

Appendix D

Louisiana DHH Medicaid Point of Sale (POS) User Guide

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1.0 INTRODUCTION

This document is designed to assist Louisiana Medicaid pharmacy providers in on-line claim submission, also known as Point of Sale (POS) processing. The Department of Health and Hospitals (DHH) has defined participation requirements for participating 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. A glossary of terms can be found in Section 8.0.

1.1 What is Point of Sale?

POS claims processing provides on-line adjudication of Medicaid claims. With POS, a claim is electronically processed entirely through the claims processing cycle in real-time, and within seconds of submission, a response is returned to the pharmacy that the recipient is eligible or ineligible and the claim is either payable, duplicated or rejected. Most pharmacies are already familiar with this type of processing as many other third party prescription processors use it.

1.2 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 POS processing. Features of POS are listed below.

- Available 24 hours a day, seven days a week (except for scheduled downtime for system maintenance)
- Available from authorized telecommunication switch 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 POS 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. This information aids in correcting claim errors or billing another source other than Medicaid.

Examples of information reported back to the pharmacist are verification of recipient eligibility and claim processing edits, including prospective payment Drug Utilization Review (UniDUR) messages. Additionally, the system fully supports in real-time a claim reversal transaction which

enables the pharmacist to reverse or credit any "return to stock" or other prescription transaction adjudicated in error.

2.0 General Information

Pharmacies using the POS system are required to transmit their POS claims through an authorized telecommunication switch vendor. A switch vendor is a telecommunications services vendor who transfers 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.

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 switch 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.

2.1 Restrictions and Qualifications Applicable 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. The National Provider Identifier (NPI) is a single provider identifier that will replace the multiple provider identifiers currently used to bill health plans. The original compliance date for the NPI was May 23, 2007 as mandated by final rule. CMS has since published a contingency or transition plan that allows acceptance of standard transactions with either the NPI or Medicaid ID until May 23, 2008. Therefore, as a transitioning measure, pharmacy claims will be accepted with either the NPI or Medicaid ID for the pharmacy provider until further notice. The NPI must be registered with Louisiana Medicaid prior to submission on a claim. See Section 3.3, National Provider Identifier, for further information on NPI registration and usage.
3. Only new claims, denied claims being resubmitted with corrections, or reversals can be submitted using the POS system. Claims may be submitted for payment using the Point of Sale system for up to one year from the date of service. Reversals may be submitted via the POS system for up to two years from the date of service.
4. Reversals unable to be processed through the POS system may be adjudicated using Form 211 – Drug Adjustment/Void Form. Please consult Chapter 37, Pharmacy Benefits Management Services of the Louisiana Medicaid Program Provider Manual for Form 211 and instructions on submitting adjustments.
5. Claims with dates of service greater than one year or those requiring supporting documentation/attachments or manual review must be submitted via hardcopy using the Universal Drug Claim Form. An explanatory cover letter with these claims should be included if additional manual review of these claims is desired. An example of the

Universal Drug Claim Form and instructions can be found in Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual.

6. 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.
7. Each pharmacy claim must include a valid individual Prescribing Provider's Medicaid I.D. number or NPI, if the NPI has been registered with Louisiana Medicaid. Louisiana Medicaid will continue to accept either the prescriber's Medicaid I.D. number or the NPI until only the NPI is required for submission.
8. Chapter 37, Pharmacy Benefits Management Services, of the Louisiana Medicaid Program Provider Manual available at www.lamedicaid.com 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 Chapter 37 appendices.

3.0 Getting Started

3.1 Provider POS Authorization

Before providers can begin submitting POS claims, they must be properly authorized by the DHH. Pharmacies without POS approval status by DHH will not be permitted to submit claims through the POS system. The steps for approval are as follows:

1. Contact the computer system “software” 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. The following telecommunication switch vendors are currently available for submission: Emdeon (ENV), McKesson (NDC), and QS1 Data Systems (QS/1).
3. The pharmacy provider enrollment packet is available online at www.lamedicaid.com under Provider Enrollment Applications. Both the **Basic Enrollment** packet as well as the **26 - Pharmacy** packet must be completed. Complete and return to **Unisys, Provider Enrollment, P.O. Box 80159, Baton Rouge, LA 70898**. Questions and issues may be directed to (225) 216-6370.

After DHH has received and reviewed all the necessary documentation, the pharmacy provider will receive written authorization from the fiscal intermediary to begin submitting claims using 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.

3.2 DHH Policy on Pharmacy Participation in POS

1. A POS enrollment amendment and certification are required prior to billing POS/UniDUR as well as an annual re-certification.
2. Providers accessing the POS 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. 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.

3.3 National Provider Identifier (NPI)

The Final NPI Rule requires providers after May 23, 2007 to have an NPI and to use only an NPI to identify themselves as a health care provider in standard transactions, including NCPDP 5.1 claims. On May 23, 2007, CMS published a contingency or transition plan that allows acceptance of standard transactions with either the NPI or Medicaid ID until May 23, 2008. Therefore, as a transitioning measure, pharmacy claims will be accepted with either the NPI or Medicaid ID for the pharmacy provider until further notice. The NPI must be registered with Louisiana Medicaid prior to submission on a claim.

Unisys developed a web application accessible on www.lamedicaid.com that is used by providers to enter their assigned NPI. Providers may log on through the secure provider website and register the NPI assigned to them by the National Plan & Provider Enumeration System (NPPES). Currently the application accommodates only one-to-one matches: one NPI to correspond to one Medicaid ID.

Effective August 19, 2007, POS claims will be accepted with the NPI in the NCPDP field called NCPDP Service Provider Identifier (201-B1) as per the federal standard. During the transition period, the Medicaid ID will also be accepted in this field. The NCPDP Service Provider ID Qualifier (202-B2) will be used to indicate whether the Service Provider Identifier (201-B1) submitted is an NPI (01) or Medicaid ID (05). The following edits will be performed:

1. If the qualifier indicates an NPI was submitted, but the NPI has not been registered with Louisiana Medicaid, then NCPDP Error Message “50” (Non Matched Pharmacy Number) will be returned to the provider.
2. If the NCPDP Service Provider ID qualifier (202-B2) is not a value of '01' for NPI or a value of '05' for Medicaid ID, then NCPDP Error Message “B2” (M/I Service Provider ID Qualifier) will be returned to the provider.
3. If an NPI is submitted on the claim the qualifier must be a '01', if the Medicaid ID is sent, the qualifier must be an '05'. The Service Provider ID qualifier must coincide with the Identifier used for billing or NCPDP Error Message “50” (Non Matched Pharmacy Number) will be returned to the provider.

The NCPDP Prescriber ID Qualifier (466-EZ) will be used to indicate whether the Prescriber Identifier (411-DB) submitted is an NPI (01) or a Medicaid Prescriber ID (05). The following edits will be performed:

1. If the NCPDP Prescriber field is not submitted or is invalid, Error Code 121 (A Prescribing Physician NPI or Medicaid ID Required) which is linked to NCPDP Error Message “25” (Missing or Invalid Prescriber Identification) will be returned to the provider.
2. During the transition period, if the prescriber Qualifier indicated an NPI is submitted, but the prescriber's NPI has not been registered with Louisiana Medicaid then Error Code “121” – A Prescribing Physician NPI or Medicaid ID Required (linked to NCPDP Error Message “56” – Non-Matched Prescriber ID and “25” – M/I Prescriber ID) will be returned to the pharmacy. After the transition period, if an unregistered NPI is submitted for the prescriber, the claim will be rejected with NCPDP Error Message “56” – Non-Matched Prescriber ID.
3. If the NCPDP Prescriber ID Qualifier (466-EZ) is neither '01' or '05' then an educational Error Code 497 (Invalid Prescriber ID Qualifier must be 01 or 05) which is linked to NCPDP Error Message “EZ” (Missing or Invalid Prescriber ID Qualifier) will be returned to the provider.

3.4 Help Information

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

3.4.1 Computer System “Software” Vendor

- To request System Vendor Manual
- What does this field mean?
- What values should I enter in this field?
- Where should I access a field?

3.4.2 Telecommunication Switch Vendor

- What should I do if I’m not getting a response?
- Why is my response time so slow?

3.4.3 Unisys Point of Sale (POS) Help Desk

1-800-648-0790 or 1-225-216-6381

The POS Help Desk is available Monday through Friday, 8:00 a.m. to 5:00 p.m. For the POS Help Desk to provide prompt and accurate assistance, please be prepared to provide the following information:

- Your seven-digit Medicaid provider number or 10-digit NPI
- The recipient’s thirteen digit Medicaid number or sixteen digit cardholder control number

Contact the POS Help Desk for:

- Questions regarding billing procedures/policy issues
- Questions about claims adjudication
- What does this rejection code mean?
- Claims payment inquiries...24 hour 7 day access available through www.lamedicaid.com
- Verify accuracy of transmission and response
- Questions regarding claim status (i.e., rejected claim)
- Request POS documentation information
- Questions regarding UniDUR edits per references
- Clinical questions regarding UniDUR criteria
- Clarification of MEVS and REVS information
- Request list of authorized telecommunication switch vendors
- If a provider is unsure of whom to contact or notify of a problem
- Explanation of remittance advices

Note: Medicare Crossover questions and claims issues for non pharmacy issues such as parenterals, durable medical equipment, wheel chairs, etc. should be directed to the Unisys Provider Relations Department at 1-800-473-2783 or 225-924-5040.

3.4.4 Unisys Recipient Eligibility Verification System (REVS) 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

- Recipient eligibility information
- Weekly check balances

3.4.5 Medicaid Eligibility Verification System (MEVS)

MEVS is an electronic system used to verify Medicaid recipient eligibility information. This electronic verification process expedites reimbursement, reduces claim denials, and helps to eliminate fraud. Eligibility information for a recipient, including third party liability, primary care providers and any restrictions, including lock-in, may be obtained by accessing information through MEVS. Only one eligibility inquiry at a time may be made when using the web application. This system is available seven days a week, twenty-four hours per day except for occasional short maintenance periods.

3.4.6 DHH Pharmacy Program

1-225-342-9768 or 1-800-437-9101

- Policy Clarification
- Questions involving receipt of annual provider enrollment POS recertification packet.

3.4.7 Your Parish Medicaid Office

- Assistance with eligibility problems
- Lock-In changes

3.4.8 Louisiana Medicaid Website (www.lamedicaid.com)

- Louisiana Medicaid Program Provider Manual
- Point of Sale User Guide
- Policy notices
- Remittance Advice messages
- Clinical Drug Information
- Claim payment status
- Recipient eligibility
- Forms and files
- Preferred Drug List
- NPI registration

4.0 Claim Submission and Processing

This Section provides basic information to assist in POS claims processing for Louisiana Medicaid. All existing pharmacy claim submission requirements apply to POS. Please refer to Chapter 37, *Pharmacy Benefits Management Services*, of the Louisiana Medicaid Program Provider Manual for particular billing policy.

4.1 Basic Information

4.1.1 Maximum Allowed Prescription per POS Transaction

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

- The additional prescriptions must be for the same recipient.
- 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.

4.1.2 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 received by 6:00 p.m. on Thursday night. All claims adjudicated during the week will be included on the Remittance Advice, which accompanies the payment the following week.

4.1.3 Cardholder Identification

Consult the Recipient Eligibility Card for the sixteen digit Medicaid Card Control number. Eligibility can be verified by consulting REVS at 1-800-776-6323 or MEVS at www.lamedicaid.com.

4.1.4 Take Charge Family Planning Section 1115 Waiver Program

DHH provides family planning services for women between the ages of 19-44 who do not qualify for Medicaid, but who have income up to 200% of the Federal Poverty Level through its Take Charge Family Planning Waiver Program.

Take Charge program enrollees receive a pink identification card similar to a regular Medicaid card in appearance. Eligibility can be verified by consulting REVS at 1-800-776-6323 or MEVS at www.lamedicaid.com.

Services not covered by this program will deny with the error code 388 – “Recipient not covered for drugs” which is linked to NCPDP “M1” and which translates to “Patient not covered in this aid Category”.

4.2 Override Information

4.2.1 Policy Clarification

Payment methodology and policy information relating to the Louisiana Medicaid pharmacy program may be found in Chapter 37, *Pharmacy Benefits Management Services*, of the Louisiana Medicaid Program Provider Manual.

4.2.2 Federal Upper Limits (FUL)/Louisiana State Maximum Allowable Costs (LMAC) Limitations

Claim payments are adjusted in accordance with the Maximum Allowable Reimbursement Methodology for drugs with FUL/LMAC.

Edits

The FUL/LMAC can be overridden when the prescribing practitioner utilizing his/her medical judgment certifies in his/her own handwriting that a specific brand name drug is medically necessary for a specific patient.

Override

Enter a value of “6” which is the exemption for FUL/LMAC limitation in the NCPDP field 408-D8 (Dispense as Written {DAW} Product Selection Code). Please consult the pharmacy system vendor manual or your pharmacy system documentation or contact your software vendor on what codes need to be entered in this field. If a code is entered in this field, it could affect the amount received.

Documentation

The certification must be written either directly on or must be a signed and dated attachment (which may be faxed) to the prescription. The certification must be in the prescriber’s handwriting. The only acceptable phrases are “brand necessary” or “brand medically necessary.”

4.2.3 Prescription Service Limitations

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.

Please Note: 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 ICF-MR facilities
- Pregnant women

Edits

EOB CODE 498 (NCPDP M4) - Number of prescriptions greater than limit

Override

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 POS claim data information:

- Enter the valid ICD-9-CM diagnosis code in the NCPDP field 424-DO (Diagnosis)
- Enter a value of “5” which is “Exemption from Rx” in the NCPDP field 461-EU (Prior Authorization Type Code)

Documentation

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:

- “medically necessary override” and
- 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.)

4.2.4 Prospective Drug Utilization Review (UniDUR) Edits

Prescription claims are processed by prospective drug utilization (UniDUR) software that provides real-time screening of prescription drug claims. UniDUR is designed to work in conjunction with the claims adjudication/eligibility system used by the state. UniDUR uses existing Medicaid recipient history records to compare the current prescription(s) for possible interactions between the patient’s active history prescriptions and the drug currently being prescribed. Conflict codes are assigned to the claims as appropriate based upon clinical criteria approved by the Louisiana DUR Board.

Conflict codes are subsequently assigned claim error codes by the claims processing system as shown below. 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.

The POS System accepts multiple occurrences of Drug Utilization Review/Professional Pharmacy Services (DUR PPS) Segment information to allow the pharmacist to override two or three denials simultaneously. Overrides are applied to a single claim when submitted simultaneously. The clinical conflict denials must be overridden in a single resubmission of the claim. For example, if a claim receives both ER and HD conflicts, two occurrences of the DUR PPS segment must be sent.

Edits

EOB CODE	NCPDP CODE	Description	Conflict Code
442	88	Drug /drug interaction *	DD
443	88	Therapeutic overlay *	TD
445	88	Duplicate drug therapy	ID
446	88	Pregnancy precaution *	PG
447	88	Compliance monitoring/Early or late refill	ER
471	88	Drug to drug interaction with sildenafil and nitrate	DD
482	88	Therapeutic duplication denial/Limited to Specific Class	TD
483	88	Pregnancy precaution ** - Denial – FDA Category X	PG
529	88	Exceeds maximum daily dose	HD
531	88	Drug Use Not Warranted – COX-2 Inhibitor	NN
656	88	Exceeds maximum duration of therapy	MX
843	83	Exact duplicate error: Identical Pharmacy Claims **	ER
893	83	Suspect Duplicate Error: Identical Pharmacy Claims	ER or ID

* Educational alerts, no overrides required

** No override allowed on these alerts

Overrides

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 POS claim data information and submitting in the following fields:

Service Codes	Requirements for Override Documentation						
	TD	DD	HD	NN	ID	ER	MX
Reason for Service Code (DUR Conflict) NCPDP 439-E4 Field							
Professional Service Code (DUR Intervention) NCPDP 440-E5 Field	M0				M0, P0, or R0		M0
Result of Service Code (DUR Outcome) NCPDP 441-E6 Field	1G				1A, 1B, 1C, 1D, 1E, 1F, or 1G		1A, 1B, 1C, 1D, 1E, 1F, or 1G 2A or 2B

NCPDP FIELD	NAME OF FIELD	VALUE	DEFINITION
439-E4	Reason for Service Code (DUR Conflict)	DD	Drug-Drug Interaction
		ER	Overuse/Early Refill (for same pharmacy)
		HD	High Dose
		ID	Ingredient Duplication (for different pharmacy)
		MX	Excessive Duration
		NN	Unnecessary Drug
		PG	Drug-Pregnancy
		TD	Therapeutic Duplication
440-E5	Professional Service Code (DUR Intervention)	M0	Prescriber Consulted
		P0	Patient Consulted
		R0	Pharmacist Consulted other source
441-E6	Result of Service Code (DUR Outcome)	1A	Filled As Is; False Positive
		1B	Filled, Prescription As Is
		1C	Filled With Different Dose
		1D	Filled With Different Directions
		1E	Filled With Different Drug
		1F	Filled With Different Quantity
		1G	Filled With Prescriber Approval
		2A	Prescription Not Filled
		2B	Prescription Filled, Directions Clarified

Documentation

- **EOB Code – 445 - Duplicate Drug Therapy**
 - Conflict Code = ID
 - Documentation Required:
 - * The pharmacist must document the specific contact and the circumstances for the override on the hardcopy prescription.
 - * The **reason for service code, professional service code and result of service code** must also be documented on the hardcopy prescription.
 - * *Narcotic Analgesics*
 - After consultation with the prescriber, the pharmacist must document the reason the prescriber required the patient to receive the narcotic analgesic at least three (3) days early.
 - The **reason for service code, professional service code and result of service code** must also be documented on the hard copy prescription.
- **EOB Code – 447 - Compliance Monitoring/Early or Late Refill**
 - Conflict Code = ER
 - Documentation Required:
 - * The pharmacist must document on the prescription hard copy the circumstances which warrant a patient's request for medication earlier than previously reported in the estimated days supply.
 - * The **reason for service code, professional service code and result of service code** must also be documented on the hardcopy prescription.
 - * *Narcotic Analgesics*

- After consultation with the prescriber, the pharmacist must document the reason the prescriber required the patient to receive the narcotic analgesic at least three (3) days early.
 - The reason **for service code, professional service code and result of service code** must also be documented on the hard copy prescription.
 - **Note:** Refer to Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual, Section 37.5.7 Prospective Drug Utilization Policies/Limits/Edits and to Point of Sale User Guide, Section 4.3 Drugs with Special Payment Criteria and Limitations, for additional information.
- **EOB Code – 471 - Drug to Drug Interaction with Sildenafil and Nitrate**
 - Conflict Code = DD
 - Documentation Required:
 - * After consultation with the prescriber, the pharmacist must document the reason the prescriber required the patient to receive a nitrate and sildenafil (Revatio).
 - * The **reason for service code, professional service code and result of service code** must also be documented on the hard copy prescription.
 - **Note:** Refer to Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual, Section 37.5.7 Prospective Drug Utilization Policies/Limits/Edits and to Point of Sale User Guide, Section 4.3, Drugs with Special Payment Criteria and Limitations, for additional information.
- **EOB Code – 482 - Therapeutic Duplication Denial/Limited to Specific Class**
 - Conflict Code = TD
 - Documentation Required:
 - * After consultation with the prescriber, the pharmacist must document the **reason for service code, professional service code and result of service code** on the hardcopy prescription for the following therapeutic classes:
 - Tricyclic Antidepressants
 - Selective Serotonin Reuptake Inhibitors (SSRI)
 - Second Generation Antihistamines and Second Generation Antihistamine Combination Agents
 - Calcium Channel Blockers
 - Potassium Replacement Agents
 - Non-steroidal Anti-inflammatory Drugs (inclusive of COX-2 Selective Agent)
 - ***Antipsychotic Agents**
 - After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive a third antipsychotic agent.
 - The **reason for service code, professional service code and result of service code** must also be documented on the hardcopy prescription.

* **Antipsychotic/SSRI Combination (Symbyax)**

- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive a third antipsychotic agent and/or a second Selective Serotonin Reuptake Inhibitor (SSRI).
- The **reason for service code, professional service code** and **result of service code** must also be documented on the hardcopy prescription.

* **Anti-Anxiety Agents**

- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive a second anti-anxiety agent.
- A valid ICD-9-CM diagnosis code must be written on the hardcopy prescription after consultation with the prescriber in order to bypass the therapeutic duplication edit for persons with epilepsy or seizures.
- The **reason for service code, professional service code** and **result of service code** must also be documented on the hardcopy prescription.

* **Short Acting and Long Acting Opiate Agents**

- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive a second short acting opiate agent or a second long acting opiate.
- The **reason for service code, professional service code** and **result of service code** must also be documented on the hardcopy prescription.

* **Note:** Refer to Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual, Section 37.5.7 Prospective Drug Utilization Policies/Limits/Edits and to Point of Sale User Guide, Section 4.3, Drugs with Special Payment Criteria and Limitations, for additional information.

• **EOB Code – 529 - Exceeds Maximum Daily Dose**

- Conflict Code = HD
- Documentation Required:

* **Acetaminophen**

- After consultation with the prescriber, the pharmacist must **document** on the hardcopy prescription the reason the prescriber required the patient to receive the high dose (in excess of four grams per day) and the codes used to override the claim.
- The **reason for service code, professional service code** and **result of service code** must also be documented on the hardcopy prescription.

*** Aspirin**

- After consultation with the prescriber, the pharmacist must **document** on the hardcopy prescription the reason the prescriber required the patient to receive the high dose (in excess of six grams per day).
- The **reason for service code, professional service code** and **result of service code** must also be documented on the hardcopy prescription.

*** Atypical Antipsychotics**

- After consultation with the prescriber, the pharmacist must **document** on the hardcopy prescription the reason the prescriber requires a dose above the maximum recommended dose for **Atypical Antipsychotics**.
- The pharmacist must supply the **reason for service code, professional service code** and **result of service code** with the POS transmission, as well as document on the hardcopy prescription.

*** Note:** Refer to Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual, Section 37.5.7 Prospective Drug Utilization Policies/Limits/Edits and to Point of Sale User Guide, Section 4.3, Drugs with Special Payment Criteria and Limitations, for additional information.

- **EOB Code – 531 - Drug Use Not Warranted – COX-2 Inhibitor**

- Conflict Code = NN

- Documentation Required:

- * If in the professional judgment of the prescriber, a determination is made which necessitates therapy with a COX-2 selective agent, the prescriber must write on the hardcopy prescription an ICD-9-CM diagnosis code of the treated condition and the **reason** a COX-2 inhibitor is needed (e.g. “Treatment Failure,” or “History of GI Bleed”).

- * This statement may be submitted as a dated and handwritten attachment to the original prescription via facsimile or handwritten on the original hardcopy prescription by the prescriber.

- * The **reason for service code, professional service code** and the **result of service code** used on the claims submission must also be documented on the hard copy prescription.

- **Note:** Refer to Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual, Section 37.5.7 Prospective Drug Utilization Policies/Limits/Edits for additional information.

- **EOB Code – 656 - Exceeds Maximum Duration of Therapy**

- Conflict Code = MX

- Documentation Required:

- * **The prescriber must write** a valid ICD-9-CM diagnosis code necessitating the reason for continued therapy on the prescription or on a signed and dated attachment via fax.

* The **reason for service code, professional service code** and the **result of service code** must also be documented on the hard copy prescription.

- **EOB Code – 843 - Exact Duplicate Error: Identical Pharmacy Claims**

An Exact Duplicate Claim is denied as:

- a claim billed by the same provider as the original claim
- the same recipient as the original claim
- the same date of service as the original claim, and
- an NDC billed that falls into the same drug description (ingredient, strength, form and route) as the original claim.

Note: IV solutions, inotropic agents, plasma proteins, antisera agents and antihemophilia factor products are excluded from this edit.

- Conflict Code = ER

- Documentation Required:

EOB Code 843 cannot be overridden through POS submission. A hard copy claim must be submitted for the override with an explanation for the additional submission.

- **EOB Code – 893 - Suspect Duplicate Error: Identical Pharmacy Claims**

A Suspect Duplicate Claim is defined as:

- a claim billed by the same or different provider as the original claim
- the same recipient as the original claim
- the same date of service as the original claim, and
- an NDC billed that falls into the same drug description (ingredient, strength, form and route) as the original claim.

Note: IV solutions, inotropic agents, plasma proteins, antisera agents and antihemophilia factor products are excluded from this edit.

- Conflict Code = ER or ID

- **Documentation Required:**

* An override should only be used if the second pharmacy attempting to bill a claim for the same ingredient for the same recipient cannot have the first claim reversed by the original billing pharmacy. A notation to that effect must be written on the hardcopy prescription.

- The **reason for service code, professional service code** and **result of service code** must also be documented on the hardcopy prescription.

4.2.5 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.

NCPDP Version 5.1 provides the capability for the pharmacist to pursue payment of a pharmacy claim using Coordination of Benefits provided by all insurances for which the recipient is a subscriber on the date of service. The Louisiana POS system stores all claims data submitted by

the pharmacist related to coordination of benefits and calculates payment to reflect prior payment by other payers when submitted on the claim.

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, prescription monthly limit and **with edits for age** only restrictions for Orlistat (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.

Edits

EOB CODE 932 - Please bill third party carrier first

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 (308-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 (308-C8) 03 = 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 (308-C8) 04 = 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 (308-C8) 06 = Other coverage denied-not participating provider

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

Other Coverage Code (308-C8) 07 = Other coverage exists – not in effect at time of service

Documentation

No documentation on hard copy prescription necessary. The Pharmacy Unit will monitor pharmacy providers' usage of override codes. Corrective actions will be offered to better utilize the coordination of benefits process.

4.2.6 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.

Edits

No edit

Overrides

- Place “03” in the NCPDP field 418-DI (Level of Service) in the event of an emergency.
- Place an “8” in the NCPDP field 461-EU (Prior Authorization Type Code) in the event of pregnancy.

Documentation

- **For Emergency Override:** The notation of “Emergency Prescription” should be written on the hard copy prescription.
- **For Pregnancy Override:** When a prescribing provider issues a prescription to a pregnant woman, he or she shall indicate on the prescription that the recipient is pregnant. In the case of a telephoned prescription, the information that the recipient is pregnant shall be communicated to the pharmacist and the pharmacist must document on the prescription that the recipient is pregnant.

4.2.7 Prior Authorization Required

The prescribing practitioner initiates the prior authorization requests for drugs whose status is “not preferred” when a request is faxed, phoned (866-730-4357) 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 Prior Authorization process provides for a turn-around response by either telephone or other telecommunications device within twenty-four (24) hours of receipt of a prior authorization request.

Emergencies:

In cases when the Prior Authorization Unit is closed (Sundays; Monday – Saturday before 8 a.m. and after 6 p.m.) or when the PA system is unavailable, the pharmacist may use the PA emergency override procedure described below. The pharmacist may also use professional judgment in situations that would necessitate an emergency supply.

In emergency situations, providers shall dispense at least a seventy-two (72) hour or a 3 day supply of medication. Refills for the dispensing of the non-preferred products in these emergency situations are not permitted. The recipient’s practitioner must contact the Prior Authorization Unit to request authorization to continue the medication past the emergency supply, and a new prescription must be issued.

Recipients are exempt from paying co-payments for emergency situations.

Edits

- EOB CODE 484 (NCPDP 75) - New RX requires PA
(prescribing provider must contact ULM)
- EOB CODE 485 (NCPDP 75) – PA required
(prescribing provider must contact ULM)
- EOB CODE 486 (NCPDP 75) – PA expired
(prescribing provider must contact ULM)

Override

Place “03” in the NCPDP Field 418-DI “Level of Service” to indicate “emergency”

Documentation

The prescribing practitioner must indicate that the prescription is an emergency prescription on the face of the prescription if hard copy or if the prescription is called into the pharmacy, the emergency status of the prescription must be communicated to the pharmacist who must indicate “Emergency Rx” on the hard copy prescription. When the pharmacist determines the prescription is an emergency, the pharmacist must indicate “Emergency by Pharmacist” on the hard copy prescription.

Hospital Discharge Prescriptions for Atypical Antipsychotics:

- When a recipient is discharged from a hospital with a prescription for an atypical antipsychotic prescription, the prescribing practitioner must indicate on the face of the prescription, if hard copy, that the prescription is a “Hospital Discharge” or if the prescription is called in to the pharmacy, the “Hospital Discharge” status of the prescription must be communicated to the pharmacist who must indicate “Hospital Discharge” on the hard copy of the prescription.
- In situations where the prescribing practitioner is unavailable and the pharmacist determines the prescription is a “Hospital Discharge” prescription, the pharmacist must indicate “Hospital Discharge” on the hard copy prescription.
- Claims for “Hospital Discharge” prescriptions needing prior authorization (PA) will be submitted using the same process used for an emergency override. The pharmacist must code the claim as an emergency prescription (enter “03” in NCPDP Field 418-DI – Level of Service). An NCPDP educational alert will notify the pharmacist that the drug requires prior authorization.
- Prescriptions for “Hospital Discharge” products shall be dispensed in a MINIMUM quantity of a 3-day supply and refills for the dispensing of the non-preferred products are not permitted. The recipient’s practitioner must contact the Prior Authorization Unit to request authorization to continue the medication past the “Hospital Discharge” supply, and a new prescription must be issued.

4.2.8 Override for Emergency Prescriptions Filled for Lock-In Recipients

Emergency claims that are denied for Lock-In recipients when filled by a pharmacy other than the “Lock-In” assigned pharmacy or assigned prescribing physician may be overridden by the POS System.

Edits

EOB CODE 218 - Recipient is MD, Pharm Restricted-MD Invalid

EOB CODE 389 - Recipient is MD, Pharm Restricted-Pharm Invalid

Override

Place “03” in the NCPDP Field 418-DI “Level of Service” to indicate “emergency”

Documentation

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

4.3 Drugs with Special Payment Criteria and Limitations

Coverage of some drugs is limited to special criteria being met. These are explained below. Refer to Chapter 37, *Pharmacy Benefits Management Services*, of the Louisiana Medicaid Program Provider Manual, Sections 37.5.6 and 37.9.5 for additional detailed criteria/limitations and override information.

The required supporting documentation for coverage of these drugs must be retained by the pharmacy as evidence of compliance with program policy, and it must be readily retrievable when requested by audit staff.

4.3.1 Acetaminophen

Policy

- Claims billed for prescriptions with a dosage of Acetaminophen that exceeds a maximum dose of four (4) grams per day will deny.

Documentation Required

- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive the high dose and the codes used to override the claim.

Accepted Values – ICD-9-CM Code(s) & Description(s)

- N/A

Required NCPDP Field(s)

439-E4 Field (DUR Conflict) – Reason for Service Code – HD

440-E5 Field (DUR Intervention) – Professional Service Code – M0

441-E6 Field (DUR Outcome) – Result of Service Code – 1G

Possible Denial EOB Code(s)

529 – Exceeds Maximum Daily Dose

4.3.2 Aspirin**Policy**

- Claims billed for prescriptions with a dosage of Acetylsalicylic Acid (Aspirin) that exceeds a maximum dose of six (6) grams per day will deny.

Documentation Required

- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive the high dose and the codes used to override the claim.

Accepted Values – ICD-9-CM Code(s) & Description(s)

- N/A

Required NCPDP Field(s)

439-E4 Field (DUR Conflict) – Reason for Service Code – HD

440-E5 Field (DUR Intervention) – Professional Service Code – M0

441-E6 Field (DUR Outcome) – Result of Service Code – 1G

Possible Denial EOB Code(s)

529 – Exceeds Maximum Daily Dose

4.3.3 Age and Gender Restricted Drugs**Policy**

- Certain drugs have age and gender restrictions placed on them. Manufacturer guidelines are followed. (i.e. – Oral contraceptives are indicated for females aged 12-55.)

- **Contact the Medicaid Pharmacy Benefits Management Section at 225-342-9768 for additional instructions.**

Documentation Required

- N/A

Accepted Values – ICD-9-CM Code(s) & Description(s)

- N/A

Required NCPDP Field(s)

- N/A

Possible Denial EOB Code(s)

234 - P/F Age Restriction

235 - P/F Sex Restriction

4.3.4 Amphetamines

Policy

- Pharmacy claims for amphetamine drug products, when prescribed for Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) and Narcolepsy will be reimbursed when the policy coverage is followed.
- Age limitations for amphetamines are from three years old to twenty-one years old.
- A diagnosis of narcolepsy is acceptable for coverage of ages greater than twenty-one years old.
- Only original prescriptions are covered with no allowances for refills.

Documentation Required

- Prescription shall be handwritten and signed by prescriber.
- ICD-9-CM Diagnosis Code (s) Handwritten and Signed by Prescriber

Accepted Values – ICD-9-CM Code(s) & Description(s)

- 314.00 = ADD
- 314.01 = ADHD
- 347= Narcolepsy

Required NCPDP Field(s)

- 424 - DO - Diagnosis Code

Possible Denial EOB Code(s)

- 020 - M/I Diagnosis Code
- 234 - Age Restriction
- 461 - Refills not Payable

4.3.5 Anti-Anxiety Drugs

Policy

- A claim for a new prescription for an anti-anxiety drug will deny as a therapeutic duplicate when the recipient has an active prescription for an anti-anxiety agent on file. If the recipient has a diagnosis of epilepsy or seizures, the therapeutic duplication edit may be overridden by entering the appropriate ICD-9-CM diagnosis code

Documentation Required

- Diagnosis code on prescription hardcopy after consultation with prescriber in order to bypass the therapeutic duplication edit for persons with seizures.
- The pharmacist must **document** on the hardcopy prescription the reason the prescriber required the patient to receive a second anti-anxiety agent.

- The **reason for service code, professional service code** and **result of service code** must also be documented on the hardcopy prescription.

Accepted Values – ICD-9-CM Code(s) & Description(s)

345.0-345.99 = epilepsy

780.30-780.39 = convulsions

Required NCPDP Field(s)

- 424-DO Diagnosis Code

- 439-E4 Field (DUR Conflict) – Reason for Service Code – TD

- 440-E5 Field (DUR Intervention) – Professional Service Code – M0

- 441-E6 Field (DUR Outcome) – Result of Service Code – 1G

Possible Denial EOB Code(s)

482-Therapeutic Duplication

4.3.6 Antipsychotic Agents (Typical and Atypical)

Policy

- Prescriptions for typical and atypical antipsychotic agents require appropriate ICD-9-CM diagnosis codes documented on all new prescriptions.

- Claims for prescriptions for a **third** antipsychotic agent will deny when there are **two active** prescriptions for antipsychotic agents on a recipient's file.

- Claims for Olanzapine/Fluoxetine will deny when there are two active prescriptions for antipsychotic agents and/or one active prescription for a Selective Serotonin Reuptake Inhibitor (SSRI) on the recipient's file.

- Claims for doses of atypical antipsychotic agents which exceed the maximum recommended doses will deny.

- In an emergency situation and the prescriber did not indicate a diagnosis code, the pharmacist may determine the patient cannot wait to receive the medication and may override the denial.

Documentation Required

- The valid ICD-9-CM diagnosis code for antipsychotic use must be written on the hardcopy prescription either by the prescriber or the pharmacist upon consultation with the prescriber.

- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive a third antipsychotic agent.

- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the reason the prescriber requires a dose above the **maximum recommended dose** for Atypical Antipsychotics.

- In the emergency situation stated above, the pharmacist must document "Emergency" and the emergency reason on the hardcopy prescription when the ICD-9-CM diagnosis code is not indicated by the prescriber and the prescriber is not available.

- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive a prescription for Olanzapine/Fluoxetine when there are two active prescriptions for antipsychotic agents and/or one active prescription for an SSRI on the recipient's file.
- The **reason for service code, professional service code and result of service code** must also be documented on the hardcopy prescription.

Note: Refer to Section 37.5.7 Prospective Drug Utilization Policies/Limits/ Edits for detailed policy.

Accepted Values – ICD-9-CM Code(s) & Description(s)

290.0 – 319.9 = Mental Disorders

781.0 = Abnormal Involuntary Movements

Required NCPDP Field(s)

424 - DO (Diagnosis Code)

418 - DI Level of Services – Enter “3” for Emergencies

439-E4 Field (DUR Conflict) – Reason for Service Code – TD or HD

440-E5 Field (DUR Intervention) – Professional Service Code – M0

441-E6 Field (DUR Outcome) – Result of Service Code – 1G

Possible Denial EOB Code(s)

575 - M/I Diagnosis Code

482 - Therapeutic Duplication

529 - Exceeds Maximum Daily Dose

4.3.7 Carisoprodol

Policy

- Payable only when total daily dose is not greater than 1400 mg (4 tablets)
- Payable only when total daily dose of combination products containing carisoprodol is not greater than 1600 mg (8 tablets)
- **No early refills permitted.**
- **No overrides are allowed.**

Documentation Required

N/A

Accepted Values – ICD-9-CM Code(s) & Description(s)

N/A

Required NCPDP Field(s)

N/A

Possible Denial EOB Code(s)

457 - Quantity and/or Days Supply exceed program maximum.

4.3.8 Diabetic Testing Supplies**Policy**

- Diabetic supplies and glucometers for long term care recipients are not covered in the Medicaid Pharmacy Program or through prior authorization because they are covered in the nursing home per diem.

- Medicare Part B may be billed if the long term care recipient is eligible for the benefit.

- Medicaid is not obligated to pay the coinsurance and deductible for long term care recipients as these items are included in the Medicaid per diem supplies.

- All diabetic supply claims for recipients who are also Medicare Part B eligible must be submitted to the Medicare DMERC. These claims then automatically cross-over to the Medicaid fiscal intermediary for payment of the coinsurance and deductible amounts, where applicable.

Documentation Required

N/A

Accepted Values – ICD-9-CM Code(s) & Description(s)

N/A

Required NCPDP Field(s)

N/A

Possible Denial EOB Code(s)

385 - Diabetic Supplies not covered for LTC recipients

536 - Bill Medicare Part B

4.3.9 Disposable Insulin Needles and Syringes**Policy**

- Payment is made for prescribed disposable insulin needles and syringes when the recipient is insulin dependent.

- The recipient's paid pharmacy claim history is reviewed at the Point of Sale to identify a paid insulin claim in the 120 days prior to the date of service for the insulin syringes and needles claims.

- When recipients begin an initial insulin therapy, the provider should submit the insulin claim first to establish the insulin requirements on the patient history then submit claims for insulin syringes and needles.

Documentation Required

N/A

Accepted Values – ICD-9-CM Code(s) & Description(s)

N/A

Required NCPDP Field(s)

N/A

Possible Denial EOB Code(s)

668 - No patient history of insulin requirement

4.3.10 Ethinyl Estradiol/Norelgestromin Transdermal Patches (Ortho Evra®)**Policy**

- Reimbursement for these transdermal patches, when dispensed using the package of three (3) must be billed in multiples of three.

- Claims billed that indicate quantities not in multiples of three (3) will deny with no provisions for override.

Documentation Required

N/A

Accepted Values – ICD-9-CM Code(s) & Description(s)

N/A

Required NCPDP Field(s)

N/A

Possible Denial EOB Code(s)

120 – Quantity Invalid/Missing

4.3.11 Fertility Drugs**Policy**

- Includes drugs such as:

- Clomiphene Citrate tab 50 mg
- Urofollitropin ampules 75 IU, and
- Menotropins ampules 150 IU and 75 IU

- Drugs are covered only for medically indicated diagnoses other than fertility.

- A hard copy claim along with a copy of the original prescription indicating a diagnosis other than infertility must be submitted to the fiscal intermediary for processing and payment.

- No POS submission is allowed.

Documentation Required

- Physician certification in own handwriting on prescription of indication other than fertility treatment

- Hard copy claim with copy of original prescription and physician's diagnosis other than fertility treatment

Accepted Values – ICD-9-CM Code(s) & Description(s)

Diagnosis other than fertility with DHH Approval

Required NCPDP Field(s)

N/A

Possible Denial EOB Code(s)

466 - Hard Copy Required; Fertility Preparation

4.3.12 Isotretinoin

Policy

- Isotretinoin will be covered only when a handwritten prescription signed by the prescribing practitioner is issued.
- Only original prescriptions are covered with no allowances for refills.

Documentation Required

- Prescription shall be handwritten and signed by prescriber.

Accepted Values – ICD-9-CM Code(s) & Description(s)

N/A

Required NCPDP Field(s)

N/A

Possible Denial EOB Code(s)

461 - Refills not payable

4.3.13 Ketorolac

Policy

- Prescriptions for oral forms with quantities in excess of 20 or a 5 days supply will deny and can be overridden if the prescriber indicates the ICD-9-CM diagnosis code and rationale for using greater than a five days supply.

Documentation Required

- The prescriber identified ICD-9-CM diagnosis code must be included in the claim submission.

Accepted Values – ICD-9-CM Code(s) & Description(s)

Medically indicated ICD-9-CM Diagnosis Code

Required NCPDP Field(s)

424-DO Diagnosis Code

Possible Denial EOB Code(s)

457 - Quantity and/or Days Supply exceed program maximum

4.3.14 Narcotic Analgesics

Policy

- Prescriptions for narcotic analgesics that are filled three (3) or more days early will deny.

Documentation Required

- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive the the prescription early and the codes used to override the claim.
- The **reason for service code**, **professional service code** and **result of service code** must also be documented on the hardcopy prescription.

Accepted Values – ICD-9-CM Code(s) & Description(s)

N/A

Required NCPDP Field(s)

- 439-E4 Field (DUR Conflict) – Reason for Service Code – ER or ID
- 440-E5 Field (DUR Intervention) – Professional Service Code – M0
- 441-E6 Field (DUR Outcome) – Result of Service Code – 1G

Possible Denial EOB Code(s)

- 447 – Compliance Monitoring/Early or Late Refill

4.3.15 Nicotine Patches, Gum and Spray

Policy

- Nicotine patches, gum and spray will be covered only when a handwritten prescription signed by the prescribing practitioner is issued.
- As a condition for drug coverage, the physicians must certify in their own handwriting either on the prescription or on an attachment that the patient is enrolled in a physician-supervised behavioral program.
- Only original prescriptions are covered with no allowances for refills.

Documentation Required

- Prescription shall be handwritten and signed by prescriber.
- Notation (on Prescription or attachment) that patient is enrolled in a physician-supervised behavioral program is a condition for drug coverage.

Accepted Values – ICD-9-CM Code(s) & Description(s)

N/A

Required NCPDP Field(s)

N/A

Possible Denial EOB Code(s)

461 - Refills not payable

4.3.16 Opiates (Long Acting and Short Acting)**Policy**

- A claim for a new prescription for an opiate (long or short acting) drug will deny as a therapeutic duplicate when the recipient has an active prescription for an opiate (long or short acting) on file.

Documentation Required

- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive a second short acting opiate agent or a second long acting opiate.

- The **reason for service code, professional service code and result of service code** must also be documented on the hardcopy prescription.

Accepted Values – ICD-9-CM Code(s) & Description(s)

N/A

Required NCPDP Field(s)

439-E4 Field (DUR Conflict) – Reason for Service Code – TD

440-E5 Field (DUR Intervention) – Professional Service Code – M0

441-E6 Field (DUR Outcome) – Result of Service Code – 1G

Possible Denial EOB Code(s)

482 - Therapeutic Duplication

4.3.17 Orlistat**Policy**

- The prescription must be handwritten and signed by prescriber; no facsimiles permitted.

- Patient must be 12 years of age or older

- Maximums of 90 capsules and 30 days supply

- Patient has a documented current body mass index (BMI) of 27 or greater

- Patient has other risk factors warranting the use of Orlistat and the prescriber identifies an approved ICD-9-CM diagnosis code which must be included in the claim submission.

- No provisions for override of the prospective drug utilization edits, i.e., early refill (ER) and duplicate drug (ID) editing.

- Only original prescriptions are covered with no allowances for refills.

Documentation Required

- Prescription shall be handwritten and signed by prescriber.
- The prescriber identifies the BMI, in his/her handwriting, on the dated prescription or a dated and signed attachment to the prescription
- The prescriber identifies with an approved ICD-9-CM diagnosis code in his/her handwriting, on the dated prescription or a dated and signed attachment to the prescription that the patient has other risk factors warranting the use of Orlistat.

Accepted Values – ICD-9-CM Code(s) & Description(s)

- 250.00 - 250.93 = Type II Diabetes
- 271.3 = Impaired Glucose Tolerance
- 251.0 - 251.2 = Hyperinsulinemia
- 272.0 - 272.4 = Dyslipidemia
- 401.00 - 405.99 = Hypertension
- 410.00 - 414.99 = Ischemic Heart Disease
- 429.2 = Cardiovascular Disease, unspecified
- 440.00 - 440.90 = Atherosclerosis
- 443.00 - 443.90 = Other peripheral vascular diseases
- 530.11 and 530.81 = Gastric Reflux Disease
- 715.05 - 715.97 = Osteoarthritis of Hips/Knees
- 780.51, 780.53 and 780.57 = Sleep Apnea
- 430.00 - 438.99 = Cerebrovascular Disease
- 348.2 = Pseudotumor cerebri
- 454.2 = Varicose Veins of the lower extremities with ulcer and inflammation
- 451.0 = Phlebitis & Thrombophlebitis of the superficial vessels of the lower extremities
- 451.11 = Phlebitis & Thrombophlebitis of the femoral vein
- 451.19 = Phlebitis & Thrombophlebitis of other deep vessels
- 451.2 = Phlebitis & Thrombophlebitis of lower extremities, unspecified
- 454.0 = Varicose veins of lower extremities, with ulcer
- 454.1 = Varicose veins of lower extremities, with inflammation
- 454.9 = Varicose veins of lower extremities, without mention of ulcer & inflammation

Required NCPDP Field(s)

- 424-DO - Diagnosis Code

Possible Denial EOB Code(s)

- 020 - M/I Diagnosis Code
- 234 - Age Restriction
- 457 - Quantity and/or Days Supply exceed program maximum
- 461 - Refills not payable

4.3.18 Sildenafil (Revatio®)**Policy**

- Prescriptions for Sildenafil (Revatio®) are covered when prescribed for primary pulmonary hypertension.

- An appropriate ICD-9-CM code must be documented on the prescription by the prescriber or communicated to the pharmacist electronically, via telephone or facsimile.
- Claims for nitrate prescriptions will deny when there is an active prescription for Sildenafil (Revatio®) on the recipient's drug history file. Conversely, prescriptions for Sildenafil (Revatio®) will deny when there is an active prescription for nitrates in the recipient's drug history file.

Documentation Required

- Appropriate ICD-9-CM diagnosis code must be documented on prescriptions by either the prescriber or the pharmacist.
- After consultation with the prescriber, the pharmacist must document the reason the prescriber required the patient to receive a nitrate and sildenafil (Revatio).
- The **reason for service code, professional service code and result of service code** must also be documented on the hard copy prescription.

Accepted Values – ICD-9-CM Code(s) & Description(s)

- 416.0 = Primary pulmonary hypertension
- 416.8 = Other chronic pulmonary heart disease

Required NCPDP Field(s)

- 424-DO Diagnosis Code
- 439-E4 Field (DUR Conflict) – Reason for Service Code – DD
- 440-E5 Field (DUR Intervention) – Professional Service Code - MO
- 441-E6 Field (DUR Outcome) – Result of Service Code – 1G

Possible Denial EOB Code(s)

- 575 - M/I Diagnosis Code
- 471 - Drug to Drug Interaction with Sildenafil and Nitrate

4.3.19 Tazarotene (Tazorac®)**Policy**

- Prescriptions for Tazarotene (Tazorac®) are covered when prescribed for psoriatic arthropathy or other psoriasis.
- An appropriate ICD-9-CM code must be documented on the prescription by the prescriber or communicated to the pharmacist electronically, via telephone or facsimile

Documentation Required

Appropriate ICD-9-CM diagnosis code must be documented on prescriptions by either the prescriber or the pharmacist.

Accepted Values – ICD-9-CM Code(s) & Description(s)

- 696.0 = psoriatic arthropathy
- 696.1 = Other psoriasis

Required NCPDP Field(s)

424-DO Diagnosis Code

Possible Denial EOB Code(s)

575 - M/I Diagnosis Code

4.4 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 which may be found at the www.lamedicaid.com link. If a field is "required" then information must be entered on the Point of Sale device. Otherwise, the field is optional.

Prescription Claim Submission Required Fields	
POINT OF SALE	
DATA ELEMENT	REQUIRED OR OPTIONAL
Service Provider ID and Provider I.D.	Required
Cardholder I.D. Number	Required
Other Coverage Code	Optional
Date of Service	Required
Eligibility Clarification Code	Optional
Patient First Name	Required
Patient Last Name	Required
Prescription/Service Reference Number	Required
Fill Number	Required
Quantity Dispensed	Required
Days Supply	Required
Product/Service I.D.	Required
Prescriber ID	Required
Usual & Customary Charge	Required
Date Written	Required
Prior Authorization Type Code (See Your Vendor's User's Manual for instructions)	Optional
Other Payer Amount	Optional
Dispense As Written (DAW)/Product Selection Code	Optional
Patient Paid Amount	Optional
Incentive Amount Submitted	Optional
Reason for Service Code	Optional
Professional Service Code	Optional
Result of Service Code	Optional
Other Payer Reject Codes	Optional
Patient Date of Birth	Optional
Patient Gender Code	Optional
Level of Service	Optional
Diagnosis Code	Optional
Other Payer Date	Optional
Other Payer ID	Optional

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

4.5 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
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.

4.5.1 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	(variable .50¢ to \$ 3.00)
Amount Paid	the calculated payment minus applicable Co-payment amount

4.5.2 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 a 530, 843, 893 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:

PPPPPPPPPP RRRRRRRRRRRRRRRR 999999
PPPPPPPPPP = Medicaid Provider ID or NPI; RRRRRRRRRRRRRRRR = recipient id;
999999999 = adjudicated date

Additional Message Area will contain the duplicate EOB codes 530, 843, 893 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.

4.5.3 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:

PPPPPPPPPP RRRRRRRRRRRRRR 999999

PPPPPPPPPP = Medicaid Provider ID or NPI; RRRRRRRRRRRRRR = 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"
- 216 - "Recipient Not Eligible on DOS"
- 217 - "Name/Number Mismatch"
- 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 Section VII 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 **1-225-216-6381**.

4.5.4 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.

5.0 Reversal Submission and Processing

5.1 Basic Information

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 switch vendor. In general, the required fields **are the NPI or 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 Chapter Thirty-Seven, the Pharmacy Benefits Management chapter, of the Louisiana Medicaid Program Provider Manual.

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

5.2 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 XXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX = ICN

5.3 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:

PPPPPPPPPP RRRRRRRRRRRRRR 999999 888 888 888 888

PPPPPPPPPP = Medicaid Provider ID or NPI; RRRRRRRRRRRRRR = recipient id; 99999999 = adjudicated date; 888 = EOB

6.0 Reject Code Message

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. The Medicaid fiscal intermediary's EOB codes are listed in Section VII, EOB Translation. Claims generating these reject codes must be corrected and resubmitted by the pharmacy. For more information on these messages contact the **POS Help Desk at 1-800-648-0790**.

An asterisk (*) indicates that the Medicaid fiscal intermediary does not currently use this code. If any of these messages are received, contact your computer system "software" vendors.

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	Provider Number Missing or Not Numeric
		289	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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
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		
*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.

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
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
22	Missing or Invalid Dispense As Written (DAW)/Product Selection Code	128	The MAC Override Indicator Must be a "C"
		576	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 NPI or Medicaid ID Required
		489	Provider Type Not Authorized to Prescribe
		491	Prescriber Number not for Individual Prescriber
		521	Prescribing Provider is Group Using Individual Provider Number
*26	Missing or Invalid Unit Of Measure		
*27	(Reserved for Future Use)		
28	Missing or Invalid Date Prescription Written	122	RX Date is Missing
		123	RX Date was After Date Filled

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*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	Invalid or Missing Diagnosis Code

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
		575	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	275 434 449 535 536 932 988	Recipient is Medicare Eligible Bill Medicare Nebulizer Med Bill Medicare First Based on Discharge Date Bill Medicare Part D Bill Medicare Part B Please bill third party carrier first 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	121 450	Prescribing Physician NPI or Medicaid ID required 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

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
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
*64	Claim Submitted Does Not Match Prior Authorization		
65	Patient is Not Covered	135 216 293 295	Patient not Covered for Pharmacy Service Recipient Not Eligible on Date of Service Recycled Recipient Ineligible on DOS Recipient Ineligible Recycled three Times
*66	Patient Age Exceeds Maximum Age		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
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
		459	Deny for File review/Call help desk
71	Prescriber is Not Covered	213	Provider Not Covered for Services Rendered By Medicaid
		262	Provider's Adjustments on Review
		514	Prescribing Provider Does not Have Prescriptive Authority
*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

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
		487	Emergency Override of a Drug that Requires PA
*76	Plan Limitations Exceeded		
77	Discontinued Product/Service ID Number	438 460	Manufacturer Notified Us That NDC is Obsolete NDC Probably Obsolete. Check Label/Computer
		462 465	CMS Notified Us that NDC is Obsolete Invalid NDC – not on CMS File
78	Cost Exceeds Maximum	650 660 918	Payment Reduced to State Maximum Payment Reduced to LMAC Maximum Medicaid Allowable Amount Reduced by Other Insurance
*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	030 272	Service Thru Date More than Two Years Old Claim Exceeds 1 Year Filing Limit
*82	Claim is Post Dated		
83	Duplicate Paid/Captured Claim	530	Recipient Was Reimbursed for This Service

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
		843	Exact Duplicate Error: Identical Pharmacy Claims
		893	Suspect Duplicate: Identical Pharmacy Claims
		898	Exact Dup. Same ICN- Dropped
84	Claim Has Not Been Paid/Captured	280	Manual Pricing Required
		250	Diag/Proc Requires Review
*85	Claim Not Processed		
*86	Submit Manual Reversal		
87	Reversal Not Processed	516	Cannot Adjust Due to Previous Financial Transaction
		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
88	DUR Reject Error	441	Outcome 2A or 2B – RX Not Filled – Transaction Reporting
		442	Drug/Drug Interaction
		443	Therapeutic Overlay
		445	Duplicate Drug Therapy

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
		446	Pregnancy Precaution
		447	Compliance Monitoring/Early or Late Refill
		471	Drug to Drug Interaction with sildenafil and nitrate
		482	Therapeutic Duplication Denial
		483	Pregnancy Precaution-Denial- FDA Category X
		529	Exceed Maximum Daily Dose
		531	Drug Use Not Warranted Cox-2 Inhibitor
		656	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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
CC	Missing or Invalid Cardholder First Name	023	Recipient Name Missing (first initial)
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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
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		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*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	497	Invalid Prescriber ID Qualifier must be '01' or '05'
*E1	Missing or Invalid Product/Service ID Qualifier		
*E3	Missing or Invalid Incentive Amount Submitted		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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	524	Capitated Service Must Be Authorized/Paid by PACE Provider
		388	Recipient Not Covered for Drugs

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
		577	Override Prescription Exceeds 8 Scripts Per Month Limit
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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*VE	Missing or Invalid Diagnosis Code Count		

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

7.0 Explanation of Benefits (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 (pending), with the exception of codes 650, 660, and 662 which when associated with a paid claim, denote a reduction in payment.

EOB CODE	DESCRIPTION
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 NPI or 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

EOB CODE	DESCRIPTION
211	Date of Service Less Than Date of Birth
213	Provider Not Covered for Services Rendered by Medicaid
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 Required
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
388	Recipient Not Covered for Drugs
389	Recipient is MD, Pharm Restricted-Pharmacy Invalid
432	Quantity Exceeds Package Size
434	Bill Medicare Nebulizer Med
436	Days Supply > 100 Exceeds Program Maximum

EOB CODE	DESCRIPTION
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
446	Pregnancy Precaution
447	Compliance Monitoring/Early or Late Refill
448	Transplant Discharge Date or other Dx needed
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	Deny 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
465	Invalid NDC Not Available
466	Hard Copy Required-Fertility Preparation
471	Drug to Drug Interaction with sildenafil and nitrate
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
497	Invalid Prescriber ID qualifier. Must be 01 or 05

EOB CODE	DESCRIPTION
498	Number of prescriptions greater than limit
514	Prescribing Provider Does not Have Prescriptive Authority
516	Cannot Adjust Due to Previous Financial Transaction
521	Prescribing Provider is Group Using Individual Prescriber Number
524	Capitated Service Must Be Authorized/Paid by PACE Provider
529	Exceeds Maximum Daily Dose
530	Recipient was Reimbursed for This Service
531	Drug Use Not Warranted Cox-2 Inhibitor
535	Bill Medicare Part D
536	Bill Medicare Part B
537	Educational – OBRA 90 Excluded Drug
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
798	History Record Already Adjusted
799	No History Record on File For This Adjustment
843	Exact Duplicate Error: Identical Pharmacy Claims
893	Suspect Duplicate Error: Identical Pharmacy Claims
898	Exact Duplicate, Same ICN –Dropped
918	Medicaid Allowable Amount Reduced by Other Insurance
920	More than 5 Refills Per Prescription not Reimbursable
932	Please Bill Third Party Carrier First
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 **1-225-216-6381**.

8.0 Glossary

1. Authorization Number - An authorization number is the Internal Control Number (ICN) returned with each adjudicated response.
2. DOB – Date of Birth.
3. Duplicate – A claim reponse of ‘D’ (duplicate claim) is returned when Medicaid has previously paid a claim.
4. Computer System “Software” Vendor – Company/entity who supports the pharmacy’s claims submission/practice management software. May be the source from whom practice management software was purchased; or the Information Technology support department for a pharmacy chain store.
5. 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.
6. National Provider ID (NPI) - A universally recognized, unique identifier assigned permanently to every provider of health care services or supplies by CMS.
7. Payable - When a claim adjudicates and has a 'P' (claim payable) status indicating that this claim was paid by Medicaid.
8. Point of Sale - POS claims processing provides on-line adjudication of Medicaid claims. With POS, a claim is electronically processed entirely through the claims processing cycle in real-time, and within seconds of submission, a response is returned to the pharmacy that the recipient is eligible or ineligible and that the claim is either payable, duplicated or rejected. Most pharmacies are already familiar with this type of processing as many other third party prescription processors use it.
9. Rejected - A claim response of 'R' (claim rejected) is returned when a prescription is rejected (denied).
10. Reversal - A reversal transaction completely reverses a previously processed claim and will appear as a credit on the next Remittance Advice.
11. Telecommunication Switch Vendor - A telecommunications services vendor who transfers via telephone lines, the prescription transaction from the pharmacy to the Medicaid fiscal intermediary.
12. 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.