WV Medicaid

WV MMIS Medicaid Health PAS-Rx Pharmacy Companion Guide

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1. Introduction

This document is designed to assist West Virginia (WV) pharmacy providers with pharmacy claim submission. The WV Department of Human Services (DHS), the State, and the Medicaid fiscal agent makes pharmacy claims processing available to WV Medicaid pharmacy providers by both real time Point of Sale (POS) and paper claim submission. The State has defined participation requirements for pharmacies, which are detailed in the Companion Guide.

The WV DHS Provider Manual, Pharmacy Services, and any applicable program laws and regulations, contain policy and claim submission requirements for pharmacy services for WV Medicaid members. Providers should also review messages contained in their Remittance Advice (RA) statements for current policy changes and updates.

In addition to administering pharmacy support for those eligible for Medicaid benefits, the State supports processing of pharmacy claims submitted in support of other funded programs.

Some terms used in this guide may be unfamiliar, especially if you are not familiar with POS or the WV Medicaid program. Refer to **Appendix A - Glossary** for a glossary of terms used in this guide.

2. General

The Health PAS-Rx system is operated in conjunction with Healthcare Payer Administration Solution (Health PAS), the WV Medicaid Management Information System (MMIS), and has available all information necessary to adjudicate a pharmacy claim. The system also reports information back to the pharmacist, which aids in correcting claim errors or for billing a source other than Medicaid. The Health PAS-Rx system is also operated concurrent with Health PAS-Rx Drug Utilization Review (DUR) processing.

Only new claims, resubmitted denied claims, or reversals can be submitted via POS. New claims can be submitted via the Universal Claim Form (UCF) paper form. Claims for members enrolled in Medicaid supported programs that require pharmacy claims via paper, must be submitted on the UCF. **Appendix B** – Claim Form – **Claim Form** contains a description and sample UCF as well as instructions for completing the form. For additional instructions or information on submitting claims submitted on a UCF, consult the billing instructions which are located at https//www.wvmmis.com, or call the Pharmacy Help Desk or the Provider Services between the hours of 7 a.m. and 7 p.m. Eastern Time (ET) Monday - Friday:

Pharmacy Help Desk: (888) 483-0801 **(or)**

Provider Services

WV and Border Providers: (888) 483-0793

All Other Providers: (304) 348-3360

Fax: (304) 348-3380

The following restrictions and qualifications apply to pharmacy claim submission:

1. Providers utilizing this service must be authorized by the State and recognized by Gainwell Technologies, the Medicaid fiscal intermediary for this method of claim submission. Claims submitted prior to being granted authorization are rejected.
2. All comments, suggestions, and/or questions regarding this Pharmacy Companion Guide should be directed to the POS Technical Support Help Desk via Provider Services during the hours of 7:00 a.m. and 7:00 p.m. Monday through Friday.

   WV and Border Providers: (888) 483-0801 or (888) 483-0793

   All Other Providers: (304) 348-3360

   Fax: (304) 348-3380

   https://www.wvmmis.com
3. Paper pharmacy claims, submitted on a UCF, requiring no special attention should be mailed to:

   Gainwell Technologies

   P.O. Box 3765

   Charleston, WV 25337
4. Claims requiring supporting documentation or attachments cannot be submitted via POS. Claims that need to be manually reviewed cannot be submitted via POS. Submit on hard copy as per the paper billing instructions provided in **Appendix B – Claim Form** and located at https://www.wvmmis.com. Enclosing a brief cover letter describing the request will expedite the review process. For example, POS claims denied for eligibility. The pharmacy resubmits the claim with a cover letter and photocopy of the member's (Identification) ID card to:

   Gainwell Technologies

   P.O. Box 3765

   Charleston, WV 25337
5. Up to four transactions (prescriptions or reversals) for the same member can be submitted at one time via POS; however, some pharmacy computer systems are limited to processing single prescription transactions. A compound transaction must be submitted as one prescription transmission.
6. Each pharmacy claim must include the Pharmacy's National Provider Identifier (NPI) and the prescribing provider's NPI. Claims submitted without this information will be rejected.

2.1 Getting Started

Before providers can begin submitting POS claims, the State must properly authorize them. The steps for approval are as follows:

1. Contact your system software vendor to obtain and install the necessary software upgrades that may be required and to obtain a system software manual.
2. Select and contract with an authorized telecommunication switch vendor. A current list of authorized telecommunication switch vendors is available upon request from Provider Services. If the preference is to use a telecommunication switch vendor that is not on the approved list, ask the vendor to contact the Provider Services at (888) 483-0793 for in-state and border providers and (304) 348-3380 for all other providers to become authorized.
3. Be responsible for the purchase of all hardware for connectivity to the switching companies and any fees associated with connectivity or transmission of information to the fiscal intermediary. The State and Gainwell will not reimburse the provider for any ongoing fees incurred by the provider to access the Health PAS-Rx system.
4. Complete and return the registration forms required to access information via the provider web portal or to receive an electronic version of a RA which is on paper and supplies providers with their claims that were submitted to Medicaid (835). Once approved by the State, the pharmacy provider will receive written authorization to begin submitting claims using the POS system. Contact the Pharmacy Help Desk for more information. Forms can be downloaded at https://www.wvmmis.com.

2.2 Help Information

Depending on the nature of the provider's inquiry, help information is available from a variety of parties:

- POS Help Desk
- Prior Authorization (PA) Help Desk
- Provider Services
- Pharmacy's telecommunication switch vendor for POS
- Pharmacy's system software vendor for POS
- POS technical support Help Desk

Following are examples of when you might need additional assistance:

Table 2-1: Assistance Examples

Question	Contact
What does this rejection code mean?	POS Help Desk
How do I get a Prior Authorization (PA)?	PA Help Desk
What does this field mean?	System Software Vendor and POS Help Desk

Question	Contact
What values should I enter in this field?	System Software Vendor and POS Help Desk
I am not getting a response. What should I do?	System Software Vendor and Switch Vendor
Why is my response time so slow?	System Software Vendor and Switch Vendor
How do I enroll?	Pharmacy Help Desk

Contact Rational Drug Therapy Program (RDTP), the POS Help Desk and PA Help Desk, for assistance in using the POS system and in billing claims electronically. RDTP can be contacted at (800) 847-3859 or by Fax at (800) 531-7787. Help desk hours are ET. Hours are 8:30 a.m. to 9:00 p.m., Monday through Saturday and Sunday 12:00 p.m. to 6:00 p.m.

RDTP is closed on the following State recognized holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. RDTP closes at 6:00 p.m. on Christmas Eve and New Year's Eve.

Contact the POS Help Desk when there is a question regarding one of the following:

- Claim status (e.g., denied, duplicate, or rejected claim)
- Claim adjudication status
- DUR edits per references
- Billing procedures and policy issues

Contact the PA Help Desk when there is a question regarding one of the following:

- PA status and request

Contact your telecommunication switch vendor when one of the following conditions arises:

- Technical network problem
- Response time is slow and not receiving support from System Software Vendor
- Response is not received

Contact your system software vendor when there is a question regarding one of the following:

- System Software Vendor Manual
- Values to be entered in a field, or where to enter and how to access data
- Response time is slow. The system vendor will contact the telecommunication switch vendor.

Contact the POS Technical Support Help Desk for assistance if your problem cannot be resolved by one of the above points of contact. The POS Technical Support Help Desk can be contacted via Pharmacy Help Desk. Help desk hours are ET. Hours are 8:00 a.m. to 5:00 p.m. Monday through Friday. Be prepared to provide the following information:

- Identify the problem/issue as pharmacy
- Provide a description of the problem
- Provide a Medicaid Provider number or NPI. Provide a system software vendor name and telecommunication vendor name (switch), if applicable.

Contact the Pharmacy Help Desk if unsure of whom to contact or notify of a problem. All comments, suggestions, and/or questions regarding this Pharmacy Companion Guide should be directed to the POS Technical Support Help Desk via Provider Services during the hours of 8 a.m. and 5 p.m. Monday through Friday.

Pharmacy Help Desk

WV and Border Providers: (888) 483-0801

All Other Providers: (304) 348-3360

Fax: (304) 348-3380

Additional frequently asked questions are located in **Appendix C - Questions and Answers.**

3. Claim Processing

Pharmacy POS claims are submitted in Health Insurance Portability and Accountability Act (HIPAA)-compliant National Council for Prescription Drug Programs (NCPDP) D.0 format as defined in the WV POS Vendor Specification document. Pharmacy paper claims submitted on UCF are converted to the HIPAA-compliant NCPDP 1.2 for processing. All pharmacy claims, regardless of submission method, are subject to the same verification and adjudication processes.

Upon completion of processing, pertinent information is returned to the provider. A real-time POS response is returned immediately to the sending provider. Examples of information reported back are verification of member and provider eligibility, claim processing messages, and DUR messages Results of processing a paper claim are indicated on the provider's RA. Paper claims that cannot be processed because of insufficient data or improper data format will be returned to the provider with a Return to Provider (RTP) letter. These claims must be corrected and resubmitted as new claims.

Edits indicate that the claim is denied or provide a warning/informational message associated with claims that can be paid. The Edit Rules document is located at http://www.wvmmis.com and http://www.wvdhhr.org/bms. Pharmacy providers should review returned messages before dispensing the drug. Edits indicating the claim is denied and adjudication not performed have a "D" following the edit number. A "W" follows the edit number when an informational message is provided for a claim.

Claims processed by Health PAS-Rx are available for financial processing. These "ready to pay" claims are released for payment cycle processing as determined by the State. All claims selected for payment cycle processing will be included on the RA, which accompanies the check.

The Health PAS-Rx is a configurable system that allows most changes to be applied in real-time making that change immediately active. Changes can be activated without interruption to claim submission and processing.

Member eligibility is associated to one or more programs. For example, a member may be eligible as a Medicaid recipient or may be eligible for a special program, such as Emergency Medical, that is administered via the State. Benefits are configured at the program level to identify allowed/covered drugs, to enter age and gender restrictions on the drug, and to indicate if a PA is required prior to dispensing the drug.

Edits are configured to select the action (ignore, deny, warn) during processing. Edits can also be modified in real-time to allow a denied response to be overridden by the help desk and in some cases the pharmacy provider. As a configurable system, applied action changes become active within a few minutes instead of days. The only impact is that the State may request an immediate change that does not allow sufficient time to ensure the pharmacy community is notified of the change. For example, if the State directs Gainwell to immediately configure a National Drug Code (NDC) as requiring a PA, the change can be implemented within minutes and become effective as soon as the change is made in real-time. Another example would be removing the capability of a pharmacy provider to override an edit that posted a deny action. This change will be immediate and could be confusing to the pharmacy provider who can no longer initiate an override for the same edit that was overridden just one hour earlier.

It is Gainwell's intent to provide pharmacy providers advance notice of changes via fax, newsletters, emails, the State, and Gainwell web sites, and as needed and agreed upon, the Pharmacy Association. However, based on the circumstance regarding the State's direction, and the provider's internal communication methods, there may not be sufficient time for all providers to receive notice before a change is implemented.

3.1 Maximum Allowed Prescriptions per Point of Sale Transaction

On a POS transaction, up to four prescriptions at a time may be submitted if the following conditions are met:

1. All prescriptions are for the same member.
2. All prescriptions are for the same Date of Service (DOS).
3. No prescription is for a compound.

Example: If six non-compound prescriptions have been filled for one member, a minimum of two POS transactions would be completed, one with four prescriptions and the other transaction with two prescriptions.

On a UCF transaction, two prescriptions at a time may be submitted if the following conditions are met:

1. Both prescriptions are for the same member.
2. Both prescriptions are for the same DOS.
3. Neither prescription is for a compound.

NCPDP Fields:

Transaction Count (109-A9)

Table 3-1: Max Allowed Prescriptions Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7056	Cmpd=1 claim	Only one compound claim in one transaction. Resubmit as a single claim transaction.	PB
7057	N/A	Value must be from ‘1’ to ‘4’ for non-compound pharmacy claims.	A9

3.2 Provider (Pharmacy and Prescriber) Verification

Pharmacy providers must provide licensing information to Gainwell to activate credentialing. All claims must contain the pharmacy provider’s NPI. The Medicaid provider file indicates the provider is not authorized on the DOS, the claim is denied and the provider will be informed via a standard NCPDP reject code as well as additional edit codes and messages. If the pharmacy provider’s licensing information has expired, the claim is denied and the provider will be informed via a standard NCPDP reject code as well as additional edit codes and messages.

Prescribing providers are identified by their NPI also. Formerly the Drug Enforcement Agency (DEA) number was used, but now the NPI is required. A NPI number must be entered on each claim. If the NPI number is not on file, the pharmacy provider is returned a warning edit and message that the number is not on file. The claim is processed.

NCPDP Fields:

Service Provider ID (201-B1), Service Provider ID Qualifier (202-B2), Prescriber ID (411-DB), Prescriber ID Qualifier (466-EZ)

Table 3-2: Provider Verification Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
101	No Providr Contrct	Contact Gainwell for corrective action.	05
104	Incmpl Prov Info	Contact Gainwell for corrective action.	05
108	Prov-No Credential	Contact Gainwell for corrective action.	05
150	No Cntract for NDC	Contact the State for corrective action.	40
152	Wrong Prov Type	Contact Gainwell for corrective action.	AD
156	Provider Not Contracted for Service	Contact Gainwell for corrective action.	40
172	Not Contracted	Contact Gainwell for corrective action.	40
7043	Prescriber ID Qual	Prescriber ID Qualifier must be ‘01’ for NPI (formerly ‘12’ for DEA). Correct and resubmit.	EZ
7047	N/A	Prescriber ID is missing - Enter a valid Prescriber ID	25

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7091	DEA Not on File	Prescriber DEA number or Prescriber NPI number is not on file warning message.	25
7124	N/A	Prescriber segment is missing or invalid. Correct and resubmit.	PN
7131	Provider ID Not Registered or Not Active on DOS	NCPDP [NABP] number or NPI number is not active on DOS. Register with state. Resubmit claims after on file.	40
7135	Incorrect Provider ID Qualifier – Must be NPI After May 22, 2007	Service provider ID qualifier must be ‘07’ for NCPDP ID (formerly NABP number) or 01 for NPI. After May 22, 2007, it must be ‘01’.	B2
7225	N/A	Prescriber ID Qualifier is missing. Correct and resubmit.	EZ
7232	DEA Num Is Not a Valid DEA Number	Prescriber DEA number is invalidly formatted or does not pass the Checksum Algorithm check. Correct and resubmit.	25
7233	Provider ID is not a valid NPI number	The NPI is invalidly formatted or does not pass the NPI Algorithm check. Correct and resubmit.	50
7234	Prescriber ID Is Not a Valid NPI Number	The NPI is invalidly formatted or does not pass the NPI Algorithm check. Correct and resubmit.	25
7237	Invalid Prescriber NPI - Pharmacy NPI used	The Prescriber NPI should cross-reference to a non-pharmacy type provider. Correct and resubmit.	25
7238	Invalid Prescriber - NPI Required On Or After August 13, 2008	The Prescriber ID must be an NPI (on or after August 13, 2008). Correct and resubmit.	25
7242	Prescriber's Provider Type not authorized to prescribe drugs in Medicaid	The prescriber’s provider type must be on the federal list of valid prescriber provider types. Contact the help desk.	71
7243	Prescribing entity disallowed from prescribing in Medicaid	Any healthcare profession who has been configured as a “suspended prescriber” cannot write prescriptions for Medicaid members. Contact the help desk.	71
7515	Prescribing physician is not on File or Active for Opioids	Prescribers must be enrolled and active to be able to prescribe Opioid drugs	25
7516	Pharmacist cannot dispense drug type	Prescribers with a provider type of 85 (pharmacist) are allowed to prescribe h the following drugs (HIC3 - W7B, W7L, W7Z, W7C, W5F, W5E and GcnSeqNos - 077103, 075222, 004514).	25

3.3 Member Verification

For a claim to process, the Medicaid members ID must be recognized in the Medicaid member file. The claims are processed based on program enrollment status on the DOS. Each member is assigned to one or more benefit programs. These programs include State and special programs in addition to Medicaid programs. Benefits (drugs)

are associated with the programs. If a member's eligibility for a specific program is terminated, a benefit that was approved one month may not be an allowable benefit the next month because it is not a covered benefit in the other program.

Health PAS-Rx selects the most appropriate benefit program based on member's program enrollment status. If a member is only eligible for one program, that program is the primary program. If a member is enrolled in more than one program, one program is indicated as the primary and the others are secondary. There can only be one active primary program enrollment at a time.

The State has identified the rules that determine primary and secondary enrollment. Based on the State's rules, a member's secondary program may/may not become the primary program when the initial primary is no longer active.

During processing, the active primary enrollment is evaluated for benefit coverage. If the benefit (drug) is not found in the primary benefit program, the secondary programs are evaluated. The system determines based on the State's eligibility rules which program is responsible for benefit payment. The State also defines which drugs are allowed under each benefit programs.

Contact the POS Help Desk for clarification of a member's benefit program assignment or to confirm the benefit (drug) coverage under the program in question. To ensure that Medicaid members are properly identified, at least two pieces of identifying data will be verified against the member's Medicaid enrollment record. Alternatively, you may call the Automated Voice Response System (AVRS) to verify eligibility.

3.3.1 Cardholder Identification

The Cardholder ID must be entered on the claim as it appears on the member card. Consult the Member Eligibility Card for the Medicaid Cardholder number.

NCPDP Fields:

Cardholder ID (302-C2)

Table 3-3: Cardholder Identification Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
217	Member may be Incarcerated-Contact RDTP @ (800) 847-3859	Call the help desk for assistance to determine member's incarceration status.	65
7178	CardID Not Found	Medicaid Id/Cardholder ID not on file. Check Medicaid ID on member's card. Resubmit after correction. Call POS Help Desk for assistance, if required.	07
7137	Not Eligibl on DoS	Member not eligible on DOS. Contact POS Help Desk to verify eligibility.	65
7197	Paper Claim Only	Member is enrolled in Tiger Morton or Emergency Medical so paper claim is required. File paper claim.	M5

3.3.2 Cardholder Identification Number/Date of Birth Mismatch

A claim with a cardholder identification number/date of birth mismatch will be denied. The provider should resolve the cardholder identification number/date of birth mismatch with the member at the POS. If necessary, the provider should contact the POS Help Desk for assistance in verifying a member's Date of Birth (DOB).

NCPDP Fields:

Cardholder ID (302-C2); Date of Birth (304-C4); Date of Service (401-D1)

Table 3-4: Date of Birth Mismatch Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7064	Invalid DOB	Member's DOB does not match what is on file. Contact POS Help Desk for assistance.	09
7185	N/A	Member's DOB is missing or not a valid date format. Correct and resubmit the claim.	09
7102	Filled Before DOB	DOS is less than date of birth. Correct date of service and resubmit.	P6
7103	Filled After Death	DOS is greater than date of death. Correct date of service and resubmit.	15
7229	N/A	Patient segment is missing. Correct and resubmit.	PK

3.3.3 Cardholder Identification Number/Name Mismatch

A claim with a cardholder identification number/name mismatch will pay. The provider should resolve the name/number mismatch with the member at the point of sale. If necessary, the provider should contact the POS Help Desk for assistance in obtaining a member's name as shown on file.

NCPDP Fields:

Cardholder ID (302-C2); Patient First Name (310-CA); Patient Last Name (311-CB)

Table 3-5: Name Mismatch Edit and Message

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7105	Name Mismatch	Name does not match what is on file warning message. Contact POS Help Desk for assistance, if necessary.	None – N/A

3.4 Reimbursement and Co-payment

Although the Service Provider is required to submit ingredient cost, the Health PAS-Rx system will also calculate ingredient cost based on least price for the NDC on the date of service. West Virginia Medicaid pharmacy imbursement is based on the lesser of:

Prior to 04/17/2006:

- Discounted Average Wholesale Price (AWP–12%)

04/17/2006 – 03/31/2017:

- Discounted Average Wholesale Price (AWP–15%) when NDC is a Brand drug.
- Discounted Average Wholesale Price (AWP–30%) when NDC is a Generic drug.
- Federal Maximum Allowed Cost (FMAC)
- (FFUL)
- Medicaid AWP
- State Maximum Allowed Cost (SMAC)
- Usual and Customary (UAC)
- Submitted Ingredient Cost

04/01/2017 – forward:

- FFUL
- NADAC
- WAC
- State Maximum Allowed Cost (SMAC)
- Usual and Customary (UAC)
- Submitted Ingredient Cost

Patient co-payment is variable based on cost of the prescription, or is exempt for specific situations. Collection of co-payment is the responsibility of the Service Provider. If a co-payment amount is not entered on the UCF or POS claim but one is required, the amount will be deducted from the amount due the Service Provider. It is assumed the Service Provider collects the co-payment.

Co-payment requirements are:

- $0.50 Prescription cost is $10.00 or less
- $1.00 Prescription cost is between $10.01 and $25.00
- $2.00 Prescription cost is between $25.01 and $50.00
- $3.00 Prescription cost is $50.01 or greater.

Co-payment exemptions are:

- Patient is a child (no more than 17 years and 11 months)
- Patient is pregnant (UCF does not provide for pregnancy indication. The member's Medicaid record must indicate patient is pregnant on date of service to be exempt from co-payment. POS NCPDP D.0 claims provide for pregnancy indication.) Pregnancy benefits co-payment exemptions that extend for 60 days post-delivery are based on the pregnancy termination date as indicated on the member's Medicaid record.
- Service is for family planning services
- Service is for a 3-day emergency supply
- Patient resides in either a Nursing Home (NH), Skilled Nursing Facility (SNF) or Intermediate Care Facility/Mental Retardation (ICF/MR) facility
- Patient is covered under the AIDS Drug Assistance Program (ADAP) benefit plan
- Service is for diabetic syringes and supplies
- Service is for the State approved Home Infusion supply

Dispensing fee amounts through 03/31/2017 are:

- $2.50 Single Ingredient Brand Drug Dispensing Fee
- $5.30 Single Ingredient Generic Drug Dispensing Fee
- $6.30 Compound with Primary Ingredient Generic Drug Dispensing Fee
- $3.50 Compound with Primary Ingredient Brand Drug Dispensing Fee
- $8.25 340B Public Health Service (PHS) Provider Dispensing fee

Dispensing fee amounts from 04/01/2017 forward is

- $10.49 Single Ingredient Dispensing Fee
- $16.49 Compound Dispensing Fee

Also, there are situations in which the reimbursement of an ingredient is calculated at zero, or no pricing is available for a drug. An informational message is returned to identify why reimbursement is zero.

Table 3-6: Reimbursement and Copayment Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7010	N/A	UAC Charge is missing or Invalid. Correct and resubmit.	DQ
7101	Mnthly Fee: NH/LCF	None. Informational message.	None – N/A
7180	DESI($0): (NDCVALUE)	If NDC is marked as Drug Efficacy Study Implementation (DESI) for secondary compound ingredients, reimbursement is zero. Informational message.	None – N/A
7181	No Rebate ($0): (NDCVALUE)	If NDC is marked as Non-Rebatable for secondary compound ingredients, reimbursement is zero. Informational message.	None – N/A
7190	NO PRICE FOUND FOR NDC	No pricing is available for the NDC.	38
7191	$0.00 PAID AFTER CALCULATION	After Coordination of Benefits (COB) calculation, the reimbursement amount is zero. Informational message.	None – N/A
7257	DME($0): (NDCVALUE)	For any NDC in the compound claim that is a Durable Medical Equipment (DME) product, pricing will pay at $0.00.	EE
7513	No Benefits($0) (NDCVALUE)	For any NDC in the compound claim there must be benefits otherwise pay at $0.00	None – N/A

3.5 Coordination of Benefits/Third Party Liability Insurance

The State reimburses for pharmacy services only when all other resources have been exhausted for the eligible member. Medicaid is often referred to as the "payer of last resort." All providers must ask Medicaid members if he or she has other public or private insurance, or if there is potential that another entity may be liable for the service expense.

The pharmacy point-of-sale system notifies the provider when other insurance information is known and is on file. It is the pharmacy's responsibility, as described in the provider agreement, to comply with all applicable laws, rules, and written polices pertaining to the West Virginia Medicaid Program. This includes the submission of prescription claims to primary insurance carriers prior to submitting these claims to Medicaid. WV Medicaid TPL policy is explained in detail in the *WV Medicaid Provider Manual, Chapter 600*. This policy and other pertinent documents can be accessed through the States' Website, www.wvdhhr.org.

Medicare: Claims submitted for persons with Medicare eligibility will deny and direct the pharmacy to submit the claims to Medicare. Drugs covered by Medicare Part B should be submitted to the Part B carrier. Any co-insurance and/or deductible amounts will automatically cross over to Medicaid as medical claims. Drugs covered by Medicare Part D should be submitted to the Part D plan. Medicare excluded drugs will be considered for coverage by Medicaid if first denied by the Medicare Part D plan. Contact the POS Help Desk for assistance, if needed.

The WV POS system will store all claim data submitted by the pharmacist related to COB/TPL and calculate payment to reflect prior payment by other payers when submitted on the claim.

Use the Other Coverage Code (OCC) when submitting a claim for a member who has other insurance coverage. One of the following values must be entered. If ‘2’ is entered, the Other Payer Amount Paid field in the COB Segment must be greater than $0.00.

2 = Other coverage exists – payment collected

3 = Other coverage exists – this claim not covered

4 = Other coverage exists – payment not collected

Other Coverage Codes of ‘0’ and ‘1’ are no longer accepted when a COB segment is submitted on claims. TPL eligibility information that is incorrect should be reported to the RDTP at (800) 847-3859 for verification. Should the member need the medication before verification occurs, the pharmacy may dispense a quantity of medication to meet the member’s needs. If other insurance is found to be active, the pharmacy will be asked to reverse claims and submit them to the primary payer(s).

3.5.1 Requirement of COB Segment

In the past, pharmacy claims could contain an Other Coverage Code with no COB/Other Payments Segment. Effective July 15, 2010, if the OCC is submitted on a claim, (‘2’, ‘3’, and ‘4’ are the only valid values) a COB/Other Payments Segment is required. Claims will be denied if an OCC is included without a COB/Other Payments segment.

3.5.2 Activation of NCPDP fields 351-NP, 352-NQ, 353-NR

Completion of the NCPDP fields 351-NP (Other Payer-Patient Responsibility Amount Qualifier), 352-NQ (Other Payer-Patient Responsibility Amount), 353-NR (Other Payer-Patient Responsibility Amount Count) is required on pharmacy claims when a payment is collected (OCC = ‘2’), and when a payment is not collected (OCC = ‘4’), as in the member’s deductible period. The 352-NQ field shall contain the member’s responsible amount, that is, the amount the member owes the pharmacy after the primary payer has either paid the claim or applied the cost of the claim to the member’s deductible.

3.5.3 Recalculation of Medicaid Payment

WV Medicaid will pay the Medicaid allowed amount or the member responsible amount, whichever is lower, as defined in *WV Medicaid Provider Manual, Chapter 600* policy in regard to TPL payments. Medicaid copayment requirements will remain unchanged.

Be aware that pursuing payments from primary carriers is required by West Virginia Medicaid and by Federal regulations. Providers that act in a repetitive manner to cause unnecessary costs for the Medicaid Program are considered to be abusing the Program and are subject to penalties and other actions as described in Chapter 800 of the Medicaid Provider Manual. Chapters 100 and 600 also contain more detailed information.

Should you have any questions or concerns, contact the Rational Drug Therapy Program Help Desk at (800) 847-3859.

NCPDP Fields:

Other Coverage Code (308-C8); COB/Other Payment Count (337-4C); Other Payer Coverage Type (338-5C); Other Payer ID Qualifier (339-6C); Other Payer Amount Paid (431-DV); Other Payer Amount Paid Qualifier (342-HC); Other Payer Date (443-E8); Other Payer-Patient Responsibility Amount Qualifier (351-NP); Other Payer-Patient Responsibility Amount (352-NQ); Other Payer-Patient Responsibility Amount Count (353-NR);

Table 3-7: Coordination of Benefits/Third Party Liability Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7007	File Medicare via Health Care Financing Administration (HCFA) 1500	Member is eligible for Medicare on Date of Service and drug covered by Medicare. Submit to Medicare, Part B.	41
7011	Bill Other Payer-Insurance Name @ xxx-xxx-xxxx	File indicates member has other insurance coverage. Submit claim to other insurer first. Contact POS Help Desk for more information on other payer.	41
7041	M/I COB Information-CONTACT RDTP @ (800) 847-3859	WV Other Coverage Codes allowed values are ‘2’ – ‘4’. Correct and resubmit.	13
7048	M/I Other Payer $	Other Payer Amount Paid is missing or invalid. Correct and resubmit.	DV
7051	N/A	Other Payer Date is missing or invalid. Correct and resubmit.	E8
7054	Bill Hospice	Member is Hospice patient and no Other Coverage and COB information provided. File claim with Hospice first. Or, provide information and resubmit.	41
7127	Medicare Eligible	Member is eligible for Medicare, but is not enrolled. Informational message. Prior to 01/01/06.	41
7194	Medicare Eligible	Member eligible for Medicare on Date of Service and drug covered by Medicare. Submit to Medicare.	41
7212	Other Payer $ not 0	If other coverage code is not a ‘2’, then the sum of all submitted other payer amount paid values must not be greater than $0.00. Correct and resubmit.	DV
7220	Bill Medicare First	Member eligible for Medicare on Date of Service but no COB segments were submitted. Submit to Medicare or submit COB segments. Effective 01/01/06.	41
7221	Wrap Around Part-D	With a TPL amount in the COB segment, Medicare Part D has already paid the claim. Effective 01/01/06.	74
7259	Patient Paid Amount must be > 0.00	When using an OCC ‘2’ or ‘4’, amount of Patient Amount Submitted (433-DX) field must be greater than $0.00	DX

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7260	Un-Reported External Eligibility, call (877) 598-5820	When using an OCC '2', contact phone number and explain what is displayed on the card	7C
7273	D0 does not support Coverage Type value 98 or 99	Other Coverage Type 98 and 99 are no longer supported. Correct and resubmit.	5C
7274	D0 does not support qualifier value 09 or blank	Other Payer ID Qualifier of '09' or spaces is no longer supported. Correct and resubmit.	6C
7275	Count is either missing or invalid	When using an OCC '2' or '4', Other Payer-Patient Responsibility Amount Count (353-NR) must be present, and must equal the sum of 351-NP and 352-NQ fields present	NR
7276	M/I Other Payer-Patient Responsibility Amount Qualifier	When using an OCC '2' or '4', Other Payer-Patient Responsibility Amount Qualifier (351-NP) must be present, and must equal '06'	NP
7277	Other Payer-Patient Responsibility Amount must be > 0.00	When using an OCC 2 or 4, amount of Other Payer-Patient Responsibility Amount (352-NQ) must be greater than $0.00	NQ
7278	M/I Patient Paid Amount Submitted	Patient Paid Amount is no longer supported. Use the 351-NP, 352-NQ and 353-NR fields.	DX
7281	Managed Care Organization (MCO) Exclusions	Member is covered by an MCO. Call the number in the return message and submit to the MCO first.	41
7283	MCO Exclusions Compounds	Member is covered by an MCO. Call the number in the return message and submit to the MCO first.	41

3.5.4 Other Payer Reject Codes

Medicaid will only consider those pharmacy claims that are denied by the primary payer for valid denial reasons. Before submitting claims to WV Medicaid, members/pharmacies must exhaust all avenues of reimbursement from the primary payor(s). This includes, but is not limited to, prior authorization, step-therapy, and limit exceptions. Claims without a valid and recognized reject reason will deny.

For more information, consult the Vendor Specification document found on the Health PAS-OnLine Website, http://www.wvmmis.com/pharmacy.screen.

NCPDP Fields:

Other Payer Reject Count (371-5E); Other Payer Reject Code (472-6E); Other Payer Coverage Type (338-5C)

Table 3-8: Other Payer Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7045	Other Payer Type	Values: ‘01’, ‘02’, or ‘03’. Correct and resubmit. Contact POS Help Desk for assistance if needed.	5C
7046	Not NCPDP Code	Code submitted not valid NCPDP reject code. Correct and resubmit. Information comes from other insurer.	6E
7050	M/I Match Of Other Payer Reject Codes	Reject count should match number of reject codes submitted. Correct and resubmit.	R2
7258	COB Reject Code not accepted	Resubmit claim with proper reject code	6E
7261	Missing COB Reject Information	Resubmit claim with reject code	5E
7262	COB Reject Code not allowed	Resubmit claim without other payer reject codes	6E

3.6 Compound Claims

Compounds can be submitted via UCF and POS. Up to 11 ingredients can be listed on the UCF and up to 25 ingredients can be entered on the electronic POS real-time claims. See **Appendix B – Claim Form** for instructions on submitting compounds via UCF. Compound ingredients are listed on the back of the UCF.

Gainwell does not supply or control pharmacy desktop applications. Consult your POS system software vendor for any additional instructions for submitting compounds compliant with NCPDP D.0 format and content requirements as defined

Refer to the NCPDP Version D.0. Vendor Spec Version 1.6 document which can be found at this location (https://www.wvmmis.com) in the Reference Material tab and Pharmacy from the drop-down list. It is the responsibility of the system software vendor to provide compatible desktop software that supports data for processing compound claims.

All claims for compound prescriptions (use code 2 to indicate a compound prescription) must contain a minimum of two ingredients. One of the ingredients must be a legend drug that is configured under an allowed program benefit. As recommended by NCPDP standards, the Product/Service ID Qualifier and the Product/Service ID field must contain all zeroes.

The first NDC in the compound segment should reflect the prime or most significant medicinal/therapeutic ingredient of the compound prescription. The primary ingredient must be a legend drug with a rebate. The first ingredient listed is the NDC used to retrieve the claim if it is to be reversed.

The secondary ingredient(s) may be legend, Over-the-Counter (OTC), and drugs indicated as DESI. During adjudication, if it is determined that the NDC could be substituted with a preferred drug, the claim will be denied. DESI drugs will be priced at $0.00. Drugs without rebate will be allowed but will be priced at $0.00. OTC drugs will be reimbursed at allowed cost. All ingredients in the compound are subject to DUR processing.

NCPDP Fields:

Compound Segment: Segment Identifier (111-AM); Compound Code (406-D6); Compound Product ID Qualifier (488-RE); Compound Product ID (489-TE); Compound Ingredient Component Count (447-EC); Compound Ingredient Quantity (448-ED); Compound Dosage Form Description Code (450-EF); Compound Route of Administration (452-EH); Compound Dispensing Unit Form Indicator (451-EG); Compound Ingredient Component Count (447-EC); Compound Ingredient Drug Cost (449-EE); Product Service ID Qualifier (436-E1); Product Service ID (407-D7); and Compound Code (406-D6); Quantity Dispensed (442-E7); Compound Ingredient Quantity (448-ED).

Table 3-9: Compound Claim Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7028	No Cmpd Segment	Product Service ID ‘00’ indicates compound claim but no Compound Segment submitted. Correct and resubmit.	PF
7032	Missing Compound Route of Administration	Missing or Invalid Route of Administration field. Correct field and resubmit claim.	EH
7034	Too Many Ingred	Number of ingredients for compound exceeds max of 25. Correct and resubmit.	EC
7039	Cmpd Prod ID Qual	The Compound Product ID Qualifier must be ‘03’ for NDC. Correct claim and resubmit.	RE
7040	M/I NDC	The Compound Product ID NDC on claim not on file. Correct and resubmit. Contact POS Help Desk for assistance.	TE
7060	N/A	Referenced edit 7060. Missing or invalid compound ingredient drug cost. Correct and resubmit.	EE
7125	Cmpd Prod ID = 00	If the claim is for a compound drug prescription, the Product Service ID must be ‘0’ in the claim segment. Correct and resubmit.	21
7126	Prod ID Qual = 00	If the claim is for a compound drug prescription, the Product/Service ID Qualifier must be ‘00’ in the claim segment. Correct and resubmit.	E1
7151	No Fill-Sched NDC	For a compound scheduled drug claim, no vacation supply is allowed. Correct and resubmit.	79
7152	No Fill-Sched NDC	For a compound scheduled drug claim, no lost prescription supply is allowed. Correct and resubmit.	79

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7157	Need 1 Legend NDC	Compound drug requires one legend NDC. Select another NDC and resubmit.	TE
7159	Need 2+ NDC	Compound claim requires two or more ingredients. Add more ingredients, and resubmit.	TE
7160	NDC Not Covered	NDC not covered as benefit (categorically removed). Fill with another NDC and resubmit. Contact POS Help Desk for assistance.	70
7161	Terminated Lot	NDC has been terminated; can't dispense. Fill with another NDC and resubmit.	70
7162	NDC Not Active	NDC not yet activated by the State. Fill with another NDC and resubmit.	70
7166	1st NDC-No Rebate	No rebate agreement. Fill with another NDC and resubmit.	AC
7167	1st NDC-DESI	DESI drug cannot be primary ingredient in compound. Reorder NDCs and resubmit.	70
7169	BILLING BRAND: USE DAW 1,4,8, or 9. 1,4,8 REQUIRE AUTHORIZATION	Need Therapeutically Equivalent Generic Drug for Compound Drug. Revise and resubmit.	AJ
7224	Generic Required	Need Therapeutically Equivalent Generic Drug for Compound Drug. Revise and resubmit. (Pre 04-17-2006)	AJ
7248	Duplicate NDC or NDC Group	Remove duplicate NDC or replace with different NDC, and resubmit.	TE
7249	Therapeutic Duplicate within Compound	Remove duplicate therapeutic NDC or replace with a different NDC, and resubmit.	TE
7253	Missing or Invalid Compound Indicator	The claim contains compound ingredients but the compound code indicates the claim is not a compound. Revise and resubmit.	PF
7266	Missing Compound Code	The claim is submitted without a Compound Code. Revise and resubmit. '1' = Not Compound, '2' = Compound.	
7279	M/I Compound Ingredient Quantity	The Quantity Dispensed (442-E7) field must equal the total of all Compound Ingredient Quantity (448-ED) fields. Correct and resubmit.	ED

3.7 Prior Authorization Required

Drugs requiring a PA are determined by the State. A drug's PA status will change based on the State's direction. This may mean that a drug which was previously dispensed without prior authorization may now require it. PAs of drugs are program dependent. A drug may require a prior authorization for a member enrolled in one program while the same drug may be dispensed without PA to a member enrolled in a different program.

The prescribing practitioner (or pharmacist if all the information is available) initiates the PA request by faxing, phoning, or emailing the request to the RDTP. RDTP is the PA

Help Desk. Each request is evaluated and the RDTP pharmacist reviewer makes a decision. The approved requests are entered into the Gainwell system. A PA can be entered in the system before the prescription is filled. If the prior authorization is already on file and approved, the claim will be processed automatically without the provider contacting the PA Help Desk. If the prior authorization is on file, but not yet approved, the provider will receive a response that prior authorization is required. The PA Help Desk responds with an authorization decision by fax or phone.

NCPDP Fields:

Prior Authorization Type Code (461-EU)

Prior Authorization Number Submitted (462-EV)

Table 3-10: Prior Authorization Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
205	Need PA-Contact RDTP @ (800) 847-3859	Benefit requires authorization. Contact the help desk.	75
7195	Wrong PA Number	PA number is not on file. Contact PA Help Desk.	EV
7198	No PA units	No units left on PA. Contact PA Help Desk.	PA
7199	Too few PA Units	Too few units left on PA.	PA
7215	Units Per Day Exceeded	PA daily dose units exceeded. Contact the help desk.	E7
7240	Edit Override Required For Ingredient(s) Listed-Contact RDTP @ (800) 847-3859	One or more secondary ingredients of a compound claim require prior authorization. Contact the help desk. Compounded secondary ingredient requires PA – EO required on primary ingredient.	75
7370	PA [referral id] expires on mm/dd/yyyy	When a PA is used on a claim, return a warning message to identify the expiration date of the PA.	3W

3.8 Dispense As Written

If the prescribing provider wants the prescription filled as written, the instruction “Brand Medically Necessary” must be written on the face of the prescription and the Dispense as Written (DAW) indicator must equal 1. The following are allowed values on the DAW indicator:

0 – No DAW

1 – Physician DAW

4 – No Generic Available

5 – Brand Dispensed as Generic

6 – Generic priced as Brand

8 – Generis not available in marketplace

9 – Substitution allowed by prescriber but plan request brand – Patient's plan requested brand

NCPDP Fields:

Dispense As Written (DAW)/Product Selection Code (408-D8)

Table 3-11: Dispense as Written Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7018	BILLING BRAND: USE DAW 1,4,8, or 9. 1,4,8 REQUIRE AUTHORIZATION	Non-compound drug is brand not on Preferred Drug List (PDL). Need Generic. Correct and resubmit claim	AJ
7223	Generic Required	Non-compound drug is brand not on PDL. Need Generic. Correct and resubmit claim (pre 04-17-2006)	AJ
7235	7235D:DAW 1 SUBMITTED-OVERRIDE MAY BE REQUIRED-CONTACT RDTP @ 800-847-3859	If the drug is not in the Hierarchical Ingredient Code (first 3 characters) (HIC3) class of H4B nor on a selected list of excluded drugs, then the presence of the DAW code '1', "Brand Medically Needy" may be entered erroneously and allow the dispensing of brand drugs un-necessarily. Contact the help desk.	75
7267	Missing DAW Code	Resubmit with DAW Code = '0'	22
7282	DAW 4-GENERIC NOT STOCKED-CONTACT RDTP @ 800-847-3859	The presence of the DAW code '4', "No Generic Available" may be entered erroneously and allow the dispensing of brand drugs un-necessarily. Contact the help desk.	22
7515	DAW Code 8 - for Brand Product	The presence of the DAW code 8, "Substitution Allowed-Generic Drug Not Available in Marketplace" may be entered erroneously and allow the dispensing of brand drugs un-necessarily	22

3.9 Prospective Drug Utilization Review Edits

Health PAS-Rx DUR is a prospective DUR software system that provides real-time screening of prescription drug claims against the First DataBank (FDB) National Drug Data File (NDDF) clinical database. Health PAS-Rx DUR is designed to work in conjunction with the pharmacy claims adjudication/eligibility system. Health PAS-Rx DUR uses existing Medicaid member pharmacy claim history records to evaluate the current prescription for possible interactions between the patient's active prescription history and the drug currently being prescribed.

The following Health PAS-Rx DUR modules are implemented in support of West Virginia Medicaid.

Table 3-12: Drug Utilization Review Conflicts and Explanations

Valid Value	DUR Conflict	Explanation
DD	Drug-Drug Interaction	Drug-Drug Interaction checks the current prescription against all active prescriptions in the patient's drug history profile for any drug-drug interaction. The clinical staff at First Data Bank defines the drug-drug interactions in Health PAS-Rx DUR.
ER	Early Refill	Prescription refill occurs before a previous fill of the same prescription is sufficiently exhausted. Early refills are identified by number of early refill days, by percentage of drug used, or by a combination of both.
HD	High Dose	Prescription is checked against a preset standard for the maximum daily dosage that should be administered for a specified drug based on the age/age group of the patient to determine if the dosage exceeds the maximum standard dosing range.
ID	Ingredient Duplication	Ingredient duplication occurs when one or more drugs in the new prescription have similar ingredients and similar routes of administration to one or more drugs in an active prescription.
LD	Low Dose	Each new prescription is checked against a preset standard for the minimum daily dosage that should be administered for a specified drug based on the age/age group of the patient. If a daily dose has been prescribed for the patient that is below the minimum standard dosing range of the drug, a Low Dosage (LD) event, with a Low Dose DUR Conflict Code, is generated.
LR	Late Refill	Prescription refill occurs after a previous fill of the same prescription is sufficiently exhausted. Late refills are identified by number of late refill days, by percentage of drug used, or by a combination of both.
PG	Pregnancy Precaution	The pregnancy precaution module targets female patients within a pre-defined age range. New prescriptions are checked against the Food and Drug Administration (FDA) Pregnancy Precaution Categories to detect drugs that may be inappropriate in pregnancy. If a pregnancy precaution is detected, a Pregnancy Precautions (PG) event, with a Pregnancy Precautions DUR Conflict Code, is generated.
TD	Therapeutic Duplication	A therapeutic duplication occurs when the patient has two or more active prescriptions that contain one or more drugs in the same therapeutic class.

Not all situations cause a claim to deny. In addition to identifying the reason for a conflict, the Health PAS-Rx DUR indicates the severity level of the conflict. If the conflict is at a severity level of “1” or “2”, the claim will deny. To override:

Severity Level 1 - contact RDTP to obtain a prior authorization and then resubmit the claim after the authorization has been entered. The prior authorization number does not have to be included on the resubmitted claim.

Severity Level 2 – resubmit the claim with a valid NCPDP Reason for Service (DUR Conflict), Professional Service (DUR Intervention) and Result of Service (DUR Outcome) code(s). Select the appropriate allowed values from the following table.

Table 3-13: Drug Utilization Review Allowed Values

Reason for Service Code:	DD = Drug-Drug Interaction	ER = Early Refill	HD = High Dose	ID = Ingredient Duplication
	LR = Late Refill	PG = Pregnancy Precaution	TD = Therapeutic Duplication	
Professional Service Code:	AS = Patient Assessment	CC = Coordination of Care	DE = Dosing Evaluation / determination	FE = Formulary Enforcement
	GP = Generic Production selection	MA = Medication Administration	M0 = Prescriber Consulted	MR = Medication Review
	PE = Patient Education/Instructio n	PH = Patient Medication History	PM = Patient Monitoring	P0 = Patient Consulted
	PT = Perform Laboratory Test	RT = Recommend Laboratory Test	R0 = Pharmacist Consulted Other Source	SC = Self-care Consultation
	SW = Literature Search/Review	TH = Therapeutic Product Interchange	TC = Payer/Processor Consulted	
Result of Service Code:	1A = Filled As Is, False Positive	1B = Filled Prescription As Is	1C = Filled with Different Dose	1D = Filled with Different Directions
	1E = Filled with Different Drug	1F = Filled with Different Quantity	1G = Filled with Prescriber Approval	1H = Brand-to-Generic Change
	1J = Rx-to-OTC Change	1K = Filled with Different Dosage Form		

NCPDP Fields:

Product/Service ID (407-D7);

Originally Prescribed Product/Service Code (445-EA),

Compound Product ID (489-TE)

Table 3-14: DUR Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7067	DD Sev 1-Contact RDTP @ (800) 847-3859	Drug-Drug interaction Severity Level ‘1’. Call PA help desk for Prior Authorization	88
7068	DD Sev 3-5	Drug-Drug Interaction Severity ‘3’ thru ‘5’. Warning message.	None – N/A
7069	TD Sev 1-Contact RDTP @ (800) 847-3859	Therapeutic Duplication Severity Level ‘1’. Call PA Help Desk to obtain Prior Authorization.	88
7070	TD Sev 3-5	Therapeutic Duplication Severity ‘3’ thru ‘5’. Warning message.	None – N/A
7071	ID Sev 1-Contact RDTP @ (800) 847-3859	Ingredient Duplication Severity Level ‘1’. Call PA Help Desk for Prior Authorization.	88
7072	ID Sev 3-5	Ingredient Duplication Severity ‘3’ thru ‘5’ Warning Message.	None – N/A
7073	ER Sev 1-Contact RDTP @ (800) 847-3859	Early Refill Severity Level ‘1’. Call PA Help Desk to obtain Prior Authorization. Call RDTP to obtain Edit Override.	88
7074	ER Sev 3-5	Early Refill Severity ‘3’ thru ‘5’. Warning Message.	None – N/A
7075	LR Sev 1-Contact RDTP @ (800) 847-3859	Late Refill Severity Level 1. Call PA Help Desk to obtain Prior Authorization. Call RDTP to obtain Edit Override.	88
7076	LR Sev 3-5	Late Refill Severity ‘3’ thru ‘5’. Warning Message.	None – N/A
7077	DUR PG SEV 1-MEMBER IS PREGNANT-CONTACT RDTP @ (800) 847-3859	Pregnancy Precaution Severity ‘1’ and member is pregnant. Call RDTP to obtain Edit Override.	88
7079	HD	High Dose event. Call PA Help Desk to obtain Prior Authorization. Call RDTP to obtain Edit Override.	88
7080	LD	Low Dose Event. Warning Message.	None – N/A
7082	DUR/ Prospective Payment System (PPS) Code Cnt	Value does not reflect the number of occurrences submitted. Correct and resubmit.	7E
7093	N/A	Referenced edit 7093. DUR/PPS code counter must be numeric. Correct and resubmit.	7E
7117	M/I DUR/PPS	DUR/PPS segment missing. Correct and resubmit.	PH
7118	DUR/PPS Qual=06	If DUR/PPS segment is submitted and the product service ID qualifier is ‘06’, then the product service ID must be ‘0’. Correct and resubmit.	R5
7138	DUR Ov Prod ID Qual	The Originally Prescribed Product/Service ID Qualifier must be ‘03’. Correct and resubmit.	EJ
7139	M/I Service Code	Professional Service Code is not valid. Correct and resubmit.	E5
7140	M/I Reason Code	Reason for Service Code is not valid. Correct and resubmit.	E4

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7141	M/I Result Code	Result of Service Code is not valid. Correct and resubmit.	E6
7170	DUR DD - DUR/Prospective Payment System (PPS)	For a compound secondary ingredient, Drug-Drug Event Severity Level of ‘1’ or ‘2’. Correct and resubmit.	88
7171	DUR TD-CONTACT RDTP @ (800) 847-3859	For a compound secondary ingredient, Therapeutic Duplication Severity Level of ‘1’. Correct and resubmit.	88
7172	DUR ID-CONTACT RDTP @ (800) 847-3859	For a compound secondary ingredient, Ingredient Duplication Severity Level of ‘1’. Correct and resubmit.	88
7173	DUR ER-CONTACT RDTP @ (800) 847-3859	For a compound secondary ingredient, Early Refill Severity Level of ‘1’. Correct and resubmit.	88
7174	DUR LR	For a compound secondary ingredient, Late Refill Severity Level of ‘1’ or ‘2’. Warning Message.	None – N/A
7175	DUR HD - DUR/PPS	For a compound secondary ingredient, High Dose. Correct and resubmit.	88
7179	No DUR Processing	RxDUR stopped processing. Therefore, DUR was not performed. Contact the help desk.	M7
7202	DD Sev 2 DUR/PPS	Drug-Drug Severity Level ‘2’. Use DUR/PPS to override.	88
7203	TD Sev 2 DUR/PPS	Therapeutic Duplication Severity Level ‘2’. Use DUR/PPS to override.	88
7204	ID Sev 2 DUR/PPS	Ingredient Duplication Severity Level ‘2’. Use DUR/PPS to override.	88
7205	ER Sev 2 DUR/PPS	Early Refill Severity Level ‘2’. Use DUR/PPS to override.	88
7206	LR Sev 2 DUR/PPS	Late Refill Severity Level ‘2’. Use DUR/PPS to override.	88
7226	N/A	Reason for Service Code is not present. Correct and resubmit	E4
7227	N/A	Professional Service Code is not present. Correct and resubmit.	E5
7228	N/A	Result of Service Code is not present. Correct and resubmit.	E6
7244	DUR PG Sev 1	Pregnancy Precaution Severity ‘1’ but member is not known to be pregnant. Warning message.	None – N/A
7245	DUR PG Sev 2-MEMBER IS PREGNANT	Pregnancy Precaution Severity ‘2’ and member is pregnant. Call RDTP to obtain Edit Override.	88
7246	DUR PG Sev 2	Pregnancy Precaution Severity ‘2’ but member is not known to be pregnant. Warning message.	None – N/A
7247	DUR PG Sev 3	Pregnancy Precaution Severity ‘3’. Warning message. Currently does not post.	None – N/A

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7250	DUR TD - DUR/PPS	For a compound secondary ingredient, Therapeutic Duplication Event Severity Level of ‘2’. Correct and resubmit.	88
7251	DUR ID - DUR/PPS	For a compound secondary ingredient, Ingredient Duplication Event Severity Level of ‘2’. Correct and resubmit.	88
7252	DUR ER - DUR/PPS	For a compound secondary ingredient, Early Refill Event Severity Level of ‘2’. Correct and resubmit.	88

3.10 Lock-In Member

Any member may be assigned ‘Lock-In’ to one pharmacy. The State manages Lock-in. The State determines which members are selected to be ‘locked in’ to a specific pharmacy. Prescriptions must be filled at the ‘Lock-In’ Pharmacy Provider for these members. Claims submitted by any other pharmacy will be denied. For assistance in identifying the member’s Lock-in Pharmacy, contact the POS Help Desk.

NCPDP Fields:

Service Provider ID Qualifier (202-B2), Service Provider ID (201-B1), Date of Service (401-D1)

Cardholder ID (302-C2)

Table 3-15 : Lock-In Edit and Message

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7121	Lock-In	Recipient can only have prescriptions filled at a specific pharmacy. Contact POS Help Desk for assistance (888) 483-0801.	M2

3.11 Hospice

Pharmacy claims will be denied for Medicaid members who are under Hospice care on the date(s) of service submitted. Submit these claims to Hospice as the primary payer. Contact the POS Help Desk to verify hospice information if necessary.

NCPDP Fields:

Date of Service (401-D1)

Cardholder ID (302-C2)

Table 3-15: Drug Utilization Review Conflicts and Explanations

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7054	File Hospice	Member is enrolled in Hospice program. Submit claim to Hospice carrier as primary insurer.	41

3.12 Limitations

The State has indicated that specific drugs have dispensing limitations. The State determines limitations and associated rules. For example, scheduled drugs must be filled within six months. The quantity dispensed within a specified number of days is another example of a limitation. Drugs and associated values are subject to change at the State's discretion. A current list of limitations can be found at www.wvdhhr.org/bms and www.wvmmis.com. Contact the POS Help Desk for assistance at (888) 483-0801.

NCPDP Fields:

Date of Service (401-D1); Quantity Dispensed (442-E7); Days' Supply (405-D5)

Table 3-16: Limitations Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7026	Exceeds Max Quantity (QTY)	Quantity dispensed exceeds daily maximum allowed. Call POS Help Desk for assistance.	E7
7095	Allowed Refills Have Been Used	Refill limit has been met. Need new prescription.	73
7097	Over 3-day max	Quantity dispensed exceeds 3-day emergency supply. (non-compound). Correct and resubmit.	AG
7119	ADAP Program, Too old to file	For ADAP program, the prescription must be filled within 60 days. A new prescription is required.	81
7130	No Partial Fill	Partial fills are not allowed. Correct and resubmit.	RK
7134	Too old to Refill	Claims for scheduled drugs must be refilled within six months of initial dispensing. Need new prescription.	81
7142	Over 3-day Max	Days' Supply exceeds max for three-day emergency supply. (compound)	AG
7143	Too old to Refill	Time range for refills has expired. Need a new prescription.	73
7146	Too old to Fill	Scheduled drug too old to file (past six months) for scheduled compound drugs. Need a new prescription.	81
7148	Lost or Stolen-Check Submission Code Validity or CONTACT RDTP at (800) 847-3859	For non-compound drugs, no lost prescription supply allowed for scheduled drugs. Call POS Help Desk for assistance.	79

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7155	Exceeds Max Days	Limitation on number of days has been set for this drug. Limit has been exceeded. Contact POS Help Desk.	AG
7187	Re-sub W/Qty Disp Not Exceeding xxxxxx.xxx Units	Quantity Dispensed exceeds maximum allowed units. Resubmit with no more than value listed in message. Call POS Help Desk for assistance.	76
7192	Over Lost Limit	Days' Supply exceeds maximum allowed for replacement of lost/stolen prescriptions. Correct and resubmit.	AG
7196	Plan Limits Exceeded - Qty Remaining is 0.000 Units	Exceeds maximum allowed units within limited period of time. Sum of Qty dispensed for fill time span exceeded Resubmit with no more than value listed in message. Call POS Help Desk for assistance.	E7
7208	Re-sub W/Qty DispNot Exceeding: xxxxxx.xxx Units	For Insulin User, allowed units exceeded. Resubmit with no more than value listed in message. Call POS Help Desk for assistance.	76
7209	Plan Limits Exceeded - Qty Remaining Is nnnnnnn.nnn Units	For Insulin User, allowed quantity dispensed within time span limit has been exceeded. Sum of Qty Dispensed for Fill Time Span Exceeded	E7
7210	Max Days - ADAP	For ADAP program, maximum days' supply has been exceeded. Contact POS Help Desk for assistance.	19
7214	Too old to file	For any prescription for a scheduled drug where the date the prescription was written is greater than six months older than the claim date of service. Correct and resubmit.	81
7216	Allowed Refills Have Been Used	For Compound drug, refill limit has been met. Need new prescription.	73
7230	Claim Amount Exceeds State Rx Claim maximum (MAX) Threshold	Drug is too costly. Contact POS Help Desk for assistance.	78
7231	Number of Rx per Month Exceeds Plan Limit of [X]	Number of prescriptions for the month has been exceeded for the benefit plan for the 21+ year old member. Contact POS Help Desk for assistance.	76
7236	[X] Rx Limit Exceed for the Month -Waived During Transition Period: [Y] Days Remain	Number of prescriptions exceeds maximum allowed based on benefit plan configuration during the transition period. Contact POS Help Desk for assistance.	76
7239	Package Unit Billing Enforced	When a drug item is designed to be sold as a package, the billing for such unit must be in multiples of the whole package size.	55
7241	Submitted Cost Exceeds 340B Expected Rate	Submitted costs are too high for a PHS provider. Submit a lower cost or contact POS Help Desk for assistance.	78

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7254	(NDC Value) QTY DISP EXCEEDS DDDDDDD.DDD UNITS	For a compound claim, quantity Dispensed exceeds maximum allowed units for the NDC listed. Resubmit with no more than value listed in message. Call POS Help Desk for assistance.	ED
7255	Plan Limits Exceeded – (NDCVALUE) QTY REMAINING IS DDDDDDD.DDD UNIT	For a compound claim, exceeds maximum allowed units within limited period of time for the NDC listed. Sum of Qty dispensed for fill time span exceeded. Resubmit with no more than value listed in message. Call POS Help Desk for assistance.	ED
7256	(NDCVALUE) DAILY DOSE EXCEEDS DDDDDDD.DDD	For a compound claim, quantity dispensed for NDC listed exceeds daily maximum allowed. Call POS Help Desk for assistance.	ED
7287	M/I Pregnancy Indicator	Deny the claim if the member’s gender is not female or the member’s age is not between 10 and 45 years based on the month the member turns10 or 46	2C
7520	State Defined Message	A claim has been submitted for drug that has a state message associated to it. This can be set at many different levels (progem, class, status, etc).	70
7546	Consider offering naloxone with this Rx	The MME average daily dose of 50 with the last 90 days has been exceeded OR the incoming claim (MME naive) exceeds the daily average of 50 MME.	76
7547	Consider offering Naloxone with this Rx	MAT drug or MAT contraindication drug prescribed so offer Naloxone	76
7548	Consider Naloxone with Benzo+Opioid	Offer Naloxone while taking a benzo and opioid a the same time	76
7549	Consider Naloxone with Sedative+Opioid	Offer Naloxone while taking a sedative and opioid a the same time	76
7550	Consider Naloxone with MuscleRelaxant+Opioid	Offer Naloxone while taking a muscle-relaxant and opioid a the same time	76

3.13 Edit Overrides

The State has directed Gainwell to configure specific edits that return a deny action to be overridden by the State, the Help Desk, or the Pharmacy Provider. Not all edits are able to be overridden. The Pharmacy Provider does not have the same override authority as the Help Desk. The Help Desk can override any edit that the Pharmacy Provider can override.

NCPDP Fields:

Cardholder ID (301-C2) Date of Service (401-D1); Service Provider ID (201-B1)

Product Service ID (407-D7); Days' Supply (405-D5); Quantity Dispensed (442-E7)

Table 3-17: Edit Override Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7301	Edit Override (EO) Qty/Supply	Mismatch of quantity/days' supply for override. Contact POS Help Desk.	64
7302	No EO Authority	Wrong authority to enact override. Contact POS Help Desk	3S

3.14 Reversals

The reversal transaction completely reverses the previously processed claim and appears as a credit on the next RA. A new claim must be submitted.

A reversal transaction is required when:

- A prescription has been filled/processed but never dispensed to the member and the drug is "returned to stock"
- A claim was paid in error
- A claim was entered incorrectly

NON-COMPOUND TRANSACTION: Health PAS-Rx requires the following information for a non-compound reversal transaction:

- Provider number
- Date prescription dispensed (Actual dispense date should be entered, not current date)
- NDC
- Prescription number

COMPOUND TRANSACTION: Health PAS-Rx requires the following information for a compound reversal transaction:

- Provider number
- Date prescription dispensed (Actual dispense date should be entered, not current date)
- NDC (Use the first NDC listed in the compound segment of the original claim, or "00000000000")
- Prescription number

NCPDP Fields:

Transaction Code (103-A3); Service Provider ID (201-B1); Date of Service (401-D1); Rx/Service Reference (REF) Number (402-D2); Product/Service ID Qualifier (436-E1) Product/Service ID (407-D7)

Table 3-18 Reversal Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7013	Too old to reverse	Claim too old to reverse. No override available.	M4
7086	N/A	Reversal must be in B2 format. Correct and resubmit.	03
7100	No Orig claim	Original claim not found. Confirm data and resubmit.	87
7149	Invalid Prod ID Qual	Invalid Product Service ID qualifier for reversal. Correct and resubmit. ('00' for compounds, '03' for non-compounds, '06' for DUR/PPS)	E1

3.15 Duplicate Claim

3.15.1 Exact Duplicate

Per NCPDP D.0 standard, a duplicate claim response contains the same information displayed on the original claim response except for the duplicate claim message. A duplicate response will be returned for paid and reversed claims. This allows the pharmacist to reprint a label, if needed. It is the provider's responsibility to determine if a duplicate is what is intended. An exact duplicate transaction is not stored as a claim. The State will not reimburse for an Exact Duplicate.

Health PAS-Rx determines an exact claim to be an exact duplicate when the following information is the same:

- Provider
- Member ID
- Date of Service
- Prescription number
- NDC

3.15.2 Suspect Duplicate

Information returned on a not exact duplicate claim response contains the information displayed on the submitted claim and will contain a duplicate claim message. The Transaction Response Status indicates that the claim has been denied.

Health PAS-Rx determines a claim to be a suspect duplicate when the following information is the same:

- Member ID
- Date of Service
- Service Provider ID
- Same Generic Code Number Sequence Number (GCNSeqNo)

NCPDP Fields:

Cardholder ID (302-C2); Date of Service (401-D1); Service Provider ID (201-B1); Product/Service ID (407-D7); Prescription/Service Reference Number (401-D2)

Table 3-19: Duplicate Claim Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
None	DUPLICATE	Message appears in same block as other edit responses when trying to enter a claim that exactly matches a claim already on file. Do NOT fill the prescription without investigating the reason for the duplicate.	None
7217	DUPLICATE RX: nnnnnnn, Adjudication (ADJ) DATE:mm/dd/ccyy ID: (claim id number)	Claim is a near match to one that is already on file. Correct the claim and resubmit.	83
7999	A claim is currently in process for this recipient. Resubmit claim	A claim is being processed for the same member of another claim that has not completed its processing. Resubmit claim.	85

3.16 Benefit (Drug) Restrictions

The product/service ID on the claim is validated for certain restrictions (refer to the table below - Benefit (Drug) Restriction Edits and Messages), and if it passes validation, then the drug may be dispensed to the member.

NCPDP Fields:

Date of Service (401-D1); Product/Service ID (407-D7); Cardholder ID (302-C2)

Table 3-20: Benefit (Drug) Restriction Edits and Messages

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
149	RX Not Covered on DOS, or may require PA. Contact RDTP @ (800) 847-3859.	Claim is filled before Benefit is effective. Contact the Help Desk.	67
155	Age Restriction	Drug is not covered for the member’s age.	60
199	Member not eligible for End Stage Renal Disease (ESRD) benefits on DOS	Benefit rider is not valid for the member on the date of service. Correct and resubmit or contact the help desk.	65
202	NDC Not Covered	Service is not part of the member’s benefit plan. Select another NDC, or contact the help desk.	70
7021	No NDC	The product ID is invalid. Correct and resubmit.	21
7062	Unit of Measure (UOM) Mismatch	The UOM does not match what is on file. Informational message returned.	None – N/A

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7092	DESI Not Covered	The NDC is less than effective and therefore marked DESI.	70
7094	Step Therapy required-Contact RDTP @ (800) 847-3859	For Step Therapy the drug submitted is not covered as lower level drugs have not been tried prior to this prescription and no PA exists.	70
7096	Missing/Invalid (M/I) Prod ID Qual	Product Service ID Qualifier is invalid. Correct and resubmit (03 for non-compound, 00 for compound, 06 for DUR/PPS override).	E1
7104	No Rebate	No drug rebate exists for this NDC. Select another NDC and resubmit.	AC
7106	NDC Excluded	NDC for non-compound drug has been categorically removed. Select another NDC and resubmit.	70
7107	Lot Termed	NDC for non-compound drug has been lot terminated. Select another NDC and resubmit.	70
7109	NDC Not Approved	Activation date has not yet been set. Resubmit claim or call POS Help Desk.	70
7111	Gender Restriction	NDC is gender specific and does not match the gender of the member. Select another NDC and resubmit.	61
7116	Over max age of 45	For prenatal vitamins, member cannot be over age 45based on the month the member turns 46	60
7514	Drug Class Requires Prescriber Enrollment, contact Gainwell @ 888-483-0801	If the drug class is H3A or H3U the prescriber must be enrolled and active to be able to dispense the drug.	25
7517	Patient in Methadone Clinic. Contact RDTP @ 800-847-3859	If a member has been in a Methadone clinic (identified by service code H0020) and they are trying to bill pharmacy claim for H3A, H3W, H3U, H20, or H21 with an adjudication date within 30 days of the methadone service then post this edit.	M1
7518	Medicaid requires ESRD Documentation from Physician	A claim has been submitted for an ESRD drug but the member doesn't have an ESRD coverage code.	65

3.17 General Validation Requirements

There are certain requirements that must be met in order for a claim to process. An example is that a claim must not be older than one year. Another example is that the Days' Supply is missing or invalid. See below for a complete list.

NCPDP Fields:

Date of Service (401-D1); Product/Service ID (407-D7); Cardholder ID (302-C2); Days' Supply (405-D5); Date Prescription Written (414-DE); Submission Clarification Code (420-DK); Quantity Dispensed (442-E7); Fill Number (403-D3); Patient Gender Code

(305-C5); Patient Last Name (311-CB); Route of Administration (995-E2); Compound Route of Administration (452-EH); Gross Amount Due (43Ø-DU); Submission Clarification Code (420-DK); Place of Service (307-C7)

Table 3-21: General Validation Requirements

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7009	After Date Filled	Date of service cannot be before the date the prescription was written. Correct and resubmit.	AB
7010	Not Applicable (N/A)	UAC charge is missing or invalid. Correct and resubmit.	DQ
7012	Too old to file	Date of service is greater than one year from the date the prescription was written. A new prescription is required.	81
7019	N/A	Date Prescription Written is missing or invalid. Correct and resubmit	28
7020	Post-dated	Claim date of service is post-dated. Correct and resubmit.	82
7024	N/A	Days' Supply is missing or invalid. Correct and resubmit.	19
7025	N/A	Quantity Dispensed is missing or invalid. Correct and resubmit.	E7
7035	M/I Claim Segment	Claim segment is missing or invalid. Correct and resubmit.	PC
7085	Invalid Version Number	Version number is missing or invalid. Correct and resubmit.	02
7087	N/A	Processor Control Code is missing or invalid. Correct and resubmit.	04
7112	N/A	Processing cannot be completed. Contact the help desk or try again later.	99
7136	Post-Dated	Claim date prescription written is post-dated. Correct and resubmit.	82
7156	M/I Ingred Cost	Ingredient Cost Submitted is missing or invalid. Correct and resubmit.	23
7193	Batch Indicator	If a batch claim (software vendor/certification ID) equals 'BAT', then the Scheduled Prescription ID Number must be set. Correct and resubmit.	EK
7200	Too Old to File	Date of Service is older than one year.	81
7263	Missing Patient Gender	Patient Gender is missing. Correct and resubmit.	10
7264	Missing Patient Last Name	Patient Last Name is missing. Correct and resubmit.	CB
7265	Missing Fill Number	Fill number is missing. Correct and resubmit.	17
7268	Missing Gross Amount Due	Gross Amount Due is missing. Correct and resubmit.	DU

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7269	Compound Route of Administration not allowed	Compound Route of Administration is no longer supported. Use Route of Administration (995-E2)	PF
7270	M/I Route of Administration	Missing Route of Administration. Correct and resubmit.	E2
7271	D0 does not support submission clarification code 0	Submission Clarification Code (SCC) 0 is no longer supported. Correct and resubmit.	34
7272	D0 does not support Place of Service Code 0	Place of Service Code 0 is not supported. Correct and resubmit.	12

3.18 Controlled Substance (CII drugs) Validation Requirements

There are certain requirements that must be met in order for a claim using a CII drug to process. An example is that a claim must be submitted with a Quantity Prescribed amount > .000.

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7521	For CII Qty Prescribed Must Be > .000	A claim has been submitted for a CII drug and the Quantity Prescribed is either missing or is not > .001.	ET
7522	CII Qty Prescribed Mismatch	Quantity Prescribed on incremental fill does not match the Quantity Prescribed transmitted on prior claims.	648
7523	Qty Dispensed is > Qty Prescribed	For a CII drug the Quantity Dispensed cannot be greater than the Quantity Prescribed on a single claim or the sum of all paid claims Quantity Dispensed.	649
7524	CII Drug - Refills Auth must be 0	The 415-DF (Number of Refills Authorized) must always be 0 for CII claims.	29
7525	CII Incremental Claim Too Old To File	Incremental Fills for CII claims is 30 for Nursing Home/Long Term Care patients and 60 are for all other patients.	15
7526	CII Rx Written Date Mismatch	All CII for the same member, provider, and Rx Number must have the same Rx Written Date.	28
7527	CII Incremental Fills Not Allowed For Cmpd Claims	Incremental CII Compound claims that have the same provider, member, and Rx Number are not allowed.	E7

3.19 COVID Claims

There are certain requirements that must be met in order for a claim using a COVID drug, kit, or vaccine to process. An example is tha a claim must be submitted with a Basis of Cost = 15 for a COVID drug or vaccine.

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7533	M/I Basis of Cost Determination	If the 423-DN value needs to equal 15	15
7534	M/I Incentive Amount Submitted	The 438-E3 value must be > 0.00.	E3
7535	Labeler doesn’t match original vaccine	If a member hasn't finished up the recommended doses within a timeframe then changing to a different manufacturer should not occur.	21
7536	Labeler doesn’t match original vaccine	If a member is switching manufacturers within a certain a time period then a warning message is sent back in the response.	21
7537	Vaccine scheduled too early	Check members history based on limitations set at either the GcnSeqno or HIC3 level.	76
7538	[manufacturer] dose2 was due on [xx/xx/xxxx]	Check members history based on limitations set at either the GcnSeqno or HIC3 level.	76
7539	Vaccine scheduled too early	Check members medical claim and compare to incoming pharmacy COVID claim.	76
7540	Labeler doesn’t match original vaccine	Check members medical claim and compare to incoming pharmacy COVID claim.	21
7541	[manufacturer] dose2 was due on [xx/xx/xxxx]	Check members medical claim and compare to incoming pharmacy COVID claim.	76
7542	Labeler doesn’t match original vaccine	If a member hasn't finished up the recommended doses within a timeframe then changing to a different manufacturer should not occur.	21
7543	Plan Limitations Exceeded	Check members medical claim and compare to incoming pharmacy COVID claim.	76
7545	Vaccine Limitation Exceeded	Total pharmacy and medical COVID claims exceeds limit	76

3.20 Diagnosis Claims

There are certain requirements that must be met in order for a claim using a COVID drug, kit, or vaccine to process. An example is tha a claim must be submitted with a Basis of Cost = 15 for a COVID drug or vaccine.

Edit #	Returned Message	Definition and Corrective Action	NCPDP Reject Code
7528	M/I Diagnosis Code	This edit will post if the Diagnosis Code is entered and is not a valid iCD-10 code	39
7529	Diagnosis Code Qualifier Value Not Supported	Diagnosis qualifier must be 02.	521
7530	Drug-Diagnosis Mismatch	A claim is submitted for a drug that requires a diagnosis code and a diagnosis code was not entered.	80
7531	M/I Clinical Segment	A claim that had a drug requiring a diagnosis code didn't a clinical segment submitted.	PD
7532	M/I Clinical Segment	A claim that had a drug requiring a diagnosis code didn't a clinical segment submitted.	PD
7544	Drug-Diagnosis Mismatch	The incoming claim needs to have a valid BMS defined diagnosis code entered for the associated drug.	80

4. Point Of Sale Transactions

4.1 What is Point of Sale

Point of Sale, or online adjudication, means that a transaction is processed entirely through the claims processing cycle, in real-time, with a response indicating that the claim is payable, is a duplicate, or is rejected. The response is returned to the pharmacy within seconds of submission. Most pharmacies are already familiar with this type of processing as many other third party prescription processors use it.

Additionally, the system fully supports claim reversal transactions in real-time that enables the pharmacist to “back out” or credit any “return to stock” or other prescription transaction adjudicated in error.

4.2 Role of the Telecommunications Switch Vendor

A switch vendor is a telecommunications services vendor who electronically transfers the prescription transaction from the pharmacy to the Medicaid fiscal intermediary and back to the pharmacy.

A switch vendor is available directly to the pharmacy via the pharmacy desktop system software. The switch vendor receives all claims and routes them to their respective processing site, all of which are connected to the switch by dedicated lines.

4.3 Features of Point of Sale

The POS system is designed to work under the general framework of standards and protocols established by the NCPDP. It uses methods of communication which are in place for other pharmacy POS processing. Features of the POS are listed below.

- System is available 24 hours a day, seven days a week (except for scheduled downtime for system maintenance).
- System is available from authorized telecommunication vendors who are connected to virtually every pharmacy in the United States.
- System returns complete claims adjudication information in real-time, including payment amount and co-payment amount on paid claims, and denial reasons on denied claims.
- System utilizes the HIPAA compliant telecommunications standard, NCPDP D.0.

POS claims processing is performed online in real-time. The rapid response time is most beneficial to retail pharmacies for processing prescriptions as they are being filled. Pharmacies using a POS system are required to transmit claims through an authorized telecommunications switch vendor. Refer to the **Getting Started** section for additional detail

4.4 Prescription Claim Submission Required Fields

The WV POS Payer Sheets can be used as a reference tool to assist in using the POS system to submit claims to the fiscal intermediary. Payer Sheets requirements are based on the NCPDP Telecommunications Standard D.0. The Payer Sheets can be found at https:www.wvdhhr.org or at http://www.wvmmis.com.

4.4.1 Claim Responses

This section describes the standard response formats for original, downtime, and reversal transactions. The transaction header response status codes are limited to:

A - Header Acceptable

R - Header Unacceptable

If the response status is an "A", each claim (prescription) will have a status code:

P - Claim Payable

R - Claim Rejected

D - Duplicate of Paid Claim

S – Duplicate of Reversal

For multiple prescription claims, the Response Information Section is repeated for each prescription. There may be a combination of paid, duplicate, and rejected prescriptions when an acceptable transmission is submitted for multiple prescriptions.

4.4.2 Claim Payable

When a claim adjudicates and has a ‘P’ (claim payable) status, the claim will appear on the Remittance Advice in the “Paid” claims section after the claim has completed financial processing. The financial processing cycle that will include the claim is determined by the State. The NCPDP D.0 response returns the amount “to be paid” and the Co-payment Amount.

4.4.3 Claim Rejected

When a claim is submitted for a member who is not eligible for the pharmacy benefit according to the current information on the member file or a restriction for the NDC, the claim will reject. In addition to the NCPDP reject code, one or more edit numbers will be returned. See the Edits and Messages document located at http://www.dhhr.wv.gov/bms/Pages/default.aspx and http://www.wvmmis.com.

4.5 Point of Sale Claim Rejections

POS claims may reject due to an error in header data or claim detail, as described in the following sub-sections.

4.5.1 Header Data Rejections

Header edits are caused because of missing or invalid fields that are detailed in the Vendor Specification document. If an error occurs and the header information is rejected, an NCPDP reject code will be received. The provider’s software system or POS device transmits a short reject message based on this code. For multiple prescription claims, the claim information section is repeated for each prescription. When there is an error in the header information, a reject code will appear in the first prescription only, but also applies to the second, third, and fourth prescriptions.

4.5.2 Claim Detail Rejections

When a claim is rejected, the response message sent back to the pharmacy will contain reason(s) why the prescription rejected. For multiple prescription claims, the claim information section is repeated for each prescription.

If additional information is required, or there are questions, call RDTP at (800) 847-3859 Monday through Saturday, 8:30 a.m. to 9 p.m. ET and Sunday, 12:00 p.m. to 6 p.m. ET.

4.6 Authorization Number to Transaction Control Number Translation

A Transaction Control Number (TCN) is assigned to claims submitted via POS and paper. The following is an explanation on how to translate the authorization number received. Claims processed by POS are identified with BB = ‘00’. Paper claims are transformed to electronic claims and submitted as a batch which is identified as BB = ‘01’ through ‘99’. The TCN is the claim identification number and appears on the Remittance Advice.

The authorization number is made up of the following information:

Format:	YYJJJPBBDDDDDLL
YY:	2 digit year (e.g., 16 = 2016)
JJJ	Julian Day of the year (e.g., 033 = February 2
P/B	Pharmacy (POS = P, Paper Claim = B)
BB	Batch number, real-time = 01
DDDDD	Document number
LL	Line number

5. Appendix A - Glossary

Acronym/Term	Definition
835	Electronic version of an Remittance Advice (RA) which is on paper and supplies providers with their claims that were submitted to Medicaid
ADAP	AIDS Drug Assistance Program
Authorization Number	An authorization number is the Transaction Control Number (TCN) returned with each adjudicated response.
AVRS	Automated Voice Response System
AWP	Average Wholesale Price
COB	Coordination of Benefits
DAW	Dispense as Written
DD	Drug Interaction
DEA	Drug Enforcement Agency
DESI	Drug Efficacy Study Implementation
DHS	Department of Human Services
DME	Durable Medical Equipment
DOB	Date of Birth
DOS	Date of Service
Duplicate	A claim response of "D" (duplicate claim) is returned when Medicaid has previously paid a claim. A claim response of "S" is returned for a duplicate Reversal.
DUR	Drug Utilization Review
EO	Edit Override
ER	Early Refill
ESRD	End Stage Renal Disease
ET	Eastern Time
FDB	First DataBank
FMAC	Federal Maximum Allowed Cost
GCNSeqNo	Generic Code Sequence Number
HD	High Dosage
Health PAS	Healthcare Payer Administration Solution
Health PAS-Rx DUR	As a part of Health PAS-Rx, claims are subjected to editing for prospective drug utilization review. Gainwell and First Data Bank developed the software used to edit pharmacy claims. The Health PAS-Rx DUR software is updated weekly to reflect the most current First Data Bank information available to the industry.
HIPAA	Health Insurance Portability and Accountability Act

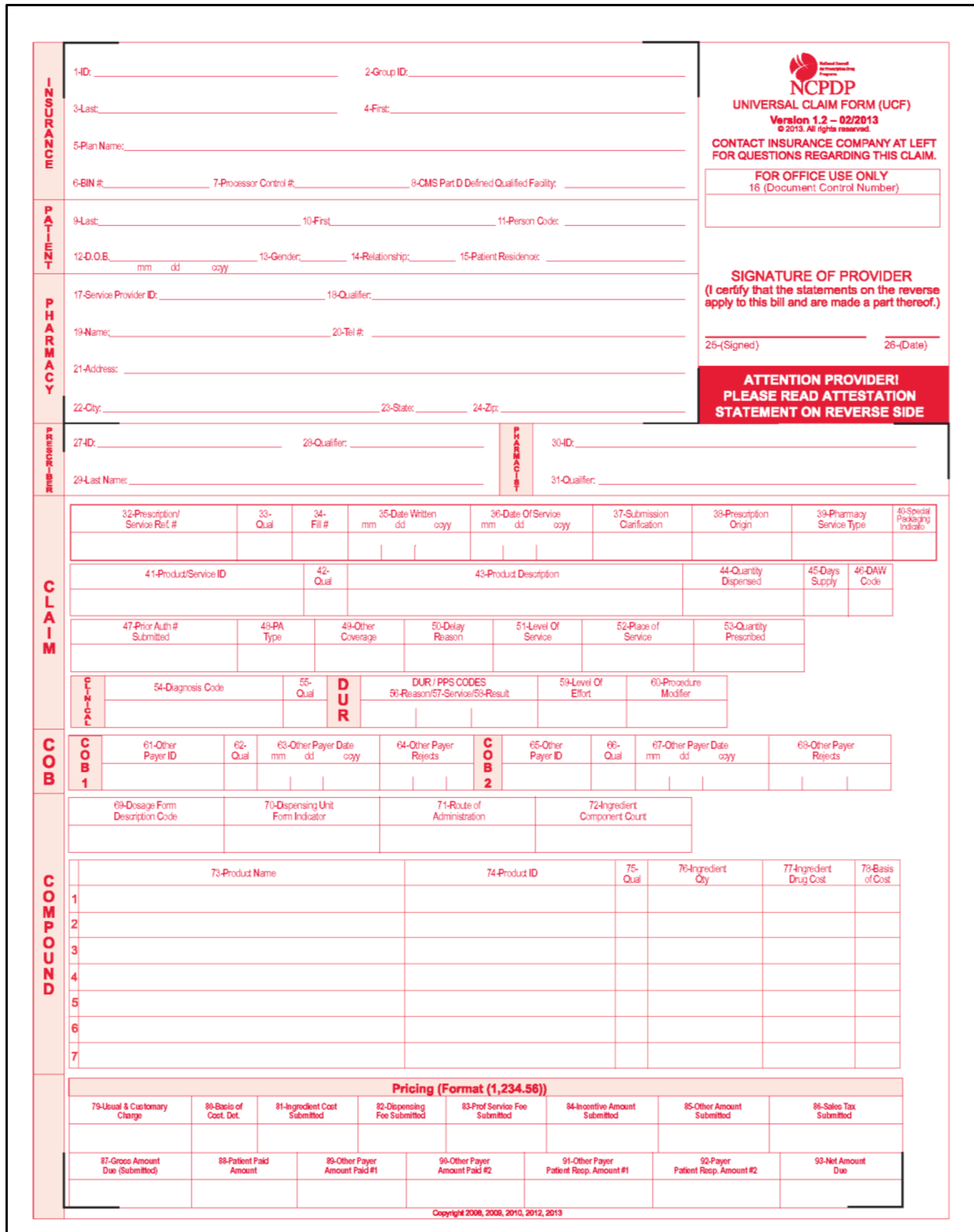
Acronym/Term	Definition
IC/MR	Intermediate Care Facility/Mental Retardation
ID	Identifier/Identification Ingredient Duplication
LD	Low Dose
LR	Late Refill
MCO	Managed Care Organization
M/I	Missing/Invalid
MAX	Maximum
MMIS	Medicaid Management Information System
MX	Maximum Duration
N/A	Not Applicable
NABP	National Association of Boards of Pharmacy
NCPDP	National Council for Prescription Drug Program
NDC	National Drug Code
NDDF	National Drug Data File
NH	Nursing Home
NPI	National Provider Identifier
OCC	Other Coverage Code
OTC	Over the Counter
PA	Prior Authorization
Payable	When a claim adjudicates and has a 'P' (claim payable) status indicating that this claim is ready for financial processing as determined by the State.
PB	Invalid Transaction Count
PDL	Preferred Drug List
PG	Pregnancy Precaution
PHS	Public Health Service
Point of Sale (POS)	Online adjudication of a pharmacy transaction, which is processed entirely through the claims processing cycle, in real-time, with a response indicating the claim is payable, duplicate, or rejected, is returned to the pharmacy within seconds of submission.
POS	Point of Sale
PPS	Prospective Payment System
Qty	Quantity
RA	Remittance Advice
RDTP	Rational Drug Therapy Program
REF	Reference

Acronym/Term	Definition
Rejected	A claim response of 'R' (claim rejected) is returned when a prescription is rejected (denied).
Reversal	A reversal transaction completely reverses a previously processed claim and will appear as a credit on the Remittance Advice.
RTP	Return to Provider
SCC	Submission Clarification Code
SMAC	State Maximum Allowed Cost
SNF	Skilled Nursing Facility
SX	Breast Feeding
TCN	Transaction Control Number
TD	Therapeutic Duplication
Telecommunication Switch Vendor	A telecommunications services vendor who electronically transfers the prescription transaction from the pharmacy to the Medicaid fiscal intermediary.
TPL	Third Party Liability
UAC	Usual and Customary
UCF	Universal Claim Form
WV	West Virginia

6. Appendix B – Claim Form

The allowable Universal Claim Form (UCF) sample can be seen in Error! Reference s ource not found. and Error! Reference source not found..

Figure 6-1: Universal Claim Form Version 1.2



NCPDP
UNIVERSAL CLAIM FORM (UCF)
Version 1.2 – 02/2013
© 2013. All rights reserved.
CONTACT INSURANCE COMPANY AT LEFT FOR QUESTIONS REGARDING THIS CLAIM.
FOR OFFICE USE ONLY
16 (Document Control Number)

INSURANCE
1-ID: 2-Group ID:
3-Last: 4-First:
5-Plan Name:
6-BIN #: 7-Processor Control #: 8-CMS Part D Defined Qualified Facility:

PATIENT
9-Last: 10-First: 11-Person Code:
12-D.O.B. mm dd ccyy 13-Gender: 14-Relationship: 15-Patient Residence:

PHARMACY
17-Service Provider ID: 18-Qualifier:
19-Name: 20-Tel #:
21-Address:
22-City: 23-State: 24-Zip:

SIGNATURE OF PROVIDER
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)
25-(Signed) 26-(Date)

ATTENTION PROVIDER!
PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE

PRESCRIBER
27-ID: 28-Qualifier:
29-Last Name:

PHARMACIST
30-ID:
31-Qualifier:

CLAIM

32-Prescription/ Service Ref. #	33-Qual	34-Fill #	35-Date Written mm dd ccyy	36-Date Of Service mm dd ccyy	37-Submission Clarification	38-Prescription Origin	39-Pharmacy Service Type	40-Special Packaging Indicator

41-Product/Service ID	42-Qual	43-Product Description	44-Quantity Dispensed	45-Days Supply	46-DAW Code

47-Prior Auth # Submitted	48-PA Type	49-Other Coverage	50-Delay Reason	51-Level Of Service	52-Place of Service	53-Quantity Prescribed

CLINICAL 54-Diagnosis Code	55-Qual	DUR / PPS CODES 56-Reason/57-Service/58-Result	59-Level Of Effort	60-Procedure Modifier

COB

COB 1 61-Other Payer ID	62-Qual	63-Other Payer Date mm dd ccyy	64-Other Payer Rejects	COB 2 65-Other Payer ID	66-Qual	67-Other Payer Date mm dd ccyy	68-Other Payer Rejects

COMPOUND

69-Dosage Form Description Code	70-Dispensing Unit Form Indicator	71-Route of Administration	72-Ingredient Component Count

	73-Product Name	74-Product ID	75-Qual	76-Ingredient Qty	77-Ingredient Drug Cost	78-Basis of Cost
1						
2						
3						
4						
5						
6						
7						

Pricing (Format (1,234.56))

79-Usual & Customary Charge	80-Basis of Cost. Det.	81-Ingredient Cost Submitted	82-Dispensing Fee Submitted	83-Prof Service Fee Submitted	84-Incentive Amount Submitted	85-Other Amount Submitted	86-Sales Tax Submitted

87-Gross Amount Due (Submitted)	88-Patient Paid Amount	89-Other Payer Amount Paid #1	90-Other Payer Amount Paid #2	91-Other Payer Patient Resp. Amount #1	92-Payer Patient Resp. Amount #2	93-Net Amount Due

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Figure 6-2: Universal Claim Form (Reverse Side)

Universal Claim Form (Reverse)

The provider agrees to the following:
- Certifies that required beneficiary signatures, or legally authorized signatures of beneficiaries, are on file;
- That the submitted claim is accurate, complete, and truthful; and
- That it will research and correct claim discrepancies.

For more instructions on this form, see the NCPDP *Manual Claim Forms Reference Implementation Guide* *available where forms are ordered or with NCPDP membership at www.ncpdp.org.*

Code List

For fields not listed below, or more values which may be available, see the *NCPDP Manual Claim Forms Reference Implementation Guide* or the NCPDP *External Code List.*

8 - CMS Part D Defined Qualified Facility
"Y" - Yes
"N" - No

13 - Patient Gender Code
"0" - Not Specified
"1" - Male
"2" - Female

14 - Patient Relationship Code
"0" - Not Specified
"1" - Cardholder
"2" - Spouse
"3" - Child
"4" - Other

15 - Patient Residence
"1" - Home
"3" - Nursing Facility
"4" - Assisted Living Facility
"9" - Intermediate Care Facility/Mentally Retarded
"11" - Hospice
"15" - Correctional Institution

18 - Service Provider ID Qualifier
"blank" - Not Specified
"01" - NPI
"05" - Medicaid
"07" - NCPDP
"99" - Other

28 - Prescriber ID Qualifier
"01" - NPI
"08" - State License
"12" - DEA
"99" - Other

31 - Provider ID Qualifier
"01" - DEA
"02" - State License
"03" - Social Security Number
"04" - Name
"05" - NPI
"06" - HIN
"07" - State issued
"99" - Other

33 - Prescription/Service Reference # Qualifier
"1" - Rx Billing
"2" - Service Billing

37 - Submission Clarification Code
"1" - No Override
"2" - Other Override
"3" - Vacation Supply
"4" - Lost Prescription
"5" - Therapy Change
"6" - Starter Dose
"7" - Medically Necessary
"8" - Process Compound for Approved Ingredients
"9" - Encounters
"10" - Meets Plan Limitations
"11" - Certification on File
"12" - DME Replacement Indicator
"13" - Payer-Recognized Emergency/Disaster Assistance Request
"14" - Long Term Care Leave of Absence
"15" - Long Term Care Replacement Medication
"16" - Long Term Care Emergency Box or Automated Dispensing Machine
"17" - Long Term Care Emergency Supply Remainder
"18" - Long Term Care Patient Admit / Readmit Indicator
"19" - Split Billing
"20" - 340B

37 - Submission Clarification Code (Continued)
"21" - LTC dispensing: 14 days or less not applicable
"22" - LTC dispensing: 7 days
"23" - LTC dispensing: 4 days
"24" - LTC dispensing: 3 days
"25" - LTC dispensing: 2 days
"26" - LTC dispensing: 1 day
"27" - LTC dispensing: 4-3 days
"28" - LTC dispensing: 2-2-3 days
"29" - LTC dispensing: daily and 3 day weekend
"30" - LTC dispensing: Per shift dispensing
"31" - LTC dispensing: Per med pass dispensing
"32" - LTC dispensing: PRN on demand
"33" - LTC dispensing: 7 day or less cycle not otherwise represented
"34" - LTC dispensing: 14 days dispensing
"35" - LTC dispensing: 8-14 day dispensing method not listed above
"36" - LTC dispensing: dispensed outside short cycle
"47" - Shortened Days Supply Fill
"48" - Fill Subsequent to a Shortened Days Supply Fill
"99" - Other

38 - Prescription Origin Code
"0" - Not Known
"1" - Written
"2" - Telephone
"3" - Electronic
"4" - Facsimile
"5" - Pharmacy

39 - Pharmacy Service Type
"1" - Community/Retail Pharmacy Services
"2" - Compounding Pharmacy Services
"3" - Home Infusion Therapy Provider Services
"4" - Institutional Pharmacy Services
"5" - Long Term Care Pharmacy Services
"6" - Mail Order Pharmacy Services
"7" - Managed Care Organization Pharmacy Services
"8" - Specialty Care Pharmacy Services
"99" - Other

40 - Special Packaging Indicator
"1" - Not unit dose
"2" - Manufacturer Unit Dose
"3" - Pharmacy Unit Dose
"4" - Pharmacy Unit Dose Patient Compliance Packaging
"5" - Pharmacy Multi-drug Patient Compliance Packaging
"6" - Remote Device Unit Dose
"7" - Remote Device Multi-drug Compliance
"8" - Manufacturer Unit of Use Package (not unit dose)

42 & 75 - Product/Service ID Qualifier
"00" - Not Specified
"01" - UPC
"02" - HRI
"03" - NDC
"04" - HIBCC
"06" - DUR/PPS
"07" - CPT4
"08" - CPT5
"09" - HCPCS

42 & 75 - Product/Service ID Qualifier (Continued)
"10" - PPAC
"11" - NAPPI
"12" - GTIN
"15" - GCN
"28" - FDB Med Name ID
"29" - FDB Routed Med ID
"30" - FDB Routed Dosage Form Med ID

46 - Dispense as Written (DAW) / Product Selection
"0" - No Product Selection Indicated
"1" - Substitution Not Allowed by Prescriber
"2" - Substitution Allowed - Patient Requested Product Dispensed
"3" - Substitution Allowed - Pharmacist Selected Product Dispensed
"4" - Substitution Allowed - Generic Drug Not in Stock
"5" - Substitution Allowed - Brand Drug Dispensed as a Generic
"6" - Override
"7" - Substitution Not Allowed - Brand Drug Mandated by Law
"8" - Substitution Allowed - Generic Drug not Available in Marketplace
"9" - Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to be Dispensed

48 - Prior Authorization Type Code
"0" - Not Specified
"1" - Prior Authorization
"2" - Medical Certification
"3" - EPSDT
"4" - Exemption from Copay and/or Coinsurance
"5" - Exemption from Rx
"6" - Family Planning Indicator
"7" - TANF (Temporary Assistance for Needy Families)
"8" - Payer Defined Exemption
"9" - Emergency Preparedness

49 - Other Coverage Code
"0" - Not Specified by patient
"1" - No Other Coverage
"2" - Other Coverage Exists - Payment Collected
"3" - Other Coverage Billed - Claim Not Covered
"4" - Other Coverage Exists - Payment Not Collected
"8" - Claim is billing for patient financial responsibility only

50 - Delay Reason Code
"1" - Proof of eligibility unknown or unavailable
"2" - Litigation
"3" - Authorization delays
"4" - Delay in certifying provider
"5" - Delay in supplying billing forms
"5" - Delay in delivery of custom-made appliances
"7" - Third party processing delay
"8" - Delay in eligibility determination
"9" - Original claims rejected or denied due to a reason unrelated to the billing limitation rules
"10" - Administration delay in the prior approval process
"11" - Other
"12" - Received late with no exceptions
"13" - Substantial damage by fire, etc to provider records
"14" - Theft, sabotage/other willful acts by employee

51 - Level of Service
"0" - Not Specified
"1" - Patient Consultation
"2" - Home Delivery
"3" - Emergency
"4" - 24 Hour Service
"5" - Patient consultation regarding generic product selection
"6" - In-Home service

52 - Place of Service (For values see https://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html)

55 - Diagnosis Code Qualifier
"00" - Not Specified
"01" - ICD9
"02" - ICD10
"03" - NCCI
"04" - SNOMED
"05" - CDT
"06" - Medi-Span Product Line Diagnosis Code
"07" - DSM IV
"08" - First DataBank Disease Code (FDBDX)
"09" - First DataBank FML Disease Identifier (FDB DxID)
"99" - Other

56 - Reason for Service &
57 - Professional Service Code &
58 - Result of Service Code (For values refer to NCPDP Reference Guide or current External Code List)

59 - DUR/PPS Level of Effort
"0" - Not Specified
"11" - Level 1 (Lowest)
"12" - Level 2
"13" - Level 3
"14" - Level 4
"15" - Level 5 (Highest)

60 - Procedure Modifier Code (See http://www.cms.hhs.gov/hcpcsreleasecodesets/anhcpcs/list.asp)

62 & 66 - Other Payer ID Qualifier
"01" - National Payer ID
"02" - HIN
"03" - BIN
"04" - NAIC
"05" - Medicare Carrier Number
"99" - Other

64 & 68 - Other Payer Reject Codes (For values refer to current NCPDP External Code List)

71 - Route of Administration (See SNOMED CT® http://www.snomed.org)

78 - Compound Basis of Cost Determination
&
80 - Basis of Cost Determination (For values refer to NCPDP Reference Guide or current External Code List)

Version 1.2

OFFICIAL RELEASE

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February 2013

The UCF version 1.2 is a two-sided form. The back of the form lists all valid values. However, not all valid values are supported by the West Virginia Medicaid. One or two non-compound claims for the same Card ID and the same DOS can be submitted on one form. Only one multi-ingredient compound claim can be submitted on the UCF version 1.2. The back of the form provides space for listing compound ingredients.

When submitting a UCF version 1.2, the following information is required:

Table 6-1: Universal Claim Form V 1.2 Information

Field	Information
I.D	Cardholder Identification Number
BIN Number	610164

Field	Information
Processor Control Number	DRWVPROD
Patient Last Name	Patient’s last name
Patient Date of Birth	Patient’s date of birth as recorded in member’s Medicaid record. Entered as MM DD CCYY (i.e., 04 01 2004)
Patient Gender	0 = Not Specified 1 = Male 2 = Female
Service Provider ID	Pharmacy Provider’s NPI (National Provider ID) Identification Number or Pharmacy Provider’s NCPDP (NABP) Identification Number
QUAL (Service ID)	01 to indicate that the Service Provider ID is the NPI ID number. 07 to indicate that the Service Provider ID is the NCPDP ID number.
Prescriber ID	National Provider ID (NPI) number of the prescribing provider or Drug Enforcement Agent (DEA) number of the prescribing provider.
QUAL (Prescriber ID)	01 to indicate the Prescriber ID is an NPI number. 12 to indicate the Prescriber ID is a DEA number.
Prescription / Service Ref #	Prescription number. (Must be all zero for a compound).
QUAL (Prescription)	01 to indicate claim is for a pharmacy prescription
Fill Number	Fill number of prescription
Date Written	Date the prescription was written. Entered as MM DD CCYY.
Date of Service	Date the prescription was dispensed. Entered as MM DD CCYY.
Product/Service ID	The NDC code for the drug being dispensed. If submitting a compound, enter all zeroes and list the NDCs on back of form listing the most significant NDC on line 1.
QUAL (Product ID)	03 to indicate Product/Service ID is an NDC. Default is 03. 06 to indicate a DUR/PPS segment is included. 00 to indicate a compound.
Qty Dispensed	Number of tablets, capsules, etc. dispensed. Must be entered as Metric Decimal Quantity.
Day’s Supply	Number of days the quantity dispensed should cover.
Dispense As Written (DAW)/ Product Selection Code	0 = No DAW 1 = Physician DAW 4 = No Generic Available 5 = Brand Dispsensed as Generic 6 = Override 8 = Generic Not Available In Marketplace 9 = Substitution Allowed By Prescriber but Plan Requests Brand - Patient's Plan Requested Brand
Other Payer ID	Required if Other Coverage 2, 3, or 4 is used. Must not be blank
Other Payer ID Qualifier	Required if Other Coverage 2, 3, or 4 is used. Blank = Not Specified 01 = National Payer ID 02 = Health Industry Number (HIN)

Field	Information
	03 = Bank Information Number (BIN) 04 = National Association of Insurance Commissioners (NAIC) 09 = Coupon 99 = Other
Other Payer Date	Required if Other Coverage 2, 3, or 4 is used. Enter as MM DD CCYY.
Other Payer Reject Codes	Required if Other Coverage Code = 4. Other Payer did not make a payment toward the claim. List from one to three reject codes returned from the Other Payer.
Usual and Customary Charge	Amount normally charged by the Service Provider for dispensing the prescription. Amount includes cost of drug and dispensing fee.
Ingredient Cost Submitted	Cost of the drug dispensed to fill the prescription.
Gross Amount Due	Total price claimed from all sources
Patient Paid Amount	Required if Other Coverage Code = 2 or 4.The Primary Insurance co-payment amount collected from the cardholder. If left blank, any amount that should have been collected is the financial responsibility of the Service Provider.
Other Payer Amount Paid (#1)	Required if Other Coverage Code = 2. Amount received from Other Insurance(s) prior to filing claim to Medicaid for reimbursement of remaining charge.
Compounds (see back of form) At least two lines must be completed. Repeat NDC, Quantity, and Cost for 2 to 11 NDCs. List most significant ingredient NDC on line one. All Fields required if Compound Segment is filled out.	
Dosage Form Description Code	01=Capsule 02=Ointment 03=Cream 04=Suppository 05=Powder 06=Emulsion 07=Liquid 10=Tablet 11=Solution 12=Suspension 13=Lotion 14=Shampoo 15=Elixir 16=Syrup 17=Lozenge 18=Enema
Dispensing Unit Form Indicator	1 = Each 2 = Grams 3 = Milliliters
Route of Administration	1=Buccal 2=Dental 3=Inhalation 4=Injection

Field	Information
	5=Intraperitoneal 6=Irrigation 7=Mouth/Throat 8=Mucous Membrane 9=Nasal 10=Ophthalmic 11=Oral 12=Other/Miscellaneous 13=Otic 14=Perfusion 15=Rectal 16=Sublingual 17=Topical 18=Transdermal 19=Translingual 20=Urethral 21=Vaginal 22=Enteral
Product ID	The NDC code for the drug being included in the compound. Start on line one.
Ingredient Quantity	Number of tablets, capsules, etc. dispensed. Must be entered as Metric Decimal Quantity.
Cost	Cost of the NDC for the line.

7. Appendix C - Questions and Answers

1. My screen says, "No response from The Medicaid fiscal intermediary." What is happening?

This situation occurs when the telecommunication switch is unable to make contact with The Medicaid fiscal intermediary Data Center in Salt Lake City, Utah. The possible explanations include:

- Your telecommunications switch is malfunctioning. (Contact your software vendor or the switch.)
- The Medicaid fiscal intermediary data center is not operational due to maintenance or emergency downtime. (Repeat POS attempt later in the day.)

2. I filled a prescription and submitted the claim through POS, but the patient never came in to pick it up. What do I do now?

Since the service for which the POS claim was submitted was never actually provided, you must reverse this claim. You may do this through the claim reversal process, available on-line. For an explanation of how to process a claim reversal, see the section in this user's guide titled, "Reversal Submission and Processing."

In order to reverse a claim, you must enter the following information from the original claim:

a. Prescription number
b. Medicaid Provider Number
c. Date of Service
d. NDC

In addition, the transaction code must indicate a reversal. The transaction code for a reversal is "B2".

3. What other types of claims also need to be reversed?

A claim needs to be reversed in the following situations:

a. If the pharmacy was paid inappropriately because of incorrectly submitted information or due to a claim processing error. (A pharmacy should reverse the claim, and bill correctly, if applicable.)
b. If the Medicaid fiscal intermediary indicates that a claim has been paid, but the response is not in the pharmacy's system. (A pharmacy can reverse a claim and bill it again in order to get a response within the pharmacy's system.)

4. A Medicaid member has no proof of eligibility. May I provide him or her with medication?

A Medicaid member is required to present a valid Medicaid card to prove eligibility. If the member has misplaced or lost their Medicaid identification card, eligibility can be

verified by calling the automated eligibility verification line, (888) 483-0793. If the POS indicates that, the client is not eligible and the automated verification system has indicated the member is eligible, request proof of identification such as a driver's license. If no proof of identification is available, request an alternative payment mechanism, i.e., cash.

5. **Will I be charged a transaction fee each time I submit a claim?**

   Yes, though the exact nature of the service charges are specified in your contract with your system vendor. Providers are cautioned to avoid unnecessary resubmissions of previously paid claims and resubmissions of denied claims without correcting the noted deficiencies. Such practice can increase the provider's service charges and tie-up the claims processing system.

6. **I just processed a claim via POS and now realize that the quantity (or days' supply, member ID#, etc.), was entered incorrectly. How do I fix this without billing Medicaid twice?**

   In order to correct a claim on-line, you must use the claim reversal process. Once you have reversed the incorrect claim, then you can resubmit a new, corrected claim via POS.

   ***Note**: Adjustments are not available using POS. An incorrectly submitted claim must be completely reversed prior to submitting the corrected claim.*

7. **I keep getting reject code 83, or duplicate claim messages. What is going on?**

   This reject code applies when a claim for the same drug for the same patient has already been paid by the claims processing system. You may be seeing this exception when you are trying to resubmit a claim and are unaware that it has already been paid. Check your remittance advice to verify that the claim was paid. All subsequent submittals of a paid claim will be denied.

8. **The Doctor increased the drug dose on a prescription I filled earlier. When I submitted a refill claim for the prescription, the claim denied because it was filled "too early." What should I do?**

   Submit the refilled prescription claim with appropriate codes in the Reason for Service (formerly DUR Conflict Code), Professional Service (formerly DUR Intervention Code), and Result of Service (formerly DUR Outcome) fields to indicate the reason the Early Refill error should not apply.

9. **What is Health PAS-Rx DUR?**

   As a part of POS, claims are subjected to editing for prospective drug utilization review. The software used to edit pharmacy claims was developed by Gainwell using data provided by First DataBank. The Health PAS-Rx DUR software is updated weekly to reflect the most current information available to the industry.

   Claims will be edited to identify and to inform a pharmacist of potential issues of concern. While certain edits may appear as informational only, other edits may result in claim denials.

10. **If the computer in my store goes down, what can I do?**

Follow your normal business procedures for working through a computer/software downtime.

End of Documentation