Procedure Number: NYMGP-09

New York State Medication Grant Program Provider Services Manual

Version 1.5

November 15, 2024

Procedure Details

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[X] Government	[ ] PBM Employer	[ ] PBM Health Plan	[ ] Specialty – Medical Pharmacy

Line of Business				
[ ] ADAP	[ ] Commercial	[X] Medicaid	[ ] Medicare Advantage (Part C)	[ ] Medicare Part D

Functional Department(s) or Product(s)
New York State Medication Grant Program

Procedure Name and Specifics	
Procedure Name:	**New York State Medication Grant Program Provider Services Manual**
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Procedure Owners and Approvals		
Cathy Ackerson	*Approval on file*	11/15/2024
Title: Mgr, Operations		Date

Revision History

Document Version	Date	Name	Comments
1.0	03/03/2021	Cathy Ackerson	Initial creation
1.1	02/03/2022	Cathy Ackerson	Annual Review; Minor revision in Dispensing/Quantity Limits
1.2	01/06/2023	Cathy Ackerson	Annual Review; Updated link to Payer Specs and professional dispensing fee
1.3	08/31/2023	Cathy Ackerson	Revision to phone numbers
1.4	12/13/2023	Cathy Ackerson	Annual Review; No revisions
1.5	11/15/2024	Cathy Ackerson	Annual Review; Revisions to Appeals of Audit Results, Provider Reimbursement.

Prime Therapeutics State Government Solutions LLC (“Prime”) performs an annual review of all policies and procedures to ensure that all data is current and any modifications and improvements to processes made over the previous year are included in the documents.

Please note that drives and file extensions referenced in this document can only be accessed from inside Prime’s network.

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1.0 Introduction

In August of 1999, the NYS Governor signed Kendra's Law into legislation. This legislation provided assisted outpatient treatment for some individuals in New York's Mental Health system. Information on this section of the law is easily accessible through the OMH web page at: https://my.omh.ny.gov/bi/aot

This legislation also provides grants for the cost of medications and other services needed to prescribe and administer medication for individuals with a mental illness who leave the local jails, state prisons or hospitals and have applied for Medicaid (Chapter 15 of Kendra's Law). Currently the way the system works, many individuals who leave these jails, prisons and hospitals receive only limited supplies of medication until they qualify for Medicaid. The Medication Grant program provides funding to counties to pay for the individual's mental health medications and services related to providing medication during their pendency of a Medicaid determination.

As the Pharmacy Benefits Manager (PBM) for the New York State Office of Mental Health's Medication Grant Program (MGP), Prime Therapeutics State Government Solutions LLC ("Prime") is committed to providing excellence in the behavioral health community, in both pharmacy benefits and network management. Prime's extensive experience as the PBM for the NY MGP dates back to the MGP's inception in September of 2000.

2.0 General Information

Information in the New York Medication Grant Program's Provider Services Manual is considered proprietary and intended for use only by pharmacy providers enrolled in the New York Medication Grant pharmacy network. Providers cannot copy, reproduce, share, or distribute information included in the provider manual.

2.1 Member Eligibility

In order to be eligible for the MGP, an applicant must:

- be identified as having a serious mental illness
- be scheduled for release from the county jail, state prison or discharged from a psychiatric hospital
- be a New York State (NYS) resident
- appear eligible for Medicaid
- be at least 18 years of age

Once a Medicaid eligibility determination has been rendered by the Center for Medicare and Medicaid (CMS), the member will be disenrolled from the Medication Grant Program (MGP).

It is expected that the pharmacy provider will deliver pharmacy services under the direct supervision of a licensed pharmacist and in conjunction with the prescriber's instructions according to applicable laws. As a participating provider in the MGP, the pharmacist must exercise professional judgment in delivering pharmacy services to an eligible MGP member.

The provider cannot discriminate against any eligible MGP member based on age, race, color, ethnic group, national origin, gender, religion, disability, medical condition, political convictions, sexual orientation, or marital/ family status. Unless professional judgment dictates otherwise, the pharmacist is expected to provide pharmacy services related to covered items to all eligible MGP members in accordance with applicable Law.

2.2 Pharmacy Provider Enrollment

- To participate in the MGP pharmacy provider network, the applicant may request an enrollment packet by contacting the New York State EPIC Provider Helpline at:

  800-634-1340

  Hours: Monday–Friday 8:00 a.m.–5:00 p.m.

- Pharmacy Providers who are interested in enrolling in the MGP must be an approved Medicaid provider and must furnish a valid Medicaid provider number as required by applicable law. The Medicaid number must be kept current at all times.
- Applicants must provide the appropriate credentialing documentation during the enrollment determination process. These documents include:

  - NYS Pharmacy Registration number
  - Medicaid Provider number
  - Federal Tax ID#
  - National Provider Identifier (NPI)
  - Disclosure of Ownership
- Applicants must meet all Federal, State, and local laws for standards of operations and must provide copies of Federal, State, and local licenses and/or business permits as required by law.
- Applicants must complete and return the enrollment packet, including all required information and documentation, to:
- Prime Therapeutics State Government Solutions LLC at 15 Cornell Road, Suite 2201, Latham NY 12210.
- All applications are reviewed and approved by the New York State Department of Health. Once a review is completed, a determination letter is mailed to the applicant. (See Sample Letters)
- Approved applicants will be enrolled in the New York State Medication Grant Program as well as the New York State Elderly Pharmaceutical Insurance Program and the American Indian Health Program

2.3 Provider Services Contact Information

- The MGP Provider Call Center is staffed with our Customer Service Representatives twenty-four hours per day, seven days per week. For assistance you may contact our representatives at: **877-209-6027**
- The MGP Member Call Center is staffed with our Customer Service Representatives from Monday through Friday between the hours of 9:00 a.m.–5:00 p.m. Members seeking assistance call contact our Member Services Call Center at **877-209-6054**
- For technical assistance such as password resets, pharmacy providers can contact Prime's Web Support Center from Monday through Friday between the hours of 8:00 a.m.–8:00 p.m. by calling **800-651-8921**, select option 3.
- For Fraud, Waste and Abuse reports contact: fraudtiphotline@primetherapeutics.com or call the SIU Pharmacy Hotline at **800-349-2919**

2.4 Confidentiality and Proprietary Rights

The provider shall comply with all applicable federal and state privacy laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), and the regulations imposed thereunder, including but not limited to the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 (Privacy Rule) and the Security Standards for Protection of Electronic Health Information at 45 CFR Parts 160 and 164

(Security Rule). Compliance must also follow New York State law which provides for greater privacy protection for MGP patients as referenced in the New York Consolidated Laws, Mental Hygiene Law – MHY § 33.13. Clinical Records Confidentiality at: http://codes.findlaw.com/ny/mental-hygiene-law/mhy-sect-33-13.html

Furthermore, the provider shall not use member information for competitive purposes or provide such information to others for monetary gain or remuneration. This information shall not be provided to a third party, except to the extent that disclosure may be required pursuant to law.

The Pharmacy shall create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which Pharmacy acknowledges and promises to perform, including, but not limited to, the following obligations and actions:

- **Safeguards** – The Pharmacy agrees to use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that the Pharmacy creates, receives, maintains, or transmits on behalf of PBM and/or Plan.
- **Pharmacy's Agents** – The Pharmacy agrees to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of the PBM and/or Plan agrees to use reasonable and appropriate safeguards to protect the PHI.
- **Notification of Security Incident** – The Pharmacy agrees to report to the PBM (Prime) within 48 hours of becoming aware of any use or disclosure of the Plan enrollee's PHI or of any security incident of which the Pharmacy becomes aware.

2.5 Fraud Waste, Abuse and Program Integrity

Prime aggressively pursues allegations of health care fraud, waste, and abuse. The Special Investigations Unit (SIU) is responsible for protecting the assets of Prime and the New York State Office of Mental Health by detecting, identifying, and deterring fraud, waste, and abuse. The mission of our program is the pursuit of suspected fraud, waste, and abuse, by enrollees, pharmacies, prescribers, and others involved in the health care system.

Our program includes procedures to detect and prevent fraud, waste, or abuse through proactive monitoring of members, prescribers and pharmacies through various approaches including data analysis, verification of services, desk audits, on-site audits, and investigations.

2.5.1 Reporting Fraud

The Pharmacy shall report any suspicion or knowledge of fraud and/or abuse to the Special Investigations Unit (SIU), including but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return monies allowed or paid on claims known to be false, incorrect, inaccurate, or fraudulent. The Pharmacy shall not attempt to investigate or resolve the reported suspicion, knowledge, or action without informing the SIU, and must cooperate fully in any investigation by the SIU, or appropriate state and federal authorities, or a

subsequent legal action that may result from such an investigation. The Pharmacy shall, upon request, make available all administrative, financial, and medical records relating to the delivery of items or services for which Plan monies are expended to the Pharmacy. Additionally, the SIU and its auditors and subcontracted auditors, shall be allowed access to any place of business and to all records of the Pharmacy, Subcontractor, or any other entity during normal business hours, except under special circumstances when after-hour admission shall be allowed. Special circumstances shall be determined by the PBM Network Manager.

Suspected fraud, waste or abuse should be reported to: fraudtiphotline@primetherapeutics.com or the SIU Pharmacy Hotline: **800-349-2919**.

2.5.2 Desktop and On-site Audits

Desk and on-site audits may be initiated based upon a random selection, as a result of tips or leads reported to Prime or the New York State Office of Mental Health or based upon the results of ongoing monitoring activities including data analysis. All audits will be conducted in accordance with applicable contractual and regulatory requirements.

Audits will include the following steps:

- Advance notice will be provided to pharmacies (for on-site audits) unless suspected fraud has been identified. When suspected fraud has been identified, no advance notice is required. Prime, and our vendors, will work with pharmacies to make reasonable accommodations when scheduling on-site audits and to ensure minimal disruption to pharmacy operations during the audit process.
- A list of documentation required for the review will be provided (along with the required timeframe and submission method for desk audits).
- A review of the records will be conducted to ensure their accuracy and compliance with regulatory and contractual requirements. When on-site we may also interview staff, review policies and procedures and other relevant documentation and will observe staff interactions with customers. Our audit staff comply with all applicable privacy regulations.
- Once records have been reviewed, a preliminary report of the findings is provided. It will include a detailed list of the discrepancies found, a reference to the contractual or regulatory requirement(s) in question, and guidelines for any opportunity to contest the initial findings. Some findings may not allow for submission of additional documentation due to their nature (e.g., wrong patient or prescriber selected).
- The audit will be closed, and a final report issued once the additional documentation has been reviewed or the time to submit additional documentation has closed. Any changes to the preliminary results based upon the review of additional documentation will be reflected in the final report.

2.5.3 Appeals of Audit Results

Once the audit is closed, pharmacy providers have 30 days to contest the findings by filing an appeal. Appeals must be submitted in writing and include the Pharmacy's name, the claims/prescriptions appealed, and any additional documentation not provided at the time of audit, along with an explanation of the appeal.

Audit findings, including associated recoveries, will be deemed finalized if an appeal is not received from the Pharmacy within the 30 days from the date of notification of the audit findings or an extended timeframe as required by law or regulation.

Documentation provided by the Pharmacy as part of its audit appeal may result in additional findings. Appeal results are considered final. For a copy of Prime's Pharmacy Audit Guidelines and Appeal form, visit the Providers and Physicians - Prime Therapeutics - Portal website.

- Documentation that conflicts with the initial documentation submitted will not be accepted during the appeal process.
- Prescribing Provider or Covered Person attestations received to support the manner in which a claim is submitted must be received directly from the Prescribing Provider or member.
- Appeals received after the due date will not be considered.

If applicable state law allows, the Pharmacy has the right to request an independent third-party review of the final audit findings. The cost of the independent third-party review is dictated by the applicable state law. The Pharmacy can request an independent third-party review within 30 days after all internal appeal processes have been exhausted, unless specified by state law. The request must be received in writing to pharmacyaudit@primetherapeutics.com

2.5.4 Right to Inspection by Government Entities

Provided that the New York State Office of Mental Health (OMH), the New York State Department of Health (DOH), the Office of the Inspector General (OIG), Office of the Comptroller of the Treasury, Medicaid Fraud Control Units (MFCU), and Department of Justice (DOJ), as well as any authorized state or federal agency or entity, shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to the Agreement, including but not limited to:

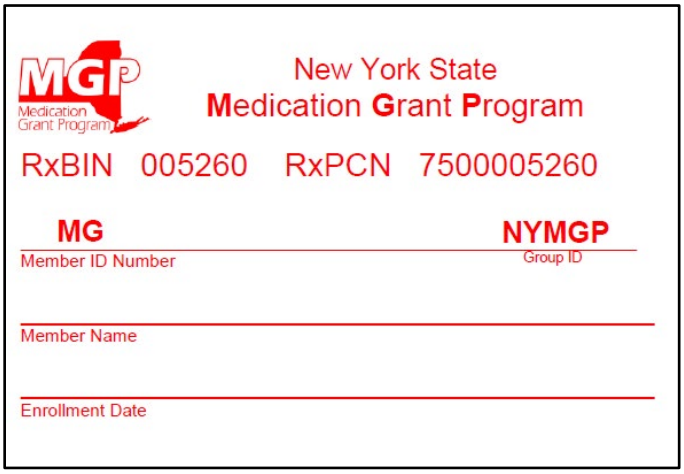
- Medical records
- Billing records
- Financial records, and/or any records related to services rendered, quality, appropriateness, and timeliness of services; and/or
- Any records relevant to an administrative, civil, and/or criminal investigation and/or prosecution

When performed or requested, the evaluation, inspection, review, or request, shall be performed with the immediate cooperation of the Pharmacy. Upon request, the Pharmacy shall assist in such reviews, including the provision of complete copies of medical records. Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not bar disclosure of protected health information (PHI) to health oversight agencies, including but not limited to Office of the Inspector General (OIG), MFCU, DHHS OIG, and Department of Justice (DOJ), so long as these agencies operate in compliance with applicable regulations. Provide that any authorized state or federal agency or entity, including, but not limited to NYSDOH, OIG, MFCU, OIG, DOJ, and the Office of the Comptroller of the Treasury may use these records and information for administrative, civil, or criminal investigations and prosecutions within the limitations set forth under HIPAA and Health Information Technology for Economic and Clinical Health.

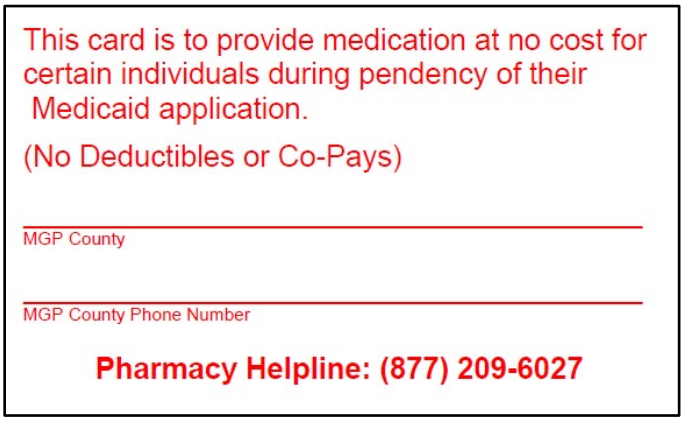
3.0 Pharmacy Claims Submission

Before the pharmacy fills a prescription for a covered medication, the pharmacist must verify the patient's enrollment in the MGP by asking the patient to present their MGP identification card. Each patient must have his/her own member identification number. All membership identification numbers begin with the alpha characters "MG" followed by seven digits. If the patient is unable to produce an identification card (see example below), the pharmacist must contact the MGP Provider Call Center to confirm the patient's eligibility in the program.

MGP Identification Card Example:



FRONT of MGP Card



BACK of MGP Card

The pharmacy must not submit a claim through the Point-of-sale (POS) system until the pharmacist has determined that the patient is actively enrolled in the MGP, the prescription is valid, and issued by a licensed prescriber.

3.1 Submitting a Claim

The pharmacy provider is required to submit pharmacy claims electronically through the Point-of-Sale system for all covered medications. The provider must submit all necessary information as outlined in the Payer Sheet, Pharmacy Service Agreement, and as required by the claims processing system for each claim. Each claim submitted by the provider constitutes a representation that the pharmacy services were provided to the eligible MGP member, and that the data transmitted on the claim submission is accurate and complete.

All claims must be submitted accurately and completely online in the current NCPDP (vD.0) HIPAA-approved format.

For claims submissions to the MGP please use the following information including Plan ID, Bank Identification Number (BIN), and Processor Control Number (PCN):

Plan ID: NYMGP

BIN: 005260

PCN: 7500005260

3.2 Payer of Last Resort

The Medication Grant Program is intended to be the payer of last resort. MGP is responsible for payment of prescription drug costs only if no other active prescription insurance exists and the member appears to be eligible for Medicaid.

3.3 Filing Limits

Any claims received after the MGP coverage has been terminated, must be submitted to Medicaid if the patient is eligible for Medicaid. If the termination was for other reasons than Medicaid coverage and the date of service of the claim is within the MGP coverage period, Prime will process the claim.

Original Claims	Transaction Type	Reversals/Re-bills/Adjustments
POS Original Claims	(NCPDP transaction B1)	365 days
POS Reversals	(NCPDP transaction B2)	unlimited
POS Re-bills (based on DOS)	(NCPDP transaction B3)	732 days

3.4 Dispensing/Quantity Limits

Dispensing limits on days' supply cannot exceed a 30-day supply or 120 units quantity, whichever is less. There are no quantity minimums.

3.5 Refill Requirements

Up to one refill is permitted within 183 days from the date the original prescription was written.

- **DEA = 0:** Original + up to 1 refill within 183 days from original Date Rx was Written
- **DEA = II:** No refills
- **DEA = III – V:** Original + up to 1 refill within 183 days from original Date Rx Written

3.6 Claim Reversals

All claims must be submitted electronically through the Point-of-Sale system. Failure to submit a claim within the allotted billing window from the date of service may result in nonpayment of the claim.

Providers are required to reverse any claim that is not delivered to or received by the eligible MGP member. The provider may only reverse and submit a claim within the same payment cycle in which the claim was originally submitted.

3.7 Rejected Claims

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

3.8 Compound Claims

- Compound claims must be submitted using the Compound Segment, which lists all the ingredients (up to 25).
- All compounds should be submitted with Compound Code (NCPDP Field # 406-D6) = 2
- Coverage rules for POS compounds will equal coverage rules as described for non-compound claims.
  - Prime will identify individual ingredients not covered by returning a Reject Code (NCPDP Field # 511-FB) and Reject Field Occurrence Indicator (NCPDP Field # 546-4F)
  - Resubmission of the claim with covered drugs only.
    - Submission Clarification Code (NCPDP Field # 420-DK) = “08” will indicate the pharmacist’s acceptance of payment for covered ingredients only.
- Compounds must be submitted using a Product/Service ID of zero.
- All compounds must be submitted with the appropriate Compound Dispensing Unit Form Indicator (NCPDP Field # 451-EH)
- All compounds must be submitted with a valid NCPDP value in the Compound Route of Administration field (NCPDP Field # 451-EH)
- Compounds must be submitted with a valid NCPDP value in the Compound Dosage Form Description field (NCPDP Field # 540-EF)

- Each ingredient's NDC must be submitted along with the quantity of the NDC used
- If at least one covered ingredient is a generic, as defined by the Medicaid fee schedule, the standard Medicaid dispense fee will apply
- If no covered ingredients are generic products, as defined by the Medicaid fee schedule, standard Medicaid dispense fee will apply
- The dispensing fee is per claim, not per ingredient

3.9 Data Fields and Submission Requirements

The acceptable data elements for claims submissions are included in the following payer specification sheets: NY Medication Grant Program NCPDP D.0 Payer Specifications

4.0 Prospective Drug Utilization Review (ProDUR)

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

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

4.1 Drug Utilization Review Edits

The following ProDUR edit will deny for the MGP:

Early Refill (ER)

- For all products, Early Refill Tolerance is 75 percent
- For all products, the system will automatically check for an increase in dose and when an increase in dosage is detected, the system will not deny the current claim for early refill.
- The Call Center may assist in overriding this reject if one of the following circumstances exists:
  - Dosage/Therapy change has occurred
  - Patient is no longer taking the original dosage
  - Dosage Time/Frequency Change has occurred
- Problem/Conflict Type: The following override codes may be used by the dispensing pharmacist in any condition where a provider-level override is allowed for ProDUR denials.

Intervention Code/Description	Outcome Code/Description	Rx Submission Code
00/no intervention	1A/filled as is, false positive	01/No override
M0/prescriber consulted	1B/filled prescription as is	02/Other override
P0/patient consulted	1C/filled with different dose	04/Lost prescription
R0/RPh Consulted other source	1D/filled with different directions	05/Therapy challenge
	1F/filled with different quantity	06/Starter dose
	1G/filled with prescriber approval	07/Medically necessary
		08/Process compound for approved ingredients
		09/Encounters

Intervention Code/Description	Outcome Code/Description	Rx Submission Code
		99/Other

NCPDP Field Reference:

- Conflict = (Field ID 439-E4)
- Intervention = (Field ID 440-E5)
- Outcome = (Field ID 441-E6)

5.0 Provider Reimbursement

Pharmacy providers receive payment electronically in the form of an ASCX-12N 835 transaction or paper check if requested by the pharmacy. The MGP reimburses providers according to the Medicaid fee schedule plus the Medicaid dispensing fee.

Drug Type	If NADAC is available reimburse at:	If NADAC is unavailable reimburse at:	Professional Dispensing Fee:
Generics	Lower of NADAC, FUL, SMAC or U&C	Lower of WAC-17.5%, FUL, SMAC or U&C	$10.18
Brands	Lower of NADAC or U&C	Lower of WAC or U&C	$10.18
OTCs (covered outpatient drugs)	Lower of NADAC, FUL, SMAC or U&C	Lower of WAC, FUL, SMAC or U&C	$10.18

Payments for each cycle shall be generated on the same schedule as the remittance advice. The pharmacy provider must comply with all HIPAA regulations which mandate ASCX-12N 835 and updates as required.

To sign up for EFT or ERA, you must visit the pharmacy resources page at https://uac.primetherapeutics.com/.

Once registration is complete, you can access the Finance Portal at the following web address: https://financeportal.primetherapeutics.com/ to view your files.

For assistance, please contact NYFinancialinquiries@primetherapeutics.com. In your email, please include your email address registered to use the Finance Portal, the first and last name linked to the registration email, the NPI or chain code registered with the email address, a statement that your issue is related to the Finance Portal, and a detailed description of your issue.

6.0 Appendices

6.1 Provider Denial Letter Template

NEW YORK STATE | EPIC Elderly Pharmaceutical Insurance Coverage Program

RECIPIENT_ADDRESS_1
RECIPIENT_ADDRESS_2
RECIPIENT_ADDRESS_3
RECIPIENT_ADDRESS_4

TODAY_EP

Dear Supervising Pharmacist:

After considering your application for enrollment, it has been determined that you do not meet the conditions of provider eligibility for participation in the program.

The Specific basis for denial is:

New York State Medicaid does not have a record of your pharmacy enrolled in the program.

If you have any questions regarding the EPIC program, feel free to contact us at 1-800-634-1340.

Sincerely,

[redacted]
EPIC Representative

¿Necesita Ayuda? Llame al 1-800-332-3742

All confidential information is protected. For a copy of the Notice of EPIC Program Privacy Practices visit the Department of Health website at http://www.health.ny.gov/health_care/epic or call 1-800-332-3742.

P.O. Box 15018, Albany, NY 12212-5018 | 1-800-332-3742

6.2 Provider Enrollment Approval Letter Template

NEW YORK STATE | EPIC Elderly Pharmaceutical Insurance Coverage Program

RECIPIENT_ADDRESS_1
RECIPIENT_ADDRESS_2
RECIPIENT_ADDRESS_3
RECIPIENT_ADDRESS_4

TODAY_EP

Dear EPIC Provider:

Thank you for your response to the EPIC Pharmacy Enrollment. This letter is to inform you that your pharmacy has been approved as an EPIC Provider. Your EPIC number will be [redacted] effective [redacted]. Enclosed are the payer specifications for the program.

Please include your EPIC Provider number on all correspondence.

If you have any questions regarding the EPIC program, please feel free to contact us at 1-800-634-1340.

Sincerely

[redacted]

EPIC Representative

¿Necesita Ayuda? Llame al 1-800-332-3742

All confidential information is protected. For a copy of the Notice of EPIC Program Privacy Practices visit the Department of Health website at http://www.health.ny.gov/health_care/epic or call 1-800-332-3742.

P.O. Box 15018, Albany, NY 12212-5018 | 1-800-332-3742

7.0 Glossary

Term	Definition
ADAP	AIDS Drug Assistance Program. Provides free medications for the treatment of HIV/AIDS and opportunistic infections.
Adjudicate	Refers to the process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements.
Allowed Amount	The maximum amount a plan will pay for a covered health care service or eligible expense.
BIN	Bank Information Number
CMS	Centers for Medicare and Medicaid Services
DEA	Drug Enforcement Administration
DOH	Department of Health. A department within the State of New York, which oversees the Medication Grant Program; our client.
DOJ	Department of Justice
DOS	Date of Service
DUR	Drug Utilization Review. A review process performed by Pharmacy Consultants, which monitors a member's prescription histories for four key factors: Drug-to-Drug, Therapeutic Drug, High Dose Drug, and Early Refill Drug interactions. Also known as DUE, or Drug Utilization Edit.
EFT	Electronic Funds Transfer
ER	Early Refill
ERA	Electronic Remittance Advice
FDA	Food and Drug Administration
FUL	Federal Upper Limit
HIPAA	Health Insurance Portability and Accountability Act of 1996. A federal law that includes mandates which protect individuals' rights in reference to the sharing or disclosing of their own health information. The mandates include insurance privacy and technology standards.
MAX	Maximum. The dollar limit amount spent by a private insurance company with any one patient; caps can be either quarterly limits or yearly limits. Also known as the CAP.
Medicaid	A federal and State program that helps with healthcare costs for some people of all ages with limited income and resources.
Medicare	A national health insurance program. Health care for the elderly and people with certain disabilities and diseases.
NADAC	National Average Drug Acquisition Cost
NCPDP	National Council for Prescription Drug Programs

Term	Definition
NDC	National Drug Code. The number which identifies a drug. The NDC number consists of 11-digits, broken into 3 sections in a 5-4-2 format. The first 5 digits identify the labeler code representing the manufacturer of the drug and are assigned by the FDA.
NPI	National Provider Identification. A unique 10-digit identification number issued to health providers, clinical social workers, professional counselors, physical therapists, occupational therapists, pharmacy technicians, and athletic trainers.
NY MGP	New York Medication Grant Program
NYSDOH	New York State Department of Health
OIG	Office of the Inspector General
OTC	Over the Counter
PA	Prior Authorization is a requirement that the physician obtain approval from the health insurance plan to prescribe a specific medication. PA is a technique for minimizing costs, wherein benefits are only paid if the medical care has been pre-approved by the insurance company.
PCN	Processor Control Number
PHI	Protected Health Information. Under Federal law is any information about health status, provision of health care, or payment for health care that is created or collected by a Covered Entity (or a Business Associate of a Covered Entity) and can be linked to a specific individual.
PII	Personally Identifiable Information. Information that can be used on its own or with other information to identify, contact, or locate a single person, or to identify an individual in context.
POS	Point of Sale. These systems help pharmacies and pharmacists digitally and electronically accept payments, track available inventory, manage customers, and confirm or approve purchase orders. These solutions are implemented by retail, clinical, and independent pharmacies alike.
ProDUR	Prospective Drug Utilization Review
QI-1	Qualified Individual. This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, the Medicaid program pays full Medicare Part B premiums only.
QI-2	Qualified Individual. This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, the Medicaid program pays full Medicare Part B premiums only.

Term	Definition
QMB	Qualified Medicare Beneficiary. This is a Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.
RX	Prescription; also known as a “script.”
Script	An abridged version of the word “Prescription;” also knows as an “Rx.”
SMAC	State Maximum Allowable Cost
U&C	Usual and Customary. The amount charged for a drug in a geographic area based on what providers in the area usually charge for the same drug.
WAC	Wholesale Acquisition Cost