Chapter 22

Pharmacy Services

The purpose of this chapter is to explain IMCare pharmacy policies and procedures. IMCare utilizes CVS Caremark as its pharmacy claims processor.

Definitions

Agreement: The Pharmacy Agreement between the pharmacy and CVS Caremark.

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 Maximum Allowable Cost (MAC) list.

Average Wholesale Price (AWP): The AWP of a prescription drug service at the time a claim is processed as established in the CVS Caremark price file and updated no less than weekly by Medi-Span or by such other national drug database as CVS Caremark 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 a Pharmacy Provider Agreement in accordance with the terms of the benefit plan, including, but not limited to, plans approved by the Centers for Medicare & Medicaid Services (CMS) under the Medicare Part D Program.

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, co-insurance, 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.

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 CVS Caremark or a benefit sponsor. Also referred to as the "Drug List."

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."

Maximum Allowable Cost (MAC): The list delineating the maximum per unit reimbursement as established and solely determined by CVS Caremark 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 CVS Caremark 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.

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.

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

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

Pharmacy Service: The dispensing of drugs, counseling, concurrent drug utilization review (DUR) and other activities as described in MN Stat. sec. 151.01, subd. 27, or as performed by a dispensing physician.

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

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 CVS Caremark.

Prescribing Provider: A doctor of medicine (MD) 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 CVS Caremark, 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 (U&C) Charge: 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 CVS Caremark price file and updated no less than twice monthly by Medi-Span or by such other national drug database as CVS Caremark may solely designate.

IMCare Contact Information

If you need additional information, please contact:

IMCare
1219 Southeast 2nd Avenue
Grand Rapids, MN 55744

For general member questions, call IMCare at 1-800-843-9536 (toll free).

IMCare website: www.imcare.org

Visit the IMCare website for the following information:

1. ***IMCare's Provider Newsletters*** and ***IMCare's 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

CVS Caremark Help Center Contact information

Phone: 1-800-364-6331 (toll free)

The CVS Caremark Contact Center has staff to assist pharmacies with processing questions or problems. Representatives are available 24 hours a day, 365 days a year.

Federal Anti-Fraud Statutes

Pharmacies cannot use pharmaceutical manufacturers' coupons, discounts, or similar promotions in order to attract prescription business from Medical Assistance (Medicaid) or Medicare recipients. Federal anti-fraud and abuse provisions prohibit certain types of business transactions or arrangements, per Title 42 United States Code (USC) Section 1320a-7b, Section 231(h) of the Health Insurance Portability and Accountability Act (HIPAA) and the Office of Inspector General (OIG) Special Fraud Alert, and Volume 59 Federal Register Issue 242 (1994) #94-31157. See Chapter 1, Requirements for Providers, for details.

How to Determine Drug Coverage

Visit our website for information regarding our drug formularies, pharmacy Utilization Management (UM) programs, and formulary exception process. Please choose the appropriate formulary, as they differ between coverage groups.

Questions regarding coverage of a particular medication can be directed to the formularies on the IMCare website or by calling CVS Caremark's 1-800-364-6331 (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 an 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 (Medicaid)-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.

Handwritten prescriptions must be executed on a tamper-resistant prescription blank with at least one characteristics from all three categories as outlined in the July 2008 National Council for Prescription Drug Programs (NCPDP) letter to Medicaid.

To help pharmacists 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.

General Claim Information

Processor Control Number (PCN)

CVS Caremark requires a separate PCN for each carrier. A bank identification number (BIN) is also required when adjudicating claims through the online system.

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.

Providers will be required to submit an NDC with all not otherwise specified (NOS) J Healthcare Common Procedure Coding System (HCPCS) codes.
Providers are required to report the NDC number of the prescription product when billing certain HCPCS codes. A list of the codes requiring NDC is available on the Minnesota Department of Human Services (DHS) website.

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. *For example,* a 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. *For example,* a 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, MinnesotaCare, MSC	34 days
PMAP, MinnesotaCare fills for antihypertensives, antidiabetic drugs/ supplies, oral contraceptives and prenatal vitamins.	100 days
IMCare Classic (Medicare Parts B & D)	93 days
IMCare Classic living in SNF (Medicare Parts B & D)	31 days

During COVID-19 or "peacetime emergency," upon request members may be granted a 90-day supply of formulary medications or medications with an existing authorization, that were previously limited to a shorter day-supply. This is applicable to PMAP, MNCare and IMCare Classic benefits.

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 IMCare. A pharmacy may not dispense a repackager's drug and then bill IMCare 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 CVS Caremark Pharmacy Help Center 1-800-364-6331 (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."

Drugs and costs not covered include the following:
1. Drugs when indicated or used for erectile dysfunction
2. Drugs determined to be less-than-effective in Drug Efficacy Study Implementation (DESI) by the United

States Food and Drug Administration (FDA) and drugs identified as identical, related, or similar to DESI drugs
3. Drugs that are limited or excluded by the state as allowed by Federal law
4. Drugs dispensed after their expiration date
5. The cost of shipping or delivering a drug
6. Drugs lost in shipping or delivery
7. Drugs, both legend and OTC, that are not prescribed by practitioners licensed to prescribe or that are not prescribed within their scope of practice
8. Herbal or homeopathic products

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.

0 = No product selection indicated
1 = Substitution not allowed by prescriber
2 = Substitution allowed – patient requesting product dispensed
3 = Substitution allowed – pharmacist selected product dispensed
4 = Substitution allowed – generic drug not in stock
5 = Substitution allowed – brand drug dispensed as a generic
6 = Override
7 = Substitution not allowed – brand drug mandated by law
8 = Substitution allowed – generic drug not available in marketplace
9 = Other

Dispense as Written — Brand Necessary

1. Prescribers must obtain authorization for any brand name multiple source drug that has an FDA "AB" rated generic equivalent.
2. Providers must continue to write, in their own handwriting, "DAW - brand medically necessary" on the prescription (a checked DAW box or a typed DAW is not acceptable) and obtain prior authorization from IMCare.
3. For prescriptions transmitted electronically, the prescriber may indicate the DAW 1 box using the e-prescribing software. However, the prescriber must enter "Brand Medically Necessary" in the "Prescriber note to Pharmacy" field. The pharmacy may not make any changes to the "Prescriber note to Pharmacy" field. If a DAW "1" appears and there is no brand necessary notation, the pharmacist must contact the prescriber for a new prescription.
4. List the specific drug being requested, including dosage form, strength, and directions.
5. Document when the generic was tried and the length of the trial period.
6. Specify the medical problem caused by the generic product. Describe the problem in detail (e.g., the medication caused hives or a rash).
7. Provide chart documentation of generic failure whenever possible.
8. Include the name and National Provider Identifier (NPI) of the prescribing physician, the NDC number, and the NPI number of the dispensing pharmacy.
9. When submitting claims, dispensing providers must use code 01: Substitution Not Allowed by Provider and include the authorization number.

An exception to this policy is when a generic drug has a higher net cost than the brand name drug. When this occurs, IMCare may prefer the brand name drug over the generic until the generic product is available at a

reduced cost. When IMCare prefers the brand over the generic, the prescriber is not required to write "DAW – brand medically necessary" on the prescription or enter "Brand Medically Necessary" in the "Prescriber note to Pharmacy" field. When a new generic drug becomes available, Visit the IMCare website or call IMCare to determine if it meets criteria on an individual basis. Visit the IMCare website for the authorization forms.

Online Claim Submission

The pharmacy is required to submit all claims online to CVS/Caremark 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 CVS Caremark. The pharmacy has 90 days from the date of service (DOS) to submit a claim online. The pharmacy is required to submit the U&C charge 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 IMCare. 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 CVS Caremark claims 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 14 days from the DOS 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 14 days from DOS.

Coordination of Benefits (COB)

COB capabilities are available on a limited basis. Please call IMCare at **1-800-843-9536** (toll free) for assistance in processing secondary claims. Keep in mind that all secondary claims submitted to IMCare 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. Secondary claims for greater than a 34-day supply will be granted on a limited basis only when the primary insurance requires that a larger supply be provided (i.e., mandatory mail order).

Claim Formats

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

Copay Charge

The copay is the amount specified by IMCare that the member is required to pay to the pharmacy for prescription drug services. CVS Caremark 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 CVS Caremark 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 Title 42 Code of Federal Regulations (CFR) Part 447.53 for additional details.

3. IMCare Classic members entering a long-term care facility (LTCF) will be responsible for any copays on their prescriptions for at least the remainder of that month, sometimes longer. For stays in the LTCF 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.

Accepting Cash Payments
Do not accept cash payment from a member, or from someone paying on behalf of the member, for any IMCare-covered prescription drug.

A pharmacy may accept cash payment for a noncovered prescription drug if **all** of the following apply:

- The member is not enrolled in the restricted member program
- The pharmacist has reviewed all available covered alternatives with the member
- The pharmacy obtains an Advance Member Notice of Noncovered Prescription (DHS-3641) (PDF)
- The prescription is not for a controlled substance (other than weight loss medications that are not part of the MA benefit, such as phentermine)
- The prescription is not for gabapentin

A pharmacy may accept cash payment for a controlled substance or gabapentin only if the pharmacy has received an Advance Member Notice of Noncovered Prescription (DHS-3641) (PDF) signed by the prescriber and all criteria has been met for a member who is not enrolled in the restricted member program. MHCP will not authorize a pharmacy to accept cash if the medication requires prior authorization or is subject to a quantity limit and the prescriber has not attempted to obtain the prior authorization or authorization to exceed the quantity limit. MHCP will authorize cash payment if the pharmacy and member complete their sections of the DHS-3641 and the prescriber also confirms the following:

- Covered alternatives are not viable options for the member
- The prescriber is aware that he or she is seeking authorization for the pharmacy to charge the member for the medication
- The prescriber is aware of the last time the medication was filled for the member, if applicable
- The prescriber attests that allowing the member to purchase the medication is medically necessary

The prescriber must sign the DHS-3641, send the completed form to the pharmacy and retain a copy of the completed form in the member's medical record. The pharmacy must also retain a copy of the completed form as documentation of approval from MHCP to accept cash payment on the date of service. The completed DHS-3641 is authorization from MHCP to accept cash payment on the date of service; you do not need to submit a copy to MHCP, unless requested. The prescriber or pharmacy does not need to call MHCP for additional authorization.

Phentermine

Phentermine is a drug used as part of a comprehensive weight loss program. Phentermine is not covered by Medical Assistance because weight loss drugs are excluded from coverage by state law. A pharmacy may accept member payment for a phentermine prescription provided:

- You inform the member before you dispense the phentermine prescription that the member is responsible for payment
- You or an authorized health care representative completes the Advance Member Notice of Noncovered Prescription (DHS-3641) (PDF) and the member signs the form

If a member's MHCP eligibility status is in question and the member offers cash payment for prescriptions, the pharmacy must verify eligibility through MN–ITS or the Eligibility Verification System (EVS). If the person does not have coverage through MHCP, you may charge that person and accept cash as payment. If the member is covered by MHCP, do not accept cash payment from the member for the prescription if he or she is enrolled in the restricted member program.

Eligible Providers and Prescribers

Eligible Dispensing Providers

1. A pharmacy that is licensed by the Minnesota Board of Pharmacy
2. A pharmacy enrolled into the CVS Caremark 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 IMCare-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 (NP) employed by or under contract with a community health board for communicable disease control

Eligible Prescribers

A physician, osteopath, dentist, podiatrist, NP, mental health certified nurse specialist, optometrist, physician assistant (PA), 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 OTC medications to IMCare members.

Provider Identifier

In accordance with State and Federal regulations, NPIs 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 NPI of an MHCP-enrolled supervising physician if the NPI of the prescribing provider is not available because the prescribing provider is an intern or resident. The Drug Enforcement Agency (DEA) number can also be submitted as identification (ID) for the prescribing provider. When a pharmacist has prescribed OTC medications, the NPI of the dispensing pharmacy may be used as the prescribing provider.

Physician-Administered Drugs

Drugs that are administered to a patient as part of a clinic or other outpatient visit should be billed to IMCare using the appropriate HCPCS code(s). Do not bill drugs administered during an outpatient visit through the pharmacy POS system. IMCare does not allow "brown-bagging" or "white-bagging" of prescription drugs administered in an office setting.

Pharmacies, including mail order pharmacies, that are providing the drugs for a clinic visit, should bill the clinic and not IMCare for the drugs dispensed. IMCare will make an exception only if a member has third-party liability and the third-party payer requires that the drugs be billed through the pharmacy benefit.

Pharmacies should not dispense drugs directly to a patient if the drugs are intended for use during a clinic or other outpatient visit.

Pharmacist Prescribing – Over-the-Counter (OTC) Medications

The following policies apply to pharmacists prescribing OTC medications:

1. OTC medication must be medically necessary, and the member 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 MN Stat. sec. 151.01, subd. 16. As with all other Medical Assistance (Medicaid) 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 members, 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 MN Stat. sec. 151 and MN Rules part 6800
6. The pharmacy's NPI 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 member's profile any updated information regarding medical necessity, drug therapy reviews, and drug counseling.
8. The pharmacist is required to have the member sign for receipt of the prescription whenever possible
9. The entire package of all OTC medications used on a maintenance or as-needed basis must be dispensed at each fill. Do not dispense a partial package of an OTC drug unless the drug is being used on a one-time basis and it is not anticipated that the patient will need a refill. All vitamin and mineral supplements should always be dispensed in the entire package quantity.
10. Pharmacies may repackage OTCs, but the entire package quantity must still be dispensed for all OTC medications used on a maintenance or as-needed basis. No additional or enhanced dispensing fee is available for the repackaging of OTC medications.
11. 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 U&C 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 CVS Caremark MAC list will supersede any submitted OTC drug prices.
12. 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 Members

Member Eligibility

A member's eligibility can be verified through the claim adjudication system or by calling the CVS/Caremark Pharmacy Help Desk at 1-800-364-6331 (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 member eligibility information by using the IMCare HealthX System, Provider Contact Center, or the automated DHS EVS, which includes a telephone service and a web portal within MN–ITS.
2. Verify member eligibility through:
   a. IMCare HealthX. Prior registration is required.
   b. IMCare: **1-800-843-9536** (toll free)
   c. DHS MN-ITS web portal
   d. DHS EVS Line: **1-651-431-2700** or **1-800-657-3613** (toll free)

Standard Eligibility Format

The eligibility format used by the majority of IMCare members includes the following elements:
1. Member ID number
2. Date of birth (DOB)
3. Gender status
4. Prescriber identifier (NPI)

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 CVS/Caremark Help Desk at 1-800-364-6331 (toll free) or use MN-ITS to verify eligibility on the DOS to obtain accurate member information prior to processing a claim. The member's Medical Assistance (Medicaid) number is the same as his/her IMCare ID number.

Responsibility of Pharmacy

All pharmacy claims for medications are processed by CVS/Caremark. Pharmacies should follow their policies and procedures for proper submission of claims. In addition to CVS/Caremark's requirements, IMCare 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 CVS Caremark for adjudication within 90 days from the date the prescription is dispensed
3. Submit no more than the U&C charge 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 UM 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 LTCFs, of the potential of non-coverage is expected of all pharmacies serving IMCare members
9. IMCare does not allow automatic refills. Prescription refills are not eligible for payment without an explicit request from a member or authorized caregiver. The pharmacy provider may not contact the member in an effort to initiate a refill unless it is part of a good faith clinical effort to assess the member's medication regimen.

   A nurse or other authorized agent of the facility may initiate a request for refill for a member residing in a skilled nursing facility, group home, or assisted living arrangement.

   Cycle fills are only allowed for enrolled unit dose dispensing pharmacies for members residing in skilled nursing facilities.

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 units 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.
   c. Two rescue inhalers such as albuterol and pirbuterol can be dispensed for members who need one for home and one for school or work even if the days' supply is greater than 34 available upon request
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 member.
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 member is allowed if the record kept by the pharmacist or dispensing physician documents that there is a significant chance of overdose by the member if a larger quantity of drug is dispensed, and if the pharmacist or dispensing physician writes of this reason on the prescription. Short cycle dispensing of solid oral doses of brand name drugs to Medicare members in LTCFs in accordance with 42 CFR 423.154 will also receive more than one dispensing fee per the PBM agreement.
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. Pharmacies may repackage OTCs, but the entire package quantity must still be dispensed at each fill for all OTC medications used on a maintenance or an as-needed basis. No additional or enhanced dispensing fee is available for the repackaging of OTC medications.
7. Effective January 1, 2014, diabetic testing supplies are part of the Point of Sale Diabetic Testing Supply Program
   a. Members with Medicare Part B may continue to obtain diabetic testing supplies from a medical supplier or pharmacy
   b. Diabetic equipment and supplies other than testing supplies may be obtained from a medical supplier or pharmacy

Unit Dose Dispensing

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

Phone: 1-800-364-6331 (toll free)

1. Unit dose packaging procedures and fees apply only to legend drugs.
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. Solid oral doses of brand name drugs dispensed to Medicare-covered members residing in LTCFs must be dispensed in no greater than 14-day increments at a time in accordance with short cycle dispensing requirements in 42 CFR 423.154. Dispensing fees for short cycle dispensing will be paid according to the PBM agreement.
5. The DOS 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 DOS transmitted via POS.
6. **Long-Term Care (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 CVS Caremark Medicare Long-Term Care (LTC) Network.

Returning Unused Unit Dose Package Drugs

Drugs dispensed in unit dose packaging must be returned to a pharmacy as specified below when the member 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 LTCF 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 CVS/Caremark for the actual amount of medication used on the electronic claim system.

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 off rates specified in the pharmacy provider agreement executed between the pharmacy and CVS/Caremark. 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 CVS/Caremark has set up and the price/patient pay schedules. Compound drugs can be submitted through the online adjudication system following current NCPDP guidelines.

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 (IV) solutions, 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 IMCare.

Insulin Supplies

Unless indicated by the POS system, insulin syringes and needles are generally a covered benefit. For IMCare Classic (HMO SNP) members, these are considered Part D-covered items and should be sent to that specific BIN and 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 IMCare Complaint, Appeals, and Grievance Coordinator at **1-800-843-9536** (toll free) for full information regarding complaints and Appeals.

Utilization Management (UM) Programs for Prepaid Medical Assistance Program (PMAP), MinnesotaCare, Minnesota Senior Care Plus (MSC+),

Administrative Determinations

Maximum Allowable Cost (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 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.

IMCare has adopted the CVS/Caremark'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 may 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 CVS/Caremark MAC list, please contact CVS/Caremark 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 IMCare 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 and Lost Medications

A pharmacy may obtain Prior Authorization for a dosage change or vacation request by calling the **IMCare at 1800-843-9536** (toll free). Controlled substances are not eligible for vacation supply requests. The following are situations that would be covered under this provision:

Process for Handling "Refill-Too-Soon" Override and Authorization Requests

Itasca Medical Care (IMCare) QI/UM staff will make the final determination whether or not to approve a medication early-refill request based on clinical information provided and internal criteria.

This applies to medication early-refill requests due to:

- lost or stolen medications
- need for early refill due to vacation/travel
- need for early refill due to medication used more often than prescribed
- need for early refill due to exceeding a managed drug limitation/quantity limit

IMCare follows Chapter 22, Pharmacy, of the DHS ***MHCP Manual***.

Criteria

1. Members will be allowed up to a 90-day supply, upon request, of formulary medications or previously authorized medications during COVID-10 or "peace time emergency."
2. Members will be allowed only one override in 12 months for lost, stolen, damaged, or destroyed non-controlled medications.
3. Members will be allowed only one vacation supply override per 12 months.

4. 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).
5. A leave of absence override maybe allowed in certain circumstances. The intent is that an authorization may be granted for a member who lives in an LTCF 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.
6. 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 contacts IMCare to request a 90-day supply of formulary or previously authorized nonformulary medications during COVID- 19 or "peacetime emergency."	Authorization is granted, and the member may continue with 90-day fills of medication for the duration of "peace-time emergency".
Member does not reside in an LTCF such as a nursing home or Intermediate Care Facility for the Developmentally Disabled (ICF/DD) and one of the following occurred with the medication: • 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: • Hospital • Correctional facility • Detoxification center	Verify and document the discharge/release from the facility
Member enters a detoxification facility for the purpose of 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
Member 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 *not* granted in the following circumstances	
Circumstance	**Action**
Member resides in an LTCF such as a nursing home or ICF/DD and medication was: • Lost • Damaged • Stolen • 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: • Lost • Damaged • Stolen • 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: • Pass meds • Work supplies • School supplies • Etc.	Authorization will not be granted

Pharmacy Controlled Substance Overrides

Override/authorization *is granted* in the following circumstances	
Circumstance	**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 *not* granted in the following circumstances:	
Circumstance	**Action**
Medication was lost, stolen, damaged, or destroyed and member resides in an LTCF such as a nursing home or ICF/DD	The facility must replace the medication at its own cost
Medication was lost, stolen, damaged, or destroyed and member does not reside in an LTCF such as a nursing home or ICF/DD	Additional authorization will not be granted

Override/authorization is *not* granted in the following circumstances:	
Circumstance	**Action**
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 IMCare 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, MinnesotaCare, MSC+ process: The IMCare designated individual, enters an authorization into CVS/Caremark claim processing system after the member or authorized representative notifies Member Services that a Formulary exception is needed. 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.
   b. IMCare Classic process: Automated at POS 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 **1-800-843-9536** (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, IMCare 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 IMCare changes its Drug Formulary or when a member changes Managed Care Organizations (MCOs), and it will be extended annually if certification is provided to IMCare by the prescribing provider.
4. IMCare 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 CVS Caremark Pharmacy Help Desk. The treating practitioner must initiate all requests for clinical pharmacy determinations. Requests should be initiated by faxing the appropriate pharmacy determination form to IMCare. 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 IMCare'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 (P&T) 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 IMCare Medical Director prior to making a final denial decision. Per MN Stat. sec. 62Q.527, the IMCare 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 Acquired Immune Deficiency Syndrome (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

IMCare is 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
IMCare Classic	24 hours	24 hours
PMAP, MinnesotaCare, MSC+	24 hours	24 hours

IMCare sends the member and requesting provider a letter of approval. IMCare and its delegated entities shall be responsible for mailing any Denial, Termination, or Reduction (DTR) of Service notices to members and practitioners that are required by Minnesota Statutes, Rules, and regulations, including but not limited to, MN Stat. Chap. 62M. Denial notices shall include Appeal rights and follow the format required by DHS as outlined in MN Stat. Chap. 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 (UM) Programs

Prior Authorization

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

The IMCare formularies clearly identify Prior Authorization requirements for those medications that require it. Please refer to the current posted Medicaid and/or Medicare formulary on the IMCare website at www.imcare.org for drugs that require a Prior Authorization.

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.

The IMCare formularies clearly identify Quantity Limit requirements for those medications that require it. Please refer to the current posted Medicaid and/or Medicare formulary on the IMCare website for drugs that are subject to Quantity Limits.

Step Therapy

Sometimes, members must try one or more preferred drugs before a non-preferred drug will be covered. The IMCare formularies clearly identify Step Therapy requirements. Please refer to the current posted Medicaid and/or Medicare formulary on the IMCare website for drugs that have a Step Therapy requirement.

Formulary Exceptions

For members sensitive or unresponsive to the formulary medication or who 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 IMCare's clinical pharmacy reviewer.

Please visit IMCare's website at www.imcare.org provider section for the Formulary Exception Form or the Medicare Part D. Coverage Determination Request form.

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 member's best **medical** interest to fill the prescription, the denial may be Appealed.

Drug Formulary

IMCare has adopted CVS/Caremark formularies for its selected populations. The formularies are developed and approved by a 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, MinnesotaCare	MSC+ only	MSC+ with Medicare	IMCare Classic
PMAP Formulary	Yes	Yes	No	No
Medicaid OTC Formulary	Yes	Yes	No	No
Medicare OTC Formulary	No	No	Yes	Yes
Medicare Part D Formulary	No	No	No	Yes
Medicare Wrap Around Formulary (for member with Medicare)	No	No	Yes	Yes

The Medicaid Wrap Around Formulary has been tailored to address the specific needs and coverage status of each demographic group. The wraparound formulary is a list of medications that a traditional Medicare Part D formulary would not cover, but IMCare has made available to its members who have Medicare. It generally consists of medications from the following classes:

1. OTC items
2. Vitamins
3. 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)

CVS/Caremark 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
9. Greater than four grams/day acetaminophen 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 Fraud, Waste, and Abuse

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

IMCare
1219 Southeast 2nd Avenue
Grand Rapids, MN 55744

Phone: or **1-866-296-0584** (toll free).

Inspection of Records and Audit per CVS/Carmark'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, CVS/Caremark has the right to inspect all records of the pharmacy related to IMCare claims.

Pharmacy Audit
Audits are conducted in compliance with Federal and State laws to ensure the privacy and confidentiality of all patient records. IMCare may delegate CVS/Caremark to conduct audits of its contracted network of pharmacy providers. Audits are performed to verify the integrity of claims submitted to IMCare 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. CVS/Caremark 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 the ***Provider Manual*** on IMCare's website.

There are several situations that could precipitate an audit request to CVS/Caremark on IMCare'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)

Medication Therapy Management (MTM)

IMCare facilitates an MTM program policy for its PMAP, MinnesotaCare, and MSC+ 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 health outcomes at the lowest cost. The program is for any IMCare member in Medical Assistance (Medicaid), MinnesotaCare, or MSC+ programs who met DHS eligibility requirements. No prior authorizations are required to perform this service to an eligible IMCare member, but all providers need to follow DHS provider manual in order to be reimbursed for their service time. Prerequisites and practice stipulations to perform these services for IMCare members are identical to the DHS MTM program. To provide MTMS to IMCare members, pharmacists must sign the provider agreement and enroll individually with Minnesota Health Care Programs (MHCP) and retain a copy on file for IMCare to review, if requested. Any pharmacist interested in performing this service to eligible IMCare members should contact IMCare at 1-800-843-9536 (toll free) for details.

MHCP Provider Manual: Medication Therapy Management Services
https://www.dhs.state.mn.us/main/idcplgIdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_136889

The Medicare prescription drug benefit provided through CVS/Caremark includes MTM services for all eligible Part D members in IMCare. The MTM program is administered by Outcomes MTM. Provider enrollment details regarding this program can be found at https://www.outcomesmtm.com/pharmacy/.

Long-Term Care Facilities (LTCFs) Billing Procedures for Pharmacies

Medicare Part A Members

Patients that qualify for Medicare Part A during some or all of their stay in an LTCF or group home are not to be billed for any supplies and medications that they require during their stay under Part A guidelines. IMCare 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 per pharmacy policy. Dispensing fees will not be paid for each partial fill.
2. Seven-day unit packages should be logged and billed no more than once per month
3. In no event may the OTC product be priced higher than the shelf price
4. 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 IMCare. Unique dispensing methods such as tray changes every 2 days or every 7 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 IMCare Prescription Benefit

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

Long-Term Care Facility (LTCF) Lost or Damaged Medication

IMCare should **NOT be billed twice** if medication sent to the LTCF 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 IMCare or the member.**

Emergency Kit Medication Billing Policy

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

1. If **only** one total dose is given, the pharmacy supplying the dose may bill IMCare for a single dose; or
2. If the dose is the **first** in a series of doses, it must be billed to IMCare 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 IMCare. If the order is for Ceftriaxone 1gm IM once daily for 7 days, and the first dose is taken from the emergency kit, the pharmacy should not bill IMCare 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 Long-Term Care Facilities (LTCFs)

IMCare does not pay for solutions, irrigations, or supplies used in LTCFs 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 LTCF. Pharmacies should not bill these products as drugs when the member is in the facility.**

"Extra" Medication Supplies for Multiple Sites

If a PMAP/MinnesotaCare/MSC+/ IMCare Classic member, 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 IMCare separately. For example, if a member receives Sinemet™ 10/100 QID (four times a day), 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 IMCare. 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 LTCFs are subject to the same days' supply limitations as all other IMCare-enrolled pharmacies.

"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 IMCare. A few days later, the pharmacy bills IMCare 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 LTCFs to provide residents with medically necessary OTC drugs used on an occasional or as-needed basis. These drugs are part of the LTCF's per diem and are reported in a cost report to IMCare.

OTC drugs prescribed for a specific resident for scheduled use should be submitted separately to IMCare for reimbursement.

Emergency Medication Usage

A transition process is implemented for Medicare beneficiaries currently living in LTCFs 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 IMCare member who resides in an LTCF 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 IMCare at **1-800-843-9536** (toll free) for a manual system override
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 United States (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

IMCare 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 CVS/Caremark the same day you bill Medicare. If all of your IMCare and Medicare provider information on file is correct, Medicare will cross the claim over to IMCare with payment details.

If Medicare does not cross the claim over to IMCare within six weeks, bill IMCare 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 PDP should call the **Senior LinkAge Line® at 1-800-333-2433** (toll free).

IMCare will not provide prescription drug coverage for dual eligibles who fail to or refuse to enroll in a Medicare Part D prescription plan. IMCare 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 IMCare at **1-800-843-9536** (toll free).

Medicare Part D Excluded Drug Categories
IMCare 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. OTC items including smoking cessation products
3. Prescription vitamins and mineral products

Contact the individual Part D prescription plan with questions about denials, drugs not covered, and authorization requirements. IMCare 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 IMCare.

Home Infusion Therapy (HIT)

HIT-related services are covered when provided by an IMCare-enrolled HIT pharmacy using the appropriate HIT per diem HCPCS codes or the specific codes used by Medicare or a TPL.

Home Infusion Pharmacy

Home infusion pharmacy refers to an established place, whether or not in conjunction with a hospital pharmacy, LTC pharmacy, or community/retail pharmacy that prepares, compounds, and dispenses parenteral or enteral drugs or medicines for the use of non-hospitalized patients and provides related pharmaceutical care services.

Eligible Providers

An HIT provider must meet the following requirements:
1. Has or is applying for a designated parenteral-enteral/home health care license category with the Minnesota

Board of Pharmacy. If located outside of Minnesota, has Home Infusion Pharmacy designation with the state in which it is located, if the state makes such designations.

2. Has the ability to provide a full range of services, including but not limited to:
    a. Providing standards for preparation, labeling, and distribution of sterile products by licensed parenteral-enteral/home care pharmacies
    b. Having a policy and procedure manual addressing sterile preparation of products, clinical services, drug disposal, drug dispensing, labeling, quality assurance, etc.
    c. Meeting physical space and equipment requirements
    d. Having 24-hour staffing (pharmacist on call)
    e. Shipping
    f. Handling of cytotoxic agents
    g. Having a process for systematic drug use review
    h. Monitoring patients
    i. Having the ability to provide administrative and professional pharmacy services, care coordination, and all necessary supplies and equipment as defined by applicable home infusion HCPCS codes

Eligible Members

MHCP and Medicare members are eligible.

Members eligible for both MHCP and Medicare must receive most of their medication through Medicare Part D. MHCP will only cover drugs excluded by law from Medicare Part D coverage. Drugs eligible for Medicare Part B coverage must be submitted to the Medicare Part B carrier.

Covered Services

Per diem codes: S5497 – S5523, S9061, S9325 – S9331, S9336 – S9379, S9490 – S9504, S9537 – S9590

Reimbursement includes:
1. Initial patient assessment
2. Professional pharmacy services
3. Infusion therapy related equipment and supplies
4. Teaching
5. Coordination of care
6. Delivery and removal of equipment and supplies

Nursing Visits (99601 and 99602)
Home infusion and specialty drug administration must be performed by a skilled infusion nurse with specialized education and training in the alternate-site administration of drugs and biologics through infusion.

Nursing services may be billed by the following:
1. Home infusion pharmacy that has employed a home infusion nurse for HIT nursing services
2. Medicare-certified home health agency

Billing

Once the pharmacy is identified as an HIT pharmacy, use the 837P (Professional) transaction to submit claims for HIT services.

1. Enter the applicable HIT HCPCS codes (per diem S codes) that define the infusion, medical supplies, and the pharmacy professional service.
2. On a separate line, enter the appropriate HCPCS codes for the drugs, and report the NDC information for

each drug in the LIN and CTP segments on a batch claim or in the Drug Pricing section on the *Services* tab in MN-ITS.

3. Use the appropriate modifiers (effective August 1, 2015, using SH and SJ modifiers will reduce line item payable to 50 percent of the current allowable charge):
   a. SH – 2nd Therapy – Second concurrently administered infusion therapy
   b. SJ – 3rd Therapy – Third or more concurrently administered infusion therapy

Refer to the Minnesota Uniform Companion Guide or the MN-ITS 837P User Guide for billing instructions.

Total Parenteral Nutrition (TPN) Billing

Lipids are currently covered under B4185 and other TPN compound drugs billable under B5000 – B5200. NDC and NDC quantities are required when billing.
The following standard products are included in the per diem:
1. Non-specialty amino acids (e.g., Aminosyn, FreAmine, Travasol)
2. Concentrated dextrose (e.g., D10, D20, D50, D60, D70)
3. Sterile water
4. Electrolytes (e.g., CaCl2, KCl, KPO4, MgSO4, NaAc, NaCl, NaPO4)
5. Standard multi-trace element solutions (e.g., MTE4, MVE5, MVE7)
6. Standard multivitamin solutions (e.g., MVI-12 or MVI-13)

The following items are not in the TPN per diem and are to be coded, billed, and reimbursed separately:
1. Specialty amino acids for renal failure (e.g., Aminess, Aminosyn-RF, NephroAmine, RenAmin)
2. Specialty amino acids for hepatic failure (e.g., HepatAmine)
3. Specialty amino acids for high-stress conditions (e.g., Aminosyn-HBC, BrachAmin, FreAmine HBC, Premasol, TrophAmine)
4. Specialty amino acids with concentrations of 15% and above when medically necessary for fluid-restricted patients (e.g., aminosyn 15%, Clinisol 15%, Novamine 15%, Prosol 20%)
5. Lipids (e.g., Intralipid, Liposyn)
6. Added trace elements not from a standard multi-trace element solution (e.g., chromium, copper, iodine, manganese, selenium, zinc)
7. Added vitamins not from a standard multivitamin solution (e.g., folic acid, vitamin C, vitamin K)
8. Products serving non-nutritional purposes (e.g., heparin, insulin, iron dextran, Pepcid, Sandostatin, Zotran)

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 PCN
05	M/I Pharmacy Number
06	M/I Group Number

07	M/I Cardholder ID Number

Code	Description
08	M/I Person Code
09	M/I DOB
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 DOS
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 DAW Code/Product Selection Code
23	M/I Ingredient Cost Submitted
24	M/I Sales Tax
25	M/I Prescriber ID
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 Number Refills Authorized
2C	M/I Pregnancy Indicator
2E	M/I Primary Care Provider
30	M/I PA/MC 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 ID
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

Code	Description
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 PA
3W	Prior Authorization in Process
3X	Authorization Number Not Found
3Y	Prior Authorization Denied
40	Pharmacy not contracted with plan on DOS
41	Submit bill to other processor or primary payer
42 – 49	(Future Use)
4C	M/I COB/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 ID
53	Non-Matched Person Code
54	Non-Matched Product/Service ID Number
55	Non-Matched Product Package Size
56	Non-Matched Prescriber ID
57	Non-Matched PA/MC Number
58	Non-Matched Primary Prescriber
59	Non-Matched Clinic ID
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

Code	Description
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/Prospective Payment System (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
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

Code	Description
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 U&C
DR	M/I Prescriber Last Name
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

Code	Description
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
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

Code	Description
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	COB/Other Payments Count Does Not Match Number of Repetitions
P5	Coupon Expired
P6	DOS Prior to DOB
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
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals 06
R6	Product/Service Not Appropriate For This Location

Code	Description
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 and 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

MN Stat. sec 62J.536 – Uniform Electronic Transactions and Implementation Guide Standards
MN Stat. Chap. 62M – Utilization Review of Health Care
MN Stat. sec. 62Q.527 – Nonformulary Antipsychotic Drugs; Required Coverage
MN Stat. Chap. 151 – Pharmacy
MN Stat. sec. 151.01, subd. 5 – Definitions: Drug
MN Stat. sec. 151.01, subd. 16 – Definitions: Prescription
MN Stat. sec. 151.01, subd. 27 – Definitions: Practice of pharmacy
MN Stat. sec. 256B.0625, subd. 13a-13g – Covered Services: Formulary committee; Drug formulary; Payment rates; Prior authorization; Preferred drug list
MN Rules Chap. 6800 – Pharmacies and Pharmacists
MN Rules part 6800.0910 – Patient Access to Pharmacist
MN Rules part 6800.2700 – Return of Drugs and Devices
MN Rules part 6800.3100 – Compounding and Dispensing
MN Rules part 6800.3110, subp. 2a – Patient Medication Profiles
MN Rules part 6800.3510 – Refill Limitations
MN Rules part 9505.0175, subp. 49 – Definitions: Usual and customary
MN Rules part 9505.0340 – Pharmacy Services

MN Rules parts 9505.5000 – 9505.5105 – Conditions for Medical Assistance and General Assistance Medical Care Payment
42 CFR 423.154 – Appropriate dispensing of prescription drugs in long-term care facilities under PDPs and MA-PD plans
42 CFR 440.120(a) – Prescribed drugs, dentures, prosthetic devices, and eyeglasses
42 CFR 447.53 – Applicability; specification; multiple charges
42 CFR 483.10 – Resident rights
59 Fed. Reg. 242 (1994) #94-31157 – Publication of OIG Special Fraud Alerts
Title XIX, section 1927 of the Social Security Act – Payment for Covered Outpatient Drugs
Title 42 USC 1320a-7b – Criminal penalties for acts involving Federal health care programs