Minnesota Health Care Programs Pharmacy Modernization Module Provider Manual

Version 2.0

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Revision History

Version	Date	Name	Comments
1.0	10/31/2024	Brigette Devine	Document Creation
2.0	03/26/2025	Kimberly Bauer	Document Revision

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1.0 Introduction

Effective November 4, 2024, Prime Therapeutics State Government Solutions LLC (Prime) will be the contracted vendor for the Minnesota Health Care Programs (MHCP) Pharmacy Modernization Module (PMM) Fee-for-Service (FFS) Point-of-Sale (POS) and AIDS Drug Assistance Program (ADAP).

Prime will administer the POS system to process pharmacy claim transactions. The POS system will accept pharmacy transactions in the National Council for Prescription Drug Programs (NCPDP) standardized version D.0; lower versions will not be accepted.

Prime will respond to the pharmacy provider with information about client eligibility, the plan allowed amount, applicable Prospective Drug Utilization Review (ProDUR) messages, and applicable rejection messages. ProDUR messages will be returned in the DUR response fields. Other important related information will appear in the free-form message area.

All arrangements with switching companies and software vendors should be handled directly by the provider with their preferred vendor.

1.1 Minnesota Medicaid Pharmacy Program

This manual provides claims submission guidelines for the MHCP PMM administered by Prime.

Important plan coverage and reimbursement policies are available in this *MHCP PMM Provider Manual*. The Prime website contains a link to this document. Subsequent revisions to this document are available on the Minnesota state Web Portal at https://minnesota.primetherapeutics.com.

Additional Minnesota Medicaid State policy information, including FFS policies, can be found at https://mn.gov/dhs/partners-and-providers/policies-procedures/.

This manual provides supplemental information for providers and members, but it does not replace the Department of Human Services (DHS) Provider Manual. All enrolled providers must follow all DHS policies and procedures included in the DHS Provider Manual.

2.0 Prime Services Support Centers

Prime has a Pharmacy Support Center (PSC), Clinical Support Center (CSC), Member Help Desk, and Web Support Center to assist pharmacies, prescribers and members.

Provider Services	Phone Number/Email	Availability/ Comments
Prime Pharmacy Call Center (will connect callers to both the PSC and CSC)	844-575-7887	24/7/365
Prime Member Help Desk	844-575-7887	24/7/365
Prime Pharmacy Call Center Fax Line	866-390-2778	24/7/365
Prime Provider Portal	https://minnesota.primetherapeutics.com/	24/7/365

2.1 Pharmacy and Clinical Support Centers

Prime provides a toll-free number for pharmacies available 7 days a week, 24 hours a day, and 365 days a year responding to questions on coverage, claims processing and plan eligibility.

Examples of concerns/issues addressed by the PSC staff include:

- **Questions on Claims Processing Messages** – It is important to contact the PSC at the time of dispensing if a pharmacy needs assistance with alert or denial messages. Prime's staff can provide claim information on all error messages, including ProDUR messaging.
- **Clinical Issues** – To address these situations, the CSC will assist with initiating clinical Prior Authorizations (PAs). A second level of assistance is available if a pharmacist's question requires a clinical response. The PSC is not intended to be a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist.

2.2 Prime Member Help Desk

The Member Help Desk will support members with the following 7 days a week, 24 hours a day, and 365 days a year:

- Understanding what medications are preferred and covered by the plan
- Providing the appropriate steps for completing a PA request with their doctor
- Assistance with claims inquiries

2.3 Prime Website Pharmacy Portal

Announcements, provider forms, drug information, *MHCP PMM Provider Manual*, policies and bulletins will be posted on the Prime Minnesota Medicaid Web Portal.

3.0 Program Setup

3.1 Member Identification Card

An Identification (ID) card will show coverage for the eligible member only. Per the Standard NCPDP, the ID card will contain the following:

- RxBIN
- RxPCN
- RxGRP
- Member ID
- Member Name
- Other required information and instructions a pharmacy needs to accurately submit claims such as but not limited to the Pharmacy Call Center Phone numbers.

Figure 3.1-1 below shows an example of the *Minnesota Medicaid ID Card.*

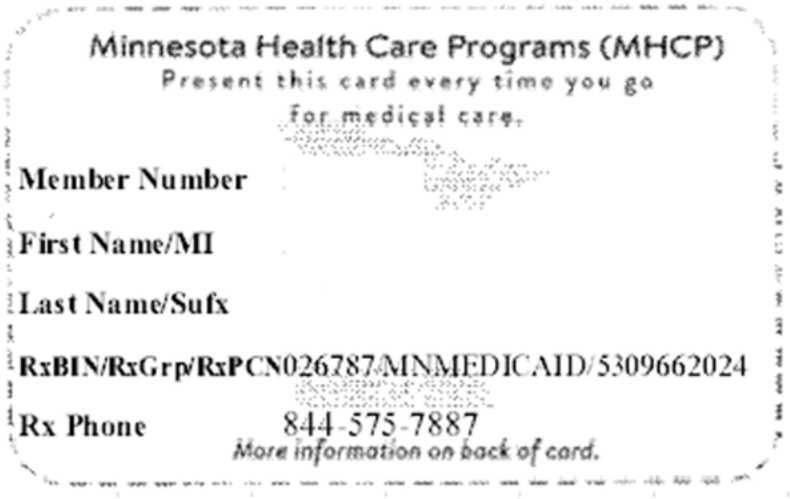

Figure 3.1-1: Minnesota Medicaid ID Card

Additional information regarding member eligibility and evidence of coverage can be found in the DHS MHCP Provider Manual online.

3.2 Claim Formats

Prime requires claims submission by POS for the Minnesota FFS Medicaid program. Web Claims Submission may be allowed in certain circumstances. The following standard formats are accepted.

Billing Media	NCPDP Version
POS	NCPDP D.0
Web Claims Submission	NCPDP D.0

3.3 Point-of-Sale – NCPDP Version D.0

As part of claims processing, Prime uses an online POS system to provide submitters with real-time online information on the following:

- Member eligibility
- Claim status
- Drug coverage
- Dispensing limits
- Pricing
- Payment information
- ProDUR

The POS system is used in conjunction with a pharmacy's in-house operating system. While there are a variety of different pharmacy operating systems, the information contained in this manual specifies only the response messages related to the interactions with the Prime online system and not the technical operation of a pharmacy's in-house-specific system. Pharmacies should check with their software vendors to ensure their system is able to process as per the payer specifications sheet.

3.3.1 Supported POS Transaction Types

A pharmacy's ability to use these transaction types depends on its software. At a minimum, pharmacies should have the capability to submit original claims (B1) and reversals (B2). Other transactions listed in the table below are also supported.

- **Original Claims Adjudication (B1)** – This transaction captures and processes the claim and returns the dollar amount allowed under the program's reimbursement formula. The B1 transaction is the prevalent transaction used by pharmacies.
- **Claims Reversal (B2)** – This transaction is used by a pharmacy to cancel a claim that was previously processed. To submit a reversal, a pharmacy must void a claim that has received a PAID status and select the REVERSAL (Void) option in its computer system.

NCPDP D.0 Transaction Code	Transaction Name
B1	**Billing**
B2	**Reversal**
E1	**Eligibility Inquiry**

3.3.2 Required Data Elements

A software vendor utilizes Prime's payer specifications to set up a pharmacy's computer system to allow access to the required fields and to process claims. The Prime claims processing system has program-specific field requirements, e.g., Mandatory, Situational, and Not Required. The table below lists abbreviations that are used throughout the payer specifications to depict field requirements. For additional information, refer to the *NCPDP D.0 Payer Specifications* on the Minnesota Web Portal.

Code	Description
M	**MANDATORY** Designated as MANDATORY in accordance with the NCPDP Telecommunication Implementation Guide Version D.0. The fields must be sent if the segment is required for the transaction.
R	**REQUIRED** Fields with this designation according to this program's specifications must be sent if the segment is required for the transaction.
RW	**QUALIFIED REQUIREMENT** "Required when" the situations designated have qualifications for use ("Required if x," "Not required if y").

Claims are not processed without all the required (or mandatory) data elements.

Required (or mandatory) fields may or may not be used in the adjudication process. Also, fields not required at this time may be required at a future date.

Claims are edited for valid format and valid values on fields that are not required.

If data are sent in fields not required for processing as indicated by the payer specifications, the data are subjected to valid format/valid value checks. Failure to pass those checks result in claim denials.

- **Required Segments** – The transaction types implemented by Prime have NCPDP-defined request formats or segments.
- **Payer Specifications** – A list of transaction types and their field requirements are available online on the Minnesota Web Portal. These specifications list B1 and B2 transaction types with their segments, fields, field requirement indicators (mandatory, situational, optional) and values supported by Prime.
- **Program Setup** – The table below lists required values unique to plan programs.

NCPDP Field	NCPDP Field Name	Description/Value
101-A1	BIN Number	026787
104-A4	Processor Control #	5309662024
301-C1	Group	MNMEDICAID
444-E9	Provider ID #	National Provider Identifier (NPI) 10 bytes (numeric)
302-C2	Cardholder ID #	Cardholder ID up to 20 bytes (numeric)
411-DB	Prescriber ID #	Prescriber's individual NPI 10 bytes (numeric)
407-D7	Product Code	National Drug Code (NDC) 11 digits

3.4 Paper Claims

Paper claims are not accepted. Providers must submit claims electronically via POS.

4.0 Program Specifications

4.1 Plan Co-Pays and Exemptions

4.1.1 FFS Medical Assistance (Medicaid) and ADAP Co-Pays

FFS and ADAP members will not be subject to co-pays.

4.1.2 MinnesotaCare Co-Pays

The following table outlines the prescription co-payment schedule for MinnesotaCare members.

Description	Identified By
Generic and Multi-Source Preferred Brand Products	$10.00
Brand	$25.00
Note: • The following co-pays for Dates of Service (DOS) from 1/1/2023 to 12/31/2023 were applied: – Brand: $35.00 – Generic: $10.00 • The following co-pays for DOS prior to 1/1/2023 were applied: – Brand: $25.00 – Generic: $7.00	

4.1.2.1 MinnesotaCare Co-Pay Exemptions

The table below provides information related to members/services that are exempt from co-pays.

MinnesotaCare Co-Pay Exemptions
• Members < 21 years of age • American Indians enrolled in a federally recognized tribe are exempt from co-pays for claims submitted at any provider. • Preventive services with a rate of A or B from the United States Preventive Services Task Force, which includes smoking cessation products, pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of HIV. – Aspirin 81 mg – Folic Acid 0.4 mg and 0.8 mg – Vitamin D 400 IU – Breast Cancer Preventative Medications

MinnesotaCare Co-Pay Exemptions
– Tamoxifine – Raloxifene – Aromatase Inhibitors – Tobacco Cessation Products ▪ Nicotine Patches, Lozenges, Gum ▪ Bupropion HCl SR (Zyban) ▪ Varenicline Tartrate (Chantix) – Certain mental health drugs: ▪ Anti-Anxiety Drugs ▪ Anti-Anxiety Drugs/Dietary Supplements ▪ Anti-Anxiety Benzodiazepine/Antispasmodic Combinations ▪ Antipsyc, Dopamine Antag., Diphenylbutylpiperidines ▪ Antipsychotics-Atypical, D3/D2 Partial AG-5HT Mixed ▪ Antipsychotics, Atyp, D2 Partial Agonist/5HT Mixed ▪ Antipsychotics, Dopamine and Serotonin Antagonists ▪ Antipsychotics, Dopamine Antagonists, Thioxanthenes ▪ Antipsychotics, Dopamine Antagonists, Butyrophenones ▪ Antipsychotics, Dopamine Antagonists, Dihydroindolones ▪ Antipsychotics, Phenothiazines ▪ Serotonin 5-HT2A Inverse Agonists

4.2 Timely Filing Limits

Claims that exceed the maximum filing limit of 365 days will deny with *NCPDP EC 81 – Claim too old* with the additional message, *"Timely filing exceeded."*

4.3 Dispensing Limits/Claim Restrictions

The FFS Medicaid plan may have dispensing limits/claim restrictions. Refer to the Preferred Drug List (PDL) and Drug Search listed on the Minnesota Medicaid Web Portal.

Please review the reject responses on the claim and contact the PSC at 844-575-7887 if further information is needed.

PA criteria are posted on the DHS website online.

Dispensing Quantity Limitations

The maximum allowable quantity for all drugs is a 34-day supply, unless one of the following is true:

- Product is birth control (may be dispensed in up to 365-day supplies); **OR**
- Product is listed on the 90-Day Supply Prescription Drug List; **OR**
- Member's primary insurance requires a 90-day supply be dispensed; **OR**
- If the smallest available package size would exceed a 34-day supply and the package is unbreakable; **OR**
- An extra supply is needed for members who need one for home and one for school or work (i.e., rescue inhaler)

Note: Providers may contact the CSC at 844-575-7887 for possible overrides in relation to the last two bullets above.

Providers should reference the PDL and Drug Search on the Minnesota Medicaid Web Portal for information related to drug/product-specific quantity per day and days' supply limitations.

4.3.2 Cost Ceiling

4.3.2.1 Cost Ceiling for FFS

A cost ceiling of $75,000.00 will apply for all drugs for FFS members.

Claims submitted that exceed $75,000.00 will deny *NCPDP EC 78 – Cost Exceeds Maximum*. Please refer to the specific reject response or contact the CSC at 844-575-7887 for assistance and possible override.

The following products will be exempt from the cost ceiling:

- Bleeding Disorder products (Antihemophilic factors, ITP)
- Immune Globulins
- Antineoplastic Agents

4.3.2.2 Cost Ceiling for ADAP

A cost ceiling of $15,000.00 will apply for all drugs for ADAP members.

Claims submitted that exceed $15,000.00 will deny *NCPDP EC 78 – Cost Exceeds Maximum.* Please refer to the specific reject response or contact the CSC at 844-575-7887 for assistance and override.

The following products will be exempt from the cost ceiling:

- Bleeding Disorder products
- Immune Globulins
- Antineoplastic Agents

- Daraprim

4.3.3 Refills

For non-controlled products, the system will automatically check for an increase in dose from the same prescriber, submitted by the same pharmacy as the previous claim, and when found, the system will not deny the current claim for early refill.

The following table provides the refill and date to prescription written limitations by product schedule.

Claims exceeding the refill limitation will deny *NCPDP EC 76 – Plan Limitations Exceeded*.

Claims exceeding the date to prescription written limitation will deny *NCPDP EC M4 – Prescription/Service Reference Number/Time Limit Exceeded*.

Note: The limitations below are applied to whichever is exceeded first.

Drug Schedule	Refill Limitations	Date to Rx Written Limitations
DEA Schedule 0	Original and 25 Refills **Note:** 80% of the previously dispensed days' supply must be exhausted before being able to refill.	365 days from original Date Rx Written
DEA Schedule 2	No refills allowed	365 days from original Date Rx Written
DEA Schedule 3 and 4	Original and 5 Refills	180 days from original Date Rx Written
DEA Schedule 5	Original and 25 Refills	365 days from original Date Rx Written

4.3.4 Controlled Product Limitations

4.3.4.1 Morphine Milligram Equivalent

Prime will utilize current Centers for Disease Control and Prevention (CDC) guidelines to establish a Maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy, notifying the provider of the excessive dose risk.

Claims submitted for an opioid product, in conjunction with additional opioids in member history that exceed 120 MME will not reject but will return a supplemental message of *"Maximum 120 MME exceeded.*"

Individual product quantity limits for opioids have been established by DHS to align with a 90 MME per day per claim limit. Claims submitted with quantities that exceed the established quantity limits will deny *NCPDP EC 76 – Plan Limitations Exceeded*.

4.3.4.2 Opioid Limitations

Claims submitted for opioid products have the following limitations:

- 7-day quantity limit for new opioids
  - 'New' is defined as a member not having a paid claim for the same product* within the last 90 days.
  - Claims submitted for new opioids for > 7 days' supply will deny *NCPDP EC 76 – Plan Limitations Exceeded*.
  - Other limitations and any other edits (i.e., PA required, age limitations) will still apply to new opioids.
- Claims submitted for a member with a paid claim for the same product* within the last 90 days will not be restricted to a 7-day supply. Existing quantity limits (i.e., 34-day supply) and any other edits will still apply.
- **Note:** Select controlled products are covered for ADAP members. When using the Drug Search tool, providers should select Major Program: HH to search for covered products related to the ADAP program.
- *Same product equates to HICL Sequence Number (HSN).

4.4 Partial Fills

Partial fills are not allowed. Claims submitted as a partial fill will be denied *NCPDP EC RK – Partial Fill Transaction Not Supported.*

4.5 Incremental Fills

Incremental fills are not allowed. Claims submitted as an incremental fill will be denied *NCPDP EC RK – Partial Fill Transaction Not Supported.*

4.6 Dispense as Written Requirements

The following Dispense As Written (DAW) codes will be accepted. These codes are to allow appropriate reimbursement for brand-name products. All edits will apply, and the use of a DAW code will not override claim edits.

Note: Claims submitted for a generic product, using DAW 0, 1, or 9 will not be denied; they will continue through adjudication and process accordingly.

DAW Code	DAW Description	Comments
DAW 0	No Product Selection Indicated	
DAW 1	Substitution Not Allowed by Prescriber	Claims submitted for a brand product with a DAW 1 will require a PA and deny *NCPDP EC AJ – Generic Drug Required* and return the addition unless a PA for the DAW 1 is on file for the drug.
DAW 9	Substitution Allowed by Prescriber but Plan Requests Brand	To be used when the brand product is preferred over the generic equivalent.

Claims submitted for DAW codes 2, 3, 4, 5, 6, 7 or 8 will deny *NCPDP EC 22 – M/I Dispense as Written (DAW)/Product Selection Code*.

4.7 Vacation Fills

Vacation overrides are not allowed.

Overrides may be granted by the Call Center (844-575-7887) if it is necessary for medically necessary travel.

4.8 Lost, Stolen, and Damaged Medication

Overrides for lost, stolen or damaged medication may be granted by the Call Center (844-575-7887) and will be limited to one override per 12 months.

4.9 Tamper-Resistant Pads

The Centers for Medicare & Medicaid Services (CMS) requires that tamper-resistant prescription pads be used for all written prescriptions to be eligible for reimbursement. The definition of tamper resistance is defined on the CMS website and includes meeting all the following industry-recognized requirements:

- Using one or more features to prevent copying/replication; **AND**
- Using one or more features to prevent erasure or modification and have features to prevent the use of counterfeit prescription forms.

4.10 Restricted Recipients

DHS's Minnesota Restricted Recipient Program (MRRP) identifies members who have used services at a frequency or amount that is not medically necessary or who have used health services that resulted in unnecessary costs to MHCP.

Once identified, restricted recipients are placed under the care of a designated Primary Care Physician (PCP), and/or pharmacy provider for a 24-month period.

Restricted recipients will be required to have all prescriptions written by their designated PCP (if applicable) and required to fill all medications at their designated pharmacy (if applicable.)

Claims submitted for a restricted recipient, using a non-designated Pharmacy NPI, will deny *NCPDP EC 50 – Non-Matched Pharmacy Number*.

Claims submitted for a restricted recipient, using a non-designated PCP NPI, will deny *NCPDP EC 56 – Non-Matched Prescriber ID*.

Providers with questions related to restricted recipients should call the Minnesota Restricted Recipient Program (MRRP) at 800-657-3674 or refer to the MHCP Provider Manual online for assistance.

4.11 Spenddown

Certain MN Medicaid members (excluding those eligible under MN ADAP) may have a monthly or six-month spenddown that must be met.

Claims submitted for a member with a spenddown will enforce the maximum amount on each claim until the spenddown has been met.

- For example:
  - Member has a spenddown amount of $50.00; a claim is submitted with a cost (based on the submitted Usual and Customary (U&C)) of $20.00. The member will be responsible for the full $20.00, leaving a remaining amount of $30.00 for the monthly spenddown.
  - Member has a spenddown amount of $50.00; a claim is submitted with a cost (based on submitted U&C) of $60.00. The member will be responsible for $50.00, and the remaining $10.00 will be paid by MN Medical Assistance.
  - Additional information about MHCP Spenddown can be found in the MHCP Provider Manual online.

5.0 Drug Information and Edits

5.1 Covered and Non-Covered Drugs

All medically necessary, Food and Drug Administration-approved drugs are covered unless the product is non-rebateable or specifically excluded as a non-benefit. When a drug requires a PA for payment, it is still "covered".

MHCP PMM utilizes a uniform PDL across the fee-for-service program and all contracted Managed Care Organizations. The PDL indicates the preferred and non-preferred status of covered drugs within a PDL category. The PDL is available on the Minnesota Medicaid Web Portal.

Drugs excluded from coverage will deny *NCPDP EC 70 – Product/Service Not Covered*.

Claims submitted for generic products, where the brand is preferred, will deny *NCPDP EC 606 – Brand Drug/Specific Labeler Code Required* with the additional message *"Brand product preferred."*

Some additional information is listed on the following pages for specific categories.

Drug Edits		
Description	**Example(s)**	**Comments**
Bulk Chemicals	Excluded, except for compound claims	Bulk chemicals that are submitted on a non-compound claim will deny for NCPDP EC 8H – Product/Service Only Covered on Compound Claim.
Cosmetic Drugs	Latisse, Botox Cosmetic, Rogaine	Drugs for cosmetic use or to treat hair loss and are excluded and will deny *NCPDP EC 70 – Product/Service Not Covered*
Cough and Cold Preparations	Benzonatate, Tessalon, Zonatuss, Promethazine with codeine	Limited cough and cold preparations are covered by FFS. Covered products include: • Guaifenesin and Dextromethorphan • Guaifenesin tablets • Guaifenesin and Codeine • Guaifenesin syrup • Guaifenesin and Hydrocodone syrup Non-covered cough and cold preparations will deny *NCPDP EC 70 – Product/Service Not Covered*.

Drug Edits		
Description	**Example(s)**	**Comments**
Drug Efficacy Study Implementation (DESI), Identical, Related, and Similar (IRS)/Less than Effective (LTE)	Midrin, Anusol HC Suppositories	Claims submitted for drugs identified as a DESI product are not considered a covered outpatient drug and will deny with NCPDP EC 70 – Product/Service Not Covered with Supplemental Message “DESI products are not covered.”
Erectile Dysfunction Drugs	Addyi, Viagra	Claims submitted for drugs used in the treatment of erectile dysfunction and female sexual dysfunction are excluded and will deny NCPDP EC 70 – Product/Service Not Covered. Note: Cialis 5 mg is covered via PA for Benign Prostatic Hyperplasia.
Fertility Drugs	Clomiphene	Claims submitted for drugs used in the treatment of infertility are excluded and will deny NCPDP EC 70 – Product/Service Not Covered.
Fexofenadine	Allegra, Allegra-D, fexofenadine, fexofenadine with pseudoephedrine	Claims submitted for fexofenadine are excluded and will deny *NCPDP EC 70 – Product/Service Not Covered*.
Cannabis	Medical marijuana	Claims submitted for medical Cannabis are not covered and will deny *NCPDP EC 70 – Product/Service Not Covered*.
Medical Foods	Deplin, Gabadone	Claims submitted for medical foods are excluded from the pharmacy benefit and will deny *NCPDP EC 70 – Product/Service Not Covered*.
Melatonin	Melatonin	Claims submitted for Melatonin are not covered and will deny *NCPDP EC 70 – Product/Service Not Covered*.
Nutritional Drinks and Shakes	Boost, Ensure, Glucerna	Claims submitted for nutritional drinks and shakes are not covered through the pharmacy benefit and will deny *NCPDP EC 70 – Product/Service Not Covered*.
Probiotics	Align, Culturelle, Florajen	Claims submitted for probiotics are not covered and will deny *NCPDP EC 70 – Product/Service Not Covered*.

Drug Edits		
Description	**Example(s)**	**Comments**
Vaccines	Pneumovax, Fluzone	Vaccine claims are not a covered pharmacy benefit and should be submitted via medical claim. Claims submitted for vaccines at POS will deny *NCPDP EC 70 – Product/Service Not Covered* and return the additional message *"Submit as 837P professional claim*."
Dummy NDCs		Claims submitted for a dummy NDC will reject *NCPDP EC 54 - Non-Matched Product/Service ID Number*.
Rebate	Required	Claim will deny with *NCPDP EC 70 – Product/Service Not Covered* with additional message "Non-rebateable product." Exceptions to the edit, for example, Medical Supplies, APIs, Certain OTCs.
Repackaged		Claims submitted for repackaged products that are not included in the federal Medicaid rebate program will deny *NCPDP EC 645 – Repackaged prod not covered by contract* with the additional message *"Repackaged product not covered."*
Unit of Measure (UOM)	• EA = Each • GM = Grams • ML = Milliliters	Submission of UOM is required. Claims submitted without a UOM will deny with *NCPDP EC 26 – M/I Unit of Measure*.

5.2 Over-the-Counter Products

All Over-the-Counter (OTC) products are subject to adjudication edits where applicable. Non-covered OTC products will deny *NCPDP EC 70 – Product/Service Not Covered*.

Pharmacy providers may prescribe and dispense OTC products in accordance with M.S. 256B.0625.

The following policies are applicable to pharmacists prescribing OTC products:

- OTC medication must be medically necessary, and the member must not need a referral to another health care professional.
- The pharmacist must review the member's drug therapy for potential adverse interactions.
- The pharmacist must provide drug counseling consistent with Minnesota Rules, 6800.0910.

- The pharmacy is required to keep a prescription on file as defined in Minnesota Statutes, 151.01, subdivision 16 for five (5) years.
  - When a pharmacist provides OTC products to members, the pharmacist is the prescriber who must sign the prescription.
  - Prescriptions may be refilled for up to 12 months as specified in Minnesota Rules, 6800.3510.
- The OTC product must be dispensed in accordance with all relevant sections of Minnesota Status, 151 and Minnesota Rules, 6800.
- Pharmacists must submit claims using the MHCP PMM pharmacy's National Provider Identifier (NPI) number as the prescriber number.
- The pharmacist must document the prescription information regarding medical necessity, drug therapy reviews, and drug counseling for the initial fill. For refills, the pharmacist must document in the member's profile any updated information related to medical necessity, drug therapy reviews and drug counseling.
- The pharmacy must dispense the lesser amount of the OTC product needed by the member for a 34-day supply, or the entire package of the product.

Pharmacy providers may use the Prime Drug Search to confirm if the OTC product is covered. Select OTCs are covered for ADAP members. When using the Prime Drug Search tool, providers should select Major Program: HH to search for covered products related to the ADAP program.

Note: Schedule V products are not considered OTC.

5.3 Diabetic Supplies

Diabetic testing supplies, including meters, test strips, lancing devices, lancets, pen needles, insulin syringes and control solutions, are covered as a pharmacy benefit.

Preferred blood glucose meters and strips will not require PA. Claims submitted for non-preferred diabetic testing supplies will deny *NCPDP EC 75 – Prior Authorization Required*.

Preferred Blood Glucose Monitors:

Product	NDC
Accu-Chek Guide	65702072910 65702061710 65702070204
Accu-Chek Guide Me	65702073110
Contour	00193718901

Product	NDC
Contour Next	00193737701
Contour Next EZ	00193725201
Contour Next ONE	00193781801
Additional Notes	
• Limit of 1 per year. Claims submitted that exceed this limitation will be denied *NCPDP EC 76 – Plan Limitations Exceeded* with the proposed message *"Call manufacturer to request additional meter."*	

Preferred Blood Glucose Testing Strips:

Product	NDC
Accu-Chek Aviva Plus Test Strips	65702040710 65702040810
Accu-Chek Guide	65702071210
Accu-Chek Smartview Test Strips	65702049210 65702049310
Contour Test Strips	00193707025 00193709021 00193708050
Contour Next Test Strips	00193731025 00193731150 00193731221
Additional Notes	
• Limit of 100 or 102 per 30 days (depending on package size). Claims submitted that exceed this limitation will be denied *NCPDP EC 76 – Plan Limitations Exceeded* with the proposed message *"Limited to 100 or 102 per 30 days."* Medically necessary requests to exceed the limit must be submitted as a PA request.	

Most miscellaneous diabetic testing supplies (e.g., control solution, lancing device, lancets) are covered. Providers may use the Prime Drug Search to confirm if the product is covered.

Miscellaneous Supplies:

Product	Maximum Quantity Allowed
Control Solution	1 bottle per month
Lancing Device	1 device per month

Product	Maximum Quantity Allowed
Lancets	400 lancets per month
Pen needles	10 per day
Additional Notes	
• Claims submitted that exceed the above limitations will be denied *NCPDP EC 76 – Plan Limitations Exceeded*.	

The following supplies are not a covered pharmacy benefit and will deny *NCPDP EC 70 – Product/Service Not Covered*:

- Alcohol swabs
- Syringes and needles
- Insulin pump supplies

Claims submitted for dual-eligible members should not be billed as a pharmacy claim. Medicare should be billed first, and the crossover sent to MHCP PMM as an 837P claim. All other third-party claims will follow coordination of benefits outlined in *Section 8.0 – Coordination of Benefits.*

Claims that exceed a 34-day supply should be submitted using the smallest package size available. If the smallest package size would result in a 90-day supply, the provider must submit the claim with 90 days as the days' supply.

5.4 Family Planning Drugs

Members eligible for the Minnesota Family Planning Program (MFPP) are eligible for a limited set of prescription drugs. Refer to the MFFP website for additional information.

Pharmacy providers may use the Prime Drug Search tool to see the list of covered contraceptives, anti-infectives and antifungals. To search for a product, use the NDC or product name and change the major program to "FP."

Coordination of Benefits (COB) will apply.

MFPP reimbursement rates are the same as MHCP PMM FFS reimbursement rates (see *Section 11.0 – Provider Reimbursement* for additional information.)

5.5 Age Restrictions

The PDL may contain products with age restrictions.

When the product has either a minimum or maximum age requirement and the member age does not meet that requirement, the claim will reject with *NCPDP EC 60 – Product/Service Not Covered for Patient Age*.

5.6 Physician-Administered Drugs

A Physician-Administered Drug (PAD) refers to a medication administered to a patient by a health care professional, typically in a clinical setting such as a hospital, clinic or doctor's office. PAD claims must be billed via an 837P medical claim to DHS. Claims are not covered when dispensed by a pharmacy to a member, or shipped to a clinic, for administration in a clinic or other outpatient facility. Pharmacies, including mail-order pharmacies who are providing the drugs for a clinic visit, may not bill MHCP PMM for the drugs dispensed if they are to be administered in a clinic or other outpatient facility.

Claims submitted for a PAD product, for a member in certain long-term care/skilled-nursing facilities, will be allowed to be billed as a pharmacy claim. PA may be required. Claims submitted where a primary payer requires the PAD drug to be submitted as a pharmacy claim will also be allowed to be billed as a pharmacy claim and will adjudicate accordingly.

Outside of these situations, prior authorization is required. Please contact the Prime Clinical Call Center for assistance.

Note: PAD pharmacy claims will only be allowed for ADAP members when the primary payer requires the claim to be submitted as a pharmacy claim and the drug is included in the ADAP benefit.

6.1 Prior Authorizations

The Prime Clinical Call Center will receive PA requests for products that require PA or have clinical edits. PA requests are made by the prescribing physician or the prescribing physician's agent (must be a documented agent). Requests may be initiated by telephone, fax or WebPA. PA requests should not be completed by the pharmacy. PA requests submitted by the pharmacy, and not the prescribing physician or prescribing physician's agent, will be denied.

6.1.1 Reconsiderations and Appeals

Reconsideration of a PA denial can be requested within thirty (30) days of the initial denial. The member's denial letter will contain a *Reconsideration Form*. Reconsiderations will be reviewed and processed in the same way as initial PA requests.

PA appeals will be handled by the Minnesota Department of Human Services (DHS). An appeal can be requested within thirty (30) days of the initial denial, or the reconsideration denial for the specific drug. If a request for an appeal is made, members should contact DHS at:

- Minnesota Department of Human Services
  Appeals Division
  P.O. Box 64941
  St. Paul, MN 55164-0941
- Fax Number: 651-431-7523

6.2 Emergency Protocols

Pharmacy providers may dispense up to a 72-hour supply of a covered medication in emergency situations.

Emergency claims will be allowed for both non-controlled and controlled products and will only override the PA requirement for rebate-eligible covered drugs; all other edits (i.e., quantity limitations, days' supply) will apply.

Emergency claims will be limited to **one** (1) emergency fill, per product and strength, per 30 days. Claims submitted that exceed this limitation will be denied *NCPDP EC 76 – Plan Limitations Exceeded*.

Beginning November 4, 2024, emergency claims may be submitted at POS and will be identified by a 'Level of Service (NCPDP Field ID: 418-DI): 3 – Emergency' being entered on the incoming claim.

Note: Pharmacy providers should contact the Call Center at 844-575-7887 for possible override of unbreakable packages.

7.0 Prospective Drug Utilization Review

ProDUR encompasses the detection, evaluation and counseling components of pre-dispensing drug therapy screening. The ProDUR system of Prime assists in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing assists the pharmacists to ensure that their patients receive the appropriate medications.

Because the Prime ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. Pharmacists use their education and professional judgments in all aspects of dispensing.

7.1 Drug Utilization Review Edits

ProDUR edits related to Early Refill (excluding increases in dose for non-controlled products from the same prescriber) will require a call to the Call Center to obtain a possible override.

The following ProDUR edits will deny for the plan:

- Early Refill (ER)
  - The early refill tolerance for non-controlled substances is 80% and 85% for controlled substances.
  - Early Refill accumulation limitations will also apply. This limitation will add up the days' supply for each time a drug is filled early. Claims submitted for the same Generic Sequence Number, where there is a total of 7 days' supply that has been filled in the last 102 days, will deny and an override will not be allowed. Once a member has accumulated an additional 7 days' worth of a drug in the last 102 days, the early refill tolerance for that drug will be 100% of the days' supply.
- Drug to Drug (DD)
- Maximum Daily Dosing (HD)

7.2 ProDUR Overrides

The following table provides the NCPDP interactive Professional Service, Result of Service, and Reason for Service codes. These codes may be used to override ProDUR denials at the POS.

Note: Override codes must be entered each time an error occurs.

Problem/Conflict Type: The following override codes may be used by providers for any situation in which a provider-level override is allowed for ProDUR denials.

Claims submitted with service codes that are not applicable to the Reason for Service codes outlined in the below table will continue to reject *NCPDP EC 88 – DUR Reject Error.*

Reason For Service Code(s)	Provider Override Allowed?	Applicable Professional Service Code(s)/Description	Applicable Result of Service Code(s)/Description
DD – Drug-Drug Interaction HD – High Dose	Y	00 – No Intervention M0 – Prescriber Consulted P0 – Patient Consulted R0 – Other Source Consulted	00 – Not Specified 1A – Filled As Is, False Positive 1B – Filled As Is 1C – Filled With Different Dose 1D – Filled With Different Drug 1E – Filled With Different Directions 1F – Filled With Different Quantity

All ProDUR alert messages appear at the end of the claim's adjudication transmission.

Alerts appear in the following format:

Format	Field Definitions
Reason for Service	Up to three characters. Code transmitted to pharmacy when a conflict is detected (e.g., ER, DD, HD).
Severity Index Code	One character. Code indicates how critical a given conflict is.
Other Pharmacy Indicator	One character. Indicates if the dispensing provider also dispensed the first drug in question. • 1 = Your Pharmacy • 3 = Other Pharmacy
Previous Date of Fill	Eight characters. Indicates previous fill date of conflicting drug in YYYY/MM/DD format.

Format	Field Definitions
Quantity of Previous Fill	Five characters Indicates quantity of conflicting drug previously dispensed.
Database Indicator	One character. Indicates source of ProDUR message. • 1 = First Databank • 4 = Processor Developed
Other Prescriber	One character. Indicates the prescriber of conflicting prescription. • 0 = No Value • 1 = Same Prescriber • 2 = Other Prescriber

8.0 Coordination of Benefits (COB)

Minnesota Medical Assistance is the payer of last resort. Providers must bill all other payers first. COB edits will be applied when Third-Party Liability (TPL) exists for the member on the DOS of the claim.

TPL refers to:

- An insurance plan or carrier
- A program
- A commercial carrier

The plan or carrier can be:

- An individual
- A group
- Employer-related
- Self-insured, and a self-funded plan

The terms *Third-Party Liability* and *other insurance* are used interchangeably to mean any source other than the plan that has a financial obligation for health care coverage.

Note: ADAP will always be the payer of last resort.

***Prior authorization is not required for claims submitted if a Third-Party Payer has made payment equal to or greater than 60 percent of the maximum allowed payment amount for the service under medical assistance.**

***See 256B.0625 Subd. 25b(c)**

8.1 COB General Instructions

8.1.1 COB Process

COB processing requires that the Other Payer Amount Paid, Other Payer ID, Other Payer Date, and Other Payer Patient Responsibility be submitted on the claim to the plan. Pharmacy providers are asked to submit the TPL carrier code when coordinating claims for payment with a primary payer.

System returns Other Payer details in the “COB Response Segment” (items returned are subject to information received on the member’s COB records):

Other Payer Details	
Other Payer Coverage Type	Other Payer ID Qualifier
Other Payer ID	Other Payer Processor Control Number (PCN)
Other Payer Cardholder ID	Other Payer Group ID
Other Payer Person Code	Other Payer Help Desk Phone Number
Other Payer Patient Responsibility Code	Other Payer Benefit Effective Date
Other Payer Benefit Termination Date	

Reimbursement will be calculated to pay the lesser of MHCP PMM’s maximum allowed amount, less than the third-party payment, or the Other Payer Patient Responsibility as reported by the primary carrier.

MinnesotaCare co-payments will also be deducted for participants’ subject to co-pay. In some cases, this may result in the claim billed to DHS being paid at $0.00.

The following are values and claim dispositions based on pharmacist submission of standard NCPDP TPL codes. Where applicable, it has been noted which **Other Coverage Code** should be used based on the error codes received from the primary carrier.

TPL Codes		
NCPDP Field #308-C8	**When to Use**	**Submission Requirements/Responses**
0 – Not Specified	Other Coverage Code (OCC) 0 is allowed; submit when recipient does not have TPL.	• Claim will reject with NCPDP EC 41 – Submit Bill to Other Processor or Primary Payer if member has TPL. • Additional fields in the COB segment should not be submitted with this OCC.
1 – No Other Coverage	OCC 1 is not allowed.	• Claim will reject with NCPDP EC 13 – M/I Other Coverage Code when claim is submitted with OCC1. • If a member has TPL on file and the TPL is no longer active, the member should contact their county or tribal processing agency or the DHS Health Care Consumer Support (HCCS) help-desk to have their enrollment record updated.

TPL Codes		
NCPDP Field #308-C8	**When to Use**	**Submission Requirements/Responses**
2 – Other Coverage Exists, Payment Collected	OCC 2 is allowed, submit when any positive amount of money is collected from another payer.	• Claim will adjudicate when all applicable fields are completed. • Claims submitted without applicable COB fields will reject *NCPDP EC 6G – Coordination of Benefits/Other Payments Segment Required for Adjudication.* **Note**: OCC2 should be utilized for ADAP members with MinnesotaCare, and/or Medicare Part D for coverage of co-pays.
3 – Other Coverage Exists, Claim Not Covered	OCC 3 is allowed, submit when the member has TPL, but the drug is not covered by the primary payer.	• Claim will adjudicate when all applicable fields are completed and one of the reject codes listed in the OCC3 – Other Payer Reject Code List is entered in the applicable field. • Pharmacies may utilize OCC 3 and the appropriate reject code for members that have a TPL record on their file, but the TPL record is no longer active. If a member has TPL on file and the TPL is no longer active, the member should contact their county or tribal processing agency or the DHS Health Care Consumer Support (HCCS) help-desk to have their enrollment record updated.
4 – Other Coverage Exists, Payment Not Collected	OCC 4 is allowed, submit when member has TPL, but no payment is collected from the primary insurer.	• Claim will adjudicate when all applicable fields are completed.
8 – Claim Billing for a Co-Pay	OCC 8 is not allowed.	• Claims submitted with OCC 8 will deny *NCPDP EC 6G – Coordination of Benefits/Other Payments Segment Required for Adjudication* and *NCPDP EC 13 – Missing/Invalid Other Coverage Code.*

For additional information related to NCPDP field submission requirements, refer to the *Payer Specifications* document on the Minnesota Medicaid Web Portal.

8.1.2 OCC 3 Reject Codes

COB claims will deny *NCPDP EC 6E – M/I Other Payer Reject Code* for Standard TPL when the pharmacy submits an OCC 3 (Other Coverage Exists, Claim Not Covered) indicating the Other Payer denied the claim and the Other Payer Reject Code is not found in the table below:

NCPDP Reject Codes	Description/Explanation
60	Product/Service Not Covered for Patient Age
65	Patient Is Not Covered
67	Filled before coverage effective
68	Filled after coverage expired
69	Filled after coverage terminated
7Y	Compound Not Covered
70	Product/Service Not Covered
A5	Not Covered Under Part D Law
MR	Product Not On Formulary

8.2 Medicare Part B Crossover Claims

Medicare crossover claims are not processed as pharmacy claims. These claims must be submitted as an 837P professional claim.

Claims submitted for a member that is dual-eligible will deny *NCPDP EC AE – QMB (Qualifier Medicare Beneficiary)* and return the additional message, *"Member Part B eligible. If drug covered by Part B, submit as 837P professional claim, otherwise product not covered."*

8.3 Medicare Part D COB

MHCP PMM does not support wrap-around/secondary coverage for members with Medicare Part D coverage for Medicare Part D eligible products (except for members with MN ADAP coverage).

Claims submitted for a Medicare Part D eligible drug, for an FFS member who has active Medicare Part D coverage or who is Medicare Part D eligible, will deny *NCPDP EC 620 – This Product/Service May Be Covered Under Medicare Part D* and return the additional message, "*Bill Medicare Part D"*.

Claims submitted for a Medicare Part D covered drug, for an ADAP member who has active Medicare Part D coverage or who is Medicare Part D eligible, will continue through adjudication

and the claim will only pay for the member Medicare Part D copay as charged by the plan and indicated via OCC 2.

Claims submitted for a Medicare Part D excluded drug will continue through the adjudication process for members with Medicare Part D coverage.

9.0 Compound Claims

All compounds must be submitted using the NCPDP version D.0 standard multi-ingredient compound functionality. Therefore, all ingredients must be identified, their units must be indicated, and the ingredient cost for each ingredient must be submitted on the claim.

At least one product in the compound must be a covered drug. Any component of a compound requiring PA will necessitate an approval prior to receiving payment.

Important Notes:

- In order for compound claims to adjudicate and reimburse appropriately, providers should enter the following information in the applicable fields of the Claim Segment header:
  - A Compound Code (NCPDP Field ID: 406-D6) value of '2 – Compound' must be entered to identify the claim as a multi-ingredient compound.
  - A value of '00 – Not Specified' must be entered in the Product/Service ID Qualifier (NCPDP Field ID: 436-E1) field.
  - A value of '0' must be entered in the Product/Service ID (NCPDP Field ID: 407-D7) field.
    - For compound segment transactions, the claim is rejected if a single zero is not submitted as the Product ID.
  - The specific NDCs for each ingredient of the compound should be entered in the Compound Product ID (NCPDP Field ID: 489-TE) fields.
  - A Submission Clarification Code (SCC) (NCPDP Field ID: 420-DK) value of '8' allows a claim to continue processing if at least one ingredient is covered. Non-rebateable or non-covered ingredients will process with the SCC, but only rebateable and covered ingredients are eligible for reimbursement.
  - The Compound Type (NCPDP Field ID: 996-G1) is required to be submitted on all compound claims. If this field is not submitted, the claim will reject.
- Pharmacies must transmit the same NDC numbers that are being used to dispense the medication.
- Compound claims must contain at least two (2) ingredients. Single ingredient claims will deny *NCPDP EC 7Z – Compound Requires Two or More Ingredients*.
- MHCP will accept up to 25 ingredients on a compound claim. Compound claims that exceed this amount will deny with *NCPDP EC 9K – Compd Ing Component Cnt Exceeds Num Ing Supported.*
- If the total cost is not equal to the sum of the ingredients' cost, the claim will deny.
- Multiple instances of an NDC within a compound will not be allowed. These claims will deny with *NCPDP EC 21 – M/I Product/Service ID*.
- Duplicate edits are applied as appropriate.
- ProDUR processing considers like ingredients for editing.

- SNO-MED is a required field for compounds—the route of administration is required – NCPDP # ROUTE OF ADMINISTRATION (Field # 995-E2)

10.0 340B Drug Discount Program

The 340B Drug Discount Program is a federal program that requires drug manufacturers to provide covered outpatient drugs to certain eligible 340B-enrolled covered entities at significantly reduced prices.

Federal law prohibits duplicate discounts, which means that manufacturers are not required to provide both a discounted 340B price and a Medicaid drug rebate for the same drug. DHS is required to establish a mechanism that 340B covered entities must utilize to prevent duplicate discounts.

To identify 340B claims, receive applicable reimbursement and prevent duplicate discounts, 340B covered entities must submit an SCC (NCPDP Field ID: 420-DK) of '20 – 340B' on all claims utilizing 340B drugs at the time of submission.

Claims submitted by a 340B covered entity, with an SCC '20' entered on the claim, will continue through adjudication and if payable, reimburse at the 340B rate (see *Section 11.0 – Provider Reimbursement* for additional information.)

Claims submitted for a 340B provider, without an SCC '20' entered on the claim, will continue through adjudication and if payable, reimburse at the non-340B rate (see *Section 11.0 – Provider Reimbursement* for additional information). 340B covered entities do not need to maintain two provider enrollment records with DHS to submit claims for 340B drugs and non-340B drugs after November 4, 2024. Additional information about enrolling with DHS, disenrolling with DHS, or associating an enrollment with 340B eligibility can be found in the MHCP Provider Manual online.

Claims submitted for a non-340B provider, with an SCC '20' entered, will deny *NCPDP EC 6Z – Provider Not Eligible to Perform Service/Dispense Product* and return a supplemental message *"340B claims not allowed for non-340B pharmacies."*

If a 340B covered entity submits a claim without the SCC '20', the claim will be invoiced for the federal Medicaid drug rebate. A 340B covered entity may reverse, and resubmit, the claim within the 365 days of timely filing if it has been incorrectly submitted with, or without, the SCC '20'. Claims corrected within timely filing will automatically be credited, or invoiced, to manufacturers as part of the standard drug rebate processes. Claims outside of the 365 days of timely filing cannot be resubmitted through the MHCP PMM and the 340B covered entity would need to resolve any duplicate discounts with the manufacturers.

11.0 Provider Reimbursement

For any prescribed drug, the maximum payment is the lower of the following:

- National Average Drug Acquisition Cost (NADAC) and Dispensing Fee; **OR**
- Minnesota State Maximum Allowable Cost (SMAC) and Dispensing Fee; **OR**
- Pharmacy's U&C
- For drugs that do not have a published NADAC, or SMAC, the maximum payment is the lower of the Wholesale Acquisition Cost (WAC) – 2% and Dispensing Fee or the pharmacy's U&C charge.

Beginning November 4, 2024, Prime will be the MHCP PMM contracted vendor to maintain the SMAC list for generic drugs. Providers may contact the Call Center at 844-575-7887 with questions related to the SMAC program, or regarding specific SMAC prices. To initiate a SMAC price review, providers should complete the *Maximum Allowable Cost Price Research Request Form* found on the Minnesota Medicaid Web Portal.

The Centers for Medicare and Medicaid Services contracts with Myers and Stauffer, LLC to calculate and maintain NADAC pricing. The NADAC for single source brand name drugs will only include a NADAC (brand) but the NADAC for multisource brand name drugs and generic drugs may include both a NADAC (brand) and NADAC (generic). Additional information may be found on the Centers for Medicare & Medicaid Service Retail Price Survey webpage. To initiate a NADAC review for a drug, providers may complete the NADAC – Request for Medicaid Reimbursement Review form, or contact the NADAC Help Desk at 855-457-5264.

Claims for legend drugs with a DOS on or after July 1, 2019, will be subject to an additional 1.8 percent payment for the MinnesotaCare provider tax added to the maximum payment described above. The 1.8 percent does not apply to the dispensing fee, diabetic testing supplies, OTC products, Indian Health Service (IHS) claims, or for claims submitted where Medicaid/ADAP is not the primary payer.

11.1 340B Claims

For any 340B claims the maximum payment is the lower of the following:

- National Average Drug Acquisition Cost (NADAC) plus Dispensing Fee; **OR**
- Minnesota State Maximum Allowable Cost (SMAC) plus Dispensing Fee; **OR**
- The calculated 340B Ceiling Price Estimate (340B SMAC) plus Dispensing Fee; **OR**
- Pharmacy's U&C
- For drugs that do not have a published NADAC, SMAC or 340B SMAC the maximum payment is the lower of the Wholesale Acquisition Cost (WAC) 2% plus Dispensing Fee or the pharmacy's U&C charge.

Reminder: 340B claims from 340B covered entities must include the SCC '20' on the claim.

11.2 Indian Health Services and Reimbursement

American Indians (AI) and Alaska Natives (AN) enrolled in Medicaid or ADAP are eligible for covered pharmacy services of the applicable MHCP PMM program, even when services are provided through IHS or tribal facilities.

Payment for pharmacy services rendered shall be paid per visit/encounter. Rates are determined by the U.S. Department of Health and Human Services and are published each year in the Federal Register (see rates below).

Indian Health Service (IHS) Claim Encounter Rate(s)		
Claims submitted for IHS pharmacies will reimburse at the following OMB Encounter Rate (determined by the DOS of the claim)		
Effective Start Date	**Effective End Date**	**Value Amount**
01/01/2021	12/31/2021	$519.00
01/01/2022	12/31/2022	$640.00
01/01/2023	12/31/2023	$654.00
01/01/2024	12/31/2024	$719.00
01/01/2025	12/31/2025	$801.00

Additional Notes

- IHS pharmacy claims will not reimburse an additional dispensing fee as it is included in the encounter rate.
- Claims submitted for an identified IHS pharmacy and IHS member will be limited to 1 encounter rate, per member, per day, 2nd and subsequent claims for same member, and same NPI will be reimbursed at $0.00.
- Claims for DME or diabetic supplies will not reimburse at the encounter rate; they will reimburse at $0.00.
- Claims submitted for a non-IHS identified member at an IHS facility will not reimburse at the encounter rate; rather, they will reimburse at the 'lesser of' logic mentioned in above tables.
- Claims submitted for an IHS-identified member under MNCare will not reimburse at the encounter rate; rather, they will reimburse at the 'lesser of' logic mentioned in above tables and will be exempt from a co-pay.

Note: Compound claims will be treated as one covered outpatient drug.

12.0 Professional Dispensing Fees

12.1 Dispense Fee for Covered Outpatient Drugs, Compound Claims and IV Drugs

- Claims submitted prior to October 1, 2024, for covered outpatient drugs, will have a dispense fee of $10.77 per claim.
- Claims submitted on or after October 1, 2024, for covered outpatient drugs, will have a dispense fee of $11.55 per claim.

12.2 Dispense Fee for OTC Drugs

- Claims submitted for OTC products that are considered a covered outpatient drug will have a dispense fee of $10.77 per claim when dispensed in quantities ≥ the manufacturer's package size for claims submitted prior to October 1, 2024.
- Claims submitted on or after October 1, 2024, for OTC products considered a covered outpatient drug will have a dispense fee of $11.55 per claim when dispensed in quantities ≥ the manufacturer's package size.

Note: No more than $10.77 (for DOS prior to October 1, 2024), and no more than $11.55 (for DOS on or after October 1, 2024) will be reimbursed for the dispensing fee.

- Claims submitted for OTC products that are not considered a covered outpatient drug will have a dispense fee of $3.65 when the claim is dispensed in quantities ≥ the manufacturer's package size.

Note: The above-mentioned dispensing fees for OTC covered, or non-covered outpatient drugs, will be prorated when a claim is submitted for < than the manufacturer's package size.

13.0 Maximum Allowable Cost

Prime's Maximum Allowable Cost (MAC) program lists pricing for drugs that are reimbursed at an upper limit per unit price, based on current market sources. All products are reviewed on a regular basis and will be adjusted as needed based on market conditions. Prime MAC lists are updated at a minimum, every seven (7) days, or in accordance with applicable law. If the availability of a drug becomes limited, the MAC will be suspended, or the drug may be permanently removed from MAC lists at Prime's sole discretion. The drug may be added back when Prime market sources confirm adequate supply and distribution.

13.1 MAC Reimbursement Inquiry and Review Process

Prime has implemented an appeal process that allows providers to dispute MAC pricing of a covered prescription drug product by filing an appeal. This process also includes a timely filing review and investigation to resolve MAC disputes.

Pharmacies can appeal Prime MAC pricing by sending an appeal to e-mail or fax below:

- E-mail at StateMACProgram@PrimeTherapeutics.com
- Fax 888-656-1951.
- *MAC Appeal Research Request* forms for submission can be located on the Minnesota Medicaid Web Portal.

The following information must be provided to initiate the appeal process:

- *MAC Appeal Research Request Form* for each drug request for review
- A copy of the original invoice that contains the acquisition cost of the drug being appealed that coordinates with the NDC
- Pharmacy NPI, Member ID, Prescription number, and date of service.
- Generic drug name and NDC that coordinates with the claim reimbursement in question
- Once a MAC pricing appeal is submitted, the MAC Pricing Specialist will investigate the claim and proceed based on the following situations:
  - ALL information required for a review must be received to continue the review. If all the information is not received, then the provider will be notified of what is needed to continue the review.
  - An initial response to all inquiries from Medicaid-enrolled pharmacy providers within 24 hours.
    - **Note:** For inquiries received on weekends or holidays, an initial response shall be provided by the end of the next business day.
  - If a MAC change is warranted, a written response indicating the outcome of the appeal shall be sent to the requesting provider within three business days.

For appeals submitted for non-MAC reimbursement, a response will return on how it was paid and who to contact for further help.

14.0 Definitions, Abbreviations and Acronyms

Term	Definition
ADAP	AIDS Drug Assistance Program
BIN	Banking Identification Number
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
CSC	Clinical Support Center
DAW	Dispense as Written
DD	Drug-to-Drug
DEA	Drug Enforcement Administration
DESI	Drug Efficacy Study Implementation
DHS	Department of Human Services
DOS	Date of Service
DUR	Drug Utilization Review
e-Prescribing	Electronic Prescribing
ER	Early Refill
FFS	Fee-For-Service
HD	High Dose
HSN	HICL Sequence Number
ID	Identification
IHS	Indian Health Service
IRS	Identical, Related, and Similar
LTC	Long-Term Care
LTE	Less than Effective
MAC	Maximum Allowable Cost
MFPP	Minnesota Family Planning Program
MHCP PMM	Minnesota Health Care Programs Pharmacy Modernization Module
MME	Morphine Milligram Equivalent
MRRP	Minnesota Restricted Recipient Program
NADAC	National Average Drug Acquisition Cost

Term	Definition
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
OCC	Other Coverage Code
OTC	Over-the-Counter
PAD	Physician-Administered Drugs
PAs	Prior Authorizations
PE	Presumptive Eligibility
PCN	Processor Control Number
PCP	Primary Care Physician
PDL	Preferred Drug List
PEP	postexposure prophylaxis
POS	Point-of-Sale
PrEP	pre-exposure prophylaxis
Prime	Prime Therapeutics State Government Solutions, LLC
ProDUR	Prospective Drug Utilization Review
PSC	Pharmacy Support Center
SCC	Submission Clarification Code
SMAC	Minnesota State Maximum Allowable Cost
TPL	Third-Party Liability
U&C	Usual and Customary
UOM	Unit of Measure
WAC	Wholesale Acquisition Cost

15.0 Appendix A – Directory

Provider Services	Phone Number/Email/Web Address	Availability/Comments
Prime Pharmacy Call Center (will connect callers to both the PSC & CSC)	Phone: 844-575-7887 Fax: 866-390-2778	24/7/365
Prime MN Medicaid Web Portal	https://minnesota.primetherapeutics.com/	
PA Appeals	MN Department of Human Services (DHS) Appeals Division P.O. Box 64941 St. Paul, MN 55164-0941 Fax No.: 651-431-7523	
Member Enrollment, ID Cards, Medical Benefit, Locating Pharmacies	DHS Health Care Consumer Support Phone: 800-657-3672	Monday-Friday 8:00 AM to 5:00 PM CT
MHCP Provider Enrollment	MN Provider Resource Center Phone: 800-366-5411	Monday-Friday 8:00 AM to 4:15 PM CT (closed from noon to 12:45 PM CT)
Provider Payments	MN Provider Resource Center Phone: 800-366-5411	Monday-Friday 8:00 AM to 4:15 PM CT (closed from noon to 12:45 PM CT)
Emergency Medical Assistance Care Plan Certification	Acentra Phone: 844-810-1472 Fax: 844-472-3779	
Minnesota DHS Office of Inspector General Fraud, Waste or Abuse Hotline	Phone: 800-657-3750 Email: OIG.Investigations.DHS@state.mn.us Hotline form	Sending a letter via US Mail to the Office of Inspector General – Program Integrity and Oversight Division – PO Box 64982, St. Paul, MN 55164-0982

Provider Services	Phone Number/Email/Web Address	Availability/Comments
Prime PI FWA Hotline	Phone: 800-349-2919 Fax: 877-290-1555 Email: FraudTipHotline@primetherapeutics.com Prime Therapeutics LLC Attn: Pharmacy Audit & SIU 2900 Ames Crossing Rd. Eagan, MN 55121	Monday-Friday 9:00 AM to 5:00 PM CT Voicemail is available on weekends, evenings and corporate holidays.