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. Pharmacy claims must be submitted with the pharmacy provider's National Provider Identifier (NPI). Claims will deny when the pharmacy provider's Medicaid number is submitted or when the pharmacy provider submits a claim with a NPI which has not been registered with Louisiana Medicaid. 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. Pharmacy providers must make every effort to send the prescribing provider's NPI in the POS claim. In rare cases where a prescriber does not have a NPI or the pharmacy cannot obtain the NPI, the pharmacy may substitute the prescriber's 7 digit Medicaid number in the claim 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 **Molina Medicaid Solutions, 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)

Pharmacy providers must use only an NPI to identify themselves as a health care provider in standard transactions, including NCPDP 5.1 claims. The NPI must be registered with Louisiana Medicaid prior to submission on a claim.

Molina Medicaid Solutions maintains 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.

POS claims are accepted with the NPI in the NCPDP field called NCPDP Service Provider Identifier (201-B1) as per the federal standard. The NCPDP Service Provider ID Qualifier (202-B2) is used to indicate the Service Provider Identifier (201-B1) submitted is an NPI (01). The following edits will be performed:

1. If the qualifier indicates a pharmacy's NPI was submitted, but the NPI has not been registered with Louisiana Medicaid or if the Medicaid ID was sent after the NPI implementation date, 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, then NCPDP Error Message "B2" (M/I Service Provider ID Qualifier) will be returned to the provider.

Pharmacy providers must make every effort to send the prescribing provider's NPI in the POS claim. In rare cases where a prescriber does not have a NPI or the pharmacy cannot obtain the NPI, the pharmacy may substitute the prescriber's 7 digit Medicaid number in the claim submission.

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. If the prescriber qualifier indicates 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 will be returned to the pharmacy.

3. If the NCPDP Prescriber ID Qualifier (466-EZ) is neither '01' nor '05' then NCPDP Error Message "EZ" (Missing or Invalid Prescriber ID Qualifier) will be returned to the provider.

Louisiana Medicaid has made available a list of registered prescriber NPI numbers to pharmacies. This list may be found at www.lamedicaid.com, under the Pharmacy and Prescribing Provider link. This list is called Prescribing Provider File (PPN). This list is password protected. The password is KARNARDO2002. The password is case sensitive.

For those pharmacists who have the authority to administer and are submitting claims for influenza vaccines, the pharmacist's NPI may be submitted in NCPDP field 444-E9 Provider ID with a qualifier "05" in NCPDP field 465-EY Provider ID Qualifier. If the pharmacist's Medicaid ID is sent in field NCPDP field 444-E9, a qualifier of "07" must be submitted in NCPDP field 465-EY. See Section 4.5 for further details regarding claim submissions for immunizations.

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 Molina Medicaid Solutions 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 Molina Medicaid Solutions Provider Relations Department at 1-800-473-2783 or 225-924-5040.

3.4.4 Molina Medicaid Solutions 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. Molina Medicaid Solutions, 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 four-prescription monthly limitation are allowed a maximum of four prescriptions per calendar month. Claims, including those for emergency prescriptions and prior authorized prescriptions that are in excess of four per calendar month per recipient are denied.

Please Note: The following federally mandated recipient groups are exempt from the four-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-DD 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 four 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 four-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 four. (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
234	60	P/F Age Restriction	PA
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
457	76	Quantity or days supply exceeds program maximum	EX
471	88	Drug to drug interaction	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								
Reason for Service Code (DUR Conflict) NCPDP 439-E4 Field	PA	DD	EX	HD	NN	TD	ID	ER	MX
Professional Service Code (DUR Intervention) NCPDP 440-E5 Field	M0						M0, P0, or R0		M0
Result of Service Code (DUR Outcome) NCPDP 441-E06 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)	PA	Drug-Age
		DD	Drug-Drug Interaction
		ER	Overuse/Early Refill (for same pharmacy)
		EX	Excessive Quantity
		HD	High Dose
		ID	Ingredient Duplication (for different pharmacy)
		MX	Excessive Duration
		NN	Unnecessary Drug
		PG	Drug-Pregnancy
		TD	Therapeutic Duplication
		RE	Suspected Environmental Risk
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 – 234 – P/F Age Restriction**
  - Conflict Code = PA
  - Documentation Required:

    *** Palivisumab (Synagis®)**

    - Palivisumab claims for recipients who are twenty-five (25) months of age or older on November 1st of the Respiratory Syncytial Virus (RSV) season will deny.
    - **The prescriber must issue a hardcopy prescription** with justification for Palivisumab use for recipients for recipients twenty-five (25) months of age or older.
    - After consultation and **written approval** from the prescriber, the pharmacist may override the age restriction.
    - The reason for **service code, professional service code** and **result of service code** must also be documented on the hard copy prescription (may be faxed).

  - **Note:** Refer to Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual, Section 37.5.8 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 – 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.

- **Note:** Refer to Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual, Section 37.5.8 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 – 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 37.5.8 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 – 457 - Quantity or Days Supply Exceeds Program Maximum**

  - Conflict Code = EX
  - Documentation Required:

  *** Carisoprodol**

  - Payable only when quantity does not exceed ninety (90) tablets per rolling ninety (90) days.
  - The quantity limit is cumulative and applies to all strengths and combinations of carisoprodol.
  - Cumulative quantities in excess of the quantity limit will not process for payment through the Point of Sale (POS) System.
  - **No early refills permitted.**
  - **No overrides are allowed.**

  *** Schedule II (C-II) Narcotic Agents**

  - **Quantity limits for Schedule II narcotic agents:**
    - **are listed in Appendix E-1.**
    - **are cumulative and are based on a rolling thirty (30) days.**
    - **apply to all strengths of an agent unless otherwise specified.**
  - Recipients receiving the agents listed in **Appendix E-1 for the management of cancer pain are not subject to a quantity limit except for fentanyl buccal and sublingual products.**
  - A valid ICD-9-CM diagnosis code must be written on the hard copy prescription for **ALL Schedule II narcotic agents (including Schedule II narcotic agents not subject to a quantity limit)** by the prescribing practitioner or by the pharmacist after consulting with the prescriber.

  ***Serotonin Agonists (Triptans)**

  - **Quantity limits for the Serotonin Agonists (Triptans):**
    - **are listed in Appendix E-1.**
    - **are cumulative and are based on a rolling thirty (30) days.**
    - **apply to all strengths of an agent unless otherwise specified.**
  - After consultation with the prescriber, the pharmacist must document on the hard copy prescription the prescriber's reason the quantity limit needs to be exceeded.
  - The **reason for service code, professional service code and result of service code** used in submitting the claim 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 37.5.8 Prospective Drug Utilization Policies/Limits/Edits and Appendix E-1 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**

- Conflict Code = DD
- Documentation Required:

***Sildenafil or Tadalafil and Nitrate**

- After consultation with the prescriber, the pharmacist must document the reason the prescriber required the patient to receive a nitrate and Sildenafil (Revatio) or Tadalafil (Adcirca®).
- 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 37.5.8 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:**

-Second Generation Antihistamines and Second Generation Antihistamine Combination Agents
-Angiotensin Converting Enzyme (ACE) Inhibitor Agents
-ACE Inhibitor/Calcium Channel Blocker Agents
-ACE Inhibitor/Diuretic Agents
-Angiotensin Receptor Antagonists (ARB)
-ARB/Calcium Channel Blocker Agents
-ARB/Thiazide Diuretic Agents
-Beta-adrenergic Blocking Agents
-Beta-adrenergic Blocking /Diuretic Agents
-Calcium Channel Blocking Agents
-Calcium Channel Blocking/Antihyperlipidemia Agents
-Potassium Replacement Agents
-Tricyclic Antidepressants
-Selective Serotonin Reuptake Inhibitors (SSRI)
-Sedative Hypnotic Agents

-Non-steroidal Anti-inflammatory Agents (inclusive of COX-2 Selective Agent)
-Proton Pump Inhibitor Agents

***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.

*** Attention Deficit Disorder Drugs**

- Incoming prescription claims for any agent listed in the following drugs will deny for therapeutic duplication if there is an active prescription for any of these agents on the recipient's file written by a <u>different</u> <u>prescriber.</u> *An active prescription is a prescription where the days supply has not expired.*

  Atomoxetine (Strattera®)
  Dexmethylphenidate (Focaline®)
  Dextroamphetamine/amphetamine
  Lisdexamfetamine (Vyvanse®)
  Dextroamphetamine
  Methylphenidate

- The pharmacist must **document** on the hardcopy prescription the reason the prescriber required the patient to receive a second agent.

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

*** Buprenorphine Agents (Suboxone® or Subutex®) and concurrent prescriptions with opioid analgesics.**

- A valid ICD-9-CM diagnosis code must be written on the hard copy prescription.

- The **reason for service code, professional service code** and **result of service code** must be documented on the hardcopy prescription when a second opioid is warranted.

*** 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 37.5.8 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 required the daily dosage limit needs to be exceeded.
- The **reason for service code, professional service code** and **result of service code** used in submitting the claim must also be documented on the hardcopy prescription **(Appendix E-2).**

*** Buprenorphine Transdermal Patches (Butrans®)**

-There are **No override provisions** through the Point of Sale (POS) System for Buprenorphine transdermal patches (Butrans®) when the maximum daily dosage is exceeded **(Appendix E-2)**.

*** Morphine ER (Avinza®)**

-There are **No override provisions** through the Point of Sale (POS) System for Morphine ER **(Avinza®)** when the maximum daily dosage is exceeded **(Appendix E-2).**

*** Opiod Agonists - (Tapentadol and Tramadol** products listed in **Appendix E-2)**

- After consultation with the prescriber, the pharmacist must **document** on the hardcopy prescription the prescriber's reason the daily dosage limit shown in **Appendix E-2** needs to be exceeded.
- The **reason for service code, professional service code** and **result of service code** used in submitting the claim 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 37.5.8 Prospective Drug Utilization Policies/Limits/Edits and Appendix E-2 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.

- N**ote:** Refer to Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual, Section 37.5.8 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 – 656 - Exceeds Maximum Duration of Therapy**

- Conflict Code = MX
- Documentation Required:

*** Proton Pump Inhibitors, H2 Antagonists & Sucralfate**

- **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.

*** Palivisumab (Synagis®)**

- After consultation with the prescribing practitioner and receipt of a handwritten justification (may be faxed) by the prescriber for the use of Palivisumab (Synagis®) outside the Respiratory Syncytial Virus (RSV) season, the pharmacist may override the maximum duration of therapy edit.
- After consultation with the prescribing practitioner and receipt of a handwritten justification (may be faxed) by the prescriber for use of Palivisumab (Synagis®) in excess of the allowable number of doses, the pharmacist may override the maximum duration of therapy edit.
- The **reason for service code, professional service code** and **the result of service code** must also be documented on the hard copy prescription and submitted with the override.

* N**ote:** Refer to Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual, Section 37.5.8 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 – 843 - Exact Duplicate Error: Identical Pharmacy Claims**

An Exact Duplicate Claim is returned as a **Duplicate** when a claim:

- is billed by the same provider as the original claim,
- is for the same recipient as the original claim,
- has the same date of service as the original claim,
- has the same NDC,
- has the same prescription number as the original claim, and
- has the same refill number as the original claim.

An Exact Duplicate Claim is returned as **Rejected** when a claim

- is billed by the same provider as the original claim,

- is for the same recipient as the original claim,
- has the same date of service as the original claim, and
- has the same NDC.

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 returned as rejected when one of two scenarios occurs:

- 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.

- 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.

OR

- the same provider as the original claim,
- the same recipient as the original claim,
- the same date of service as the original claim,
- the same prescription number as the original claim, and
- the same refill number as the original claim.

*EOB Code 893 (when returned with the second scenario) cannot be overridden.

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

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 (3Ø8-C8) 01 = No other coverage

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

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

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

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

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

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

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

- Recipient has court ordered medical child support.

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

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

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

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

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

Other Coverage Code (3Ø8-C8) Ø7 = 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
- Individuals determined to be American Indians

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

Note: Refer to Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual, Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits for additional information.

Note: Refer to the Louisiana Board of Medical Examiners published rules regarding the use of medications used in the treatment of non-cancer related chronic or intractable pain. These rules are included in Title 46: Professional and Occupational Standards. Subchapter B – Medications

Used in the Treatment of Non-Cancer-Related Chronic or Intractable Pain. See http://www.lsbme.la.gov/46v45MedicalProfessionlsSeptember2009practice.htm#_Toc24314086

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 most amphetamines are from three years old to twenty-one years old.

- When a FDA approved indication exists for an amphetamine product for ages greater than twenty-one, that product is covered when a diagnosis of ADD, ADHD or narcolepsy is submitted with the pharmacy claim.

- For those products which do not have a FDA approved indication for ages greater than twenty-one, only a diagnosis of narcolepsy is acceptable.

- 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 doses of atypical antipsychotic agents which exceed the maximum daily doses listed in Appendix E-2 will deny.

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

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.

- 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 **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 dose** for Atypical Antipsychotics (Appendix E-2).

- 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 Refer to Chapter 37, *Pharmacy Benefits Management Services*, of the Louisiana Medicaid Program Provider Manual, Section 37.5.8 Prospective Drug Utilization Policies/Limits/ Edits and Appendix E-2 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 "03" 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 Buprenorphine Agents (Suboxone® and Subutex®)

Policy
- Prescriptions for buprenorphine agents (Suboxone® and Subutex®) drugs are covered only when the prescriber:

- is a physician,
- has an XDEA number and is licensed to prescribe buprenorphine containing drugs, and
- is on file with the fiscal intermediary as having submitted a Provider Enrollment Update Form and a copy of his/her current Controlled Substance Registration Certificate indicating the XDEA number.

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

- Patient must be 16 years of age or older.

- Prescriptions for buprenorphine agents containing drugs (Suboxone® and Subutex®) require appropriate **ICD-9-CM diagnosis codes** documented on the prescription **hard copy either** by the prescriber or the pharmacist when this information is communicated by the prescriber to the pharmacist electronically, via telephone or facsimile.

- Prescriptions are only payable when the daily dose does not exceed the maximums:
  - Suboxone® - 24mg/day
  - Subutex® - 16mg/day

No overrides are allowed.

- Incoming prescriptions for **Suboxone® or Subutex®** will deny when there is an active prescription for either **Suboxone® or Subutex®** on the recipient's file. *An active prescription is a prescription in which the days supply has not expired.* **No overrides are allowed.**

- **Concurrent prescriptions for opioid analgesics and/or benzodiazepines with Suboxone® or Subutex® active prescriptions** will be reimbursed only when issued by the **same physician** who prescribed Suboxone® or Subutex® for the patient. *An active prescription is a prescription in which the days supply has not expired.*

- When a patient has an active prescription for any opioid analgesic (including Suboxone® or Subutex®) issued by the **same prescriber**, the incoming prescription will deny as a therapeutic duplication. *The pharmacist shall contact the physician for his/her authorization to assure the physician wants concurrent therapy before filling the incoming opioid prescription and* ***override the denial edit.***

- Concurrent opioid analgesic and/or benzodiazepine prescriptions written by a **different prescriber** for patients on Suboxone® or Subutex® will deny. **No overrides are allowed.**

Documentation Required

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

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

Note: Refer to Refer to Chapter 37, *Pharmacy Benefits Management Services*, of the Louisiana Medicaid Program Provider Manual, Section 37.5.8 Prospective Drug Utilization Policies/Limits/ Edits for detailed policy.

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

304.0 - 304.03 = Opioid Type Dependence
304.7 - 304.73 = Combinations of Opioid Type Drug with Any Other

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)

234 - Age Restriction
461 - Refills not payable

471 - Drug to Drug Interaction
482 - Therapeutic Duplication
514 - Prescribing Provider Does Not Have Prescriptive Authority
529 - Exceeds Maximum Daily Dose
575 - Missing or Invalid Diagnosis Code

4.3.8 Buprenorphine Transdermal Patches (Butrans®)

Policy
- Prescriptions for buprenorphine transdermal patches (Butrans®) require appropriate **ICD-9-CM diagnosis codes** documented on the prescription **hard copy either** by the prescriber or the pharmacist when this information is communicated by the prescriber to the pharmacist electronically, via telephone or facsimile.

- Claims submitted for buprenorphine patches without a diagnosis code or with a diagnosis code related to the management of addictive disorders or substance abuse will deny.

- There is no provision to override the denial when a diagnosis code related to the management of addictive disorders or substance abuse is submitted. **No Overrides are allowed.**

- Prescriptions are only payable when the daily dose does not exceed the maximums **(Appendix E-2). No Overrides are allowed.**

Documentation Required
- The valid ICD-9-CM diagnosis must be written on the hardcopy prescription either by the prescriber or the pharmacist upon consultation with the prescriber.

- In the emergency situation when the prescriber does not indicate a diagnosis code on the prescription and the prescriber cannot be reached, a denial for a missing ICD-9-CM diagnosis code may be overridden if the pharmacist determines that the recipient cannot wait to receive the medication.

Note: Refer to Refer to Chapter 37, *Pharmacy Benefits Management Services*, of the Louisiana Medicaid Program Provider Manual, Section 37.5.8 Prospective Drug Utilization Policies/Limits/ Edits and **Appendix E-2** for detailed policy.

Accepted Values – ICD-9-CM Code(s) & Description(s)
Diagnosis other than one related to the management of addictive disorders or substance abuse.

Required NCPDP Field(s)
424-DO – (Diagnosis Code)
418-DI Level of Services – **Enter "03" for Emergencies**

Possible Denial EOB Code(s)
575 - Missing/or Invalid Diagnosis Code
529 - Exceeds Maximum Daily Dose- No POS overrides

4.3.9 Carisoprodol

Policy
- Payable only when quantity does not exceed ninety (90) tablets per rolling ninety (90) days.

- The quantity limit is cumulative and applies to all strengths and combinations of carisoprodol.

- Cumulative quantities in excess of the quantity limit will not process for payment through the Point of Sale (POS) System.

- **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.

4.3.10 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

4.3.11 Drospirenone/Ethinyl Estradiol/Levomefolate Calcium (Beyaz®)

Policy
- Reimbursed when a valid ICD-9 Code is submitted on the pharmacy claim.

- Diagnosis codes for cosmetic indications will not be accepted.

- No overrides allowed.

Documentation Required
N/A

Accepted Values – ICD-9-CM Code(s) & Description(s)
Diagnosis code other than a cosmetic diagnosis code.

Required NCPDP Field(s)
424-DO - Diagnosis Code

Possible Denial EOB Code(s)
575 – M/I Diagnosis Code

4.3.12 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

4.3.13 Etonogestrel/Ethinyl Estradiol (Nuvaring®) Vaginal Ring

Policy
-Claims will deny when etonogestrel/ethinyl estradiol (Nuvaring®) vaginal ring is billed for quantities of four and greater. There is no provision for override.

-In addition, there will be a valid days supply range dependent on the quantity billed:
-If quantity = 1, then days supply must be 21 to 28,
-If quantity = 2, then days supply must be 42 to 56, and
-If quantity = 3, then days supply must be 63 to 84.

Documentation Required
- After consultation with the prescriber, the pharmacist must document the approval.

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)
457 – Quantity and/or Days Supply Exceeds Program Maximum

4.3.14 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

4.3.15 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

4.3.16 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

4.3.17 Medroxyprogesterone Acetate Injectable

Policy
-Claims will deny when medroxyprogesterone acetate injectable is billed with a days supply less than 84 with a bill quantity of one for female recipients. Quantities of two and greater will not be payable with no provision for override.

-Claims will deny when medroxyprogesterone acetate sub-q 104 injectable is billed with a days supply less than 84 with a bill quantity of 0.65 for female recipients. Quantities of 1.3 and greater will not be payable with no provision for override.

Documentation Required
- After consultation with the prescriber, the pharmacist must document the approval.

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)
457 – Quantity and/or Days Supply Exceeds Program Maximum

4.3.18 Morphine ER (Avinza®)

Policy
- An ICD-9-CM diagnosis code indicating the reason for use must be written on the hard copy prescription.

- Reimbursed when a valid ICD-9-CM Code is submitted on the pharmacy claim.

- The maximum daily dose for Morphine ER (**Avinza®**) is shown in **Appendix E-2**.

- There are **No Override** provisions through the Point of Sale (POS) System for Morphine ER (**Avinza®**) when the maximum daily dosage is exceeded.

Documentation Required
All Schedule II Narcotic Agents prescriptions require a diagnosis code for payment.

Accepted Values – ICD-9-CM Code(s) & Description(s)
A valid ICD-9-CM Code submitted on the pharmacy claim.

Required NCPDP Field(s)
424-DO - Diagnosis Code

Possible Denial EOB Code(s)
529 - Exceeds Maximum Daily Dose- No POS overrides
575 – M/I Diagnosis Code

4.3.19 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 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

4.3.20 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

4.3.21 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

4.3.22 Opioid Agonists (Tapentadol and Tramadol products)

Policy
- Reimbursed when a valid ICD-9 Code is submitted on the pharmacy claim.

- Reimbursed when the maximum daily doses shown in Appendix E-2 are not exceeded.

- Claims for doses the maximum daily doses listed in Appendix E-2 will deny.

Documentation Required
- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the prescriber's reason the daily dosage limit shown in Appendix E-2 needs to be exceeded.

- 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 – 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

4.3.23 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 (Appendix E-1)

- 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

4.3.24 Palivisumab (Synagis®)

Policy
- Claims billed for prescriptions for Palivisumab (Synagis®) will only be reimbursed when prescriptions have met the following criteria:

- Dates of service are within the Respiratory Syncytial Virus (RSV) season;
- Synagis® therapy will only be reimbursed for recipients who are twenty-four (24) months or younger on Novernber 1st of the RSV season;
- Claims for Synagis® will only process for payment every twenty-eight (28) days;
- A maximum of five (5) doses of Synagis® will be reimbursed each RSV season;
- An appropriate **ICD-9-CM diagnosis code must be documented on the hardcopy** prescription after written, electronic or verbal consultation with the prescribing practitioner. In the **emergency situation,** 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.**

- RSV Season

- Synagis® claims with dates of service outside of RSV season will deny.
- The RSV season begins November 1st and ends March 31st.
- Claims billed for dates of service outside the RSV season will require **a hardcopy prescription** with **justification for Synagis® use handwritten by the prescriber.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review. Medical records may be requested by the pharmacy compliance audit program for verification purposes of pharmacy claims billed for Synagis® outside the five (5) month RSV season.

- Age Restriction
Claims for Synagis® therapy will only be reimbursed for recipients who are twenty-four (24) months or younger on November 1st of the RSV season. Once a recipient meets the age requirement for Synagis®, subsequent claims during that RSV season will continue to be reimbursed without further age evaluation. Claims for recipients who are twenty-five (25) months of age or older on November 1st will deny.

When justified by the prescriber, pharmacy claims for Synagis® may be reimbursed for recipients twenty-five (25) months of age or older; however, these **pharmacy claims will require a hardcopy prescription with justification for Synagis® use handwritten by the prescriber.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.

- Early Refill
Claims for Synagis® will only process for payment **every twenty-eight (28) days.** When a pharmacy submits a claim for Synagis® and the same pharmacy submitted the active paid claim, the incoming claim will deny. After consultation with and written, electronic, or verbal approval from the prescribing practitioner, the pharmacist may override the **early refill edit.**

When a pharmacy submits a claim for Synagis® and **another pharmacy** has previously submitted the active paid claim, the incoming claim will deny for duplicate drug therapy. After consultation with and written, electronic, or verbal approval from the prescribing practitioner, the pharmacist may override the **duplicate drug therapy edit.**

Note: *An active prescription is a prescription in which the days supply has not expired.*

- Maximum Number of Doses Allowed

- Based upon the diagnosis code submitted, a maximum of five (5) does of Synagis® will be reimbursed each RSV season.
- If a diagnosis code of 765.27 (33-34 completed weeks of gestation) is billed, the maximum of three (3) doses will be reimbursed each RSV season.
- Claims billed for Synagis® outside the allowable number of doses will deny for exceeding the maximum duration of therapy.
- Claims billed for greater than the number of allowable doses will require **a hardcopy prescription with justification handwritten by the prescriber.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.
- Medical records may be requested by the pharmacy compliance audit program for verification purposes of pharmacy claims billed for Synagis® outside the five (5) month RSV season.

-ICD-9-CM Diagnosis Code Requirement
Synagis® claims submitted without an appropriate diagnosis code or without any diagnosis code will deny.

Documentation Required
- After consultation with the prescribing practitioner and receipt of a handwritten justification for use of Synagis® outside the RSV season, the pharmacist may override the

maximum duration of therapy edit. This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.

- Pharmacy claims will require **a hardcopy prescription justification for Synagis® use handwritten by the prescriber in order to override the age restriction edit.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.

- After consultation with the prescribing practitioner and receipt of a **handwritten justification from the prescriber** for use of Synagis® in excess of the **allowable number of doses**, the pharmacist may override the **maximum duration of therapy edit.**

- **Written, electronic, or verbal approval** from the prescribing practitioner must be obtained to override the **early refill edit**, and the pharmacist must document with the appropriate codes.

- **Written, electronic, or verbal approval** from the prescribing practitioner must be obtained to override the **duplicate drug therapy edit**, and the pharmacist must document with the appropriate codes.

- An appropriate **ICD-9-CM** diagnosis code must be documented on the hardcopy prescription after **written, electronic, or verbal consultation** with the prescribing practitioner.

In the event that the prescribing provider cannot be contacted, the pharmacist may override the missing or invalid diagnosis code edit. The pharmacist must document **"Emergency Prescription"** on the hardcopy prescription and submit the override.

Note: Refer to Refer to Chapter 37, *Pharmacy Benefits Management Services*, of the Louisiana Medicaid Program Provider Manual, Section 37.5.8 Prospective Drug Utilization Policies/Limits/ Edits for detailed policy.

Accepted Values – ICD-9-CM Code(s) & Description(s)
415.0 = Acute cor pulmonale
416.0 = Primary pulmonary hypertension
416.8 = Pulmonary hypertension, secondary
745.0 = Truncus arteriosus
745.10-745.11 = Transposition of the great vessels
745.19 = Other transposition of the great vessels
745.2 = Tetralogy of Fallot
746.1 = Tricuspid atresia and stenosis, congenital
746.2 = Ebstein's anomaly
747.41 = Total anomalous pulmonary venous return
747.83 = Persistent pulmonary hypertension, primary pulmonary hypertension of the newborn (Persistent fetal circulation)
765.21 = Less than 24 completed weeks of gestation
765.22 = 24 completed weeks of gestation
765.23 = 25-26 completed weeks of gestation
765.24 = 27-28 completed weeks of gestation
765.25 = 29-30 completed weeks of gestation

765.26 = 31-32 completed weeks of gestation
765.27 = 33-34 completed weeks of gestation
770.7 = Chronic respiratory disease arising in prenatal period (CLD/PBD/interstitial pulmonary fibrosis of infancy/Wilson-Mikity syndrome)

- Other diagnoses may be used to justify Synagis® depending on recipient-specific factors.
- As an example, in infants/children
    - with congenital heart disease, immunoprophylaxis with Synagis® is based on the degree of physiologic cardiovascular compromise;
    - with neuromuscular conditions, the decision to provide immunoprophylaxis is based on the degree to which the condition compromises the handling of respiratory secretions.
- The following diagnosis codes could be used to justify immunoprophylaxis with Synagis®, and are subject to prescriber assessment and judgment.

042 = Human immunodeficiency virus (HIV) disease
045.00-045.13 = Infantile paralysis
277.00-277.09 = Cystic fibrosis
279.00-279.90 = Disorders involving the immune system
335.0 = Werdnig-Hoffman disease
335.10-335.11 = Spinal muscular atrophy
335.20-335.24 = Motor neuron disease
343.0-343.9 = Infantile cerebral palsy
358.0-358.9 = Myoneural disorders
359.0-359.9 = Muscular dystrophies and other myopathies
396.0-396.9 = Diseases of mitral and aortic valves
424.1 = Aortic stenosis
425.00-425.90 = Cardiomyopathy
428.0-428.9 = Heart failure
519.1 = Other diseases of the trachea and bronchus, not elsewhere classified (Must specify tracheomalacia or tracheal stenosis)0
745.4 = Ventricular septal defect
745.5 = Atrial septal defect
745.60-745.69 = Atrioventricular canal (endocardial cushion defect)
746.7 = Hypoplastic left heart
746.89 = Hypoplastic right heart
748.3 = Other anomalies of the larynx, trachea and bronchus (Must specify congenital tracheal stenosis, atresia of trachea, absence or agenesis of bronchus, trachea)
748.4 = Congenital cystic lung
748.5 = Agenesis, hypoplasia, and dysplasia of the lung
748.61 = Congenital bronchiectasis
750.15 = Macroglossia
750.9 = Uvula anomaly
759.89 = Congenital malformation syndromes affecting multiple systems, not elsewhere classified (Beckwith Wiedmann syndrome)

Required NCPDP Fields
424 – DO – Diagnosis Code
418 – DI (Level of Service) – Enter "03" for Emergencies
439-E4 Field (DUR Conflict) – Reason for Service Code – MX, PA, 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)
234 – P/F Age Restriction
445 – Duplicate Drug Therapy
447 – Compliance Monitoring/Early or Late Refill
575 – M/I Diagnosis Code
656 – Exceeds Maximum Duration of Therapy

4.3.25 Schedule II (C-II) Narcotic Agents

Policy
- An ICD-9-CM diagnosis code indicating the reason for use must be written on the hard copy prescription for **ALL Schedule II narcotic agents (including Schedule II narcotic agents not subject to a quantity limit)** by the prescribing practitioner or by the pharmacist after consulting with the prescriber.

- Quantity limits for Schedule II narcotic agents:
  are listed in Appendix E-1.
  are cumulative and are based on a 30 rolling days.
  apply to all strengths of an agent unless otherwise specified.

- EXCEPT for Fentanyl buccal and sublingual products, recipients in one of the following cancer related ICD-9-CM diagnosis code ranges and receiving agents listed in **Appendix E-1 for the management of cancer pain are not subject to a quantity limit:**

ICD-9-CM Diagnosis Code Range	Description
140 - 149.99	Malignant neoplasm of lip, oral cavity, and pharynx
150 - 159.99	Malignant neoplasm of digestive organs and peritoneum
160 - 165.99	Malignant neoplasm of respiratory and intrathoracic organs
170 - 176.99	Malignant neoplasm of bone, connective tissue, skin, and breast
179 - 189.99	Malignant neoplasm of genitourinary system
190 - 199.99	Malignant neoplasm of other and unspecified sites
200 - 208.99	Malignant neoplasm of lymphatic and hematopoietic tissue
209.9 – 209.39	Malignant carcinoid tumors

- Special Cases

- **Methadone**
  - All prescriptions for methadone must have a diagnosis code for payment.
  - There are no provisions for an override when a diagnosis code is omitted.
  - Methadone products, when used for the treatment of opioid addiction in detoxification or maintenance programs shall only be dispensed by opioid treatment programs certified by the Substance Abuse and Mental Health Services Administration.
- **Fentanyl**
  - Claims for fentanyl buccal and sublingual agents must contain a cancer related ICD-9-CM diagnosis in order for the claim to process for payment through the Point of Sale (POS) System.
  - The buccal and sublingual agents are subject to quantity limits (see Appendix E-1).

Documentation Required

- After consultation with the prescriber, the pharmacist must document on the hard copy prescription the prescriber's reason the quantity limit needs to be exceeded.

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

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

N/A – All Schedule II Narcotic Agents prescriptions require a diagnosis code for payment; see above for cancer related ICD-9-CM Codes exempt from quantity limits.

Required NCPDP Field(s)

424-DO – (Diagnosis Code)
418-DI Level of Services – **Enter "03" for Emergencies**
439-E4 Field (DUR Conflict) – Reason for Service Code – EX
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 - Missing/or Invalid Diagnosis Code
457 - Quantity and/or Days Supply exceed program maximum.

4.3.26 Serotonin Agonists (Triptans)

Policy
- Quantity limits for the Serotonin Agonists (Triptans):
  are listed in Appendix E-1.
  are cumulative and are based on a rolling thirty (30) days.
  apply to all strengths of an agent unless otherwise specified.

- If the prescribing practitioner chooses to exceed the quantity limit, the prescriber must provide the reason why the quantity limit needs to be exceeded.

Documentation Required
- After consultation with the prescriber, the pharmacist must document on the hardcopy prescription the prescriber's reason why the limit needed to be exceeded.

- The **reason for service code, professional service code** and **result of service code** used for submitting the claim 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 – EX
440-E5 Field (DUR Intervention) – Professional Service Code – M0
441-E6 Field (DUR Outcome) – Result of Service Code – 1G

Possible Denial EOB Code
457 - Quantity and/or Days Supply exceed program maximum.

4.3.27 Sildenafil (Revatio®) and Tadalafil (Adcirca®)

Policy
- Prescriptions for Sildenafil (Revatio®) and Tadalafil (Adcirca®) 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®) or Tadalafil (Adcirca®) on the recipient's drug history file. Conversely, prescriptions for Sildenafil (Revatio®) Tadalafil (Adcirca®) 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) or Tadalafil (Adcirca®).

- 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

4.3.28 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 Suspected Environmental Risk Treatment Claims

Medicaid providers' claims billing indicators are to be used to identify services provided to Louisiana Medicaid recipients when treated for an oil spill-related illness or injury. This information is necessary to track and evaluate health outcomes and costs related to the BP Oil Spill.

Pharmacy POS Transactions – Providers are asked to use the following indicator on applicable claims submitted for processing and payment.

Required NCPDP Field
439-E4 Field (DUR Conflict) – Reason for Service Code - **RE** - (Suspected Environmental Risk)

4.5 Medication Administration

Note: Refer to Chapter 37, *Pharmacy Benefits Management Services* of the Louisiana Medicaid Program Provider Manual, Section 37.14 Medication Administration by Pharmacists, for additional information.

4.5.1 Influenza Vaccine Administration by Pharmacists

Policy

- Louisiana Medicaid will reimburse enrolled **pharmacies** when this immunization is administered by a pharmacist who has the Authority to Administer authorized by the Louisiana Board of Pharmacy.

- The administering pharmacist's Louisiana Medicaid provider number or his/her NPI must be submitted in the claim.

- Effective January 1, 2011, Louisiana Medicaid reimburses enrolled pharmacies for the cost of the influenza vaccine as well as the administration of the vaccine (intramuscular or intranasal) for Medicaid recipients who are nineteen years of age and older when the administering pharmacist is an enrolled Medicaid provider.

- No reimbursement of the vaccine or supplies will be made for children under the age of nineteen years of age. Only the administration fee (intramuscular or intranasal) will be reimbursed for these recipients.

- Pharmacy Claims submission:
  - When a prescription for the vaccine is issued by a prescribing practitioner, that practitioner's NPI or Louisiana Medicaid provider number shall be entered into NCPDP field 411-DB (Prescriber ID). In this scenario, the vaccinating pharmacist's Louisiana

Medicaid provider number or NPI shall be entered into NCPDP field 444-E9 (Provider ID).

- When a prescription does not exist, the vaccinating pharmacist becomes the prescriber and shall enter his/her Louisiana Medicaid provider number or NPI in **both** NCPDP field 411-DB (Prescriber ID) and in NCPDP field 444-E9 (Provider ID).

- Claims for the administration fee will not be subject to the following program limits and edits:
  Four prescription limit
  Requiring billing of other insurance
  Lock-In

- Recipients may not be charged co-payments for the administration fee.

Documentation Required

- Once administered, pharmacists shall document these immunizations in the Louisiana Immunization Network for Kids Statewide (LINKS) registry found at www.dhh.la.gov.

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

Required NCPDP Field(s)

NCPDP Field Number	NCPDP Field Name	Value	Comment
407-D7	Product/Service ID	11 Digit NDC	Vaccine NDC
409-D9	Ingredient Cost Submitted	Usual and Customary Charge	Usual and Customary Charge of the Vaccine
411-DB	Prescriber ID	Prescriber/Pharmacist Medicaid Number or NPI	Enter the Prescriber's LA Medicaid Issued Number or NPI **OR** IN THE Absence of a Prescription, the Vaccinating Pharmacist's LA Medicaid Issued Number or NPI
438-E3	Incentive Amount Submitted	Usual Administration Fee	Usual Amount Charged for Vaccine Administration
473-7E	DUR/PPS Code Counter	1	Number of Occurrences
440-E5	Professional Service Code	MA	Medication Administered
444-E9	Provider ID	Pharmacist Medicaid Number or NPI	The Vaccinating Pharmacist's LA Medicaid Issued Number or NPI
465-EY	Provider ID Qualifier	05	NPI
		07	State Issued

Possible Denial EOB Code(s)
089-Missing/Invalid Incentive Amount
210-Provider not Certified for This Procedure
233-Procedure/NDC Not Covered for Service Date Given
431-Missing/Invalid Professional Service Code
444-Missing/Invalid Service Provider
509-Missing/Invalid Service Provider ID Qualifier

4.6 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 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.

4.7 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.

4.7.1 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

4.7.2 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 an 843EOB code is present with a Response Status of “D”, then this indicates it is a duplicate claim and Medicaid has already paid another claim with the same provider identifier, recipient identifier, date of service, NDC, refill number, and prescription number. Please reference Appendix C for an explanation of the EOB codes.

Message Area will contain the following for duplicate reject reasons:

PPPPPPPPPP RRRRRRRRRRRRR 999999

PPPPPPPPPP = Medicaid Provider ID or NPI; RRRRRRRRRRRR = recipient id; 99999999 = adjudicated date

Additional Message Area will contain the duplicate EOB code 843. This message indicates to the pharmacist that an identical 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.

4.7.3 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. Note: Duplicate claims are rejected when the billing provider identifier, recipient identifier, date of service, and NDC match; although the refill number and/or prescription number do not. EOB's for these claims include 530, 843, and 893:

The Message Area contains:

PPPPPPPPPP RRRRRRRRRRRR 999999

PPPPPPPPPP = Medicaid Provider ID or NPI; RRRRRRRRRRRR = recipient id; 99999999 = adjudicated date

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

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

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

215 - "Recipient Not on File"
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 Molina Medicaid Solutions Help Desk at **1-800-648-0790 or 1-225-216-6381**.

4.7.4 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 XXXXXXXXXXXXX
XXXXXXXXXXXXX = 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 RRRRRRRRRRRRR 999999 888 888 888 888

PPPPPPPPPP = Medicaid Provider ID or NPI; RRRRRRRRRRRRR = 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
		142	Billing Provider NPI Missing/Not On File
		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		
09	Missing or Invalid Birthdate	134	DOB Mismatch for CCN
		224	Invalid Birthdate on Recipient File

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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	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
16	Missing or Invalid Prescription/Service Reference Number	125	Prescription Number Missing
17	Missing or Invalid Fill Number	126	Missing or Invalid Refill Code, not numeric or > 5.
19	Missing or Invalid Days Supply	124	Days Supply Missing, Not Numeric, or Zero
*2C	Missing or Invalid Pregnancy Indicator		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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
*23	Missing or Invalid Ingredient Cost Submitted		
25	Missing or Invalid Prescriber Identification	121	A Prescribing Physician NPI or Medicaid ID Required
		129	Prescribing Provider NPI Missing/Not On File
		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
*29	Missing or Invalid Num. Refills Authorized		
*3A	Missing or Invalid Request Type		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*3N	Missing or Invalid Prior Authorized Number Assigned		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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	Invalid PAC Action Code/Call Help Desk
		239	Price missing on p/f/Call help desk Does Not Have Valid Price for DOS

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
		458	MAC/FUL Cost Zero/Call help desk
39	Missing or Invalid Diagnosis Code	020	Invalid or Missing Diagnosis Code
		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	Provider Not Eligible on Dates of Service
		202	Provider Cannot Submit This Claim Type
41	Submit Bill To Other Processor Or Primary Payer	275	Recipient is Medicare Eligible
		434	Bill Medicare Nebulizer Med
		449	Bill Medicare First Based on Discharge Date
		535	Bill Medicare Part D
		536	Bill Medicare Part B
		932	Please bill third party carrier first
		988	Item Covered by Medicare
*42-49	(Reserved for Future Use)		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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
		142	Billing Provider NPI Missing/Not On File
*51	Non-Matched Group ID		
52	Non-Matched Cardholder Identification	133	Invalid CCN
		215	Recipient Not on File
		223	Recycled Recipient Not on File
		294	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	Prescribing Physician NPI or Medicaid ID required
		129	Prescribing Provider NPI Missing/Not On File
		450	Prescribing Provider Not on File - Status = O
*58	Non-Matched Primary Prescriber		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*6C	Missing or Invalid Other Payer ID Qualifier		
*6E	Missing or Invalid Other Payer Reject Code		
60	Product/Service Not Covered For Patient Age Drug Not Covered for Patient Age	234	P/F Age Restriction
61	Product/Service Not Covered For Patient Gender Drug Not Covered for Patient Gender	235	P/F Sex restriction
62	Patient/Card Holder ID Name Mismatch	217	Name and/or Number on Claim Does Not Match File Record
63	Institutionalized Patient Product/Service ID Not Covered	385	Diabetic Supplies not Covered for LTC Recipient
*64	Claim Submitted Does Not Match Prior Authorization		
65	Patient is Not Covered	135	Patient not Covered for Pharmacy Service
		216	Recipient Not Eligible on Date of Service
		293	Recycled Recipient Ineligible on DOS
		295	Recipient Ineligible Recycled three Times
*66	Patient Age Exceeds Maximum Age		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*67	Filled Before Coverage Effective		
*68	Filled After Coverage Expired		
69	Filled After Coverage Terminated	364	Recipient Ineligible/Deceased
*7C	Missing or Invalid Other Payer ID		
*7E	Missing or Invalid DUR/PPS Code Counter		
70	Product/Service Not Covered	099	Item Covered Under Durable Medical Equipment Program Only
		149	DESI Ineffective – not payable
		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

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
		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
		487	Emergency Override of a Drug that Requires PA
76	Plan Limitations Exceeded	457	Quantity or days supply exceeds program maximum
77	Discontinued Product/Service ID Number	438	Manufacturer Notified Us That NDC is Obsolete
		460	NDC Probably Obsolete. Check Label/Computer
		462	CMS Notified Us that NDC is Terminated
		465	Invalid NDC – not on CMS File

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
78	Cost Exceeds Maximum	650	Payment Reduced to State Maximum
		660	Payment Reduced to LMAC Maximum
		918	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	Service Thru Date More than Two Years Old
		272	Claim Exceeds 1 Year Filing Limit
*82	Claim is Post Dated		
83	Duplicate Paid/Captured Claim	530	Recipient Was Reimbursed for This Service
		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

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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
		446	Pregnancy Precaution
		447	Compliance Monitoring/Early or Late Refill
		471	Drug to Drug Interaction
		482	Therapeutic Duplication Denial
		483	Pregnancy Precaution-Denial-FDA Category X

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
		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
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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
AG	Days Supply Limitation For Product/Service	436	Days Supply > 100 Exceeds Program Maximum
*AH	Unit Dose Packaging Only Payable For Nursing Home Recipients		
*AJ	Generic Drug Required		
*AK	Missing or Invalid Software Vendor/Certification ID		
*AM	Missing or Invalid Segment Identification		
*A9	Missing or Invalid Transaction Count		
*BE	Missing or Invalid Professional Service Fee Submitted		
B2	Missing or Invalid Service Provider ID Qualifier		
*CA	Missing or Invalid Patient First Name		
*CB	Missing or Invalid Patient Last Name		
CC	Missing or Invalid Cardholder First Name	023	Recipient Name Missing (first initial)
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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*CG	Missing or Invalid Employer Street Address		
*CH	Missing or Invalid Employer City Address		
*CI	Missing or Invalid Employer State/Province Address		
*CJ	Missing or Invalid Employer Zip Postal Zone		
*CK	Missing or Invalid Employer Phone Number		
*CL	Missing or Invalid Employer Contact Name		
*CM	Missing or Invalid Patient Street Address		
*CN	Missing or Invalid Patient City Address		
*CO	Missing or Invalid Patient State/Province Address		
*CP	Missing or Invalid Patient Zip/Postal Zone		
*CQ	Missing or Invalid Patient Phone Number		
*CR	Missing or Invalid Carrier ID		
*CW	Missing or Invalid Alternate ID		
*CX	Missing or Invalid Patient ID Qualifier		
*CY	Missing or Invalid Patient ID		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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	Billed Charges Missing or not Numeric
		276	High Variance Error
		277	Low Variance Error
*DR	Missing or Invalid Doctor's Last Name		
*DS	Missing or Invalid Postage Amount		
*DT	Missing or Invalid Unit Dose Indicator		
DU	Missing or Invalid Gross Amount Due	978	Calculated pricing is zero/ Call help desk
*DV	Missing or Invalid Other Payer Amount		
DX	Missing or Invalid Patient Paid Amount	662	Payment Reduced by COPAY
*DY	Missing or Invalid Date Of Injury		
DZ	Missing or Invalid Claim/Reference ID	021	Former Reference Number Missing or Invalid
*EA	Missing or Invalid Originally Prescribed Product/Service Code		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*EM	Missing or Invalid Prescription/Service Reference Number Qualifier		
*EN	Missing or Invalid Associated Prescription/Service Reference Number		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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	576	Missing or Invalid PA/MC Code for Rx Override
*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	509	Missing/Invalid Service Provider 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	089	Missing/Invalid Incentive Amount
*E4	Missing or Invalid Reason For Service Code		
E5	Missing or Invalid Professional Service Code	431	Missing/Invalid Professional Service Code

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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	210	Provider Not Certified for this Procedure
		244	Missing/Invalid Service Provider
		444	Missing/Invalid Service Provider
*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

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
		528	LaCHIP Affordable Submit Claim To Office Of Group Benefits
		388	Recipient Not Covered for Drugs
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 of Monthly Prescription Limit
		920	Greater than five refills per script not reimbursable
M5	Requires Manual Claim	242	110-MNP Required for Recip Liability Amount
		448	Transplant Discharge Date or other Dx needed

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
		466	Hard Copy Required-Fertility Preparation
		966	Submit Hardcopy of claim
*M6	Host Eligibility Error		
*M7	Host Drug File Error		
*M8	Host Provider File Error		
*ME	Missing or Invalid Coupon Number		
*MZ	Error Overflow		
*NE	Missing or Invalid Coupon Value Amount		
*NN	Transaction Rejected At Switch Or Intermediary		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*PK	Missing or Invalid Patient Segment		
*PM	Missing or Invalid Pharmacy Provider Segment		
*PN	Missing or Invalid Prescriber Segment		
*PP	Missing or Invalid Pricing Segment		
*PR	Missing or Invalid Prior Authorization Segment		
*PS	Missing or Invalid Transaction Header Segment		
*PT	Missing or Invalid Workers' Compensation Segment		
*PV	Non-Matched Associated Prescription/Service Date		
*PW	Non-Matched Employer ID		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions		
*P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions		
*P5	Coupon Expired		
*P6	Date Of Service Prior To Date Of Birth	211	Date of Service Less Than Date of Birth
*P7	Diagnosis Code Count Does Not Match Number Of Repetitions		
*P8	DUR/PPS Code Counter Out Of Sequence		
*P9	Field Is Non-Repeatable		
*RA	PA Reversal Out Of Order		
*RB	Multiple Partials Not Allowed		
*RC	Different Drug Entity Between Partial & Completion		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*RG	M/I Associated Prescription/service Reference Number On Completion Transaction		
*RH	M/I Associated Prescription/Service Date On Completion Transaction		
*RJ	Associated Partial Fill Transaction Not On File		
*RK	Partial Fill Transaction Not Supported		
*RM	Completion Transaction Not Permitted With Same 'Date Of Service' As Partial Transaction		
*RN	Plan Limits Exceeded On Intended Partial Fill Values		
*RP	Out Of Sequence 'P' Reversal On Partial Fill Transaction		
*RS	M/I Associated Prescription/Service Date On Partial Transaction		
*RT	M/I Associated Prescription/Service Reference Number On Partial Transaction		
*RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment		

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

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

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

EOB CODE	DESCRIPTION
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
089	Missing/Invalid Incentive Amount
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
129	Prescriber Provider NPI Missing/Not on File
133	Invalid CCN
134	DOB Mismatch for CCN
135	Patient Not Covered for Pharmacy Service
142	Billing Provider NPI Missing/Not On File
149	DESI Ineffective – Not Payable
200	Provider/Attending Provider Not on File
201	Provider Not Eligible on Dates of Service

EOB CODE	DESCRIPTION
202	Provider Cannot Submit This Claim Type
210	Provider Not Certified for This Procedure
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	Procedure/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
431	Missing/Invalid Professional Service Code
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
444	Missing/Invalid Service Provider
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 Terminated
463	Drug Does Not Need MAC Override
465	Invalid NDC Not Available
466	Hard Copy Required-Fertility Preparation
471	Drug to Drug Interaction
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
498	Number of prescriptions greater than limit
509	Missing/Invalid Service Provider ID Qualifier

EOB CODE	DESCRIPTION
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
528	LaCHIP Affordable Submit Claim To Office Of Group Benefits
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 for RX override
577	Override of Monthly Prescription 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 Molina Medicaid Solutions 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 response of 'D' (duplicate claim) is returned when Medicaid has previously paid a claim that matches on billing provider identifier, recipient identifier, date of service, NDC, refill number, and prescription number.

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). Note: Duplicate claims are rejected when the billing provider identifier, recipient identifier, date of service, and NDC match; although the refill number and/or prescription number do not.

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. Molina Medicaid Solutions 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.