Louisiana DHH Medicaid Point of Sale (POS)

User Guide

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I. Introduction

This document is designed to assist Louisiana pharmacy providers in on-line claim submission, also known as Point of Sale (POS) processing. The Department of Health and Hospitals (DHH) and the Medicaid fiscal intermediary have made Point of Sale processing available to Louisiana Medicaid providers as an additional method of claim submission. The DHH has defined participation requirements for pharmacies.

Some of the terms used in this guide may be unfamiliar, especially if one is not familiar with Point of Sale or the Louisiana Medicaid Program. Refer to Appendix A for a glossary of terms used in this guide.

What is Point of Sale?

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

Role of the Telecommunications Switch Vendor

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

A switch vendor is available in a dial-up mode, directly to the pharmacy. 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.

Features of Point of Sale

The POS system is designed to work under the general framework of standards and protocols established by the National Council for Prescription Drug Programs (NCPDP). It uses methods of communication which are in place for other pharmacy Point of Sale processing. Features of Point of Sale are listed below.

- Available 24 hours a day, seven days a week (except for scheduled downtime for system maintenance)
- Available from authorized telecommunication vendors who are connected to virtually every pharmacy in the United States.
- Returns complete claims adjudication information real-time; provides payment amount, co-payment amount on paid claims, and denial reasons on denied claims.
- Utilizes the Health Insurance Portability and Accountability Act (HIPAA) compliant telecommunications standard, NCPDP 5.1.

The Point of Sale system is operated in conjunction with the Louisiana Medicaid Management Information System (LMMIS) and has available all information necessary to adjudicate a claim. The system also reports information back to the pharmacist which aids in correcting claim errors or billing another source other than Medicaid.

Examples of information reported back are verification of recipient eligibility and claim processing edits, including Drug Utilization Review (DUR) messages. Additionally, the system fully supports in real-time a claim reversal transaction which enables the pharmacist to "backout" or credit any "return to stock" or other prescription transaction adjudicated in error.

II. General Information

Pharmacies using the Point of Sale system are required to transmit their Point of Sale claims through an authorized telecommunication switch vendor. The Point of Sale system is regarded as another method of claims submission for pharmacy claims and is most beneficial to retail pharmacies.

This method, however, differs from other input methods because it is performed on-line in real-time. This means that it is principally used to process prescriptions as they are being filled. This requires rapid response time. As a result, providers must use an authorized telecommunication vendor who is continuously available on-line to the Medicaid fiscal intermediary.

Although the POS system is not designed for batch (paper claims or Electronic Media Claims) billing, some software companies have designed claims submission systems that utilize the POS system in a pseudo-batch environment.

The following restrictions and qualifications apply to Point of Sale submission:

1. Providers utilizing this service must be authorized by DHH and the Medicaid fiscal intermediary for this method of claim submission. Claims submitted prior to authorization will be rejected.

2. Only new claims, resubmitted denied claims, or reversals can be submitted via Point of Sale; adjustments must be submitted via hardcopy invoice. For instructions on submitting adjustments, please consult the Provider manual.

3. Claims requiring "supporting" documentation or attachments cannot be submitted via Point of Sale. They must be submitted via hardcopy claim. (Example: Spend Down Claims). These claims are to be sent to Unisys, P O Box 91024, Baton Rouge, LA 70821 - 4169. Please submit an explanatory cover letter with these claims if additional manual review of these claims is desired.

4. Claims that need to be manually reviewed cannot be submitted via Point of Sale. Please submit on hard copy as per the provider manual. A brief cover letter describing the request will expedite the review process. (Example: POS claims denied for eligibility that are resubmitted with a photocopy of the recipient's I.D. card). Send the cover letter to Unisys Provider Relations, P.O. Box 91024, Baton Rouge, LA 70821.

5. Although one to four prescriptions for the same recipient can be submitted at one time via Point of Sale, please note that only one reversal may be submitted in a single submission. Some pharmacy computer systems are limited to processing single prescription transactions.

6. Previously rejected claims can be submitted after correction using the Point of Sale system for up to one year from date of service.

7. Each pharmacy claim must include a valid individual Prescribing Provider's Medicaid I.D. number.

8. The *Louisiana Prescription Drug Services Manual* (Chapter Thirty-eight of the Medicaid Services Manual) and provider update policy statements should be used for policy and claim submission instructions. Providers should also review messages contained in their weekly Remittance Advice statements for current policy changes and updates to the Provider Manual appendices.

III. Getting Started

Pharmacy providers participating in the Louisiana Medicaid Point of Sale system should contact their computer system vendor for further information. Pharmacies must return to DHH the forms distributed through the DHH mailing of the Provider Enrollment Packet. DHH will notify the pharmacy by letter when the enrollment process is completed. Unisys signs contracts with and tests telecommunication "switch vendors" that wish to participate in the POS program. At this time, the following "switch vendors" are scheduled to participate: Envoy/WebMD/Healtheon, NDC, and QS/1.

DHH policy on pharmacy participation in POS is defined as follows:

I. Provider participation

A. A Point-of-Sale enrollment amendment and certification is required prior to billing POS/UniDUR as well as an annual re-certification.

B. All Medicaid enrolled pharmacy providers will be required to participate in the Pharmacy Benefits Management System.

C. Providers accessing the POS/UniDUR system will 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 DHH, Bureau of Health Services Financing will not reimburse the provider for any ongoing fees incurred by the provider to access the POS/UniDUR system.

E. Eligibility verification is provided through the POS system.

F Physicians and pharmacy providers will be required to participate in the educational and intervention features of the Pharmacy Benefits Management System.

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Help Information

Based on the type of problem experienced, Point of Sale help information is available from a variety of parties:

- The pharmacy's telecommunication switch vendor
- The pharmacy's system vendor
- Unisys:
    - **REVS System 1-800-776-6323** (Automated Recipient Eligibility Verification System information, Weekly Check Balances)
    - **POS Help Desk 1-800-648-0790** or **1-225-237-3381**
- DHH - Pharmacy Program 1-225-342-9768 for questions involving receipt of Provider Enrollment POS Packet.

Following are examples of when you might need additional assistance:

	Question	**Contact**
1.	What does this field mean?	System Vendor
2.	What values should I enter in this field?	System Vendor
3.	What does this rejection code mean?	POS Help Desk
4.	I am not getting a response. What should I do?	Switch Vendor
5.	Why is my response time so slow?	Switch Vendor

Contact the appropriate party in order to expedite solving your problem or question. If unsure of whom to contact or notify of a problem, please call the Unisys Help Desk at **1-800-648-0790**.

Contact your Telecommunication switch vendor when one of the following conditions arise:

- Technical network problem
- Response time is slow
- A response is not received.

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

- Request System Vendor Manual
- What value should be entered in a field, or where to access a field
- Response time is slow. The system vendor will contact the telecommunication vendor.

The POS Help Desk will assist providers in using the Point of Sale system and in billing claims electronically. Providers should contact the POS Help Desk when there are questions or problems relating to Point of Sale claims adjudication.

For the POS Help Desk to provide prompt and accurate assistance, please be prepared to provide the following information:

1. Seven-digit Medicaid provider number
2. System vendor name
3. Telecommunication vendor name (Switch)

Contact the Medicaid fiscal intermediary POS Help Desk at **1-800-648-0790 or 1-225-237-3381**, Monday-Friday, 8:00 a.m. to 5:00 p.m., when additional information concerning one of the following is needed:

- Confirmation of receipt of submitted claims
- Verify accuracy of transmission and response
- Request list of authorized telecommunication vendors (Switches)
- Request POS documentation
- Questions regarding billing procedures/policy issues
- Questions regarding claim status (i.e., rejected claim)
- Questions regarding UniDUR edits per references.

Note: The most current eligibility information is obtainable through the POS system.

Questions regarding eligibility information should be directed to:

1. **Recipient Eligibility Verification System** (REVS) is available at **1-800-776-6323**. This is a synthesized voice response to your eligibility inquiry. A touch-tone telephone is required in order to use REVS. It is available 24 hours a day, 7 days a week with the exception of short maintenance periods

2. If REVS information needs clarification, please call the Pharmacy Provider POS Help Desk at **1-800-648-0790** or **1-225-237-3381.** A Provider Inquiry Analyst will assist you with your inquiry. You are limited to one inquiry per phone call.

3. Call your Parish Medicaid Office for assistance with eligibility problems

Clinical questions regarding UniDUR criteria, which cannot be resolved with available pharmacy references, can initially be addressed to the POS Help Desk at **1-800-648-0790 or 1-225-237-3381**. Should additional information be needed by pharmacists or physicians, Unisys will forward claim information to the University of Louisiana at Monroe, School of Pharmacy. Telephone follow-up of the referral will be by ULM to the provider and/or physician who made the initial request.

IV. Provider POS Authorization

Before providers can begin submitting Point of Sale claims, they must be properly authorized by the Department of Health and Hospitals. The steps for approval are as follows:

1. Contact the system vendor to obtain and install the necessary software upgrades that may be required, and to obtain a system vendor manual.

2. Select and contract with an authorized telecommunication switch vendor. A current list of the authorized telecommunication switch vendors is available upon request from Unisys POS Help Desk. The following telecommunication switch vendors are available for submission: Envoy/WebMD/Healtheon, NDC, and QS/1. If the preference is to use a telecommunication switch vendor that is not on the approved list, ask the vendor to contact the Unisys POS Help Desk **1-800-648-0790** or **1-225-237-3381** to become authorized.

3. Complete and return to **Unisys, Provider Enrollment, P.O. Box 80159, Baton Rouge, LA 70898, t**he three (3) agreements included in the "Provider Enrollment Packet" that is sent to each pharmacy. The following agreements are located in this Packet and are listed below:

- Point-of-Sale Agreement - Appendix D
- Provider Enrollment Amendment - Appendix E
- POS Certification - Appendix F

After DHH has received and reviewed all the necessary documentation, the pharmacy provider will receive written authorization to begin submitting claims using the Point of Sale system.

NOTE: Pharmacies without POS approval status by DHH will not be permitted to submit claims through the POS system.

The Provider Certification Agreement is a one-year agreement. Renewals will be required annually. DHH will mail renewal applications to pharmacies on a yearly basis.

V. Claim Submission and Processing

This section provides some basic information to assist in Point of Sale claim processing for Louisiana Medicaid. All existing pharmacy claim submission requirements apply to Point of Sale. Please refer to the Medicaid Provider manual for particular billing requirements.

Maximum Allowed Prescriptions Per POS Transaction

Up to four prescriptions at a time may be submitted if the following conditions are met:

1. The additional prescriptions must be for the same recipient.
2. The additional prescriptions must be for the same date of service.

Example: If six prescriptions have been filled for one recipient, two POS transactions would be completed, one with four prescriptions and the other transaction with two prescriptions.

Cardholder Identification

Consult the Recipient Eligibility Card for the sixteen digit Medicaid Card Control number.

"Name/Number Mismatch"

Edit 217 -

A claim with this edit will deny for name/number mismatch. A provider should receive in his/her response the name of the recipient as it appears on the recipient file with information to resubmit as displayed if the provider can resolve the name/number mismatch with the recipient at the point of sale. If not, then the provider should make a copy of the card. A facsimile will be generated for this edit. If the provider was unable to resolve the name/number mismatch, then the provider should return the facsimile with a copy of the eligibility card for immediate handling by the designated Medicaid fiscal intermediary staff noted above.

Prior Authorization Required

Prior authorization of drugs whose status is not "preferred" is required. The prescribing practitioner initiates the prior authorization requests when a request is faxed, phoned or mailed to the University of Louisiana School of Pharmacy at Monroe. The requests are evaluated and the pharmacist reviewer makes a decision. Approved requests are added to the claims adjudication system, and the decision response is faxed or phoned to the requester. The following are edits associated with the prior authorization process:

Edit 484 - New RX requires PA
Edit 485 – PA required
Edit 486 – PA expired

Edit 487 – Emergency override of drug that requires PA

Edits 485 and 486 will result in denial of the associated claim. The prescribing provider must contact the University of Louisiana School of Pharmacy at Monroe to obtain prior authorization of the drug.

Prescription Service Limitations

Edit 498 **-** Number of prescriptions greater than limit

For services beginning **March 3, 2003**, an eight-prescription limit per recipient per calendar month in the Medicaid Pharmacy Program is in effect.

The following federally mandated recipient groups are exempt from the eight-prescription monthly limitation:

- Persons under the age of twenty-one (21) years
- Persons living in long term care facilities such as nursing homes and ICR-MR facilities
- Pregnant women

Recipients who are not exempt from the eight-prescription monthly limitation are allowed a maximum of eight prescriptions per calendar month. Claims, including those for emergency prescriptions and prior authorized prescriptions that are in excess of eight per calendar month per recipient are denied with error text message number 498 (number of prescriptions greater than limit) which is linked to NCPDP error code M4.

"Medically Necessary Override"

Edit 575 **-** Missing/Invalid ICD-9-CM Diagnosis Code
Edit 576 – Missing or invalid PA/MC code or number for RX override
Edit 577 – Override/prescription exceeds 8 scripts per month limit

The eight-prescription monthly limit can be overridden when the prescribing practitioner authorizes the medical necessity of the drug and communicates to the pharmacist the following information in his own handwriting or by telephone or other telecommunications device: (1) "medically necessary override" and (2) a valid ICD-9-CM Diagnosis Code that directly relates to each drug prescribed that is over eight. (No ICD-9-CM literal description is acceptable.)

When submitting a claim for a recipient exceeding the eight prescriptions per month and the prescribing practitioner has communicated the required information, the pharmacist must submit an override by supplying the following Point of Sale claim data information:

- **NCPDP field #424** (Diagnosis), an ICD-9-CM diagnosis code
- **NCPDP field #416** (PA/MC Code & Number) enter a value of "5" which is "Exemption from prescription limits."

Prescription claims with overrides receive an educational edit message, EOB-577 (Override/Prescription exceeds 8 Rxs per Month Limit"). We recommend you contact your software vendor for user specific information related to these fields.

Prospective Drug Utilization Review (Uni-DUR) Edits

Edit 442 – Drug to drug interaction, conflict code DD
Edit 443 – Therapeutic overlay, conflict code TD
Edit 445 – Duplication drug therapy, conflict code ID
Edit 446 – Pregnancy precaution, conflict code PG
Edit 447 – Early or late refill, conflict code ER
Edit 471 - Drug to Drug Interaction Viagra Nitro, conflict code DD
Edit 482 – Therapeutic Duplication Denial, conflict code TD
Edit 483 - Pregnancy Precaution-Denial-FDA Category X, conflict code PG
Edit 656 - Exceeds maximum duration of therapy, conflict code MX

Prescription claims are processed by prospective drug utilization software that assigns conflict codes to the claims as appropriate based upon clinical criteria approved by the Louisiana DUR Board. These conflict codes are subsequently assigned claim error codes by the claims processing system as shown above. Because there are valid situations in which the conflict should not cause a claim to deny, override procedures are in place to allow the pharmacist to override the conflict with valid NCPDP Reason for Service (DUR Conflict), Professional Service (DUR Intervention) and Result of Service (DUR Outcome) codes.

When submitting a claim for a recipient and the prescribing practitioner has communicated the required information, the pharmacist can submit an override by supplying the following Point of Sale claim data information:

- Reason for Service Code (DUR Conflict) – TD, ID, ER, and MX are allowed
- Professional Service Code (DUR Intervention) –
    - MX and TD Reasons for Service require Professional Service Code = M0
    - ID and ER Reasons for Service require Professional Service Codes = 'M0' 'P0' 'R0'
- Result of Service Code (DUR Outcome) –
    - ER and TD Reasons for Service require Result of Service Code = '1A' '1B' '1C' '1D' '1E' '1F' '1G'

Additionally, the MX conflict requires a valid ICD-9-CM diagnosis code to justify acute therapy. We recommend you contact your software vendor for user specific information related to these fields.

Co-payment/Patient Paid Amount

Currently, most recipients must pay a variable ($.50 - $3.00) co-payment amount per prescription. The exceptions to this requirement are prescriptions filled related to the following conditions:

- Emergency

- Long Term Care
- Pregnancy
- Family Planning
- Recipient is less than 21 years of age

The co-payment amount will be automatically deducted from the “Total Amount Paid" field received in the Point of Sale response and will be reflected in the “Patient Paid Amount” field in the response. The recipient remains liable for payment of the co-payment amount.

MAC Override/Co-payment Exceptions

The MAC override will be entered as a value in the "Dispense as Written" field. Co-payment exceptions will be entered in the “Prior Authorization Type Code”, “Level of Service” or “Customer Location” (NCPDP Data Elements 461-EU, 418-D1, and 307-C7, respectively) field. Please consult the pharmacy system vendor manual or your pharmacy system software documentation or contact your software vendor on what codes need to be entered in these fields. If a code is entered in these fields, it could affect the amount received.

Coordination of Benefits

Federal regulations and applicable state laws require that third-party resources be used before Medicaid is billed. ***Third-party*** refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, which can be applied toward the Medicaid recipient’s medical and health expenses.

Pharmacy claims billed to Medicaid first when drug coverage with another insurance company is noted on the recipient’s resource file and with no indication that the applicable private insurance has been previously billed will deny with the NCPDP Reject code ***41 (Submit Bill To Other Processor Or Primary Payer)***. Pharmacy providers will receive EOB message ***932 (Please Bill Third Party Carrier First).*** The Medicaid carrier code for the other insurance as well as the other insurance’s name and telephone number if available will be sent in the rejection response. A crosswalk of carrier codes will be posted at www.lamedicaid.com.

Valid insurance coverage may differ from what is on the recipient’s resource file. Pharmacy providers may enter the correct coverage and coordinate benefits. Providers may contact the DHH MMIS Unit at 225-342-9498 with updated insurance coverage.

The recipient’s primary insurance information should be entered into the appropriate fields in the patient profile of the pharmacy’s software. After payment is received for the pharmacy claim from the primary payer, the pharmacy provider should send the other insurance company’s Medicaid carrier code in NCPDP field ***34Ø-7C (other Payer ID)***, the other payer’s coverage type in NCPDP field ***338-5C (Other Payer Coverage Type)***, the other payer’s amount paid in NCPDP field ***431-DV (Other Payer Amount Paid)*** and the provider’s usual and customary charge in NCPDP field ***426-DQ (Usual and Customary Charge)***. A value of ***Ø2=Other coverage exists-payment collected*** is entered in NCPDP field ***3Ø8-C8***

when the other insurance pays claim. The paid claim will include the EOB message ***918 (Medicaid Allowable Amount Reduced by Other Insurance)*** to indicate that the other payer's payment has been deducted from the amount reimbursed by Medicaid.

Medicaid will reimburse providers for the recipient's responsibility of coinsurance, co-payments, and deductibles with other insurance companies up to the maximum Medicaid allowed amount. This will be accomplished by Medicaid payment of the outstanding balance remaining after the payment by the primary payer has been deducted from the Usual and Customary Charge up to the maximum Medicaid allowed amount. Medicaid co-payments should still be collected if applicable.

Override capabilities will exist to allow providers to process claims and receive payment when a recipient would be delayed in receiving their prescriptions.

Certain conditions exist where Medicaid is mandated to pay and chase claims. Should a Medicaid recipient have court ordered medical child support, a pharmacy provider may override the coordination of benefits edit. Pharmacy claims that are deemed preventative care for ages under 21and pregnant women may be overridden. **Documentation of court ordered medical child support or preventative care on the hard copy prescription by the pharmacist is required for the above circumstances.**

Certain restrictions will be by-passed. Claims that are coordinated with primary insurance companies will process without edits for prior authorization for non-preferred drugs, eight prescription monthly limit and with edits for age restrictions for Xenical.

Pharmacy providers must continue to submit Medicare payable drug claims to the Medicare carrier prior to billing Medicaid for those individuals eligible for Medicare Part B coverage. After Medicare processes the claim, the information will automatically cross-over to the fiscal intermediary for payment of the coinsurance and deductible, where applicable. Should the recipient have other private insurance in addition to Medicare, the pharmacy claim must be coordinated with Medicare and the private insurance company before submitting to Medicaid last. Medicare may be primary or secondary to a private insurance payer. To determine whether Medicare is primary or not, Medicare may be contacted at 1-800-999-1118.

Coordination of Benefits fields included in Version 5.1 include:

COB/Other Payments Segment
Other Payer Coverage Type (Field 338-5C)
Other Payer ID Qualifier (Field 339-6C)
Other Payer ID (Field 34Ø-7C)
Other Payer Date (Field 443-E8)
Other Payer Amount Paid Count (Field 341-HB)
Other Payer Amount Paid Qualifier (Field 342-HC)
Other Payer Amount Paid (Field 431-DV)
Other Payer Reject Count (Field 471-5E)
Other Payer Reject Code (Field 472-6E)

These fields are optional unless prior payments are to be reported. The implementation of Cost Avoidance edits make the fields required for claims for recipients with third party resources available. The COB fields will be used to indicate other responsible parties to the non-primary payer as well as the date upon which payment or denial was made. If a provider bills other third-party payers and subsequently bills Medicaid, the following data fields are required:

COB/Other Payments Segment

Other Payer ID (Field 34Ø-7C)	Enter the Medicaid Carrier Code.
Other Payer Coverage Type (Field 338-5C)	First occurrence contains the primary payer (Ø1). The second occurrence contains the secondary payer (Ø2). The third occurrence contains the tertiary payer (Ø3).
Other Payer Date (Field 443-E8)	Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.
Other Payer Amount Paid (Field 431-DV)	Amount of any payment known by the pharmacy from other sources. The Other Payer Amount Paid field no longer represents the total amount paid by other payers. It is specific to each occurrence of other payer information.
Other Payer Reject Code (Field 472-6E)	Error Code explaining why the previous "Other Payer" denied payment of the claim.

Coordination of Benefits Override

In certain cases, override capabilities exist to allow Medicaid to be the primary payer. Several scenarios and appropriate overrides are listed below. **When appropriate, reject codes from the other insurance should be submitted to Medicaid when pharmacy claims are overridden.**

Other Coverage Code (3Ø8-C8) 01 = No other coverage

- Pharmacy submits claim to other insurance company. Claim denies due to coverage expired. Pharmacist inquires of recipient regarding other insurance coverage. Recipient does not have or cannot supply pharmacy with other insurance information.

- Pharmacy submits claim to other insurance company. The other insurance company does not include a pharmacy benefit. Pharmacist asks recipient for other insurance coverage, but recipient has none.

Other Coverage Code (3Ø8-C8) Ø3 = Other coverage exists-claim not covered

- Pharmacy submits claim to other payer. The other payer denies due to non-coverage of drug.

Other Coverage Code (3Ø8-C8) Ø4 = Other coverage exists-payment not collected.

- Recipient has insurance coverage (ex. 80-20 insurance) which requires the recipient to pay for the prescriptions then the insurance company would reimburse the recipient a certain percentage of the claim.

- Pharmacy submits claim to other payer. The recipient must meet a deductible before benefits pay for pharmacy claims. The other payer applies the claim to the recipient's deductible for the other insurance. The provider then submits the usual and customary charge to Medicaid.

- Recipient has court ordered medical child support.

- Preventative care for a recipient under the age of 21 or a woman who is pregnant.

- Pharmacy submits claim to other insurance company. The other insurance company is a mail-order only company.

- Recipient has other insurance coverage. The pharmacy claim requires prior authorization from the other insurance. The prior authorization process shall be commenced by the provider. Should the access of the recipient's prescription be delayed due to the prior authorization process, the pharmacy may submit the claim to Medicaid with the above other coverage code. However, once the prior authorization is acquired, **the claim must be reversed** and coordinated with all insurance carriers with Medicaid as last payer.

Other Coverage Code (3Ø8-C8) Ø6 = Other coverage denied-not participating provider.

- Recipient has insurance coverage but the pharmacy and/or physician is out of the insurance company's network.

The Pharmacy Unit will monitor pharmacy providers' usage of override codes. Corrective actions will be offered to better utilize the coordination of benefits process.

Contact the Point of Sale Helpdesk at 1-800-648-0790 with any questions or problems.

Override for Emergency Prescriptions Filled for Lock-In Recipients

DHH now allows submission of claims through POS for Lock-In recipients when filled on an emergency basis by a pharmacy other than the "Lock-In" assigned provider. NCPDP Field 418-DI "Level of Service" is used to indicate an emergency situation when a value of "3=Emergency" is submitted on the claim. This override may be used to resubmit a claim for payment when it has been previously denied for NCPDP Reject Code M2 "Recipient Locked In" in conjunction with LMMIS Error Code 218 "Recipient is MD, Pharm Restricted-MD Invalid", or Error Code 389 "Recipient is MD, Pharm Restricted-Pharmacy Invalid".

This override is provided because DHH recognizes that there will be unusual circumstances when it is necessary for a pharmacy or physician provider to grant services for a Lock-In recipient when the provider is not the Lock-In provider. Payment will be made to any pharmacist enrolled in Medicaid of Louisiana who grants services to a Lock-In recipient in emergency situations or when life sustaining medicines are required. Prescriptions written as a result of an emergency visit or as a discharge prescription following a hospital admission are applicable for payment if the correct emergency procedure is followed.

The notation "Emergency Prescription" should be written on the hardcopy prescription by either the prescribing physician or the dispensing pharmacist.

Prescription Claim Submission Required Fields

The following chart is a reference tool to assist in using the Point of Sale system to submit claims to the fiscal intermediary. These requirements are based on the NCPDP Telecommunications Standard 5.1 and were followed by the chosen system vendor in setting up individual systems for Louisiana Medicaid. Qualifiers inherent to the NCPDP 5.1 format are not included, but are specified in the vendor specifications. If a field is "required" then information must entered on the Point of Sale device. Otherwise, the field is optional.

Prescription Claim Submission Required Fields		
POINT OF SALE		**UCF PAPER CLAIM EQUIVALENT**
DATA ELEMENT	**REQUIRED OR OPTIONAL**	
Service Provider ID and Provider I.D.	Required	Service Provider I.D. and Provider I.D.
Cardholder I.D. Number	Required	I.D.
Other Coverage Code	Optional	Other Coverage Code
Date of Service	Required	Date of Service
Eligibility Clarification Code	Optional	*See Previous section titled "Use of Eligibility Override." Does not appear on paper claim form, but is available on adjustment form.
Patient First Name	Required	Patient Name
Patient Last Name	Required	Patient Name
Prescription/Service Reference Number	Required	Prescription/Serv. Ref. #
Fill Number	Required	Fill #
QuantityDispensed	Required	Qty Dispensed
Days Supply	Required	Days Supply
Product/Service I.D.	Required	Product/Service I.D.
Prescriber ID	Required	Prescriber I.D.
Usual & Customary Charge	Required	Usual & Cust. Charge
Prior Authorization Type Code (See Your Vendor's User's Manual for instructions)	Optional	PA Type (See Your Vendor's User's Manual for instructions)
Other Payer Amount	Optional	Other Payer Amount Paid
Dispense As Written (DAW)/Product Selection Code	Optional	DAW Code
Patient Paid Amount	Optional	Patient Paid Amount
Incentive Amount Submitted	Optional	Incentive Amount Submitted
Reason for Service Code	Optional	DUR/PPS Codes
Professional Service Code	Optional	DUR/PPS Codes
Result of Service Code	Optional	DUR/PPS Codes
Other Payer Reject Codes	Optional	Other Payer Reject Codes
Patient Date of Birth	Optional	Patient Date of Birth
Patient Gender Code	Optional	Patient Gender Code
Level of Service	Optional	Level of Service
Diagnosis Code	Optional	Diagnosis Code

The claim section may be repeated for up to four prescriptions.

Submission Deadline for the Weekly Payment Cycle

Point of Sale is another method of claim submission. Unisys, the Medicaid fiscal intermediary, pays all adjudicated claims on a weekly payment cycle. To meet the weekly payment cycle, all submissions and completed transactions must be in by 6:00 p.m. on Thursday night. All claims adjudicated during the week will be included on the Remittance Advice, which accompanies the check mailed the following week.

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
C - Claim Captured
D - Duplicate Claim
R - Claim Rejected

Each response status is explained in detail in the sections which follow. For multiple prescription claims, the Response Information Section is repeated for each prescription. There may be a combination of paid, captured, duplicate, and rejected prescriptions when an acceptable transaction is submitted for multiple prescriptions.

Claim Payable

When a claim adjudicates and has a 'P' (claim payable) status, the claim will appear on your next Remittance Advice in the "Paid" claims section. This response returns with an Internal Control Number (ICN), Billed Charges (displayed in the additional messages field), Total Amount Paid, and the Co-payment Amount.

For example, the full response for a payable claim will include:

Billed Charges	(in the additional messages area)
Co-payment Amount	$ 1.00 (for Drugs priced between $10.00 and $25.00)
Amount Paid	the calculated payment minus applicable Co-payment amount

Claim Captured Response

When a claim is submitted for a recipient that is not eligible for Medicaid according to the current information on the recipient file, or a gender restriction for the national drug code (NDC), the claim will reject for Explanation of Benefits (EOB) codes 215, 216, or 235. The format for these rejections is explained under the section “Claim Detail Rejected”. Please reference Appendix C for a description of the EOB codes

EOBs with codes of 239, 458, 459, and 978 will continue to pend and receive a claim “capture response”.

Please implement the following:

Edit #	Messages	Media Type	Action
238	Invalid PAC/Call Help Desk	All	Deny
239	Price missing on p/f/Call Help Desk	All	Pend
280	Manual Pricing Pend	1 or 7	Deny
458	MAC/FUL cost is Zero/Call Help Desk	All	Pend
459	Pending for file review/Call Help Desk	All	Pend
978	Calculated pricing is zero/Call Help Desk	All	Pend

The additional messages will contain:

XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX
(EOB Codes 215, 216 or 235 occur)
Example: 215

Duplicate Claim

The information returned on a duplicate claim response contains the same information displayed on the original "paid" claim response. The only difference is that the duplicate response will contain a duplicate claim EOB code. If an 843 or 898 EOB code is present in the response then this indicates it is a duplicate claim and Medicaid has already paid another similar claim. Please reference Appendix C for an explanation of the EOB codes.

Message Area will contain the following for duplicate reject reasons:

PPPPPPP RRRRRRRRRRRRR 999999

PPPPPPP = provider; RRRRRRRRRRRR = recipient id; 99999999 = adjudicated date

Additional Message Area will contain the duplicate EOB codes 843 or 898.

This message indicates to the pharmacist that a claim for that drug has already been paid on that date of service for that recipient. To facilitate the display of data, the telecommunication switch vendor may compress the message areas together.

VI. Claim Rejected

Header Data Rejected

If an error occurs and the header information is rejected, a NCPDP rejection code will be received, which in turn is transformed by an individual's system or POS device into a short reject message. There will not be any additional information in the message areas. 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 but will also apply to the second, third, and fourth prescription.

Claim Detail Rejected

When a claim is rejected, the message area will contain the EOB code for up to ten reasons why the prescription rejected. These codes are the same as those which appear on the Remittance Advice. For multiple prescription claims, the claim information section is repeated for each prescription.

The Message Area contains:

PPPPPPP RRRRRRRRRRRR 999999

PPPPPPP = provider; RRRRRRRRRRRR = recipient id; 99999999 = adjudicated date

The additional messages area will contain EOB codes for each reject reason:

XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX
Example: 005 207

Rejected Claim Response: The following messages will accompany the Recipient Edits.

215 - "Recipient Not on File - Copy Card - Submit DOB"
216 - "Recipient Not Eligible on DOS - Copy Card - Submit DOB"
217 - "Name/Number Mismatch - Copy Card"
235 - "P/F Sex Restriction"

The rejected claim response will show the EOB code that correlates to claims denial. This three-digit code can be referenced in Appendix C for the appropriate explanation. If additional information is required or there are questions, please call the Unisys Help Desk at **1-800-648-0790 or 1-225-237-3381**.

Authorization Number to ICN Translation

The following is an explanation on how to translate your authorization number received from your POS terminal to an Internal Control Number (ICN). The authorization number is made up of the following information:

Year	Position 1
Julian Day	Positions 2-4
Media Code	Position 5
Batch Number	Positions 6-8
Sequence Number	Positions 9-11
Line Number	Positions 12-13

The authorization number is the Medicaid Internal Control Number (ICN) as it appears on the Remittance Advice. For example, an authorization number for a Point of Sale adjudicated claim would appear like this: 2032620010001. This indicates that the claim was submitted on February 1, 2002. The Julian Date is 032, the Batch Number is 200, the sequence Number is 100, and the Line Number is 01.

VII. Reversal Submission and Processing

If a provider has submitted a claim and it was paid in error, they must transmit a reversal transaction through their POS device. The reversal transaction completely reverses the previously processed claim and appears as a credit on the next Remittance Advice. If the initial claim was entered incorrectly, a reversal transaction should be submitted, and then a new, corrected claim resubmitted. NOTE: The actual dispense date should be entered, not the current date. The difference between the original claim and the replacement claim is added to, or deducted from the payment amount on the next Remittance Advice. A reversal will create a credit of the original payment amount and will cause an automatic recoupment of this balance by the Medicaid system.

The data elements that must be entered for a claim reversal may vary somewhat depending on the provider's specific telecommunications vendor. In general, the required fields are the **provider number**, the **date the prescription was dispensed**, and the **prescription number**. If the provider receives a message stating NCPDP Code - 87, "Reversal Not Processed", a hardcopy paper void may be submitted to the Medicaid fiscal intermediary. Hardcopy paper void instructions can be found in the *Louisiana Prescription Drug Services Manual* (Chapter Thirty-eight of the Medicaid Services Manual) and in Appendix H of this document.

Reversal transactions must also be done when a prescription has been filled, a claim has been submitted and paid, but the prescription has not been picked up by or dispensed to a recipient. When "returning the prescription to stock", transmit a reversal transaction. This quick and simple transaction allows providers to easily remain in compliance with Medicaid regulations prohibiting the submission of claims for services not actually provided.

CLAIM REVERSAL FORMAT

DATA ELEMENTS	REQUIRED OR OPTIONAL
Service Provider I.D.	Required
Date of Service	Required
Prescription/Service Reference Number	Required
Reason for Service Code	Optional
Professional Service Code	Optional
Result of Service Code	Optional

Accepted Reversal Response

Only one reversal may be submitted per transaction. The message area will contain useful information as described below.

Message Area will contain:

REVERSED CLAIM ICN XXXXXXXXXXXXX
XXXXXXXXXXXXX = ICN

Rejected Reversals

If an error occurs and the reversal rejects, providers will receive an appropriate EOB code indicating that they must resubmit the reversal transaction. Please note that the rejected reversal will not appear on the Remittance Advice. The message area will contain useful information as described below.

Message Area will contain:

PPPPPPP RRRRRRRRRRRRR 999999 888 888 888 888

PPPPPPP = provider; RRRRRRRRRRRRR = recipient id; 99999999 = adjudicated date; 888 = EOB

Appendix A - Glossary

1. **Authorization Number** - An authorization number is the Internal Control Number (ICN) returned with each adjudicated response.

2. **Captured** – A claim response of 'C' (claim captured) is returned when a claim pends with edit codes 239, 458, 459, and 978.

3. **Date of Birth** - DOB.

4. **Duplicate** - A claim response of 'D' (duplicate claim) is returned when Medicaid has previously paid a claim.

5. **DUR** – Drug Utilization Review

4. **EOB Code** - The Medicaid fiscal intermediary Explanation of Benefits (EOB) code indicates why a claim is captured or rejected, and will appear in the message area of your Point of Sale response.

5. **Payable** - When a claim adjudicates and has a 'P' (claim payable) status indicating that this claim was paid by Medicaid.

6. **Point of Sale** - On-line 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, captured, duplicate, or rejected is returned to the pharmacy within seconds of submission.

7. **Rejected** - A claim response of 'R' (claim rejected) is returned when a prescription is rejected (denied).

8. **Reversal** - A reversal transaction completely reverses a previously processed claim and will appear as a credit on the next Remittance Advice.

9. **Telecommunication Switch Vendor** - A telecommunications services vendor who transfers via telephone lines, the prescription transaction from the pharmacy to the Medicaid fiscal intermediary.

10. **UniDUR** - As a part of POS, claims are subjected to editing for prospective drug utilization review. Unisys and First Data Bank developed the software used to edit pharmacy claims. The UniDUR software is updated twice a month to reflect the most current UniDUR information available to the industry.

Appendix B - Reject Code Messages

Following is a list of the National Council Prescription Drug Program (NCPDP) two-digit rejection codes. An explanation follows with the Medicaid fiscal intermediary corresponding three-digit Explanation of Benefits (EOB) code. Reference Appendix B for the description of the Medicaid fiscal intermediary EOB codes. Claims generating these reject codes must be corrected and resubmitted by the pharmacy.

An asterisk (*) indicates that the Medicaid fiscal intermediary does not currently use this code. If any of these messages are received, contact system vendors. For more information on these messages contact the **POS Help Desk at 1-800-648-0790**.

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*01	Missing or Invalid Bin Number		
*02	Missing or Invalid Version Number		
03	Missing or Invalid Transaction Code	001	Invalid Claim Type Modifier
*04	Missing or Invalid Processor Control Number		
05	Missing or Invalid Pharmacy Number	002 289	Provider Number Missing or Not Numeric Invalid Provider Number When Deny Applied
*06	Missing or Invalid Group Number		
07	Missing or Invalid Cardholder ID Number	003	Recipient Number Invalid or Less Than 13 Digits
*08	Missing or Invalid Person Code		
09	Missing or Invalid Birthdate	134 224	DOB Mismatch for CCN Invalid Birthdate on Recipient File
*1C	Missing or Invalid Smoker/Non-Smoker Code		
*1E	Missing or Invalid Prescriber Location Code		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*10	Missing or Invalid Patient Gender Code		
*11	Missing or Invalid Relationship Code		
*12	Missing or Invalid Patient Location		
13	Missing or Invalid Other Coverage Code	011	TPL Indicator not Y, N, or Space
*14	Missing or Invalid Eligibility Clarification Code		
15	Missing or Invalid Date of Service	005 006 007 008 009	Service From Date Missing/Invalid Invalid or Missing Thru Date Service thru Date less than Service From Date Service From Date Later than Date Processed Service Thru Date Greater than Date of Entry
16	Missing or Invalid Prescription/Service Reference Number	125	Prescription Number Missing
17	Missing or Invalid Fill Number	126	Missing or Invalid Refill Code, not numeric or > 5.
19	Missing or Invalid Days Supply	124	Days Supply Missing, Not Numeric, or Zero
*2C	Missing or Invalid Pregnancy Indicator		
*2E	Missing or Invalid Primary Care Provider ID Qualifier		
20	Missing or Invalid Compound Code	431	Missing or Invalid Compound Code
21	Missing or Invalid Product/Service ID	127	NDC Code Missing or Incorrect

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
22	Missing or Invalid Dispense As Written (DAW)/Product Selection Code	128 576	The MAC Override Indicator Must be a "C" Missing or Invalid PA/MC Code and Number
*23	Missing or Invalid Ingredient Cost Submitted		
25	Missing or Invalid Prescriber Identification	121	A Prescribing Physician Medicaid ID Must be Supplied
*26	Missing or Invalid Unit Of Measure		
*27	(Reserved for Future Use)		
28	Missing or Invalid Date Prescription Written	122 123	RX Date is Missing RX Date was After Date Filled
*29	Missing or Invalid Num. Refills Authorized		
*3A	Missing or Invalid Request Type		
*3B	Missing or Invalid Request Period Date-Begin		
*3C	Missing or Invalid Request Period Date-End		
*3D	Missing or Invalid Basis Of Request		
*3E	Missing or Invalid Authorized Representative First Name		
*3F	Missing or Invalid Authorized Representative Last Name		
*3G	Missing or Invalid Authorized Representative Street Address		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*3H	Missing or Invalid Authorized Representative City Address		
*3J	Missing or Invalid Authorized Representative State/Province Address		
*3K	Missing or Invalid Authorized Representative Zip/Postal Zone		
*3M	Missing or Invalid I Prescriber Phone Number		
*3N	Missing or Invalid Prior Authorized Number Assigned		
*3P	Missing or Invalid Authorization Number		
*3R	Prior Authorization Not Required		
*3S	Missing or Invalid Prior Authorization Supporting Documentation		
*3T	Active Prior Authorization Exists Resubmit At Expiration Of Prior Authorization		
*3W	Prior Authorization In Process		
*3X	Authorization Number Not Found		
*3Y	Prior Authorization Denied		
*32	Missing or Invalid Level of Service		
*33	Missing or Invalid Prescription Origin Code		
*34	Missing or Invalid Submission Clarification Code		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*35	Missing or Invalid Primary Care Provider ID		
38	Missing or Invalid Basis of Cost	238 239 458	Invalid PAC Action Code/Call Help Desk Price missing on p/f/Call help desk Does Not Have Valid Price for DOS MAC/FUL Cost Zero/Call help desk
39	Missing or Invalid Diagnosis Code	020 575	Invalid or Missing Diagnosis Code Missing/Invalid ICD-9-CM Diagnosis Code
*4C	Missing or Invalid Coordination Of Benefits/Other Payments Count		
*4E	Missing or Invalid Primary Care Provider Last Name		
40	Pharmacy Not Contracted With Plan On Date Of Service	201 202	Provider Not Eligible on Dates of Service Provider Cannot Submit This Claim Type
41	Submit Bill To Other Processor Or Primary Payer	275 434 449 988	Recipient is Medicare Eligible Bill Medicare Nebulizer Med Bill Medicare First Based on Discharge Date Item Covered by Medicare
*42-49	(Reserved for Future Use)		
*5C	M/I Other Payer Coverage Type		
*5E	M/I Other Payer Reject Count		
50	Non-Matched Pharmacy Number	200	Provider/Attending Provider Not on File

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*51	Non-Matched Group ID		
52	Non-Matched Cardholder Identification	133 215 223 294	Invalid CCN Recipient Not on File Recycled Recipient Not on File Recipient Not on File Recycled three Times
*53	Non-Matched Person Code		
54	Non-Matched Product/Service ID Number	231	NDC Code Not on File
55	Non-Matched Product Package Size	432	Quantity Exceeds Package Size
56	Non-Matched Prescriber Identification	450	Prescribing Provider Not on File - Status = O
*58	Non-Matched Primary Prescriber		
*6C	Missing or Invalid Other Payer ID Qualifier		
*6E	Missing or Invalid Other Payer Reject Code		
60	Product/Service Not Covered For Patient Age Drug Not Covered for Patient Age	234	P/F Age Restriction
61	Product/Service Not Covered For Patient Gender Drug Not Covered for Patient Gender	235	P/F Sex restriction
62	Patient/Card Holder ID Name Mismatch	217	Name and/or Number on Claim Does Not Match File Record
63	Institutionalized Patient Product/Service ID Not Covered	385	Diabetic Supplies not Covered for LTC Recipient

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*64	Claim Submitted Does Not Match Prior Authorization		
65	Patient is Not Covered	135	Patient not Covered for Pharmacy Service
		216	Recipient Not Eligible on Date of Service
		293	Recycled Recipient Ineligible on DOS
		295	Recipient Ineligible Recycled three Times
		364	Recipient Ineligible/Deceased
*66	Patient Age Exceeds Maximum Age	S	
*67	Filled Before Coverage Effective		
*68	Filled After Coverage Expired		
69	Filled After Coverage Terminated	364	Recipient Ineligible/Deceased
*7C	Missing or Invalid Other Payer ID		
*7E	Missing or Invalid DUR/PPS Code Counter		
70	Product/Service Not Covered	099	Item Covered Under Durable Medical Equipment Program Only
		299	Proc/Drug Not Covered by Medicaid
		233	Proc/NDC Not Covered for Service Date Given
		439	Manufacturer has identified product as food supplement

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
71	Prescriber is Not Covered	213	Provider Not Covered for Services Rendered By Medicaid
		262	Provider's Adjustments on Review
*72	Primary Prescriber is Not Covered		
73	Refills Are Not Covered	452	Schedule 2 Narcotic Cannot Be Refilled
		461	Refills not Payable
*74	Other Carrier Payment Meets Or Exceeds Payable		
75	Prior Authorization Required	484	New RX will require PA
		485	PA Required – MD must Call ULM Operations Staff
		486	PA Expired – MD Must Call ULM Operations Staff
		487	Emergency Override of a Drug that Requires PA
		489	Provider Type Not Authorized to Prescribe
		491	Prescriber Number Not For Individual Prescriber
*76	Plan Limitations Exceeded		
77	Discontinued Product/Service ID Number	438	Manufacturer Notified Us That NDC is Obsolete
		460	NDC Probably Obsolete. Check Label/Computer
		462	CMS Notified Us that NDC is Obsolete
		465	Invalid NDC – not on CMS File

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
78	Cost Exceeds Maximum	650	Payment Reduced to State Maximum
		660	Payment Reduced to LMAC Maximum
*79	Refill Too Soon		
*8C	Missing or Invalid Facility ID		
*8E	M/I DUR/PPS Level Of Effort		
80	Drug Diagnosis Mismatch	668	No Patient History of Insulin Requirements
81	Claim Too Old	030	Service Thru Date More than Two Years Old
		272	Claim Exceeds 1 Year Filing Limit
*82	Claim is Post Dated		
83	Duplicate Paid/Captured Claim	843	Exact Duplicate Error: Identical Pharmacy Claims
		898	Exact Dup. Same ICN- Dropped
84	Claim Has Not Been Paid/Captured	280	Manual Pricing Pend
		459	Pending for File review/Call help desk
		250	Diag/Proc Requires Review
*85	Claim Not Processed (See Note 1)		
*86	Submit Manual Reversal		
87	Reversal Not Processed	796	Adj./Void Billing Provider Mismatch
		797	Duplicate Adjustment Records Entered
		798	History Record Already Adjusted
		799	No History Record on File for This Adjustment

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
88	DUR Reject Error	441 442 443 445 446 447 471 482 483 656	Outcome 2A or 2B – RX Not Filled – Transaction Reporting Drug/Drug Interaction Therapeutic Overlay Duplicate Drug Therapy Pregnancy Precaution Drug to Drug Interaction Viagra Nitro Therapeutic Duplication Denial Pregnancy Precaution-Denial-FDA Category X Compliance Monitoring/Early or Late Refill Exceeds maximum Duration of Therapy
* 89	Rejected Claim Fees Paid		
*90	Host Hung Up		
*91	Host Response Error		
*92	System Unavailable/Host Unavailable		
*95	Time Out		
*96	Scheduled Downtime		
*97	Payer Unavailable		
*98	Connection To Payer Is Down		
*99	Host Processing Error		
*AA	Patient Spenddown Not Met		
AB	Date Written Is After Date Filled	123	RX Date was After Date Filled

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
AC	Product Not Covered Non-Participating Manufacturer	472	Manufacturer has not Entered Into CMS Rebate Agreement
AD	Billing Provider Not Eligible To Bill This Claim Type	202	Provider Cannot Submit This Claim Type
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare	330	QMB Not Medicaid Eligible
*AF	Patient Enrolled Under Managed Care		
AG	Days Supply Limitation For Product/Service	436	Days Supply > 100 Exceeds Program Maximum
*AH	Unit Dose Packaging Only Payable For Nursing Home Recipients		
*AJ	Generic Drug Required		
*AK	Missing or Invalid Software Vendor/Certification ID		
*AM	Missing or Invalid Segment Identification		
*A9	Missing or Invalid Transaction Count		
*BE	Missing or Invalid Professional Service Fee Submitted		
*B2	Missing or Invalid Service Provider ID Qualifier		
*CA	Missing or Invalid Patient First Name		
*CB	Missing or Invalid Patient Last Name		
CC	Missing or Invalid Cardholder First Name	023	Recipient Name Missing (first initial)

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
CD	Missing or Invalid Cardholder Last Name	023	Recipient Name Missing (first 5 letters of last name)
*CE	Missing or Invalid Home Plan		
*CF	Missing or Invalid Employer Name		
*CG	Missing or Invalid Employer Street Address		
*CH	Missing or Invalid Employer City Address		
*CI	Missing or Invalid Employer State/Province Address		
*CJ	Missing or Invalid Employer Zip Postal Zone		
*CK	Missing or Invalid Employer Phone Number		
*CL	Missing or Invalid Employer Contact Name		
*CM	Missing or Invalid Patient Street Address		
*CN	Missing or Invalid Patient City Address		
*CO	Missing or Invalid Patient State/Province Address		
*CP	Missing or Invalid Patient Zip/Postal Zone		
*CQ	Missing or Invalid Patient Phone Number		
*CR	Missing or Invalid Carrier ID		
*CW	Missing or Invalid Alternate ID		
*CX	Missing or Invalid Patient ID Qualifier		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*CY	Missing or Invalid Patient ID		
*CZ	Missing or Invalid Employer ID		
*DC	Missing or Invalid Dispensing Fee Submitted		
*DN	Missing or Invalid Basis Of Cost Determination		
DP	Missing or Invalid Drug Type	479	DUR data Unnecessary for Conflict, Intervention, Outcome
DQ	Missing or Invalid Usual & Customary Charge	022 276 277	Billed Charges Missing or not Numeric High Variance Error Low Variance Error
*DR	Missing or Invalid Doctor's Last Name		
*DS	Missing or Invalid Postage Amount		
*DT	Missing or Invalid Unit Dose Indicator		
DU	Missing or Invalid Gross Amount Due	978	Calculated pricing is zero/ Call help desk
*DV	Missing or Invalid Other Payer Amount		
DX	Missing or Invalid Patient Paid Amount	662	Payment Reduced by COPAY
*DY	Missing or Invalid Date Of Injury		
DZ	Missing or Invalid Claim/Reference ID	021	Former Reference Number Missing or Invalid
*EA	Missing or Invalid Originally Prescribed Product/Service Code		
*EB	Missing or Invalid I Originally Prescribed Quantity		
*EC	Missing or Invalid I Compound Ingredient Component Count		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*ED	Missing or Invalid Compound Ingredient Quantity		
*EE	Missing or Invalid Compound Ingredient Drug Cost		
*EF	Missing or Invalid Compound Dosage Form Description Code		
*EG	Missing or Invalid I Compound Dispensing Unit Form Indicator		
*EH	Missing or Invalid I Compound Route Of Administration		
*EJ	Missing or Invalid Originally Prescribed Product/Service ID Qualifier		
*EK	Missing or Invalid Scheduled Prescription ID Number		
*EM	Missing or Invalid Prescription/Service Reference Number Qualifier		
*EN	Missing or Invalid Associated Prescription/Service Reference Number		
*EP	Missing or Invalid Associated Prescription/Service Date		
*ER	Missing or Invalid Procedure Modifier Code		
*ET	Missing or Invalid Quantity Prescribed		
*EU	Missing or Invalid Prior Authorization Type Code		
*EV	Missing or Invalid Prior Authorization Number Submitted		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*EW	Missing or Invalid I Intermediary Authorization Type ID		
*EX	Missing or Invalid Intermediary Authorization ID		
*EY	Missing or Invalid Provider ID Qualifier		
*EZ	Missing or Invalid Prescriber ID Qualifier		
*E1	Missing or Invalid Product/Service ID Qualifier		
*E3	Missing or Invalid Incentive Amount Submitted		
*E4	Missing or Invalid Reason For Service Code		
*E5	Missing or Invalid Professional Service Code		
*E6	Missing or Invalid Result Of Service Code		
E7	Missing or Invalid Quantity Dispensed	120	Quantity Invalid/Missing
*E8	Missing or Invalid Other Payer Date		
*E9	Missing or Invalid Provider ID		
*FO	Missing or Invalid Plan ID		
*GE	Missing or Invalid Percentage Sales Tax Amount Submitted		
*HA	Missing or Invalid Flat Sales Tax Amount Submitted		
*HB	Missing or Invalid Other Payer Amount Paid Count		
*HC	Missing or Invalid Other Payer Amount Paid Qualifier		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*HD	Missing or Invalid Dispensing Status		
*HE	Missing or Invalid Percentage Sales Tax Rate Submitted		
*HF	Missing or Invalid Quantity Intended To Be Dispensed		
*HG	Missing or Invalid Days Supply Intended To Be Dispensed		
*H1	Missing or Invalid Measurement Time		
*H2	Missing or Invalid Measurement Dimension		
*H3	Missing or Invalid Measurement Unit		
*H4	Missing or Invalid Measurement Value		
*H5	Missing or Invalid Primary Care Provider Location Code		
*H6	Missing or Invalid DUR Co-Agent ID		
*H7	Missing or Invalid Other Amount Claimed Submitted Count		
*H8	Missing or Invalid Other Amount Claimed Submitted Qualifier		
*H9	Missing or Invalid Other Amount Claimed Submitted		
*JE	Missing or Invalid Percentage Sales Tax Basis Submitted		
*J9	Missing or Invalid DUR Co-Agent ID Qualifier		
*KE	Missing or Invalid Coupon Type		
*M1	Patient not covered in this aid category		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
M2	Recipient Locked-In	218	Recipient is MD, Pharm Restricted-MD Invalid
		389	Invalid Provider Number When Deny Applied
*M3	Host PA/MC Error		
M4	Prescription Number/Time Limit Exceeded	453	Schedule 2 Narcotic Cannot Be Refilled
		454	New Prescription Not Filled Within six Months of Date Prescription
		455	Refill Not Filled Within six Months
		498	Number of prescriptions greater than limit
		920	Greater than five refills per script not reimbursable
M5	Requires Manual Claim	242	110-MNP Required for Recip Liability Amount
		448	Transplant Discharge Date or other Dx needed
		466	Hard Copy Required-Fertility Preparation
		966	Submit Hardcopy of claim
*M6	Host Eligibility Error		
*M7	Host Drug File Error		
*M8	Host Provider File Error		
*ME	Missing or Invalid Coupon Number		
*MZ	Error Overflow		
*NE	Missing or Invalid Coupon Value Amount		
*NN	Transaction Rejected At Switch Or Intermediary		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*PA	PA Exhausted/Not Renewable		
*PB	Invalid Transaction Count For This Transaction Code		
*PC	Missing or Invalid Claim Segment		
*PD	Missing or Invalid Clinical Segment		
*PE	Missing or Invalid COB/Other Payments Segment		
*PF	Missing or Invalid Compound Segment		
*PG	Missing or Invalid Coupon Segment		
*PH	Missing or Invalid DUR/PPS Segment		
*PJ	Missing or Invalid Insurance Segment		
*PK	Missing or Invalid Patient Segment		
*PM	Missing or Invalid Pharmacy Provider Segment		
*PN	Missing or Invalid Prescriber Segment		
*PP	Missing or Invalid Pricing Segment		
*PR	Missing or Invalid Prior Authorization Segment		
*PS	Missing or Invalid Transaction Header Segment		
*PT	Missing or Invalid Workers' Compensation Segment		
*PV	Non-Matched Associated Prescription/Service Date		
*PW	Non-Matched Employer ID		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*PX	Non-Matched Other Payer ID		
*PY	Non-Matched Unit Form/Route of Administration		
*PZ	Non-Matched Unit Of Measure To Product/Service ID		
*P1	Associated Prescription/Service Reference Number Not Found		
*P2	Clinical Information Counter Out Of Sequence		
*P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions		
*P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions		
*P5	Coupon Expired		
*P6	Date Of Service Prior To Date Of Birth	211	Date of Service Less Than Date of Birth
*P7	Diagnosis Code Count Does Not Match Number Of Repetitions		
*P8	DUR/PPS Code Counter Out Of Sequence		
*P9	Field Is Non-Repeatable		
*RA	PA Reversal Out Of Order		
*RB	Multiple Partials Not Allowed		
*RC	Different Drug Entity Between Partial & Completion		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*RD	Mismatched Cardholder/Group ID-Partial To Completion		
*RE	M/I Compound Product ID Qualifier		
*RF	Improper Order Of 'Dispensing Status' Code On Partial Fill Transaction		
*RG	M/I Associated Prescription/service Reference Number On Completion Transaction		
*RH	M/I Associated Prescription/Service Date On Completion Transaction		
*RJ	Associated Partial Fill Transaction Not On File		
*RK	Partial Fill Transaction Not Supported		
*RM	Completion Transaction Not Permitted With Same 'Date Of Service' As Partial Transaction		
*RN	Plan Limits Exceeded On Intended Partial Fill Values		
*RP	Out Of Sequence 'P' Reversal On Partial Fill Transaction		
*RS	M/I Associated Prescription/Service Date On Partial Transaction		
*RT	M/I Associated Prescription/Service Reference Number On Partial Transaction		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment		
*R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions		
*R2	Other Payer Reject Count Does Not Match Number Of Repetitions		
*R3	Procedure Modifier Code Count Does Not Match Number Of Repetitions		
*R4	Procedure Modifier Code Invalid For Product/Service ID		
*R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals Ø6		
*R6	Product/Service Not Appropriate For This Location		
*R7	Repeating Segment Not Allowed In Same Transaction		
*R8	Syntax Error		
*R9	Value In Gross Amount Due Does Not Follow Pricing Formulae		
*SE	Missing or Invalid Procedure Modifier Code Count		
*TE	Missing or Invalid Compound Product ID		
*UE	Missing or Invalid Compound Ingredient Basis Of Cost Determination		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*VE	Missing or Invalid Diagnosis Code Count		
*WE	Missing or Invalid Diagnosis Code Qualifier		
*XE	Missing or Invalid Clinical Information Counter		
*ZE	Missing or Invalid Measurement Date		

Appendix C - EOB Translation

Following is a numerical list of the EOB codes and their descriptions. EOB codes are listed in the message area of the Point of Sale response and only appear if the claim is rejected or captured (pended), with the exception of codes 650, 660, and 662 which when associated with a paid claim, denote a reduction in payment.

EOB CODE	DESCRIPTION
001	Missing or Invalid Bin Number
002	Provider Number Missing or Not Numeric
003	Recipient Number Invalid or Less Than 13 Digits
005	Service From Date Missing/Invalid
006	Invalid or Missing Thru Date
007	Service Thru Date less than Service From Date
008	Service From Date Later than Date Processed
009	Service Thru Date Greater than Date of Entry
011	TPL Indicator not Y, N, or Space
020	Invalid or Missing Diagnosis Code
021	Former Reference Number Missing or Invalid
022	Billed Charges Missing or not Numeric
023	Recipient Name is Missing
024	Billing Provider Number not Numeric
030	Service Thru Date More than Two Years Old
099	Item Covered Under Durable Med Equipment Program Only
120	Quantity Invalid/Missing
121	A Prescribing Physician Medicaid ID Must be Supplied
122	RX Date Missing or Invalid
123	RX Date was After Date Filled
124	Days Supply Missing, Not Numeric, or Zero
125	Prescription Number Missing
126	Refill Code Missing, Not Numeric, or Greater Than 5
127	NDC Code Missing or Incorrect
128	The MAC Override Indicator Must be a “C”
133	Invalid CCN
134	DOB Mismatch for CCN
135	Patient Not Covered for Pharmacy Service
200	Provider/Attending Provider Not on File
201	Provider Not Eligible on Dates of Service
202	Provider Cannot Submit This Claim Type
211	Date of Service Less Than Date of Birth
213	Provider Not Covered for Services Rendered by Medicaid

EOB CODE	DESCRIPTION
215	Recipient Not on File - Make Copy of Card
216	Recipient Not Eligible on Date of Service - Make Copy of Card
217	Name/Number Mismatch - Copy Card
218	Recipient is MD, Pharm Restricted-MD Invalid
223	Recycled Recipient Not on File
224	Invalid Birthdate on Recipient File
231	NDC Code Not on File
233	Proc/NDC not covered for service date given
234	P/F Age Restriction
235	P/F Sex Restriction
238	Invalid PAC/ Call help desk
239	Price missing of p/f/Call help desk
242	110-MNP Required for Recipient Liability Amount
250	Diagnosis/Procedure Requires Review
262	Provider's Adjustments on Review
272	Claim Exceeds 1 Year Filing Limit
275	Recipient is Medicare Eligible
276	High Variance Error
277	Low Variance Error
280	Manual Pricing Pend
289	Invalid Provider Number When Deny Applied
293	Recycled Recipient Ineligible on DOS
294	Recipient Not on File Recycled 3 Times
295	Recipient Ineligible Recycled 3 Times
299	Proc/Drug Not Covered by Medicaid
330	QMB Not Medicaid Eligible
364	Recipient Ineligible/Deceased
385	Diabetic Supplies not covered for LTC recipient
389	Recipient is MD, Pharm Restricted-Pharmacy Invalid
431	Missing or Invalid Compound Code
432	Quantity Exceeds Package Size
434	Bill Medicare Nebulizer Med
436	Days Supply > 100 Exceeds Program Maximum
438	Manufacturer Notified Us That NDC is Obsolete
439	Manufacturer Has Identified Product as Food Supplement
441	Outcome 2A or 2B- RX not Filled – Transaction Reporting
442	Drug/Drug Interaction
443	Therapeutic Overlay
445	Duplicate Drug Therapy

EOB CODE	DESCRIPTION
446	Pregnancy Precaution
447	Compliance Monitoring/Early or Late Refill
448	Transplant Discharge Date or other Dx needed
449	Date of service is within transplant window, bill Medicare
450	Prescribing Provider Not on File - Status = O
452	Schedule 2 Narcotic Cannot Be Refilled
453	Schedule 2 Narcotic Not Filled Within 5 Days
454	New Prescription Not Filled Within 6 Months of Date Prescription
455	Refill Not Filled Within 6 Months
457	Quantity and/or Days Supply Exceeds Program Maximum
458	MAC/FUL Cost is Zero/Call help desk
459	Pending for file review/ Call help desk
460	NDC Probably Obsolete. Check Label/Computer
461	Refills not Payable_____
462	CMS Notified Us that NDC is Obsolete
463	Drug Does Not Need MAC Override
466	Hard Copy Required-Fertility Preparation
471	Drug to Drug Interaction Viagra Nitro
472	Manufacturer has not entered into CMS rebate agreement
479	DUR data Unnecessary for Conflict, Intervention, Outcome
482	Therapeutic Duplication Denial
483	Pregnancy Precaution-Denial-FDA Category X
484	New RX will require PA
485	PA Required – MD must call ULM Operations Staff
486	PA Expired – MD Must Call ULM Operations Staff
487	Emergency Override of a Drug that Requires PA
489	Provider Type Not Authorized to Prescribe
491	Prescriber Number Not For Individual Prescriber
498	Number of prescriptions greater than limit
575	Edit 575 - Missing/Invalid ICD-9-CM Diagnosis Code
576	Missing or invalid PA/MC code or number for RX override
577	Override/prescription exceeds 8 scripts per month limit
650	Payment Reduced to State Maximum
656	Exceeds Maximum Duration of Therapy
660	Payment Reduced to LMAC Maximum
662	Payment Reduced by COPAY
668	No Patient History of Insulin Requirements
796	Adj./Void Billing Provider Mismatch
797	Duplicate Adjustment Records Entered

EOB CODE	DESCRIPTION
798	History Record Already Adjusted
799	No History Record on File For This Adjustment
843	Exact Duplicate Error: Identical Pharmacy Claims
898	Exact Dupe Same ICN –Dropped
920	GT 5 Refills Per Script Not Reimbursed
966	Submit hard copy claim
978	Calculated pricing is zero/ Call help desk
988	Item Covered by Medicare

* Other exceptions are constantly being added and changed. If providers receive an exception that is not listed, call the Unisys POS Help Desk **at 1-800-648-0790 or 1-225-237-3381**.

Appendix D - Medicaid Pharmacy Point Of Sale Agreement

STATE OF LOUISIANA
MEDICAID PHARMACY POINT OF SALE AGREEMENT

This Pharmacy Point of Sale Agreement (hereinafter Agreement), made and entered into this _____ day of _____, 20_____, by and between the Louisiana Department of Health and Hospitals (Hereinafter Agency), acting in its own right as the Agency responsible for administering the Medicaid Assistance Program (Title XIX) in and by _____ (hereinafter Provider).

In consideration of the mutual promises and covenants contained herein and other good and valuable consideration, the pharmacy agrees to provide said services in accordance with the following terms and conditions.

1. This Agreement is in addition to the Provider Enrollment Application between the Agency and Provider, including, but not limited to the right of the Agency or its representatives to perform audit functions or the requirement that the Provider maintain the original prescription on file.

2. Provider shall submit to the Agency, through the fiscal agent (hereinafter Agent), for Louisiana Medicaid, via a Point of Sale (POS) device, claims for prescriptions dispensed to Louisiana Medicaid recipients.

3. The Provider shall safeguard the Medicaid program against abuse in its utilization of claims entry through the POS system.

4. The Provider shall correctly enter the claims data, monitor the data and certify that the data entered is correct.

5. The Provider shall reverse any claim which is adjudicated (submitted for payment) and then not dispensed to a Medicaid recipient.

6. The Provider shall allow the Agency access to claims data and assure that transmission of claims data is restricted to authorized personnel so as to preclude erroneous payment by the Agent resulting from carelessness or fraud.

7. The Provider shall allow the Director of the Agency or any of its designees and representatives of the Office of the Medicaid Fraud Control Unit to review and copy all records.

8. The Provider shall abide by all Federal and State statutes, rules, regulations and manuals and provider updates governing the Louisiana Medicaid Program and those conditions as set out in the State of Louisiana, Department of Health and Hospitals Medicaid Provider Agreement entered into previously.

9. The Provider agrees to charge no more for Medicaid services than is charged to the general public.

PROVIDER:_____
Print or Type Name Signature/Title

_____
Address

_____ Phone Number

Appendix E - Pharmacy Provider Enrollment Amendment

PHARMACY PROVIDER ENROLLMENT AMENDMENT

LA Pharmacy Permit # _____ Medicare Provider # _____
Provider Name: _____

Store Address (Both physical and mailing address):

E-mail address: _____

Phone #: ( )_____ FAX #: ( ) _____

Electronic Switch Vendor: ❑ Envoy/WebMD/Healtheon ❑ NDC ❑ QS- ❑ Other: _____
Software Vendor: _____

Pharmacy Services Provided (Check all that apply):
❑ Retail ❑ Nursing Home (Please list on reverse) ❑ Group Home ❑ IV Therapy ❑ 24 hour pharmacy

Pharmacy Indicator: (check only one please)
(Louisiana defines a chain as 15 or more Medicaid enrolled pharmacies under common ownership)
❑ Independent pharmacy ❑ Chain pharmacy

INDEPENDENT OWNER INFORMATION		**CHAIN INFORMATION (IF APPLICABLE) (Fill out if checked "Chain" above)**
Owner Name		**Corporate Name**
Address		**Address**
City State Zip		**City State Zip**
Phone		**Financial Contact Financial Phone**

Name/Title/Phone Number of individual reviewing Remittance Advice:

Appendix F - Point of Sale Certification**

POINT OF SALE CERTIFICATION

I certify that all Point of Sale claims are rendered by a legally qualified person, that the charge is within the Department's prescription package policy and that the payment has not been previously received. I have read and understand all published regulations, Prescription Drug Services Manual and Provider Updates concerning pharmaceutical payments and agree that all point of sale services adhere to those regulations. I also agree to keep such records as are necessary or required to disclose fully the extent of Point of Sale services provided to individuals under the State's Title XIX plan and to furnish all information regarding any payments claimed for providing such Point of Sale services as the state agency or the Medicaid Fraud Control Unit may request for five (5) years from the date of services.

I understand that payment and satisfaction of the claims will be from federal and state funds and that any false or misleading claim statements, documents or concealment of material fact, may be prosecuted under applicable federal and state laws.

Provider Name:_____

Provider Number:_____

Authorized representative (print):_____
(If the provider is a corporation or partnership, the authority for the authorized representation must be attached to the Point-of-Sale Certification and Enrollment Amendment)

_____
(Title)

Authorized representative (signature):_____

_____
Signature of Pharmacist-in-Charge License Number

Date:_____

Mail completed Form to:

Bureau of Health Services Financing
P. O. Box 91030 BIN #24
Baton Rouge, LA 70821

Appendix G - 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. Do not call Medicaid or your DHH Parish Office, as they will be of no help to you in this situation.)

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

Since the service for which the POS claim was submitted for was never actually provided, you must void 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:

a) Prescription number
b) Medicaid Provider Number (seven digits)
c) Date of Service

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.)

c) The recipient did not pick up the prescription from the pharmacy.

4. A Medicaid recipient has no proof of eligibility. Can I provide him with medication?

If you submit the claims using POS, you will know the individual's eligibility status before the drugs are actually dispensed. If the claims are adjudicated as payable, then the client must be eligible and services may be provided. If the claims are rejected for recipient ineligibility, then the client must produce some form of valid eligibility. If the provider has proof of eligibility, the rejected claim may be resubmitted using the eligibility clarification code feature. If no proof is available, the client is probably NOT eligible and must use alternative payment mechanisms, i.e., cash, to obtain prescriptions.

All the above is presuming that the pharmacist knows the recipient's Medicaid I.D. number. If this number is not known, then the claim cannot be submitted.

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. The POS system has been established as a fee-per-service system. 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 realized that the quantity (days supply, recipient 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 (or "voided") the incorrect claim, then you can resubmit a new, corrected claim via POS. Please note that adjustments, as defined in your Pharmacy Provider Manual, are not available using POS. Incorrectly paid claims must be completely reversed first, then the corrected claim submitted.

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

NCPDP rejects code 83 translates into Medicaid's EOB's 843 and 898. These edits will cause the claim to deny. They apply 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 next week to verify that the claim was paid. All subsequent submittals of a paid claim will be denied. Be aware that a claim status of "3" (Denied) will be returned to you.

8. How do I submit a "Spend-Down" recipient's claims?

Spend-Down claims must continue to be submitted on paper claims using the current process. Consult the *Louisiana Prescription Drug Services Manual* (Chapter Thirty-eight of the Medicaid Services Manual).

9. 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?

A. Reverse the original claim through POS
B. Resubmit the original claim through POS adjusting the "Estimated Days Supply" (EDS)
C. Submit the refilled prescription claim

Or

D. 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.

10. I have a transplant patient's claims denied as "Medicare eligible". How can I get these claims paid?

Medicare assumes initial payment responsibility following a **Medicare covered** transplant surgery. Submit claims either electronically or hardcopy to the Medicare carrier. Hardcopy claims submitted to the Medicare carrier must be on a HCFA 1500 claim form.

The claims should automatically crossover from Medicare to Medicaid for payment of the co-insurance and deductible. In order for the crossover to occur, the Medicaid provider record must contain the Medicare "Cross-over I.D."

If the coinsurance and deductible are not paid by Medicaid, the pharmacy provider should contact the Provider Enrollment Department at Unisys (225-237-3392) to ensure that the provider file contains the Medicare "Cross-over I.D.". In the event that occurs, the pharmacy provider should submit a HCFA 1500 claim form with the Medicare EOB to Unisys.

If it is determined that the transplant was not a **Medicare covered** transplant, contact the Medicaid Pharmacy Benefits Management Section at **225-342-9479** to request an update to the recipient file to bypass the Medicare edit. Then, the pharmacy claim should be submitted directly to Medicaid.

11.What is UniDUR?

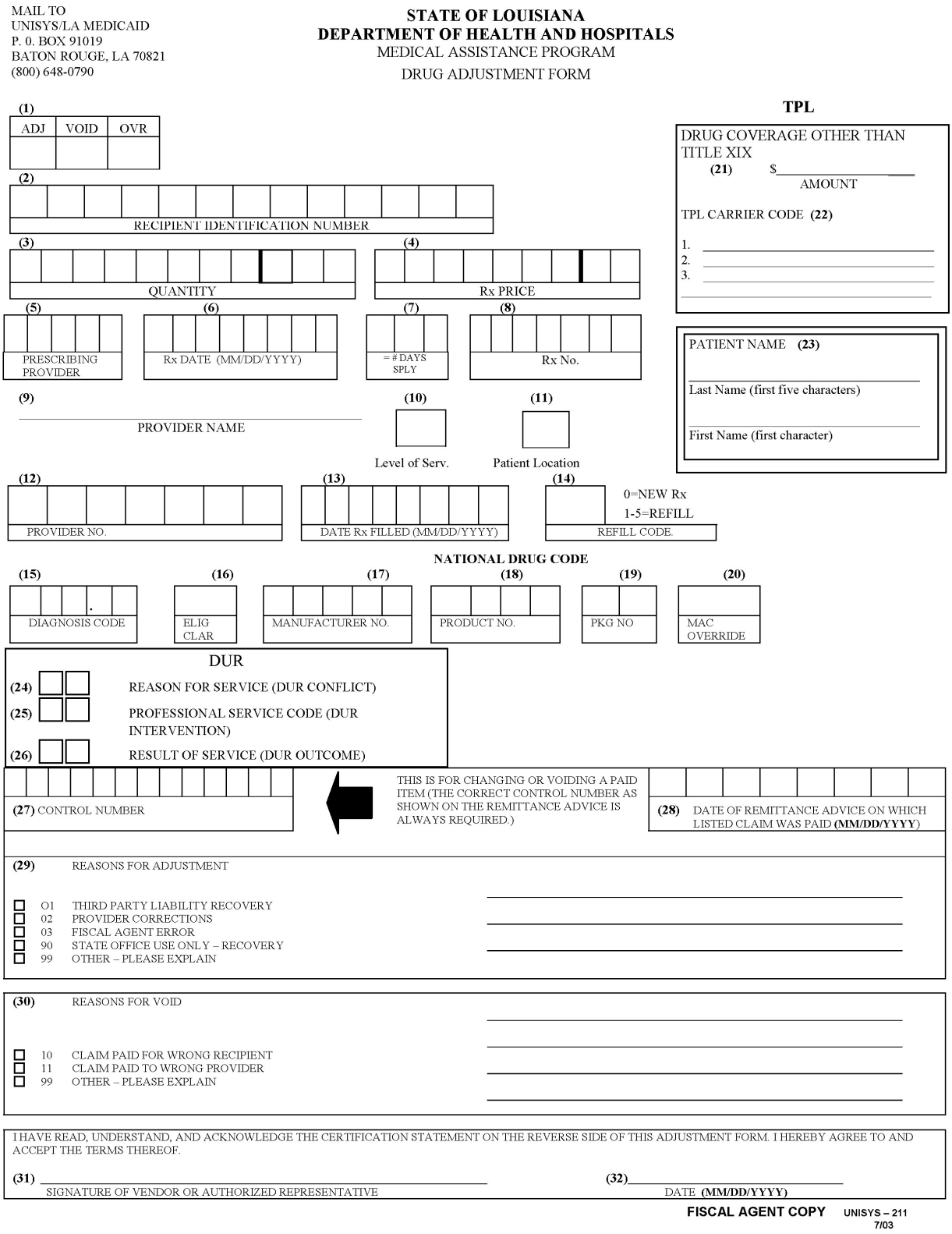
As a part of POS, claims are subjected to editing for prospective drug utilization review. Unisys and First Data Bank developed the software used to edit pharmacy claims. The UniDUR software is updated twice a month to reflect the most current UniDUR information available to the industry.

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.

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

Providers should continue business as usual. They should maintain a record of the prescriptions dispensed and comply with the Louisiana Board of Pharmacy regulations. When the computer comes back up, the provider can batch submit the claims that were dispensed during the 'down period' or file them claim by claim via the POS system.

Appendix H – Drug Adjustment Form (Unisys 211)



MAIL TO
UNISYS/LA MEDICAID
P. 0. BOX 91019
BATON ROUGE, LA 70821
(800) 648-0790

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL ASSISTANCE PROGRAM
DRUG ADJUSTMENT FORM

(1) ADJ | VOID | OVR

(2) RECIPIENT IDENTIFICATION NUMBER

(3) QUANTITY

(4) Rx PRICE

(5) PRESCRIBING PROVIDER

(6) Rx DATE (MM/DD/YYYY)

(7) = # DAYS SPLY

(8) Rx No.

(9) PROVIDER NAME

(10) Level of Serv.

(11) Patient Location

TPL

DRUG COVERAGE OTHER THAN TITLE XIX
(21) $_____ AMOUNT

TPL CARRIER CODE (22)
1. _____
2. _____
3. _____

PATIENT NAME (23)
_____ Last Name (first five characters)
_____ First Name (first character)

(12) PROVIDER NO.

(13) DATE Rx FILLED (MM/DD/YYYY)

(14) REFILL CODE. 0=NEW Rx 1-5=REFILL

NATIONAL DRUG CODE

(15) DIAGNOSIS CODE

(16) ELIG CLAR

(17) MANUFACTURER NO.

(18) PRODUCT NO.

(19) PKG NO

(20) MAC OVERRIDE

DUR
(24) REASON FOR SERVICE (DUR CONFLICT)
(25) PROFESSIONAL SERVICE CODE (DUR INTERVENTION)
(26) RESULT OF SERVICE (DUR OUTCOME)

(27) CONTROL NUMBER

THIS IS FOR CHANGING OR VOIDING A PAID ITEM (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

(28) DATE OF REMITTANCE ADVICE ON WHICH LISTED CLAIM WAS PAID **(MM/DD/YYYY)**

(29) REASONS FOR ADJUSTMENT

- ☐ 01 THIRD PARTY LIABILITY RECOVERY
- ☐ 02 PROVIDER CORRECTIONS
- ☐ 03 FISCAL AGENT ERROR
- ☐ 90 STATE OFFICE USE ONLY – RECOVERY
- ☐ 99 OTHER – PLEASE EXPLAIN

(30) REASONS FOR VOID

- ☐ 10 CLAIM PAID FOR WRONG RECIPIENT
- ☐ 11 CLAIM PAID TO WRONG PROVIDER
- ☐ 99 OTHER – PLEASE EXPLAIN

I HAVE READ, UNDERSTAND, AND ACKNOWLEDGE THE CERTIFICATION STATEMENT ON THE REVERSE SIDE OF THIS ADJUSTMENT FORM. I HEREBY AGREE TO AND ACCEPT THE TERMS THEREOF.

(31) _____ SIGNATURE OF VENDOR OR AUTHORIZED REPRESENTATIVE

(32) _____ DATE **(MM/DD/YYYY)**

FISCAL AGENT COPY UNISYS – 211 7/03

Instructions For Completing Drug Adjustment Form (Unisys 211)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OR AUTHORIZED REPRESENTATIVE.

FIELD	FIELD NAME	ENTRY	DESCRIPTION
1	ADJUSTMENT/VOID/OVR	Required	ADJUSTMENT/VOID/OVR: Check the appropriate box for Adjustment, Void, or DUR Override.
2	RECIPIENT IDENTIFICATION NUMBER	Required	ADJUSTMENT/VOID: Enter recipient's 13-digit Medicaid ID number exactly as it appeared on the original claim form.
3	QUANTITY	Required	ADJUSTMENT: Enter the correct information or exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
4	Rx PRICE	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
5	PRESCRIBING PROVIDER	Required	ADJUSTMENT: Enter the 5-digit Medicaid Provider ID for the prescribing practitioner. VOID: Enter the 5-digit Medicaid Provider ID for the prescribing practitioner.
6	Rx DATE	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected in MM/DD/YYYY format. VOID: Enter the information exactly as it appeared on the original claim form.
7	= # DAYS SPLY	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
8	Rx NO.	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
9	PROVIDER NAME	Not required	ADJUSTMENT/VOID: Enter the name exactly as it appeared on the original claim form.
10	LEVEL OF SERV	Not required	ADJUSTMENT/VOID: Enter NCPDP value of"03" if the service was provided on an emergency basis and no co-pay was collected.

FIELD	FIELD NAME	ENTRY	DESCRIPTION
11	PATIENT LOCATION	Not Required	ADJUSTMENT/VOID: Enter NCPDP Patient Location Code value of “04”if the service was for an LTC recipient and no co-pay was collected.
12	PROVIDER NO.	Required	ADJUSTMENT/VOID: Enter the provider number exactly as it appeared on the original claim form.
13	DATE Rx FILLED	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected in MM/DD/YYYY format. VOID: Enter the information exactly as it appeared on the original claim form.
14	REFILL CODE	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form. Note: Where “0” = New Rx, “1-5” = Refill of prescription
15	DIAGNOSIS CODE	Required, If Applicable	ADJUSTMENT/VOID: Enter valid ICD9-CM Diagnosis Code if applicable.
16	ELIG CLAR	Not Required	ADJUSTMENT/VOID: Enter NCPDP value if applicable.
17	MANUFACTURER NO	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
18	PRODUCT NO.	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
19	PKG	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
20	MAC OVERRIDE	Required, If Applicable	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.

FIELD	FIELD NAME	ENTRY	DESCRIPTION
21	DRUG COVERAGE OTHER THAN TITLE XIX (TPL BOX)	Not Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
22	TPL CARRIER CODE (TPL BOX)	Not Required	ADJUSTMENT/VOID: Enter valid Louisiana Carrier Code if applicable.
23	PATIENT NAME	Required	ADJUSTMENT/VOID: Enter the name exactly as it appeared on the original claim form.
THIS BLOCK IS FOR PROVIDERS TO USE FOR DUR OVERRIDES			
24	REASON FOR SERVICE	Not Required	(DUR CONFLICT) OVERRIDE: Enter the Reason for Service Code associated with the Error to be overridden. (Example: ER for Early Refill).
25	PROFESSIONAL SERVICE CODE	Not Required	(DUR INTERVENTION) OVERRIDE: Enter the Professional Service Code that describes the intervention activity performed by the pharmacist. (Example: MO for Prescriber Consulted).
26	RESULT OF SERVICE	Not Required	(DUR OUTCOME) OVERRIDE: Enter the Result of Service Code describing the disposition of the prescription. (Example: 1G for Filled with Prescriber Approval).
BOTTOM OF FORM			
27	CONTROL NUMBER	Required	Enter the 13-digit internal control number (ICN) exactly as it appears on your Remittance Advice).
28	DATE OF REMITTANCE ADVICE ON WHICH LISTED CLAIM WAS PAID	Required	Enter the exact date of the Remittance Advice using (8) digits, i.e., MM/DD/YYYY format.
29	REASONS FOR ADJUSTMENT	Required If Applicable	Place an "X" in the appropriate box and describe the reason for the adjustment, where the values are: '**01' = Third Party Liability Recovery** **'02' = Provider Corrections** **'03' = Fiscal Agent Error** **'90' = State Office Use Only – Recovery** **'99' = Other – please explain**

FIELD	FIELD NAME	ENTRY	DESCRIPTION
30	REASONS FOR VOID	Required If Applicable	Place an "X" in the appropriate box describing the reason for the void, where the values are: **'10' = Claim Paid for Wrong Recipient** **'11' = Claim Paid to Wrong Provider** **'99' = Other – please explain**
31	SIGNATURE OF PROVIDER OR AUTHORIZED REPRESENTATIVE	Required	ADJUSTMENT/VOID: Enter the complete and legal signature of provider or his/her authorized representative.
32	DATE	Required	ADJUSTMENT/VOID: Enter the date this form was completed using (8) digits. i.e., MM/DD/YYYY format.

IF YOU HAVE ANY QUESTIONS CONCERNING THE PROCESS TO COMPLETE THE DRUG ADJUSTMENT FORM, PLEASE CONTACT THE PHARMACY BENEFITS MANAGEMENT DEPARTMENT AT UNISYS **(225) 237-3381** OR CALL **800-648-0790**.