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Pharmacy Provider Manual

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urac ACCREDITED
Pharmacy Benefit Management
Expires 12/01/2019

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HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) provides, among other things, strong protection for personal health information. It gives individuals certain rights concerning their health information, sets boundaries on how it is used, establishes formal safeguards, and holds violators accountable. The HIPAA Privacy regulations give the individual the right to control his own identifiable health information even when it is created and maintained by others. The regulations went into effect on April 14, 2003.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by PharmPix, Corp. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or member; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

PHI may not be released to anyone who is not authorized to receive the information or who does not have a need to know that information. Information released will be the minimum necessary to achieve the stated goal unless the member releases the information, the information is required by law, or is necessary for treatment. Authorization is **always** required for any use or disclosure of PHI that is not permitted under the Privacy regulations.

To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose PHI, with certain limits and protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

Please refer to the Final Privacy Rule published in the Federal Register on December 28, 2000, for regulatory details about permitted uses and disclosures of PHI.

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1.0 Introduction

The Point-of-Sale (POS) system will require pharmacies to submit claims to PharmPix electronically in the National Council for Prescription Drug Programs (NCPDP) standardized Version D.0; lower versions will not be accepted. After submission, PharmPix will respond to the pharmacy provider with information regarding member eligibility, the allowed amount, applicable Concurrent Drug Utilization Review (CDUR) messages, and applicable Rejection messages. CDUR messages will be returned in the DUR response fields; other important related information will be displayed in the free-form message area. It is of utmost importance that all providers see the appropriate messages exactly as PharmPix returns them.

Paper claims will also be accepted. In those cases where a paper claim is needed, PharmPix will require a Universal Claim Form (UCF). Approved providers may submit claims directly using web-based claim entry.

All arrangements with switching companies should be handled directly by the provider with their preferred switching company.

1.1 Important Telephone Numbers

Responsibility	Phone Numbers	Availability
Pharmacy Contracting and Retail Network Relations	787-522-5252 ext. 117 retailnetwork@PharmPix.com	Monday -- Friday 9:00 a.m. – 6:00 p.m., W. T
Pharmacy Help Desk	1-888-742-7601 787-522-1599; 1597; 1596	24 hours

Other Phone Numbers

Office: (787)522-5252
Fax: 1-866-912-2830
Pharmacy Help Desk: (787)522-1599; (787)522-1597; (787)522-1596.

1.2 Address

Address	Format
Provider Paper Claims Billing Address: PharmPix, Corp. 2 Calle 1, Ste. 500 Guaynabo, PR 00968	Universal Claim Form (UCF)

Paper Claims Billing Instructions

See *Appendix A: Universal Claim Form*.

Website

www.PharmPix.com

Software Vendor

Note: Software vendors must use NCPDP Version D.0. If you have any questions or need assistance in any way, please contact (787) 522-5252 or email marcos@PharmPix.com.

1.3 Service Support

Online System Not Available

If for any reason the online system is not available, providers should submit claims when the online capability resumes. To facilitate this process, the provider's software should have the capability to submit backdated claims.

Technical Problem Resolution

To resolve technical problems, providers should follow the steps outlined below:

1. Check the terminal and communications equipment to ensure that electrical power and telephone services are operational. Call the telephone number the modem is dialing and note the information heard (i.e. fast busy, steady busy, recorded message). Contact the software vendor if unable to access this information in the system.
2. If the pharmacy provider has an internal Technical Support Department, the provider should forward the problem to that department. The pharmacy's technical support staff will coordinate with PharmPix to resolve the problem.
3. If the pharmacy provider's LAN network is experiencing technical problems, the pharmacy provider should contact the LAN network's technical support area. The LAN network's technical support staff will coordinate with PharmPix to resolve the problem.
4. If unable to resolve the problem after following the steps outlined above, the pharmacy provider should contact the PharmPix Pharmacy Call Center at:

PharmPix Pharmacy Call Center 1-888-PHARM01- (Nationwide Toll Free Number)

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2.0 Program Setup

2.1 Claim Format

Point-of-Sale (POS) claims must be submitted in the NCPDP Version D.0 format.

The Universal Claim Form (UCF) must be submitted for paper submissions. See *Appendix A* for sample UCF and instructions.

2.2 Media Options

Point-of-Sale (POS)

Provider Submitted Paper

2.3 Networks

PharmPix Network

2.4 Transaction Types

The following transaction codes are defined according to the standards established by the NCPDP. The ability to use these transaction codes will depend on the pharmacy's software. At a minimum, all providers should have the capability to submit original claims (Transaction Code B1) and reversals (Transaction Code B2).

Full Claims Adjudication (Transaction Code B1)

This transaction captures and processes the claim and returns to the pharmacy the dollar amount allowed under the PharmPix reimbursement formula.

Claims Reversal (Transaction Code B2)

This transaction is used by the pharmacy to cancel a claim that was previously processed. To submit a reversal, the provider must void a claim that has received a **Paid** status. To reverse a claim, the provider selects the Reversal (Void) option in the pharmacy's computer system.

Note: The following fields must match on the original paid claim and on the void request for a successful claim reversal:

- Service Provider ID
- Prescription Number
- Date of Service (date filled)
- NDC
- Cardholder ID

Eligibility Verification (Transaction Code E1)

This transaction is used by the pharmacy to determine a member's eligibility in the program. This transaction is rarely used, as this information is provided as part of the claim transaction.

2.5 Version D.0 Transaction

Please review the following for program requirements; some transactions may be required at a future date to be determined:

NCPDP Lower Version Transaction Code	NCPDP Lower Version Transaction Name	NCPDP Version D.0 Transaction Code	NCPDP Version D.0 Transaction Name
00	Eligibility Verification	E1	Eligibility Verification
01 - 04	Rx Billing	B1	Billing
11	Rx Reversal	B2	Reversal
21 - 24	Rx Downtime Billing	N/A	N/A
31 - 34	Rx Re-billing	B3	Re-bill
41	Prior Authorization Request with Request for Payment	P1	Prior Authorization Request and Billing
45	Prior Authorization Inquiry	P3	Prior Authorization Inquiry
46	Prior Authorization Reversal	P2	Prior Authorization Reversal
51	Prior Authorization Request Only	P4	Prior Authorization Request Only

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2.6 Version D.0 Segments

Data in NCPDP Version D.0 is grouped together in segments. Please review the following for program requirements; some segments may be required at a future date to be determined.

NCPDP Request Segment Matrix								
Segment	**Transaction Code**							
	E1	**B1**	**B2**	**B3**	**P1**	**P2**	**P3**	**P4**
Header	M	M	M	M	M	M	M	M
Patient	S	S	S	S	S	S	S	S
Insurance	M	M	S	M	M	S	M	M
Claim	N	M	M	M	M	M	M	M
Pharmacy Provider	S	S	N	S	S	S	S	S
Prescriber	N	S	N	S	S	S	S	S
COB/ Other Payments	N	S	N	S	S	N	S	S
Worker's Comp	N	S	N	S	S	S	S	S
DUR/ PPS	N	S	S	S	S	S	S	S
Pricing	N	M	S	M	M	S	S	S
Coupon	N	S	N	S	S	S	S	S
Compound	N	S	N	S	S	S	S	S
PA	N	S	N	S	M	S	M	M
Clinical	N	S	N	S	S	N	N	S

NCPDP Designations

M = Mandatory

S = Situational

N = Not Sent

Note: Some segments indicated as "Situational" by NCPDP may be "Required" to support specific transactions for this program.

2.7 Required Data Elements

The PharmPix system has program-specific "mandatory/required," "situational," and "not sent" data elements for each transaction. The pharmacy provider's software vendor will need the Payer Specifications before setting up the plan in the pharmacy's computer system. This will allow the provider access to the required fields. Please note the following descriptions regarding data elements:

Code	Description
M	Designated as **MANDATORY** in accordance with the NCPDP Telecommunication Implementation Guide Version D.0. These fields must be sent if the segment is required for the transaction.
S	Designated as **SITUATIONAL** in accordance with the NCPDP Telecommunication Implementation Guide Version D.0. It is necessary to send these fields in noted situations. Some fields designated as situational by NCPDP may be required for all PharmPix transactions.
R***	The "R***" indicates that the field is **REPEATING**. One of the other designators, "M," or "S" will precede it.

PharmPix claims will not be processed without all the mandatory data elements. Required fields may or may not be used in the adjudication process. The complete PharmPix Specifications, including NCPDP field number references, is in *Appendix B*. Fields "not required for this program" at this time may be required at a future date.

2.8 Timely Filing Limits

Point-of-Sale (POS) claims are generally submitted at the time of dispensing. However, there may be mitigating circumstances that require a claim to be submitted after being dispensed.

For all original claims, reversals, and adjustments, the timely filing limit from the date of service (DOS) is 7 days.

Claims that exceed the prescribed timely filing limit will **deny** with NCPDP Error Code 81/*Timely Filing Exceeded.* Requests for overrides of Timely Filing Limits should be directed to the PharmPix Pharmacy Call Center.

3.0 Program Particulars

3.1 Dispensing Limits

Days Supply

Prescription quantities are limited to the units specified by the prescriber. The pharmacy must submit accurate days supply information. Submitting incorrect days supply information can cause a false cDUR messages and claims denials. It could also result in a pharmacy being targeted for a post-payment audit.

Maintenance Drugs or Acute treatment intended by physician for 30 days supply (depending on clients' benefit design).
Per Rx maximum = 32 days.

Maintenance Drugs intended by physician for 90 days supply (this might not apply depending on clients' benefit design intentions)
Per Rx maximum = 96 days.

Exceptions:

Maintenance Drugs:

PharmPix uses Medispan code for appropriate identification of approved maintenance drug classes.

Maximum Quantity

Designated drugs are limited to specific quantities. These drugs are identified by PharmPix based on
clinical use, FDA indications or safety concerns.

Quantity limits may be per fill or cumulative over a designated timeframe.

Providers should submit a Prior Authorization request with the appropriate clinical justification for override consideration.

Maximum Duration

Designated drugs are limited to a maximum annual or lifetime duration of therapy. These drugs are identified by PharmPix based on clinical use, FDA indications or safety concerns.

Providers should submit a Prior Authorization request with the appropriate clinical justification for override consideration.

Refills

Refills must conform to current federal and local statutes, rules, regulations and policies. The provider shall not process an automatic refill for a prescription for an eligible plan member unless and until such refill has been authorized by the eligible plan member.

- **Non-controlled drugs:** limited to an original plus up to 5 refills within 180 days from original Date Rx Written if the prescription is written and filled in the jurisdiction of the Commonwealth of Puerto Rico. Since November 20, 2014 the prescription has a validity of one year.

- **Schedule II:** no refills allowed.

- **Schedule III - IV - V:** limited to an original plus 5 refills within 180 days from original Date Rx Written if the prescription is written and filled in the jurisdiction of the Commonwealth of Puerto Rico.

Partial Fills

In those cases where a provider does not dispense the full amount per the prescriber's directions, the pharmacy provider should submit the claim as a partial fill and indicate it as such on the claim transaction.

Age

Prenatal Vitamins: limited to 50 years old and under or as stipulated by client.

Multi-Vitamins w/ Fluoride: limited to 16 years old and under or as stipulated by client.

Designated drugs are subject to age edits. These drugs are identified by PharmPix based on clinical use, FDA indications or safety concerns.

Gender

Prenatal vitamins: limited to females.

Designated drugs are subject to gender edits. These drugs are identified by PharmPix based on clinical use, FDA indications or safety concerns.

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Dollar Limit

Claims with a dollar amount greater than $500 (or as stipulated by clients) will deny and return NCPDP Error Code 78/*Cost Exceeds Maximum.*

Providers should validate that the appropriate quantity was entered.

Providers may contact the Pharmacy Call Center for override consideration.

Diagnosis Code

Providers should enter the appropriate ICD-9 code to indicate the patient's diagnosis when required.

3.2 Mandatory Generic Requirements

Providers should dispense generic drugs whenever appropriate.

3.3 Proprietary Maximum Allowable Cost (MAC) Program

The Maximum Allowable Cost (MAC) Program is a service developed and maintained by PharmPix for its clients. Its purpose is to encourage a provider to use a less expensive therapeutically equivalent drug. PharmPix Clinical Management Consultants regularly review the current drug price sources. A drug may be considered for MAC pricing if there are 2 or more manufacturers and it is listed as multi-source in the Medispan database. Other factors considered are therapeutic equivalency ratings and availability in the marketplace. The MAC pricing is updated weekly or more frequently as needed to reflect the actual acquisition cost. The specific drug pricing resources, algorithm, and MAC prices are proprietary and confidential. Distribution and access to this information is therefore limited to prevent PharmPix competitors from obtaining free access to the information, which would result in not having to incur the costs associated with developing, maintaining, or licensing their own MAC service.

If a provider does not think a MAC price is valid, he/she may appeal the price by calling and or faxing the dispute to the PharmPix MAC Department. If available, the provider will be supplied with 1 or more manufacturers that have a price comparable to the MAC price. If it is determined that there are no longer any manufacturers in that price range or if the provider can document that he/she does not have access to the supplied manufacturers, the MAC price and effective date will be adjusted accordingly, retroactive to the date of service for the MAC price prescription in question or other relevant date. Once the change is in effect, the provider will be informed, and he/she can re-bill the claim for the price adjustment.

Prior Authorization

Designated drugs require Prior Authorization.

Providers should submit a Prior Authorization request for override consideration.

Preferred Drug List (PDL)

Designated drugs are considered non-preferred.

Providers should submit a Prior Authorization request with the appropriate clinical justification for override consideration.

Step Therapy

Designated drugs require step therapy. These drugs are identified by PharmPix.

Providers should submit a Prior Authorization request with the appropriate clinical justification for override consideration.

3.5 Member Payment Information

Co-payment

There is a standard tiered co-payment structure based upon member's eligibility and benefit package.

PharmPix systems will show the copay or co-insurance required to collect on each transaction.

Annual Benefit Maximum

Depending on the client, a maximum annual benefit may exist.

Deductible

Depending on the client, a deductible may exist.

Annual Out of Pocket Co-payment Cap

Depending on the client, an Annual Out of Pocket Co-pay Cap may exist.

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3.6 Prior Authorization

The PharmPix Prior Authorization (PA) process is designed to provide rapid, timely responses to prior authorization requests. Prior authorizations will be managed by each PharmPix client or by PharmPix as the clients prefer.

The following tables provide the products for each prior authorization method.

Prior Authorization: Clinical Call Center	
Contact the PharmPix Clinical Call Center: 1-888-742-7601 **PA Request Forms can be requested at**: 1-888-742-7601 Normal FAX: 1-866- 912-2030Urgent FAX: 1-866-912-2891 **For prior authorization or override consideration regarding the following denial reasons:**	
Reason	**Action**
Prior Authorization Required	Pharmacy provider or prescriber sends fax using appropriate form.
PDL	Pharmacy provider or prescriber sends fax using appropriate form.
H2RAs	Pharmacy provider or prescriber sends fax using appropriate form.
Quantity/Days Supply/ Dosing Limitations	Pharmacy provider or prescriber sends fax using appropriate form.
Step Therapy	Pharmacy provider or prescriber sends fax using appropriate form.
Brand Necessary	Prescriber sends fax using appropriate form.
Medicare Part B	A claim for a Medicare-covered drug will deny if the member enrollment information indicates that member has Medicare Part B coverage for the DOS. If the drug is being administered for a non-Medicare covered reason, the pharmacy provider or prescriber sends fax using appropriate form.

Prior Authorization/Override: Pharmacy Call Center	
Contact the PharmPix Pharmacy Call Center: 1-888-742-7601 **For override consideration regarding the following denial reasons:**	
Reason	**Action**
Dollar Limit	A claim greater than $500 (or as stipulated by client) will deny. Providers should first validate that the appropriate quantity has been submitted. Providers should then contact PharmPix Pharmacy Call Center for override consideration.
Timely Filing Limits	A claim exceeding 180 days from the original DOS, for a prescription filled in the Commonwealth of Puerto Rico, will deny. Providers should counsel the member of the need of a new prescription. Since November 20, 2014 for non-controlled drugs the prescription has a validity of one year.
Lock-Ins	Providers should contact the PharmPix Pharmacy Call Center for override consideration.

Provider Level Overrides	
Provider level overrides allowed. **For override consideration regarding the following denial reasons:**	
Reason	**Action**
CDUR	After a professional/clinical evaluation, providers may override the following CDUR conditions (depending on client's specifications) : − Therapeutic Duplication − Duplicate Ingredient − Early Refill − Drug to Drug Interactions In order to override when approved conditions are met, providers should use appropriate DUR codes to indicate the Reason for Service (Conflict), Professional Service (Intervention), and Result of Service (Outcome).
Emergency	Providers may override Prior Authorization conditions in emergency situations. In order to override, when approved conditions are met, providers should enter the appropriate Level of Service code to override.
COB/TPL	Providers may override coordination of benefits (COB) using designated override codes in approved conditions. In order to override, when approved conditions are met, providers should enter the appropriate COB codes and/or Prior Authorization Type code.

3.7 Emergency Procedures

All providers should follow normal prior authorization procedures, except in emergency conditions.

The emergency override is intended for unique circumstances where general prior authorization procedures cannot be followed, and the situation is considered life threatening.

Providers may override PA Requirements by entering LEVEL OF SERVICE (NCPDP Field #418-DI) – "3" (emergency) under the following guidelines:

- Overrides must be outside of normal business hours.
- Overrides must be for a 3-day supply, except where the package must be dispensed intact.
- OTCs cannot be overridden.
- Drugs normally not covered cannot be overridden.

3.8 Coordination of Benefits (COB)

Online COB (cost avoidance) is required.

PharmPix's clients may be the payer of last resort. Providers must bill all other payers first whenever members provide the information to them.

PharmPix will return the following Other Payer details in the "Additional Message" field:

- Other Payer ID (if available)
- Other Payer (carrier) Name
- Policy Number (If available)

Reimbursement will be calculated to pay up to the client allowed amount less the third-party payment.

Claims submitted with PRIOR AUTHORIZATION TYPE CODE (NCPDP Field #461-EU) = "8" (payer defined exemption) will bypass the Third-Party Liability (TPL) editing for all carriers and pay (pay and chase).

Medicare Part D

Medicare Part D clients will be subject to a different set of rules set forth in Part D of The Medicare Prescription Drug, Improvement and Modernization Act of 2003 and the regulations promulgated there under as may be amended, "Medicare Drug Rules".

Dual Eligible benefits may be different from those Medicare non-dual eligible members.

TPL Processing Grid

Other Coverage Code (NCPDP Field # 308-C8)	Claim Disposition	Notes
0 = Not specified		This code will not override TPL File.
1 = No other coverage identified	Allow for override.	Used when primary payer is billed and responds patient not on file. NCPDP Error Code 65 (see OCC 7)
2 = Other coverage exists, payment collected	Allow for override.	Used when payment is collected from the primary payer.
3 = Other coverage exists, claim not covered	Allow for override.	Used when the primary payer denies the claim for drug not covered. NCPDP Error Code 70, 73, 76
4 = Other coverage exists, payment not collected	Allow for override.	Used when the primary pays the claim, but does not receive anything from the primary payer due to deductible.
5 = Managed care plan denial	Do not allow for override.	No industry protocols for standard usage.
6 = Other coverage exists, not a participating provider	Allow for override.	Used when the provider is not in the network for the primary payer. NCPDP Error Code 40
7 = Other coverage exists, not in effect on DOS	Allow for override.	Used when primary payer is billed and denies for patient coverage terminated. NCPDP Error Code 65, 67, 68, 69
8 = Co-payment only	Do not allow for override.	Intended for use in higher NCPDP versions.

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Other Payer Reject Code (NCPDP Field # 472-6E)

"40" - Pharmacy not contracted with plan on date of service.

"65" - Patient is not covered.

"67" - Filled before coverage effective.

"68" - Filled after coverage expired.

"69" - Filled after coverage terminated.

"70" - Product/Service not covered.

"73" - Refills are not covered.

"76" - Plan limitations exceeded.

3.9 Medicare Covered Drugs

Medicare Part B drugs will not be covered by PharmPix clients. These claims will deny with NCPDP Error Code 41 and the supplemental message of "Submit bill to other process or primary payer" with the additional message: "Bill Medicare Part B; Other payer not cost avoided."

Crossover billing is not part of the POS system.

3.10 Lock-In

A member may be locked in to a prescriber, plan, or both.

4.0 Prospective Drug Utilization Review (CDUR)

Concurrent Drug Utilization Review functions are provided at the point-of-service (POS) and include real-time system edits that can impact prescribing patterns. When a claim is submitted by the pharmacy, it is assessed against patient demographics and prior drug utilization that is maintained in PharmPix's database. Electronic messages are sent to the pharmacy, during the adjudication process, to inform the pharmacist of the potential drug problem. Concurrent Drug Utilization Review (CDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The PharmPix's CDUR system assists the pharmacist in these functions by addressing situations in which potential drug problems may exist. CDUR performed prior to dispensing helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available.

Concurrent online edits include, but are not limited to, the following:

- Duplicate Therapy
- Ingredient Therapy
- Drug-Drug Interaction
- Drug-Gender Precaution
- Drug-Age Precaution
- Drug-Disease Interaction
- Drug-Allergy Interaction
- Early Refill
- High-Low Dose
- Drug-Pregnancy Precaution

Because PharmPix' CDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. PharmPix recognizes that the pharmacist uses his/her education and professional judgment in all aspects of dispensing. CDUR is offered as an informational tool to aid the pharmacist in performing his/her professional duties. Pharmacies are required to evaluate every CDUR message for clinically appropriate intervention if needed.

4.1 Therapeutic Problems

Prospective (concurrent) Drug Utilization Review edits apply to all claims unless otherwise identified.

4.2 Pharmacy Call Center

The PharmPix Pharmacy Call Center is available 24 hours per day, seven days a week. The telephone numbers are 787-522-1599; 787-522-1596 and 787-522-1597. Alert message information is available from the Call Center after the message appears. If you need assistance with any alert or denial messages, it is important to contact the Call Center about PharmPix CDUR messages at the time of dispensing. The Call Center can provide claims information on all error messages sent by the CDUR system. This information includes: NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days supply.

The PharmPix Call Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. PharmPix has used reasonable care to accurately compile CDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their patients.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, PharmPix' staff pharmacists are available for consultation.

PharmPix CDUR is an integral part of the claims adjudication process. CDUR includes: reviewing claims for therapeutic appropriateness before the medication is dispensed, reviewing the available medical history, focusing on those patients at the highest severity of risk for harmful outcome, and intervening and/or counseling when appropriate.

4.3 CDUR Alert/Error Messages

All CDUR alert messages appear at the end of the claims adjudication transmission. Alerts will appear in the following format:

Format	Field Definitions
REASON FOR SERVICE:	2 characters. Code identifying the type of utilization conflict detected; e.g., "TD" (Therapeutic Duplication).
CLINICAL SIGNIFICANCE:	1 character. Code indicating the significance or severity level of a clinical event. 1 = Major 2 = Moderate 3 = Minor
OTHER PHARMACY INDICATOR:	1 character. Indicates if the dispensing provider also dispensed the first drug in question. 0 = No Value 1 = Your pharmacy 3 = Other pharmacy
PREVIOUS DATE OF FILL:	8 characters. Indicates previous fill date of conflicting drug in YYYYMMDD format.
QUANTITY OF PREVIOUS FILL:	5 characters. Indicates quantity of conflicting drug previously dispensed.
DATA BASE INDICATOR:	1 character. Indicates source of CDUR message. 1 = Medispan 4 = Processor Developed
OTHER PRESCRIBER:	1 character. Indicates the prescriber of conflicting prescription. 0 = No Value 1 = Same Prescriber 2 = Other Prescriber

5.0 Edits

5.1 Online Claims Processing Messages

Following an online claim submission by a pharmacy, the system will return a message to indicate the outcome of processing. If the claim passes all edits, a "**Paid**" message will be returned with the PharmPix allowed amount for the paid claim. A claim that fails an edit and is rejected (denied) will also return a message. Following is a list of NCPDP rejects and descriptions.

As shown below, an NCPDP error code is returned with an NCPDP message. Where applicable, the NCPDP field that should be checked is referenced. Check the Solutions box if you are experiencing difficulties. For further assistance, contact PharmPix at:

Pharmacy Call Center

1-888-PHARM01

(Nationwide Toll-Free Number)

Point-of-Sale (POS) Reject Codes and Messages:

~ All edits may not apply to this program ~

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
01	M/I BIN	101	Enter 610228
02	M/I Version Number	102	NCPDP Version D0 is required.
03	M/I Transaction Code	103	Transactions allowed = B1, B2, B3.
04	M/I Processor Control Number	104	Enter PCN number as shown on members' ID card
05	M/I Pharmacy Number	201	Enter the PharmPix Pharmacy Provider ID or National Provider Identifier (NPI). Check with the software vendor to ensure appropriate number has been set up in your system.
06	M/I Group Number	301	PharmPix
07	M/I Cardholder ID Number	302	Enter the PharmPix Member ID number only; do not enter any other patient ID. Do not enter any dashes. Providers should always examine a member's ID card before services are rendered. It is the provider's responsibility to establish the identity of the member and to verify the effective date of coverage for the card presented.

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
08	M/I Person Code	303	
09	M/I Birth Date	304	Format = YYYYMMDD (no dashes).
1C	M/I Smoker/Non-Smoker Code	334	
1E	M/I Prescriber Location Code	467	
10	M/I Patient Gender Code	305	Values: 0 = not specified 1 = male 2 = female
11	M/I Patient Relationship Code	306	1 (cardholder).
12	M/I Patient Location	307	
13	M/I Other Coverage Code	308	See *Section 3.8 - Coordination of Benefits*.
14	M/I Eligibility Clarification Code	309	
15	M/I Date of Service	401	Format = YYYYMMDD (no dashes). A future date is not allowed in this field.
16	M/I Prescription/Service Reference Number	402	Format = NNNNNNN.
17	M/I Fill Number	4Ø3	Enter "0" for a new prescription. Acceptable values for a refill prescription range from 1 to 99.
19	M/I Days Supply	405	Format = NNN. Enter the day's supply, "PRN" is not allowed.
2C	M/I Pregnancy Indicator	335	Enter "2" to indicate the patient is pregnant and to waive co-payment. After 60 days postpartum, stop entering "2" to override co-payment.
2E	M/I Primary Care Provider ID Qualifier	468	
20	M/I Compound Code	406	
21	M/I Product/Service ID	407	Enter 11-digit NDC only. Do not enter any dashes.

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
22	M/I Dispense As Written (DAW)/Product Selection Code	408	Enter "1" to indicate substitution not allowed by prescriber.
23	M/I Ingredient Cost Submitted	409	
25	M/I Prescriber ID	411	Enter the State License Number for the state in which the prescriber practices. Do not enter DEA Number. When National Provider Identifier (NPI) is mandatory, the prescriber NPI must be entered.
26	M/I Unit Of Measure	600	Enter the appropriate Unit of Measure for the product dispensed. Values: EA = each GM = grams ML = milliliters
28	M/I Date Prescription Written	414	Format = YYYYMMDD (no dashes). A future date is not allowed.
29	M/I Number Refills Authorized	415	Enter the number of refills as authorized by the prescriber.
3A	M/I Request Type	498-PA	
3B	M/I Request Period Date-Begin	498-PB	
3C	M/I Request Period Date-End	498-PC	
3D	M/I Basis Of Request	498-PD	
3E	M/I Authorized Representative First Name	498-PE	
3F	M/I Authorized Representative Last Name	498-PF	
3G	M/I Authorized Representative Street Address	498-PG	
3H	M/I Authorized Representative City Address	498-PH	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
3J	M/I Authorized Representative State/Province Address	498-PJ	
3K	M/I Authorized Representative Zip/Postal Zone	498-PK	
3M	M/I Prescriber Phone Number	498-PM	
3N	M/I Prior Authorized Number Assigned	498-PY	
3P	M/I Authorization Number	503	
3R	Prior Authorization Not Required	407	
3S	M/I Prior Authorization Supporting Documentation	498-PP	
3T	Active Prior Authorization Exists Resubmit At Expiration Of Prior Authorization		
3W	Prior Authorization In Process		
3X	Authorization Number Not Found	503	
3Y	Prior Authorization Denied		
32	M/I Level Of Service	418	
33	M/I Prescription Origin Code	419	
34	M/I Submission Clarification Code	420	
35	M/I Primary Care Provider ID	421	
38	M/I Basis Of Cost	423	
39	M/I Diagnosis Code	424	Enter the appropriate ICD-9 code.

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
4C	M/I Coordination Of Benefits/Other Payments Count	337	
4E	M/I Primary Care Provider Last Name	570	
40	Pharmacy Not Contracted With Plan On Date Of Service	None	Enter PharmPix Pharmacy Provider ID number or National Provider Identifier (NPI); check DOS. Call the Provider Management/Enrollment Department if necessary (see Section 1.1).
41	Submit Bill To Other Processor Or Primary Payer	None	
5C	M/I Other Payer Coverage Type	338	
5E	M/I Other Payer Reject Count	471	
50	Non-Matched Pharmacy Number	201	Enter PharmPix Pharmacy Provider ID or National Provider Identifier (NPI). Check lock-in status of member.
51	Non-Matched Group ID	301	Enter group only.
52	Non-Matched Cardholder ID	302	Enter member's PharmPix ID number only; do not enter any other patient ID. Do not enter any dashes.
53	Non-Matched Person Code	303	
54	Non-Matched Product/Service ID Number	407	Enter 11-digit NDC.
55	Non-Matched Product Package Size	407	
56	Non-Matched Prescriber ID	411	Enter State License Number until National Provider Identifier (NPI) is mandatory.
58	Non-Matched Primary Prescriber	421	
6C	M/I Other Payer ID Qualifier	422	
6E	M/I Other Payer	472	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
	Reject Code		
60	Product/Service Not Covered For Patient Age	302, 304, 401, 407	
61	Product/Service Not Covered For Patient Gender	302, 305, 407	
62	Patient/Card Holder ID Name Mismatch	310, 311, 312, 313, 320	
63	Institutionalized Patient Product/Service ID Not Covered		Drug not covered for member in Long Term Care facility.
64	Claim Submitted Does Not Match Prior Authorization	201, 401, 404, 407, 416	
65	Patient Is Not Covered	303, 306	
66	Patient Age Exceeds Maximum Age	303, 304, 306	
67	Filled Before Coverage Effective	401	Enter member's PharmPix ID number only; do not enter any other patient ID. Do not enter any dashes. Check DOS. Check Group Number.
68	Filled After Coverage Expired	401	Enter member's PharmPix ID number only; do not enter any other patient ID. Do not enter any dashes. Check DOS. Check Group Number.
69	Filled After Coverage Terminated	401	
7C	M/I Other Payer ID	340	
7E	M/I DUR/PPS Code Counter	473	
70	Product/Service Not Covered	407	Enter 11-digit NDC. Drug not covered.
71	Prescriber Is Not Covered	411	
72	Primary Prescriber Is Not Covered	421	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
73	Refills Are Not Covered	402, 403	
74	Other Carrier Payment Meets Or Exceeds Payable	409, 410, 442	
75	Prior Authorization Required	462	Validate 11-digit NDC. Follow Prior Authorization procedures if appropriate.
76	Plan Limitations Exceeded	405, 442	Validate days supply and quantity dispensed. Follow Prior Authorization procedures if appropriate.
77	Discontinued Product/Service ID Number	407	Validate 11-digit NDC. NDC is obsolete.
78	Cost Exceeds Maximum	407, 409, 410, 442	Claims will deny if greater than $500.00 (or as stipulated by client). Provider must contact the PharmPix Pharmacy Call Center for override consideration.
79	Refill Too Soon	401, 403, 405	80% of days supply from previous claim has not been utilized. Prior fill may be from a different provider.
8C	M/I Facility ID	336	
8E	M/I DUR/PPS Level Of Effort	474	
80	Drug-Diagnosis Mismatch	407, 424	
81	Claim Too Old	401	Check DOS. Contact the PharmPix Pharmacy Call Center for override consideration when appropriate.
82	Claim Is Post-Dated	401	
83	Duplicate Paid/Captured Claim	201, 401, 402, 403, 407	
84	Claim Has Not Been Paid/Captured	201, 401, 402	
85	Claim Not Processed	None	
86	Submit Manual Reversal	None	
87	Reversal Not Processed	None	Provider number, DOS and Rx number must equal original claim.

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
88	DUR Reject Error		
89	Rejected Claim Fees Paid		
90	Host Hung Up		Processing Host Did Not Accept Transaction/Did Not Respond Within Time Out Period.
91	Host Response Error		
92	System Unavailable/Host Unavailable		
95	Time Out		
96	Scheduled Downtime		
97	Payer Unavailable		
98	Connection To Payer Is Down		
99	Host Processing Error		Do Not Retransmit Claim(s).
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	QMB (Qualified Medicare Beneficiary)-Bill Medicare		
AF	Patient Enrolled Under Managed Care		
AG	Days Supply Limitation For Product/Service		
AH	Unit Dose Packaging Only Payable For Nursing Home Members		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
AJ	Generic Drug Required		
AK	M/I Software Vendor/Certification ID	110	
AM	M/I Segment Identification	111	
A9	M/I Transaction Count	109	
BE	M/I Professional Service Fee Submitted	477	
B2	M/I Service Provider ID Qualifier	202	
CA	M/I Patient First Name	310	
CB	M/I Patient Last Name	311	
CC	M/I Cardholder First Name	312	
CD	M/I Cardholder Last Name	313	
CE	M/I Home Plan	314	
CF	M/I Employer Name	315	
CG	M/I Employer Street Address	316	
CH	M/I Employer City Address	317	
CI	M/I Employer State/Province Address	318	
CJ	M/I Employer Zip Postal Zone	319	
CK	M/I Employer Phone Number	320	
CL	M/I Employer Contact Name	321	
CM	M/I Patient Street Address	322	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
CN	M/I Patient City Address	323	
CO	M/I Patient State/Province Address	324	
CP	M/I Patient Zip/Postal Zone	325	
CQ	M/I Patient Phone Number	326	
CR	M/I Carrier ID	327	
CW	M/I Alternate ID	330	
CX	M/I Patient ID Qualifier	331	
CY	M/I Patient ID	332	
CZ	M/I Employer ID	333	
DC	M/I Dispensing Fee Submitted	412	
DN	M/I Basis Of Cost Determination	423	
DQ	M/I Usual And Customary Charge	426	
DR	M/I Prescriber Last Name	427	
DT	M/I Unit Dose Indicator	429	
DU	M/I Gross Amount Due	43Ø	
DV	M/I Other Payer Amount Paid	431	
DX	M/I Patient Paid Amount Submitted	433	Do not submit any value > 0.
DY	M/I Date Of Injury	434	
DZ	M/I Claim/Reference ID	435	
EA	M/I Originally Prescribed Product/Service Code	445	
EB	M/I Originally	446	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
	Prescribed Quantity		
EC	M/I Compound Ingredient Component Count	447	
ED	M/I Compound Ingredient Quantity	448	
EE	M/I Compound Ingredient Drug Cost	449	
EF	M/I Compound Dosage Form Description Code	450	
EG	M/I Compound Dispensing Unit Form Indicator	451	
EH	M/I Compound Route Of Administration	452	
EJ	M/I Originally Prescribed Product/Service ID Qualifier	453	
EK	M/I Scheduled Prescription ID Number	454	
EM	M/I Prescription/Service Reference Number Qualifier	445	
EN	M/I Associated Prescription/Service Reference Number	456	
EP	M/I Associated Prescription/Service Date	457	
ER	M/I Procedure Modifier Code	459	
ET	M/I Quantity Prescribed	460	
EU	M/I Prior Authorization Type Code	461	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
EV	M/I Prior Authorization Number Submitted	462	
EW	M/I Intermediary Authorization Type ID	463	
EX	M/I Intermediary Authorization ID	464	
EY	M/I Provider ID Qualifier	465	
EZ	M/I Prescriber ID Qualifier	466	Enter “08” State License Number or “01” National Provider Identifier (NPI).
E1	M/I Product/Service ID Qualifier	436	
E3	M/I Incentive Amount Submitted	438	
E4	M/I Reason For Service Code	439	
E5	M/I Professional Service Code	440	
E6	M/I Result Of Service Code	441	
E7	M/I Quantity Dispensed	442	
E8	M/I Other Payer Date	443	
E9	M/I Provider ID	444	
FO	M/I Plan ID	524	
GE	M/I Percentage Sales Tax Amount Submitted	482	
HA	M/I Flat Sales Tax Amount Submitted	481	
HB	M/I Other Payer Amount Paid Count	341	
HC	M/I Other Payer Amount Paid Qualifier	342	
HD	M/I Dispensing Status	343	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
HE	M/I Percentage Sales Tax Rate Submitted	483	
HF	M/I Quantity Intended To Be Dispensed	344	
HG	M/I Days Supply Intended To Be Dispensed	345	
H1	M/I Measurement Time	495	
H2	M/I Measurement Dimension	496	
H3	M/I Measurement Unit	497	
H4	M/I Measurement Value	499	
H5	M/I Primary Care Provider Location Code	469	
H6	M/I DUR Co-Agent ID	476	
H7	M/I Other Amount Claimed Submitted Count	478	
H8	M/I Other Amount Claimed Submitted Qualifier	479	
H9	M/I Other Amount Claimed Submitted	480	
JE	M/I Percentage Sales Tax Basis Submitted	484	
J9	M/I DUR Co-Agent ID Qualifier	475	
KE	M/I Coupon Type	485	
M1	Patient Not Covered In This Aid Category		
M2	Member Locked In		
M3	Host PA/MC Error		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
M4	Prescription/Service Reference Number/Time 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	486	
MZ	Error Overflow		
NE	M/I Coupon Value Amount	487	
NN	Transaction Rejected At Switch Or Intermediary		
PA	PA Exhausted/Not Renewable		
PB	Invalid Transaction Count For This Transaction Code	103, 109	
PC	M/I Claim Segment	111	
PD	M/I Clinical Segment	111	
PE	M/I COB/Other Payments Segment	111	
PF	M/I Compound Segment	111	
PG	M/I Coupon Segment	111	
PH	M/I DUR/PPS Segment	111	
PJ	M/I Insurance Segment	111	
PK	M/I Patient Segment	111	
PM	M/I Pharmacy Provider Segment	111	
PN	M/I Prescriber Segment	111	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
PP	M/I Pricing Segment	111	
PR	M/I Prior Authorization Segment	111	
PS	M/I Transaction Header Segment	111	
PT	M/I Workers' Compensation Segment	111	
PV	Non-Matched Associated Prescription/Service Date	457	
PW	Non-Matched Employer ID	333	
PX	Non-Matched Other Payer ID	340	
PY	Non-Matched Unit Form/Route of Administration	451, 452, 600	
PZ	Non-Matched Unit Of Measure To Product/Service ID	407, 600	
P1	Associated Prescription/Service Reference Number Not Found	456	
P2	Clinical Information Counter Out Of Sequence	493	
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions	447	
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions	337	
P5	Coupon Expired	486	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
P6	Date Of Service Prior To Date Of Birth	304, 401	
P7	Diagnosis Code Count Does Not Match Number Of Repetitions	491	
P8	DUR/PPS Code Counter Out Of Sequence	473	
P9	Field Is Non-Repeatable		
RA	PA Reversal Out Of Order		
RB	Multiple Partials Not Allowed		
RC	Different Drug Entity Between Partial & Completion		
RD	Mismatched Cardholder/Group ID-Partial To Completion	301, 302	
RE	M/I Compound Product ID Qualifier	488	
RF	Improper Order Of "Dispensing Status" Code On Partial Fill Transaction		
RG	M/I Associated Prescription/Service Reference Number On Completion Transaction	456	
RH	M/I Associated Prescription/Service Date On Completion Transaction	457	
RJ	Associated Partial Fill Transaction Not On File		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
RK	Partial Fill Transaction Not Supported		
RM	Completion Transaction Not Permitted With Same "Date Of Service" As Partial Transaction	401	
RN	Plan Limits Exceeded On Intended Partial Fill Values	344, 345	
RP	Out Of Sequence "P" Reversal On Partial Fill Transaction		
RS	M/I Associated Prescription/Service Date On Partial Transaction	457	
RT	M/I Associated Prescription/Service Reference Number On Partial Transaction	456	
RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment		
R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions	478, 480	
R2	Other Payer Reject Count Does Not Match Number Of Repetitions	471, 472	
R3	Procedure Modifier Code Count Does Not Match Number Of Repetitions	458, 459	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
R4	Procedure Modifier Code Invalid For Product/Service ID	407, 436, 459	
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals Ø6	407, 436	
R6	Product/Service Not Appropriate For This Location	307, 407, 436	
R7	Repeating Segment Not Allowed In Same Transaction		
R8	Syntax Error		
R9	Value In Gross Amount Due Does Not Follow Pricing Formula	430	
SE	M/I Procedure Modifier Code Count	458	
TE	M/I Compound Product ID	489	
UE	M/I Compound Ingredient Basis Of Cost Determination	490	
VE	M/I Diagnosis Code Count	491	
WE	M/I Diagnosis Code Qualifier	492	
XE	M/I Clinical Information Counter	493	
ZE	M/I Measurement Date	494	

5.2 Host System Problems

Occasionally, providers may receive a message that indicates their network is having technical problems communicating with PharmPix.

NCPDP	Message	Meaning
90	Host Hung Up	Host disconnected before session completed.
92	System Unavailable/Host Unavailable	Processing host did not accept transaction or did not respond within time-out period.
93	Planned Unavailable	Transmission occurred during scheduled downtime. PharmPix will provide system availability.
99	Host Processing Error	A general transmission problem occurred.

System Hours of Availability

24-hour availability

5.3 DUR Fields

In those cases where provider-level overrides have been authorized, providers should use the following codes when applicable.

NCPDP	Message
88	DUR Reject Error

DUR Reason for Service

The DUR Reason for Service (previously "Conflict Code") is used to define the type of utilization conflict that was detected (NCPDP Field #439-E4).

Valid DUR Reason for Service Codes for the PharmPix program are:

ER NON-CONTROLLED EARLY REFILL 80%

DD DRUG/ DRUG INTERACTION

TD THERAPEUTIC DUPLICATION

ID DUPLICATE INGREDIENT

NCPDP	Message
E4	M/I DUR Conflict/Reason for Service Code

DUR Professional Service

The DUR Professional Service (previously "Intervention Code") is used to define the type of interaction or intervention that was performed by the pharmacist (NCPDP Field #440-E5).

Valid DUR Professional Service Codes for the PharmPix program are:

GP generic product selection

M0 prescriber consulted

MR medication review

PH patient medication history

P0 patient consulted

R0 RPh consulted other source

NCPDP	Message
E5	M/I DUR Intervention/Professional Service Code

DUR Result of Service

The DUR Result of Service (previously "Outcome Code") is used to define the action taken by the pharmacist in response to a CDUR Reason for Service or the result of a pharmacist's professional service (NCPDP Field #441-E6).

Valid DUR Result of Services Codes for the PharmPix program are:

1A filled as is, false positive

1B filled prescription as is

1C filled with different dose

1D filled with different directions

1E filled with different drug

1F filled with different quantity

1G filled with prescriber approval

2A prescription not filled

2B not filled, directions clarified

3C discontinued

3D regimen changed

3E therapy changed

NCPDP	Message
E6	M/I DUR Outcome/Result of Service Code

6.0 Provider Reimbursement

6.1 Provider Payment Algorithms

The provider is paid at the lesser of:

AWP – XX% for generic + dispense fee

AWP – XX% for brand + dispense fee

MAC + dispense fee

Usual and Customary

Gross Amount Due

340b

Providers should submit acquisition costs as U/C. Standard Payment Algorithm used.

6.2 Provider Dispensing Fees

Dispensing fee may vary depending on the contract negotiations.

6.3 Claims Processing

A. Ingredient Cost

The basis for calculating the ingredient cost of a claim is defined in the pharmacy's Affiliation Agreement. Average Wholesale Price, or AWP, shall mean the list ingredient price for a pharmaceutical as established by MediSpan.

B. Dispensing Fees

Dispensing Fee is the payment for the pharmacist service in dispensing the prescribed drug. PharmPix dispensing fees are indicated in the pharmacy's Provider Agreement.

C. Remittance Advice

All approved claims submitted are reported in complete detail to the pharmacy.

NOTE: Claims denied through the PharmPix on-line claims adjudication system do not appear on the Remittance Advice.

In addition to various data elements submitted by the pharmacy, the Remittance Advice includes the amount of the PharmPix ingredient cost, dispensing fees, sales tax, if applicable, enrollee copayments, claim disposition code (reject or payment), data transmission charge, claims status and net amount paid.

7.0 Provider Compliance (Audits/FWA Program)

7.1 Fraud Waste or Abuse (FWA)

PharmPix does not knowingly tolerate fraudulent activity by any of its contracted providers and will investigate and report any such known activity to the appropriate regulatory federal and state agencies for investigation and further action.

The Centers of Medicare & Medicaid Services (CMS) establishes that all sponsors are required

to have a comprehensive plan to detect, correct and prevent fraud, waste and abuse. It's particularly important that pharmacies and their employees be fully informed of Medicare Part D Programs and other federal requirements relating to the detection, correction, and prevention of fraud, waste, and abuse (FWA). CMS regulations require that effective January 1, 2009 all entities contracted with a Medicare Part D Plan Sponsor participate in an approved annual compliance training program. To accomplish this, an attestation verifying your entire workforce has been trained must be submitted to PharmPix. Pharmacies must offer, on an annual basis, compliance training to all their employees who work with Medicare Part D, and attendance must be tracked and available upon audit.

In addition to helping prevent fraud, pharmacies contracted with PharmPix are required to comply with numerous CMS requirements. Following are examples of CMS requirements but are not limited to (see agreement):

- Screening of employees against the OIG/GSA lists to ensure that no employee is prohibited from participation in the Medicare program.
- Posting or distribution of the Medicare rights notice for beneficiaries who disagree with the information provided by the pharmacy.
- Retention of prescription records for 10 years and the provision of these records and other documents to CMS, or those designated by CMS, upon request

For suspected fraud, waste, or abuse by enrollees, prescribing providers or pharmacies notify PharmPix, at www.PharmPix.com or call 787-522-5252. All information will be kept confidential.

7.2 Audits

PharmPix conducts routine audits to affiliated pharmacies to determine level of compliance with Operating Guidelines and the Affiliation Agreement. Pharmacies are continuously monitored with respect to the following items:

1. Percentage of controlled substances dispensed
2. Number of claims filled per contract
3. Average ingredient cost
4. DUR Success Rate
5. Reversal Rate
6. Generic Dispensing Rate
7. Plan Cost per Unique Member per Month
8. Number of Prescriptions per Unique Member per Month
9. Refills Fill Rate

10. Quantity vs Days Supply
11. DAW Code
12. Plan Sponsor Complaints

Pharmacies that are deemed outliers will be target for desk and/or onsite audit. The audit orientation and information requested to pharmacies will be related to the items the pharmacy was found to be outlier. Audits are conducted in compliance with federal and state laws to assure the privacy and confidentiality of all patients' records. Audits are completed to verify the integrity of claims submitted to PharmPix.

Non-compliance with audit request is grounds for termination of the Affiliation Agreement.

No fees can be applied to PharmPix for time involved to perform audit. Each entity is responsible for their own expenses and provider shall bear expense of providing records required to PharmPix.

Auditors shall not be allowed to accept money or gifts from providers.

PharmPix has the right to inspect all records and monitor claims data for potential billing errors on a daily basis. If discrepancy is found, the auditor will contact the pharmacy via fax, phone or mail to inquire about, validate and help resolve the claim(s) in question. Most of the claims can be resolved through faxing, over the telephone, or through claim reversal and resubmission.

If a request for a hard copy is needed on claim(s) in question, the pharmacy will be asked to provide a copy. If the pharmacy refuses or provides no documentation after three requests, the claim will be reversed by the Auditor.

All prescription documentation must have:

- Patient's full name, address and age.
- Date of the prescription
- Prescriber's full name, address, telephone number, signature and license number (must be the same as the transmitted information)
- Drug name, quantity, strength and directions for use of the medication prescribed
- Signature and license number of the dispensing pharmacist
- Generic substitution stamp
- Identification of the controlled prescription with the capital letter C.

Any missing information must be noted on the reverse of the original prescription after verifying with the prescriber and/or patient, according to it corresponds.

Missing or stamped date in the prescription it must be confirmed with the prescriber before being corrected at the pharmacy and noted in the reverse of the original prescription.

Prescriptions must contain complete documentation of the drug, quantities dispensed and directions for use. "As directed" sigs will not be allowed. Pharmacy must obtain concise directions to accurately fill the prescription. The pharmacist records on the reverse of the original prescription the date and hour, directions for use and initials the prescription showing who received the instructions from the prescribing physicians.

Some claim-specific audit objectives include, but are not limited to, the following errors:

- Dispensing unauthorized, early or excessive refills
- Dispensing an incorrect drug
- Billing the wrong member
- Billing an incorrect physician
- Using an NCPDP/National Provider Identifier (NPI) number inappropriately
- Calculating the day supply incorrectly
- Using a dispense as written (DAW) code incorrectly
- Over-billing quantities
- Missing hard copy for prescriptions
- Missing signature log/delivery manifest
- Missing date in the hard copy

Any payments made to pharmacy that are in excess of the amount of the pharmacy payment because of error, inaccurate claims, and discrepancies or due to any other reason, may be recovered by PharmPix. PharmPix shall notify pharmacy in writing of the audit results and will withhold the outstanding amount owed from future claims payment.

Audits are HIPPA compliant with guidelines of disclosure for treatment, payment or health care operations. An audit cannot be denied sighting HIPPA regulations as the reason.

Claims adjudicated are reviewed by the auditor. The auditor verifies the following, but not limited to, common dispensing errors:

- *Quantity*: The quantity submitted should be the number of units (e.g., tablets, capsules, milligrams, or milliliters) dispensed according to the metric decimal quantity of the medication or product and in accordance with the actual medication specifications or NCPDP guidelines and the client-specific plan design limitations.

- *Days Supply*: The days supply submitted should correlate to the number of days the medication will last the patient when taken according to directions and in accordance with the actual medication specifications and the client-specific plan design limitations.
- *Insulin*: Prescription claims for insulin products must be submitted for each individually prescribed insulin or insulin product. If the directions are "as directed," missing, or indicate a sliding scale, the pharmacy should verify the maximum number of units prescribed daily with the prescriber or member, and document accordingly on the prescription hard copy.
- *Inhalers*: Prescription claims for inhalers must be submitted with the appropriate metric decimal quantity per prescribed quantity and in accordance with the actual drug specifications and the client-specific plan design limitations.
- *Ophthalmic/Otic Drops*: Ophthalmic and Otic drop products should be calculated according to a standard of 20 drops/ml and in accordance with client-specific plan design limitations.
- *Topical Products:* Consider the frequency and size of area to be treated. Generally, the smallest package size available should be transmitted. Consider the "Rule of Hand" (each gram will usually cover an area represented by four handprints). Document all calculations and prescriber clarification on the prescription. If area of application is not indicated in the prescription, the calculated days' supply should be based using the measure of one gram per application.
- *LMWH*: Prescription claims for LMWH must be submitted with the appropriate prescribed metric quantity and in accordance with client-specific limitations.
- *"As directed" and prescriptions without directions*: Prescriptions indicated with "as directed" or missing directions must be clarified with the prescriber and/or member. The pharmacy must verify, document, and submit the appropriate quantity and days supply for the prescription claim. "As directed" and prescribed claims lacking instructional documentation or clarification are subject to chargeback

A. DESK AUDIT

During a desk audit, pharmacy is contacted via the telephone, fax or mail, and asked to provide photocopies of specific prescriptions in question related to claims paid to the pharmacy during a specified period. Documentation may include original prescriptions, signature logs, computer records, wholesaler and manufacturer invoices and receipt of purchase for medication. PharmPix performs desk audits on a routine basis. The auditor will provide a timeline of return date parameters for the pharmacy. The pharmacy will fax, or mail requested items at no cost to PharmPix. The pharmacy will return requested information by the dates provided; failure to do so may result in termination of contract.

Pharmacies are identified based upon internal analysis including, but not limited to, the following:

- Paid claims whose cost is greater than $500.00
- Paid claims whose cost is between $100.00 to $500.00
- Referrals
- Compounded prescriptions

B. ON-SITE AUDITS

PharmPix will notify the pharmacies of its intent to audit and will provide specific directions regarding the process. On-site audits will be conducted during regular business hours with prior notice to the pharmacy. Pharmacy must prepare an area for the audit process and assistance must be provided to support the auditor. Pharmacies selected for audit are notified via certified mail 30 days prior to a schedule audit date. The pharmacy is then contacted by the auditor to schedule an appointment. During the audit, the pharmacy will be required to have available prescriptions, signature logs and/or invoices for the time period specified in the audit letter. The auditor may take photograph, scan, or copy the reviewed prescriptions. Upon completion of the audit, the pharmacy will be counseled regarding any issues, if discovered by the auditor. A complete evaluation of the reviewed items will be completed by PharmPix. The results of the evaluation will be communicated to the pharmacy via fax and/or certified mail in a timely manner (See Appendix E). The pharmacy will have 30 calendar days from the receipt of the communication to send PharmPix, via fax or mail, evidence that could change the results of the audit.

During the on-site audit the auditor will verify the following:

- Signature Logs
- DACO and Bioequivalent drugs list accessible to members (PR pharmacies only).
- Security of the controlled drugs
- Refrigerator temperature
- Pharmacy permits
- Health certificate of all pharmacy employees
- Management of expired medications
- Professional Registration of pharmacy personnel
- Brown Bag Audit (See Appendix C)

- Evidence of training records (e.g. FWA training)
- Others

1. Signature Logs

PharmPix Prescription Drug Program pharmacies are required to maintain a log of signatures of the enrollees or their representatives, receiving prescriptions (See Appendix D). An electronic signature log is also acceptable.
The log must contain:

1. The date the prescription was picked up by the enrollee or his/her representative.
2. The prescription number
3. The signature of the enrollee to whom the prescription was dispensed or their representative.
4. Enrollee or representative identification number and card name

The signature log must be kept by the pharmacy for a period of at least two years or according to contract agreement, Federal and local laws and must be made available to PharmPix representatives upon request. Any claims submitted to PharmPix for reimbursement for which a valid entry in the pharmacy's signature log cannot be obtained will not be considered valid. Reimbursement made to the pharmacy for such a claim will be recovered.

2. Claim Reversals

Prescriptions billed to PharmPix, which are not picked up by the enrollee within 7 days, must be canceled by the pharmacy. Claims in the current remittance cycle will be reversed and no payment made to the pharmacy. A reversal for a previously paid claim will result in the withholding of the amount of the previously paid claim on the next Remittance Advice.

Pharmacies may cancel previously billed claims by initiating a reversal on the PharmPix system or by submitting appropriate information to PharmPix identifying the claim which has been paid and indicating that the claim should be canceled.

3. Other Requirements

Pharmacies are required to:

1. Review the concurrent DUR messages and take appropriate action
2. Substitute generic products, when available
3. Counsel patients about their medications and their therapy compliance

4. Refrain from independently implementing therapeutic substitution or utilization management programs.

8.0 Retail Network Management

8.1 Pharmacy Rights and Responsibilities

Pharmacy Rights

- To be treated with respect and dignity.
- To receive timely communications from PharmPix on items affecting pharmacy services.
- To expect reimbursement in a timely fashion for covered drug products and services.
- To express a complaint and receive a response within a reasonable amount of time.
- To expect confidentiality of business and credentialing documents.

Pharmacy Responsibilities

- Comply with laws and regulations, while providing services in a manner compliant with the highest standards.
- Maintain the confidentiality of Members in accordance with HIPAA privacy laws.
- Maintain all materials relating to pricing, contracts, programs, services, and business practices of PharmPix as proprietary and confidential.
- Non-discrimination against Members.
- Display all DUR alerts to the dispensing pharmacist; respond to all online edits.
- Take appropriate action regarding suspected adverse drug reactions and errors.
- Inform patients or caregivers about drug recalls.
- Educate consumers and caregivers about the appropriate means to dispose of expired,damaged, and unstable medications.
- Assure that medications and devices are maintained within appropriate temperature, light, and humidity standards during storage and shipment.
- Provide instructions to the patient on storage, dosing, side effects, potential interactions, and use of medication dispensed in accordance with professional practice guidelines.
- Collect from each Member the applicable copayment or coinsurance.
- Maintain credentials for facility and staff in good standing.

- Licensed pharmacist available 100% of the hours of service.

8.2 Credentialing/Re-credentialing

PharmPix permits the participation in our pharmacy network of any pharmacy – including mail order, home-infusion pharmacies and specialty pharmacies- that are willing to accept our terms and conditions and are in compliance with federal and state laws.

A written agreement must be in place with a pharmacy and credentialing criteria must be completed in order for it to be included in the pharmacy network.

PharmPix requires each provider to meet with participation requirements, including but not limited to, licensure, and insurance and provider agreement requirements. Credentialing and re-credentialing initiatives are critical to ensure that participating providers abide by the criteria established by PharmPix, as well as state and federal laws and regulations. All pharmacies must be approved by the Credentialing Committee before becoming part of the PharmPix Provider Network and must be re-credentialed every two years to maintain active status in the network.

PharmPix wants to make certain that all pharmacies meet standards, including quality, safety, cleanliness, patient confidentiality and access. PharmPix retains the absolute right to conduct a facility review any time a deficiency, breaches of standards of care or delivery are suspected.

8.3 Dispute Process

If the participating pharmacy finds a discrepancy in payment reimbursement, has a concern regarding a claim, pharmacy's status within the provider network, an action taken by PharmPix related to the pharmacy's competency or conduct, or any contractual issue (including financial disputes and violations of subcontracting restrictions), the inquiry may be directly submitted to PharmPix's Retail Network Department.

The inquiry may be placed by one of the following means:

Phone: (787)522-5252; ext. 169
Fax: 1-866-912-2810
Email: retailnetwork@pharmpix.com; or
Mail: PharmPix, Corp.
Retail Network Department
Metro Office Park
2 Street 1 Suite 500
Guaynabo, PR 00968

The retail network management team will review the inquiry and provide an answer to the provider in a timely manner. If an immediate answer is not available, the inquiry will be escalated to the Operations Director for review. If the Operations Director is unable to resolve the inquiry, an acknowledgement letter will be sent to the provider within ten (10) business days of the receipt of the inquiry. This acknowledgement letter includes a description of the complaint, a description of the complaint procedures, a description of the appeal procedures, and relevant time frames. PharmPix has thirty (30) calendar days to acknowledge, investigate, and resolve the complaint after the formal oral or written complaint. The complaint resolution letter includes a description of the appeal process and time frames for the complaint process and final decision.

If provider chooses to appeal a complaint resolution, the provider is referred to the Quality Management Committee for any appeal decisions. If the provider chooses to appeal the final decision, a letter acknowledging the appeal request is sent to the complainant within ten (10) business days of receipt of appeal request. Following a thorough investigation, a letter informing the complainant of the final decision on the appeal is sent, and includes a statement of the specific medical, clinical, and/or contractual criteria used to make the final decision. PharmPix has (30) calendar days to indicate that the appeal process in complete after receipt of request for appeal.

Appendix A: Universal Claim Form

Universal Claim Form

The *Universal Claim Form (UCF)* will be required for all paper claims. UCFs can be obtained from your wholesaler (see *Section 1.1 - Important Telephone Numbers for Universal Claim Forms*) and should be submitted to PharmPix. See *Section 1.2 - Addresses* for Provider Paper Claims Billing Address.

How to Complete 5.1 UCF Form

1. Fill in all applicable areas on the front of the form.
2. Verify patient information is correct and that patient named is eligible for benefits.
3. Patient signs certification on front side for prescription(s) received.
4. Enter Compound Rx in the Product Service ID area of claim block #1 and list the first ingredient name, NDC, quantity, and cost in the area below. On back of claim form, provide information for the remaining ingredients. Claim block #2 should not be used when submitting claims for compounds.

Please use a separate claim form for each compound prescription.

5. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
6. Limit 1 set of DUR/PPS codes per claim.
7. The medication being billed must match what is being/was dispensed.
8. Each area is numbered. Fill each area using the following codes:

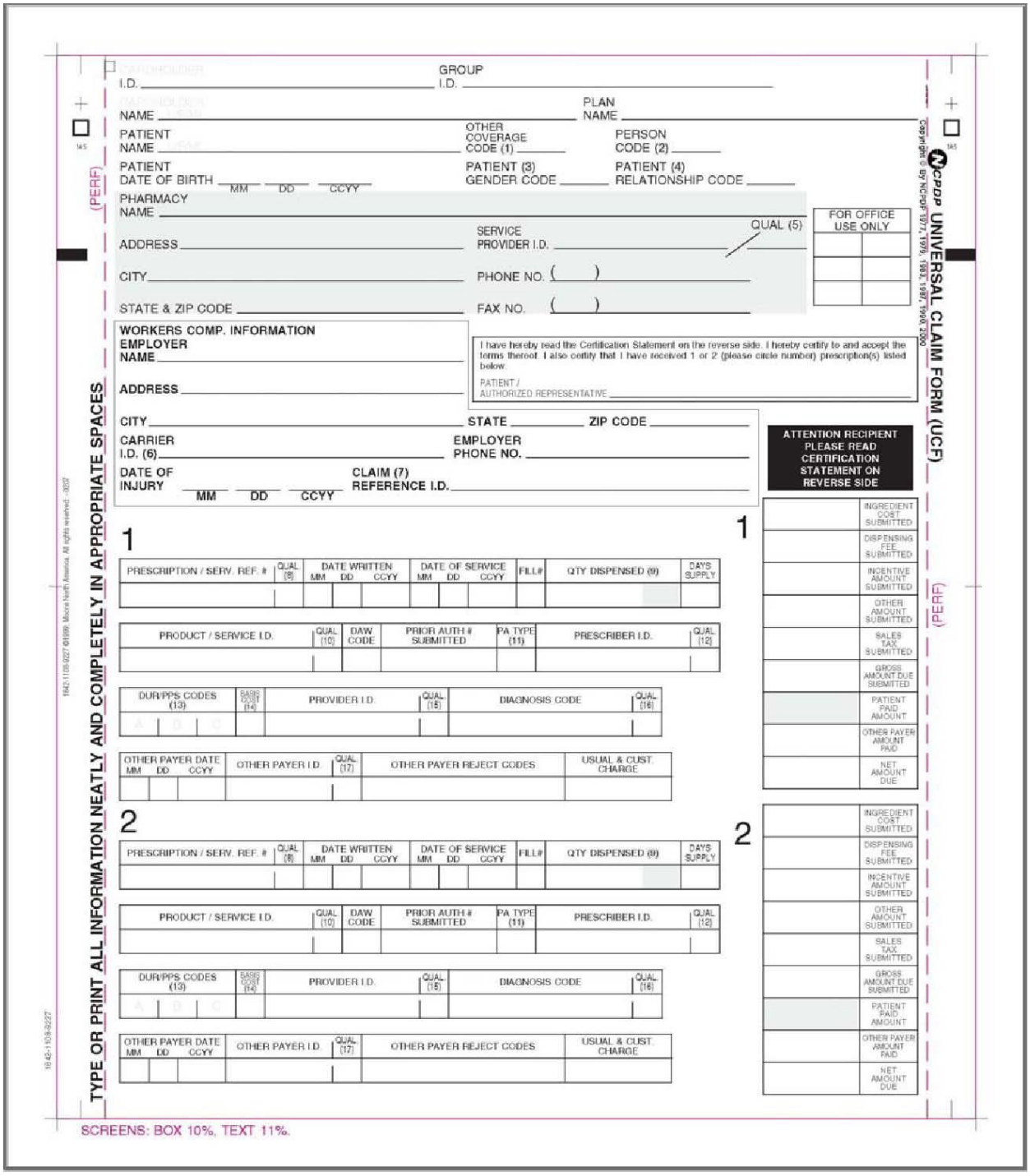
Definitions/Values

Definitions	Values
OTHER COVERAGE CODE	1 = No other coverage identified 2 = Other coverage exists payment collected 3 = Other coverage exists this claim not covered 4 = Other coverage exists payment not collected 6 = Other coverage denied not a participating provider 7 = Other coverage exists not in effect at time of service
PERSON CODE	Code assigned to a specific person within a family. All members are "01."

Definitions	Values
PATIENT GENDER CODE	0 = Not specified 1 = Male 2 = Female
PATIENT RELATIONSHIP CODE	1 = Cardholder
SERVICE PROVIDER ID QUALIFIER	05 = MEDICAID ID or 01 = National Provider Identifier (NPI) 99 = Other
CARRIER ID	Carrier code is assigned in the Worker's Compensation Program.
CLAIM/REFERENCE ID	Identifies the claim number assigned by Worker's Compensation Program.
PRESCRIPTION SERVICE REFERENCE # QUALIFIER	Blank = Not Specified 1 = Rx billing 2 = Service bill
QUANTITY DISPENSED	Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).
PRODUCT SERVICE ID QUALIFIER	Code qualifying the value in Product/Service ID (407-07). 03 = National Drug Code (NDC)
PRIOR AUTHORIZATION TYPE CODE	0 = Not Specified 1 = Prior Authorization 2 = Medical Certification 3 = EPSDT (Early Periodic Screening Diagnosis Treatment) 4 = Exemption From Co-Payment 6 = Family Planning Indicator 8 = Payer Defined Exemption
PRESCRIBER ID QUALIFIER	08 = State License Number or 01 = National Provider Identifier (NPI)
DUR/PROFESSIONAL SERVICE CODES	For values, refer to current NCPDP data dictionary. A = Reason for Service B = Professional Service Code C = Result of Service

Definitions	Values
BASIS OF COST DETERMINATION	01 = AWP (average wholesale price) 07 = Usual and Customary 09 = Other
PROVIDER ID QUALIFIER	
DIAGNOSIS CODE QUALIFIER	Blank = Not Specified 00 = Not Specified 01 = International Classification of Diseases (ICD9) 99 = Other
OTHER PAYER ID QUALIFIER	99 = Other

Universal Claim Form - Page 1 - Sample



UNIVERSAL CLAIM FORM (UCF)

GROUP I.D.

PLAN NAME

NAME

PATIENT NAME

OTHER COVERAGE CODE (1)

PERSON CODE (2)

PATIENT DATE OF BIRTH MM DD CCYY

PATIENT (3) GENDER CODE

PATIENT (4) RELATIONSHIP CODE

PHARMACY NAME

ADDRESS

SERVICE PROVIDER I.D. QUAL (5)

CITY

PHONE NO. ( )

STATE & ZIP CODE

FAX NO. ( )

FOR OFFICE USE ONLY

WORKERS COMP. INFORMATION
EMPLOYER NAME

ADDRESS

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT / AUTHORIZED REPRESENTATIVE

CITY STATE ZIP CODE

CARRIER I.D. (6)

EMPLOYER PHONE NO.

DATE OF INJURY MM DD CCYY

CLAIM (7) REFERENCE I.D.

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

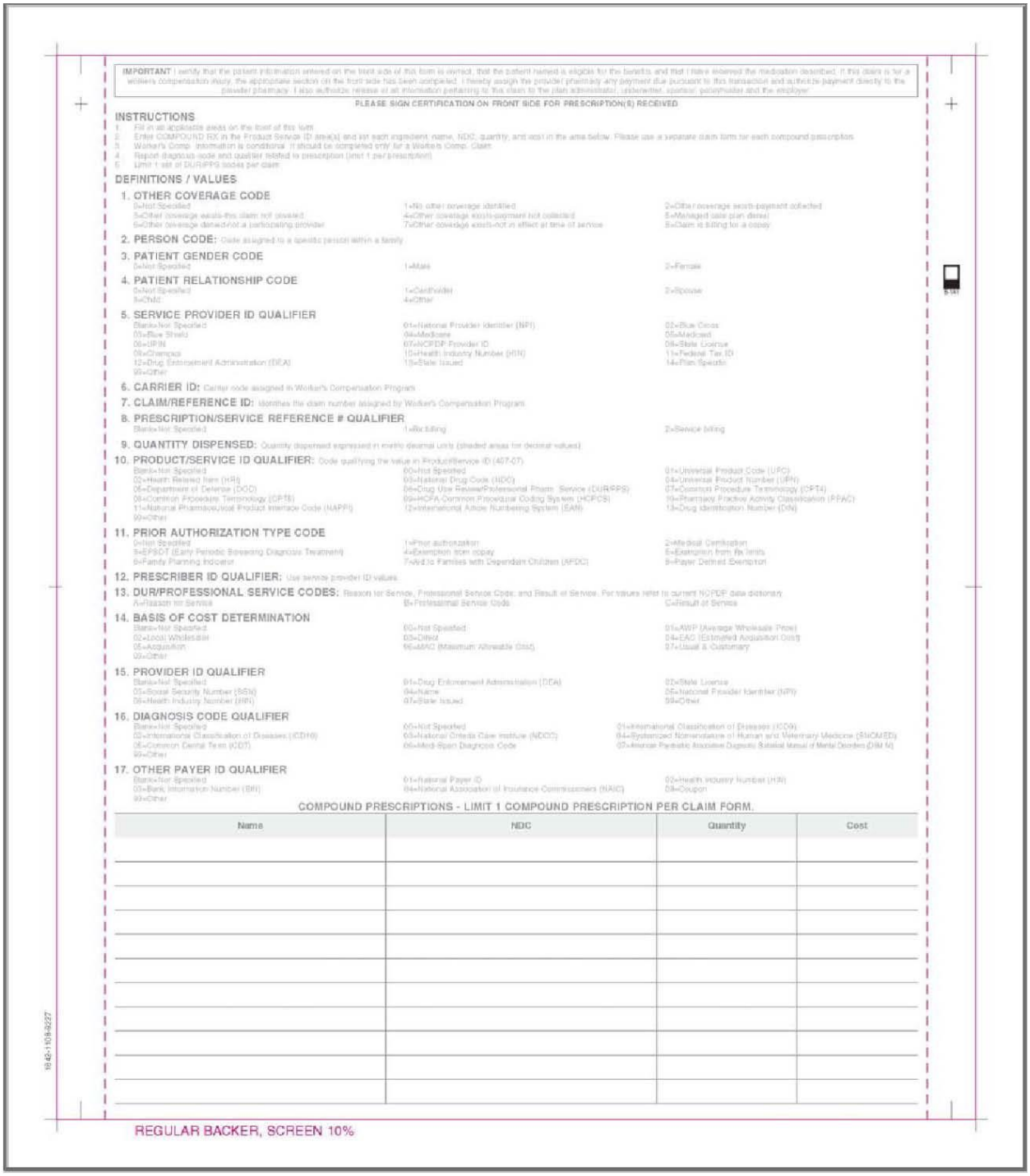
	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

(PERF) TYPE OR PRINT ALL INFORMATION NEATLY AND COMPLETELY IN APPROPRIATE SPACES (PERF)

SCREENS: BOX 10%, TEXT 11%.

2 Street 1, Suite 500 Guaynabo, PR 00968 | Tel. 787.522.5252 | Fax 1.866.912.2830 | www.pharmpix.com

Universal Claim Form - Page 2 - Sample



IMPORTANT I certify that the patient information entered on the front side of this form is correct, that the patient named is eligible for the benefits and that I have entered the medication described. If this claim is for a workers compensation injury, the appropriate section on the front side has been completed. I hereby assign the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsor, policyholder and the employer.

PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

1. Fill in all applicable areas on the front of this form
2. Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
3. Worker's Comp. information is conditional. It should be completed only for a Worker's Comp. Claim.
4. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
5. Limit 1 set of DUR/PPS codes per claim.

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE
   0=Not Specified; 1=No other coverage identified; 2=Other coverage exists-payment collected; 5=Other coverage exists-this claim not covered; 4=Other coverage exists-payment not collected; 5=Managed care plan denial; 6=Other coverage denied-not a participating provider; 7=Other coverage exists-not in effect at time of service; 8=Claim is billing for a copay
2. PERSON CODE: Code assigned to a specific person within a family
3. PATIENT GENDER CODE
   0=Not Specified; 1=Male; 2=Female
4. PATIENT RELATIONSHIP CODE
   0=Not Specified; 1=Cardholder; 2=Spouse; 3=Child; 4=Other
5. SERVICE PROVIDER ID QUALIFIER
   Blank=Not Specified; 01=National Provider Identifier (NPI); 02=Blue Cross; 03=Blue Shield; 04=Medicare; 05=Medicaid; 06=UPIN; 07=NCPDP Provider ID; 08=State License; 09=Champus; 10=Health Industry Number (HIN); 11=Federal Tax ID; 12=Drug Enforcement Administration (DEA); 13=State Issued; 14=Plan Specific; 99=Other
6. CARRIER ID: Carrier code assigned in Worker's Compensation Program
7. CLAIM/REFERENCE ID: Identifies the claim number assigned by Worker's Compensation Program
8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER
   Blank=Not Specified; 1=Rx billing; 2=Service billing
9. QUANTITY DISPENSED: Quantity dispensed expressed in metric decimal units (shaded areas for decimal values)
10. PRODUCT/SERVICE ID QUALIFIER: Code qualifying the value in Product/Service ID (407-D7)
    Blank=Not Specified; 00=Not Specified; 01=Universal Product Code (UPC); 02=Health Related Item (HRI); 03=National Drug Code (NDC); 04=Universal Product Number (UPN); 05=Department of Defense (DOD); 06=Drug Use Review/Professional Pharm. Service (DUR/PPS); 07=Common Procedure Terminology (CPT4); 08=Common Procedure Terminology (CPTE); 09=HCPA Common Procedural Coding System (HCPCS); 10=Pharmacy Practice Activity Classification (PPAC); 11=National Pharmaceutical Product Interface Code (NAPPI); 12=International Article Numbering System (EAN); 13=Drug Identification Number (DIN); 99=Other
11. PRIOR AUTHORIZATION TYPE CODE
    0=Not Specified; 1=Prior authorization; 2=Medical Certification; 3=EPSDT (Early Periodic Screening Diagnosis Treatment); 4=Exemption from copay; 5=Exemption from Rx limits; 6=Family Planning Indicator; 7=Aid to Families with Dependent Children (AFDC); 8=Payer Defined Exemption
12. PRESCRIBER ID QUALIFIER: Use service provider ID values
13. DUR/PROFESSIONAL SERVICE CODES: Reason for Service, Professional Service Code, and Result of Service. For values refer to current NCPDP data dictionary. A=Reason for Service; B=Professional Service Code; C=Result of Service
14. BASIS OF COST DETERMINATION
    Blank=Not Specified; 00=Not Specified; 01=AWP (Average Wholesale Price); 02=Local Wholesaler; 03=Direct; 04=EAC (Estimated Acquisition Cost); 05=Acquisition; 06=MAC (Maximum Allowable Cost); 07=Usual & Customary; 99=Other
15. PROVIDER ID QUALIFIER
    Blank=Not Specified; 01=Drug Enforcement Administration (DEA); 02=State License; 03=Social Security Number (SSN); 04=Name; 05=National Provider Identifier (NPI); 06=Health Industry Number (HIN); 07=State Issued; 99=Other
16. DIAGNOSIS CODE QUALIFIER
    Blank=Not Specified; 00=Not Specified; 01=International Classification of Diseases (ICD9); 02=International Classification of Diseases (ICD10); 03=National Criteria Care Institute (NDCC); 04=Systemized Nomenclature of Human and Veterinary Medicine (SNOMED); 05=Common Dental Term (CDT); 06=Medi-Span Diagnosis Code; 07=American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV); 99=Other
17. OTHER PAYER ID QUALIFIER
    Blank=Not Specified; 01=National Payer ID; 02=Health Industry Number (HIN); 03=Blank Information Number (BIN); 04=National Association of Insurance Commissioners (NAIC); 05=Coupon; 99=Other

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM.

Name	NDC	Quantity	Cost

1842-1109-0227

REGULAR BACKER, SCREEN 10%

Appendix B: PharmPix, Corp Payer Sheet

Effective as of	10/01/2017
Payer Sheet Revision	1.8
Contact/Information	787-522-5252

1. BILLING TRANSACTION (B1)

- The following lists the segments available in a standard Billing Transaction for version D.0 mandatory from 10/01/2017.
- The Coordination of Benefits segment must be completed if billing with COB.
- The Compound segment must be completed if billing a compound.

Key to field status:

M=Mandatory
O=Optional
S=Situational
R=Repeating

Transaction Header Segment: Mandatory in all cases

Field #	NCPDP Field Name	Value	M/O/R/S
101-A1	BIN Number	610228	M
102-A2	Version/Release Number	D0	M
103-A3	Transaction Code	B1	M
104-A4	Processor Control Number		M
109-A9	Transaction Count		M
202-B2	Service Provider ID Qualifier		M
201-B1	Service Provider ID		M
401-D1	Date of Service		M
110-AK	Software/Vendor Certification ID		O

Patient Segment: Mandatory

Field	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	01	M
331-CX	Patient ID Qualifier		O
332-CY	Patient ID		O
3Ø4-C4	Date Of Birth		M

Field	NCPDP Field Name	Value	M/O/R/S
3Ø5-C5	Patient Gender Code		M
31Ø-CA	Patient First Name		O
311-CB	Patient Last Name		O
322-CM	Patient Street Address		O
323-CN	Patient City Address		O
324-CO	Patient State / Province Address		O
325-CP	Patient Zip/Postal Zone		O
326-CQ	Patient Phone Number		O
333-CZ	Employer ID		O
335-2C	Pregnancy Indicator		O

Insurance Segment: Mandatory

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	04	M
302-C2	Cardholder ID		M
312-CC	Cardholder First Name		O
313-CD	Cardholder Last Name		O
314-CE	Home Plan		O
524-FO	Plan ID		O
309-C9	Eligibility Clarification Code		O
301-C1	Group ID		M
303-C3	Person Code		O
306-C6	Patient Relationship code		O
359-2A	Medigap ID		O
360-2B	Medicaid Indicator		O
361-2D	Provider Accept Assignment Indicator		O
997-G2	CMS Part D Defined Qualified Facility		O
115-N5	Medicaid ID Number		O
116-N6	Medicaid Agency Number		O

Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	07	M
455-EM	Prescription/Service Reference Number Qualifier		M
402-D2	Prescription/Service Reference Number		M
436-E1	Product/Service ID Qualifier		M
407-D7	Product/Service ID		M
456-EN	Associated Prescription/Service Ref. #		O
457-EP	Associated Prescription/Service Date		O
458-SE	Procedure Modifier Code Count		O

Field #	NCPDP Field Name	Value	M/O/R/S
459-ER	Procedure Modifier Code		O
442-E7	Quantity Dispensed		M
403-D3	Fill Number		M
405-D5	Days Supply		M
406-D6	Compound Code		M
408-D8	Dispense As Written/Product Selection Code		O
414-DE	Date Prescription Written		O
415-DF	Number of Refills Authorized		M
419-DJ	Prescription Origin Code		M
420-DK	Submission Clarification Code		O
308-C8	Other Coverage Code		O
429-DT	Unit Dose Indicator		O
453-EJ	Orig. Prescribed Product/Service ID Qualifier		O
445-EA	Originally Prescribed Product/Service Code		O
446-EB	Originally Prescribed Quantity	Req. for Partial Fills	S
600-28	Unit of Measure		O
418-DI	Level of Service		O
461-EU	Prior Authorization Type Code		O
462-EV	Prior Authorization Number Submitted		O
463-EW	Intermediary Authorization Type ID		O
464-EX	Intermediary Authorization ID		O
343-HD	Dispensing Status		O
344-HF	Quantity Intended to be Dispensed		O
345-HG	Days Supply Intended to be Dispensed		O
357-NV	Delay Reason Code		O
391-MT	Patient Assignment Indicator		O
995-E2	Route of Administration		O
996-G1	Compound Type		O
147-U7	Pharmacy Service Type		O

Pharmacy Provider Segment: Optional

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	02	M

Prescriber Segment: Mandatory

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	03	M

Field #	NCPDP Field Name	Value	M/O/R/S
466-EZ	Prescriber ID Qualifier		M
411-DB	Prescriber ID		M
427-DR	Prescriber Last Name		O
498-PM	Prescriber Phone Number		O
468-2E	Primary Care Provider ID Qualifier		O
421-DL	Primary Care Provider ID		O
470-4E	Primary Care Provider Last Name		O
364-2J	Prescriber First Name		O
365-2K	Prescriber Street Address		O
366-2M	Prescriber City Address		O
368-2P	Prescriber Zip/Postal Zone		O

COB/Other Payments Segment: Situational
Submit this segment if billing using COB

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	05	M
337-4C	COB/Other Payments Count		M
338-5C	Other Payer Coverage Type		M
339-6C	Other Payer ID Qualifier		O
340-7C	Other Payer ID		O
443-E8	Other Payer Date		O
341-HB	Other Payer Amount Paid Count		M
342-HC	Other Payer Amount Paid Qualifier		M
431-DV	Other Payer Amount Paid		M
471-5E	Other Payer Reject Count		O
472-6E	Other Payer Reject Code		O
993-A7	Internal Control Number		O
353-NR	Other Payer-Patient Responsibility Amount Paid Count		O
351-NP	Other Payer-Patient Responsibility Amount Paid Qualifier		O
352-NQ	Other Payer-Patient Responsibility Amount		O
392-MU	Benefit Stage Count		O
393-MV	Benefit Stage Qualifier		O
394-MW	Benefit Stage Amount		O

Workers' Compensation Segment: Optional

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	06	S
434-DY	Date of Injury		S

DUR/PPS Segment: Optional

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	08	S

Pricing Segment: Mandatory

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	11	M
409-D9	Ingredient Cost Submitted		O
412-DC	Dispensing Fee Submitted		O
433-DX	Patient Paid Amount Submitted		O
438-E3	Incentive Amount Submitted		O
478-H7	Other Amount Claimed Submitted Count		O
479-H8	Other Amount Claimed Submitted Qualifier		O, R
480-H9	Other Amount Claimed Submitted		O, R
481-HA	Flat Sales Tax Amount Submitted		O
482-GE	Percentage Sales Tax Amount Submitted		O
483-HE	Percentage Sales Tax Rate Submitted		O
484-JE	Percentage Sales Tax Basis Submitted		O
426-DQ	Usual and Customary Charge		O
430-DU	Gross Amount Due		O
423-DN	Basis of Cost Determination		O

Coupon Segment: Optional

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	09	S
485-KE	Coupon Type		S
486-ME	Coupon Number		S
487-NE	Coupon Value Amount		S

Compound billing method

1. In the CLAIM segment enter a dummy NDC and Compound Code=2
2. In the Compound Segment enter the fields marked as mandatory in the next table for each ingredient in the compound

Compound Segment: Situational
Submit this segment if billing a compound

Field #	NCPDP Field Name	Value	M/O/R/S

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	10	M
450-EF	Compound Dosage Form Description Code		M
451-EG	Compound Dispensing Unit Form Indicator		M
452-EH	Compound Route of Administration		M
447-EC	Compound Ingredient Component Count		M
488-RE	Compound Product ID Qualifier		M, R
489-TE	Compound Product ID		M, R
448-ED	Compound Ingredient Quantity		M, R
449-EE	Compound Ingredient Drug Cost		O, R
490-UE	Compound Ingredient Basis of Cost Determination		O, R
362-2G	Compound Ingredient Modifier Code Count		O, R
363-2H	Compound Ingredient Modifier Code		O, R

Prior Authorization Segment: Optional

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	12	S

Clinical Segment: Optional

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	13	S

2. REVERSAL TRANSACTION (B2)

The following lists the segments available in a Reversal Transaction (transaction code B2) for version D.0

Reversal Transaction Header Segment: Mandatory in all cases

Field #	NCPDP Field Name	Value	M/O/R/S
101-A1	BIN Number	610228	M
102-A2	Version/Release Number	D0	M
103-A3	Transaction Code	B2	M
104-A4	Processor Control Number		M
109-A9	Transaction Count		M
202-B2	Service Provider ID Qualifier		M
201-B1	Service Provider ID		M
401-D1	Date of Service		M
110-AK	Software/Vendor Certification ID		O

Reversal Insurance Segment: Optional

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	04	S
302-C2	Cardholder Id		S
301-C1	Group Id		S
303-C3	Person Code		S

Reversal Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/O/R/S
111-AM	Segment Identification	07	M
455-EM	Prescription/Service Reference Number Qualifier		M
402-D2	Prescription/Service Reference Number		M
436-E1	Product/Service ID Qualifier		M
407-D7	Product/Service ID		M
456-EN	Associated Prescription/Service Ref. #		O
457-EP	Associated Prescription/Service Date		O
458-SE	Procedure Modifier Code Count		O
459-ER	Procedure Modifier Code		O, R
442-E7	Quantity Dispensed		O
403-D3	Fill Number		O
405-D5	Days Supply		O
406-D6	Compound Code		O

Field #	NCPDP Field Name	Value	M/O/R/S
408-D8	Dispense As Written/Product Selection Code		O
414-DE	Date Prescription Written		O
415-DF	Number of Refills Authorized		O
419-DJ	Prescription Origin Code		O
420-DK	Submission Clarification Code		O
460-ET	Quantity Prescribed		O
308-C8	Other Coverage Code		O
429-DT	Unit Dose Indicator		O
453-EJ	Orig. Prescribed Product/Service ID Qualifier		O
445-EA	Originally Prescribed Product/Service Code		O
446-EB	Originally Prescribed Quantity		O
454-EK	Scheduled Prescription ID Number		O
343-HD	Dispensing Status		O
344-HF	Quantity Intended to be Dispensed		O
345-HG	Days Supply Intended to be Dispensed		O

Appendix C: Brown Bag Audit Form

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2 Street 1, Suite 500 Guaynabo, PR 00968 | Tel. 787.522.5252 | Fax 1.866.912.2830 | www.pharmpix.com

Brown Bag Audit Form

Date_____ Prescription(s) Number_____

Pharmacy Name_____ NPI_____

Patient's Name_____ Submission Date _____

Correct Doctor submitted?	Yes _____ No_____
Correct Drug submitted?	Yes_____ No_____
Correct Dose submitted?	Yes_____ No_____
Correct Member's Name Submitted?	Yes_____ No_____
Were drugs counted correctly?	Yes_____ No_____
Is the correct drug inside the bottle?	Yes_____ No_____

Based on the above, the pharmacy must reverse the claim(s)?

Yes_____ No_____

Observations: _____

_____

_____

_____ _____

PharmPix Auditor Pharmacy Manager

Note: Brown Bag Audit is performed in order to verify processed claims which at the audit date have not been pick-up by the beneficiary or representative. This form may be used for multiple drugs in one prescription.

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Appendix D: PharmPix Signature Claim Log

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2 Street 1, Suite 500 Guaynabo, PR 00968 | Tel. 787.522.5252 | Fax 1.866.912.2830 | www.pharmpix.com

Signature Claim Log

Patient, Guardian or Legal Representative: Your signature certifies you received a service or item dispensed on the date(s) listed below and that the information contained hereon is correct and that the person for whom the prescription was written is eligible for the benefits. You also certify that you have received the medication identified and authorize release of all of the information contained on this log and prescription to which it corresponds, to the plan administrator, the underwriter, the sponsor, the policyholder, and the employer. You hereby assign to this provider pharmacy any payment due pursuant to this transaction and authorize payment directly to this provider pharmacy. **Pharmacy:** Please maintain register of the signature of the beneficiary or that of his/her representative at the time the dispensed prescription is being picked-up. **Acknowledgement of Receipt of HIPAA Privacy Statement:** The undersigned acknowledges that they have been provided a copy of the HIPAA Privacy Statement. If the undersigned is not the patient, the undersigned certifies that they have the consent of the patient to receive health information, and they will provide the copy of the HIPAA Privacy Statement and acknowledgement of receipt to the patient to be returned to the pharmacy.

Date	Prescription Number	Identification Number	Patient Counseling Accepted=A Refused=R	Dispensing Pharmacist Signature	Signature of Patient, Guardian or Legal Representative

I certify that PharmPix member's prescriptions whose signatures are enclosed here have been processed and dispensed correctly, complying with parameters and laws established by the Regulating Agencies. These meet the requirements and stipulations of PharmPix's Pharmacy Provider agreement. I certify that all transactions are legal and that all documentations are available for future audit processes.

_____

Pharmacy Name, Address and NPI

Appendix E: Possible Audit Discrepancies and Resolutions

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Dear Pharmacy:

Enclosed you will find the list of the possible discrepancies found during the audit conducted to your pharmacy recently.

Any payments made to pharmacy that are in excess of the amount of the pharmacy payment because of error, inaccurate claims, and discrepancies or due to any other reason, may be recovered by PharmPix. PharmPix will notify the pharmacy in writing of the results and will withhold the outstanding amount owed from future claims payment.

Pharmacies shall not process an automatic refill for a prescription for an eligible plan member unless and until such refill has been authorized by the eligible plan member.

_____

PharmPix Auditor

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