



Pharmacy Provider Manual

February 2009

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INTRODUCTION AND CONTACT INFORMATION

US Script is a pharmacy benefit management company located in Fresno, California. We provide pharmacy benefit design, administration, and management services as well as a sophisticated, state-of-the-art pharmacy claim-processing program to health plan sponsors. Programs such as (a) drug utilization reviews, (b) clinically based formularies, (c) generic substitution programs, and (d) disease-oriented managed care allow third-party payers to effectively manage the cost of providing prescription benefits for their health care members.

US Script is a wholly owned subsidiary of CenCorp Health Solutions™ (CenCorp), a subsidiary of Centene Corporation® (Centene). CenCorp strives to provide specialized health solutions to the complex problems faced by patients, healthcare providers, pharmaceutical companies, distributors and payers.

Centene and its wholly owned health plans have a long and successful track record offering Medicaid managed care services. For more than 20 years, Centene has provided comprehensive managed care services to the Medicaid population and currently operates health plans in Indiana, Kansas, Missouri, New Jersey, Ohio, Texas, Wisconsin and Georgia.

Contact Information

For questions or other information regarding information communicated in the US Script provider manual, please send inquiries to the following:

US Script
Chief Operating Officer
2425 W. Shaw Avenue
Fresno, CA 93711

GENERAL INFORMATION

Information in the US Script provider manual is considered proprietary and intended for use by providers who are credentialed in the US Script Pharmacy Network only. Providers cannot copy, reproduce, distribute or share information included in this provider manual except as authorized by provider agreement.

US Script Provider Services Call Center

The US Script Provider Services Call Center is staffed with customer service representatives 24 hours a day, seven days a week.

Phone: (800) 460-8988

See “Frequently Asked Questions by Providers” section for more information.

US Script Prior Authorization Help Desk

The US Script Prior Authorization (PA) Help Desk is staffed with PA triage specialists during the following hours (Pacific Standard Time):

Phone: (866) 399-0928

Monday through Friday 6:00 AM to 5:00 PM

During regular business hours, licensed clinical pharmacists and pharmacy technicians will be available to answer questions and assist providers.

After hours and during holidays, providers should call the US Script Provider Services Call Center.

Phone: (800) 460-8988

US Script Pharmacy Claim Submission

US Script
2425 W. Shaw Avenue
Fresno, CA 93711

FREQUENTLY ASKED QUESTIONS BY PROVIDERS

- 1. What eligibility information do you have on file for this plan member (e.g., member identification number, group identification number, date of birth, gender)?**

When a provider submits a claim using a plan member's eligibility information which does not match the eligibility information for this member in the US Script adjudication claims system, the claim will be rejected. When this occurs, the provider will receive a denial message due to non-matched eligibility data. Upon receipt of a denial message, the provider will verify eligibility information with the eligible plan member to ensure that the provider has the correct information. If correct, the provider is encouraged to contact a customer services representative at US Script to clarify any discrepancies in eligibility information. Until the discrepancies are corrected, the plan member's claims will continue to reject. Moreover, the provider should advise the eligible plan member to contact and inform his/her health plan sponsor of the incorrect eligibility information and request that the information be corrected.

- 2. What is the plan member's co-payment for Brand medications and Generic medications?**

The provider needs to submit the claim through the claims processing system to receive the adjudicated response, which will include the co-payment amount to collect as well as any relevant information about eligibility plan coverage, pricing and applicable clinical programs and services. The customer service representative at US Script can help the provider by releasing information about the amount the eligible plan member must pay as per their health plan design.

- 3. What is the prior authorization approval procedure for an eligible plan member?**

US Script only administers prior authorization (PA) services for some of its health plan sponsors. A Medicaid provider needs to note the PA response, which generally includes the on-line retransmission instruction or appropriate contact information and telephone numbers. A commercial provider needs to contact the US Script call center for prior authorization procedures. The representative at the call center will assist by providing information about the member's group, directing the provider the health plan administrator, or assisting at the point of service with the prior authorization number code.

4. What is the procedure for authorizing claims identified as “refill too soon,” “cost exceeds maximum,” “plan limitations exceeded,” or “submit to primary carrier, US Script to be billed as a secondary payer”?

Many health plan sponsors allow eligible plan members to secure an early refill for a vacation supply. If the eligible plan member states that he/she is eligible for an early refill (e.g., vacation overrides, spilled or lost medications), the provider can submit the claim as usual. If the claim rejects as an early refill or exceeds plan limitations, the provider should contact US Script’s call center for coverage verification. If the health plan sponsor allows for an early refill, the representative from the call center will issue the appropriate prior authorization so that the claim can be processed.

A claim for which US Script is the secondary payer may trigger a “submit to primary carrier, US Script to be billed as a secondary payer” message. This message indicates that the member has dual coverage and that payment must be coordinated with the primary payer through coordination of benefits (COB). Many times the secondary claims are not accepted online and must be submitted on a paper claim. This will have to be verified on a case by case basis.

5. What are the annual benefits for the eligible plan member?

When the provider submits the claim, the adjudicated response will provide messaging to include plan coverage limits. The representatives at the call center will also provide plan limitation information, (e.g., co-pays, maximum benefit, plan guidelines).

6. What is your bank identification number (BIN) and processor control number (PCN)?

With the many different types of plans that we have, there can be more than one PCN for the same pharmacy chain depending on which type of plan the specific member is on. The BIN is often provided on the member’s identification card. If the number is not provided, please call the Provider Services Call Center for the US Script BIN or PCN.

SCRIPT PHARMACY NETWORK APPLICATION AND CREDENTIALING GUIDELINES

Provider Enrollment and Participation

To apply as a provider and participate in the US Script Pharmacy Network, the applicant must dial (800) 413-7721, and then press the menu option for Pharmacy Relations. Applicants should be prepared to present the provider name, corresponding NCPDP number, contact name, business address, telephone number, facsimile number, email address, and the purpose for the call. Following this initial contact, US Script will initiate the process for the applicant to enroll and participate in the US Script Pharmacy Network.



Credentialing Standards

Credentialing and re-credentialing initiatives exist to ensure that participating providers abide by the criteria established by US Script as well as governmental regulations and standards. The applicant must comply with the credentialing and re-credentialing initiatives required by US Script, and agree to provide US Script with documentation and other relevant information that may be required in association with such initiatives.

US Script has developed a standardized process for the receipt, review, documentation and verification of applicants' credentials for participation in the US Script Pharmacy Network. All applicants are subject to this review and verification process. US Script has the right to determine whether an applicant meets and maintains the appropriate credentialing standards to participate as a provider in the US Script Pharmacy Network.

Application for Enrollment in US Script Pharmacy Network

When applying for enrollment in the US Script Pharmacy Network, the credentialing pharmacy network account representative at US Script will send the applicant the US Script Pharmacy Credential Application, Pharmacy Participation Agreement Checklist, and Pharmacy Participation Agreement.

Pharmacy Credentialing Application

The applicant is required to complete, sign and return the Pharmacy Credential Application to the Credentialing Department at US Script. Said application requires complete documentation of the following pharmacy-specific criteria:

- Pharmacy profile information (e.g., name, address, telephone number, after-hours emergency telephone number, facsimile number, email address, contact person for credentialing, NABP number, federal identification number, name and license number of pharmacist-in-charge)
- Pharmacy hours of operation
- Pharmacy services provided
- License and policy maintenance (e.g., State(s) in which provider is licensed or registered; license/registration number and expiration date; history of pending felony and/or misdemeanor charges or convictions; history of limited, suspended, revoked or reprimanded license; history of fraud or abuse; violations leading up

to suspension or revocation of pharmacy license or DEA registration; history of being investigated or sanctioned by Medicare or Medicaid; compliance with American with Disabilities Act of 1990; privacy; and accessibility)

Said application requires documentation of the following pharmacist-in charge specific criteria:

- Any misdemeanors, felony convictions or charges pending against them
- History of loss of pharmacy license anywhere (e.g., limited, suspended, revoked or reprimanded)
- History of disciplinary action including restriction/limitation on license or ability to otherwise practice
- Malpractice claims history within the past 5 years
- Fraud or abuse convictions within the past 5 years

There are certain other accessibility requirements that are integral to US Script application process which include, but are not limited to the following:

- Eligible plan member must have access to a pharmacy-employed pharmacist 24 hours a day, 7 days a week via phone, pager, or answering service/machine.
- Pharmaceutical products are dispensed in an acceptable business facility subject to an onsite visit by US Script.

Pharmacy-employed pharmacists must be proficient in reading, writing and speaking the English language, demonstrating proficiency in communicating clinical advice, and providing clinical services to eligible plan members in the English language.

Pharmacy Participation Agreement Checklist

A set of minimum level criteria is used to determine the applicant's eligibility for participation in the US Script Pharmacy Network. If applicant is a representative of a pharmacy chain, such applicant is requested to submit a spreadsheet listing all pharmacies in addition to the following requested information.

Licensure

The applicant must meet all standards of operation as described in Federal, State and local law. The applicant must furnish copies of Federal, State and local licenses and/or business permits as required by applicable law when applying for enrollment as a provider in the US Script Pharmacy Network. The applicant must at all times maintain in good standing with said licenses and/or permits.

Once credentialed to participate in the US Script Pharmacy Network, the provider must notify US Script immediately in writing if its licenses and/or permits are canceled, revoked, suspended or otherwise terminated. Failure to immediately notify US Script in writing of any such action may result in immediate termination from the pharmacy network. Moreover, failure to maintain the appropriate licenses and/or permits will result in immediate termination from the US Script Pharmacy Network as a provider.

Insurance

When applying for enrollment as a provider in the US Script Pharmacy Network, applicant must furnish copies of policies for general and professional liability insurance, including malpractice, at a minimum in the amount of \$1,000,000.00 per occurrence and \$3,000,000.00 in aggregate or as otherwise required by Law. The applicant must at all times maintain said policies in amounts necessary to ensure that the provider and any of its personnel are insured against any claims for damages arising from the provision of pharmacy services.

Once credentialed to participate in the US Script Pharmacy Network, the provider must notify US Script immediately in writing if its insurance is canceled, suspended or otherwise terminated. Failure to immediately notify US Script in writing of any such termination of insurance coverage may result in immediate termination from the pharmacy network. Additionally, failure to maintain the minimum coverage will result in immediate termination as a provider.

Drug Enforcement Agency Controlled Substance Registration Certificate

The applicant must furnish a copy of Drug Enforcement Agency (DEA) Controlled Substance Registration Certificate as required by applicable law when applying for enrollment as a provider in the US Script Pharmacy Network. The applicant must at all times maintain good standing with said registration.

Once credentialed to participate in the US Script Pharmacy Network, the provider must notify US Script immediately in writing if the DEA registration certificate is canceled, revoked, suspended or otherwise terminated. Failure to immediately notify US Script in writing of any such action may result in immediate termination from the pharmacy network. Furthermore, failure to maintain the DEA registration certificate may result in immediate termination from the US Script Pharmacy Network as a provider.

Medicaid Provider Number

When applying for enrollment as a provider in the US Script Pharmacy Network, the applicant must furnish its Medicaid Provider Number as required by applicable law. The provider must at all times maintain its current Medicaid Number.

Once credentialed to participate in the US Script Pharmacy Network, the provider must notify US Script immediately in writing if its Medicaid Number is canceled, revoked, suspended or otherwise terminated. Failure to immediately notify US Script in writing of any such action may result in immediate termination from the pharmacy network. Also, failure to maintain the Medicaid Provider Number may result in immediate termination from the US Script Pharmacy Network as a provider.

Pharmacy Participation Agreement

The applicant is required to complete, sign and return the US Script Pharmacy Participation Agreement. Said agreement requires complete documentation including, but not limited to the provider's name and address; telephone phone number; facsimile number; current state license number; current federal tax identification number; current NABP number and corporate status.

Primary Source Verification of Applicant's Documentation

The Contract File Credential Information Checklist is used to track the receipt date of the applicant's required documentation submitted for enrollment and credentialing in the US Script Pharmacy Network. All relevant documents and records are assembled in the provider's credentialing file.

Once the applicant's credentialing file is complete, the credentialing specialist will execute primary source verification of the applicant's credentials. This includes, but is not limited to querying various databases and other sources of information to verify evidence of a current and valid permit to operate a pharmacy in the applicant's respective State(s); current insurance policies; current and valid DEA registration; current and valid Medicaid Number; any malpractice activity; any State disciplinary actions including terminations, suspensions or reductions in privileges; any violations leading to suspension or revocation of pharmacy license or DEA registration; and any sanction activities related to Medicare, Medicaid or other governmental programs or agencies.

US Script reserves the right to schedule an onsite visit with the applicant to verify information provided on the application and evaluate suspected deficiencies and/or inconsistencies in the application. US Script wants to ensure that all pharmacies meet standards, including safety, cleanliness, patient confidentiality and access standards.

The applicant is considered to be "credentialed" and accepted into the US Script Pharmacy Network when all required documentation has been verified as being valid and current, all credentialing criteria have been met, and the applicant's credentialing status has been approved by the Quality Oversight Board of Director's Committee at US Script. Moreover, the Pharmacy Participation Agreement will not be signed by an authorized US Script designee and executed until this initial enrollment and credentialing process has been completed, and the applicant has been formally accepted for participation in the US Script Pharmacy Network.

US Script Credentialing Committee

Each week, the credentialing specialist at US Script will prepare a network credentialing report which includes information regarding the eligibility status of providers applying for enrollment and credentialing privileges in the pharmacy network. Said report is forwarded to the Credentialing Chair for their review and recommendations. The Credentialing Committee reviews those applicants whose credentials meet the criteria for participation in the US Script Pharmacy Network.

Applicant files that do not meet the US Script Pharmacy Network criteria, contain any deficiencies identified via the credentialing process, or have issues identified with the integrity of administrative policies and procedures will be documented and referred to the Credentialing Committee for review. The Credentialing Committee will determine the type and extent of the occurrence and refer the occurrence to the Quality Improvement/Utilization Committee for further review and recommendations. Final determination will be made by the Quality Oversight Committee and may include action up to and including termination from the Pharmacy Network. All such occurrences and corrective action will be placed in the provider's credential file.

The credentialing specialist will notify the applicant in writing of any recommendation to deny participation in the US Script Pharmacy Network. The applicant is informed in writing that he/she may appeal the decision in writing to the Credentialing Committee within 10 business days of the receipt of the decision. The Committee will notify the applicant of the appeal decision within 20 days of the receipt of the appeal. All completed credentialing records will be filed in a secure area.

Re-Credentialing Standards

Providers accepted into the pharmacy network are subject to re-credentialing every 3 years. The process for re-credentialing is identical to that of credentialing, except that as part of the review, US Script will consider any eligible plan member complaints; quality improvement review studies; utilization management review studies; pharmacy audits and customer satisfaction surveys. The entire re-credentialing process is commenced approximately 90 days prior to the re-credentialing date, which is based on the network approval date. A date tickler file will automatically identify and set into motion the re-credentialing process to assure timely and complete review processes.

As with the initial credentialing verification process, the credentialing specialist performs primary source credential verifications by querying databases and other sources of information as necessary. Upon satisfactory completion of verifications and a preliminary assessment that applicant meets credentialing criteria, the credentialing review specialist may schedule an onsite visit with the pharmacy to verify information provided on the application and evaluate suspected deficiencies and/or inconsistencies in the application. US Script wants to make certain that all pharmacies meet standards, including safety, cleanliness, patient confidentiality and access standards. US Script retains the absolute right to conduct a facility review any time a deficiency, breaches of standards of care or delivery are suspected.

Changes in Documentation and Other Information

Provider must notify US Script in writing within 10 days of any changes in the documentation and other information provided to US Script in connection with any credentialing or re-credentialing initiatives.

Advertising and Promotions

Without the prior written consent of US Script, provider must not use words, symbols, trademarks or service marks which US Script uses, in advertising or promotional materials or otherwise, and provider must not advertise or publicly display that it is a member pharmacy without the prior written consent of US Script. Provider must immediately cease any and all usage of such immediately upon termination of this agreement

US Script may list provider by name, address, and telephone number for each of its locations in applicable directories, brochures or other publications for distribution and/or use by US Script, payers and eligible persons.

Termination from Pharmacy Network

Providers are instructed to contact the US Script Pharmacy Network Coordinator if they have been suspended or excluded from participating in Medicare, Medicaid or any other Federal program for any reason. US Script will take appropriate action when

occurrences of poor quality, fraud or abuse are identified, including suspending or terminating affiliation with the contracted pharmacy.

Office of Inspector General

Providers sanctioned by the Office of Inspector General (OIG) who are not eligible to participate in Medicare, Medicaid, and other Federal health care programs are not eligible to participate in the US Script Pharmacy Network.

If sanctioned by the OIG and excluded from participation in Federal health care programs, the provider will be immediately terminated from the US Script Pharmacy Network. However, if the provider is terminated based upon information on the OIG website, and the provider in good faith disputes the validity of that information in writing to US Script, the provider will be given a 45-day extension to provide proof of the provider's reinstatement or other ability to participate in Federal health care programs.

Reporting of Investigations and Disciplinary Actions

As stated in the foregoing, the provider must notify US Script immediately in writing if its license(s) and/or permit(s) have been suspended or revoked, or are in jeopardy of being suspended or revoked for any reason. The provider must also notify US Script immediately in writing if it receives notice of any proceedings that may lead to disciplinary actions, or if any disciplinary actions are taken against the provider or any of its personnel, including actions by Boards of Pharmacy, the Office of Inspector General (OIG), or other regulatory bodies. Failure to immediately notify US Script in writing of any such investigations or disciplinary actions may result in immediate termination as a provider.

Confidentiality and Proprietary Rights

All eligible persons' information related to Prescription Drug Benefits and other records identifying eligible persons shall be treated by the provider as confidential and proprietary. All materials relating to pricing, contracts, programs, services, business practices and procedures of US Script are proprietary and confidential. The provider must maintain the confidential nature of such materials and return them to US Script upon termination of the agreement.

The provider acknowledges that any unauthorized disclosure or use of information or data obtained from or provided by US Script would cause US Script immediate and irreparable injury or loss that cannot be fully remedied by monetary damages. Accordingly, if a provider should fail to abide by these provisions, US Script is entitled to seek and obtain injunctive relief, monetary remedies or other such damages as available by law against the provider.

Court Orders, Subpoenas, or Governmental Requests

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

PHARMACY CLAIM SUBMISSION, ADJUDICATION AND PAYMENT GUIDELINES

Professional Judgment

The provider is required to deliver pharmacy services under the direct supervision of a licensed pharmacist and according to prescriber instructions in accordance with applicable law. The provider must exercise professional judgment at all times in rendering pharmacy services to an eligible plan member. Moreover, the provider may refuse to deliver pharmacy services to an eligible plan member based on that professional judgment.

Nondiscrimination

The provider cannot discriminate against an eligible plan member on the basis of race, color, national origin, gender, religion, disability, medical condition, political convictions, sexual orientation, or marital/ family status. Unless professional judgment dictates otherwise, the provider is required to deliver pharmacy services related to covered items to all eligible plan members in accordance with applicable Law.

Identification Cards

US Script and/or health plan sponsors will provide eligible plan members with identification cards. An identification card may show coverage for the eligible plan member only, or it may show coverage for the eligible plan member and his/her dependent(s). Although identification cards vary by health plan, a sample of a typical identification card produced by US Script is illustrated below.



As illustrated, the identification card will be designed and produced using the National Council for Prescription Drug Programs (NCPDP) format, and will contain the Eligible plan member identification number, the bank identification number (RxBIN) and the group (RxGRP) and/or processor control number (RxPCN). On occasion, health plan sponsors may distribute identification cards that do not include all of the information highlighted above.

The provider is required to request the identification card from the eligible plan member and utilize the information on the identification card to submit claims through the US Script adjudication claims system. The provider will not be paid for rendering pharmacy services to an plan member whose eligibility was not correctly submitted.

Eligible Plan Member Fees

The provider is required to submit claims only for the eligible plan member for whom a prescription for a covered item was written by the prescriber and dispensed to the eligible plan member.

The provider is required to collect any administrative, transaction, access or other types of fees at the point-of-service from the eligible plan member, when applicable. The total amount collected from the eligible plan member for providing pharmacy services related to a covered item will be transmitted through the US Script adjudication claims system, and may be debited from provider's claims payment account.

Collection of Eligible Plan Member Pay Amounts

Health plan sponsors determine the co-payment amounts which provider is required to collect from an eligible plan member for the pharmacy services related to a covered item. The eligible plan member co-payment amounts will vary by health plan sponsor and/or health plan. Unless otherwise directed by US Script, the provider is required to collect from the eligible plan member the co-payment amount as indicated by the US Script claims adjudication system. The provider cannot waive, discount, reduce or increase the plan member co-payment amount determined by the claims adjudication system. Moreover, if US Script determines that the provider has charged or collected from an eligible plan member in excess of the member co-payment amount determined by the claims adjudication system, the provider must promptly reimburse the eligible plan member for the excess amount upon request from US Script. Otherwise, US Script retains the right to recover said excess amounts or unauthorized fees from the provider (including by offset against other amounts owed to the provider) and return the recovered amounts to the appropriate eligible plan member.

Refills

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

Compounds

Prescriptions which are compounded for eligible plan members must be submitted to US Script using the NDC of the most expensive legend drug. The compound must contain at least one ingredient that is a legend drug.

Limitation on Collection

The provider cannot bill; charge; collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against an eligible plan member for the provision of pharmacy services related to a covered item in any event, including nonpayment by or bankruptcy of a health plan sponsor or US Script. However, this does not prohibit the provider from collecting the authorized co-payment amount or charging the eligible plan member for noncovered items disclosed and agreed to in advance by eligible plan member.

Submitting a Claim

The provider is required to submit pharmacy claims electronically through the US Script claims adjudication system for all covered items. The provider must also submit all necessary information requested in the Pharmacy Service Agreement and required by

the claims adjudication system for each claim. Each claim submitted by the provider will constitute a representation by the provider to US Script that the pharmacy services were provided to the eligible plan member, and that the information transmitted is accurate and complete.

Claim Definition

A claim is an electronic request for reimbursement for any covered prescription transaction. A claim will be paid or denied. For each claim processed, a claims detail report is mailed to the pharmacy that submitted the original claim. For further information, the provider can access the adjudication software system transaction inquiry on the US Script website for explanation of the denial. US Script shall adjudicate clean pharmacy claims in a timely manner according to industry standards.

Clean Claim Definition

A “clean claim” refers to a claim received by US Script for adjudication in a nationally accepted format and in compliance with standard coding guidelines which requires no further information, adjustment, or alteration by the provider in order to be processed and paid by US Script. The following exceptions apply to this definition: (a) a claim for which fraud or abuse is suspected and (b) a claim for which a third party resource should be responsible.

Non Clean Claim Definition

“Non-clean claims” are submitted claims that require further investigation or development beyond the information contained therein. The errors or omissions in claims will result in a request for additional information from the provider or other external sources to resolve or correct data omitted from the claim; review of additional records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines of a health plan.

Filing/Reversing a Claim

All claims must be submitted electronically through the US Script claims adjudication system. Failure to submit a claim within 30 days from the date of the fill may result in nonpayment of the claim.

The provider must reverse all prescriptions not received by an eligible plan through the electronic claims system. The provider may only reverse and submit a claim within the same payment cycle in which the claim was originally submitted.

Rejected Claims

Rejected claims may be resubmitted in the same manner as the original claim with corrected information.

Taxes

If any taxes, assessments and/or similar fees (“taxes”) are imposed on the provider by a governmental authority based on the provider’s provision of prescription drugs to eligible persons, the provider may request reimbursement from the payer or eligible plan member for such taxes that are allowed and imposed by applicable law. The provider

must transmit the applicable tax amount allowed by law through the claims adjudication system. In no event does this give the provider any additional or different rights than those allowed by law. In no event shall US Script be liable for any such taxes, assessments or similar fees or the determination of the amount of such taxes, assessments or similar fees.

Data Fields and Submission Requirements

The following payer sheet includes optimal data elements in NCPDP Version 5.1 required by US Script for claims processing.

<http://www.usscript.com/Script/PDFs/PharmacyServices/PayerSheet.pdf>

US Script requires all providers to file claims electronically with the following criteria:

- All documentation must be legible
- Providers must submit claims data for every member's prescription drug transaction
- Providers must ensure that all data and documents submitted to US Script, to the best of their knowledge, information and belief, are accurate, complete and truthful
- All claims data must be submitted by electronic media in an approved format

Claim Payment

Clean claims will be adjudicated within 30 days of the receipt of the claim for most health plans, unless otherwise specified by law. For example, claims for members of the Peach State Health Plan will be adjudicated (finalized as paid or denied) within fifteen (15) business days of the receipt.

No later than the fifteenth (15) business day after the receipt of a provider claim that does not meet clean claim requirements, US Script will pend the claim and request additional information through the US Script website or explanation of benefits for all outstanding information such that the claim can be deemed clean.

Claims Payment/Remittance Advice

US Script will pay the provider according to the published payment schedules and the agreed upon rates subject to the terms and conditions of the Pharmacy Participation Agreement, and will supply the provider with a report showing the record of all claims submitted, processed and paid in each processing cycle. Said reports may be distributed by mail, posted on the US Script website or presented by other electronic means.

If the provider is receiving pharmacy remittance electronically, the provider must adhere to HIPAA regulations which mandate ASCX-12N 835 and updates as required. US Script will not provide any other electronic formats. Providers with questions regarding the testing, creation and receipt of the 835 data file should contact US Script by either fax to 559-244-3793 or mail to the following address:

US Script
Provider Network Services
2425 West Shaw Avenue
Fresno, California 93711

Unsatisfactory Claim Payment

If a provider has a question or is not satisfied with the information they have received related to a claim, they should contact US Script's Accounts Payable department at 800-413-7721.

- Providers may discuss questions with US Script representatives regarding the amount reimbursed or denial of a particular claim. Providers may also submit in writing, with all necessary documentation, including the Explanation of Payment (EOP) for consideration of additional reimbursement.
- Any response to approved adjustments will be provided by way of check with accompanying EOP.

All disputed claims will be processed in compliance with the claims payment resolution procedure described herein.

Pricing Changes

US Script may change the applicable AWP discount and dispensing fee and/or transaction fee by giving the provider written notice of such amendment thirty (30) days prior. The provider may reject such amendment by providing written notice to US Script. Such notice must be received by US Script prior to the effective date of the amendment. US Script has the right to immediately terminate the Agreement or provider participation from a particular network in the event any such amendment is rejected by provider.

Signature Log

Unless otherwise agreed to in writing by US Script, the provider must utilize a third party signature log that contains all information required by US Script and health plan sponsors in accordance with industry standards. Said information must include, but is not limited to the following: date, prescription number, name of the third party program, and authorization for the release of the information to US Script and/or health plan sponsor.

Documentation

The provider is required to maintain all documents and records related to covered items dispensed to the eligible plan member in accordance with industry standards. Documents and records must be in a readily obtainable location for a minimum of three years or as required by law. Said documents and records may include, but are not limited to the following: original prescriptions; signature logs; daily prescription logs; wholesaler, manufacturer and distributor invoices; prescriber information and patient profiles. Refer to the Professional Audit section for more detail on documentation requirements.

CLINICAL PHARMACY PROGRAMS AND SERVICES

Provider Information Updates

Providers must notify US Script in writing of any changes in name, address, telephone number, services, and/or ownership. Said information is required to be sent by either: (1) facsimile to 559-244-3793, or (2) mail to the following address:

US Script
Provider Network Services
2425 West Shaw Avenue
Fresno, California 93711



Directories

The provider must allow US Script and health plan sponsors to list the provider in applicable directories and databases for distribution and use by eligible plan members, health plan sponsors and others as determined by US Script and/or plan sponsors. Moreover, US Script may list the providers that participate in performance initiatives foremost in paper and web-based directories and in health plan sponsor reporting.

Performance Initiatives

The provider must support US Script performance initiatives such as, but not limited to, performance drug program, drug utilization review, formulary adherence, prior authorization, managed drug limitations, dose optimization, and prerequisite step therapy. Refer to the Clinical Programs and Services section of this manual for a further description of these initiatives.

Educational Materials

US Script may educate provider about products, programs and services as well as distribute health plan sponsor announcements. Educational materials may be distributed through various means, including e-mail, facsimile, mail, or posted on the US Script website and/or affiliate health plan sponsor website.

Eligible Plan Member Complaints

The provider is required to cooperate with US Script and/or health plan sponsors to resolve complaints by eligible plan members. The provider must make a reasonable effort to rectify the situation that leads to the complaint from an eligible plan member. The provider must maintain written records of events and actions surrounding each complaint.

The provider must support all clinical programs and services, and utilize software that will display all messages related to clinical programs and services. Said provider software must provide patient drug and medical information records, as allowed by applicable law.

Subject to applicable law, the provider must provide US Script any and all reasonably available information that US Script needs to perform such clinical programs and services, and conduct drug utilization review accordingly.

The provider must act upon all messages related to clinical programs, subject to professional judgment.

Generic Drug Standards

Whenever permitted, the provider is required to dispense a generic drug in accordance with applicable laws. Additionally, the provider is required to use reasonable efforts to fulfill US Script and health plan sponsor mandatory generic programs. The provider is required to stock a sufficient amount of drugs under their generic name coinciding with the practice of local prescribers, the US Script and/or local health plan sponsor formulary(s) or their preferred drug lists.

The provider is required to contact the prescriber to encourage a change to a generic substitute when the prescription contains a “dispense as written” signature for a multisource brand medication. When a multisource brand medication is dispensed, provider must submit the correct “dispense as written” code as set forth in the section of this Manual entitled DAW Codes and Descriptions.

DAW CODES AND DESCRIPTIONS

0 – No Product Selection Indicated: This is the field default value appropriately used for prescriptions where selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed.

1 – Substitution Not Allowed by Prescriber: This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written.

2 – Substitution Allowed – Patient Requested Product Dispensed: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name, and the product is available from multiple sources.

3 – Substitution Allowed – Pharmacist Selected Product Dispensed: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name, and the product is available from multiple sources.

4 – Substitution Allowed – Generic Drug Not In Stock: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the market place.

5 – Substitution Allowed – Brand Drug Dispensed As Generic: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, and the pharmacist is utilizing the brand product as the generic entity.

6 – Override: This value is used by various claims processors in very specific instances, as defined by the claims processors and/or its client(s).

7 – Substitution Not Allowed – Brand Drug Mandated By Law: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.

8 – Substitution Allowed – Generic Drug Not Available in Marketplace: This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed or is temporarily unavailable.

9 – Other: This value is reversed and currently not in use. NCPDP does not recommend use of this value at the present time. Please contact NCPDP if you intend to use this.

Drug Utilization Review

Inappropriate drug therapy can cause member injury and lead to additional health care costs. In an effort to reduce the number of situations where an eligible plan member may receive inappropriate drug therapy, US Script provides a concurrent drug utilization review (DUR) program that detects a potential therapeutic problem or drug interaction at the point of service.

The functions of the DUR program are to:

- Analyze prescriptions submitted through US Script
- Screen prescriptions for several types of therapeutic or drug interaction problems
- Serve as a clinical information service

US Script's claims adjudication system will electronically alert the dispensing pharmacy of therapeutic or drug interaction problems via the following standard NCPDP point of service (POS) alerts:

- “DA” drug allergy
- “DC” inferred drug-disease precaution
- “DD” drug-drug interaction
- “DF” drug-food interaction
- “ER” overuse precaution
- “HD” high dose alert
- “ID” ingredient duplication
- “LD” low dose alert
- “LR” underuse precaution
- “MC” actual drug-disease precaution
- “MN” insufficient duration alert
- “MX” excessive duration alert
- “OH” drug-alcohol interaction
- “PA” pediatric
- “PG” pregnancy
- “PR” prior adverse reaction
- “TD” duplicate therapy
- Clinical Significance
- Other Pharmacy Indicator
- Previous Fill Date
- Previous Fill Quantity
- Database Indicator
- Other Prescriber Indicator

The DUR program is not intended to replace the knowledge, expertise, skill, and sound professional judgment of the provider or prescriber. The provider is responsible for acting or not acting upon the DUR information generated and transmitted through the claims adjudication system and for performing provider services in each jurisdiction consistent with the scope of their respective licenses.

Drug use inconsistent with the US Script criteria may be appropriate in certain clinical settings.

Formularies

US Script develops and assists health plan sponsors in developing formularies that achieve desirable clinical outcomes and help control overall health care costs. Formularies are provided as a reference for drug therapy selections. The final choice of specific drug selection for an eligible plan member rests solely with the prescriber.

The provider must support all formulary initiatives and inform an eligible plan member when a nonformulary drug has been prescribed, and as stated in the foregoing, use best efforts to contact the prescriber to encourage formulary compliance. When a claim is submitted for a nonformulary drug and the health plan has a drug formulary, it will reject with **CODE 75: PRIOR AUTHORIZATION REQUIRED**. In many cases, the member co-payment is higher for a nonformulary medication.

Prior Authorization

For some health plans, certain medications will require a prior authorization (PA). In these situations, the prescriber is required to supply additional documentation to US Script and/or the health plan sponsor to determine whether certain criteria are met for the drug to be covered under the health plan.

If a medication is designated for prior authorization, the claim can reject with the following messages:

“NOT ON PDL”

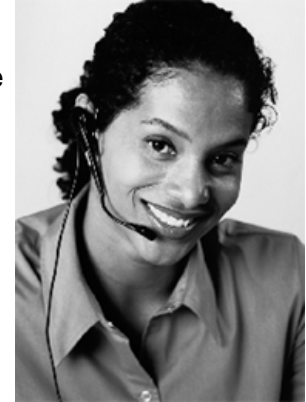
“PRIOR AUTHORIZATION REQUIRED”

In most cases, the claims system response will also provide the correct contact information in the subsequent message. If the prescriber feels the drug is medically necessary, he or she will need to call the number listed in the messaging to initiate coverage.

The provider must support all clinical programs and services and inform eligible persons when a drug designated for prior authorization has been prescribed. The provider must use its best efforts to contact and inform the prescriber when prior authorization messaging occurs.

PROVIDER COMPLAINT PROCESS TO IDENTIFY & RESOLVE FORMAL COMPLAINTS/GRIEVANCES

US Script's Provider Services Call Center provides customer service to providers (e.g., located primarily at pharmacies and medical offices). The following provider complaint process details the steps needed for review and follow-up of a formal oral or written complaint to the Provider Services Call Center.



Provider Complaint Process

When a provider contacts the call center and presents a formal oral or written complaint about our service(s), the customer service representative fills out a Provider Service Tracking Log. The Provider Service Tracking Log includes:

- Provider name
- Member ID
- NABP # (Pharmacy), DEA # (Physician) or other identification #
- Date of complaint
- Type and description of complaint
- Attempted resolution
- If call is escalated, this is notated on the document
- Escalation resolution
- Status of provider satisfaction at the end of the call

If the customer service representative is unable to resolve the formal complaint with the provider, the provider will be immediately referred to the Manager. The complaint is discussed and an effective problem resolution sought.

If the Manager is unable to resolve the complaint with the complainant, an acknowledgement letter will be sent to the complainant within five (5) business days of receipt of formal complaint. This acknowledgement letter includes a description of the complaint, a description of the complaint procedures, a description of the appeal procedures, and relevant time frames.

US Script has thirty (30) days to acknowledge, investigate, and resolve the complaint after the formal oral or written complaint. The complaint resolution letter includes a description of the appeal process and time frames for the complaint process and final decision.

If provider chooses to appeal a complaint resolution, the provider is referred to the Director of Pharmacy of the health plan for any appeal decisions.

If the provider chooses to appeal the final decision, a letter acknowledging the appeal request is sent to the complainant within five (5) business days of receipt of appeal request.

Following a thorough investigation, a letter informing the complainant of the final decision on the appeal is sent, and includes a statement of the specific medical, clinical, and/or contractual criteria used to make the final decision.

The health plan has (30) calendar days to indicate that the appeal process is complete after receipt of request for appeal.

Eligible Plan Member Complaint Process

If an eligible plan member is unhappy with anything about US Script or its pharmacy network, he/she should contact US Script via the following method:

- Call the Customer Service Call Center at (800) 460-8988
- Fill out the Grievances/Appeals Form included in the New Member Handbook. Additional forms can be requested from the Customer Service Call Center
- Write a letter telling US Script about the complaint. The letter should include the eligible plan member's first and last name, member identification number, address, and telephone number. It should also include any information that helps explain the complaint. The form should be mailed to:

US Script
Director, Quality Improvement
2425 W. Shaw Avenue
Fresno, CA 93711

Grievances sent to US Script will be reviewed and investigated by the Director of Quality Improvement. If needed, the Director will share the grievance with managers at US Script. The Director will contact the eligible plan member by mail or phone within 48 hours and tell him/her the result of the review.

If the eligible plan member is unhappy with a prior authorization decision or the terms of his/her benefit plan, he/she has to file an appeal. Decisions about benefit coverage are made by the health plan sponsor. The eligible plan member should refer to his/her health plan member handbook or health plan's member advocate to learn how to file for an appeal with the health plan.

If a plan member contacts the Provider Services Call Center to register a complaint, the call center staff will refer the plan member to the health plan sponsor's member advocate. The member advocate bears the responsibility to assist members in understanding and using the complaint system and any appeals of adverse determination.

PROFESSIONAL AUDIT

Inspections Rights

US Script reserves the right to audit compliance with the provider during the term of the Pharmacy Participation Agreement and for two (2) years following termination of the Agreement for any reason. This includes, but is not limited to, prescriptions for covered items for eligible plan members, U&C submissions, and claims paid to the provider by US Script. US Script reserves the right to inspect all provider records relating to the Agreement.

Audit Types

US Script's claims adjudication system audits every pharmacy claim concurrently.

Retrospective audits may be conducted in the form of a telephone inquiry, an investigational audit, and/or an on-site audit.

Telephone Inquiries

US Script monitors claims data for reasonableness and potential billing errors on a daily basis. If a discrepancy is found, a representative from US Script will contact the provider via telephone to inquire about, validate and help resolve the discrepancy.

Most of these discrepancies can be validated over the telephone and resolved through a claim reversal and resubmission. In this case, no documentation is requested, and an on-site visit would not be necessary.

Investigational Audits

For an investigational audit, providers are contacted via telephone or through the mail, and asked to provide photocopies of specific documents and records related to claims paid to the provider by US Script during a specified period. Documentation may include, but not be limited to original prescriptions, signature logs, computer records, and invoices showing purchase or receipt of dispensed medications.

US Script will identify any discrepancies found in the documentation and request that the provider review and respond to the discrepancies.

On-site Audits

For an on-site audit, US Script will typically notify provider approximately two weeks prior to a scheduled audit date. Auditors will generally review specific documents and records related to claims paid to provider by US Script during the previous three (3) years.

Auditable Documents and Records

The provider will provide US Script health plan sponsors, governmental agencies, and departments and/or their representatives or agents access to examine, audit, and copy any and all records deemed by US Script as necessary to determine compliance with the terms of the agreement. Documents and records must be readily accessible. The provider must give auditors access to examine and copy any and all documents and records that US Script deems necessary to determine whether the provider is compliant with the provisions and terms set forth in the provider agreement, including all US Script documents. Such documents and records may include, but are not limited to, the following:

- Original prescriptions
- Signature logs
- Daily prescriptions logs
- Wholesaler, manufacturer and distributor invoices
- Refill information
- Prescriber information
- Patient profiles/doctor orders

Documents and Records Access

The provider must make available to the auditor a clutter free work area, located away from the busiest area of the pharmacy, but with ease of access to the documents and records that are required for the audit.

The provider must maintain proper staffing on the scheduled audit date to ensure that the provider is reasonably available for questions and the retrieval of information.

The provider authorizes the release of information deemed necessary to determine the provider's compliance with the provider agreement to appropriate agencies and parties—including, but not limited to, governmental authorities, third party payers, wholesalers, professional review organizations, and other such parties—as requested by the aforementioned agencies and parties, or by US Script.

US Script will try to minimize the burden on the provider while requesting the necessary information to perform an audit. However, if a US Script auditor is denied access to the provider or if the provider fails to release all the requested documentation, 100 percent of the amount for the paid claims in question will become immediately due and owing and US Script may offset such amounts against any amounts owed by US Script to the provider.

Provider must promptly comply with all requests for documentation and records.

Document Requirements

Original Prescriptions

All prescription documentation, including telephone, oral and computer-generated orders, must contain the following information:

- Full name of the patient for whom the prescription was written by the prescriber and the address at which the patient resides
- Full name, address and telephone number of the prescriber
- Name, quantity and strength of the medication prescribed
- Specific dosage directions
- Generic substitution instructions (if applicable)
- Notation when patient requests that a multisource brand medication be dispensed
- Refill instructions
- Miscellaneous or other information as required in accordance with applicable law(s)
- Prescription hard copies for insulin and diabetic supplies must contain complete documentation of items, quantities dispensed and directions for use
- Prescription records must be stored for at least three years or such longer period as required by law
- Hard copies of prescriptions must be renewed at least annually, or such shorter period as required by applicable law

During the audit, it may be difficult to remember the circumstances surrounding a particular prescription. Therefore, US Script 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 to resolve the discrepancy.

Signature Log

The provider must utilize a third party signature log that contains all information required at that time by US Script's plan sponsors and industry standards. The information must include, but not be limited to, the date of fill, the prescription number and the name of the third party payer.

For each claim adjudicated through the claims system, the provider must obtain the signature of the eligible person (or his or her authorized representative) on the third party signature log to confirm that he or she has received the medication recorded and has read and agrees with the certification statement (NCPDP0-approved patient disclaimer).

Eligible plan members whose plan sponsor requires 100 percent co-payment at the point of service or who have prescriptions delivered or mailed must also sign the third party signature log. Options for delivered or mailed prescriptions include:

- If delivered to a home or business address, the provider must obtain the signature at the door; if the eligible plan member or authorized representative is unavailable to sign, the provider may leave for the eligible plan member a pre-addressed, confidential envelope containing information including the date of fill, prescription number, third party program, and a space for the signature expressly for the eligible plan member to sign and send back to the provider.
- If the eligible plan member is sent monthly billing statements, the provider may insert a form listing the dates of fill and prescription numbers; the eligible plan member or authorized representative should be instructed to sign and return the form with his or her payment.

The third party signature log must be in date order and readily accessible for a minimum of three years (or as required by law) from the date of the last signature, corresponding with the length of time required for retaining prescription hard copies.

Wholesaler, Manufacturer and Distributor Invoices

Wholesaler, manufacturer and distributor invoices must be maintained for a minimum of three years or as required by law to substantiate that the drugs dispensed were purchased from an authorized source. US Script may request that the provider gives authorization to the wholesaler, manufacturer or distributor to release corresponding purchase invoices to US Script to facilitate the purchase verification process. The provider must promptly comply with such requests. If the provider fails to promptly provide such authorization, US Script has the right to charge back 100 percent of the amount for any paid claims in question.

Audit Resolution

If discrepancies are found during an audit, US Script will send the provider a report listing all of the discrepancies along with documentation guidelines that show how to address a discrepancy and validate the paid claims in question.

The provider must respond to US Script in writing within 30 days with proper supporting documentation for the paid claims in question. Documentation must be mailed to US Script via certified mail, Federal Express, United Parcel Service, or any other certified carrier, and must be received by the final due date specified by US Script.

Any claims that are not documented and validated in accordance with the US Script requirements shall become due and owing to US Script by the provider at the expiration of the 30-day period. In addition, if an audit chargeback exceeds \$2,500, the provider will reimburse US Script \$250 for the cost of the audit. Any and all such amounts shall become immediately due and owing by the provider to US Script.

Any such amounts owing to US Script for discrepant claims or other charges for noncompliance and audit-related costs will be offset against any amounts US Script owes to the provider. Methods used to collect amounts due as a result of audit discrepancies may include, but are not limited to, a request for check, and will therein be offset against the provider's account payable.

When US Script collects from the provider amounts due as a result of audit discrepancies, the provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an eligible person or plan sponsor in relation to such adjustment or chargeback.

The provider may be terminated from participation in the US Script Pharmacy Network if US Script determines that the provider is not in noncompliance with the provisions and terms set forth in the provider agreement.

US Script may report its audit findings to plan sponsors, appropriate governmental entities, regulatory agencies, professional review and audit organizations, and other such entities.