2020 Pharmacy Provider Manual

HOW THIS MANUAL IS ORGANIZED

This pharmacy provider manual has been organized by topic, which includes a table of contents. This manual is an administrative program guide to assist network retail, mail order, long-term care, and home infusion pharmacy providers with an understanding of the Pharmacy Benefit Management services administered by PerformRx, LLC.

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INTRODUCTION

PerformRx strives to collaborate with clients to reduce cost, increase performance and better coordinate health care with cutting-edge, proprietary technology. Our goal is to provide continuous improvement in the quality and efficiency of health care management to improve patient outcomes and financial performance.

URAC ACCREDITED PHARMACY BENEFIT MANAGEMENT

URAC ACCREDITED DRUG THERAPY MANAGEMENT

PROGRAM CONTACT INFORMATION

Contact information phone, fax, and email.

DEPARTMENT	Phone/Fax	EMAIL
General Inquiries	Phone 1-866-533-5492	Email: info@PerformRx.com
Request a PerformRx Information Pack:	Phone: 1-866-533-5492	Email: PerformRx Sales & Marketing
Media-related Inquiries	Phone: 1-215-863-6364 Fax: 1-215-937-8776	Email: Corporate Communications)
Pharmacy Network & Contracting	Fax: 1-800-684-5504	Email: Pharmacy Network Management
Pharmacy Help Desk	Phone 1-866-533-5492	Email: Pharmacy Helpdesk
Specialty Drug Management Services:	Phone: 1-800-555-5690	Email: http://www.performrx.com/contact.php

SUMMARY OF PLAN BENEFITS

Transitional Supplies	New enrollees are eligible to receive a transitional supply within first ninety days of coverage. Transitional supplies should be dispensed for the quantity written, not to exceed a **30 days' supply**.
Over the Counter Medications	Please visit the plan's website to search the formulary.
Early Refill Policy	The plan will allow a lost, stolen, spilled, and vacation early refill per rolling twelve (12) months. Pharmacies may accept a member's refill request at 7**5% utilization**.
Mail Order	For assistance, contact Walgreens at 1-800-999-2655.
Coordination of Benefits	If the member states that they have a primary insurance, the pharmacy must first bill the claim to the primary insurance. If a member indicates that there is no primary insurance, the pharmacy may enter the **"502"** prior authorization code to override a COB rejection.

*__Note__: To obtain additional information about COB claims, please go to our website http://www.performrx.com/hcp-payersheets.php and reference the client's payer sheets.

POINT OF SERVICE CLAIM PROCESSING

BIN	Please reference your prescription card for BIN specifics.
PCN	Please reference your prescription card for PCN specifics.
Electronic Claims Submission	Claims can be submitted and reversed for up to **90 days** from the original date of service.
Multi-Ingredient Compounds	The pharmacy will submit compound claims through the claims processor using the **Multi Ingredient Compound (MIC) Prescription Logic**. See the payer sheet for a list of the processing requirements. http://www.performrx.com/hcp-payersheets.php
Vaccines	Pharmacists in participating pharmacies may administer vaccines if allowed by state law. See the payer sheet for a list of the processing requirements. http://www.performrx.com/hcp-payersheets.php
Universal Claims Forms	Universal claim forms may be submitted up to **365 days** from the original date of service. The mailing address: **PerformRx** **P.O. Box 516** **Essington, PA 19029**
Dispense as Written (DAW) Codes	**DAW 0:** No dispense as written (substitution allowed) **DAW 1:** Brand requested by physician requires prior authorization/coverage determination **DAW 2:** Patient requested product dispensed **DAW 5:** Brand Product selected as generic **DAW 7:** Brand drug mandated by law/regulation **DAW 8:** Product not available (applicable only when generic products are not available in the marketplace)
Prescription Origin Codes	**1:** Written Prescription **2:** Telephonic Prescription **3:** Electronic Prescription **4:** Facsimile Prescription

Hospice	Please contact Pharmacy Provider Services for assistance with claim rejections related to the enrollee's hospice status.
Long Term Care (LTC)	See page 17 for processing requirements.

Electronic Claims Submission

Pharmacies are required to submit claims electronically to the claims processing system in NCPDP Version D.0 format. Pharmacies can submit and reverse claims online up to **90 days** from the original date of service based on the client's benefit design.

If a pharmacy attempts and is unable to submit a claim for reimbursement electronically through the claims processing platform, the pharmacy may submit the claim information via a paper universal claim form (UFC) up to **365 days** from the original date of service.

On-Line Claim Billing Requirements

Pharmacies are required to submit claims with a valid prescriber NPI number, BIN/PCN, and member identification number on all pharmacy claims. Please refer to the specific client's Payer Sheets located on our website at http://www.performrx.com/hcp-payersheets.php.

Product Service Codes/ Dispense As Written Codes

The claims processor supports the standard NCPDP/NPI Dispense as written (DAW) product service codes. To ensure accurate reimbursement and compliance with regulatory requirements, always use the correct DAW codes during the submission of a claim.

Prescription Origin Codes

CMS requires Pharmacies to submit a valid prescription origin code on Medicare prescription claims. All claims will be denied at the point of sale when submitting an invalid or missing prescription origin code. If the pharmacist is not able to populate these values within the pharmacy's practice management system, the pharmacist should contact the pharmacy's current software vendor for assistance.

CLAIMS PROCESSING INTERPRETATION TOOL

The **Claims Processing Interpretation Tool** can be used as a guide to understand what a rejection means when a pharmacy receives a rejection message after processing a pharmacy claim.

Rejection	Reasons
National Drug Code (NDC) number is not on file	The NDC number that the pharmacy is using is not on file with First Data Bank (FDB). To resolve this issue, the pharmacy will use an alternate NDC number or call Pharmacy Provider Services for assistance.
The member is not eligible	The pharmacy will contact Pharmacy Provider Services for verification.
The member has other insurance	The member may have a primary insurance. The pharmacy will bill the claim to the primary insurer and bill the Medicaid plan second. If the member states coverage with the primary is no longer active, the pharmacy will process the claim with the prior authorization code "502."
The claim rejects for duplicate therapy	The pharmacy needs to verify the drug therapy and call Pharmacy Provider Services for assistance.
The claim rejects for "refill too soon"	**Dosage Increase:** The pharmacy should use the prior authorization code '**555555**.' If the claim does not pay, check the free-form messaging for the next refill date. For all other early refill reasons, verify the reason for the early refill and contact Pharmacy Provider Services.
The medication requires a prior authorization/product service not covered/step-therapy	The pharmacy will call Pharmacy Provider Services for assistance.
The claim rejects for quantity	The pharmacy needs to call Pharmacy Provider

Rejection	Reasons
limit/dosing	Services for assistance.
The claim rejects for an obsolete medication	The NDC number that the pharmacy is using is obsolete. To resolve this issue, the pharmacy will use an alternate NDC number or call Pharmacy Provider Services for assistance.
The medication may be covered under part B	The pharmacy needs to verify the diagnosis and payer of transplant, if applicable and call Pharmacy Provider Services for assistance.
The claim rejects for invalid prescriber ID	The prescriber ID number on the claim may not be the prescriber's National Prescriber Identification (NPI) Number. The pharmacy will verify the information, update, and resubmit the claim. If additional assistance is required, the pharmacy will call Pharmacy Provider Services.
The claim rejects for invalid days' supply	The days' supply on the claim is more than/less than the plan's allowable days' supply. *Please review the maximum days' supply guidelines found on pages 5-6.*
The claim rejects for invalid date of birth	The pharmacy needs to verify the member's date of birth. If the date of birth is incorrect, the pharmacy will update their system and reprocess the claim. If the date of birth in the system matches the member's actual birthdate, the pharmacy will contact Pharmacy Provider Services for assistance.

MEMBER ELIGIBILITY

Member Eligibility

A covered member's eligibility can be verified through the claims processor during claim adjudication or by contacting Pharmacy Provider Services.

Member Identification Number

The identification number for the member can be found above the member's name on the member's identification card.

If the member does not have their identification card, contact Pharmacy Provider Services for assistance.

PRIOR AUTHORIZATIONS

Prior Authorization / Coverage Determination	For medications that require pre-authorization/coverage determination, inform the prescriber of the requirement. If the enrollee does not have a prior authorization/coverage determination, on file for the medication, the pharmacy will provide the enrollee with a copy of the *Medicare Drug Coverage and Rights* Form.
Status of a Prior Authorization / Coverage Determination	To check on the status of a member's prior authorization/coverage determination, contact Pharmacy Provider Services.

FORMULARY

A list of medications covered by the plan can be found on the plan's website.

Part D covered	The following medications may be covered by the plan under Part D (this is not an all-inclusive list): ▪ Most prescription drugs ▪ Insulin (excludes insulin used in a pump) ▪ Insulin supplies, such as standard and needle-free syringes, needles, gauze, alcohol swabs and insulin pens. ▪ Most vaccines (product and administration); exceptions include flu and pneumonia vaccines, Hepatitis B vaccines (when they meet the CMS coverage requirements for Part B coverage) and vaccines used for the treatment of an injury or illness (e.g., tetanus vaccine). ▪ Prescription-based smoking cessation products ▪ Injectable drugs that may be self-administered ▪ Injectable or infusible drugs administered in the home setting and not covered by Medicare Part A or Part B ▪ Infusion drugs not covered under Part B and administered in the home via intravenous (IV) drip or push injection. Examples include, but are not limited to, intramuscular drugs, antibiotics, parenteral nutrition, immunoglobulin and other infused drugs. **If a claim rejects for any of the aforementioned products, contact Pharmacy Provider Services for assistance.*
Part B covered	Pharmacy Provider Services provides assistance with the following items thru Medicare Part B billing (this is not an all-inclusive list): ▪ Diabetic testing supplies, such as blood glucose meters, test strips and lancets. ▪ Oral immunosuppressive drugs secondary to a Medicare-approved transplant ▪ Oral antiemetic drugs for the first 48 hours after chemotherapy ▪ Inhalation drugs delivered through a nebulizer with the service location being the patient's home. ▪ Certain drugs administered in the home setting that require the use of an infusion pump, such as certain antifungal or antiviral drugs and pain medications ▪ Flu and pneumonia vaccines ▪ Insulin used in a pump ▪ Physician-administered injectable drugs **If a claim rejects for any of the aforementioned products, contact Pharmacy Provider Services for assistance. Roche is the preferred brand for diabetic supplies. Contact Pharmacy Provider Services regarding formulary alternatives for diabetic supplies.*

SPECIALTY MANAGEMENT

Coverage Procedure for all High Cost Self-injectable Medications

All high cost injectable medications require pre-authorization/coverage determination. For assistance with injectable medications, please contact Pharmacy Provider Services.

Home Infusion Billing

For assistance with Home Infusion billing, please contact Pharmacy Provider Services.

LONG TERM CARE (LTC)

Long term care claims must be submitted with the patient location code of '3' in the NCPCP Patient location field to assure correct LTC reimbursement.

LTC Codes

Type of Service	Location	Service
Long Term Care Resident	Patient Residence = 03 or 09	Place of Service = 01
Assisted Living Resident	Patient Residence = 04	Place of Service = 01
Home Infusion (at home)	Patient Residence = 01	Place of Service = 01
Home Infusion Therapy (at Assisted Living Facility)	Patient Residence = 04	Place of Service = 01
Assisted Living Facility as retail	Patient Residence = 04	Place of Service = 01
ICF/MR	Patient Residence = 09	Place of Service = 54
Hospice	Patient Residence = 11	Place of Service = 34

Override Codes

The pharmacy should use the applicable processing code to process the claim.

Reason	Claims processor POS Code
Lost Medication (maximum of 3-day supply)	4
Therapy change (maximum day supply)	5
Meets Plan Limitations	10
Leave of absence (maximum of 7-day supply)	14
Emergency Box Kit	16
Re-admit	18

Long Term Care (LTC) Transitional Supply

Medicare part D enrollees who reside in Long Term Care who are new to the Part D program or new to the a specific plan may be entitled to up to 98 day supply which can be dispensed in 31 day increments within the first 90 days of enrollment.

Pharmacies experiencing problems with processing transitional supplies should contact Pharmacy Provider Services for assistance.

PHARMACY NETWORK

Pharmacy Payment Cycle

The claim processor processes check payments four times per month. The cycles run the 8th, 16th, 24th and the last day of the month. Checks are mailed within eight business days from the end of each cycle. Please contact Pharmacy Network Management if additional information is needed. All regular claims will be paid by PerformRx, utilizing PerformRx check stock. Consequently, PerformRx contracted pharmacies will receive up to two checks each cycle.

Pricing Information

The claims processor updates the PerformRx pricing file, including average wholesale prices (AWPs) and wholesale acquisition costs (WACs), routinely with updates from First Data Bank (FDB).

Pharmacies can now access our web portal PerformMAX in order to view PerformRx's MAC list, which is updated on a weekly basis.

Please go to the following link https://pharmacy.performrx.net this will take you to the PerformMAX login screen. At the bottom of the screen, you should see a new user option. Click "Register here" to go to the "Create Membership" screen. Please select "Pharmacy" as your user type, then fill out the necessary fields and click the "Submit" button. You will receive a notification that your request has been submitted and is being reviewed by PerformRx. PerformRx will review and verify your application. Upon verification, you will receive an automated email from PerformMax notifying you of your approval. When you log in to PerformMAX, you will use your email as the login name and the password that you selected when creating your membership. You will then be able to access the MAC list search function by doing the following:

1. Click on the "Medicare Part D" menu, on the top right of the screen
2. Click on "MAC Price List"
3. Enter the NDC number
4. Click Search

Pharmacy Credentialing

Credentialing and re-credentialing initiatives exist to ensure that participating providers abide by the criteria established by PerformRx as well as governmental regulations and standards.

Participating pharmacies are responsible for ensuring that all pharmacy credentials are valid and up-to-date at all times. Participating pharmacies are responsible for informing PerformRx Pharmacy Network Services of any changes in their credentialing information and ensure their pharmacy certificates are current and up-to-date. Updates should be faxed to **1-866-935-3499** or via email PharmacyNetworkCredentials@performrx.com.

Pharmacy providers who receive a claim rejection message "Provider not valid on date of service" should contact PerformRx's Pharmacy Network Services for assistance at PharmacyNetwork@performrx.com.

Pharmacy Audits

Pharmacies must cooperate with PerformRx auditors and promptly provide access to all information/documents deemed necessary by auditors, including prescription hard copies, patient signature logs, purchase invoices and documentation, including without limitation all computer data. PerformRx provides authorized representatives to audit the pharmacy's records pertaining to member's prescriptions and the provision of covered services with thirty days' notice. The audit record must be maintained for ten years.

PerformRx may notify pharmacies of complaints it receives with respect to customer service, any irregular billing practice or procedure, overpayment, fraud or abuse, non-compliance with PerformRx policies and procedures, or any other problem that PerformRx may discover by audit or otherwise. The Pharmacy must comply with PerformRx for appropriate resolution to PharmacyAudit@performrx.com.

A third party audit vendor conducts audits on behalf of PerformRx. On-site and/or desktop audits are randomly conducted on a routine basis.

The criteria currently used in conducting retrospective on-site and/or desktop audits include, but are not limited to:

1. Excessive quantity dispensed for days' supply limitations
2. Early refill
3. Duplicate dispensing for school/work/LOA
4. Drug billed is different than that dispensed

5. Possible Rx splitting
6. Package billing errors
7. Valid prescriptions
8. DAW parameters
9. Duplicate therapy / prescriptions
10. Temporary supply
11. Diagnosis codes

Pharmacy records may be requested and reviewed by PerformRx at any time.

Signature Logs

Pharmacy Signature log records and/ or electronic facsimile signatures are to be kept on file in accordance with the standard pharmacy practice, state and federal guidelines and laws. The signature log (includes delivered prescriptions) must be kept by the pharmacy for a period, corresponding to the state pharmacy laws in which the pharmacy is located for retaining prescription hard copies. Signature log format should contain the following:

- Member name
- Prescription/medication Reference number
- Date medications were picked up, and or delivered to a member.
- The signature of the member to whom the prescription was dispensed or the member's representative.

Signature logs and/ or electronic facsimile signatures must be retrievable for in-store or desktop audits upon request or written notice. Pharmacy is not entitled to payment for any claim for which there is no signature of the eligible person or authorized representative on the Third Party Signature Claim Log. PerformRx may reverse any claim for which the pharmacy does not produce this information for an audit.

Audit Appeals Process

Pharmacies wishing to appeal the results of a finalized audit may do so in writing within thirty calendar days from the date of the audit letter to PharmacyAudit@performrx.com or to the following address:

PerformRx, LLC
200 Stevens Drive, 4th Floor
Philadelphia, PA 19113
Attn: PerformRx Pharmacy Audit Services

Once all documentation from the audit is received, PerformRx's third party audit vendor contacts the pharmacy via an appeal letter.

To ensure an impartial review, finalized pharmacy audit documentation is independently reviewed by the third party audit company. PerformRx's audit vendor is responsible for the appeals process, which ensures unbiased pharmacy auditing practices.

Pharmacy Complaints

The pharmacy shall promptly investigate all concerns or complaints related to the quality of Pharmaceutical Services provided under the pharmacy's contractual agreement. The pharmacy shall provide written reports to PerformRx of the action(s) taken in response to such quality issues, within ten (10) days of PerformRx' s referral of such issues to pharmacy, and thereafter as necessary until resolved. The Pharmacy Network Email Is pharmacynetwork@performrx.com and the fax number is 1-800-684-5504.

Cultural Competency

In providing counseling and consultation to members and when providing information regarding treatment options (including the option of no treatment), all such information shall be delivered in a culturally competent manner.

Participating Pharmacy Responsibilities

- Prescription Verification- Prior to dispensing any covered medication, the pharmacy shall verify the accuracy and authenticity of all prescriptions.
- Eligibility Verification- Prior to delivering Pharmaceutical Services, the pharmacy shall verify that the person requesting such services is an eligible member, by using the PerformRx authorized Online Claims Adjudication System (OCAS) or by contacting PerformRx directly.
- Dispensing- the pharmacy agrees to dispense covered medication(s) and provide pharmaceutical services to members as authorized by the claims processor via OCAS.
- Signature Logs- the pharmacy shall maintain a signature log that evidences the receipt of covered medications and covered services, including the date of receipt, in accordance with Pharmacy Laws and Pharmacy Standards. The log shall be signed by the recipient member or an authorized representative.
- The pharmacy must notify PerformRx of changes of location, ownership, any changes that could impact member access to the pharmacy.

Compliance to Policy and Procedures

- A third party audit vender will verify if the pharmacy is maintaining prescription record keeping which also follows the most current CMS guidelines. The pharmacy will document Federal Tax ID, State Tax ID, pharmacy insurance information, DEA, State, Board, and employee licenses and expiration dates.

- The pharmacy's compliance program shall be subject to audit by PerformRx and/or the plan in accordance with the audit provisions of this Agreement. Notwithstanding such audit rights, the pharmacy shall, upon reasonable request of PerformRx, provide PerformRx with certification of its compliance with the training and conflict of interest requirements. The pharmacy represents that it complies with minimum standards for pharmacy practice as established by the State(s) in which it operates.
- The authority of the Physical Health – Managed Care Organization (PH-MCO) to ensure the pharmacy's participation and/or compliance with the PH-MCO's Quality Management, Utilization Management, member grievance and other policies and procedures, as amended from time to time.
- All participating pharmacies are required to adhere to all regulatory and contractual requirements. Please refer to your pharmacy agreement.

FRAUD, WASTE AND ABUSE

FRAUD is understood to mean a dishonest and deliberate course of action that results in the obtaining of money, property or an advantage to which the recipient would not normally be entitled.

WASTE entails the expenditure or allocation of resources, treatment, or in this context, pharmaceuticals significantly in excess of need.

ABUSE defined here as a subset of waste and entails the exploitations of "loopholes" to the limits of the law, primarily for financial gain.

A pharmacist is required to exercise sound professional judgment with respect to the legitimacy of prescription orders dispensed. The law does not require a pharmacist to dispense a prescription order of doubtful origin. To the contrary, the pharmacist who deliberately turns the other way when there is every reason to believe that the purported prescription order had not been issued for a legitimate medical purpose may be prosecuted, along with the issuing physician, for knowingly and intentionally distributing controlled substances.

How to Report Suspected Fraud or Abuse

To report suspected fraud or abuse or other compliance violations anonymously, contact PerformRx:

Source	
Online	http://www.performrx.com/fraud-waste-form.php
Telephone	1-800-684-5501
Email	fraudfighter@performrx.com

To find additional information about Fraud and Abuse, go to http://www.cms.hhs.gov/FraudAbuseforProfs/ on the CMS website.

MEMBER RIGHTS

Member Rights & Responsibilities

Our health plan is committed to treating its members with respect. Our health plan, its Network Providers, and other Providers of service, may not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis prohibited by law.

Member Rights

Our plan must honor your rights as a member of the plan.

- We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
- We must treat you with fairness and respect at all times.
- We must ensure that you get timely access to your covered services and drugs.
- We must protect the privacy of your personal health information.
- We must give you information about the plan, its network of providers, and your covered services.
- We must support your right to make decisions about your care.
- You have the right to make complaints and to ask us to reconsider decisions we have made.
- You have the right to know what you can do if you believe you are being treated unfairly or your rights are not being respected.
- You are able to get more information about your rights.

You also have some responsibilities as a member of the plan.

- Get familiar with your covered services and the rules you must follow to get these covered services.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.
- Tell your doctor and other health care providers that you are enrolled in our plan.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
- Be considerate.
- Pay what you owe.
- Tell us if you move.