1590 University Ave | Dubuque, IA 52001
888-884-6331

Pharmacy Provider Manual

Last Revision Date: 1/1/2025

This manual contains detailed explanations of processes and procedures related to participation in MedOne's pharmacy network. The manual also contains helpful contact information and answers to frequently asked questions.

About MedOne

At MedOne, our mission is to help individuals understand their pharmacy benefit, so they can conveniently access the most appropriate Prescription Drug treatment at the most affordable price. We partner with third party administrators (TPAs), consultants and self-funded employers to create and manage transparent prescription benefit solutions to drive clinical outcomes while controlling rising pharmacy spend.

Headquartered in Dubuque, Iowa, MedOne has significant prescription benefit management experience with roots in the pharmacy industry dating back to 1904. MedOne delivers a full-service, transparent pharmacy benefit program to plan sponsors and their Members. MedOne provides a full spectrum of value-based services including:

- Proprietary pharmacy claims processing
- Custom Formulary management
- Flexible plan design options and decision support
- National pharmacy network access
- Rigorous specialty medication management
- Results-oriented clinical programs
- Next-level client and member experience

We look forward to partnering with you to serve our Members!

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MEDONE CONTACT INFORMATION

Pharmacy Help Desk

Assists with all member-related questions or issues

Available 24 hours a day, 7 days a week, 365 days a year

Phone: 888-884-6331
Website: www.medone-rx.com

Pharmacy Provider Services

Available to assist with credentialing, contracts, reimbursement, network set-up, MAC and pricing research

Available from 8:00 a.m. – 5:00 p.m., M-F, CST

Contracting

Phone: 563-293-8142
Email: providerrelations@medone-rx.com
Fax: 563-588-8725

Credentialing

Phone: 563-293-8141
Email: credentialing@medone-rx.com
Fax: 563-588-8725

Payment

Phone: 563-293-8140
Email: remittanceinquiry@medone-rx.com
Fax: 563-588-8725

Pricing Inquiry (MAC Appeal)

Phone: 563-293-8139
Email: pricinginquiry@medone-rx.com
Fax: 563-588-8725

Prior Authorizations

Phone: 888-884-6331
Website: www.medone-rx.com

Audit Department

Phone: 563-293-8138
Email: audit@medone-rx.com
Fax: 563-588-8725

MedOne Communications

MedOne strives to ensure our network pharmacies are informed of pertinent information that may affect their business. Below are various methods of communication that are used:

- *Emails/Telephonic:* MedOne has an exceptional Provider Relations Department available to our pharmacies, pharmacists and corporate offices. When working on a specific issue, MedOne will work with you personally via the telephone or email.
- *Fax Blasts:* MedOne utilizes this form of communication when there is a unique issue or area of concern of which pharmacies should be made aware. This information may go out globally to all pharmacies or to the affected localized area.
- *Payor Sheet:* MedOne makes it easy to process claims accurately by having our Payor sheets available for network pharmacies. Please contact Provider Relations to receive a MedOne Payor Sheet.
- *Point-of-Sale (POS) Messaging:* MedOne has a state-of-the-art POS system informing pharmacies prospectively regarding any concerns about the claim being processed.
- *Website (www.medone-rx.com):* MedOne's website is accessible 24/7 and includes a wealth of information available to aid pharmacies in their business. Our website is an important resource for Participating Pharmacies that includes the most up-to-date policies and procedures, guidance, Formulary and forms necessary to provide Covered Products to Members.

JOINING MEDONE'S NETWORK

Initial Contracting Process

To become a provider for MedOne, pharmacies, PSAOs and chains must complete and submit a MedOne Pharmacy Network Agreement (MPNA) and applicable amendments for providing pharmacy services. Providers must also submit copies of required documentation to show they meet MedOne's credentialing requirements.

To obtain a contract, contact MedOne at:

- Phone: 563-293-8143
- Email: providerrelations@medone-rx.com
- Fax: 563-588-8725

The following documentation will need to be submitted:

- Completed, dated and signed contract, addendum(s), exhibits and attestations

To submit contract and related documentation, use one of the following options:

- Mail to: MedOne, LC, Attn: Provider Relations Dept.; 1590 University Avenue, Dubuque, IA 52001
- Email: providerrelations@medone-rx.com
- Fax: 563-588-8725
- If further information is needed or if information is incomplete, MedOne will contact the provider.

Updating Pharmacy Information

Pharmacy updates are processed utilizing NCPDP information on a monthly basis. Please submit all changes to NCPDP immediately in order to ensure timely processing. Participating Pharmacies must notify MedOne in writing within one business week of any changes in the documentation and other information provided to MedOne in connection with any credentialing or re-credentialing initiatives.

CREDENTIALING/RECREDENTIALING

MedOne conducts credentialing and re-credentialing to ensure participating providers abide by the criteria established by MedOne as well as governmental regulations and standards. All participating providers must comply with the credentialing and re-credentialing initiatives required by MedOne and agree to provide MedOne with documentation and other relevant information that may be required in association with such initiatives. MedOne retains the right to conduct a facility review any time a deficiency or breach of standard of care is suspected.

MedOne's Credentialing Requirements

- Participating Pharmacy must at all times keep and maintain in good standing all valid Federal, State and local licenses and permits as required by Law to operate a pharmacy
- Participating Pharmacy must require and verify all employees have appropriate licenses/permits as required by Federal, State and local Laws
- Participating Pharmacy will ensure all employees are qualified to perform their professional duties and act within their scope of licensure
- Participating Pharmacy must verify that provider and all personnel employed by or contracted by provider are not on the OIG, GSA, SAM or State Exclusion Lists upon new hire/contract and monthly thereafter; unless Federal, State or local Laws indicate otherwise
- Participating Pharmacy must immediately remove any person on the OIG, GSA SAM or State Exclusion Lists from work related to all health care programs, take corrective actions and report findings to MedOne's Provider Relations Department
- Participating Pharmacy must inform MedOne immediately that an employee, owner or pharmacy is on the Exclusion Lists
- Participating Pharmacy will maintain, at its cost and expense, policies of general and professional liability insurance, including malpractice, at a minimum amount outlined in the MPNA or as otherwise required by Law

MedOne will perform random audits of chains' and PSAOs' credentials by requesting the electronic credentialing documentation. MedOne will verify the following during the audit:

- State licensure has been verified in the last year
- DEA certification has been verified in the last year
- Professional liability has been verified within the last year

Pharmacy Services Administration Organizations (PSAOs)

Pharmacy providers may delegate contracting responsibilities to a PSAO. Pharmacies are to report their affiliation with a PSAO to MedOne.

PSAOs are required to sign an attestation stating they, and on behalf of the pharmacy:

- Have a contractual relationship with their affiliated pharmacies
- Must submit their policy and procedure practices for maintaining their pharmacy credentials
- Are responsible for ensuring their affiliated pharmacies are maintaining valid State licenses, DEA certification and liability insurance coverage
- Are responsible for reporting any sanctions or investigations that involve the PSAO or their affiliated pharmacies
- Are responsible for notifying MedOne of any deficiencies
- Must submit a spreadsheet of their affiliated pharmacies—the spreadsheet must include:
    - Pharmacy DEA number and expiration date
    - State license number and expiration date
    - Liability insurance name, policy number and expiration date
    - Pharmacist-In-Charge license and expiration date

Chains

Pharmacies should have a quality assurance policy in place to aid in reviewing error prevention and analyzing causes and contributing factors that may lead to medication, system and/or processing errors.

Chains are required to sign an attestation stating they and their pharmacy locations:

- Are responsible for maintaining valid State licenses, DEA certification and liability insurance coverage
- Are responsible for any sanctions or investigations that involve their pharmacy locations
- Are responsible for notifying MedOne of any deficiencies
- Must submit a spreadsheet of their locations annually—the spreadsheet must include:
    - Pharmacy DEA number and expiration date
    - State license number and expiration date
    - Liability insurance name, policy number and expiration date
    - Pharmacist-In-Charge license and expiration date
    - Days and Hours of Operation

Re-Credentialing Standards

Participating Pharmacies are subject to re-credentialing at a minimum of every 3 years. The process for re-credentialing is identical to that of credentialing, except that MedOne will also consider member complaints, pharmacy audits and customer satisfaction surveys. MedOne retains the right to conduct a facility review any time a deficiency, breaches of standards of care or delivery are suspected.

Court Orders, Subpoenas or Governmental Requests

If MedOne receives a court order, subpoena or governmental request relating to a Participating Pharmacy, MedOne will comply with such order, subpoena or request and the Participating Pharmacy must indemnify and hold harmless MedOne for, from and against any and all costs (including reasonable attorney's fees and costs) losses, damages or other expenses MedOne may incur in connection with responding to such order, subpoena or request.

CLAIMS—GENERAL

Claims Adjudication

All Participating Pharmacies must comply with the most current HIPAA approved NCPDP Telecom Standard for pharmacy drug claims, coordination of benefits and related pharmacy services.

Down-Time Procedures

MedOne strives to minimize planned adjudication downtime and to resolve unexpected downtime issues as quickly as possible. In the event of an unexpected downtime, or an extremely rare planned downtime, we ask that our network pharmacies attempt to service our Members with minimal disruption.

MedOne's Pharmacy Help Desk is available to assist pharmacies with maintaining business operations during planned adjudication downtime. Should unexpected downtime occur, MedOne's Business Continuity Plan will focus first on recovering claims processing and Pharmacy Help Desk phone lines. MedOne asks that our network pharmacies dispense the necessary medication, receive the applicable patient pay amount and submit electronically when possible. If online submission is not possible, call the Pharmacy Help Desk for assistance with:

- Confirming eligibility
- Verifying coverage
- Expected time claims processing will resume

Reversals

- Pharmacies are required to complete reversals of the Prescription Drug claim within the same payment cycle as the submission or up to fourteen (14) calendar days after the claim was adjudicated for prescriptions that have not been picked up by member.
- If unable to reverse a claim online, contact the Pharmacy Help Desk for assistance.

Vacation/Replacement Medication

- Allowances for vacation medication and/or lost, stolen or forgotten medication varies by Payor benefit design. Some client Payors allow vacation quantities, while others do not. Please contact the Pharmacy Help Desk to obtain individual member benefit information

Identification Cards

MedOne or other client Payors will provide Members with prescription drug ID cards to be presented to a provider. While ID card information may vary by plan sponsor, member information necessary to file a claim is contained on the ID card or can be obtained and is described as follows:

- Cardholder ID —Consists of numeric digits or alpha-numeric digits
    - If ID cannot find a Member match, claim rejects "No patient match found."
- Group Number —This field may contain up to 4 alpha-numeric characters which may be required for On-Line Adjudication Processing.
- Dependent coverage may include spouse and/or children. Some Payor ID cards may be coded to indicate which family members are covered. Covered family members are identified by the following relationship codes:

- “1” Cardholder — Eligible Primary Person or Subscriber
- “2” Spouse of the Cardholder
- “3 and following” Dependent of Primary Important

Note: Prescription claims must be submitted to MedOne only for the member for whom the prescription is written by the Prescriber.

MedOne expects network pharmacy to verify the identity of each individual seeking payment for Covered Products. If the person does not have an identification card, but believes the person is a MedOne member, the pharmacy can verify eligibility by contacting the Pharmacy Help Desk or by following the instructions on documents provided by the member.

Required Pharmacy and Provider Identification Numbers

National Provider Identifier (NPI) is the required pharmacy and Prescriber identifier by the Health Insurance Portability and Accountability Act of 1996 replacing legacy identifiers (i.e., NCPDP number, DEA) on all electronically transmitted claims into MedOne. The NPI is a unique 10-digit identifier assigned to health care providers, such as Prescribers and pharmacies, to use when submitting a HIPAA standard transaction. MedOne requires the use of the NPI in transactions.

- Pharmacy NPI field—pharmacy is required to submit valid and accurate information identifying their Type 2 (Organizational) NPI in NCPDP field 201-B1 (Service Provider ID) with the qualifier “01” in NCPDP field 202-B2 (Service Provider ID Qualifier)
- Prescriber NPI field—pharmacy is required to submit valid and accurate information identifying the Prescriber’s Type 1 (Individual) NPI in NCPDP field 444-E9 (Provider ID) along with the qualifier “01” in the NCPDP field 465-EY (Provider ID Qualifier). Organizational NPIs will reject.

Drug Information Source

MedOne contracts with Medi-Span as its source of prices for pharmaceuticals. In the rare instance where Medi-Span does not publish an AWP or WAC price, MedOne will determine the price from other sources.

CLAIMS—SUBMISSON OF CLAIMS

Bin-PCN-Payor Sheets

Minimum required fields when submitting claims: (Required fields are subject to Plan Specifications)

- BIN: 610311 (from ID Card)
- PCN: MD1 (from ID Card)
- Group (from ID Card)
- Member ID (from ID Card)
- First Name
- Last Name
- Date of Birth
- Gender Relationship Code
- Pharmacy NPI
- Prescriber NPI

- Rx Number
- NDC
- Quantity
- Days' Supply
- Date Filled
- U&C Gross Amount Due (GAD)

Payor Sheets are available upon request by contacting providerrelations@medone-rx.com.

Claim Edits

Following an online claim transmission by a pharmacy, the MedOne adjudicating system will return a response to indicate the outcome of processing. If the claim passes all edits, a "Paid" response will be returned with the MedOne allowed amount for the paid claim. A "Rejected" response, along with NCPDP rejection codes, will be returned when a claim fails one or more edits.

Quantity Dispensed

Participating Pharmacies must dispense the quantity authorized by the Prescriber as allowed by State Law or up to the plan limitations. For proper reimbursement, the actual quantity dispensed to the member should be submitted in the "Quantity Dispensed" field (442-E7).

Many NDC numbers are packaged in sizes that are not whole numbers. When entering a claim for a drug that is packaged in a metric decimal-sized package (e.g. 1Ø.6 or 2.5) be sure to submit the decimals on your claim. Enter the exact metric decimal quantity. Do not round up or down.

There are three standard billing units used to describe drug products:

- EA—each
- ML—milliliters
- GM—grams

Submission of quantities for standard billing units are determined by Medi-Span. The following are general quantity dispensed guidelines:

- Products that are measured in units and not by weight or volume are billed as the number of "each" dispensed.
- Products such as solutions and injectable liquids that are measured by liquid volume are billed as the number of milliliters dispensed.
- Oral antibiotic suspensions, eye drops, and other non-injectable dosage forms that require reconstitution prior to dispensing and are labeled by volume should be expressed in milliliters.
- Products that are measured by weight (ointments, creams, etc.) are billed as the number of "grams" dispensed and are labeled with grams on the product.

For questions on quantity dispensed, please contact providerrelations@medone-rx.com.

Unbreakable Packages

An unbreakable package, also referred to as a unit-of-use package, is prescription medication that cannot be further sub-divided into fewer dispensed quantities or contains a quantity

designed and intended to be dispensed directly to a patient for a specific use without modification except for the addition of a prescription label by a dispensing pharmacist.

Pharmacies should bill for multiples of whole packages with the true day supply and allow for the claim to reject before reducing day supply or quantity.

Days' Supply

NCPDP's "Days' Supply" field (4Ø5-D5) is one of the key fields referenced for Drug Utilization Review (DUR) and Early Refill edits. An incorrect day supply can result in inaccurate DUR alerts and cause claims to reject for early refill. MedOne requires pharmacies to use the following method to determine proper day supply:

Quantity ÷ total dosage units per day = # of days medication will last member

Many plan benefits may permit extended days' supplies. Pharmacies should always transmit the accurate Days' Supply of the quantity dispensed. The on-line adjudication system will communicate the allowable number of days per the member's plan limitations. Participating Pharmacy shall have no right to dispense quantities of Covered Products to Members in excess of Days' Supply as limited by the applicable Plan Specifications or an executed applicable network addendum to this Agreement, except as otherwise permitted in this document and applicable Law.

Refills

Pharmacies cannot push-bill or auto-refill for prescriptions that are mailed to patients. Refills must be specifically indicated by the Prescriber. Original orders or refill requests initiated by the pharmacy should not contain default number of refills. The number of refills authorized must be initiated by the Prescriber.

Refill Limitations:

- DEA schedule = Ø -- Original + 11 refills within 365 days from original Prescription Written Date (or as further limited per Federal/State regulations)
- DEA schedule = 2 -- No refills allowed
- DEA schedule = 3, 4, 5 -- Original + 5 refills within 185 days from original Date Rx Written (or per Federal/State regulations)

NDC# / Package Size

It is the pharmacy's obligation to submit claims using the lowest ingredient cost dosage form and lowest cost package/size container available. When a pharmacy submits a claim, they must submit the correct NDC for the medication being dispensed to the member. Claims for repackaged and/or relabeled NDCs submitted to MedOne will be subject to full audit recovery. Drugs labeled to be dispensed only in the original container or package must be dispensed in the original packaging for all of MedOne' plans covering such drug products. All other packages are considered "breakable" and as such must be dispensed in the quantity prescribed.

MedOne allows original manufacturer NDCs only. MedOne does not allow use of repackaged products. MedOne will reject any repackaged NDC.

Generic Substitution

MedOne encourages its pharmacies to dispense generics whenever possible. Pharmacies should substitute a generically equivalent drug for the brand prescribed unless the Prescriber writes in his/her own handwriting the words "Brand Necessary," "Brand Medically Necessary" or some such wording as required by Law on the face of the prescription (42 C.F.R. §447.331 and 22 T.A.C. §309.3). For electronic prescriptions, MedOne will follow the NCPDP standard designation for “Dispense as Written (i.e., DAW = 1).” The Prescriber must indicate on the electronic prescription that DAW = 1 and in the “Notes to the Pharmacy,” the Prescriber must type “Brand Medically Necessary” or some such wording as required by Law to indicate that the brand is to be dispensed. If the electronic prescription is received by the pharmacy with DAW = 1 without the corresponding message, the pharmacist must contact the Prescriber for a new prescription. Handwritten prescriptions must include the words “Brand Medically Necessary” in the Prescriber’s own handwriting on the face of the prescription.

For telephoned prescriptions, the pharmacist should manually write “DAW” on the prescription and indicate whether it is Prescriber-originated or patient-originated. Member liability does vary by Payor’s Plans Specifications. Some Payor’s plans allow use of DAW codes; others do not allow use of DAW codes. Please rely on the on-line adjudication processing system. MedOne monitors frequent submissions of DAW codes and trial adjudications. Use of DAW-1 that was not initiated by the Prescriber in the original prescription order is not allowed. MedOne considers such inappropriate use as Fraud, Waste and Abuse and may refer findings of major activity to authorities. Patient request for brand must utilize DAW-2. Pharmacies must annotate on the hard copy the request by the patient to have the pharmacy dispense a brand name in place of a generic. Claims identified that do not contain the appropriate annotation are subject to recovery. Prescriptions with a DAW request must indicate the DAW code in the NCPDP field 408-D8 (also known as Product Selection Code) on the submitted claim.

Dispense as Written (DAW) Codes

The bullets below indicate the specific DAW codes to be used when submitting claims. Codes allowed may differ between Payor plans and may also affect reimbursement.

- DAW 0 - NO DISPENSE AS WRITTEN (Substitution allowed or no product selection indicated)
    - Use when dispensing a Generic Drug; that is, when no party (i.e. neither prescribing provider, nor pharmacist, nor participant) requests the branded version of a multi-source product.
    - Use when dispensing a multi-source generic, even if the prescribing provider indicates the DAW code for the generic product and does not specify a manufacturer.
    - Use when dispensing single-source brands (i.e. Crestor) because generic substitution is not possible.
- DAW 1 - PHYSICIAN writes DISPENSE AS WRITTEN or BRAND MEDICALLY NECESSARY
    - Use when the prescribing provider specifies the branded version of a drug on the hardcopy prescription or in orally communicated instructions.
- DAW 2 - PATIENT REQUESTED
    - Use when the patient or their representative requests the branded drug even though the original prescription did not indicate "Dispense As Written."

- DAW 3 - PHARMACIST SELECTED BRAND
    - This means the pharmacist chose which brand of a drug to provide, even though a generic product option is available.
- DAW 4 - GENERIC NOT IN STOCK
    - This means a brand name was dispensed instead of a generic version because the generics were all out of stock.
- DAW 5 - BRAND DISPENSED, PRICED AS GENERIC
    - Use when dispensing a brand as a generic.
    - Claims submitted with DAW 5 will be reimbursed at the generic price.
- DAW 6 – OVERRIDE
    - This is an alternate code used whenever an override is needed
- DAW 7 - SUBSTITUTION NOT ALLOWED; BRAND MANDATED BY LAW
    - State Law specifically requires brand name product to be dispensed.
- DAW 8 - GENERIC NOT AVAILABLE
    - Use when the brand product is dispensed since the generic is not currently manufactured, distributed or is temporarily unavailable in the marketplace.
    - Pharmacies are required show documentation from their wholesaler verifying this information.
- DAW 9 - OTHER/SUBSTITUTION ALLOWED
    - Appropriate when the Prescriber indicates product substitution is allowed, but the member's Plan Formulary prefers brand to be dispensed.

Compound Prescriptions

Compounded medications may be the best choice when a commercial product is not available or the particular dosage form is not available. A compounded medication consists of two or more FDA approved ingredients, one of which must be a Formulary Federal Legend Drug. Individual ingredients are mixed together in the exact strength and dosage form tailored for an individual patient. The pharmacist is responsible for compounding approved ingredients of acceptable strength, quality and purity with appropriate packaging and labeling in accordance with USP and good compounding practices.

For a compound to be covered by MedOne, one of the active ingredients must be covered on the member's Formulary. In general, any drug used in a compound must follow the member's Formulary as if each drug component was being dispensed individually. The Payor must include compound drugs as a covered benefit for the member for MedOne to allow reimbursement. Please contact the appropriate Pharmacy Help Desk to see if a client allows for compounded prescriptions. NDCs submitted for the compound must be the exact formulation of what is dispensed in the compound. Any compounded prescription ingredient that is not approved by the FDA is considered a non-covered product and will not be eligible for reimbursement but still must be submitted with the claim. All compounds must include a compound worksheet or recipe within the prescription documentation. This worksheet or recipe must be submitted if claim is requested for audit. Worksheet or recipe must include the following:

- Name, Strength and dosage form of the compound
- Names, quantities, NDCs and lot numbers of all ingredients included in compound
- Date, time and name of the person who compounded the medication
- Prescription number of the compound

- Beyond use date of compound; determination for beyond use date may be requested

Compound drug labeling must include all active ingredients and strengths in the name. Label should also include lot number (if one was given) and expiration date of compound. All compound billings and worksheets must include every ingredient and the exact metric quantity of each ingredient.

MedOne uses a combination of the submitted ingredient claims detail and Level of Effort (LOE) to fully adjudicate a Compound Prescription.

- Use the Compound Code of "02" (NCPDP field 406-D6) when submitting compound claims
- MedOne requires compound claims to include the correct NDC for each ingredient (active and non-active) within the Compound Prescription. There must be a minimum of 2 NDCs and a maximum of 25 NDCs (NCDPD field 447-EC)
- The claim must include a qualifier of "03" (NDC) to be populated in NCPDP field 448-RE followed by NCPDP field 489-TE (NDC's)
- Pharmacy must submit final product quantity
- Pharmacy must submit total ingredient cost
- Pharmacy must submit claim on line and follow the POS messaging regarding coverage of the ingredients.

If a PA is required, pharmacy will follow messaging to obtain PA. Pharmacy shall not try to circumvent the PA process either by altering the day supply and maintaining the same quantity or by reducing the quantity and day supply to achieve a paid claim. If an NDC for a non-covered drug is submitted, the claim will be denied.

Many MedOne clients require a prior authorization for compounds. Forms are available at www.medone-rx.com. If a rejection is received, the pharmacy should proceed with obtaining a PA. If a compound includes a drug that requires prior authorization under the member's plan, the prior authorization must be approved before the compound is submitted. Submit the minutes spent compounding the prescription for reimbursement. The minutes listed are to be populated within NCPDP Field 474-8E (level of effort- DUR segment).

LOE Indicator	DUR/PPS Code	Compound Fee	Compound Type
1	11	$5.00	Single Ingredient Batched Capsule Any Combination of Commercially Available Products.
2	12	$10.00	Two of Three Ingredient Batched Capsule Transdermal Gel
3	13	$15.00	Suspensions and Solutions Four or More Ingredient Batched Capsule Tablet Triturate
4	14	$20.00	Topical Containing Controlled Ingredients Troche, Lozenges, Creams, Ointments, Gels Suppositories

			Complex Suspension (e.g. pediatric) Custom Capsule Chemotherapy Ointment/Gel/Cream Hormone Therapy
5	15	$50.00	All Sterile Compounds

Coordination of Benefits (COB)

MedOne supports electronic COB, split billing and secondary claims in accordance with the current standards of NCPDP. The COB segment is required when submitting secondary claims. COB values 0,1,3,8 are supported and will drive the claim if secondary adjudication applies. Participating Pharmacy agrees to cooperate with MedOne in the effective implementation of COB programs, including, but not limited to, Online Adjudication Processing for COB claims.

Claims denied by the primary carrier should be submitted with the current NCPDP standard reject code identified on the COB segment. If the pharmacy receives a reject message indicating group does not accept secondary coverage, notify the member.

Pharmacies are required to accurately coordinate benefits for Members and submit both primary and secondary claims as directed by the Member and in compliance with applicable Laws and regulations. Many of MedOne's commercial plans do participate in coordinating benefits for their Members.

COB claims can be submitted electronically up to 90 days from date of service.

Timely Filing Limits

Point-of-sale claims are generally submitted at the time of dispensing. However, there may be reasons that require a claim to be submitted after being dispensed. Transmission of claims using the current date for a past service date is a violation of program policy and could result in an audit exception.

The timely filing limit from the date of service is 90 days for all original claims. Claims that exceed the prescribed timely filing limit will deny with NCPDP Error 81, "Claim Too Old by x days."

CLAIMS—REMITTANCE

Electronic Fund Transfer (EFT) and 835 Remittances

MedOne offers pharmacies the option of receiving payments via automated clearing house (ACH) along with electronic ASC X12 5010 835 remittances (accessible through our File Transfer Protocol [FTP] server).

In order for Participating Pharmacies to receive ACH payments, they must complete:

- Electronic Fund Transfer (EFT) Authorization Form
- 835 Authorization Form

The above forms can be found in the Appendix or can be requested from MedOne's Provider Relations Department. Completed forms can be sent to MedOne.

- Mail: MedOne, Attn: Provider Relations 1590 University Avenue, Dubuque, IA 52001
- Fax: 563-588-8725
- Email: remittanceinquiry@medone-rx.com

Please allow 21 business days for setup as MedOne does place test files on the FTP server to assure a smooth transition for your pharmacy(ies).

It is the responsibility of the pharmacy to obtain 835 files from the file server within 14 business days. MedOne reserves the right to charge an additional fee to recreate an 835 file.

Rejected claims denied through the Online Adjudication Processing system do not appear on the Remittance Advice.

Remittances

Pharmacies receiving payment via paper check will receive paper remittances sent directly to the pharmacy. Pharmacies receiving ACH payments will receive electronic 835 remittances.

Payment Cycle

MedOne' standard pharmacy payment cycle is twice monthly, unless required by Federal or State Law for an alternative payment frequency.

- Date of fill 1st - 15th: Clean Claims payable within 30 days

- Date of fill 16th - last day of month: Clean Claims payable within 30 days

Pricing Inquiries

MedOne produces its own proprietary MAC list and corresponding unit costs on behalf of our clients. MedOne utilizes multiple sources of information to independently determine each product's unit cost on the MedOne MAC List. Sources included in this evaluation are pharmacy acquisition cost information from various wholesalers and retail pharmacy providers, publicly available state reported average acquisition cost information, publicly available NADAC information as published by CMS, as well as other applicable data. All pricing is pass-through, whereby the pharmacy reimbursement is the same as the client invoice on claims.

If you experience negative reimbursement for a drug, you may contact Provider Relations to obtain a **MedOne Pricing Inquiry Form**.

When filling out the form, please be sure all pertinent and required information is provided. Inquiries must be completed accurately in order to receive response. Please email the completed form to pricinginquiry@medone-rx.com.

How we will respond:

- We will respond via phone or in writing in accordance with state and federal Laws and regulations.
- If the NDC is approved for adjusted pricing, you can reprocess within 7 business days and the effective date would be for the fill date indicated on the MedOne Pricing Inquiry Form.

CLAIMS— PRESCRIPTION UTILIZATION PROGRAM

MedOne has several proprietary clinical programs to help Members conveniently access the most appropriate medication at the most affordable price.

Formulary

Clients utilize a Formulary as part of their overall cost-containment programs, attempting to deliver a balance between cost-containment and quality of care. MedOne works with plan sponsors to help them create a Formulary that will meet the needs of their Members. Should a non-Formulary drug be prescribed, the pharmacy should make an effort to contact the Prescriber to ask if the prescription may be changed to a Formulary covered product.

Step Therapy

Step therapy is a safe and effective method to reduce the cost of treatment by ensuring that a proven and cost-effective therapy is tried before progressing to more costly remedies. Step therapy requirements are automated at the point of sale and will adjudicate if all requirements are met. Pharmacies should refer to MedOne's website to access the current step therapy protocol.

Prior Authorization (PA)

Prior authorization requires the Prescriber to receive pre-approval for coverage of select drugs under the terms of the MedOne client pharmacy benefit plan.

To prevent delays, MedOne requires the use of the most current Prior Authorization form specific to the member's plan. Correct PA form and current exception to coverage criteria may be received directly from the Pharmacy Help Desk or at www.medone-rx.com. Use of the incorrect form may result in a delay of coverage determination for the member. Use of expired or incorrect forms from third-parties may result in a delay of coverage determination for the member.

If the pharmacy receives reject 70, Product/Service Not Covered Plan/Benefit Exclusion:

1) Pharmacy can change to a Formulary product, or
2) Pharmacy or Prescriber can initiate exception to coverage process
    a. Contact Pharmacy Help Desk to begin Exception to Coverage process
    b. Pharmacy Help Desk will provide MedOne's Exception to Coverage form to Prescriber (including information required for approval)
    c. Prescriber's signature and direct authorization on form is required
    d. Once determination has been made, notification will go to the pharmacy and Prescriber

If pharmacy receives a reject 75: Prior Authorization Required:

1) Pharmacy can change to an unrestricted Formulary product, or
2) Pharmacy or Prescriber can initiate Prior Authorization process
    a. Contact Pharmacy Help Desk to begin Prior Authorization process
    b. Pharmacy Help Desk will provide MedOne's PA form to Prescriber
    c. Prescriber's signature and direct authorization on form is required. Once determination has been made, notification will go pharmacy and Prescriber.

Non-Urgent Prior Authorization Requests

- Prescriber or pharmacy requests correct form or accesses the form on www.medone-rx.com
- Prescriber completes and faxes the completed request to the number listed on the form
- If additional information is needed, the Prescriber will be contacted
- A decision will be rendered within the timeframe indicated on the form after receiving complete information
- The decision of the request will be faxed to the Prescriber and communicated to the pharmacy by phone
- If complete information is not received within the required timeframe, the request will be denied

Urgent (Life-Threatening) Requests

- Prescriber requests or obtains the applicable clinical prior authorization form from www.medone-rx.com
- Prescriber should contact the Pharmacy Help Desk as notification that an urgent request has been submitted. The Prescriber can also write URGENT on the Prior Authorization form that is sent in if the need for the request is due to a life-threatening situation.
- Prescriber will be notified of the decision within one business day

DUR Programs

MedOne requires each Participating Pharmacy to include within their pharmacy system, a system that conducts prospective Drug Utilization Review at the time of dispensing fill. Prospective review should take place at the dispensing pharmacy's POS. The prospective review at the POS should compare the prescribed medication against previous drug history for:

1. Overutilization or underutilization;
2. Therapeutic duplication;
3. Drug-disease contraindications;
4. Drug-drug interactions;
5. Incorrect drug dosage or duration of drug treatment;
6. Drug-allergy interactions;
7. Clinical abuse/misuse;
8. Drug-prescriber contraindications.

MedOne will conduct retrospective reviews that monitor Prescriber and contracted pharmacies for outlier activities. Retrospective reviews should also determine whether services were delivered as prescribed and consistent with payment policies and procedures.

Concurrent Drug Utilization Review (CDUR)

MedOne's CDUR Program consists of various levels of responses, depending upon the level of severity of the interaction being measured. MedOne' claims adjudication system will review potential Drug-Drug Interactions, Dose Check (high/low, maximum/minimum), Drug-Sex Interactions, Drug-Age Interactions, Duplicate Therapy, among others.

Potential levels of interactions are absolute, major, moderate or undetermined. Depending on the severity of the interaction, MedOne may return a DUR message.

Retrospective Drug Utilization Review (RDUR)

MedOne's RDUR Program is an ongoing and periodic examination of claims data to identify patterns of inappropriate or unnecessary medical care. Participation in these programs may vary by Payor.

AUDITS

Overview

As the Prescription Benefit Manager (PBM) for various Payors, MedOne has an obligation to ensure all contracted services are being provided. While MedOne may perform pharmacy audit functions to ensure program integrity, both MedOne and providers are required to comply with the audit language in the MedOne Pharmacy Network Agreement (MPNA).

Audited pharmacies are identified based on internal analysis, external information provided to MedOne or compliance calls to MedOne. Advanced notice is provided to pharmacies, unless otherwise specified in the MPNA, required by applicable State/Federal Law or suspected fraud has been identified. When there is suspected fraud, no audit notice is required.

MedOne audits may be in one of the following forms: desk, on-site, invoice, pre-payment review, correspondence and special investigational. MedOne will follow all required audit rules for states with specific pharmacy auditing regulations.

On-site Audits

Pharmacies selected for an on-site audit will receive notification thirty (30) days prior to the audit or as specified in the MedOne Pharmacy Network Agreement. The notification will inform the pharmacy of:

- Date and time of the audit
- Auditor photo
- Pharmacy records required for audit (masked list of prescription numbers, signature logs, invoices, etc.)

On-Site audits will be conducted during the pharmacy's regular business hours. An auditor will visit the pharmacy to review the pharmacy's documentation in support of the claims submitted to MedOne. The auditor will also examine that the pharmacy is in compliance through verification of licenses, certifications, procedures and with specific sections of the provider agreement and applicable rules, Laws and regulations.

In order for both parties to remain HIPAA compliant, a pharmacy staff member will need to retrieve documentation. Audit documentation, including prescriptions and supporting documentation, may be copied/scanned by the auditor.

Following an on-site audit, the auditor will give general feedback about what was observed during the audit. Pharmacies will receive preliminary findings within fourteen (14) business days following the audit. Along with the findings will be information on how pharmacies may appeal the results of the audit.

Desk Audits

A desk audit is a retrospective audit on adjudicated claims. MedOne will send out a formal letter requesting copies of prescriptions and signature logs be emailed, faxed or mailed to MedOne within thirty (30) calendar days. If documentation is not received within thirty (30) days, a second notification will go out requesting the information.

After initial review of the claims is complete, a letter or fax will be sent to the pharmacy with preliminary audit results. At that time, the pharmacy will be given the opportunity to appeal the results. All appeals must be in writing. Acceptable appeal documentation may include items such as Prescriber notes, Prescriber letter, written and/or electronic documentation of changes made to original hard copy with dates specified or other items that support the claim in question. Final audit results will be faxed or mailed to the pharmacy after the appeal window closes and will include dollar amounts of any financial recovery. No further appeals will be accepted.

Appeals

Prescriber statements will only be accepted on the Prescriber letterhead and should include:

- Prescriber address and telephone number
- Member name
- Drug name and strength
- Written date and method of transmission (origin)
- Specific directions (include original and clarified directions)
- Quantity and refills authorized
- Prescriber signature and date
- NOTE: Telephone prescriptions are not acceptable for post-audit documentation. Statements prepared by the pharmacy for the Prescriber to sign will not be accepted.

Member statements may be considered and should include:

- Member address and telephone number
- Drug name
- Prescription number
- Date of service
- Member signature

The auditor in charge will review the appeal and supporting documentation. Pharmacies will be notified of the final audit results once the appeal window is closed.

Audit Recoveries

Recoveries may be necessitated by claim errors resulting from poor documentation or filing procedures. Premature destruction, incomplete records or missing records will not be accepted as reasons for incomplete documentation. All unsubstantiated claims are subject to full recovery as a MedOne Overpayment. Audit recoveries may be handled by:

- Offsetting the audit recovery amount from the pharmacy's next remittance
- Requesting the pharmacy to reverse and reprocess the claim, if the claim is less than 90 days old

In the event of a discrepancy in audit language between the MedOne Provider Manual and the MedOne Pharmacy Network Agreement, the MedOne Pharmacy Network Agreement shall take precedence.

DEFINITIONS

Average Wholesale Price (AWP) means the average wholesale price for a given pharmaceutical product, as published by Medi-Span or another national drug database reporting service subscribed to by MedOne and updated weekly in MedOne's claims processing system.

Brand Drug means a prescribed drug designated as brand drug according to MedOne in its systems and modified from time to time consistent with designations provided to MedOne by its drug database reporting service. Medi-Span Brand Drugs include those medications with a Multi-Source Code of (M), (N), or (O).

Clean Claim means a claim which contains all pertinent information necessary for submission and passes all adjudication edits, in accordance to the standards of the National Council for Prescription Drug Programs (NCPDP).

Compound Prescription means a mixture of two or more FDA approved ingredients with at least one ingredient that utilizes a Prescription Drug that is a Covered Product. A prescription will not be considered a Compound Prescription if it is reconstituted or if, to the active ingredient, only water, alcohol, sodium chloride solutions or bulk chemical products are added.

Covered Products means, with respect to Participating Pharmacy, the dispensing of Prescription Drugs and the provision of other related services, which a Member is entitled to receive, and for which the appropriate Payor is obligated to pay, pursuant to applicable Plan Specifications and Agreement.

Days' Supply means the number of days the dispensed quantity of a Covered Product is expected to last. The Days' Supply is calculated as the quantity dispensed divided by the number of units used each day as directed by the prescribing Practitioner's direction for use and shall be subject to each Payor's Plan Specifications. Participating Pharmacy for purposes of calculation of Copayment, Coinsurance or Deductible must submit via Online Adjudication Processing the accurate number of Days' Supply of a Covered Product dispensed to Member.

Drug Enforcement Administration (DEA) means a federal Law enforcement agency, under the United States Department of Justice, tasked with combating drug smuggling and use within the United States.

Drug Utilization Review (DUR) means a review of drugs used in a population to determine effectiveness, potential dangers, problems with drug interaction, cost savings and other issues.

Exclusion Lists means those lists administered by the Office of Inspector General (OIG) and the General Services Administration (GSA), which includes the System for Awards Management (SAM) list and any State-specific exclusion lists. This also includes exclusion lists administered by State healthcare programs including but not limited to Medicaid. The lists provide information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs.

Formulary means a list of preferred Prescription Drugs developed, published and periodically revised by MedOne or a Payor, which Practitioners are encouraged to prescribe and Participating Pharmacies are required to dispense, consistent with their professional judgment and applicable Law, and which Members are encouraged to use.

Generic Drug means a prescribed drug designated as generic drug according to MedOne in its systems and modified from time to time consistent with designations provided to MedOne by its drug database reporting service and/or a multi-source drug as defined by a drug data base compendia vender such as Medi-Span that assigns values to drugs labeling them as Generic Drugs that are identical, or bioequivalent to a Brand Drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Medi-Span Generic Drugs include those medications with a MultiSource Code of (Y).

HHS means the United States Department of Health and Human Services or its successor.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 as amended.

HIPAA Privacy Rule means the Federal rules and regulations related to the use and disclosure of patients' Protected Health Information under 45 DFR Parts 160 and 164.

HIPAA Rules mean the medical records privacy, security and standard transaction rules and regulations under 45 CFR Parts 160, 162 and 164 and successor guidance and regulations including but not limited to the Health Information Technology for Economic and Clinical Health (HITECH) Act, which is Title XIII of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5, Affordable Care Act of 2010, and HIPAA Omnibus Rule of 2013.

Law(s) means any federal, state or local law, ordinance, rule, regulations or judicial or administrative interpretation thereof.

Member(s) means individuals covered under a Payor's plan.

National Council for Prescription Drug Programs (NCPDP) means the national council for prescription programs or its successor.

National Drug Code (NDC) means a unique 10 or 11-digit, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug and Cosmetic Act.

National Provider Identifier (NPI) means the National Provider Identifier provided by the Centers for Medicare and Medicaid Services through the National Plan & Provider Enumeration System (NPPES), or its successor, as published by NCPDP or another NPI reporting service used by MedOne.

Office of Inspector General (OIG) means the Federal government entity dedicated to combating fraud, waste and abuse and to improving the efficiency of Health and Human Service (HHS) programs. This entity is also responsible for administrating the List of Excluded Individuals/Entities (LEIE).

Online Adjudication Processing means the transmission of Prescription Drug claims from Participating Pharmacy to MedOne in compliance with the current transaction standards as of the date of service set forth in applicable Law including the HIPAA Rules and, in turn, Participating Pharmacy receiving, via online messaging, information including, but not limited to, eligibility and coverage determination, and applicable Deductibles, Coinsurance and Copayments.

Overpayment means the amount of money received for Covered Products by a Participating Pharmacy in excess of the Calculated Price less applicable Coinsurance, Copayment,

Deductible, or the amount of money paid for on behalf of an individual determined to be not a Member on the date of service or for non-Covered Products.

Participating Pharmacy/Pharmacies means the pharmacies that have entered into Participating Pharmacy Agreements with MedOne to provide Covered Products to Members.

Payor means an employer, health maintenance organization, insurance company, managed care organization, preferred provider organization, self-funded plan or group, third party administrator or any other entity or individual responsible for funding payments of Covered Products and has selected one or more of MedOne's networks.

Plan Specifications means the coverages, exclusions and limitations of Covered Products under a Payor's health benefit plan, as may be identified through an Online Adjudication Processing of Covered Products; excluded items; applicable Coinsurance, Copayment and Deductible amounts; benefit maximums; and other items in connection with a particular plan specification required by a Payor.

Practitioner/Prescriber means a physician or other health provider (including but not limited to a nurse practitioner or physician assistant) licensed in the State where the prescription is issued and who is authorized by Law to prescribe medication, devices and/or supplies to individuals, including Members.

Prescription Drugs means federal legend drugs requiring a prescription and all mixtures and Compound Prescriptions containing a minimum of one prescription ingredient pursuant to federal and/or state Law.

Protected Health Information (PHI) means individually identifiable health information related to the past, present, or future physical or mental health or condition of a Member; the provision of health care to a Member; or the past, present or future payment for the provision of health care to a Member, as more fully defined in the HIPAA Privacy Rule or otherwise deemed confidential under federal or state Law.

Wholesale Acquisition Cost (WAC) means the wholesale acquisition cost for a given pharmaceutical product, as published by Medi-Span or another national drug database reporting service subscribed to by MedOne, updated weekly in MedOne's claims processing system.

APPENDIX—MEDONE DOCUMENTS

835 Authorization Form

835 Authorization Form

MedOne will send Participating Pharmacies remittance details electronically in HIPAA 835 format. Please fill out this Authorization Form completely and return it to us using one of these methods:

By Fax: 563-588-8725 Attn: Provider Relations

By Email: remittanceinquiry@medone-rx.com

To be completed by Payor:

1. Include or Exclude Rejected Claims: Exclude
2. Communication
    a. Email Address: remittanceinquiry@medone-rx.com
    b. Telephone Number: 563-293-8140
    c. Fax: 563-588-8725

To be completed by Payee:

Payee Name: _____

Payee Address: _____

Payee Tax ID: _____

Affiliation Number(s)/NCPDP: _____

Communication Method: Payee Pull from MedOne FTP Server

Payee Contact (who reconciles payments)

Contact Name: _____

Phone: _____

Fax: _____

Email Address: _____

Technical Contact (who will pull 835 from MedOne FTP server)

Contact Name: _____

Phone: _____

Fax: _____

Email Address: _____

Please be sure to send any updates that will affect your electronic remits or payments to MedOne in a timely manner. Failure to do this may result in incorrect payment or payment address. MedOne will rely on the information contained herein to process and deliver Pharmacy's remittance advice and payments.

Authorized Signature: _____

Submission Date: _____

EFT Authorization Form

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (ACH CREDITS)

I (we) hereby authorize MEDONE, LC , hereinafter called ADMINISTRATOR, to initiate credit entries to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

_____ _____

(Financial Institution Name) (Branch)

_____

(Address) (City/State) (Zip)

_____ _____

(Routing Number) (Account Number)

Type of Account: (Check One) _____ Checking _____ Savings

This authority is to remain in full force and effect until ADMINISTRATOR has received written notification from me (or either of us) of its termination in such time and manner as to afford ADMINISTRATOR and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

_____ _____

(Print Your Company Name) (Signature)

_____ _____

(Print Tax ID Number) (Date)

PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM!

Pricing Inquiry Request Form

Please fill out the following fields in Excel and send to pricinginquiry@medone-rx.com. Items in red are mandatory. You may also contact MedOne Provider Relations to obtain the Pricing Inquiry Form.

Pricing Inquiry Fields

- Appeal Date
- Contact Name
- Email Address
- Date Filled
- Rx Number
- BIN
- PCN
- NCPDP Number
- NDC Number (11 Digits)
- Quantity
- Pharmacy Name
- GPI Number (14 Digits)
- Acquisition Cost/Unit
- Invoice Number