



American Health Care Provider Manual

The American Health Care Provider Manual is designed to answer your questions regarding online claim submission for American Health Care plan participants and address other issues; this version supersedes all previous versions. The Provider Manual is an extension of and incorporated into the Pharmacy Provider Agreement and is incorporated into the Pharmacy Provider Agreement with American Health Care. The Provider must adhere to the provisions and terms set forth in the Participating Provider Agreement. Lack of adherence to any of the provisions and terms of the Participating Pharmacy Provider Agreement, which includes the Provider Manual, and all other applicable documents are viewed as a breach of the Pharmacy Provider Agreement.

If you need additional information, please contact the applicable Provider Help Desk. American Health Care's pharmacy help desk may be reached by telephone at 1-800-872-8276, select option for "pharmacy." Please refer to the member identification card and the online transaction response for the appropriate number to call. Help Desk representatives are available to assist 24/7.

It is important to always refer to the Provider Web Portal at www.americanhealthcare.com for the most up-to-date documents, Provider Manual, payer sheets, and other important communications. General questions can be referred to American Health Care, 3850 Atherton Road, Rocklin, CA 95765.

American Health Care BANK IDENTIFICATION NUMBERS/PROCESSOR CONTROL NUMBERS (RxBINs/PCN) and IDENTIFICATION CARDS:

610118/AHC

014872/AHC

018240/AH3C

018240/2K44/8099

018240/2K44/8099A

018240/2K44/8099C

018240/63C5/CWA1

018240/63C5/CWA1A

018240/63C5/CWA1B

018240/63C5/CWA1C

018240/63C5/CWA2

018240/63C5/CWA2A

018240/63C5/CWA2B

(800) 872-8276

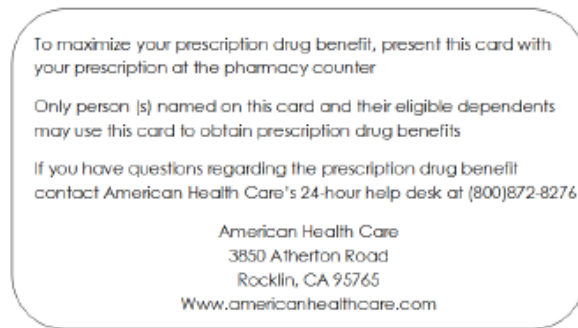
info@americanhealthcare.com

www.americanhealthcare.com

018240/63C5/CWA2C
 018240/63C5/CWA3
 018240/63C5/CWA3A
 018240/63C5/CWA3B
 018240/63C5/CWA3C



Front View of ID Card



Rear View of ID Card

Member identification cards are generally printed using the standard format of the National Council for Prescription Drug Programs (NCPDP). Some plans have custom identification cards. Please ask the member for their ID card to ensure accurate submission.

Claim Submission Provider Obligations

All claims must be submitted online within thirty (30) days of the date the prescription was filled, unless longer period is permissible by client and or law. The following elements from the member identification card must be submitted for successful claims adjudication.

- Member identification number,
- Person code (when printed on card),
- RxGRP (when printed on card), and
- BIN/Processor Control Number.

For additional required data elements, please refer to the applicable Payer Specifications.

Software

American Health Care requires that all claims must be submitted using NCPDP Telecommunication Standard Version D.0, later version, or other standard as dictated by applicable governing or industry setting organizations.

Reversals

Claims can be reversed up to 30 days after the submission date (or as specified by plan), but should be reversed within 14 days, or as soon as reasonably practical, or as specified by certain governing requirement to assure prescriptions with inaccurate information or those not dispensed to members are credited in a timely fashion.

Formulary

Formularies vary by plan and can change regularly. American Health Care suggests the use of the plan's website or any of the commercially available tools to facilitate easier formulary management when speaking with prescribers.

Compounds

All American Health Care plans require multi-ingredient compound claims submission. Please use the following guidelines when submitting compounds:

- One of the ingredients must be a legend drug product,
- Compound indicator field must indicate that the claim is a compounded prescription,
- Appropriate fields in the compound segment (see payer sheet for additional information) must be completed,
- Reimbursement is the lower of submitted cost, Usual and Customary price, or AWP. Other reimbursement pricing methods may be used. Submission of compounds are subject to increased audit and may incur additional costs should they be misrepresented, and
- Reimbursement for reasonable waste only includes associated volumes necessary in compounding the prescription which are not used within additional compound preparation.

Note: Reconstituted preparations, such as powdered antibiotics that are mixed with water prior to dispensing, reconstituted topical preparations, or compound kits are not considered compounded prescriptions.

Tax

Tax is calculated based on the applicable state or local law governing tax on prescription drugs. In order to be reimbursed for payment of tax, the Provider must enter the tax amount in the appropriate tax field.

Coordination of Benefits

Coordination of Benefits (COB) is handled on a plan-specific basis. The Provider is obligated to facilitate COB processing as a network participant. It is prudent for the Provider to verify with members to ensure they do not have alternative primary or secondary insurers. Please be sure to refer to the online transaction response to facilitate COB processing.

Processing, Pricing, Updates, Payments

Claims submitted by Provider for plans utilizing a American Health Care national network, plan, other networks, or via electronic claims submission point-of-service adjudication system for retail prescription benefit management or prescription processing are reimbursed for prescription drugs at the lesser of the plan or network Average Wholesale Price (AWP) discount or other referenced based pricing; plus or minus a discount or maximum allowable cost (MAC) (when applicable for prescription or over the counter drug products); the Provider's submitted gross amount due, the Provider's Usual and Customary price (U&C) that would be given under the same circumstances if the member did not possess prescription benefit coverage; or submitted ingredient cost, and the applicable plan or network dispensing fee including taxes if applicable. AWP, and brand or generic medication classification, is determined by American Health Care in all cases. American Health Care shall utilize client or plan parameters, Medi-Span or other national source, and internal processes as a reference but not as the sole determinant of price. WAC-referenced based pricing may be implemented should AWP become obsolete, if plan requires or market conditions warrant such pricing methodology. Other nationally recognized referenced based price sources may also be implemented as market conditions warrant or under the circumstances where AWP becomes obsolete. All network reimbursement methodologies includes, but are not limited to, retail commercial, Medicare Part D (this includes Medicare Part D Long Term, Indian Health Services, Indian Tribal Organization, and Home Infusion), Medicaid, 340B, hospice care, prescription benefit program for injured employees / workers compensation programs, automobile accidents, consumer driven health plans, consumer discount cards,



over-the-counter products or other plan-defined custom networks or medications, as applicable. In the event of a conflict between the Provider Agreement and the Provider Manual, the Provider Manual shall prevail. Except in cases of an explicit request by a Medicare beneficiary to not utilize their coverage.

Providers are required to submit all claims via on-line adjudication where a member presents a prescription drug card with the aforementioned RxBINs; this includes, but is not limited to, all Provider or otherwise discount programs that are established as the Providers Usual and Customary price (even if the price is zero). The network and associated rates in the Provider Agreement may or may not be utilized by American Health Care clients. The Provider Agreement is not an entitlement, nor does it warrant access to members. American Health Care client membership may utilize alternative networks or reimbursement as determined by American Health Care. Upon successful adjudication of a claim, Provider has deemed to accept reimbursement terms, conditions, and rates, and network participation with American Health Care. In the event of a conflict between the Provider Manual, Provider Agreement, Addendums, Fee Schedules, on-line adjudicated price or, any other pricing arrangement, the on-line adjudicated price shall govern, unless an error in overpayment occurs.

MAC means the maximum allowable cost for pharmaceutical products. The MAC (Maximum Allowable Cost) is developed by American Health Care and may be amended at any time at its sole discretion.

American Health Care typically administers two billing cycles per month, with cycle-ending dates on the 15th and the last day of each month. For Medicare Part D claims, or for any other more restrictive state program which requires prompt payment, American Health Care administers four billing cycles per month, with cycle-ending dates on the 7th, 15th, 23rd, and the last day of each month, with payment being issued six days following the last day of each cycle.

Unless otherwise stated, American Health Care is the Payer to the Provider. Provider shall not pursue payment for services or other additional fees from any other source.

Provider agrees that they are prohibited from contacting American Health Care clients and its members (American Health Care client/plan) for disputed issues between Provider, member and client or American Health Care, including but not limited to processing issues, reimbursement or payment issues without written

consent by an authorized American Health Care representative. Provider agrees that they are prohibited from directing the member or a member's claims to a plan other than the American Health Care plan presented by the member, and violation of such is considered a breach of contract, and subsequently subject to penalties or sanctions up to and including termination, as determined by American Health Care. Provider is subject to penalties or sanctions up to and including termination in the event it is determined by American Health Care that communications between Provider and member or Provider and a American Health Care client disclosed confidential information, disparaged, harmed or disrupted American Health Care relationship with its client. Penalties shall be invoked in amounts at a minimum of \$5,000 per incident and or per day, and may be subject to additional actions taken by American Health Care, including and up to termination from participation, and withdrawal and/or the holding of funds as deemed necessary by American Health Care until issue is resolved. Updates to the Provider Manual are made available periodically to Provider. All Communications, Updates, and Notices are available through the American Health Care Provider Web Portal (www.americanhealthcare.com), or sent via U.S. mail, electronic mail, facsimile, or courier. It is the Provider's responsibility to check for updates.

Claim System

The electronic claim processing system is generally available 24 hours per day, 7 days per week, with the exception of regularly scheduled downtime, which generally occurs at non- peak hours in order to minimize the impact to our network Providers. All claims must be submitted via the online adjudication system. Variant transmission fees will be incurred by the Provider per on-line or paper (if allowed) transaction. The transmission fees are assessed to support network Provider payment and reconciliation, help desk support, as well as but not limited to Provider network compliance, transactional, and billing education or other initiatives.

However, excessive or disruptive process inquiries, including but not limited to non-contracted Provider status, duplicate payment and remittance requests, excessive member/Provider grievances, third party biller intervention, incomplete or inaccurate credentialing submissions, contract compliance and/or failure of the Provider to submit claims through the American Health Care designated adjudication on-line adjudication process are subject to higher transmission fees as determined by American Health Care. Should a claim be submitted by a third

party or other means separate from the Provider itself, the claim may be subject to non-payment.

American Health Care reserves the right to make payment directly to Provider at its sole discretion.

Local Pick-Up Program

If Provider participates in the American Health Care local pick-up program, Provider shall be responsible for product fulfillment to eligible members under prescription benefit plans to be identified by American Health Care. Product fulfillment means the dispensing of prescriptions to eligible members, including, but not limited to, the following specific activities: receiving bulk shipment of prescriptions (excluding refrigerated items) already filled, labeled and packaged by one of American Health Care's Providers, signing and returning to American Health Care the packing slip confirming receipt of the order, storing the prescription orders in a designated location, handing prescription orders to eligible members or their authorized representatives who pick them up at the dispensing Provider, offering to counsel eligible members about the prescription orders being dispensed and having a licensed pharmacist providing counseling to those who accept the offer to counsel, and maintaining any records required by law in connection with its services. This process may not be available in all states and may vary by state in accordance with applicable state laws.

Provider Audit

American Health Care, or its client, authorized agent, governmental agencies or their representatives, hereafter referred to as American Health Care auditors, reserves the right to audit a Provider's compliance with the agreements in effect. American Health Care has the right to inspect all records of the Provider relating to this agreement. The Provider shall maintain adequate prescription and financial records relating to the provision of pharmaceutical services to our customers, including but not limited to: Provider books/databases, daily prescription logs, patient profiles, prescription hardcopies, prescriber information, signature/delivery logs, refill information, wholesaler-/ manufacturer/ distributor and all other purchase invoices and other such documentation necessary for all pharmaceutical services provided. Provider shall also maintain all policies and procedures related to maintenance of such records.

Provider shall maintain and retain all records described herein for a minimum of (10) ten years or as required by state or federal law, regulations and guidance. American Health Care auditors may also conduct compliance evaluations to confirm compliance with other requirements to include: FWA/compliance training, LEIE/EPLS verifications, posting and/or distribution of the CMS 10147 notice, etc.

American Health Care auditors shall have the right to audit any Provider during normal business hours and upon reasonable notice (usually 14 days), unless required otherwise, for any aspect of performance under the Pharmacy Provider Agreement, to include the provisions set forth within this Provider Manual, by reviewing records and documents relating to such performance.

Documents must be readily accessible. The Provider shall cooperate with American Health Care auditors, and promptly provide access to all information or documents deemed necessary by the American Health Care auditors. American Health Care at its sole expense may reproduce any record; however, no original copy may be removed from the Provider. A failure to cooperate with the aforementioned shall constitute a material breach of your American Health Care Agreement.

American Health Care may report audit findings to its clients, appropriate governmental entities, regulatory agencies, and professional review and audit organizations.

American Health Care does provide the opportunity to appeal the results of an audit based on state audit guidelines or mandates. However, the appeals process is conducted in writing via the submission of a written appeal to American Health Care, Industry Relations - Provider Audit Appeals, 3850 Atherton Road, Rocklin, CA 95765. Please be aware that the appeal process is not a vehicle for submission of new materials for inclusion in the audit review, but is designed to provide a re-determination of previously submitted post audit documentation.

If an American Health Care auditor is denied access to the Provider or is not provided access to the required requested audit documents, 100% of the amount paid for that claim(s) become due immediately. American Health Care may offset this said amount against any future payments due to the Provider and impose certain fines or penalties. Any audit resulting in a financial recovery American Health Care may offset the said amount against future payments.

Types of Audits

American Health Care routinely monitors online claims data and conducts audits on a continuous basis. American Health Care auditors conduct industry standard desktop audits and on-site audits, scheduled during normal business hours with prior written notice, unless otherwise necessary and audits of an investigational nature. In order to conduct these audits, Providers may be contacted by telephone, mail, fax, and or email and are required to provide such records by the due date in a manner mutually agreeable by the parties, while at all times ensuring safe transmission of sensitive documentation.

Telephone Audits

American Health Care monitors claims data for potential billing errors and reasonable claim submissions on a daily basis. If a potential discrepancy is found, an American Health Care auditor will contact the Provider via telephone to inquire about, validate, and help resolve the discrepancy. Unless supporting documentation is required, most of these discrepancies can be validated over the telephone and resolved through claim reversal and resubmission by the Provider.

Desktop Audits and Investigational Audits

American Health Care conducts desktop audits and investigational audits to verify the accuracy and validity of claim submissions. Providers are typically contacted via telephone, fax or mail and asked to provide photocopies of specific documents and records related to claims paid to the Provider by American Health Care during a specified period. Requested documentation may include, but not be limited to, original prescriptions, signature logs, computer records, and invoices showing purchase or receipt of dispensed medications. American Health Care will identify any discrepancies found in the documentation and will advise the Provider as such via post audit reports.

Onsite Audits

American Health Care conducts onsite Provider audits that are scheduled during normal business hours with prior written notice unless otherwise necessary. Onsite Auditors require a clutter free work area which is located away from the busiest area of the dispensing department with easy access to the required documents outlined in the audit notice; American Health Care auditors attempt to minimize

any disruption of the business processes while on-site. Please note; it is also helpful to have assistant dedicated Provider staff member present to answer general questions, retrieve information required and facilitate an effective on-site audit. The Provider shall receive a post audit report, which allows for a 30 calendar day period, unless another time is dictated by state or federal guidelines or law, to contest any findings identified. At the completion of the audit the Provider shall also receive a final audit report with the claims identified as discrepant and due for recovery. All documentation must be received no later than 30 calendar days from the date of the discrepancy report. Beyond that date, the audit shall be considered final.

Documentation Original Prescriptions

All prescription documentation, regardless of the way it has been created, generated or transmitted shall contain the following:

- Full name of the member for whom the prescription was written, and the address of the member along with a date of birth,
- Full name and address, telephone number and any other required identifiers of the prescriber,
- Name, strength and quantity of the medication prescribed,
- Specific dosing directions, if a prescription contains ambiguous directions the Provider must clarify these directions and notate the conversation to clarify,
- Substitution instructions where applicable, or substitution requested by member clearly notated,
- Refill instructions,
- Miscellaneous or other informational notations as required by applicable laws or regulations, and
- Complete documentation of items, quantities to be dispensed, and directions for use for diabetic supplies and insulin.

Prescription records must be updated at a minimum yearly, or such shorter period required by applicable law; if applicable law does not specify a time period, American Health Care requires that prescription hard copies be updated yearly. American Health Care recommends that Providers document as much information as possible on the prescription itself, outlining any unusual circumstances that occurred while dispensing the medication. A notation on the prescription may eliminate a question from the auditor or help resolve a discrepancy.

Compound Medication

Compounded medications (see additional section Compounds within the Claim Submission section of this Provider Manual) require the following additional documentation:

- A detailed compound worksheet documenting the products, NDC's of the products, quantity used, costs associated with each product and compounding procedures, and
- A valid prescription which clearly details the intent of the prescriber for the medication being compounded.

Signature Log – Hard Copy or Electronic

Provider must utilize a signature/delivery log that contains all the information required by American Health Care. This should include; fill date, date of pickup, the prescription number, third party name, patient or patient representative signature or electronic capture of information to prove receipt of medication, and the authorization to release information to a third party program.

Provider must obtain a legible written signature or electronic capture that corresponds to a matched printed name or another authorized person to confirm receipt of the prescription product. Capture of non-signature data elements to document receipt of the medication (e.g. electronic delivery notice or point of sale information) must be only upon express permission of American Health Care. If any state or federal laws require additional verification of the person picking up the medication, please include this notation on the signature log documents. Proper verification of the person picking up the prescription is essential to ensure the deterrence of potential fraud and abuse.

- If delivered to a home or business address, Provider must obtain the signature at the time of delivery.
- If patient is sent monthly billing statements, Provider may insert a form listing the dates of fill and prescription numbers; the Eligible Person or authorized representative should be instructed to sign and return the form with his/her payment.
- Provider utilizing mail services must include information to document tracking of shipment, confirmation of delivery, or other proof of delivery.

These prescription signature logs must be in date order where appropriate and readily accessible for a minimum of three years or longer as required by law.

Wholesaler, Manufacturer and Distributor Invoices

Wholesaler, manufacturer, and distributor invoices and other purchase invoices and documents must be accessible and also maintained for a minimum of three years or as required by law or regulation to substantiate that the drugs dispensed were purchased from an authorized and reputable source. Provider must be able to document the source is authorized to include state or federal licensure, oversight by regulatory agencies to include the Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA), and ability to obtain pedigree information for medications. The Provider must promptly comply with any requests to produce such documentation. If the Provider fails to promptly provide such requested documents, American Health Care may offset 100% of the amount for any of the paid claims in question and impose additional fines or penalties.

Submissions and Documentation Expectations

Please use the following information to help avoid problems and be prepared for an audit.

Days' Supply and Quantity Submission:

Providers are responsible for entering the correct days' supply of medication for all submissions. Audits routinely include discrepancies for days' supply errors. Therapy should be included in determination of days' supply. Examples of appropriate days' supply submission include:

- The days' supply for 28 doses of a medication, taken 28 per month, is 30 days, and
- The days' supply for 4 patches, 1 patch applied once weekly, is 28 days.

Provider must clarify ambiguous dosage instructions regarding utilization prior to dispensing. If a prescription contains ambiguous directions (e.g. no directions, —Use as Directed, or "prn"), Provider must obtain more detailed directions so the days' supply can accurately be calculated. The directions may be obtained by direct communications with either the patient or Prescriber. Documentation of the directions on the original prescription is required. The days' supply should accurately reflect the documented directions and quantity dispensed.

Other required days' supply and quantity submission requirements are as follows:

- The quantity dispensed must be entered exactly as it is on the prescription or as documented if less than prescribed,
- Provider must enter the exact metric decimal quantity dispensed (no rounding), Provider should review claims submission to ascertain that the quantity is accurate on all claims based on the specificity of the product and Prescriber instructions,

- If the Prescriber indicates ambiguous directions, the Provider must determine the dosing schedule in order to submit the claim correctly,
- If the quantity to be dispensed is uncertain, the Provider must contact the Prescriber to determine the appropriate amount to dispense and document said amount appropriately on the original prescription,
- Any subsequent changes in the original dispensing limitations (i.e. increase in quantity) that are approved by the Prescriber must be documented on the original prescription or in a readily retrievable electronic format, acceptable by the State Board of Pharmacy in which Provider is located,
- A 30-day supply is no longer standard; some programs permit extended days supplies. Always transmit the accurate days' supply and allow the on-line system to communicate the allowable days' supply,
- Claims submitted to American Health Care in accordance with a client program to allow limited dispensing of a non-covered item (e.g. three (3) day supply approved for a drug requiring Prior Authorization) may be dispensed with the smallest commercially available package size and submitted using the allowable days' supply.

Insulin and Diabetic Supplies:

Provider may only submit the NDC associated with the actual insulin or diabetic supply filled and dispensed. Diabetic insulin and supply must be calculated to accurately submit the days' supply. Directions notated —as needed^{ll} or —as directed^{ll} require a documented interaction with the prescriber or patient on the prescription.

If the Prescriber indicates —as directed^{ll} or —as directed as per sliding scale,^{ll} the Provider must obtain the dosage range, note it on the prescription hard copy, and calculate the days' supply by using the maximum daily dosage. The directions may be obtained by direct communications with either the patient or Prescriber.

Inhalers and Inhalation Products:

When submitting a claim, enter the quantity to be dispensed exactly as written by the Prescriber on the prescription form. Dispensing limitations vary widely among plans. Depending on the patient's medical condition, it may be necessary to dispense more than one inhaler. If plan design allows and the Prescriber writes accordingly, the patient may obtain more than one inhaler per prescription.

Product Selection (Dispense as Written) Codes:

(800) 872-8276

info@americanhealthcare.com

www.americanhealthcare.com

American Health Care supports the NCPDP standard Product Selection Codes (PSC's). Accurate reimbursement is tied to proper PSC submission; the Provider must always specify the correct PSC when submitting a claim. Please be advised that incorrect PSC codes are the most common cause of Provider chargebacks and may lead to removal from the network.

Product Selection Codes (PSC):

PSC 0 - Dispense as Written: Substitution Allowed, or no product selection indicated

- Use the PSC 0 code when dispensing a generic drug; that is, when no party (i.e., neither prescriber, nor pharmacist, nor member) requests the branded version of a multi-source product.

PSC 1 – Substitution not allowed by prescriber

- Use when the Prescriber specifies the branded version of a drug on the hard copy prescription or in the orally communicated instructions.
- Must be evidenced on the prescription hard copy (original and updates). This documentation must occur prior to services being rendered; that is, before the medication is dispensed.
- No PSC 1 code defaults should be set; this leads to removal from the network.

PSC 2 - Substitution allowed - patient requesting product dispensed

- A PSC 2 code should be transmitted when the member requests that the prescriber be contacted to obtain approval for a brand drug when the prescriber did not initially mandate dispense as written.
- Must be evidenced on the prescription hard copy (original and updates). This documentation must occur prior to services being rendered; that is, before the medication is dispensed.

PSC 3 - Substitution allowed - pharmacist selected product dispensed

PSC 4 - Substitution allowed - generic drug not in stock

PSC 5 - Substitution allowed - brand drug dispensed as a generic

- Use when dispensing a brand as a generic.

PSC 6 – Override

- Not in use

PSC 7 - Substitution not allowed; Brand mandated by law

PSC 8 - Substitution allowed - generic drug not available in marketplace

- Proof from wholesaler is required proving the generic was not available on fill date and will be requested upon audit.

PSC 9 – Other

- Not in use

Some members have a choice between brand and generic drugs. However, in some programs, the member pays the difference between the cost of the brand and the available generic drug.

Prescriber Identification:

Identification of the prescriber requires a National Provider Identifier (NPI). For all claims, including controlled substance prescriptions, the Provider must use the Prescriber's NPI. If the Prescriber does not have an NPI or Provider cannot obtain the Prescriber's NPI after making reasonable efforts to do so, an alternative identifier may be submitted as permitted by State and Federal guidelines and regulations. Provider must maintain the DEA number on the original hard copy for all controlled substance prescriptions in accordance with State and Federal Laws. Provider is responsible to confirm the Prescriber's ability to prescribe a controlled substance, e.g. confirmation that they are allowed to prescribe CII medication when claimed medication is a CII.

Ophthalmic Products:

Eye drops should be calculated using 15 drops per mL, unless a more specific drop per mL or uses/package exists. Prescriptions with defined length of therapy may use that period for days' supply when smallest package size for therapy is used (e.g. 5ml ophthalmic with acute therapy of 5 days).

Prescription Hard Copies:

- The hard copy (original and any updates) of the prescription, including telephone prescriptions, must contain data elements required by state pharmacy laws in which Provider is located and all of the prescriber instructions — including Product Selection Code instructions — that support the Provider's claim transmission. Prescriptions in which the dosage/quantity is changed require either written documentation on the prescription or a new hard copy prescription to be issued.
- In cases of the prescriber writing —As Directed, documentation as to the exact directions or, at a minimum, the maximum (—up to) dose of medication taken per day must be documented on the hard copy or electronically and be viewable upon request. If undocumented at the time of the audit, the entire claim is marked as discrepant until proper documentation is provided. Only prescriptions generated by the prescriber are accepted as post audit documentation for as directed prescriptions.
- If less or more medication (if permitted) is given than ordered by the prescriber, the reason for this must be documented. Any increase in the

amount of medication over the original prescribing order must be documented for prescriber authorization.

Signature Log:

- Provider shall require the signature of the member or the member's representative on a permanent record before dispensing any prescription.
- At each Provider location, Provider shall maintain a hard copy or (pre-approved by American Health Care) electronic signature log which contains the following: the prescription number; the date the medication is received by the member; and the signature of each member who receives a medication or the signature of his/her designee.
- A log in date order must be maintained for all claims submitted on-line to American Health Care.
- Signature logs must be maintained for ten years or longer—corresponding to the state and/or federal regulations and law, which Provider is located for retaining prescription hard copies. The logs must be available for inspection and audit by an American Health Care auditor.

Dispensing Limitations:

- Enter the quantity to be dispensed exactly as written on the prescription form.
- A 30-day supply is no longer standard; some programs permit extended days supplies. Always transmit the accurate days' supply and allow the on-line system to communicate the allowable days' supply.
- Note subsequent changes or refill authorizations approved by the prescriber on the hard copy, or in a readily retrievable electronic format, acceptable by the State Board of Pharmacy in which Provider is located.

U&C:

Usual and Customary (U&C) charge means the usual and customary price charged by the Provider to the general public at the time of dispensing, including any advertised or sale prices, discounts, coupons or other deductions.

Product Selection Codes (PSC):

- When an auditor cites a prescription for a missing or incorrect PSC code, follow-up documentation is not permitted.
- A transmitted PSC 1 code must be supported on the prescription hard copy (original and update).
- No PSC 1 code defaults should be set; this may lead to removal from network participation.

- A PSC 2 code should be transmitted when the member requests that the prescriber be contacted to obtain approval for a brand drug when the prescriber did not initially mandate dispense as written.
- Avoid use of PSC 7 for NTI drugs, please use the correct codes 0, 1, or 2 and communicate with the prescriber.

Long Term Care (LTC):

American Health Care reserves the right to audit an LTC Provider's books, records, prescription files and signature logs for the purpose of verifying claims submission information. LTC Providers are required to have signed prescriber's order available for audit. These orders may be in the form of a standard prescription or copies of signed prescriber's orders from a medical chart. Record retention is important, and time to retrieve these documents is considered in complying with audit requirements. LTC Providers are not required to have a signature from the member as proof of receipt. However, LTC Providers must have delivery logs, manifests or other American Health Care approved proof of delivery of medications to facilities readily available during an audit.

Abuse of the Short Cycle Dispensing regulations as defined by CMS to be implemented on 1/1/2013 will be subject to audit and recover of abuse and attempt to achieve multiple dispensing fees based on days' supply manipulation. American Health Care may audit for an attempt to gain more than 2 dispensing fees in a one month period.

Miscellaneous:

Claims are adjudicated based on data provided to American Health Care. If a claim is adjudicated based on incorrectly submitted data, an adjustment may be necessary.

Provider must charge the member the patient pay amount indicated in the on-line response.

Provider should follow all audit guidelines as notated on the communications to the Provider via telephone, letter or electronic requests.

American Health Care may deny payment for unsupported claims or missing signatures.

American Health Care has the right to assess reasonable fines, penalties and fees to cover unexpected costs. These actions may include the imposition of fines or

penalties due to repeated audits, termination from the network, corrective action plans.

Please refer to the audit communications as provided by American Health Care auditors for discrepancies identified and the actions a Provider can take to remedy these discrepancies.

Fraud, Waste and Abuse (FWA)

American Health Care does not knowingly allow fraudulent activity of any kind by any of its contracted Providers, associates, members, vendors, contractors and/or other business entities, and investigates and reports any such known activity to the appropriate regulatory, federal and state agencies for further action and investigation.

American Health Care contracts with clients, including those which are Medicare or Medicaid entities. These clients are required by the Centers for Medicare & Medicaid Services (CMS) to have a comprehensive plan to detect, correct and prevent fraud, waste and abuse.

Providers are required to maintain proper policies and procedures related to training on Compliance, Fraud, Waste and Abuse and must have a policy and procedure for checking the Office of the Inspector General (OIG) List of Excluded Individuals (LEIE) and Government Services Administration (GSA) Excluded Parties Lists System (EPLS) to confirm no employee, volunteer, consultant, governing body member, or contracted individual or entity is excluded from participation in federal programs. LEIE and EPLS verifications must be conducted at least monthly and upon initial hire or contracting.

Providers are required to maintain training logs of all required trainings, type and method, vendor and date and time and signoffs from the staff on its completion when required by American Health Care or clients. These logs must be made available within 72 hours to American Health Care in case of an audit or CMS request. If you find that an individual or entity responsible for the provision of pharmacy services is on the LEIE or EPLS as excluded you have a duty to report this issue and all the claims associated with this individual or entity to American Health Care at the Provider Relations address contained herein or to the American Health Care Compliance Hotline at the toll-free number at (866) 532-0657, available any time, 24 hours a day, seven days a week.

The appropriate entry of the Prescriber and patient information is paramount in being able to identify true occurrences of fraudulent and abusive practices as well as reduction in waste associated with payment of claims for excluded Prescribers. Please see the Prescriber Identification section of this Provider Manual for additional details. Provider also agrees that they will follow all federal or state requirements to include Medicaid rules in instances of state Medicaid managed care programs, including accurate submissions and temporary supply rules which are mandated by many of these programs. In addition, the Provider will facilitate when professionally capable or provide a valid reason for their inability to participate in a state Medicaid plans Lock –In program for its membership.

The Provider can always report any suspected fraud, waste or abuse by calling the American Health Care Ethics and Compliance Hotline, toll-free number at (866) 532-0657, available 24 hours a day, and seven days a week.

FWA Program

An entity involved in providing services for Medicare Part D members is responsible for implementing a program to control fraud, waste and abuse and to facilitate compliance in the delivery of prescription drugs through the Medicare benefit.

Examples of Provider fraud may include but are not limited to the following:

- Filling less than the prescribed quantity of a drug,
- Billing for brand-name drugs when generic drugs are dispensed,
- Billing multiple payers for the same prescriptions,
- Dispensing expired or adulterated prescription drugs,
- Forging or altering prescriptions,
- Refilling prescriptions erroneously,
- Billing for non-existent prescriptions,
- Prescription drug shorting-without notifying the member,
- Illegal remuneration schemes,
- TrOOP manipulation, and/or
- Manipulation of quantity limits.

The Provider will notify American Health Care on the Compliance Hotline at (866) 532-0657 if the Provider has reason to believe potentially fraudulent prescription or inappropriate claims activity is occurring.

Examples of member or prescriber fraud may include but are not limited to the following:

- a member presenting a prescription not written by the prescriber identified,

- a member presenting a forged or altered prescription, calling in their own prescriptions, over-utilizing prescriptions, selling their prescriptions or membership information,
- Medications inconsistent with the practice or specialty of a Prescriber,
- Illegal remuneration schemes,
- Prescriptions not medically necessary, and/or
- Cash or other benefits to switch drugs to prescribe certain medications.

Compliance and Fraud, Waste and Abuse (FWA) training is an important component of Provider operations and is required to be completed annually and upon initial hire for all local, state and federally funded pharmacy benefit programs. For example, CMS requires that FWA be completed by anyone who works with or, provides services to or supports the Medicare Part D drug plan benefit. Annually and upon reasonable request, Providers are required to attest to the training mentioned above and provide specific proof down to the employee and or contractor level that such training was completed. Non-compliance with this provision may result in remedies to include corrective actions or termination of the Providers from the American Health Care network.

Credentialing and Quality Management

Provider must comply with the credentialing and quality management initiatives required by American Health Care. Provider agrees to provide American Health Care with documentation and other information that may be needed in connection with such initiatives.

American Health Care has the right to reasonably determine, at its sole discretion, whether or not Provider meets and maintains the appropriate credentialing and quality management standards to serve as a Provider for American Health Care and its clients.

Standards of Operation

Provider must meet all standards of operation as described in Federal, State and local law as related to the provision of pharmacy services. Shipping pharmacy services to patients by mail or other remote delivery carrier as a routine business practice is unapproved without the express written permission of American Health Care.

Licensure

Provider must at all times maintain in good standing with all Federal, State and local licenses and/or permits as required by applicable state and or federal law, regulations, and guidelines Provider must furnish copies of said licenses and/or permits upon enrolling as a Provider with American Health Care and as requested by American Health Care. Failure to maintain the appropriate licenses and/or permits will result in immediate termination as a Provider.

Provider must notify American Health Care in writing at the Provider Contracting address below, if:

- Provider's license or permit is, or is in jeopardy of being, suspended or revoked; Provider receives notice of any proceedings that may lead to disciplinary action,
- Any disciplinary action is taken against Provider or any of its personnel, including but not limited to, action taken by a Board of Pharmacy, OIG, GSA, law enforcement or other regulatory body,
- There is a subpoena of records related to pharmacy services or Provider's business conduct,
- There is a seizure by law enforcement of Provider's prescription records, computer systems, financial records, accounts or real property, or
- There is an investigation by law enforcement or regulatory body related to pharmacy services.

Required notification to American Health Care must be provided within seven (7) days of the occurrence and include information of the agency conducting the investigation or governing the disciplinary action, if applicable. Failure to timely and properly notify American Health Care may result in immediate termination of the Pharmacy Provider Agreement or suspension as a participating Provider. American Health Care may in its sole and absolute discretion immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding or claims adjudication suspension) of Provider if American Health Care has reason to believe that Provider has engaged in, or is engaging in, any behavior which, (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or the general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; or (3) otherwise reflects negatively upon the Provider's ability to fulfill the requirements of the Pharmacy Provider Agreement.

Suspension and Termination

Providers who are not eligible to participate in Medicare, Medicaid, and other Federal health care programs are not eligible to participate in any of the American Health Care networks. If a provider is found to be excluded from participation in Federal health care programs, the Provider will be immediately terminated from participation in all American Health Care networks.

Provider shall not allow any employers or contractors excluded from participation in Medicare, Medicaid, and other Federal health care programs to provide services that involve furnishing, ordering or prescribing an item or service that will be paid by Medicare, Medicaid, or other Federal health care programs.

American Health Care suspension may include cancellation of checks, payment suspension of future cycle checks, or restriction of claims submission. American Health Care's ultimate remedies under this section include immediate termination of the Provider Agreement.

Insurance

Provider must at all times hold policies for general and professional liability insurance, including malpractice, in amounts necessary to ensure that the Provider and any of its personnel are insured against any claim(s) for damages arising from the provision of Pharmacy Services. Such policies must have coverage, at a minimum, in the amount of \$1,000,000.00 per person and \$3,000,000.00 in aggregate, unless otherwise agreed to by American Health Care, or such greater amount required by Law.

The Provider must furnish copies of said policies upon enrolling as a Provider with American Health Care and as requested by American Health Care thereafter. Failure to maintain the minimum coverage may result in immediate termination as a Provider.

The Provider must notify American Health Care immediately in writing if its insurance is canceled, lapsed or otherwise terminated. Failure to immediately notify American Health Care in writing of any such termination of insurance coverage may result in immediate termination as a Provider.

The requirements in this section apply to the extent permissible under applicable federal and state regulations, guidance and laws.

Quality Management

The Provider must participate in quality management initiatives or other client sponsored programs, as requested by American Health Care and/or client. The Provider must also maintain internal quality management standards and procedures and furnish an outline of said standards and procedures as requested by American Health Care.

Provider Enrollment

To enroll as a Provider to participate in an American Health Care or client network, Provider must contact the American Health Care Industry Relations by email at ContractRequest@americanhealthcare.com and request enrollment forms.

Changes in Documentation, Requests for Documentation and Other Information Provider Information Updates

Unless otherwise specified, Provider must notify American Health Care in writing within ten (10) business days of any changes in the documentation and other information provided to American Health Care in connection with enrolling as a Provider and in any credentialing or quality management initiatives. Such information includes, but is not limited to, changes in name, address, telephone number, fax number, services, or ownership, and must be sent by either:

- (1) Email to ProviderR@americanhealthcare.com, or
- (2) Mail to:

American Health Care
Attn: Provider Contracting, Industry Relations
3850 Atherton Road
Rocklin, CA 95765

The Provider must also report appropriate information to NCPDP to ensure the changes are accurately updated within our system.

Upon request, the Provider is required to respond to American Health Care within ten (10) business days of a request for documentation necessary to support claims processing or audits by Plan (or of Plan) and within thirty (30) days of receipt of Provider contact verification forms or the Pharmacy Credentialing Request Form requests. Provider must submit accurate and complete documentation to American Health Care within these time periods.

Miscellaneous

For additional information, including obligations and responsibilities of a Provider, reimbursement inquiries, or information pertaining to the American Health Care, please visit www.americanhealthcare.com. This location is the single best source for updates, forms, attestation documents and all other important communications please check regularly.

If an independent Provider is affiliated with a third party contracting or purchasing group, the affiliated Provider is subject to all terms and conditions of the written agreement between American Health Care and that entity. Communication should also be directed through the third party contracting entity or purchasing group.

MAC pricing appeals should always be directed to American Health Care; appeal requests must be submitted on our current form available at <https://macappeals.ahcrx.com/>. All fields on the form are required; incomplete forms may not be acknowledged. Your most recent invoice for the NDC submitted on the claim must accompany the appeal form. Please download these forms and submit using the fax numbers provided on the form within 45 days of the claim fill date. Responses will only come via fax to the original requesting Provider.

American Health Care updates its files through weekly file feeds received from NCPDP, or other nationally recognized Provider data vendor, as determined by American Health Care. American Health Care updates and maintains all pertinent Provider information including, but not limited to: Provider demographics, NPI, State License, Medicaid ID, open and close dates, Provider affiliation, ownership, and Provider dispenser type via these Provider data feeds. It is required that the Provider make any system updates through the American Health Care Provider data vendor.

Provider must comply with all CMS regulations regarding the provision of written notices to Medicare beneficiaries, Providers must comply with CMS- Memo 10147.

To the extent the Provider is owned, operated or controlled by, or affiliated with a pharmacy benefit management business entity. Provider represents and warrants that it has a firewall in place to protect any and all information received due to the receipt of a Participating Provider Agreement and protects from

disclosure outside of the performance of its obligations under this agreement any information received that is proprietary with only those participants who are on a need to know basis to carry out such agreement provisions. Any intentional disclosure shall result in immediate termination and legal action as necessary.

American Health Care Provider payments must correctly reconcile to Provider. For example, if Provider receives a payment from American Health Care that does not have the Providers correct NPI, NCPDP number, name, address, prescriptions processed by Provider or other key identifiers Provider must report by calling AND in writing electronic or otherwise to American Health Care within fourteen (14) days upon receipt. Determination of payment accuracy will occur by American Health Care within fourteen (14) days. In the event any payment has been sent to a Provider in error.

The Provider is subject to immediate offsets from future payments, or is required to immediately reimbursement American Health Care via a bank drawn check or electronic fund transfer as directed by American Health Care. Knowledge of, or the lack of knowledge of an overpayment provides no rights to the receiver, all inappropriate payments must be returned immediately as described above (offset, check) and interest, at the greater of a rate of 1.5% per month of the total balance or that required by law. Knowledge by receiver (Provider) of extended (greater than 30 days) of any overpayment, may be subject to network termination, penalties, including but not limited to court costs, collection agents, travel, and attorney's fees as required to recover the funds.

Provider Manual Addendum

Providers located in Massachusetts

To the extent that Provider provides pharmacy services to members of a Health Maintenance Organization (—HMOII), Insurer, or Carrier licensed under Massachusetts law (collectively and/or individually, —PayerII), Provider agrees to comply with any requirements for participation as a Provider in Massachusetts.

Provider agrees to comply with the requirements outlined below for participation as a contracted Provider in Massachusetts, where applicable:

- Provider is not required to indemnify Payer for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against Payer based on Payer's management decisions, utilization review provisions or other policies, guidelines or actions. 211 CMR 52.12(2).
- Provider shall not bill members for charges for covered pharmacy services other than for deductibles, copayments, or coinsurance. 211 CMR 52.12(8).
- Provider shall not bill members for nonpayment by American Health Care or Payer of amounts owed under the Agreement due to the insolvency of American Health Care or Payer. This requirement shall survive the termination of the Agreement for services rendered prior to the termination of the Agreement, regardless of the cause of the termination. 211 CMR 52.12(9).
- Provider shall comply with American Health Care's and Payer's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services. 211 CMR 52.12(10).
- Provider agrees that in no event, including but not limited to nonpayment by American Health Care or Payer of amounts due to Provider under this Agreement, insolvency of American Health Care or Payer or any breach of this Agreement by American Health Care or Payer, shall Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the member, persons acting on the member's behalf, other than American Health Care or Payer, the employer or the group contract holder for services provided pursuant to the Agreement except for the payment of applicable co-payment, co-insurance, or deductibles for services covered by the Payer. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to the termination, regardless of the cause of such termination. Payer's members, any persons acting on

the member's behalf, other than American Health Care or Payer, and the employer or group contract holder shall be third party beneficiaries of this clause. This provision supersedes any oral or written agreement hereafter entered into between Provider and the member, persons acting on the member's behalf, other than American Health Care or Payer, and employer or group contract holder. Mass. Ann. Laws Ch. 176G, Sect. 21.

- American Health Care shall not refuse to contract with or compensate for covered pharmacy services of an otherwise eligible Provider solely because Provider has in good faith:
 - communicated with or advocated on behalf of one of more of his/her/its prospective, current or former patients regarding the provisions, terms or requirements of American Health Care or Payer's health benefit plans as they relate to the needs of Provider's patients; or
 - Communicated with one or more of his/her/its prospective, current, or former patients with respect to the method by which Provider is compensated by American Health Care or Payer for services provided to patient. 211CMR 52.12(1).
- Where applicable, neither party shall terminate this Agreement without cause. 211 CMR 52.12(5): American Health Care shall provide a written statement to Provider of the reason or reasons for termination of the Agreement. 211 CMR 52.12(6).

American Health Care shall notify Provider in writing of modifications in payments, modifications in covered services or modifications in American Health Care's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided sixty (60) days before the effective date of such modification unless such other date for notice is mutually agreed upon between American Health Care and Member Provider. 211 CMR 52.12(7).

Within forty-five (45) days after the receipt by American Health Care of a claim for reimbursement to Provider for pharmacy services, Payer through American Health Care shall (1) make payment for such services provided, (2) notify Provider in writing of the reason or reasons for nonpayment, or notify Provider in writing of what additional information or documentation is necessary to complete claims for such reimbursement. If Payer fails to comply with this provision for any claims related to the provision of health care services, Payer shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which



shall accrue beginning forty-five (45) days after American Health Care's receipt of request for reimbursement at the rate of one and one half percent (1.5%) per month, not to exceed eighteen percent (18%) per year. This provisions relating to interest payments shall not apply to a claim that American Health Care or Payer is investigating because of suspected fraud. Mass. Ann. Laws 175 Sect. 110(G); 176A Sect. 8(e); 176B Sect. 4 and 7; 176G Sect. 6; 176I Sect. 2.