list-style-type: none"> • Lost • Stolen • Damaged • Destroyed 	Additional authorization will not be granted
Member received authorization once during the last 12 months due to travel	Additional authorization will not be granted
Pharmacy is trying to be reimbursed for <ul style="list-style-type: none"> • Pass meds • School supplies • Work supplies • Etc. 	Authorization will not be granted

Pharmacy Controlled Substance Overrides

Override/authorization is granted in the following circumstances	
Circumstances	Action
Prescriber increased the dose of the medication	Verify with the prescriber and document that the dose was increased
Pharmacy entered the wrong days supply on the first fill.	Reverse the claim and rebill
Change in living arrangement (for example, the member was admitted to or discharged from a nursing home)	Verify and document the change in living arrangement
Member was discharged from a hospital and the hospital kept the medications that were taken from the member at admission.	Verify and document the hospitalization and discharge

Override/authorization is <i>not</i> granted in the following circumstances:	
Circumstances	Action
Medication was lost, stolen, damaged, or destroyed and member resides in an LTC facility such as a nursing home or ICF/MR	The facility must replace the medication at its own cost
Medication was lost, stolen, damaged, or destroyed and member does not reside in an LTC facility such as a nursing home or ICF/MR	Additional authorization will not be granted
Member was released from a correctional facility or detoxification center and the facility kept the medication	Additional authorization will not be granted
Pharmacy is trying to be reimbursed for “pass meds,” “school supplies,” “work supplies,” etc.	Authorization will not be granted
Member must travel out-of-state and will not return before the supply of a medication runs out	Authorization will not be granted

Transition Medication Allowances

1. Newly enrolled PrimeWest Health members will be granted a supply of non-formulary medication upon request if they were taking the medication prior to enrollment. This transition period will not exceed 90 days.
 - a. PMAP process: The PrimeWest Health Utilization Management and Pharmacy Manager, or designated individual, contacts Clinical Review at Prime to request a prior authorization be placed for benefit eligible medications after the member or authorized representative notifies Member Services that a Formulary exception is needed.
 - b. MSHO/SNBC process: Automated at point of sale to allow non-formulary or Utilization Management edits be overridden for the first fill. Subsequent fills are on case by case basis for approval. Contact Member Services **1-866-431-0801** (toll free) to initiate this process. At the time the initial fill is allowed,

it is expected that the dispensing pharmacy will request that a pharmacy determination be submitted by the prescribing health care provider. The member also receives a formal letter notifying him/her of the transition process and to contact his/her provider for assistance.

2. Medications excluded by the DHS or CMS contract, State and Federal statutes, or medications excluded from the formulary for safety reasons may not be granted approval.
3. Subject to conditions specified in [MN Stat. sec. 62Q.527](#), PrimeWest Health will allow a member to continue to receive a prescribed drug to treat a diagnosed mental illness or emotional disturbance for up to one year, upon certification by the prescribing health care provider that the drug will best treat the member's condition. This continuing care benefit is allowed if PrimeWest Health changes its drug formulary or when a member changes MCOs, and will be extended annually if certification is provided to PrimeWest Health by the prescribing provider.
4. PrimeWest Health will not cover the prescribed drug if it has been removed from the formulary for safety reasons.

Clinical Pharmacy Determinations

These types of requests require clinical information and cannot be overridden by the Help Desk. The treating practitioner must initiate all requests for clinical pharmacy determinations. Requests should be initiated by faxing the [Physician Request for Pharmacy Exception](#) to Prime. Expedited requests for pharmacy determinations for medications that are urgently needed may be initiated by phone. All pharmacy determinations shall be completed within timelines established by State and Federal regulations.

Pharmacy determinations: Our clinical review teams will make one of the following three determinations after reviewing requests for pharmacy determinations:

1. Approved – after documentation is provided that meets established criteria.
2. Denied – after all necessary information is reviewed and the request does not meet the criteria for approval. The physician reviewer has the final determination about whether the request is denied or approved. For a denied claim, more information may be needed; the prescriber may submit additional information and have the claim Appealed.
3. More information needed – if incomplete or illegible records are submitted, a request for clarification will be made. If additional information is not supplied within a reasonable time period, the request will be denied.

Review of requests for pharmacy determinations: The pharmacy review team will use evidenced-based clinical guidelines to review pharmacy determination requests following PrimeWest Health's adopted criteria and guidelines. The clinical guidelines are based on primary literature, governmental associations, peer reviewed medical guidelines, and have received Pharmacy and Therapeutics Committee approval. When a request for a pharmacy determination is received, clinical review may discuss treatment options, the member's clinical history, and previous drug treatment with the treating practitioner. Clinical review may also request medical records for peer review prior to making a decision.

Potential denials: Potential denials will be reviewed by a clinical pharmacist and a delegated physician expert or PrimeWest Health Medical Director prior to making a final denial decision. Per [MN Stat. sec. 62Q. 527](#), the PrimeWest Health pharmacy clinical review shall authorize the following non-formulary requests if supported by a health care provider's statement of need:

1. Prescriptions related to the direct treatment of oncology and AIDS patients
2. Requests for specific brand name drugs based on practitioner determination that a generic alternative is not acceptable
3. Requests for specific brand name drugs based on practitioner determination that previous treatment with formulary drugs failed
4. Requests for a medication where there is no formulary alternative to requested prescription

5. Medications used to treat mental illness or emotional disturbances

Response to Physician Request for Pharmacy Determination

PrimeWest Health and/or its delegated PBM are responsible for notifying members and providers of approved pharmacy determinations. An approval response will be faxed back to the practitioner as soon as possible, not to exceed timelines established by Minnesota Statutes, Rules, and Regulations. Established turn-around times are as follows:

Program	Standard	Urgent
MSHO	72 hours	24 hours
SNBC	72 hours	24 hours
PMAP	10 days	72 hours

PrimeWest Health and/or its delegated PBM send the member and requesting provider a letter of approval. PrimeWest Health and its delegated entities shall be responsible for mailing any Denial, Termination, and Reduction of Service notices to members and practitioners that are required by Minnesota Statutes, Rules, and Regulations, including but not limited to, MN Stat. 62M. Denial notices shall include Appeal rights and follow the format required by DHS as outlined in MN Stat. 62M and related regulations. All denials will include a written or verbal notice to the practitioner and servicing facility that includes the following information:

1. Outcome of the review
2. Reason for the outcome, including a brief explanation of why the patient does not meet the criteria established by the clinical guidelines
3. Re-direction to potential formulary alternatives
4. Statement telling how the practitioner can Appeal or submit additional information that may be helpful or relevant to the case for review

Utilization Management Programs**Prior Authorization**

Some drugs require a Prior Authorization before they can be covered. Documentation from the prescribing provider is needed for Prior Authorization.

Program Name	Type of Program	Medicare Part D Programs (MSHO/SNBC)	Prepaid Medical Assistance Program (PMAP)	Short Description of Program
Antifungal Lamisil™ & and Sporonox®	Prior Authorization		X	Prohibits cosmetic use, steers dosing toward FDA-approved doses and durations
Aldara®	Prior Authorization	X		Program requires FDA labeling and duration of treatment be followed
Erythropoietin stimulating agents	Prior Authorization	X		Requires that hemoglobin levels fall into appropriate range; approved for various diagnoses
Forteo™	Prior Authorization	X	X	Requires use of bisphosphonates or Evista® prior to use of Forteo™

Hepatitis C treatments	Prior Authorization	X	X	Requires lab work and other diagnostic measures prior to authorization
Human growth hormone	Prior Authorization	X	X	Requires prescribing to follow FDA-approved indications
Intravenous immune globulin	Prior Authorization	X		Requires prescribing to follow FDA-approved indications
Noxafil® -Vfend®	Prior Authorization	X		Requires prescribing to follow FDA-approved indications
Provigil®	Prior Authorization	X		Requires proper diagnosis and prescribing based upon FDA approval
Revatio™	Prior Authorization	X		Only allows its use for pulmonary hypertension or other related diagnosis. Not approved for erectile dysfunction.
Xolair®	Prior Authorization	X	X	Requires lab work and other diagnostic measures prior to authorization
Oral oncology: Gleevec®, Nexavar®, Sprycel®, Sutent®, Tarceva®, Tasigna®, Tykerb®	Prior Authorization	X		Requires prescribing to follow FDA-approved indications
Xenazine®	Prior Authorization	X		Requires prescribing to follow FDA-approved indications

Quantity Limits

Some drugs have limits on the amount a member can get in a given time period. The prescribing provider can ask for a higher quantity by submitting a formulary exception.

Program Name	Type of Program	Medicare Part D Programs (MSHO/SNBC)	Prepaid Medical Assistance Program (PMAP)	Short Description of Program
Antidepressants/ Antipsychotics	Quantity Limits	X		Limits dispensing to FDA-approved quantities per month
Chantix®	Quantity Limits	X		Limits dosing to 168 days of therapy
Abortive triptan therapy	Quantity Limits	X	X	Limits treatment to 6 headaches/month, on average. Encourages preventive therapy over abortive.
Aldara™	Quantity Limits	X		Limits dosing to 12 packets per month
Bisphosphonates	Quantity Limits	X		Limits dispensing to FDA-approved quantities per month
Celebrex®	Quantity Limits	X		Limits dispensing quantity to 2 capsules per day
Fentanyl transdermal	Quantity Limits	X		Limits dosing to 1 transdermal patch every 48 hours
Januvia™ and Janumet™	Quantity Limits	X		Follows FDA-approved dosing regimens to establish a monthly quantity

Ketorolac	Quantity Limits	X	X	Limits use to 5 days per FDA recommendations
Low molecular weight heparin	Quantity Limits	X		Limits total monthly dose of selected products. Encourages short-term use of these products as a primary source of anticoagulation unless indicated.
Nasal inhalers	Quantity Limits	X	X	Follows FDA dosing to determine number of inhalers allowed in a 34-day supply
Nuvigil®	Quantity Limits	X		Follows FDA-approved dosing regimens to establish a monthly quantity
Onglyza™	Quantity Limits	X		Follows FDA-approved dosing regimens to establish a monthly quantity
Ophthalmic prostaglandin	Quantity Limits	X		Limits monthly quantity based upon FDA-approved dosage and expected use
Oral inhalers asthma/COPD	Quantity Limits	X	X	Follows FDA dosing to determine number of inhalers allowed in a 34-day supply
Oxycodone ER	Quantity Limits	X	X	Limits dispensing quantity to FDA-approved schedule of 2 – 3 tablets daily of most strengths
Proton pump inhibitors	Quantity Limits	X	X	Optimizes dosing and dispensing quantities per FDA-approved regimens
Statins	Quantity Limits	X	X	Optimizes dosing and dispensing quantities per FDA-approved regimens
Urinary incontinence	Quantity Limits	X		Limits dispensing to FDA-approved quantities per month
Zostavax®	Quantity Limits	X		Limited to 1 dose per lifetime for patients 60 years or over only

Step Therapy

Sometimes, members must try one or more preferred drugs before a non-preferred drug will be covered.

Program Name	Type of Program	Medicare Part D Programs (MSHO/SNBC)	Prepaid Medical Assistance Program (PMAP)	Short Description of Program
ACE/ARB	Step Therapy	x		Requires trial of generic ACE inhibitor. Applies to ARB or ARB combination.
Actos®/Avandia®	Step Therapy	X		Encourages use of other agents as first-line therapy
Anticonvulsants	Step Therapy	X		Discourages use as first-line therapy in non-seizure related indications
Atypical antipsychotics	Step Therapy	X		Requires trial of formulary product in past 90 days, limits dosing to FDA thresholds or unless the patient is stabilized on the non-formulary product
Byetta®	Step Therapy	X		Metformin, a sulfonyleurea, or a thiazolidinedione must be used in combination with Byetta® in people with type 2 diabetes only

Biologic Immunomodulators: Enbrel[®], Humira[®], Orencia[®], Amevive[®], Rituxan[®], Remicade[®]	Step Therapy	X	X	Requested agent has been used previously and either previous use of the agent has been beneficial in slowing the progression of the disease or in decreasing symptom severity or a prescriber has provided documentation of trial and failure of the preferred biologic
Leukotriene modifiers	Step Therapy	X		Requires use of inhaled corticosteroid prior to a leukotriene antagonist being used to treat asthma or nasal allergies
Insomnia	Step Therapy	X		Requires past documented use and failure of zolpidem immediate release product or the patient has a contraindication, allergy, or intolerance to the available generic insomnia agents
Atopic dermatitis	Step Therapy	X		Requires documented trial and failure of topical corticosteroids
Renin inhibitors	Step Therapy	X		Encourages trial of generic ACE inhibitors
Antidepressants: Cymbalta[®], Venlafaxine XR, Venlafaxine IR, Effexor XR[®], Pristiq[®]	Step Therapy	X		Requires prior use of a generic product or history of allergy or contraindication to generic product prior to approval.
Zetia[®]	Step Therapy	X		Requires that Zetia [®] be used in combination with a fenofibrate or statin
Multiple sclerosis	Step Therapy	X		Requires a contraindication, allergy, intolerance to a formulary MS agent, or documentation that patient is stable on the requested medication
Triptans	Step Therapy	X		Requires a medication history that indicates previous use of identical brand triptan agent or a generic triptan agent or that the patient has an allergy, contraindication, or intolerance to generic agent(s)
Proton pump inhibitor	Step Therapy	X	X	Patient's medication history includes use of a preferred generic PPI and/or indicates a contraindication, allergy, or intolerance to the available preferred generic PPI(s)
Bisphosphonates	Step Therapy	X		Encourages use of generic and formulary brand medications

Formulary Exceptions

For members sensitive or unresponsive to the formulary medication or have a known contraindication to **all** of the formulary choices in that therapeutic class, have the prescriber complete the appropriate formulary exception form and have the prescriber fax the form to Prime, PrimeWest Health's clinical pharmacy reviewer.

Please visit the PrimeWest Health website for information on the [formulary exception process](#).

[Formulary Exception Form](#)

[Formulary Exception Form – Part D](#)

Pharmacy Claims Screening

Paid Claims: Some DUR conflict codes are posted for informational purposes only and allow the claim to be paid.

Denied Claims: If a claim is denied for payment based on a DUR conflict code, the pharmacist’s professional judgment will need to be used to decide whether or not to fill the prescription. If it is in the recipient’s best **medical** interest to fill the prescription, the denial may be Appealed.

Drug Formulary

PrimeWest Health has adopted Prime’s formularies for its selected populations. The formularies are developed and approved by a Pharmacy and Therapeutics (P&T) Committee, which is an independent panel of physicians and pharmacists representing various practice disciplines. The P&T Committee meet no less than quarterly to review the [current formularies](#). Different populations adhere to different formularies, as shown below.

Plan	PMAP	MSHO/SNBC
PMAP Formulary (Prime National Formulary)	Yes	No
OTC Formulary	Yes	Yes
Medicare Part D Formulary	No	Yes
Medicare Wrap Around Formulary	No	Yes

The OTC formulary is different for PMAP and MSHO members as it has been tailored to address specific needs of each demographic group. The wraparound formulary is a list of medications that a traditional Medicare Part D formulary would not cover, but PrimeWest Health has made available to its MSHO members. It generally consists of medications from the following classes:

1. Benzodiazepines
2. Barbiturates
3. OTC items
4. Vitamins
5. Cough and cold products

When providing any prescription drug service to a member, the pharmacy shall comply with the Drug Formulary. When a non-formulary product is prescribed, the claim will reject with NCPDP reject code 70 “NDC Not Covered.” The pharmacy should make an effort to contact the prescribing provider to ask if the prescription can be changed to a formulary product.

Drug Utilization Review (DUR)

Prime Therapeutics will alert the pharmacy through the online system in situations that include, but are not limited to, the following:

1. Drug regimen compliance screening
2. Drug-drug interaction screening
3. Drug inferred health state screening

4. Dosing/duration screening
5. Drug-age caution screening
6. Drug-sex caution screening
7. Duplicate prescription screening
8. Duplicate therapy screening

The pharmacy is responsible for reviewing any claim where there is a DUR rejection from the online adjudication system. Pharmacists should use their professional judgment to follow up with patients and counsel them regarding the DUR messages.

Pharmacy Audit

Suspected waste, fraud, and abuse

For suspected waste, fraud, or abuse by a member, prescribing provider, or a pharmacy, notify the PrimeWest Health Compliance Coordinator at:

PrimeWest Health
2209 Jefferson St, Ste 101
Alexandria, MN 56308

1-320-763-4135 or **1-888-588-4420** (toll free) (ask to speak with the Corporate Compliance Officer)

Inspection of Records and Audit per Prime's Pharmacy Network Agreement

Maintenance of Records

The pharmacy shall maintain records that comply with State and Federal law, rules, and regulations regarding prescription drug services provided to members

Inspection Rights

During the term of agreement and for two years following termination of the agreement for any reason, Prime has the right to inspect all records of the pharmacy related to PrimeWest Health claims.

Pharmacy Audit

Audits are conducted in compliance with Federal and State laws to assure the privacy and confidentiality of all patient records. PrimeWest Health may delegate Prime to conduct audits of its contracted network of pharmacy providers. Audits are performed to verify the integrity of claims submitted to PrimeWest Health and payments to the pharmacy. The pharmacy will provide auditors access to pharmacy records, including invoices and prescription files, related to prescription drug services provided under its Pharmacy Network Agreement. Prime may use these records to compare the online claims with the hard copies of prescriptions and other documentation. For additional information related to audits, please refer to your Prime Therapeutics Pharmacy Provider Manual.

There are several situations that could precipitate an audit request to Prime on PrimeWest Health's behalf:

1. Notification by a benefit sponsor or member of suspected fraudulent activity (see below)
2. Pharmacy exceeds the normal profile in one or more audit profile categories
3. Routine area audit of pharmacies in a specific geographic location

Fraudulent Activity

Based on the claims submission requirements, the following are examples of unacceptable and, in some cases, fraudulent practices:

1. Billing for a quantity of a legend drug that is greater than the quantity prescribed
2. Billing for a higher-priced drug when a lower priced drug was prescribed and dispensed to the member
3. Dispensing a brand-name drug, billing for the generic, and then charging the member for the difference
4. Billing for a legend drug without a prescription
5. Submitting a claim with an NDC other than the NDC on the package from which the drug was dispensed
6. Dispensing a smaller quantity than was prescribed in order to collect more than one professional dispensing fee. If a patient requests a smaller amount, a notation should be made on the hard copy of the prescription.
7. Billing more than once per month for maintenance drugs for members in nursing facilities. A maintenance drug is a drug ordered on a regular, ongoing, scheduled basis. This limitation does not apply to treatment medications (e.g., topical preparations) or drugs ordered with a stop date of less than 30 days.

Medication Therapy Management (MTM)

PrimeWest Health facilitates an MTM program policy for its PMAP population in accordance with its DHS contract. MTM is a pharmacist-focused initiative to educate patients with complicated medication regimens in hope of achieving better outcomes. The program is for any PrimeWest Health member in MA, MinnesotaCare, or MSC+ programs who has two or more chronic conditions being treated with four or more prescriptions per month. No prior authorizations are required to perform this service to a PrimeWest Health member, but all providers need to be contracted with PrimeWest Health in order to be reimbursed for their service time. Prerequisites and practice stipulations to perform these services are similar to the DHS MTM program launched in April 2006. Any pharmacist interested in performing this service to eligible PrimeWest Health members should contact the Provider Contact Center at **1-866-431-0802** (toll free) for details.

The Medicare prescription drug benefit provided through Prime includes MTM services for all Part D members in PrimeWest Health. The majority of the program is administered through a call center, but DUR edits may appear during claim processing that require a pharmacist's services.

LTC Facilities Billing Procedures for Pharmacies

Medicare Part A Recipients

Patients that qualify for Medicare Part A during some or all of their stay in an LTC facility or group home are not to be billed for any supplies and medications that they require during their stay under Part A guidelines. PrimeWest Health is not to be billed for any of these medications or services either. The facility is responsible to provide all prescribed medications and therapies (this comes out of the per diem payment). It is strictly prohibited to **require** patients to bring their own medications from home to use during their Medicare Part A stay or to deny therapies that are medically necessary. Medications sent with the patient from the hospital upon discharge may be used (if reordered by the prescriber) as long as the patient has no objections. Nothing prohibits the home or the pharmacy from requesting therapeutic alternatives from the prescriber that are therapeutically equivalent but perhaps more cost effective. In the end, the prescriber has the final authority as to what is medically necessary to treat the patient during his/her stay under Part A.

Pharmacies that provide services to nursing home patients should be familiar with the following guidelines:

1. Claims should be billed no more than once per month
2. Seven-day unit packages should be logged and billed no more than once per month
3. OTC products should be dispensed in the original container. They cannot be broken into smaller quantities and dispensed in increments.

4. In no event may the OTC product be priced higher than the shelf price
5. Items that are normally supplied by the nursing home on a per diem basis, such as test strips and syringes, should not be billed to PrimeWest Health. Unique dispensing methods such as tray changes every two days or every seven days do not justify additional fees. One fee per month is reimbursable even if the product is delivered to a nursing home one tablet at a time.

Prescribed Medications Not Covered Under the PrimeWest Health Prescription Benefit

Federal law requires that LTC facilities provide residents with all prescribed medications that are not covered by the outpatient pharmacy program. These drugs are part of an LTC facility's per diem and are reported in a cost report to DHS. **Nothing prohibits the LTC facility or pharmacy from requesting a formulary product from the prescriber.**

LTC Facility Lost or Damaged Medication

PrimeWest Health should **NOT be billed twice** if medication sent to the LTC facility is lost, stolen, destroyed, or damaged. If the pharmacy loses the medication before delivering it to the facility, the pharmacy must send a replacement supply to the facility **at their expense**. If the loss occurs after it is delivered, the pharmacy can send a replacement supply that **MUST** be billed to the facility **not to PrimeWest Health or the member**.

Emergency Kit Medication Billing Policy

If an LTC facility uses a dose of medication from an emergency kit, that dose may be billed separately to PrimeWest Health only if certain conditions are met:

1. If **only** one total dose is given, the pharmacy supplying the dose may bill PrimeWest Health for a single dose; or
2. If the dose is the **first** in a series of doses, it must be billed to PrimeWest Health together with subsequent doses. For example, if the order is for Ceftriaxone 1gm IM once, and the dose is taken from the emergency kit, the pharmacy may replace that dose and bill PrimeWest Health. If the order is for Ceftriaxone 1gm IM once daily for seven days, and the first dose is taken from the emergency kit, the pharmacy should not bill PrimeWest Health for one dose to replace what was taken from the kit and six doses for the remainder of the supply. **All seven doses must be billed as one prescription.**

Solutions, Irrigations, and Supplies for LTC Facilities

PrimeWest Health does not pay for solutions, irrigations, or supplies used in LTC facilities for respiratory or wound care. This includes normal saline for irrigation, sterile water for irrigation, compounded antibiotic irrigation solutions, saline for inhalation, or trach care, etc. **These are all part of the per diem paid to the LTC facility. Pharmacies should not bill these products as drugs when the member is in the facility.**

“Extra” Medication Supplies for Multiple Sites

If a PMAP/MSHO recipient, especially a resident of a nursing facility or group home, needs a small quantity of medication for passes, school, a job, or day programs, the pharmacy cannot bill PrimeWest Health separately. For example, if a recipient receives Sinemet™ 10/100 QID, the pharmacy cannot separately bill for 90 tablets for use in a group home and 30 tablets for use elsewhere. The total 120 tablets must be billed at one time to PrimeWest Health. The pharmacy can package the medication in any manner consistent with State and Federal pharmacy laws and regulations. In this example, that might mean packaging 90 tablets in a unit dose container and 30 in a vial. However, packaging the prescription in two containers does not entitle the pharmacy to two dispensing fees.

Supply Requirements

LTC pharmacies and facilities are subject to the same days supply limitations as all other PrimeWest Health enrolled pharmacies. Minnesota Rules requires initial or refill supply of maintenance drugs to be dispensed in not less than a 30-day supply unless the pharmacy is using unit dose dispensing.

When unit dose dispensing is used, the pharmacy may not bill more frequently than once per calendar month or when a minimum of 30 dosage units have been dispensed, whichever option results in less frequent billing.

"Catch-up" Supplies of Medication

Current Minnesota Statutes and Rules prohibit billing for "catch-up" supplies. Some pharmacies that service nursing facilities dispense small "catch-up" supplies of medications if the home runs out before the end of a billing cycle.

For example, the pharmacy dispensed a 31-day supply only to have the facility call 25 days later indicating that it is out of the drug. The pharmacy then dispenses a six-day supply and bills PrimeWest Health. A few days later, the pharmacy bills PrimeWest Health for another 31-day supply in order to get back on schedule. This is prohibited as only one dispensing fee is authorized per 31-day billing cycle.

OTC Drugs

During the course of a Medicare or Medicaid stay, Federal law requires LTC facilities to provide residents with medically necessary OTC drugs used on an occasional or as needed basis. These drugs are part of the LTC facility's per diem and are reported in a cost report to PrimeWest Health.

OTC drugs prescribed for a specific resident for scheduled use should be dispensed in the manufacturer's unopened package and submitted separately to PrimeWest Health for reimbursement.

Emergency Medication Usage

A transition process is implemented for Medicare beneficiaries currently living in LTC facilities or receiving medications from LTC pharmacies. This process allows for medications that are not on the Part D formulary but are required in the medical management for beneficiaries. In the event a PrimeWest Health member who resides in an LTC facility requires urgent medication use that is not on formulary, the following options are available to better serve that member:

1. Contact the prescriber with a therapeutic substitution available on formulary (preferred method)
2. Call the Pharmacy Help Desk at **1-800-821-4795** (toll free) for a manual system override. (For MSHO members only)
3. Have the prescriber submit a formulary exception request

Safety Recall Notifications

1. Members taking medications affected by Class I recalls for safety reasons will be identified through claims data and mailed a notice of the recommended action to be taken. These notices may contain other covered formulary options that are comparable to the affected recalled medication. The prescribing health care provider will also be notified through U.S. mail with similar information. These notices will be sent as expeditiously as possible.
2. Members taking medications affected by Class II recalls or voluntary drug withdrawals for safety reasons will be identified through claims data and mailed a notice of the recommended action to be taken. These

notices may contain other covered formulary options that are comparable to the affected recalled medication. The prescribing health care provider will also be notified through U.S. mail with similar information. These notices will be sent within 30 days of the recall notification by the FDA or manufacturer.

3. Medications subject to a Class I recall are removed from the Medi-Span libraries and are not eligible for payment.

Medicare Part B

Commonly covered drugs

1. Drugs used for immunosuppressive therapy
2. Oral chemotherapy drugs
3. Oral anti-emetics used for cancer patients
4. Drugs used for inhalation and administered by nebulization
5. Blood clotting factors
6. Influenza vaccines

PrimeWest Health will pay Medicare Part B co-insurance as directed by Medicare Part B for eligible members.

Use your POS software to bill for self-administered Medicare Part B drugs using the appropriate [NDC](#). Do not bill Prime the same day you bill Medicare. If all of your PrimeWest Health and Medicare provider information on file is correct, Medicare will cross the claim over to Prime with payment details.

If Medicare does not cross the claim over to Prime within six weeks, bill Prime using the 837P claim format. Use the appropriate HCPCS J code and modifiers. Report the corresponding NDC in the appropriate fields on the claim and include Medicare determination and payment details.

Medicare Part D

Members eligible for Medicare Parts A and B (dual eligibles) must enroll in a Medicare Part D plan for prescription drug coverage. Any individual seeking assistance in enrolling in a Medicare Part D prescription drug plan should call the Senior [Linkage Line](#)[®] at **1-800-333-2433** (toll free).

PrimeWest Health will not provide prescription drug coverage for dual eligibles who fail to or refuse to enroll in a Medicare Part D prescription plan. PrimeWest Health members who provide proof and use credible insurance to opt out of Medicare Part D will not be eligible for Low-Income Subsidy (LIS).

If the member is a dual eligible but the Medicare Part D plan cannot be verified, contact PrimeWest Health at **1-866-431-0802** (toll free).

Medicare Part D Excluded Drug Categories

PrimeWest Health will cover certain classes of drugs for dual eligibles if excluded by law from the Medicare Part D program and if the drug or product is on the approved formulary list. Medicare Part D excludable drug categories include the following:

1. Agents used for symptomatic relief of cough and colds
2. Barbiturates
3. Benzodiazepines
4. OTC items including smoking cessation products
5. Prescription vitamins and mineral products

Contact the individual Part D prescription plan with questions about denials, drugs not covered, and authorization requirements. PrimeWest Health will not cover a Part D eligible drug solely because it is “non-formulary” for a particular Part D plan.

Medicare Part D copay amounts are the member’s responsibility; do not bill PrimeWest Health.

Definitions

Agreement: The Pharmacy Agreement between the pharmacy and Prime Therapeutics, LLC

Ancillary Charge: A charge in addition to the copay that the member is required to pay to a pharmacy for prescription drug services. The Ancillary charge is assessed when the prescribing provider or member has requested a drug that is not on the Drug Formulary or the MAC list.

Average Wholesale Price (AWP) “Average Wholesale Price” or “AWP” means the average wholesale price of a prescription drug service at the time a claim is processed as established in the Prime price file and updated no less than weekly by Medi-Span or by such other national drug database as Prime may solely designate.

Benefit Plan: Any health care plan, program, group or individual plan policy, agreement, or other arrangement sponsored, issued, or administered by a benefit sponsor, which includes outpatient pharmaceutical services or benefits, or access to pricing under this Agreement in accordance with the terms of the benefit plan, including, but not limited to, plans approved by CMS under the Medicare Part D Program.

Plan Sponsor: An entity that sponsors, issues or administers a benefit plan and has agreed with Prime to use a Prime-administered network to process and adjudicate the prescription drug service.

CMS: The Center for Medicare & Medicaid Services.

Compound Prescription: A prescription where two or more medications are mixed together. One of these drugs must be a Federal legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound prescription if it is reconstituted or if only water, alcohol, or sodium chloride solutions are added to the active ingredient.

Copay: The amount a member is required to pay under the benefit plan for the prescription drug service, and shall include applicable deductibles, coinsurance, payments made by a subscriber for covered drugs under the Medicare Part D program after exhausting the Medicare Part D initial coverage limit, or ancillary charges.

Member: A person who is properly enrolled in or covered by a benefit plan and entitled to obtain a prescription drug service at the time a prescription is dispensed. This includes a subscriber under the Medicare Part D program.

Drug Formulary: A document or documents listing various pharmaceutical products that are provided to pharmacies, members, physicians, or other health care providers for the purpose of guiding the prescribing and dispensing of pharmaceutical products. The drug formulary may be amended from time to time by Prime or a benefit sponsor.

Federal Legend Drug: A drug that is required by law to bear on its packaging, “Caution: Federal law prohibits dispensing without a prescription” or “Rx Only.”

HHS: The United States Department of Health and Human Services.

Maximum Allowable Cost (MAC): The list delineating the maximum per unit reimbursement as established and solely determined by Prime for a multiple source prescription drug, medical product, or device at the time a claim is processed. The MAC is subject to review and modification by Prime in its sole discretion.

Medicare Part D Program: The program created by Congress in the Medicare Modernization Act of 2003 that created the Medicare Part D prescription drug benefit program under Part D of Title XVIII of the Social Security Act.

Payor: The entity that is financially responsible for payment of a prescription drug service. A benefit sponsor or member or both may be the payor.

Pharmacy: A pharmacy, established place of business, licensed by a state board of pharmacy, in which prescriptions, drugs, medicines, chemicals, and poisons are prepared, compounded, dispensed, vended, or sold to or for the use of patients and from which related clinical pharmacy services are delivered.

Pharmacy Service: The dispensing of drugs, counseling, concurrent DUR and other activities as described in MS [151.01](#), subd. 27, or as performed by a dispensing physician.

Pharmacy Payment: The amount payable to the pharmacy under the terms of the Agreement.

Point of Sale (POS): The method of submitting claims online through an automated claim adjudication process, which includes interactive communications between a terminal located at a pharmacy and a claims processor designated by Prime.

Prescribing Provider: A Doctor of Medicine or other health care professional who is duly licensed and qualified under the laws of the jurisdiction in which prescription drug services are received and may, in the usual course of his/her practice, legally prescribe prescription drug services for members.

Prescription Drug Service: An outpatient drug product, item, or service that is covered under a member's benefit plan and is provided to a member pursuant to a prescription issued by a prescribing provider in accordance with the Pharmacy Agreement.

Signature Logs: The pharmacy shall maintain a signature log, or other evidence specifically approved by Prime, at each pharmacy location for each prescription drug service dispensed to a member, which acknowledges receipt of the prescription drug service. Each member (or his/her authorized agent) who receives a prescription drug service shall be required to sign the log, acknowledging the date the prescription drug service was received, and the prescription number. Electronic prescriptions must have provisions for documenting receipt of the prescription authorized by both pharmacy and patient.

Usual and Customary Charge (U&C): The lowest price the pharmacy would charge to a particular customer if such customer were paying cash for the identical prescription drug services on the date dispensed. This includes any applicable discounts including, but not limited to, senior discounts, frequent shopper discounts, and other special discounts offered to attract customers. A pharmacy cannot have a U&C charge for prescription drug programs that differs from either cash customers or other third-party programs. The pharmacy must submit the accurate U&C charge with respect to all claims for prescription drug services.

Wholesale Acquisition Cost: The wholesale acquisition cost of a prescription drug service at the time a claim is processed as established in the Prime price file and updated no less than twice monthly by Medi-Span or by such other national drug database as Prime may solely designate.

NCPDP Telecommunication Reject Codes

Reject Codes for Telecommunication Standard

Reject Codes

The following table contains an explanation of each transaction reject code and its description.

Code	Description
00	M/I means Missing/Invalid
01	M/I BIN
02	M/I Version Number
03	M/I Transaction Code
04	M/I Processor Control Number
05	M/I Pharmacy Number
06	M/I Group Number
07	M/I Cardholder Identification Number
08	M/I Person Code
09	M/I Birthdate
10	M/I Patient Gender Code
11	M/I Patient Relationship Code
12	M/I Patient Location
13	M/I Other Coverage Code
14	M/I Eligibility Clarification Code
15	M/I Date of Service
16	M/I Prescription/Service Reference Number
17	M/I Fill Number
18	M/I Metric Quantity
19	M/I Days Supply
1C	M/I Smoker/Non-Smoker Code
1E	M/I Prescriber Location Code
20	M/I Compound Code
21	M/I NDC Number
22	M/I Dispense as Written Code (DAW) / Product Selection Code
23	M/I Ingredient Cost Submitted
24	M/I Sales Tax
25	M/I Prescriber Identification
26	M/I Unit of Measure
27	(Future Use) M/I Amount Due (V1.0 only)
28	M/I Date Prescription Written
29	M/I # Refills Authorized
2C	M/I Pregnancy Indicator

Code	Description
2E	M/I Primary Care Provider
30	M/I P.A./M.C. Code and Number
31	(Future Use)
32	M/I Level of Service
33	M/I Prescription Origin Code
34	M/I Submission Clarification Code
35	M/I Primary Care Provider ID
36	M/I Clinic Identification
37	(Future Use)
38	M/I Basis of Cost
39	M/I Diagnosis Code
3A	M/I Request Type
3B	M/I Request Period Date-Begin
3C	M/I Request Period Date-End
3D	M/I Basis of Request
3E	M/I Authorized Representative First Name
3F	M/I Authorized Representative Last Name
3G	M/I Authorized Representative Street Address
3H	M/I Authorized Representative City Address
3J	M/I Authorized Representative State/Province Address
3K	M/I Authorized Representative Zip/Postal Zone
3M	M/I Prescriber Phone Number
3N	M/I Prior Authorized Number Assigned
3P	M/I Authorization Number
3R	Prior Authorization Not Required
3S	M/I Prior Authorization Supporting Documentation
3T	Active prior Authorization Exists Resubmit an Expiration of P.A.
3W	Prior Authorization in Process
3X	Authorization Number Not Found
3Y	Prior Authorization Denied
40	Pharmacy not contracted with plan on date of service
41	Submit bill to other processor or primary payor
42-49	(Future Use)
4C	M/I Coordination of Benefits/Other Payments Count
4E	M/I Primary Care Provider Last Name
50	Non-Matched Pharmacy Number
51	Non-Matched Group Number
52	Non-Matched Cardholder Identification
53	Non-Matched Person Code
54	Non-Matched Product/Service ID Number
55	Non-Matched Product Package Size
56	Non-Matched Prescriber Identification
57	Non-Matched P.A./M.C. Number
58	Non-Matched Primary Prescriber
59	Non-Matched Clinic Identification

Code	Description
5C	M/I Other Payer Coverage Type
5E	M/I Other Payer Reject Count
60	Product/Service Not Covered For Patient Age
61	Product/Service Not Covered For Patient Gender
62	Patient/Card Holder ID Name Mismatch
63	Institutionalized patient Product/Service ID Not Covered
64	Claim Submitted Does Not Match Prior Authorization
65	Patient is Not Covered
66	Patient Age Exceeds Maximum Age
67	Filled Before Coverage Effective
68	Filled After Coverage Expired
69	Filled After Coverage Terminated
6C	M/I Other Payer ID Qualifier
6E	M/I Other Payer Reject Code
70	Product/Service Not Covered
71	Prescriber is Not Covered
72	Primary Prescriber is Not Covered
73	Refills are Not Covered
74	Patient Pays Exceeds Payable
75	Prior Authorization Required
76	Plan Limitations Exceeded
77	Discontinued Product/Service ID Number
78	Cost Exceeds Maximum
79	Refill Too Soon
7C	M/I Other Payer ID
7E	M/I DUR/PPS Code Counter
80	Drug-Diagnosis Mismatch
81	Claim Too Old
82	Claim is Post-Dated
83	Duplicate Paid/Captured Claim
84	Claim Has Not Been Paid/Captured
85	Claim Not Processed
86	Submit Manual Reversal
87	Reversal Not Processed
88	DUR Reject Error
89	Rejected Claim Fees Paid
8C	M/I Facility ID
8E	M/I DUR/PPS Level of Effort
90	Host Hung Up (Host disconnected before session completed)
91	Host Response Error (Response not in appropriate format to be displayed)
92	System Unavailable/Host Unavailable (Processing host did not accept transaction/did not respond within time-out period)
93	Planned Unavailable (Transmission occurred during scheduled down time)
94	Invalid Message (Transaction not decipherable)
95	Time Out

Code	Description
96	Scheduled Downtime
97	Payer Unavailable
98	Connection to Payer is Down
99	Host Processing Error
A9	M/I Transaction Count
AA	Patient Spenddown Not Met
AB	Date Written Is After Date Filled
AC	Product Not Covered Non-Participating Manufacturer
AD	Billing Provider Not Eligible to Bill This Claim Type
AE	OMB (Qualified Medicare Beneficiary) - Bill Medicare
AF	Patient Enrolled Under Managed Care
AG	Days Supply Limitation For Product/Service
AH	Unit Dose Packaging Only Payable for Nursing Home Recipients
AJ	Generic Drug Required
AK	M/I Software Vendor/Certification ID
B2	M/I Service Provider ID Qualifier
BE	M/I Professional Service Fee Submitted
CA	M/I Patient's First Name
CB	M/I Patient's Last Name
CC	M/I Cardholder's First Name
CD	M/I Cardholder's Last Name
CE	M/I Home Plan
CF	M/I Employer Name
CG	M/I Employer Street Address
CH	M/I Employer City Address
CI	M/I Employer State/Province Address
CJ	M/I Employer Zip Postal Zone
CK	M/I Employer Phone Number
CL	M/I Employer Contact Name
CM	M/I Patient Street Address
CN	M/I Patient City Address
CO	M/I Patient State/Province Address
CP	M/I Patient Zip/Postal Zone
CQ	M/I Patient Phone Number
CR	M/I Carrier ID
CT	M/I Patient Social Security Number
CW	M/I Alternate ID
CX	M/I Patient ID Qualifier
CY	M/I Patient ID
CZ	M/I Employer ID
DC	M/I Dispensing Fee Submitted
DN	M/I Basis Of Cost Determination
DP	M/I Drug Type Override
DQ	M/I Usual & Customary
DR	M/I Prescriber Last Name

Code	Description
DS	M/I Postage Amount Claimed
DT	M/I Unit Dose Indicator
DU	M/I Gross Amount Due
DV	M/I Other Payer Amount Paid
DW	M/I Basis of Days Supply Determination
DX	M/I Patient Paid Amount Submitted
DY	M/I Date of Injury
DZ	M/I Claim/Reference ID Number
E1	M/I Product/Service ID Qualifier
E2	M/I Alternate Product Code
E3	M/I Incentive Amount Submitted
E4	M/I Reason For Service Code
E5	M/I Professional Service Code
E6	M/I Result of Service Code
E7	M/I Quantity Dispensed
E8	M/I Other Payer Date
E9	M/I Provider ID
EA	M/I Originally Prescribed Product/Service Code
EB	M/I Originally prescribed Quantity
EC	M/I Compound Ingredient Component Count
ED	M/I Compound Ingredient Quantity
EE	M/I Compound Ingredient Drug Cost
EF	M/I Compound Dosage Form Description Code
EG	M/I Compound Dispensing Unit Form Indicator
EH	M/I Compound Route of Administration
EJ	M/I Originally Prescribed Product/Service ID Qualifier
EK	M/I Scheduled Prescription ID Number
EM	M/I Prescription/Service Reference Number
EN	M/I Associated Prescription/Service Reference Number
EP	M/I Associated Prescription Service Date
ET	M/I Quantity Prescribed
EU	M/I Prior Authorization Type Code
EV	M/I Prior Authorization Number Submitted
EW	M/I Intermediary Authorization Type ID
EX	M/I Intermediary Authorization ID
EY	M/I Provider ID Qualifier
EZ	M/I Prescriber ID Qualifier
FO	M/I Plan ID
GE	M/I Percentage Sales Tax Amount Submitted
H1	M/I Measurement Time
H2	M/I Measurement Dimension
H3	M/I Measurement Unit
H4	M/I Measurement Value
H5	M/I Primary Care Provider Location Code
H6	M/I DUR Co-Agent ID

Code	Description
H7	M/I Other Amount Claimed Submitted Count
H8	M/I Other Amount Claimed Submitted Qualifier
H9	M/I Other Amount Claimed Submitted
HA	M/I Flat Sales Tax Amount Submitted
HB	M/I Other Payer Amount Paid Count
HC	M/I Other Payer Amount Paid Qualifier
HD	M/I Dispensing Status
HE	M/I Percentage Sales Tax Rate Submitted
HF	M/I Quantity Intended To Be Dispensed
HG	M/I Days Supply Intended To Be Dispensed
J9	M/I DUR Co-Agent ID Qualifier
JE	M/I Percentage Sales Tax Basis Submitted
KE	M/I Coupon Type
M1	Patient Not Covered in this Aid Category
M2	Recipient Locked In
M3	Host PA/MC Error
M4	Prescription Number/Tune Limit Exceeded
M5	Requires Manual Claim
M6	Host Eligibility Error
M7	Host Drug File Error
M8	Host Provider File Error
ME	M/I Coupon Number
MZ	Error Overflow
NE	M/I Coupon Value Amount
NN	Transaction Rejected At Switch Or Intermediary
P1	Associated prescription/Service Reference Number Not Found
P2	Clinical Information counter Out of Sequence
P3	Compound Ingredient Component Count Does Not Match Number of Repetitions
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number of Repetitions
P5	Coupon Expired
P6	Date Of Service Prior To Date Of Birth
P7	Diagnosis Code Count Does Not Match Number Of Repetitions
P8	DUR/PPS Code Counter Out of Sequence
P9	Filed Is Non-Repeatable
PA	PA Exhausted/Not Renewable
PB	Invalid Transaction Count For This Transaction Code
PV	Non-Matched Associated Prescription/Service Date
PW	Non-Matched Employer ID
PX	Non-Matched Other Payer ID
PY	Non-Matched Unit Form/Route of Administration
PZ	Non-Matched Unit Of Measure To Product/Service ID
R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions
R2	Other Payer Reject Count Does Not Match Number of Repetitions
R3	Procedure Modifier Code Count Does Not match Number of Repetitions
R4	Procedure Modifier Code Invalid For Product/Service ID

Code	Description
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals 06
R6	Product/Service Not Appropriate For This Location
R9	Value In Gross Amount Due Does Not Follow Pricing Formula
RA	PA Reversal Out of Order
RB	Multiple Partials Not Allowed
RC	Different Drug Entity Between Partial & Completion
RD	Mismatched Cardholder/Group ID-Partial To Completion
RE	M/I Compound Product ID Qualifier
RF	Improper Order Of 'Dispensing Status' Code On Partial Fill Transaction
RG	M/I Associated Prescription/Service Reference Number On Completion Transaction
RH	M/I Associated Prescription/Service Date On Completion Transaction
RJ	Associated Partial Fill Transaction Not On File
RK	Partial Fill Transaction Not Supported
RM	Completion Transaction not Permitted With Same 'Date Of Service' As Partial Transaction
RN	Plan Limits Exceeded On Intended Partial Fill Values
RP	Out of Sequence 'P' Reversal on Partial Fill Transaction
RS	M/I Associated Prescription/Service Date On Partial Transaction
RT	M/I Associated Prescription/Service Reference Number On Partial Transaction
RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment
SE	M/I Procedure Modifier Code Count
TE	M/I Compound Product ID
UE	M/I Compound Ingredient Basis Of Cost Determination
VE	M/I Diagnosis Code Count
WE	M/I Diagnosis Code Qualifier
XE	M/I Clinical Information Counter
ZE	M/I Measurement Date

Legal References

MS [151](#) (chapter – Pharmacy)

MS [151.01](#), subd. 5, 27 and 49 (Definitions)

MS [256B.0625](#), subd.13a-13g (Covered Services – Drugs)

MN Rules [6800](#) (Chapter-Pharmacies and Pharmacists)

MN Rules [6800.2700](#) (Return of drugs and devices)

MN Rules [6800.3100](#) (Compound and Dispensing)

MN Rules [6800.3110](#), subp. 2a (Patient Medication Profiles)

MN Rules [9505.0175](#), subp. 49 (Usual and Customary)

MN Rules [9505.0340](#) (Pharmacy Services)

MN Rules [9505.5000 to 9505.5105](#) (Prior Authorization Applicability)

42 CFR 440.120(a)

Title XIX, Section [1927](#) of the Social Security Act (Payment for Covered Outpatient Drugs)

42 CFR 483.10

Title XII, Section [483.10](#) (Resident rights)