UNISYS

PHARMACY PROVIDER TRAINING

Spring 2006

LOUISIANA MEDIACID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of pre-certification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

This training packet has been developed for presentation at the Spring 2006 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as recipient eligibility and ID cards, and third party liability. Such information is presented only in the Basic Medicaid Information Training packet. This packet may be obtained by attending the Basic Medicaid Information workshop; by requesting a copy from Unisys Provider Relations; or by downloading it from the Louisiana MEDICAID website, www.lamedicaid.com.

FOR YOUR INFORMATION!
SPECIAL MEDICAID BENEFITS
FOR CHILDREN AND YOUTH

THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES.
TO REQUEST THEM CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY IN YOUR AREA.
(See listing of numbers on attachment)

MR/DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Mentally Retarded/ Developmentally Disabled (MR/DD) Request for Services Registry (RFSR). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have mental retardation and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and Specialized Medical Equipment and Supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate Mentally Retarded/Developmentally Disabled (MR/DD) Waiver.

(If you are accessing services for someone 0-3 please contact EarlySteps at 1-866-327-5978.)

SUPPORT COORDINATION

A support coordinator works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services) then assists you in obtaining them. **If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.**

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED.
TO ACCESS THESE SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955
(or TTY 1-877-544-9544)

MENTAL HEALTH REHABILITATION SERVICES

Children and youth with mental illness may receive Mental Health Rehabilitation Services. These services include clinical and medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. All mental health rehabilitation services must be approved by mental health prior authorization unit.

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

Children and youth who require psychological and/or behavioral services may receive these services from a licensed psychologist. These services include necessary assessments and evaluations, individual therapy, and family therapy.

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.**

PERSONAL CARE SERVICES
Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. PCS services do not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS services must be ordered by a physician. The PCS service provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES
Children and youth may be eligible to receive Skilled Nursing Services in the home. These services are provided by a Home Health Agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY SERVICES, and PSYCHOLOGICAL EVALUATION AND TREATMENT
If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR SCHOOL OR EARLY INTERVENTION CENTER. *EARLYSTEPS* CAN BE CONTACTED (toll free) AT 1-866-327-5978. CALL KIDMED REFERRAL ASSISTANCE AT 1-877-455-9955 TO LOCATE OTHER THERAPY PROVIDERS.

MEDICAL EQUIPMENT AND SUPPLIES
Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve physical or mental conditions. Medical Equipment and Supplies must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

TRANSPORTATION
Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours in advance.

Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

IF YOU NEED A SERVICE THAT IS NOT LISTED ABOVE CALL THE REFERRAL ASSISTANCE COORDINATOR AT KIDMED (TOLL FREE) 1-877-455- 9955 (OR TTY 1-877-544-9544).
IF THEY CANNOT REFER YOU TO A PROVIDER OF THE SERVICE YOU NEED,
CALL 1-888-758-2220 FOR ASSISTANCE.

OTHER MEDICAID COVERED SERVICES

° Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
° Ambulatory Surgery Services
° Certified Family and Pediatric Nurse Practitioner Services
° Chiropractic Services
° Developmental and Behavioral Clinic Services
° Diagnostic Services-laboratory and X-ray
° Early Intervention Services
° Emergency Ambulance Services
° Family Planning Services
° Hospital Services-inpatient and outpatient
° Nursing Facility Services
° Nurse Midwifery Services
° Podiatry Services
° Prenatal Care Services
° Prescription and Pharmacy Services
° Health Services
° Sexually Transmitted Disease Screening

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION. This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

If you need a service that is not listed above call KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

If you do not RECEIVE the help YOU need ask for the referral assistance coordinator.

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY

METROPOLITAN HUMAN SERVICES DISTRICT
1010 Common Street, 5th Floor
New Orleans, LA 70112
Phone: (504) 599-0245
FAX: (504) 568-4660

CAPITAL AREA HUMAN SERVICES DISTRICT
4615 Government St. - Bin # 16 - 2nd Floor
Baton Rouge, LA 70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Free: 1-800-768-8824

REGION III
690 E. First Street
Thibodaux, LA 70301
Phone: (985) 449-5167
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

REGION IV
214 Jefferson Street - Suite 301
Lafayette, LA 70501
Phone: (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

REGION V
3501 Fifth Avenue, Suite C2
Lake Charles, LA 70607
Phone: (337) 475-8045
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

REGION VI
429 Murray Street - Suite B
Alexandria, LA 71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

REGION VII
3018 Old Minden Road
Suite 1211
Bossier City, LA 71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

REGION VIII
122 St. John St. - Room 343
Monroe, LA 71201
Phone: (318) 362-3396
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
21454 Koop Drive - Suite 2H
Mandeville, LA 70471
Phone: (985) 871-8300
FAX: (985) 871-8303
Toll Free: 1-800-866-0806

JEFFERSON PARISH HUMAN SERVICES AUTHORITY
3101 W. Napoleon Ave – S140
Metairie, LA 70001
Phone: (504) 838-5357
FAX: (504) 838-5400

TABLE OF CONTENTS

STANDARDS FOR PARTICIPATION

Provider participation in Medicaid of Louisiana is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. These standards are listed as follows:

- Provider agreement and enrollment with the Bureau of Health Services Financing (BHSF) of the Department of Health and Hospitals (DHH).

- Agreement to charge no more for services to eligible recipients than is charged on the average for similar services to others.

- Agreement to accept as payment in full the amounts established by the BHSF and refusal to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients; a recipient may be billed for services which have been determined as non-covered or exceeding a limitation set by the Medicaid Program. Patients are also responsible for all services rendered after eligibility has ended.

- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services.

- **NOTE: Records must be retained for a period of five (5) years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHH, or the state Attorney General's Medicaid Fraud Control Unit.**

- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the *1964 Civil Rights Act*, Section 504 of the *Rehabilitation Act of 1978*, and, where applicable, *Title VII of the 1964 Civil Rights Act*.

Picking and Choosing Services

On March 20, 1991, Medicaid of Louisiana adopted the following rule:

> ***Practitioners who participate as providers of medical services shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by the provider as a Medicaid patient.***

This rule prohibits Medicaid providers from "picking and choosing" the services for which they agree to accept a client's Medicaid payment as payment in full for services rendered. Providers must bill Medicaid for **all** Medicaid covered services that they provide to their clients.

Providers continue to have the option of picking and choosing from which patients they will accept Medicaid. Providers are not required to accept every Medicaid patient requiring treatment.

Statutorily Mandated Revisions to All Provider Agreements

The 1997 Regular Session of the Legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437.14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

- comply with all federal and state laws and regulations;
- provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- have all necessary and required licenses or certificates;
- maintain and retain all records for a period of five (5) years;
- allow for inspection of all records by governmental authorities;
- safeguard against disclosure of information in patient medical records;
- bill other insurers and third parties prior to billing Medicaid;
- report and refund any and all overpayments;
- accept payment in full for Medicaid recipients providing allowances for copayments authorized by Medicaid;
- agree to be subject to claims review;
- the buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
- notification prior to any change in ownership;
- inspection of facilities; and,
- posting of bond or letter of credit when required.

MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive. The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify Provider Enrollment immediately that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.

Surveillance Utilization Review

The Department of Health and Hospitals' Office of Program Integrity, in partnership with Unisys, perform the Surveillance Utilization Review function of the Louisiana Medicaid program. This function is intended to combat fraud and abuse within Louisiana Medicaid and is accomplished by a combination of computer runs, along with medical staff that review providers on a post payment basis. Providers are profiled according to billing activity and are selected for review using computer-generated reports. The Program Integrity Unit of DHH also reviews telephone and written complaints sent from various sources throughout the state, including the fraud hotline.

☞ Program Integrity and SURS would also like to remind all providers that they are bound by the conditions of their provider agreement which includes but is not limited to those things set out in Medical Assistance Program Integrity Law (MAPIL) R.S. 46:437.1 through 440.3, The Surveillance and Utilization Review Systems Regulation (SURS Rule) Louisiana Register Vol. 29, No. 4, April 20, 2003, and all other applicable federal and state laws and regulations, as well as Departmental and Medicaid policies. Failure to adhere to these could result in administrative, civil and/or criminal actions.

Providers should anticipate an audit during their association with the Louisiana Medicaid program. When audited, providers are to cooperate with the representatives of DHH, which includes Unisys, in accordance with their participation agreement signed upon enrollment. Failure to cooperate could result in administrative sanctions. The sanctions include, but are not limited to:

- Withholding of Medicaid payments
- Referral to the Attorney General's Office for investigation
- Termination of Provider Agreement

Program Integrity and the Unisys Surveillance Utilization Review area remind providers **that a service undocumented is considered a service not rendered**. Providers should ensure their documentation is accurate and complete. All undocumented services are subject to recoupment. Other services subject to recoupment are:

- Upcoding level of care
- Maximizing payments for services rendered
- Billing components of lab tests, rather than the appropriate lab panel
- Billing for medically unnecessary services
- Billing for services not rendered
- Consultations performed by the patient's primary care, treating, or attending physicians

Fraud and Abuse Hotline

The state has a hotline for reporting possible fraud and abuse in the Medicaid Program. Providers are encouraged to give this phone number/web address to any individual or provider who wants to report possible cases of fraud or abuse.

Anyone can report concerns at (800) 488-2917 or by using the web address at http://www.dhh.state.la.us/offices/fraudform.asp?id=92

MEDICARE PART D

Medicare Part D covered drugs include most prescription drugs, biological products, certain vaccines, insulin, and medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze). Some drugs will be excluded from Medicare Part D coverage as they are part of the Medicaid non-mandatory coverage provisions under sections 1927 (d)(2) and (d)(3) of the Social Security Act or they are covered by Medicare Part A or B. The one exception is smoking cessation products, such as nicotine patches and gum, which will be covered by Medicare Part D. Reimbursement of prescription claims are determined by each individual prescription drug plan. Medicare Part D will not cover those medications reimbursed by Medicare Part B. However, should Medicare Part B deny coverage because the drug does not meet the criteria for a Part B covered indication, the pharmacy provider should contact the Part D prescription plan.

Medicaid Coverage for Excluded Part D Drugs

To the extent that the Louisiana Medicaid Program covers the following Medicare excluded drugs for Medicaid recipients who are not full benefit dual eligibles, Medicaid will be required to cover the excluded drugs for full benefit dual eligibles:

- Benzodiazepines;
- Barbiturates;
- Agents when used for anorexia, weight loss, weight gain;
- Agents when used to promote fertility;
- Agents when used for cosmetic purposes or hair purposes;
- Agents when used for symptomatic relief cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride;
- Nonprescription drugs; and
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated test or monitoring services be purchased exclusively from the manufacturer or its designee.

All existing Louisiana Medicaid Pharmacy Program limits, co-payments and reimbursement policies apply to the Part D excluded prescriptions paid by Louisiana Medicaid. Louisiana Medicaid will not cover PDP or MA PD non-preferred drugs, as there is a Medicare appeal process to obtain these medications.

Co-payments

The Medicaid co-payment schedule will apply for prescriptions for those Part D excluded drugs that are covered by Medicaid.

NOTE: If a Lock-In recipient becomes eligible for Medicare Part D, DHH will remove the recipient from Lock-In restrictions. Providers should notify DHH of a Lock-In recipient's eligibility for Medicare Part D or questions concerning this Lock-In change should be directed to Unisys Point-Of-Sale (POS) at (800)-648-0790.

COORDINATION OF BENEFITS

Third Party Liability (TPL)

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.

Federal law mandates that Medicaid is the payor of last resort. With NCPDP 5.1, providers are able to coordinate benefits or "split-bill" pharmacy claims through the Medicaid Point of Sale system. Providers must bill recipients' primary insurance companies before billing Medicaid. Medicaid will reimburse providers for the recipient's responsibility of coinsurance, co-payments and/or deductibles with other insurance companies up to the maximum Medicaid allowed amount. This will be accomplished by Medicaid payment of the outstanding balance remaining after the payment by the primary payor has been deducted from the usual and customary charge. Again the payment will be up to the maximum Medicaid allowed amount. Medicaid co-payments should still be collected if applicable.

Pharmacy Providers' Roles

The provider should inquire of the recipient, if that recipient has private insurance coverage with prescription benefits. This information is entered in the patient's profile of the pharmacy's software. When a pharmacy claim is filled, it is submitted to the primary insurance company/companies. The other payor's paid amount should be submitted on the pharmacy claim to Medicaid.

Pharmacy claims billed to Medicaid first when drug coverage with another insurance company is noted on the recipient's resource file and with no indication that the applicable private insurance has been previously billed will deny.

Providers may log in www.lamedicaid.com to view the Medicaid Eligibility Verification System (MEVS). Providers may view the recipient's other insurance company and Medicaid carrier code number.

Valid insurance coverage may differ from what is on the recipient's resource file. Pharmacy providers may enter the correct coverage and coordinate benefits. Providers may contact the DHH MMIS Unit at 225-342-9498 with updated insurance coverage. Also, providers may instruct recipients to contact their local Medicaid offices to update their insurance coverage.

Note: Refer to Appendix D POS User Guide for claim submission details.

Coordination Of Benefits Exemptions

Certain conditions exist that are exempt from coordination of benefits and Medicaid is mandated to pay and chase claims. A pharmacy provider may override the coordination of benefits edit when:

- A Medicaid recipient has court ordered medical child support;
- Pharmacy claims are deemed preventative care for ages under twenty-one; and
- Pharmacy claims are deemed preventive care for pregnant women.

Documentation of court ordered medical child support or preventative care on the hard copy prescription by the pharmacist is required for the above circumstances.

Exemptions To Medicaid Program Restrictions

Certain restrictions will be by-passed. Claims that are coordinated with primary insurance companies will process without edits for:

- Prior Authorization for non-preferred drugs;
- Eight prescription monthly limit; and
- Orlistat excluding the age edit.

Claims For Recipients With Multiple Insurance Coverage

Some recipients have Medicare and one or more insurances.

Should a recipient have other private insurance in addition to Medicare, the pharmacy claim must be coordinated with Medicare and the private insurance company before submitting to Medicaid last. Medicare may be primary or secondary to a private insurance payor. To determine whether Medicare is primary or not, Medicare may be contacted at 1-800-999-1118.

Override Capabilities And Codes

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

Note: Refer to Appendix D, POS User Guide for detailed billing information.

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

The following are scenarios for usage of override codes:

- 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 exists - This claim not covered
  - Pharmacy submits claim to other payor. The other payor denies due to non-coverage of drug.

- 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 payor. The recipient must meet a deductible before benefits pay for pharmacy claims. The other payor 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 twenty-one 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 payor.

- 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 exists - Not in effect at time of service

CLAIM FORMS

NCPDP Universal Claim Form (UCF)

The NCPDP Universal Claim (UCF), also referred to as "DAH2PT," has replaced the current state assigned claim form. Effective October 1, 2003, when it is necessary to paper bill LA Medicaid for services, pharmacy providers must use this universal form regardless of date of service.

All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form. Claims submitted on the UCF claim form should be submitted to the following address for processing:

Unisys/LA Medicaid
P.O. Box 91019
Baton Rouge, LA 70821

When dispensing prescriptions for recipients with retroactive Medicaid eligibility, the pharmacist must file these claims hard copy for special handling. These claims should be sent to:

Bureau of Health Services Financing
MMIS Unit
P.O. Box 91030
Baton Rouge, LA 70821

A sample of the Universal Claim Form and the billing instructions follow. Please note that all fields are not numbered; however, all fields are denoted as "Required", "Not Required", or "Leave Blank" as appropriate. "Required" information must be entered to ensure processing of the claim. "Not required" information is optional, based on entry of a previous field. "Leave Blank" is a field unrelated to pharmacy claims.

NCPDP Universal Claim Forms may be purchased from:

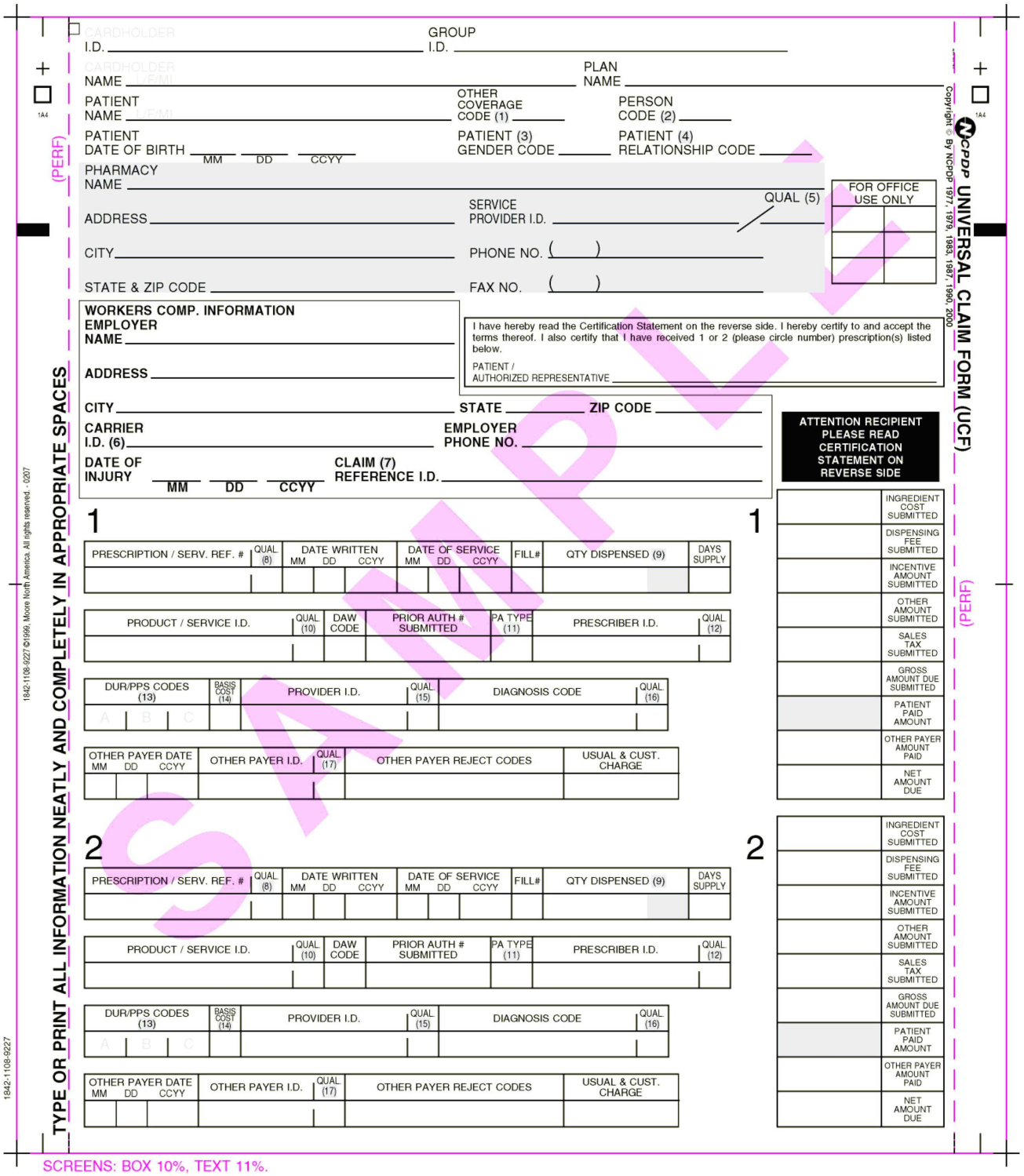
Moore North America, Inc.
Phone: 615-754-0445

OR

NCPDP website
www.ncpdp.org/standards_purchase.asp

Please contact the Unisys POS Help Desk at (800) 648-0790 or (225) 216-6381 with questions concerning claim form completion.

NCPDP Universal Claim Form (UCF) Sample (Page 1)



Instructions For Completing the NCPDP Universal Claim Form (UCF)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PHARMACY BENEFITS MANAGEMENT DEPARTMENT AT UNISYS.

N/A	ENTER THE RECIPIENT'S 13 DIGIT MEDICAID ID. (REQUIRED)
N/A	ENTER THE GROUP ID (NOT REQUIRED)
N/A	ENTER THE NAME (NOT REQUIRED)
N/A	ENTER THE PLAN NAME (NOT REQUIRED)
N/A	ENTER THE PATIENT NAME (REQUIRED)
FIELD NO. 1	COMPLETE 'OTHER COVERAGE CODE' USING THE VALUES NOTED BELOW. (NOT REQUIRED). 0 = NOT SPECIFIED 1 = NO OTHER COVERAGE IDENTIFIED 2 = OTHER COVERAGE EXISTS – PAYMENT COLLECTED 3 = OTHER COVERAGE EXISTS – THIS CLAIM NOT COVERED 4 = OTHER COVERAGE EXISTS – PAYMENT NOT COLLECTED 5 = MANAGED CARE PLAN DENIAL 6 = OTHER COVERAGE DENIED – NOT A PARTICIPATING PROVIDER 7 = OTHER COVERAGE EXISTS – NOT IN EFFECT AT TIME OF SERVICE 8 = CLAIM IS BILLING FOR A CO-PAY
FIELD NO. 2	ENTER THE CODE ASSIGNED TO A SPECIFIC PERSON WITHIN A FAMILY IN THIS FIELD. (NOT REQUIRED)
N/A	ENTER THE RECIPIENT'S DATE OF BIRTH (NOT REQUIRED)
FIELD NO. 3	COMPLETE 'PATIENT GENDER' USING THE VALUES NOTED BELOW. (NOT REQUIRED). 0 = NOT SPECIFIED 1 = MALE 2 = FEMALE
FIELD NO. 4	THIS FIELD MUST BE COMPLETED USING A VALUE OF '1', IDENTIFYING A CARDHOLDER. (REQUIRED)
N/A	ENTER THE ADDRESS OF THE PHARMACY (NOT REQUIRED)
N/A	ENTER THE 7 DIGIT MEDICAID PROVIDER ID. (REQUIRED)
FIELD NO. 5	THIS FIELD MUST BE COMPLETED USING A VALUE OF '05' IDENTIFYING MEDICAID. (REQUIRED)
N/A	ENTER THE CITY NAME FOR THE ADDRESS OF THE PHARMACY (NOT REQUIRED)
N/A	ENTER THE PHONE NUMBER FOR THE PHARMACY IN (999)999-9999 FORMAT)
N/A	ENTER STATE CODE & ZIP CODE OF ADDRESS OF PHARMACY. (NOT REQUIRED)
N/A	ENTER THE FAX NUMBER (NOT REQUIRED)
N/A	ENTER THE EMPLOYER NAME (NOT REQUIRED)
N/A	ENTER THE EMPLOYER ADDRESS (NOT REQUIRED)
N/A	ENTER THE EMPLOYER CITY (NOT REQUIRED)
N/A	ENTER THE EMPLOYER STATE (NOT REQUIRED)
N/A	ENTER THE EMPLOYER ZIP CODE (NOT REQUIRED)
FIELD NO. 6	LEAVE THIS FIELD BLANK
N/A	ENTER THE EMPLOYER PHONE NUMBER (NOT REQUIRED)

N/A	ENTER THE WORKER'S COMP. DATE OF INJURY (NOT REQUIRED)
FIELD NO. 7	LEAVE THIS FIELD BLANK
N/A	ENTERTHE PRESCRIPTION NUMBER. (REQUIRED)
FIELD NO. 8	THIS FIELD MUST BE COMPLETED USING A VALUE OF '1' IDENTIFYING AN RX BILLING (REQUIRED)
N/A	ENTER THE DATE THE PRESCRIPTION WAS WRITTEN BY THE PRESCRIBER IN MMDDCCYY FORMAT. (REQUIRED)
N/A	ENTER THE DATE THE PRESCRIPTION WAS FILLED IN MMDDCCYY FORMAT (REQUIRED)
N/A	ENTER '0' IF A NEW PRESCRIPTION, '1' FOR THE FIRST REFILL, '2' FOR THE SECOND REFILL, ETC. (REQUIRED)
FIELD NO. 9	ENTER THE QUANTITY DISPENSED EXPRESSED IN METRIC DECIMAL UNITS (SHADED AREAS FOR DECIMAL VALUES) IN THIS FIELD (REQUIRED)
N/A	ENTER THE DAYS SUPPLY (REQUIRED)
N/A	ENTER THE NDC FOR THE DRUG FILLED (REQUIRED)
FIELD NO. 10	COMPLETE THIS FIELD USING A VALUE OF '03', IDENTIFYING NATIONAL DRUG CODE (NDC) (REQUIRED)
N/A	ENTER VALID DISPENSE AS WRITTEN (DAW) CODES (NOT REQUIRED)
N/A	ENTER THE PRIOR AUTHORIZATION # SUBMITTED (NOT REQUIRED)
FIELD NO. 11	IF REQUIRED, PRIOR AUTHORIZATION TYPE CODE MUST BE COMPLETED USING THE FOLLOWING VALUES NOTED BELOW: (NOT REQUIRED) 0 = NOT SPECIFIED 1 = PRIOR AUTHORIZATION 2 = MEDICAL CERTIFICATION 3 = EPSDT (EARLY PERIODIC SCREENING DIAGNOSIS TREATMENT) 4 = EXEMPTION FROM CO-PAY 5 = INDICATES EXEMPTION FROM SERVICE LIMITS * 6 = INDICATES FAMILY PLANNING DRUGS * 7 = AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) 8 = INDICATES CO-PAY EXEMPTION DUE TO PREGNANCY *
N/A	ENTER THE 5 DIGIT PRESCRIBER PROVIDER NUMBER. (REQUIRED)
FIELD NO. 12	THIS FIELD MUST BE COMPLETED USING A VALUE OF '05' INDICATING MEDICAID (REQUIRED)
FIELD NO. 13	WHEN COMPLETING THIS FIELD, USE THE VALUES BELOW FOR REASON FOR SERVICE (Formerly DUR Conflict Code), 'PROFESSIONAL SERVICE' (Formerly DUR Intervention Code) AND 'RESULT OF SERVICE' (Formerly DUR Outcome Code). FOR SPECIFIC VALUES REFER TO CURRENT NCPDP DATA DICTIONARY (NOT REQUIRED) Block 1 = REASON FOR SERVICE Block 2 = PROFESSIONAL SERVICE CODE Block 3 = RESULT OF SERVICE Examples: Block 1 – ER (Early Refill) Block 2 – M0 (Prescriber Consulted) Block 3 – 1G (Filled, with prescriber approval)

FIELD NO. 14 COMPLETE THE BASIS OF COST DETERMINATION FIELD USING THE FOLLOWING VALUES: (NOT REQUIRED)
BLANK = NOT SPECIFIED
00 = NOT SPECIFIED
01 = AVERAGE WHOLESALE PRICE (AWP)
02 = LOCAL WHOLESALER
03 = DIRECT
04 = ESTIMATED ACQUISITION COST (EAC)
05 = ACQUISITION
06 = MAXIMUM ALLOWABLE COST (MAC)
07 = USUAL & CUSTOMARY
09 = OTHER

N/A ENTER THE PROVIDER ID (NOT REQUIRED)

FIELD NO. 15 THIS FIELD MUST BE COMPLETED USING '99', 'OTHER', IDENTIFYING A MEDICAID ID (NOT REQUIRED)

N/A ENTER THE ICD9 DIAGNOSIS CODE, IF RELEVANT. SEE THE POINT OF SALE USERS' MANUAL FOR SPECIFIC SITUATIONS WHERE THE DIAGNOSIS CODE IS APPLICABLE. (NOT REQUIRED – USE IF APPLICABLE)

FIELD NO. 16 IF USED, THIS FIELD MUST BE COMPLETED USING A VALUE OF '01', IDENTIFYING AN INTERNATIONAL CLASSIFICATION OF DISEASES (ICD9) CODE (NOT REQUIRED)

N/A ENTER DATE OTHER PAYER MADE PAYMENT ON THE PHARMACY SERVICE (REQUIRED – USE IF APPLICABLE)

N/A ENTER THE LOUISIANA MEDICAID CARRIER CODE (REQUIRED – USE IF APPLICABLE)

FIELD NO. 17 IF CARRIER CODE IS ENTERED, THIS FIELD MUST BE COMPLETED USING A VALUE OF '99', IDENTIFYING 'OTHER' FOR A MEDICAID CARRIER ID. (NOT REQUIRED)

N/A ENTER THE PRIMARY NCPDP REJECT CODE ASSOCIATED WITH THE OTHER PAYER DENIAL OF THE CLAIM FOR PAYMENT (REQUIRED – USE IF APPLICABLE)

N/A ENTER THE BILLED CHARGES FOR THE CLAIM (USUAL AND CUSTOMARY CHARGE) (REQUIRED)

N/A ENTER THE INGRIDEIENT COST SUBMITTED (NOT REQUIRED)

N/A ENTER THE STANDARD MEDICAID PAYABLE DISPENSING FEE AS SUBMITTED (NOT REQUIRED; STANDARD MEDICAID PAYABLE DISPENSING FEE WILL BE USED TO CALCULATE PAYMENT)

N/A ENTER THE INCENTIVE AMOUNT SUBMITTED (NOT REQUIRED)

N/A ENTER THE OTHER AMOUNT SUBMITTED (NOT REQURIED)

N/A ENTER THE SALES TAX SUBMITTED (NOT REQUIRED)

N/A ENTER THE GROSS AMOUNT DUE (NOT REQUIRED)

N/A ENTER THE AMOUNT OF CO-PAYMENT COLLECTED FROM THE RECIPIENT (NOT REQUIRED)

N/A ENTER THE AMOUNT PAID BY THE OTHER PAYER (REQUIRED – USE IF APPLICABLE)

N/A ENTER THE NET AMOUNT DUE (NOT REQUIRED)

IF YOU HAVE ANY QUESTIONS CONCERNING THE PROCESS TO COMPLETE THE NCPDP UNIVERSAL CLAIM FORM (UCF), PLEASE CONTACT PHARMACY BENEFITS MANAGEMENT AT 1-800-648-0790 OR 225-237-3381.

* Indicates specific values for LMMIS use.

DRUG ADJUSTMENT FORM (UNISYS 211)

The 211 Adjustment/Void Form is provided to bill LA Medicaid paper pharmacy adjustments, voids, and now, DUR overrides, to previously submitted pharmacy claims
This form was modified as a result of the LMMIS HIPAA implementation.

Effective October 1, 2003, when it is necessary to adjust or void a claim, pharmacy providers must use this revised form, regardless of date of service. A blank copy of this form is provided on page 15 for your use.

The highlighted fields on the following sample form designate fields that have been added or changed on the Drug Adjustment form.

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

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

(1) ADJ | VOID | OVR

(2) RECIPIENT IDENTIFICATION NUMBER

(3) QUANTITY

(4) Rx PRICE

(5) PRESCRIBING PROVIDER

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

(7) = # DAYS SPLY

(8) Rx No.

(9) PROVIDER NAME

(10) Level of Serv.

(11) Patient Location

(12) PROVIDER NO.

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

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

NATIONAL DRUG CODE

(15) DIAGNOSIS CODE

(16) ELIG CLAR

(17) MANUFACTURER NO.

(18) PRODUCT NO.

(19) PKG NO

(20) MAC OVERRIDE

DUR

(24) REASON FOR SERVICE (DUR CONFLICT)

(25) PROFESSIONAL SERVICE CODE (DUR INTERVENTION)

(26) RESULT OF SERVICE (DUR OUTCOME)

TPL

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

TPL CARRIER CODE **(22)**

1. _____
2. _____
3. _____

PATIENT NAME **(23)**

Last Name (first five characters)

First Name (first character)

(27) CONTROL NUMBER

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

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

(29) REASONS FOR ADJUSTMENT

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

(30) REASONS FOR VOID

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

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

(31) _____ SIGNATURE OF VENDOR OR AUTHORIZED REPRESENTATIVE

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

FISCAL AGENT COPY UNISYS – 211 7/03

Instructions For Completing the Drug Adjustment Form (Unisys 211)

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

Field No.	Field Name	Entry	Description
1	**ADJUSTMENT/VOID/OVR**	Required	ADJUSTMENT/VOID/OVR: Check the appropriate box for Adjustment, Void, or DUR Override.
2	**RECIPIENT IDENTIFICATION NUMBER**	Required	ADJUSTMENT/VOID: Enter recipient's 13-digit Medicaid ID number exactly as it appeared on the original claim form.
3	**QUANTITY**	Required	ADJUSTMENT: Enter the correct information or exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
4	**Rx PRICE**	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
5	**PRESCRIBING PROVIDER**	Required	ADJUSTMENT/VOID: Enter the 5-digit Medicaid Provider ID for the prescribing practitioner.
6	**Rx DATE**	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected in MM/DD/YYYY format. VOID: Enter the information exactly as it appeared on the original claim form.
7	**=# DAYS SPLY**	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
8	**Rx NO.**	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.

Field No.	Field Name	Entry	Description
9	**PROVIDER NAME**	Not Required	ADJUSTMENT/VOID: Enter the name exactly as it appeared on the original claim form.
10	**LEVEL OF SERV**	Required, If Applicable	ADJUSTMENT/VOID: Enter NCPDP value of“03” if the service was provided on an emergency basis and no co-pay was collected.
11	**PATIENT LOCATION**	Not Required	ADJUSTMENT/VOID: Enter NCPDP Patient Location Code value of “04” if the service was for an LTC recipient and no co-pay was collected.
12	**PROVIDER NO.**	Required	ADJUSTMENT/VOID: Enter the provider number exactly as it appeared on the original claim form.
13	**DATE Rx FILLED**	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected in MM/DD/YYYY format. VOID: Enter the information exactly as it appeared on the original claim form.
14	**REFILL CODE**	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form. Note: Where “0” = New Rx, “1,2, 3, 4, 5” = Refill of prescription
15	**DIAGNOSIS CODE**	Required, if applicable	ADJUSTMENT/VOID: Enter valid ICD9-CM Diagnosis Code if applicable.
16	**ELIG CLAR**	Not Required	ADJUSTMENT/VOID: Enter NCPDP value if applicable.
17	**MANUFACTURER NO**	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
18	**PRODUCT NO.**	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.

Field No.	Field Name	Entry	Description
19	**PKG**	Required	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
20	**MAC OVERRIDE**	Required, If Applicable	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
21	**DRUG COVERAGE OTHER THAN TITLE XIX (TPL BOX)**	Required (Use if applicable)	ADJUSTMENT: Enter the correct information or enter the information exactly as it appeared on the original claim form if the information does not need to be corrected. VOID: Enter the information exactly as it appeared on the original claim form.
22	**TPL CARRIER CODE (TPL BOX)**	Required (Use if applicable)	ADJUSTMENT/VOID: Enter valid Louisiana Carrier Code if applicable.
23	**PATIENT NAME**	Required	ADJUSTMENT/VOID: Enter the name exactly as it appeared on the original claim form.
THIS BLOCK IS FOR PROVIDERS TO USE FOR DUR OVERRIDES			
24	**REASON FOR SERVICE**	Not Required	(DUR CONFLICT) OVERRIDE: Enter the Reason for Service Code associated with the Error to be overridden. (Example: ER for Early Refill).
25	**PROFESSIONAL SERVICE CODE**	Not Required	(DUR INTERVENTION) OVERRIDE: Enter the Professional Service Code that describes the intervention activity performed by the pharmacist. (Example: MO for Prescriber Consulted.
26	**RESULT OF SERVICE**	Not Required	(DUR OUTCOME) OVERRIDE: Enter the Result of Service Code describing the disposition of the prescription. (Example: 1G for Filled with Prescriber Approval).
BOTTOM OF FORM			
27	**CONTROL NUMBER**	Required	Enter the 13-digit correct internal control number (ICN) exactly as it appears on your Remittance Advice).
28	**DATE OF REMITTANCE ADVICE ON WHICH LISTED CLAIM WAS PAID**	Required	Enter the exact date of the Remittance Advice using (8) digits, i.e., MM/DD/YYYY format.

Field No.	Field Name	Entry	Description
29	**REASONS FOR ADJUSTMENT**	Required, if applicable	Place an “X” in the appropriate box and describe the reason for the adjustment, where the values are: ‘01’ = Third Party Liability Recovery ‘02’ = Provider Corrections ‘03’ = Fiscal Agent Error ‘90’ = State Office Use Only – Recovery ‘99’ = Other – please explain.
30	**REASONS FOR VOID**	Required if applicable	Place an “X” in the appropriate box describing the reason for the void, where the values are: ’10’ = Claim Paid for Wrong Recipient ‘11’ = Claim Paid to Wrong Provider ‘99’ = Other – please explain
31	**SIGNATURE OF PROVIDER OR AUTHORIZED REPRESENTATIVE**	Required	ADJUSTMENT/VOID: Enter the complete and legal signature of provider or his/her authorized representative.
32	**DATE**	Required	ADJUSTMENT/VOID: Enter the date this form was completed using 8 digits. i.e., MM/DD/YYYY format.

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

IMPORTANT UNISYS ADDRESSES

Please be aware that **different post office boxes** are used for the various Medicaid programs. If you are submitting an original "clean" hard copy claim for payment or adjustments/voids, please utilize the following post office boxes and zip codes.

Type of Claim	P.O. Box	Zip Code
Pharmacy	91019	70821
CMS-1500 Claims Case Management Chiropractic Durable Medical Equipment EPSDT Health Services FQHC Hemodialysis Professional Services Independent Lab Mental Health Rehabilitation PCS Professional Rural Health Clinic Substance Abuse and Mental Health Clinic Waiver	91020	70821
Inpatient & Outpatient Hospitals, Freestanding Psychiatric Hospitals, Hemodialysis Facility, Hospice, Long Term Care	91021	70821
Dental, Home Health, Rehabilitation, Transportation (Ambulance and Non-ambulance)	91022	70821
ALL Medicare Crossovers and All Medicare Adjustments and Voids	91023	70821
KIDMED	14849	70898

Unisys also has different post office boxes for various departments. They are as follows:

Department	P.O. Box	Zip Code
EMC, Unisys business & Miscellaneous Correspondence	91025	70898
Prior Authorization	14919	70898
Provider Enrollment	80159	70898
Provider Relations	91024	70821

TIMELY FILING GUIDELINES

In order to be reimbursed for services rendered, all providers must comply with the following filing limits set by Medicaid of Louisiana:

- Straight Medicaid claims must be filed within 12 months of the date of service.
- KIDMED screening claims (KM-3 forms or 837P with K-3 segment) must be filed within 60 days from the date of service.
- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare fiscal intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulations.
- Claims which fail to cross over via tape and have to be filed hard copy MUST be adjudicated within six months from the date on the Medicare Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service.
- Claims with third-party payment must be filed to Medicaid within 12 months of the date of service.

Dates of Service Past Initial Filing Limit

Medicaid claims received after the initial timely filing limits cannot be processed unless the provider is able to furnish proof of timely filing. Such proof may include the following:

A Remittance Advice indicating that the claim was processed earlier (within the specified time frame).

OR

Correspondence from either the state or parish Office of Eligibility Determination concerning the claim and/or the eligibility of the recipient.

To ensure accurate processing when resubmitting the claim and documentation, providers must be certain that the claim is legible. Proof of timely filing documentation must reference the individual recipient and date of service.

At this time Louisiana Medicaid **does not** accept printouts of Medicaid electronic remittance advice screens as proof of timely filing. Documentation **must** reference the individual recipient and date of service. Postal "certified" receipts and receipts from other delivery carriers are not acceptable proof of timely filing.

Submitting Claims for Two-Year Override Consideration

Providers requesting two-year overrides for claims with dates of service over two years old must provide proof of timely filing and must assure that each claim meets at least one of the three criteria listed below:

- The recipient was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date retroactive eligibility was granted.
- The recipient won a Medicare or SSI appeal in which he or she was granted retroactive Medicaid Benefits.
- The failure of the claim to pay was the fault of the Louisiana Medicaid Program rather than the provider's each time the claim was adjudicated.

All provider requests for two-year overrides must be mailed directly to:

Unisys Provider Relations Correspondence Unit
P.O. Box 91024
Baton Rouge, La 70821

The provider must submit the claim with a cover letter describing the criteria that has been met for consideration along with all supporting documentation. Supporting documentation includes but is not limited to proof of timely filing and evidence of the criteria met for consideration.

Claims submitted without a cover letter, proof of timely filing, and/or supporting documentation will be returned to the provider without consideration. Any request submitted directly to DHH staff will be routed to Unisys Provider Relations.

PRIOR AUTHORIZATION AND PREFERRED DRUG LIST

The Medicaid program administers a prior authorization process for services in its Pharmacy Benefits Management System.

This process utilizes a preferred drug list (PDL) for selected therapeutic classes. Drugs included on the PDL are automatically prior authorized. Drugs in these classes that are not included on the PDL require prescribers to obtain prior authorization.

PDL Provider Notification

Providers are notified of the drugs selected for placement on the PDL by therapeutic classes prior to implementation of the prior authorization process and as additional drugs are subsequently added to the list.

Lists of covered drug products, including those that require prior authorization, will be provided by either the Louisiana Medicaid website or provider notices.

Prior Authorization Process General Information

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. In emergency situations, providers may dispense at least a seventy-two (72) hour or a three (3) day supply of medication.

Prior Authorization and PDL Information Site

Information is available on the Louisiana Medicaid Website at www.lamedicaid.com.

Who Can Obtain Prior Authorization

The prescribing practitioner is responsible for obtaining prior authorization. Pharmacist or recipient calls/requests will not be accepted. The prescribing practitioner must have and provide his/her valid individual Louisiana Medicaid prescribing provider number to obtain prior authorization. Only individual provider numbers will be accepted. The prescribing practitioner may obtain the PA by telephone, facsimile or mail.

Phone:	1-866-730-4357
Fax:	1-866-797-2329 – Do not send a cover sheet with the facsimile
Mail:	ULM School of Pharmacy 1401 Royal Avenue Monroe, LA 71201

The hours of operation for the ULM Prior Authorization Unit are 8am to 6pm Central Time, Monday through Saturday.

Note: If a prescribing practitioner does not have an individual prescriber number, refer to the Louisiana Medicaid Program Provider Manual, Pharmacy Benefits Management Services, Section 37.4, Prescribers, for detailed information.

Prior Authorization Request Form

A facsimile of Form RXPA is found as Appendix F. It can also be found at www.lamedicaid.com.

Emergency Procedures

Prescriptions indicating emergency situations shall be dispensed in a MINIMUM quantity of a three (3) day supply**. 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.

This process may be used when the Prior Authorization Unit is closed (Sundays; Monday – Saturday before 8am and after 6 pm) or when the PA system is unavailable. The pharmacist may also use professional judgment in situations that would necessitate an emergency supply.

The prescribing practitioner must indicate that the prescription is an emergency Rx on the face of the prescription if hard copy or if the prescription is called in to 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.

Note: Refer to Appendix D Point of Sale User Guide for detailed claim submission information.

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

DHH will monitor emergency prescriptions/recipients on an ongoing basis through management reports, pharmacy provider audits, and other monitoring programs to review the number of these prescriptions and the reasons for them.

Prescriptions Issued Prior to the Effective Dates of Prior Authorization

The prior authorization process does not impact original prescriptions (or refills) issued by a prescribing practitioner prior to a drug's effective date of prior authorization. Refills of prescriptions issued prior to an effective PA date will not be impacted as long as they are within the five refills and six-month program limits.

Grandfathering of Antipsychotic Medication

Act 177 of the 2005 Regular Session of the Louisiana Legislature authorizes the Department of Health and Hospitals to review atypical antipsychotic and hepatitis C drugs for placement on the Medicaid Preferred Drug List (PDL). These drugs were reviewed at the August 17, 2005, Pharmaceutical and Therapeutics Committee meeting and are included on the current PD #05-02. The legislation contains a "grandfathering" provision which provides for the following: *Medicaid recipients that have had a prescription filled for an atypical antipsychotic or hepatitis C drug from May 1 – October 31 (six months prior to the effective date of the drug class being placed on the PDL) will not need to obtain prior authorization for their drug if the drug that they are currently taking should be non-preferred.*

Recipient with Retroactive Eligibility

Drugs that are not on the preferred drug list are sometimes dispensed to patients who are awaiting Medicaid eligibility determinations. The Medicaid Pharmacy Program will reimburse pharmacy providers for these claims when the date of service falls within the recipients' retroactive time period. A Medicaid recipient's retroactive time period is defined as the time period between the first date of eligibility and the date that the recipient's eligibility is placed on the Medicaid recipient file. Pharmacy providers shall submit these claims electronically.

Important Facts

Should a recipient elect to self-pay for an original prescription which requires a PA, then attempts to have Medicaid pay for a refill of this prescription, this pharmacy claim will deny.

If an approved prior authorization exists in the system, the pharmacy claim will bypass the PA edit and continue with existing POS edits. If an approved prior authorization does not exist, the pharmacy claim will be denied through the POS system.

An approved prior authorization does not guarantee payment of the claim by Medicaid. It only indicates that the drug has been approved as a course of treatment within the Medicaid Program. All existing POS claim edits will continue to be applied.

The prior authorization process does not verify recipient Medicaid eligibility. It only verifies that the recipient is "on file" (i.e., has a valid Medicaid ID number on file – not that the recipient is eligible on the date of service). Recipient eligibility will continue to be verified by the Pharmacy POS subsystem or through the MEVS or REVS automated recipient eligibility systems.

Only practitioners' individual prescriber numbers are accepted to request prior authorization of a non-preferred drug. Any provider number other than an individual prescribing provider number WILL NOT be accepted to prior authorize non-preferred drugs.

Fax or Mail this form to:
LA Medicaid Rx PA Operations
ULM College of Pharmacy
1401 Royal Avenue
Monroe, LA 71201
Fax: 866-RX PA FAX
(866-797-2329)

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXPA01
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

*Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).*

Date of Request:*	Number of Fax Pages (including cover page):*
Practitioner Information	**Patient Information**
Name:*	Name (last, first):*
LA Medicaid Prescribing Provider Number:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth:*
Call-Back Phone Number (include area code):*	
Fax Number (include area code):	Projected Duration:*
Requested Drug Information	
Drug Name:*	Drug Strength:
Diagnosis Code (ICD-9-CM):	Diagnosis Description:*

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred product(s)? ☐YES ☐NO

2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐YES ☐NO
If YES, list the condition(s) in the box below:

3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐YES ☐NO
If YES, list the interaction(s) in the box below:

4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐YES ☐NO
If YES, list the side effects in the box below:

Practitioner Signature:* _____

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

MONTHLY PRESCRIPTION SERVICE LIMITATIONS

Limit

Medicaid reimburses up to eight (8) prescriptions per calendar month per recipient. Claims including those for emergency prescriptions and prior-authorization prescriptions that are in excess of eight per calendar month per recipient will deny.

Exceptions to Limit

The following federally mandated recipient groups are exempt from the eight prescriptions per calendar month limitations:

- Persons under twenty-one years of age;
- Persons who are residents of long-term care institutions, such as nursing homes and ICF/MR facilities; and
- Pregnant women.

Limit Override Procedures

The eight prescriptions per month limit can be exceeded when the prescriber determines an additional prescription is medically necessary and communicates the following information to the pharmacist 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 the eight prescription limit (an ICD-9-CM literal description is not acceptable).

The prescriber should use the Electronic Clinical Drug Inquiry found at www.lamedicaid.com in his/her clinical assessment of the patient's disease state or medical condition and the current drug regime before making a determination that more than eight prescriptions per calendar month is required by the recipient.

Printed statements without the prescribing practitioner's signature, check-off boxes or stamped signatures are not acceptable documentation.

An acceptable statement and ICD-9-CM are required for each prescription in excess of eight for that month.

Pharmacists and prescribers are required to maintain documentation to support the override of a prescription limitation.

Note: Refer to Appendix D of the Point of Sale User Guide for detailed billing instructions.

PRESCRIBER NUMBERS

Individual Prescribing Practitioner ID Numbers

Effective Drug Utilization Review and analysis by the Louisiana Medicaid Pharmacy Benefits Management (LMPBM) system requires the use of a valid five-digit (only) individual prescribing practitioner identification number. Audits and analyses by the LMPBM have identified continued use of group prescribing provider numbers and invalid prescribing provider numbers being billed on pharmacy claims.

In order to better identify the appropriate prescribing practitioners, DHH has implemented a series of edits to validate the individual prescriber noted on pharmacy claims. To achieve LMPBM's goal of only paying for prescriptions when a valid five digit **individual** prescriber number is entered on the claim, the Department will continue to implement edits in the system.

Edits will be implemented for the following reasons:

- **Prescribing Practitioner ID number billed is a group provider number. (Effective June 15, 2006)**
  Pharmacy claims will deny when the prescribing practitioner ID number is billed using a group provider number from a dentist, optometrist, podiatrist, TB clinic, family planning clinic, or long term care facility. Pharmacy claims from these practitioner types billed with an individual prescribing practitioner number will still be processed for payment.

- **Prescribing Practitioner ID number billed is a group provider number. (Effective July 15, 2006)**
  Pharmacy claims will deny when the prescribing practitioner ID number is billed using a group provider number from a group practice setting. This will include pharmacy billings when the group numbers from physicians' offices are used.

The following schedule includes the most current changes regarding prescriber billing on pharmacy claims.

Reason	NCPDP Reject Code	EOB Code	Effective Date
Prescribing Practitioner is Deceased	25	121	March 7, 2004
Invalid Provider Number	25	121	March 7, 2004
Prescribing Practitioner Has Had His License Suspended Or Revoked	71	514	April 15, 2004

NCPDP Reject Code 25 - "Missing or Invalid Prescriber Identification"
EOB Code 121 - "Missing or Invalid Prescriber Identification"
NCPDP Reject Code 71 - "Prescriber is not covered"
EOB Code 514 - "Prescribing provider does not have prescriptive authority"

You are asked to make every effort to assure that the prescribing practitioner number that you bill is accurate. You may find a listing of prescribing practitioner numbers on the website www.lamedicaid.com or call the POS Pharmacy Help Desk at 800-648-0790.

Most of the prescriber practitioners who deliver health care services in the state operated mental health clinics, developmental centers and public health clinics have been assigned individual prescriber ID numbers.

Collaborative Prescriber Criteria

Advanced Practice Registered Nurses (APRN)

The Louisiana State Board of Nursing defines APRN as nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists (CRNA). In 1997, APRNs were granted limited prescriptive authority by the Louisiana Legislature to prescribe assessment studies, drugs and therapeutic devices. APRNs are required to obtain prescriptive authority by petitioning the Louisiana State Board of Nursing.

The Louisiana State Board of Nursing states that an APRN with limited prescriptive authority may prescribe drugs as indicated by approved State Board of Nursing clinical practice guidelines and a collaborative practice agreement between a physician and the APRN.

APRNs with limited prescriptive authority shall comply with all applicable federal and state laws in prescribing, distributing and administering drugs. The Louisiana State Pharmacy Board requires that a prescription written by an APRN shall include the following:

- APRN name;
- Office address;
- Telephone number;
- RN designation;
- Specialty area of the APRN;
- Identification number assigned by the Louisiana State Board of Nursing;
- Collaborating physician's name and primary office address;
- Date the prescription is ordered; and
- Patient's name and if generic substitution is acceptable.

The LMPBM Program requires that each APRN with limited prescriptive authority obtain and maintain an individual provider/prescriber number. Pharmacists are required to use the individual APRN Medicaid provider/prescriber number when billing a pharmacy claim. Pharmacists are not permitted to use the APRN/collaborating physician provider/prescriber number when submitting pharmacy claims to Medicaid.

Prescriber Numbers

A listing of prescribing practitioner numbers is available on the website. This listing is updated on a monthly basis.

Listed below are the instructions for obtaining this information via the web.

- On the computer connected to the Web, launch the internet browser (Internet Explorer or Netscape Navigator).
- Type www.LAMEDICAID.com in the address bar or the browser.
- Once the web site has been loaded, look on the left side of the screen at the list of available links.
- Go to the link labeled Downloadable Forms/Files.
- Under Downloadable Forms/Files, select the RXPA PPN Link.
- This will start a download of the prescriber zip file (called PPN.zip) to the PC. Download this file to the PC.
- Open the file PPN.zip using WINZIP. (Free WINZIP, downloads are available on the internet at www.winzip.com.)
- Once opened, double click the PPN.PDF file.
- A prompt will appear on the screen requiring a password in order to un-zip the file. The password is KARNARDO2002. (Password is case sensitive.)
- The PPN.pdf file can be viewed with Adobe Acrobat. (A free download of Adobe Acrobat is available at www.adobe.com.)

Note: Refer to the Louisiana Medicaid Program Provider Manual, Pharmacy Benefits Management Services, Section 37.4.6, Accessing Prescriber Numbers, for more detailed information.

LOCK-IN EMERGENCY

Providers not named on the Lock-In segment accessed through MEVS or REVS can provide services; however, no payment will be made to these providers. The Bureau of Health Services Financing (BHSF) recognizes that there will be unusual circumstances when it is necessary for a pharmacy or physician provider to grant services for a Lock-In recipient when the provider is not named on the eligibility file on REVS or MEVS. Payment will be made to any physician or pharmacist **enrolled** in Louisiana Medicaid who grants services to a Lock-In recipient in emergency situations, or when life-sustaining medicines are required. Prescriptions written as a result of an emergency visit or as a discharge prescription following a hospital admission are applicable for payment if the correct emergency procedure is followed. These claims should be submitted electronically with an emergency override. The notation "Emergency Prescription" or "Discharge Prescription" should be written on the hardcopy prescription by either the prescribing physician or the dispensing pharmacist. Please ensure that the notation is included on the hard copy claim for audit purposes.

Note: Refer to Appendix D Point of Sale User Guide for detailed information regarding submission of these claims.

Effective January 1, 2006, Lock-In recipients who are both Medicaid and Medicare eligible were removed from Lock-In enrollment. These recipients will now receive most pharmacy services through Medicare Part D.

RETROSPECTIVE DRUG UTILIZATION REVIEW

The federal retrospective DUR requirements recognize the functions of Medicaid Management Information Systems (MMIS) and Surveillance and Utilization Review (SUR) subsystems which were in effect prior to OBRA 1990. The regulations, therefore, permit states to *limit retrospective DUR review activities to those that focus on appropriate and medically necessary care to avoid duplication of activities relating to fraud and abuse under the SUR program*.

LaDUR

The retrospective drug utilization review program in Louisiana is called LaDUR. The LMPBM System, through a contract with the fiscal intermediary, Unisys, administers LaDUR as a component of its Drug Utilization Review (DUR) system.

The LaDUR program includes four regional committees, each comprised of three pharmacist providers and one physician provider located throughout the state, who conduct monthly reviews of Medicaid patients' prescription profiles. (These reviews assess the possibility of underutilization, over-utilization, or contra-indications of prescription therapy by querying a recipient's disease history and drug utilization.) The committees correspond with patients' prescribers and pharmacists regarding their observations in an effort to identify prescription therapies and utilization patterns that correspond to specified therapeutic criteria.

LaDUR's Enhanced Focus

LaDUR has been enhanced in recent years by shifting its focus from a fundamental review of therapeutic drug criteria based on a patient's prescription utilization to the examination of a patient's disease states.

Extensive technical programming enhancements have allowed identification of prescription use or absence within a disease state. This shifts the program's focus from issues of over-utilization and drug duplication to a disease management focus. For example, clinical practice guidelines from the American Diabetes Association were reviewed by the DUR Board to develop standards for LaDUR. Standards developed include reviewing the drug regimens of patients with diabetes and concurrent hypertension for angiotensin-converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) utilization.

PROVIDER PEER BASED PROFILING

Provider Peer Based Profiling (PPBP) is one of the newest components of the LMPBM System's Drug Utilization Review System. In accordance with the Louisiana Legislature's mandate, the LMPBM System is required to develop peer-based prescribing and dispensing practice patterns for health care providers who participate in the Louisiana Medicaid Program and to develop and maintain a process to promote such practice patterns through the Drug Utilization Review Board.

PPBP Objectives

The objectives of this program are to:

- Identify, evaluate, and monitor existing levels of delivery of pharmaceutical care by prescribing providers;
- Improve the quality of recipients' pharmaceutical care; and
- Identify and help correct aberrant prescribing and dispensing patterns of pharmaceutical care services delivery patterns.

PPBP Functions

The program focuses on educational outreaches to the providers whose prescribing and/or dispensing practices are aberrant to his/her peers. By intervening with prescribers and pharmacists having questionable practices, the LMPBM System's educational components will motivate change.

The program provides database extract programs to:

- Identify peer-based appropriate/acceptable standards of prescribing and dispensing patterns by parish or region;
- Rank providers within these patterns;
- Develop provider specific educational interventions to address aberrant practicing patterns; and
- Develop reporting system for:
  - Audit trails
  - Intervention Tracking Reports
  - Special Projects Reports

PROSPECTIVE DRUG UTILIZATION REVIEW (UNI-DUR)

Prior to filling or refilling a prescription, the pharmacist must review the prescription and the patient record for therapeutic appropriateness.

If there is an indication of possible drug contraindications or abuse, the pharmacist must take appropriate action to resolve the issue(s).

UniDUR Features

UniDUR has the following features.

- UniDUR provides real-time screening of all Point of Sale (POS) prescription drug claims against the Louisiana Medicaid clinical database.
- UniDUR reports "clinical events" as defined by the Louisiana Medicaid Pharmacy Benefits Management (LMPBM) Section. The events are based on extensive development research done by the LMPBM System staff, contractors, Unisys and University of Louisiana at Monroe (ULM) School of Pharmacy; and the Drug Utilization Review (DUR) Board.
- UniDUR provides an on-line response to a pharmacy within seconds of significant UniDUR events with the disposition of the claim.

How UniDUR Works

The UniDUR system accepts POS transactions from the Medicaid claims adjudication system, and screens each prescription against a patient's prescription profile. The profile includes the patient's active drug products, medical diagnosis profile, gender and age.

Screening occurs using one or more of the clinical screening modules that are based upon the clinical criteria defined by the LMPBM System staff. The results of the screening are returned to the claims adjudication system in the form of clinical events. The system then completes the adjudication of the claim according to the program's established parameters and sends a response to the pharmacy.

Clinical Events

If a potential drug issue is identified, a clinical event is triggered, and the pharmacy will receive a UniDUR message. The LMPBM screens prescriptions for the following potential drug issues:

- Compliance Monitoring – refills too early or too late;
- Prescribing Limits – excessive or inadequate dosages, or duration of therapy;
- Therapeutic Duplication – two or more prescriptions with duplicative actions, whether prescribed by the same or different prescribers;
- Drug-Drug Interaction – drugs that should not be taken concurrently;

- Drug-Disease Precaution – specific drugs that may cause harm in patients with certain known medical conditions;
- Disease-Drug Precaution – diseases where specified drugs are suggested for use to deter disease progression or complications;
- Pregnancy Precaution – drugs with high risk of fetal harm dispensed to childbearing women.

Note: Refer to Section 37.5.7 Prospective Drug Utilization Policies/Limits/Edits of the Louisiana Medicaid Program Provider Manual for detailed policy information.

Medicaid Responses to a Clinical Event

Depending on the severity of the clinical event, Medicaid may:

- Suppress the response to the pharmacy, but report it in aggregate to Medicaid staff;
- Return the response to the pharmacy for informational purposes, not require any action, and pay the claim as submitted; or
- Return the response to the pharmacy and require the pharmacist to take appropriate action and report that action in the form of a claim override. Medicaid will deny payment if the pharmacist does not correctly override the claim.

Required Action

When a UniDUR response is received, the pharmacist must verify the information against the patient's drug profile and current prescription, evaluate the conflict, and decide whether or not to dispense the drug. Actions can range from conferring with the patient and checking the patient's profile to consulting with the prescriber.

If the message is "early refill" or "therapeutic duplication" the pharmacist must determine whether the prescription should be filled, refused, or changed.

If the pharmacist or recipient is unaware of any conflicting prescriptions, the pharmacist may call the Unisys Point of Sale Help Desk at 1-800-648-0790 for additional information on the UniDUR message.

Note: Refer to Appendix D Point of Sale User Guide and Section 37.5.7 for detailed information and instructions on the Prospective Drug Utilization Review (UniDUR) feature of the LMPBM System.

Antipsychotic Agents (Typical and Atypical) and Maximum Dosage

Medicaid's Drug Utilization Review Board joined the Department of Health and Hospitals Office of Mental Health to establish parameters for reviewing antipsychotic agents. To help ensure the safety and well being of Medicaid patients, and to avoid duplication of benefits, **effective August 10, 2005**, prescriptions for antipsychotic agents:

- **will require an appropriate ICD-9 diagnosis code on all new prescriptions. The accepted diagnosis codes fall in the range from 290.0 through 319.9. The numeric code must be documented on the hardcopy prescription by either the prescriber or the pharmacist. The ICD-9 code may be communicated to the pharmacist electronically or via telephone or facsimile;**

- **will deny when the recipient has two active antipsychotic prescriptions on their file. The prescription will be screened per recipient to search for two active prescriptions for antipsychotic agents. An active prescription is a prescription in which the days supply has not expired;**

- **that are classified as atypical antipsychotic agents, will be screened for doses exceeding the maximum recommended dose.**

(1) Pharmacy claims for **new** prescriptions for antipsychotic agents shall be submitted with an **ICD-9** diagnosis code in **NCPDP field 424-DO** (Diagnosis code). Claims submitted without an appropriate diagnosis code or without any diagnosis code or without any diagnosis code will deny with:

> **NCPDP rejection code 39** (Missing or invalid ICD-9 diagnosis codes) mapped to **EOB code 575** (Missing or invalid diagnosis code).

If the prescriber does not indicate a diagnosis code, and the pharmacist determines the patient cannot wait to receive the medication, the pharmacy provider may override the denial in

> **NCPDP field 418-DI** (Level of Service) by entering the numeral "3" (Emergency).

The pharmacy provider must **document** "EMERGENCY" on the hardcopy prescription. Also, the pharmacist must **document** on the hardcopy prescription the **reason** for the emergency.

(2) Incoming pharmacy claims for antipsychotic agents billed for recipient who have **two** (2) active prescriptions for antipsychotic agents on file will deny with:

> **NCPDP rejection code 88** (DUR Reject Error) mapped to **EOB code 482** (Therapeutic Duplication).

The pharmacist may override the denial upon 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 pharmacist must supply the codes listed below with the Point of Sale submission.

> **NCPDP field 439-E4** (Reason for Service Code) – **TD** (Therapeutic Duplication)
> **NCPDP field 440-E5** (Professional Service Code) – **M0** (Prescriber Consulted)
> **NCPDP field 441-E6** (Result of Service Code) – **1G** (Filled with Prescriber Approval)

Listed below are the current antipsychotic agents reviewed. As new antipsychotic agents become available, they will be included in the screening process.

Typical Antipsychotic Agents

CHLORPROMAZINE	THIOTHIXENE	HALOPERIDOL
PERPHENAZINE	FLUPHENAZINE	MESORIDAZINE
TRIFLUOPERAZINE	PROCHLORPERAZINE	THIORIDAZINE
LOXAPINE	PIMOZIDE	MOLINDONE

Atypical Antipsychotic Agents

Generic Name	Brand Name	Maximum Dose Per Day
ARIPIPRAZOLE	ABILIFY	30mg/day
CLOZAPINE	CLOZARIL	900mg/day
OLANZAPINE	ZYPREXA	40mg/day
QUETIAPINE	SEROQUEL	1200mg/day
RISPERIDONE	RISPERDAL	16mg/day
ZIPRASIDONE	GEODON	200mg/day

Pharmacy claims for doses for **atypical antipsychotic agents** (listed above) which exceed the maximum recommended does will deny with:

> **NCPDP rejection code 88** (DUR Reject Error) mapped to **EOB code 529** (Exceeds maximum daily dose).

The pharmacist may override the denial upon consultation with the prescriber. The pharmacist must **document** on the hardcopy prescription the **reason** the prescriber requires a dose above the maximum recommended dose. To override the denial, the pharmacist must supply the codes listed below with the Point of Sale submission.

> **NCPDP field 439-ER** (Reason for Service Code) – **HD** (High Dose)
> **NCPDP field 440-E5** (Professional Service Code) – **M0** (Prescriber Consulted)
> **NCPDP field 441-E6** (Result of Service Code) – **1G** (Filled with Prescriber Approval)

Anti-Anxiety Agents

Effective August 10, 2005, an incoming pharmacy claim for an anti-anxiety medication for a recipient who has an active prescription for an anti-anxiety agent on file will deny with:

> **NCPDP rejection code 88** (DUR Reject Error) mapped to **EOB code 482** (Therapeutic duplication).

The pharmacist may override the denial upon consultation with the prescriber. The pharmacist must **document** on the hardcopy prescription the **reason** an additional anti-anxiety agent was requested by the prescriber. The pharmacist must supply the codes listed below with the Point of Sale submission.

> **NCPDP field 439-E4** (Reason for Service Code) – **TD** (Therapeutic Duplication)
> **NCPDP field 440-E5** (Professional Service Code) – **M0** (Prescriber Consulted)
> **NCPDP field 441-E6** (Result of Service Code) – **1G** (Filled with Prescriber Approval)

Listed below are the current anti-anxiety agents reviewed. As new anti-anxiety agents become available, they will be included in the screening process:

ALPRAZOLAM	HALAZEPAM
BUSPIRONE	HYDROXYZINE
CHLORDIAZEPOXIDE	LORAZEPAM
CHLORAZEPATE	MEPROBAMATE
DIAZEPAM	OXAZEPAM

Effective **August 10, 2005**, an incoming prescription for an anti-anxiety agent began denying as a therapeutic duplication (EOB code 482) when there was/is an active prescription for an anti-anxiety agent on a recipient's 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 codes in:

NCPDP field 424-DO (Diagnosis Code)

The approved ICD-9-CM diagnosis codes for epilepsy are 345.0 through 345.99 and for convulsions are 780.30 through 780.99.

The pharmacist may override the denial **after consultation with the prescriber**. The prescriber must supply the ICD-9-CM diagnosis code. The pharmacist must **document (1) the reason for the override and (2) the ICDl-9-CM diagnosis code on the hardcopy prescription**. To override the denial, in **NCPDP field 424-DO field (Diagnosis Code)** enter the ICD-9-CM diagnosis code obtained from the prescriber.

Short-Acting Opiate Agents

Medicaid's Drug Utilization Review Board established parameters for reviewing short-acting opiates agents. To help ensure the safety and well being of Medicaid patients, and to avoid duplication of benefits, **effective December 1, 2005**, an incoming pharmacy claim for a short-acting opiate agent will deny when there is an active prescription for a short-acting opiate agent on a recipient's history file. The incoming claim will deny with:

NCPDP rejection code 88 (DUR Reject Error) mapped to **EOB code 482** (Therapeutic Duplication).

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

The pharmacist may override the denial **after consultation with the prescriber**. The pharmacist must **document on the hardcopy prescription (1) the reason** the prescriber required the patient to receive a second short-acting opiate agent, and **(2) the NCPDP DUR override codes.** The pharmacist must supply the codes listed below with the Point of Sale submission.

NCPDP field 439-ER (Reason for Service Code) – **TD** (Therapeutic Duplication)
NCPDP field 440-E5 (Professional Service Code) – **M0** (Prescriber Consulted)
NCPDP field 441-E6 (Result of Service Code) – **1G** (Filled with Prescriber Approval)

Listed below are the current short-acting opiate agents reviewed in the screening process. As new short-acting opiate agents are made available, they will be included in the screening process.

Butorphanol Tartrate	Fentanyl Citrate Buccal	Oxycodone/Acetaminophen
Codeine Phosphate	Hydrocodone/Acetaminophen	Oxycodone/Aspirin
Codeine Phosphate/Acetaminophen	Hydrocodone/Ibuprofen	Pentazocine/Acetaminophen
Codeine Sulfate	Hydromorphone HCl IR	Pentazocine/Naloxone
Codeine/ Acetaminophen/Caffeine/Butalbital	Levorphanol Tartrate	Propoxyphene HCl
Codeine/ Acetaminophen/Butalbital	Meperidine HCl	Propoxyphene Napsylate
Codeine/ Aspirin/Butalbital	Meperidine/Promethazine	Propoxyphene/Acetaminophen
Codeine/ /Carisoprodol/Aspirin	Methadone HCl	Propoxyphene/Aspirin/Caffeine
Dihydrocodeine/Acetaminophen/Caffeine	Morphine Sulfate IR	Tramadol HCl
Dihydrocodeine/Aspirin/Caffeine	Oxycodone HCl IR	Tramadol HCl/Acetaminophen
	Oxycodone/Ibuprofen	

Long-Acting Opiate Agents

Effective **December 1, 2005**, an incoming pharmacy claim for a long-acting opiate agent will **deny** when there is an **active** prescription for along-acting opiate agent on the recipient's file. The incoming claim will deny with:

> **NCPDP rejection code 88** (DUR Reject Error) mapped to **EOB code 482** (Therapeutic Duplication).

The pharmacist may override the denial **after consultation with the prescriber**. The pharmacist **must document on the hardcopy prescription (1) the reason** an additional long-acting opiate agent was requested by the prescriber, and **(2) the NCPDP DUR override codes.** The pharmacist must supply the codes listed below with the Point of Sale submission.

> **NCPDP field 439-ER** (Reason for Service Code) – **TD** (Therapeutic Duplication)
> **NCPDP field 440-E5** (Professional Service Code) – **M0** (Prescriber Consulted)
> **NCPDP field 441-E6** (Result of Service Code) – **1G** (Filled with Prescriber Approval)

Listed below are the current long-acting opiate agents reviewed in the screening process. As new long-acting opiate agents are made available, they will be included in the screening process.

Fentanyl Transdermal
Morphine Sulfate CR
Oxycodone HCL CR

Carisoprodol

Effective **December 1, 2005**, an incoming pharmacy claim for **carisoprodol** will **deny** when the **total daily dose is greater than 1400mg**. Combination products containing carisoprodol will deny when the total daily dose of carisoprodol is greater than 1600mg. The incoming claim will deny with:

> **NCPDP rejection code 76** (Quantity or days supply exceeds program maximum) mapped to **EOB code 457** (Quantity or days supply exceeds program maximum).

There are no provisions for an override exceeding program maximum of carisoprodol. Also, there are no provisions for an override of the early refill edit for carisoprodol prescriptions.

Ketorolac

Effective **December 1, 2005**, an incoming pharmacy claim for oral forms of **ketorolac** shall **deny** for a **quantity greater than twenty (20) or a days supply greater than five (5) days** as exceeding the program's maximum allowed quantity. The incoming claim will deny with:

> **NCPDP rejection code 76** (Quantity or days supply exceeds program maximum) mapped to **EOB code 457** (Quantity or days supply exceeds program maximum).

The pharmacist may override the denial **after consultation with the prescriber**. The prescriber must supply the ICD-9-CM diagnosis code and the rationale for using greater than a five days supply of ketorolac. The pharmacist must **document (1) the reason for the override and (2) the ICDI-9-CM diagnosis code on the hardcopy prescription**. To override the denial, in **NCPDP field 424-DO field (Diagnosis Code)** enter the ICD-9-CM diagnosis code obtained from the prescriber.

Olanzapine/Fluoxetine

Effective **December 1, 2005**, pharmacy claims for a olanzpine/fluoxetine (Symbyax) will deny as a therapeutic duplication when there are **two** active prescriptions for antipsychotic agents on a recipient's file or when there is **one** active prescription for a selective serotonin reuptake inhibitor (SSRI) on the recipient's history file.

The incoming claim for the antipsychotic/SSRI combination product will deny with:

> **NCPDP rejection code 88** (DUR Reject Error) mapped to **EOB code 482** (Therapeutic Duplication).

The pharmacist may override the denial **after consultation with the prescriber**. The pharmacist **must document on the hardcopy prescription (1) the reason** an additional antipsychotic agent or antidepressant agent was requested by the prescriber, and **(2) the NCPDP DUR override codes.** The pharmacist must supply the codes listed below with the Point of Sale submission.

> **NCPDP field 439-ER** (Reason for Service Code) – **TD** (Therapeutic Duplication)
> **NCPDP field 440-E5** (Professional Service Code) – **M0** (Prescriber Consulted)
> **NCPDP field 441-E6** (Result of Service Code) – **1G** (Filled with Prescriber Approval)

In addition, effective **December 1, 2005**, pharmacy claims for olanzapine/fluoxetine (Symbyax) will deny when the dose of olanzapine exceeds 18mg total per day and/or the total daily dose of fluoxetine exceeds 75 mg. These pharmacy claims will **deny** with:

> **NCPDP rejection code 88** (DUR Reject Error) mapped to **EOB code 529** (Exceeds maximum daily dose).

The pharmacist may override the denial after consultation with the prescriber. The pharmacist must document on the hardcopy prescription (1) the reason the prescriber requires a dose above the maximum recommended dose, and (2) the NCPDP DUR override codes. To override the denial, the pharmacist must supply the codes listed below with the Point of Sale submission.

NCPDP field 439-ER (Reason for Service Code) – **HD** (High Dose)
NCPDP field 440-E5 (Professional Service Code) – **M0** (Prescriber Consulted)
NCPDP field 441-E6 (Result of Service Code) – **1G** (Filled with Prescriber Approval)

Unnecessary Drug Therapy

The Food and Drug Administration issued a Public Health Advisory on December 23, 2004, summarizing the agency's recent recommendations concerning the use of non-steroidal anti-inflammatory drugs (NSAIDs), including those known as COX-2 selective agents. The December advisory was issued because of recently released data from controlled clinical trials showing that the COX-2 selective agents (Vioxx®, Celebrex ®, and Bextra®) may be associated with an increased risk of serious cardiovascular events, especially when they are used for long periods of time or very high-risk settings (e.g., immediately after heart surgery).

The FDA made the following interim recommendations:

- Physicians prescribing Celebrex® (celecoxib) or Bextra® (valdecoxib) should consider this emerging information when weighing the benfits against risks for individual patients. Patients who are at a high risk of gastrointestinal (GI) bleeding, having a history of intolerance to non-selective NSAIDs, or are not doing well on non-selective NSAIDs may be appropriate candidates for COX-2 selective agents.
- Individual patient risk for cardiovascular events and other risks commonly associated with NSAIDs should be taken into account for each prescribing situation.

The FDA is collecting and will be analyzing all available information from the most recent studies to determine whether additional regulatory action is needed. The most current information from the FDA regarding this therapeutic class is available at www.fda.gov. Please consider this evolving information when evaluating the risks and benefits of dispensing COX-2 inhibitors for your patients.

To help ensure the safety and well being of Medicaid patients, **effective March 15, 2005**, the prescribing practitioner **must include**:

- **The condition being treated with the COX-2 selective agent by indicating the ICD-9 diagnosis code of the treated condition (e.g., Osteoarthritis – 715.0) on all new prescriptions written for a COX-2 selective agent; and**
- **The reason a COX-2 selective agent is used rather than a non-selective NSAID (e.g., treatment failure or history of a GI bleed).**

The ICD-9 diagnosis code and the rationale for the choice of a COX-2 selective agent must be noted in the prescriber's handwriting. A rubber stamp notation is not acceptable. The ICD-9 diagnosis code and the rationale may be submitted as an attachment to the original prescription via facsimile.

Medicaid's Drug Utilization Review Board recommended a review of patients' Medicaid medication histories and ages to indicate patients' risk factors for gastrointestinal complications when non-selective NSAIDs are used. All prescriptions for COX-2 agents shall include a diagnosis and, when patients appear to be at greater risk for gastrointestinal complications from non-selective NSAIDs, Medicaid will process COX-2 selective agent claims without an override.

- Pharmacy claims for new prescriptions for COX-2 selective agents shall be submitted with an **ICD-9 treatment diagnosis code in NCPDP field 424-DO (diagnosis code)**.
- Claims submitted without a diagnosis code will deny **with NCPDP rejection code 39 (missing or invalid diagnosis code)** mapped to **EOB code 575 (missing or invalid diagnosis code).**

A prescription written for a COX-2 selective agent for a Medicaid patient will only process without an override when the following conditions **are met**:

- **An ICD-9 diagnosis code indicating the reason for treatment is documented and submitted**

and when one of the following conditions exists:

- **Patient has current prescription for H2 receptor antagonist or**
- **Patient has current prescription for proton pump inhibitor or**
- **Patient has current prescription for warfarin or**
- **Patient has current prescriptions indicating chronic use of oral steroids or**
- **Patient is sixty years old or greater.**

When a diagnosis code is submitted and one of the above conditions does not exist, the claim will deny with

NCPDP rejection code 88 (DUR Reject Error) mapped to **EOB code 531 (drug use not warranted – COX 2).**

If, in the professional judgment of the prescriber, a determination is made which necessitates therapy with a COX-2 selective agent, the pharmacist may override edit **531 (drug use not warranted – COX 2).** The pharmacy provider must supply the conflict code, intervention code and outcome codes, as listed below, the Point of Sale submission of the claim and have the information recorded on the hardcopy.

- **NCPDP 439-E4 (Reason for Servcie – Conflict Code)**
  - **NN – Unnecessary Drug**
- **NCPDP 440-E5 (Professional Service Code – Intervention Code)**
  - **M0 – Prescriber Consulted**
- **NCPDP 441-E6 (Result of Service – Outcome Code)**
  - **1G – Filled with Prescriber Approval**

The goal is to assure appropriate use of COX-2 selective agents and allow a pharmacy to process when gastrointestinal risks appear likely with use of a non-selective non-steroidal anti-inflammatory drug. A prescription for a COX-2 selective agent will deny, if the claim does not include an ICD-9 diagnosis code and one of the above stated criteria is met.

Procedures in the pharmacy audit program have been established to verify the providers' documentation and compliance associated with program policy. Therefore, pharmacists are reminded to document all interventions and outcomes on the prescription hardcopies for access during the pharmacy audit process as well as documenting those actions in the claim record.

Sildenafil (Revatio®)

Effective November 22, 2005, Louisiana Medicaid began reimbursing for Sildenafil citrate (Revatio®) when prescribed for Primary Pulmonary Hypertension. For proper reimbursement, an appropriate ICD-9-CM diagnosis code will be required on all prescriptions. The following diagnosis codes are acceptable:

ICD-9-CM Code	Description
416.0	Primary pulmonary hypertension
416.8	Other chronic pulmonary heart disease

One of the above numeric codes must be documented on the hardcopy prescription by either the prescriber or the pharmacist. The ICD-9-CM code may be communicated to the pharmacist electronically, via telephone or facsimile.

Pharmacy claims for prescriptions for Sildenafil citrate (Revatio®) shall be submitted with an ICD-9-CM diagnosis code in **NCPDP field 424-DO (Diagnosis code).** Claims submitted without an appropriate diagnosis code or without any diagnosis code will deny with:

> **NCPDP rejection code 39 (Missing or invalid ICD-9 CM Diagnosis Code)** which is linked to **EOB code 575 (Missing or invalid ICD-9-CM Diagnosis Code).**

Drug to Drug Interaction with Nitrates

Due to a drug interaction between Sildenafil citrate (Revatio®) and nitrates, pharmacy claims for nitrates will deny when there is an active claim on the drug for Sildenafil citrate (Revatio®). Conversely, pharmacy claims for Sildenafil citrate (Revatio®) will deny when there is an active prescription on the recipient's file for a nitrate.

If there is an active claim on file, the incoming claim will deny with:

> **NCPDP rejection code 88 (DUR Reject Error)** which is linked to **EOB code 471 (Drug to Drug Interaction, Sildenafil with Nitrates).**

The pharmacist may override this drug to drug interaction denial upon consultation with the prescriber. The pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive a nitrate with Sildenafil citrate (Revatio®). In addition, the pharmacist must document on the hardcopy prescription the codes listed below (DD-Reason for Service code, M0-Professional Service Code and 1G-Result of Service Code) which also must be supplied with the Point of Sale submission:

NCPDP field 439-E4 (Reason for Service Code) – **DD** (Drug-Drug Interaction)
NCPDP field 440-E5 (Professional Service Code) – **M0** (Prescriber Consulted)
NCPDP field 441-E6 (Result of Service Code) – **1G** (Filled with Prescriber Approval)

Procedures in the pharmacy audit program have been established to verify the provider's documentation and compliance associated with program policy. Therefore, pharmacists are reminded to document diagnosis codes, reason for overrides and DUR (Reason for Service Code, Professional Service Code, and Result of Service Code) override codes on the hardcopy prescription.

In the future, as new drugs are added to the same therapeutic class as Sildenafil citrate (Revatio®), which is used in the treatment of Primary Pulmonary Hypertension, these new edits and policy will be applicable.

Duration Of Therapy

H2 Antagonists, Proton Pump Inhibitors (PPIs) and Sucralfate

The Louisiana Medicaid Pharmacy Benefits Management (LMPBM) program implemented the duration of therapy module for the H2 antagonists, proton pump inhibitors (PPIs) and sucralfate in April 1997. At that time, acute dosage guidelines for these drugs were being monitored. The chronic use of these agents at full therapeutic dosages is generally not indicated. The duration of therapy period begins every calendar year. Effective August 11, 2002, LMPBM implemented changes to the acute dosage schedule of these drugs as follows:

Proton Pump Inhibitors

Generic Description	Acute mg/day dose	Duration of Therapy
Omeprazole	20 mg	16 weeks (120 days)
Lansoprazole	30 mg	16 weeks (120 days)
Pantoprazole	40 mg	16 weeks (120 days)
Rabeprazole	20 mg	16 weeks (120 days)
Esomeprazole	40 mg	16 weeks (120 days)

H2 Antagonist & Sucralfate

Generic Description	Acute mg/day dose	Duration of Therapy
Ranitidine HCl	300 mg	12 weeks (90 days)
Cimetidine	1200 mg	12 weeks (90 days)
Nizatidine	300 mg	12 weeks (90 days)
Famotidine	40 mg	12 weeks (90 days)
Sucralfate	4000 mg	12 weeks (90 days)

Claims exceeding the appropriate acute duration of therapy will deny with EOB code **#656 (Exceeds maximum duration of therapy)** which is linked to NCPDP rejection code **#88 (DUR reject error)**. Maintenance dose drug therapy will continue to be payable after the 90 days or 120 days of the appropriate drug therapy.

If, in the professional judgment of the prescriber, a determination is made to continue acute therapy beyond the appropriate duration of therapy, the physician must **indicate in writing on the prescription or an attachment,** a diagnosis code necessitating the continuation of acute therapy. Recipient specific diagnosis information from the prescriber via facsimile is acceptable.

For acute therapy to continue as a reimbursable service beyond the above listed duration of therapy, the pharmacy provider must supply the conflict code, intervention code and outcome code, as listed below, with POS submission of the claim and have the information recorded on the hard copy.

NCPCP field 439	DUR Conflict Code	MX	Maximum duration of therapy
NCPDP field 440	Intervention code	M0 (zero)	Prescriber Consulted
NCPDP field 441	Outcome Code Options:		

- 1A – Filled as is, false positive
- 1B – Filled prescription as is
- 1C – Filled, with different dose
- 1D – Filled, wit different directions
- 1E – Filled , with different drug
- 1F – Filled , with different quantity
- 1G – Filled, with prescriber approval
- 2A – Prescription not filled
- 2B – Not filled, directions clarified

An acceptable ICD 9 diagnosis code must appear in NCPDP field #424 indicating that condition identified by the prescriber which warrants continuation of the acute dosage. The pharmacy provider must supply that information accurately as provided by the prescriber. Only claims with one of the diagnoses listed below will be reimbursable.

041.86	H. Pylori
202.60 through 202.68	Systemic Mastocytosis
237.4	Multiple Endocrine Adenomas
251.5	Zollinger-Ellison Syndrome
530.10	Esophagitis
530.11	Gastroesophageal Reflux Disease (GERD)
530.19	Esophagitis
530.81	Gastroesophageal Reflux Disease (GERD)
530.20	Barrett's Esophagitis
531.00 through 531.91	Gastric Ulcer
532.00 through 532.91	Duodenal Ulcer
533.00 through 533.91	Peptic Ulcer (H. Pylori)
535.00 through 535.51	Gastritis
535.50	Gastroduodenitis
535.51	Gastroduodenitis
535.60	Duodenitis
535.61	Duodenitis
536.80	Dyspepsia

536.80	Gastric hypersecretion
537.90	Unspecified disorder of stomach and duodenum
555.90	Crohn's Disease
569.90	Unspecified disorder of the intestines
577.10	Chronic Pancreatitis
578.90	Gastrointestinal Bleeding

For non-POS claims, pharmacy providers will receive a claim denial for acute therapy exceeding the duration of therapy limits. The pharmacists must intervene with the prescriber prior to dispensing the prescription which exceeds the duration limits. Documentation on the prescription hard copy is required in the cases where, in the professional judgment of the prescriber, acute therapy is continued. If the prescriber has previously authorized continuing acute therapy beyond the appropriate duration, the appropriate diagnosis, as identified by the prescriber, must be entered into that field on the pharmacy facsimile. The facsimile will be sent to the provider with the remittance advice. The pharmacy provider should then sign the facsimile which signifies: (1) the prescriber and pharmacist are aware that the duration of therapy has been exceeded, (2) an appropriate diagnosis justifies continuing therapy at an acute dose and (3) the pharmacy provider is compliant with all Medicaid rules and regulations.

Procedures in the pharmacy audit program have been established to verify the provider's documentation associated with duration of therapy and compliance with program regulations. Therefore, pharmacists are reminded to document all interventions and outcomes on the prescription hard copies for access during the pharmacy audit process as well as documenting those actions in the claim record.

Therapeutic Duplication

The Medicaid Program denies pharmacy claims for oral formulations of drugs in the following classes and specific drugs if the recipient has an active paid claim on file for another drug in the same therapeutic class. An active prescription is a prescription in which the days supply has not expired.

If an override is determined appropriate after contacting the prescriber, additional hard-copy documentation of the reason for service code, professional service code and result of service code is required on the new prescription for audit purposes. Additional requirements may be associated with certain drug classes or specific drugs.

Tricyclic Antidepressants

Amitriptyline HCl
Amoxapine
Clomipramine HCl
Desipramine HCl
Doxepin HCl
Imipramine HCl
Imipramine Pamoate
Maprotiline HCl
Nortriptyline HCl
Protriptyline HCl
Trimipramine Maleate

Selective Serotonin Reuptake Inhibitors

- Citalopram HBr
- Escitalopram Oxalate
- Fluoxetine HCl
- Fluvoxamine Maleate
- Paroxetine HCl
- Paroxetine Mesylate
- Sertraline HCl

Second Generation Antihistamines And Second Generation Antihistamine Combination Agents

- Cetirizine
- Cetirizine/Pseudoephedrine
- Desloratadine
- Fexofenadine
- Fexofenadine/Pseudoephedrine
- Loratadine
- Loratadine/Pseudoephedrine

Calcium Channel Blockers

- Amlodipine
- Bepridil
- Diltiazem
- Felodipine
- Isradipine
- Nicardipine
- Nifedipine
- Nimodipine
- Nisoldipine
- Verapamil

Potassium Replacement

- Potassium Bicarbonate / Potassium Citrate / Citric Acid
- Potassium Chloride / Potassium Bicarbonate / Citric Acid
- Potassium Acetate
- Potassium Bicarbonate
- Potassium Bicarbonate / Citric Acid
- Potassium Chloride
- Potassium Chloride / Potassium Bicarbonate
- Potassium Gluconate

Non-Steroidal Anti-Inflammatory Drugs

- Celecoxib
- Diclofenac Potassium
- Diclofenac Sodium
- Diclofenac Sodium / Misoprostol
- Diflunisal
- Etodolac
- Fenoprofen Calcium
- Flurbiprofen
- Ibuprofen
- Ibuprofen / Hydrocodone Bitartrate
- Ketoprofen
- Ketorolac Tromethamine
- Meclofenamate Sodium
- Mefenamic Acid
- Meloxicam
- Nabumetone
- Naproxen
- Naproxen Sodium
- Oxaprozin
- Piroxicam
- Sulindac
- Tolmetin Sodium

The Department may add drugs to these lists as new drugs appear on the market.

Note: Refer to Section 37.9.5 of the Louisiana Medicaid Program Provider Manual for override information as well as Appendix D Point of Sale User Guide for detailed billing information.

PREGNANCY

Pregnancy and Category X Drugs

The Medicaid Program denies pharmacy claims with FDA Pregnancy Category X drugs for pregnant women. Pharmacy claims submitted for a drug in this category for recipients with a co-payment designation of pregnancy will be denied.

The specific drugs that are currently included in FDA Pregnancy Category X are listed below. The Medicaid Program may add drugs to these lists as new drugs appear on the market or as FDA indications change.

There is no override option for these claims.

FDA PREGNANCY CATEGORY X

Acetohydroxamic Acid
Acitretin
Androgens
Bexarotene
Bicalutamide
Bosentan
Chorionic Gonadotropin (Human)
Clomiphene Citrate
Danazol
Dihydroergotamine Mesylate (Inj;Nasal)
Dutasteride
Ergotamine Tartrate
Estazolam
Estradiol
Estramustine
Estrogen, Conjugated Synthetic A
Estrogenic Agents
Estrogens, Conjugated
Ethinyl Estradiol
Ethynodiol Acetate
Etonogestrel
Finasteride
Fluorouracil (Topical)
Fluoxymesterone
Flurazepam Hydrochloride
Goserelin
HMG COA Reductase Inhibitors
Isotretinoin
Leflunomide
Leuprolide Acetate
Levonorgestrel
Medroxyprogesterone Acetate (Intramuscular)
Medroxyprogesterone Acetate (Non-Intramuscular)

Megestrol Acetate
Menotropins
Mestranol
Methotrexate
Methyl Testosterone
Miglustat
Misoprostol
Nafarelin Acetate
Nandrolone (Decanoate, Phenpropionate)
Norelgestromin
Norethindrone (As Progestogen)
Norgestrel (As Progestogen)
Oral Contraceptives
Oxandrolone
Oxymetholone
Oxytocin (Nasal/Inhalar)
Quazepam
Quinine
Raloxifene
Ribavirin
Rosuvastatin
Stanozolol
Tazarotene
Temazepam
Testosterone
Thalidomide
Triazolam
Vitamin A
Warfarin Sodium

Pregnancy and FDA Category D Drugs

Pharmacy claims submitted with FDA Pregnancy Category D drugs will receive an educational edit in the response from Louisiana Medicaid. These claims will not deny.

Pregnancy Co-Payment 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.

AUDIT PROCESS

Audit Purpose

The purpose of the pharmacy review/audit function is to assure that Medicaid pharmacy providers are billing and being reimbursed in compliance with federal and state laws and regulations and Louisiana Medicaid Pharmacy Program policy.

Audit Authority

State Medicaid programs are required to conduct reviews and audits of claims in order to comply with federal regulations 42 CFR 447.202.

The Louisiana Department of Health and Hospitals (DHH) is a covered entity under HIPAA. Therefore, DHH is exempt from the HIPAA privacy regulations regarding records for any claims which Medicaid reimbursement is sought. This exemption extends to DHH contractors (currently the University of New Orleans for LMPBM pharmacy review and audit support functions) when acting on behalf of DHH. The federal HIPAA privacy regulations, 45 CFR 164.506 (a), provide that covered entities are permitted to use or disclose Protected Health Information (PHI) for treatment, payment, or health care operations. In addition, a "HIPAA Authorization" or "Opportunity to Agree or Object" by the individual is not required for uses and disclosures required by law.

Audit Overview and Process

Since the inception of Medicaid, the Louisiana Medicaid Pharmacy Program has complied with the federal audit mandate. This was done primarily by conducting annual field audits of providers and auditing each pharmacy for multiple types of discrepancies.

In early 2005 the Medicaid program brought the pharmacy audit functions in-house and contracted with the University of New Orleans (UNO) to perform certain tasks associated with the process. Louisiana also revised and enhanced its pharmacy compliance review/audit process through new technology to make audits more efficient and cost effective.

The LMPBM Section and UNO use a technology based risk assessment methodology to identify paid pharmacy claims that may be out of compliance with Medicaid rules and policies. This review ensures the review of paid claims on a timely basis, resulting in quicker corrective action by the provider.

Medicaid monitors the use of overrides for bypassing denial edits. Improper use of overrides and codes associated with these overrides by pharmacy providers may result in the disallowance of these overrides and administrative sanctions by Medicaid and the Board of Pharmacy.

Program reviews are also conducted of billings to assure required documentation is noted on hardcopy prescriptions for all pharmacy claims when an override indicator was used.

Therefore, pharmacists may receive written or telephonic requests from the auditors requesting additional information or copies of the hardcopy prescriptions or invoices in an effort to complete audit functions. When applicable, they may only ask for affirmation of correct billing.

Provider Responsibilities

Each provider upon enrolling in the Title XIX Medicaid Program agrees to dispense prescriptions and operate within the Program's laws and regulations as set forth in the Louisiana Medicaid Program Provider Manual and other directives.

In an effort to facilitate the pharmacy audit process, information must be available upon request. This information is necessary in order to comply with the requirements for a pharmacy services provider enrolled in Louisiana's Medicaid Program as stated in the PE-50 (Provider Enrollment Form) and to meet the requirements of the Louisiana State Board of Pharmacy.

At the time of audit, all Medicaid pharmacy providers must be able to produce a daily log, or prescription register. This daily log whether routinely produced in hard copy or producible in hard copy at the time of audit, must contain at a minimum, for audit purposes, the following prescription data:

- Prescription number;
- Indicator as to new or refill prescription (0-5);
- Date of dispensing;
- Patient's name;
- Prescriber's name;
- Drug name;
- NDC number;
- Quantity dispensed;
- Plan identifier indicating case or plan making payment; and
- Amount paid (including both copayment and plan payment, which may or may not be separated, i.e., *AMOUNT PAID = AMOUNT PLAN PAID + AMOUNT PATIENT PAID*).

Providers are required to refund overpayments identified by the audits and take appropriate corrective action.

LIST OF MEDICATIONS AND CORRECT DECIMAL QUANTITY MEASURES

Generic Description	Brand Name	Strength		Package Size		Examples of Decimal Quantities	
ALBUTEROL		90MCG	17	GM	17	34	51
ALBUTEROL	PROVENTIL HFA®	90MCG	6.7	GM	6.7	13.4	20.1
ALBUTEROL	PROVENTIL® SOLUTION	0.83MG/ML	3	ML	3	6	9
ALBUTEROL SULFATE/ IPRATROPIUM	COMBIVENT®	103-18 MCG	14.7	GM	14.7	29.4	44.1
ANAKINRA	KINERET®	100MG/0.67ML	0.67	ML	0.67	1.34	2.01
AZITHROMYCIN	ZITHROMAX®	200MG/5ML	22.5	ML	22.5	45	67.5
BECLOMETHASONE	QVAR®	40MCG	7.3	GM	7.3	14.6	21.9
BECLOMETHASONE	QVAR®	80MCG	7.3	GM	7.3	14.6	21.9
BECLOMETHASONE							
NASAL	VANCENASE®	42MCG	7	GM	7	14	21
BIMATOPROST	LUMIGAN®	0.03%	7.5	ML	7.5	15	22.5
BIMATOPROST	LUMIGAN®	0.03%	2.5	ML	2.5	5	7.5
BUDESONIDE NASAL	RHINOCORT AQUA®	32 MCG	8.4	ML	8.4	16.8	25.2
BUTORPHANOL							
TARTRATE		10MG/ML	2.5	ML	2.5	5	7.5
CICLOPIROX	PENLAC®	8%	6.6	ML	6.6	13.2	19.8
CIPROFLOXACIN OPTHALMIC	CILOXAN®	0.3%	2.5	ML	2.5	5	7.5
CIPROFLOXACIN / DEXAMETHASONE OTIC	CIPRODEX®	0.3-0.1%	7.5	ML	7.5	15	22.5
CLOBETASOL PROPIONATE		0.05%	15	GM	15	30	45
CLOBETASOL PROPIONATE		0.05%	30	GM	30	60	90
CLOBETASOL PROPIONATE		0.05%	60	GM	60	120	180
CROMOLYN SODIUM	INTAL®	800 MCG	14.2	GM	14.2	28.4	42.6
CROMOLYN SODIUM	INTAL®	800 MCG	8.1	GM	8.1	16.2	24.3
CYANOCOBALAMIN	NASCOBAL®	500 MCG/0.1ML	2.3	ML	2.3	4.6	6.9
DALTEPARIN	FRAGMIN®		0.2	ML			
DALTEPARIN	FRAGMIN®		9.5	ML			
DESMOPRESSIN	DDAVP®	0.1MG/ML	2.5	ML	2.5	5	7.5
DESMOPRESSIN	STIMATE®	1.5MG/ML	2.5	ML	2.5	5	7.5
DESONIDE		.05%	59	ML	59	118	177
DESONIDE		.05%	118	ML	118	236	354
DICLOFENAC	VOLTAREN® OPTHALMIC	0.10%	2.5	ML	2.5	5	7.5
ENOXAPARIN	LOVENOX®		0.4	ML			
ENOXAPARIN	LOVENOX®		0.6	ML			
ENOXAPARIN	LOVENOX®		0.8	ML			

Generic Description	Brand Name	Strength		Package Size		Examples of Decimal Quantities	
ENOXAPARIN	LOVENOX®		0.3	ML			
ETHINYL ESTRADIOL/ NORELGESTROMIN PATCH PACKAGE SIZE = 1	ORTHO EVRA®	0.02MG/0.15MG /24H	1	EA	1	NA	NA
ETHINYL ESTRADIOL/ NORELGESTROMIN PATCH PACKAGE SIZE = 3	ORTHO EVRA®	0.02MG/0.15MG /24H	3	EA	3	6	9
ESTRADIOL CYPIONATE/ MEDROXYPROGESTERONE ACETATE	LUNELLE®		0.5	ML			
ESTRADIOL	ESTRACE® CREAM	0.01%	42.5	GM	42.5	85	127.5
ESTROGEN, CONJUGATED/ MEDROXYPROGESTERONE ACETATE	PREMPRO®	0.625MG-2.5MG	28	GM	28	56	84
ESTROGEN, CONJUGATED/ MEDROXYPROGESTERONE ACETATE	PREMPRO®	0.625MG-5MG	28	GM	28	56	84
ESTROGENS, CONJUGATED	PREMARIN® CREAM	0.625 MG/GM	42.5	GM	42.5	85	127.5
FILGRASTIM	NEUPOGEN®	480 MCG/0.8ML	0.8	ML	0.8	1.6	2.4
FILGRASTIM	NEUPOGEN®	300 MCG/ML	1	ML	1	2	3
FILGRASTIM	NEUPOGEN®	480 MCG/1.6ML	1.6	ML	1.6	3.2	4.8
FILGRASTIM	NEUPOGEN®	300 MCG/ 0.5 ML	0.5	ML	0.5	1	1.5
FLURBIPROFEN	OCUFEN®	0.03%	2.5	ML	2.5	5	7.5
FLUTICASONE	FLONASE®	50MCG	16	GM	16	32	48
FLUTICASONE	FLOVENT®	44 MCG	7.9	GM	7.9	15.8	23.7
FLUTICASONE	FLOVENT®	44MCG	13	GM	13	26	39
FLUTICASONE	FLOVENT®	110MCG	13	GM	13	26	39
FLUTICASONE	FLOVENT®	220MCG	13	GM	13	26	39
GENTAMICIN SULFATE		0.3%	3.5	GM	3.5	7	10.5
HYDROCORTISONE		1%	118	ML	118	236	354
HYDROCORTISONE		2.5%	59	ML	59	118	177
HYDROCORTISONE		2.5%	118	ML	118	236	354
HYDROCORTISONE	PROCTOSOL-HC®	2.5 %	28.35	GM	28.35	56.7	85.05
HYDROCORTISONE ACETATE/PRAMOXINE HCL	PRAMOSONE®	2.5%	28.4	GM	28.4	56.8	85.2
INSULIN	NOVOLIN 70/30®	70-30 U/ML	1.5	ML	1.5	3	4.5
INSULIN	NOVOLIN R®	100 U/ML	1.5	ML	1.5	3	4.5
INTERFERON BETA-1A	AVONEX® ADMINISTRATION PACK	30MCG	4	KITS	4	8	12

Generic Description	Brand Name	Strength		Package Size		Examples of Decimal Quantities	
INTERFERON BETA-1A/ALBUMIN	REBIF®	22MCG/.5 ML	0.5	ML	0.5	1	1.5
INTERFERON BETA 1A/ALBUMIN	REBIF®	44MCG/.5 ML	0.5	ML	0.5	1	1.5
IPRATROPIUM INHALER		18MG	14	GM	14	28	42
PRATROPIUM BROMIDE SOLUTION		0.2MG/ML	2.5	ML	2.5	5	7.5
LATANOPROST	XALATAN®		2.5	ML			
MICONAZOLE	MONISTAT-DERM®	2%	28.35	GM	28.35	56.7	85.05
MUPIROCIN	BACTROBAN®	2%	22	GM	22	44	66
NEDOCROMIL	TILADE®	1.75 MG	16.2	GM	16.2	32.4	48.6
NEOMYCIN SULFATE /POLYMYXIN B /HYDROCORTISONE	CORTISPORIN®		7.5	ML	7.5	15	22.5
NEOMYCIN SULFATE/ POLYMYXIN B SULF/ DEXAMETHASONE	DEXACINE®	0.1%	3.5	GM	3.5	7	10.5
NITROGLYCERIN	NITROLINGUAL®	0.4 MG/DOSE	14.49	GM	14.49	28.98	43.47
NITROGLYCERIN	NITROLINGUAL®	0.4 MG/DOSE	12	GM	12	24	36
PAPAIN/ UREA		0.83MMU/G	30	GM	30	60	90
PEGFILGRASTIM	NEULASTA®	10MG/ML	0.6	ML	0.6	1.2	1.8
PENCICLOVIR	DENAVIR®	1%	1.5	GM	1.5	3	4.5
PODOFILOX	CONDYLOX®	0.5%	3.5	ML	3.5	7	10.5
SULFACETAMIDE SODIUM/ PREDNISOLONE ACETATE	BLEPHAMIDE S.O.P.®	10-0.2%	3.5	GM	3.5	7	10.5
TERCONAZOLE SUPPOSITORY	TERAZOL 3®	80 MG	3	EA	3	6	9
TOBRAMYCIN SULFATE	TOBREX®	0.30%	3.5	GM	3.5	7	10.5
TOBRAMYCIN SULFATE/ DEXAMETHASONE	TOBRADEX®	0.3-0.1%	3.5	GM	3.5	7	10.5
TRAVOPROST	TRAVATAN®	0.004%	2.5	ML	2.5	5	7.5
TRIAMCINOLONE	NASACORT®	55 MCG	10	ML	10	20	30
TRIAMCINOLONE NASAL	NASACORT AQ®	55 MCG	16.5	GM	16.5	33	49.5
TRYPSIN/ BALSAM							
PERU/ CASTOR OIL			113.4	ML	113.4	226.8	340.2
TRYPSIN/BALSAM							
PERU/CASTOR OIL			56.7	ML	56.7	113.4	170.1
UREA		40%	28.35	GM	28.35	56.7	85.05

This list is not all-inclusive. As new products with volumes expressed in decimal quantities become available or are made known to the LMPBM Section, this list will be updated.

OTHER MEDICAID POLICY

Xenical®

Medicaid will provide reimbursement to outpatient pharmacies for Xenical® (orlistat) prescriptions based on the following criteria:

- An authorized prescriber has hand-written the prescription - no facsimiles allowed;
- Patient is twelve years of age or older;
- Only original prescriptions—no refills are allowed;
- Maximums of ninety (90) capsules and thirty (30) days supply;
- Patient has a documented current body mass index (BMI) of twenty-seven (27) or greater and the prescriber had identified the BMI, in his/her handwriting, on the dated prescription or a dated and signed attachment to the prescription;
- Patient has other risk factors warranting the use of Orlistat and the prescriber has identified an approved ICD-9-CM diagnosis code in his/her handwriting, on the dated prescription or a dated and signed attachment to the prescription; and
- No provisions for override of the prospective drug utilization edits, i.e., early refill (ER) and duplicate drug (ID) editing.

The following risk factors, as identified by ICD-9-CM numeric codes only, are acceptable:

ICD-9-CM Code	Description
250.00 through 250.93	Type II Diabetes
271.3	Impaired Glucose Tolerance
251.0 through 251.2	Hyperinsulinemia
272.0 through 272.4	Dyslipidemia
401.00 through 405.99	Hypertension
410.00 through 414.99	Ischemic Heart Disease
429.2	Cardiovascular Disease, unspecified
440.00 through 440.90	Atherosclerosis
443.00 through 443.90	Other peripheral vascular diseases
530.11 and 530.81	Gastric Reflux Disease
715.05 through 715.97	Osteoarthritis of Hips/Knees
780.51, 780.53 and 780.57	Sleep Apnea
430.00 through 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

ICD-9-CM Code	Description
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

The prescriber identified ICD-9-CM diagnosis code must be included in the claim submission. The required supporting documentation for coverage must be retained by the pharmacy as evidence of compliance with program policy, and it must be readily retrievable when requested by audit staff.

Amphetamines

Pharmacy claims for amphetamine drug products, when prescribed for ADD, ADHD, and narcolepsy will be reimbursed when the policy for coverage is followed. The prescription must be hand-written with the prescribing physician's written statement of the medically accepted indication for the drug (the ICD-9 code) which appears in peer-reviewed medical literature or which is accepted by one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations and the United States Pharmacopoeia-Drug Information. This documentation must be retained by the pharmacy provider as evidence of compliance with program policy and readily retrievable when requested by the pharmacy audit staff.

Any claim submitted for an amphetamine product shall include a medically accepted indication as described above and this information shall be entered in NCPDP field #424. The ICD 9 diagnosis codes are as follows:

ADD	314.00
ADHD	314.01
Narcolepsy	347.00

If the provider fails to enter a diagnosis in NCPDP field #424 or an unacceptable diagnosis is identified, the claim will deny with EOB #020 (Missing/Invalid Diagnosis Code) which is linked to NCPDP rejection code #39 (Missing or Invalid Diagnosis Code).

Birth Control Patch Billing

Johnson and Johnson produces and markets the Ortho Evra patch for the following NDC's:

NDC	Strength	Package Quantity	Marketed As
00062-1920-01	20-150/24H	1 patch per box	Replacement Patch Only
00062-1920-15	20-150/24H	3 patches per box	1 month supply

Pharmacy paid claim level reviews have revealed many instances of NDC 00062-1920-01 being billed for greater than a quantity of one (1) which indicates the use of this patch not as a

replacement patch, but as a 1 month supply. Specifically, as provided in the package insert, Ortho Evra, NDC 00062-1920-01 is intended for use as a replacement patch in the event that a patch is inadvertently lost or destroyed.

The manufacturer of Ortho Evra is disputing rebate payments on claims for more than a quantity of one (1) for NDC 00062-1920-01, and for quantities not divisible by three for NDC 00062-1920-15.

Furthermore, the manufacturer offers rebate coupons to the general public for up to three (3) single replacement patches per year (NDC 00062-1920-01), and is also offering that additional rebate to the state. However, they will only provide the additional rebate on NDC 00062-1920-01 that is being used as intended, as a replacement patch, rather than as a one month's supply. Therefore accurate provider billing of these NDCs is vital in order to maximize revenue collected for the state.

Please ensure that billings for these NDCs accurately reflect the NDC being dispensed.

Diastat Unit Billing Errors

Approximately 50% of LA Medicaid providers are billing Medicaid incorrectly for Diastat claims. The correct billing unit for Diastat is a KIT. Each kit is packaged with 2 syringes. Please do NOT bill per syringe. Reimbursement is based on each KIT dispensed. LA Medicaid is reviewing claims for DIASTAT and will recoup money from claims billed per syringe.

Billing example:

Quantity of Diastat KITS Dispensed	Quantity of SYRINGES Dispensed	Correct Quantity to Bill LA Medicaid
1	2	1
2	4	2

Currently the Diastat NDCs are as follows:

66490-0650-20
66490-0651-20
66490-0652-20
66490-0654-20
66490-0655-20
00187-0658-20
00187-0659-20

DME PRIOR AUTHORIZATION

Emergency Requests

In the past, there has been some confusion within the provider community concerning the Louisiana Medicaid policy related to emergency requests for prior authorized services. Below is the policy. Please contact the Unisys Prior Authorization Unit at 800/488-6334 with questions concerning this policy.

A request is considered an emergency if a delay in obtaining the medical equipment, appliance, or supplies would be life-threatening to the beneficiary. Therefore, the PAU only considers the following items for emergency approval:

- Apnea monitors
- Breathing equipment
- Hyperalimentation therapy aids (parenteral and enteral)
- Suction machines

NOTE: In addition to the above items for life-threatening situations, emergency request may be taken for the temporary rental of wheelchairs for post-operative needs after a hospital discharge.

The providers of emergency items must contact the PAU immediately by telephone and provide the following information:

- Beneficiary's name, age, and 13-digit identification number
- Treating physician's name
- Diagnosis
- Time period of need for the item
- Complete description of the item(s) requested
- Reason that the request is a medical emergency
- Cost of the item

The decision will be made by the PAU within two working days of the date the completed request is received, and the PAU will contact the provider by telephone. Then, the PAU will follow up with written confirmation of the decision.

Electronic Prior Authorization

The Electronic Prior Authorization (ePA) Web Application provides a secure, web based tool for providers to submit prior authorization (PA) requests and to view the status of previously submitted requests. This tool is intended to eliminate the need for hard-copy paper PA requests as well as provide a more efficient and timely method of receiving PA request results. Each day, the Unisys Prior Authorization department will review and determine the approval/denial status of PA requests. The resulting decisions will be updated on a nightly basis back to the e-PA web application. This enables the provider to see the decision for a PA request the following business day after the status was determined.

The requirement to submit standard supporting documentation to the Unisys Prior Authorization department remains unchanged.

Providers who do not have access to a computer and/or fax machine will not be able to utilize the web application. However, prior authorization requests will continue to be accepted and processed using the current hard-copy PA submission methods.

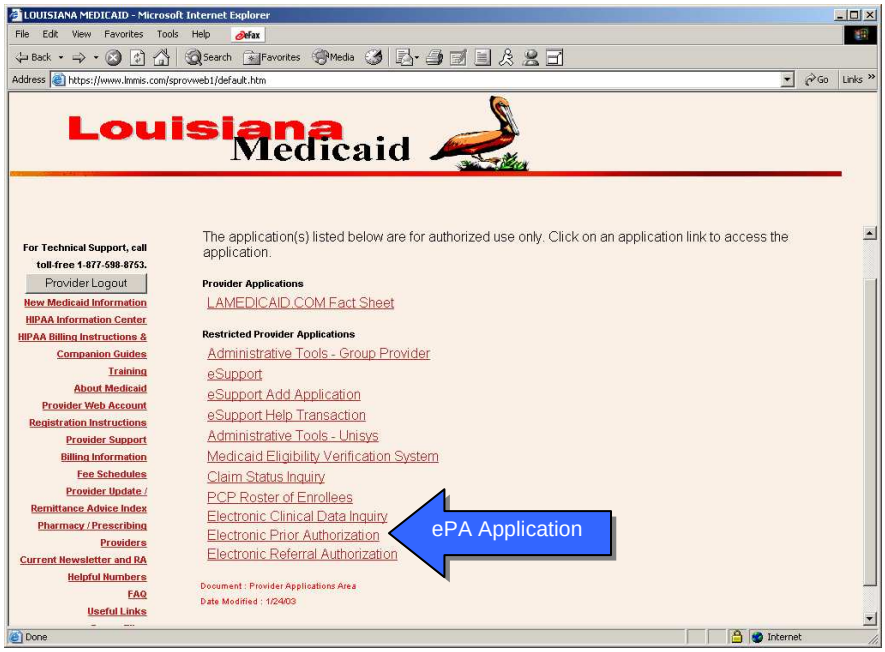
Reconsideration requests cannot be accepted via the e-PA web application and should be submitted using the existing process.

---------- Important Note ----------

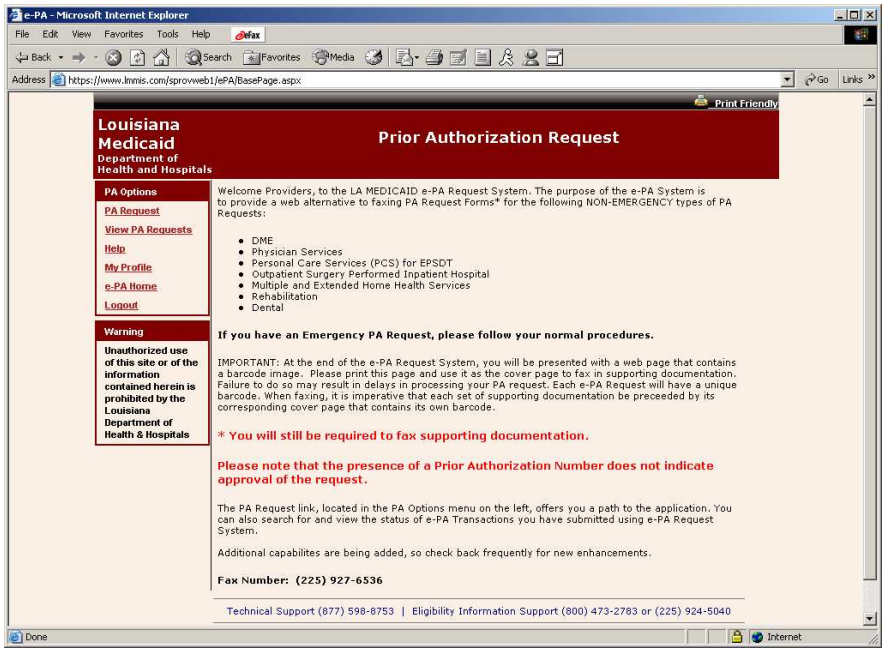
If the supporting documentation is not faxed to Unisys or the Request Response page is not used as a cover sheet or is un-readable, then the request will remain in a Pending Review status and will not be processed by the Unisys PA department. To identify whether or not the supporting documentation was received and processed without error, the provider can view the Request Response page (presented in Section 3.0 of this document) and review the Encounter # field at the bottom of the page. If this number is Zero (0), then the attachments have not been received or were not appropriately cross-referenced matched to the request. Reprint the request page and re-fax it and the supporting documentation again. If the faxed documentation is received and processed correctly, the encounter number field will reflect this change one business day after the documents were faxed.

The following screenshots illustrate the process in order to submit a prior authorization.

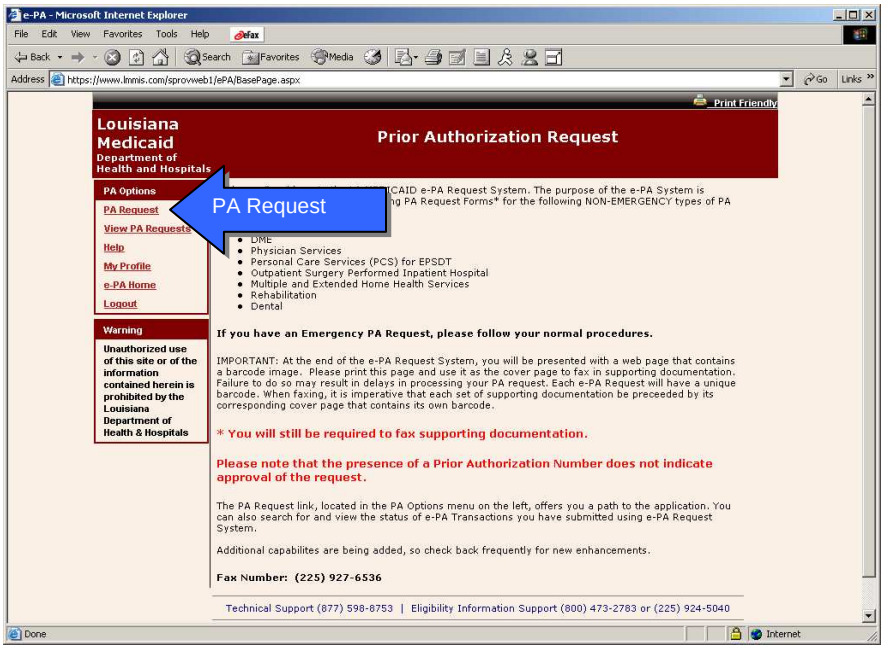
The **Provider Applications Area** screen is displayed. Select the **Electronic Prior Authorization** hyperlink.



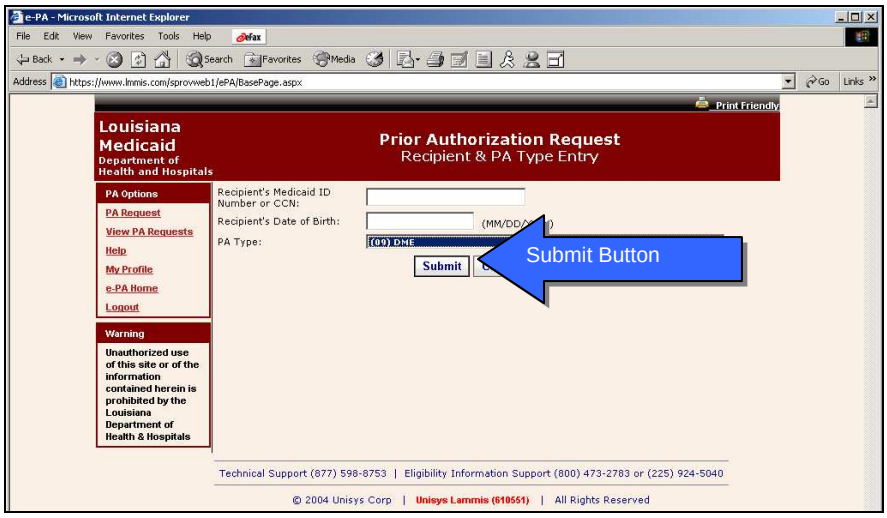
The **Louisiana Medicaid Prior Authorization Web Application** Home screen is displayed.



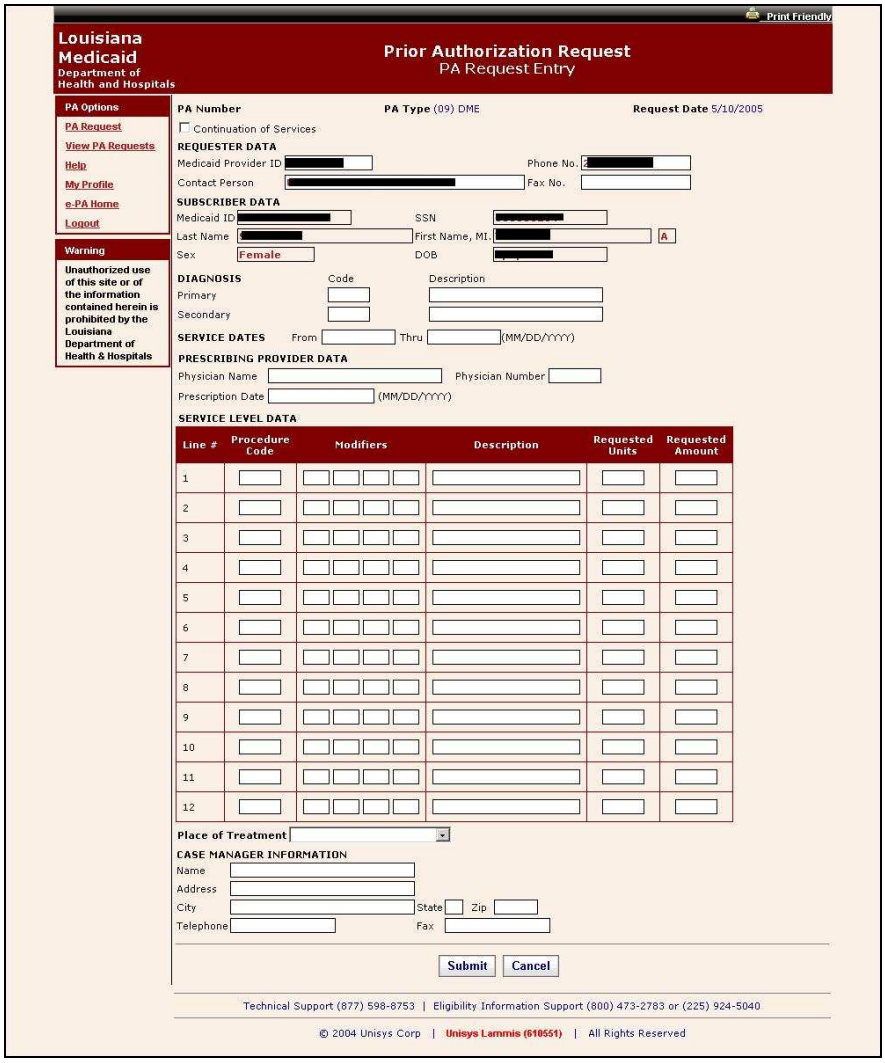
Select the PA Request link located in the upper left side of the main application page. The PA Type entry page will be displayed.



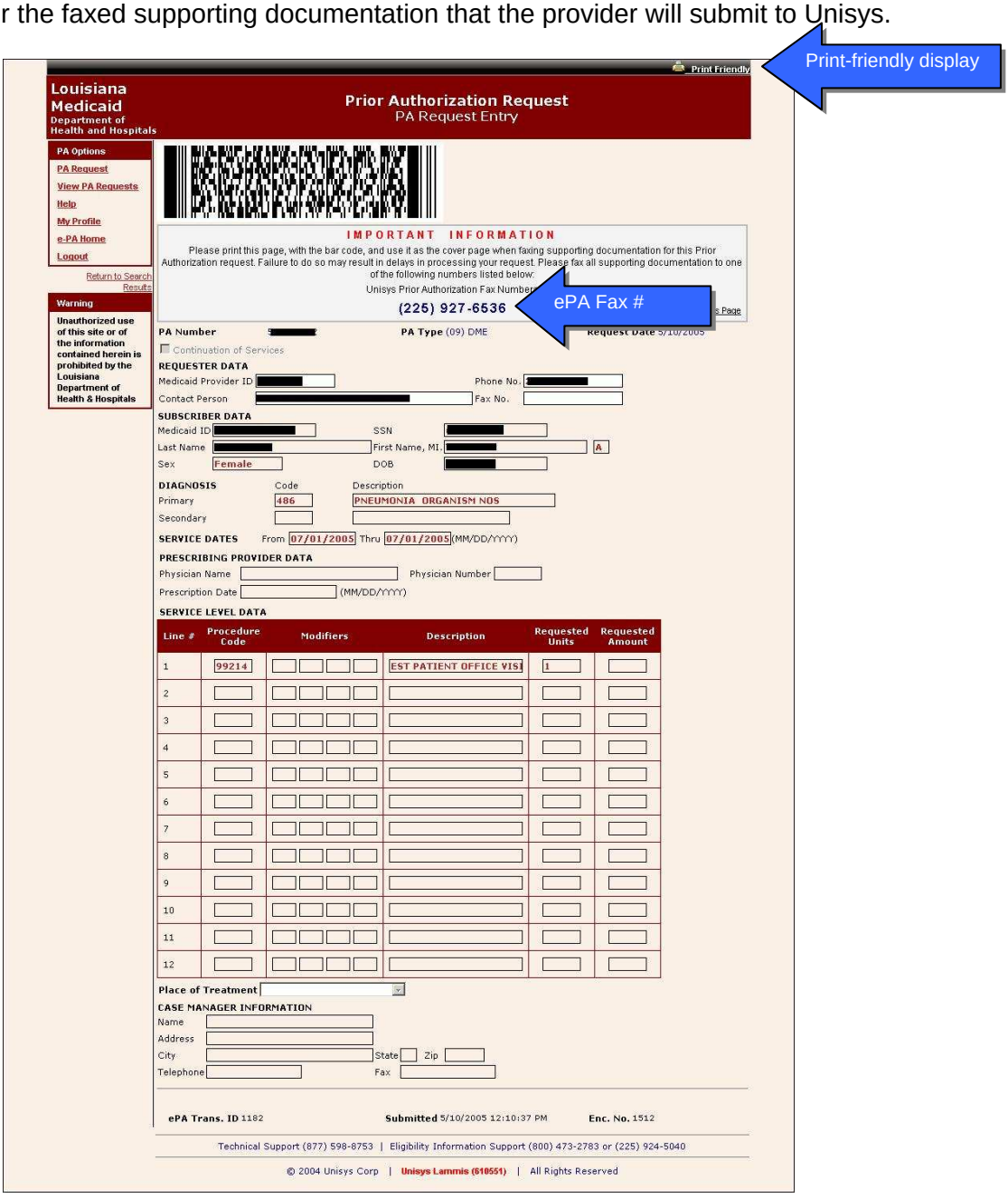
On the Recipient & PA Type Entry page, enter the recipient's Medicaid ID number or CCN and the date of birth in the appropriate boxes. In the PA Type drop-down list, select (09) DME as the type of PA request, then select the Submit button. The Prior Authorization Entry page will be displayed.



On the PA Request Entry page, enter the appropriate information as you would for any standard PA request. If you failed to fill in all the required fields, the application will present a user-friendly pop-up box, listing the required fields that must still be entered. Once you have completed all the required fields, select the Submit button at the bottom of the page. The PA Request Entry (response) page will then be displayed.



The PA Request Entry page will be displayed with the addition of a header at the top that includes a bar code. This bar code will enable Unisys to match the faxed supporting documentation to the original electronic PA request. This page must be printed and used as a cover sheet for the faxed supporting documentation that the provider will submit to Unisys.



Using the printed version of the PA Request Entry (response) page as a cover sheet, fax the request and the supporting documentation to the fax number indicated in the response header.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 08/17/2005 RECIPIENT NAME DWAR M
PRIOR AUTH. NBR 5 259 RECIPIENT NUMBER 8: 096

*
. JT
702

PROVIDER NUMBER 1: 3

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW. IF ANY OF THE APPROVED ASTERISKED(*) SERVICES ARE REQUIRED BEYOND THE APPROVED DATES OF SERVICE, YOU MUST FILE A REQUEST FOR A CONTINUATION OF APPROVED SERVICES BY 02/02/2006 (25 DAYS BEFORE THE END OF THE APPROVED SERVICE DATE). IF YOU FAIL TO SUBMIT A CONTINUATION OF SERVICES REQUEST BY 02/02/2006, THESE SERVICES WILL NOT BE CONTINUED.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
*A4351 -INTERMITTENT URINARY CATH	$ 1,231.20	08/28/2005-02/27/2006	APPROVED
A4927 -GLOVES NON STERILE PER 10	6	08/28/2005-02/27/2006	APPROVED
*A4402 -OSTOMY LUBRICANT	$ 6.36	08/28/2005-02/27/2006	APPROVED

* RESUBMITTAL DATE: ____/____/_____

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY. PAYMENT ON A CLAIM WILL ONLY BE MADE WHEN THE CLAIM IS BILLED CORRECTLY AND ALL CONDITIONS FOR PAYMENT ARE MET.

ALL CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE APPROPRIATE REFERRALS TO BE PAID.

Changing Date of Service for Prior Authorization

It is a requirement of Medicaid that providers not bill for durable medical equipment, services, supplies, prosthetics, or orthotics until the services have been rendered or the items have been delivered or shipped to the recipient. It is also a requirement that the date of service and the date of delivery be the same date in order for a claim to be paid.

When requesting authorization of payment for these items or services, the provider should request authorization on the actual date of the service, delivery, or shipment of the item, or if not known, the provider should request a span date of sufficient duration to allow for authorization by PAU and delivery of the service or item. This will prevent unnecessary denial of payment on the claim.

In the event a provider needs to change the date of service to match the date of delivery, a reconsideration request must be submitted to PAU. A copy of the delivery ticket must be attached if the delivery of the service or item has already been made.

When selecting the anticipated day of delivery, please allow for the PA turnaround time and other anticipated delays in service, such as shipping, etc. If the actual delivery date is different from the approved date of service, then a request to change the date may be submitted (but is not required IF the delivery ticket vouches the exact date of delivery).

Requests for adjustments to dates of service must be sent in writing to the Prior Authorization Unit at Unisys and should always include the reason for the adjustment and documentation of the delivery date. Telephone requests are not allowed for the change.

The following guidelines should be followed and considered in requesting a change in the dates of service from Unisys.

1. A telephone authorization has been obtained for DME services to be provided after a recipient's discharge from a hospital facility. If the discharge was delayed beyond the anticipated date of discharge and service, a date of service may be adjusted at the provider's request, to reflect the actual discharge date as the date of service.

2. A change in providers after prior authorization is given for services may justify a change in the "thru" or end date of services for the old provider's PA file.

3. When a delay in the delivery of an item, after its prior authorization by Unisys, is justified as unavoidable by the provider, the date of service would be adjusted to match the delivery date. The provider must document the reason for the delay and the actual date of delivery (documented with a delivery ticket). An adjustment of the date of service may only be considered, however, if the date of delivery is within six months of the original, anticipated date of service that was entered onto the prior authorization file when the request was approved. Any delays of delivery longer than six months after the date of service on the PA file cannot be considered for a date of service adjustment. Delays by the provider in submissions of a claim for payment, not involving a justified delay in delivery, cannot be considered by the Prior Authorization Unit as a reason for changing the date of service on the PA file. Any delays by the provider in submitting a claim after delivery, which result in a problem in meeting the timely filing deadlines, can be

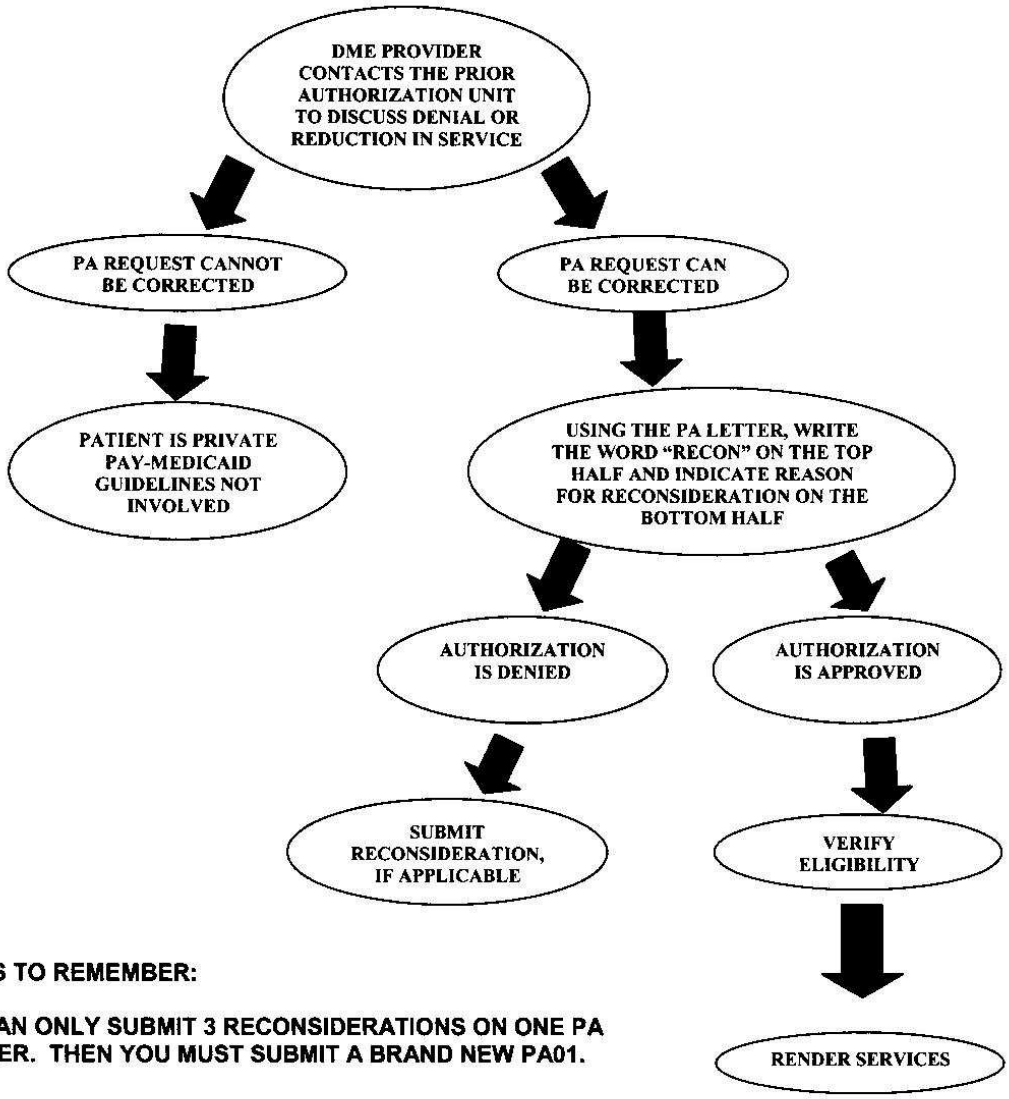
considered only for resolution through the established procedures for an override of the timely filing limits for claims.

4. If a provider is approved for a service and is able to deliver the approved item at an earlier time than the anticipated date of service that was entered on the Prior Authorization file, the provider may ask that the date of service be adjusted to an earlier date to match his/her earlier delivery date. The provider must send documentation (copy of the delivery ticket) with the request.

The provider is allowed to wait to deliver until prior authorization has been approved; however, the item must be delivered before the claim can be submitted; (it is a violation of Federal and State Medicaid Policy to bill for a service that has not been delivered but has been ordered). Please remember that information on DME claims (not prior authorization request) cannot be changed after submittal.

The prior authorization system was designed to act on an original request with the receipt of medical information or a request for extension of services which is considered a “new” request and must contain all necessary information in order for the Prior Authorization Unit to approve the service. This includes the original/current diagnosis, an up-to-date prescription and other pertinent documentation to support that the services, supplies, and equipment are on going. Request that simple include a statement that this is a lifetime condition or a reference to previously submitted information will not be approved. The prescription date shown in field 9 should fall within 60 days of the initial request or re-request (continuation). The Department has initiated two support mechanisms to assist the provider in securing approval for the request in a timely manner. The reconsideration process “and the PAL” are both in place to assist the providers who service clients. If you, as a provider, are experiencing difficulties with the Prior Authorization process and you have exhausted the resources available through both these, you may consider contacting the Provider Relations Unit for a visit to review your internal process for a request.
If the actual delivery day is 6 months or more past the authorized date(s), the provider must submit the request for the date of service change to the DME Program Manager at DHH.

Reconsideration Process



POINTS TO REMEMBER:

YOU CAN ONLY SUBMIT 3 RECONSIDERATIONS ON ONE PA NUMBER. THEN YOU MUST SUBMIT A BRAND NEW PA01.

EVERY RECONSIDERATION MUST CONTAIN THE SAME DOCUMENTATION SUBMITTED WITH THE ORIGINAL PA01 ALONG WITH ANY ADDITIONAL DOCUMENTATION TO SUBSTANTIATE MEDICAL NECESSITY

RECON

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 08/17/2005 RECIPIENT NAME [illegible]
PRIOR AUTH. NBR [illegible] RECIPIENT NUMBER [illegible]

PROVIDER NUMBER 1

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT REQUEST FOR PRIOR AUTHORIZATION OF MEDICAL TREATMENT/ SERVICES/EQUIPMENT FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW. IF ANY OF THE APPROVED ASTERISKED(*) SERVICES ARE REQUIRED BEYOND THE APPROVED DATES OF SERVICE, YOU MUST FILE A REQUEST FOR A CONTINUATION OF APPROVED SERVICES BY 07/04/2005 (25 DAYS BEFORE THE END OF THE APPROVED SERVICE DATE). IF YOU FAIL TO SUBMIT A CONTINUATION OF SERVICES REQUEST BY 07/04/2005, THESE SERVICES WILL NOT BE CONTINUED.

PROCEDURE/MOD1/MOD2/DESCRIPTION	UVS/AMOUNT	DATES OF SERVICE	STATUS
*A5500 -DIAB SHOE FOR DENSITY INS	2	07/29/2005-07/29/2005	APPROVED
K0628 -DIABETIC SHOE DIRECT FORM	2	07/29/2005-07/29/2005	APPROVED
E0607 -HOME BLOOD GLUCOSE MONITO		07/29/2005-07/29/2005	DENIED -164

THE REASON FOR DENIED PRIOR AUTHORIZATION REQUESTS IS LISTED BELOW, IN ACCORDANCE WITH POLICY REFERENCED IN THE MEDICAID ELIGIBILITY MANUAL, SECTIONS 0-100 THROUGH 0-204.
164 - NEED MEDICAL DOCUMENTATION THAT THE PATIENT IS INSULIN DEPENDENT.

* RESUBMITTAL DATE: ____/____/_____

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY. PAYMENT ON A CLAIM WILL ONLY BE MADE WHEN THE CLAIM IS BILLED CORRECTLY AND ALL CONDITIONS FOR PAYMENT ARE MET.

ALL CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE APPROPRIATE REFERRALS TO BE PAID.

DOCUMENTATION ATTACHED SUBSTANTIATING INSULIN DEPENDENCE

WEB APPLICATIONS

LAMEDICAID.COM has several applications (**e-CCR, e-CDI, e-CSI, e-MEVS, e-RA**) that can be used by Louisiana Medicaid providers. These applications require that providers establish an online account with LAMEDICAID.COM.

Some of the pharmacy web applications and documentation that may be found on line are:

- e-MEVS (Medicaid Eligibility Verification System) for recipient eligibility inquiries
- e-CSI (Claims Status Inquiry) for inquiring on claims status
- e-CDI (Clinical Data Inquiry) for inquiring on pharmacy prescriptions as well as other recipient medical claims data
- Pharmacy Preferred Drug Listing (PDL)
- Pharmacy Appendices
- Manual and Appendices
- Training Packets
- POS User Manual
- Vendor Specifications
- Forms
- Links
- Third –Party Liability (TPL) Listing
- Pharmacy provider notices
- Prescribing provider listing

To establish an online account with LAMEDICAID.COM providers must have the following:

1. A valid 7-digit Provider ID number assigned by Louisiana Medicaid
2. An Internet account with an Internet Service Provider (not provided by DHH or Unisys)
3. A valid e-mail address (not provided by DHH or Unisys)
4. A Web Browser that supports SSL with 128-bit encryption (for example, Microsoft Internet Explorer v5 or v6 or Netscape Navigator v6 or v7)

Provider Login And Password

To ensure appropriate security of recipient's patient health information (PHI) and provider's personal information, the secure area of the web site is available to providers only. It is the responsibility of each provider to become "Web Enrolled" by obtaining a login and password for this area of the site to be used with his/her provider number. Once the login and password are obtained by the provider who "owns" the provider number, that provider may permit multiple users to login using the provider number. This system allows multiple individuals to login using the same login and password OR a provider may have up to 500 individual logins and passwords established for a single provider number. The administrative account rights are established when a provider initially obtains a login and password, and should remain with the provider or designated office staff employed by the provider.

A login and password may be obtained by using the link, Provider Web Account Registration Instructions. Should you need assistance with obtaining a login and password or have questions about the technical use of the application, please contact the Unisys Technical Support Desk at 877-598-8753.

☞ Unisys has received inquiries from billing agents/vendors attempting to access this web application. DHH and CMS Security Policy restrictions will not permit Unisys to allow access of this secure application to anyone except the owner of the provider number being used for accessing the site. In cases where an outside billing agent/vendor is contracted to submit claims on behalf of a provider, any existing business partner agreement is between the provider and the billing agent/vendor. Unisys may not permit anyone except the provider to receive or ask for information related to a login and password to access secured information.

Specific enrollment instructions are found on the LAMEDICAID.COM website.

For Technical Support, call the Webmaster toll-free 1-877-598-8753.

Web Applications

There are a number of web applications available on the Medicaid website, however, the following applications are the most commonly used:

- Medicaid Eligibility Verification System (e-MEVS) for recipient eligibility inquiries; and
- Claims Status Inquiry (e-CSI) for inquiring on claims status; and
- Clinical Data Inquiry (e-CDI) for inquiring on recipient pharmacy prescriptions as well as other medical claims data; and
- Prior Authorization (e-PA) for requesting prior authorizations electronically.

These applications are available to providers 24 hours a day, 7 days a week at no cost.

e-MEVS:

Providers can now verify eligibility, primary insurance information, and service limits for a Medicaid recipient using this web application accessed through www.lamedicaid.com. This application provides eligibility verification capability in addition to MEVS swipe card transactions and REVS. An eligibility request can be entered via the web for a single recipient and the data for that individual will be returned on a printable web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Since its release, the application has undergone some cosmetic and informational changes to make it more user-friendly and allow presentation of more complete, understandable information.

e-CSI:

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to remittance advices for this purpose. A LA Medicaid/HIPAA Error Code Crosswalk is available on this website by accessing the link, Forms/Files.

Once enrolled in the website, all active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application.

e-CDI:

The e-CDI application provides a Medicaid recipient's essential clinical history information at the authorized practitioner's finger tips at any practice location.

The nine (9) clinical services information components are:

1. Clinical Drug Inquiry
2. Physician/EPSDT Encounters
3. Outpatient Procedures
4. Specialist Services
5. Ancillary Services
6. Lab & X-Ray Services
7. Emergency Room Services
8. Inpatient Services
9. Clinical Notes Page

This information is updated on a monthly basis, with the exception of the Clinical Drug Inquiry, which is updated on a daily basis. The Clinical Drug Inquiry component will provide clinical historical data on each Medicaid recipient for the current month, prior month, and prior four months. All other components will provide clinical historical data within a six-month period. These updates are based on Medicaid claims history. A print-friendly version of the information on each of the web pages will be accessible and suitable for the recipient's clinical chart.

The major benefits of the use of e-CDI by the practitioner will include:

1. Displays a list of all services (i.e. drugs, procedures, MD visits, etc.) by all providers that have provided services to each individual recipient.
2. Provides the practitioner rapid access to current clinical data to help him/her evaluate the need for "modifications" of an individual Medicaid recipient's health care treatment.
3. Promotes the deliberate evaluation by a practitioner to help prevent duplicate drug therapy and decreases the ordering of duplicate laboratory tests, x-ray procedures, and other services.
4. Supplies a list of all practitioner types providing health care services to each Medicaid recipient.
5. Assists the practitioner in improving therapeutic outcomes and decreasing health care costs.

e-PA

The Electronic Prior Authorization (e-PA) Web Application has been developed for requesting prior authorizations electronically. E-PA is a web application found on the www.lamedicaid.com website and provides a secure web based tool for providers to submit prior authorization requests and to view the status of previously submitted requests. This application is currently restricted to the following prior authorization types:

01 – Inpatient
05 – Rehabilitation
06 – Home Health
09 – DME
14 – EPSDT PCS
99 - Other

Providers who do not have access to a computer and/or fax machine will not be able to utilize the web application. However, prior authorization requests will continue to be accepted and processed using the current PA hard-copy submission methods.

Reminders:

PA Type 09: When submitting a request with a miscellaneous procedure code, the provider must submit a PA01 Form with the description of the item they are requesting.

NO EMERGENCY REQUEST CAN BE SUBMITTED VIA e-PA.

RECONSIDERATION REQUESTS (RECONS) CANNOT BE SUBMITTED VIA THE e-PA WEB APPLICATION AND SHOULD BE SUBMITTED USING THE EXISTING PROCESS.

Additional DHH Available Websites

www.lamedicaid.com: Louisiana Medicaid Information Center which includes field Analyst listing, RA messages, Provider Updates, preferred drug listings, general Medicaid information, fee schedules, and program training packets

www.lamedicaid.com/provweb1/HIPAA/HIPAAindex.htm: Louisiana Medicaid HIPAA Information Center

www.dhh.louisiana.gov: DHH website – LINKS (includes a link entitled "Find a doctor or dentist in Medicaid")

www.dhh.state.la.us: Louisiana Department of Health and Hospitals (DHH)

www.la-kidmed.com: KIDMED – program information, Frequently Asked Questions, outreach material ordering

www.la-communitycare.com: CommunityCARE – program information, PCP listings, Frequently Asked Questions, outreach material ordering

https://linksweb.oph.dhh.louisiana.gov: Louisiana Immunization Network for Kids Statewide (LINKS)

www.ltss.dhh.louisiana.gov: Division of Long Term Community Supports and Services (DLTSS)

www.dhh.louisiana.gov/offices/?ID=77: Office of Citizens with Developmental Disabilities (OCDD)

www.dhh.louisiana.gov/offices/?ID=257: EarlySteps Program

www.dhh.state.la.us/offices/?ID=111: DHH Rate and Audit Review (nursing home updates and cost report information, Outpatient Surgery Fee Schedule, Updates to Ambulatory Surgery Groups, contacts, FAQ)

www.doa.louisiana.gov/employ_holiday.htm: State of Louisiana Division of Administration site for Official State Holidays

PROVIDER ASSISTANCE

Many of the most commonly requested items from providers including, but not limited to, the Field Analyst listing, RA messages, Provider Updates, preferred drug listings, general Medicaid information, and program training packets are available online at www.lamedicaid.com.

UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure/ information/clarification, ordering printed material, requesting a Field Analyst visit, etc., and may be reached by calling:

(800) 473-2783 or (225) 924-5040*
FAX: (225) 216-6334**

*Please listen to the menu options and press the appropriate key for assistance.

NOTE: Providers should access eligibility information via the Medicaid Eligibility Verification System (MEVS) or the automated Recipient Eligibility Verification System (REVS) at (800)776-6323 or (225)216-7387. Providers may also check eligibility by accessing the web-based application, e-MEVS, now available on the Louisiana Medicaid website. Questions regarding an eligibility response may be directed to Provider Relations.

- **Providers Relations cannot assist recipients. Providers should not give their Medicaid provider billing numbers to recipients for the purpose of contacting Unisys. Recipients with a provider number may be able to obtain information regarding the provider (last check date and amount, amounts paid to the provider, etc.) that would normally remain confidential.**

Provider Relations will accept faxed information regarding provider inquiries on an **approved case by case basis. However, faxed claims **are not** acceptable for processing.

UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving problem claims.

All requests to the Correspondence Unit should be submitted to the following address:

Unisys Provider Relations Correspondence Unit
P. O. Box 91024
Baton Rouge, LA 70821

NOTE: All correspondence sent to Provider Relations, including recipient file updates, must include a separate cover letter explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). **A copy of the claim form along with applicable corrections and/or attachments must accompany all resubmissions.**

Provider Relations staff does not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence Unit, so these may take additional time for final resolution.

Requests to update Third Party Liability (TPL) should be directed to:

DHH-Third Party Liability
Medicaid Recovery Unit
P.O. Box 91030
Baton Rouge, LA 70821

"Clean claims" should not be submitted to Provider Relations as this delays processing. Please submit "clean claims" to the appropriate P.O. Box. A complete list is available in this training packet under "Unisys Claims Filing Addresses".

NOTE: CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.

UNISYS PROVIDER RELATIONS FIELD ANALYSTS

Upon request, Provider Relations Field Analysts are available to visit and train new providers and their office staff on site. Providers are encouraged to request Analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **However, since Field Analysts routinely work in the field, they are not available to answer calls regarding eligibility, routine claim denials, and requests for printed material, or other policy documentation. These calls should be directed to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.**

FIELD ANALYST	PARISHES SERVED	
Kellie Conforto (225) 216-6269	Assumption Calcasieu Cameron Jeff Davis Lafourche	St. Mary St. Martin (**below Iberia**) Terrebonne Vermillion
Martha Craft (225) 216-6306	Jefferson Orleans Plaquemines St. Bernard	St. Charles St. James St. John the Baptist St. Tammany (**Slidell only**)
Sharon Harless (225) 216-6267	East Baton Rouge (**Baker & Zachary only**) West Baton rouge Iberville Pointe Coupee	St. Helena East Feliciana West Feliciana Woodville (MS) Centerville (MS)
Erin McAlister (225) 216-6201	Ascension East Baton Rouge (**excluding Baker & Zachary**) Livingston	St. Tammany (**excluding Slidell**) Tangipahoa Washington McComb (MS)
LaQuanta Robinson (225) 216-6249	Acadia Allen Evangeline Iberia	Lafayette St. Landry St. Martin (**above Iberia**) Beaumont (TX)
Kathy Robertson (225) 216-6260	Avoyelles Beauregard Caldwell Catahoula Concordia Franklin Grant LaSalle	Natchitoches Rapides Sabine Tensas Vernon Winn Natchez (MS) Jasper (TX)
Anna Sanders (225) 216-6273	Bienville Bossier Caddo Claiborne DeSoto East Carroll Jackson Lincoln Madison	Morehouse Ouachita Red River Richland Union Webster West Carroll Marshall (TX) Vicksburg (MS)

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

Department	Toll Free Phone	Phone	Fax
REVS - Automated Eligibility Verification	(800) 776-6323	(225) 216-7387	
Provider Relations	(800) 473-2783	(225) 924-5040	(225) 216-6334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 216-6381	(225) 216-6334
Electronic Media Claims (EMC) - Unisys		(225) 216-6000 option 2	(225) 216-6335
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 929-6803
Home Health P.A. - Unisys **EPSDT PCS P.A.** - Unisys	(800) 807-1320		(225) 216-6342
Dental P.A. - LSU School of Dentistry		(225) 216-6470	(225) 216-6476
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 216-6370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline – Unisys	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – **DHH**	(800) 834-3333 (225) 342-9808	Providers may request verification of eligibility for presumptively eligible recipients; recipients may request a new card or discuss eligibility issues.
Eligibility Operations – **BHSF**	(888) 342-6207	Recipients may address eligibility questions and concerns.
LaCHIP Program	(877) 252-2447	Providers or recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Office of Public Health - **Vaccines for Children Program**	(504) 838-5300	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
Specialty Care Resource Line - **ACS**	(877) 455-9955	Providers and recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED. Providers may inquire about PCP assignment for CommunityCARE recipients and CommunityCARE monitoring/certification, and obtain information on KIDMED linkage, referrals, monitoring, and certification.
CommunityCARE Nurse Helpline – **ACS**	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - **OPH**	(866) 327-5978	Providers and recipients may obtain information on EarlySteps Program and services offered.
LINKS	(504) 838-5300	Providers and recipients may obtain immunization information on recipients.
Program Integrity	(225) 219-4153	Providers may request termination as a recipient's lock-in provider.
Division of Long Term Supports and Services (DLTSS)	(225) 219-0200 (800) 660-0488	Providers and recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 219-0200 (800) 660-0488	Providers and recipients may request assistance regarding waiver services to waiver recipients.

DHH PROGRAM MANAGER REQUESTS

Questions regarding the rationale for Medicaid policy, procedure coverage and reimbursement, medical justification, written clarification of policy that is not documented, etc. should be directed in writing to the manager of your specific program:

Program Manager - (i.e. DME, Hospital, etc.)
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

PHONE NUMBERS FOR RECIPIENT ASSISTANCE

The telephone listing below should be used to direct **recipient** inquiries appropriately.

Department	Phone	Purpose
Fraud and Abuse Hotline	(800) 488-2917	Recipients may anonymously report any suspected fraud and/or abuse.
Regional Office – DHH	(800) 834-3333 (225) 342-9808	Recipients may request a new card or discuss eligibility issues.
Eligibility Operations – BHSF	(888) 342-6207	Recipients may address eligibility questions and concerns.
LaCHIP Program	(877) 252-2447	Recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Specialty Care Resource Line - ACS	(877) 455-9955	Recipients may obtain referral assistance.
CommunityCARE/KIDMED Hotline - ACS	(800) 259-4444	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, express complaints concerning the CommunityCARE program, request enrollment in the KIDMED program, and obtain information on KIDMED.
CommunityCARE Nurse Helpline – ACS	(866) 529-1681	CommunityCARE recipients may call 24 hours a day, 7 days a week, to speak with a nurse regarding health questions and problems.
EarlySteps Program - OPH	(866) 327-5978	Recipients may obtain information on EarlySteps Program and services offered.
LINKS	(504) 838-5300	Recipients may obtain immunization information.
Division of Long Term Supports and Services (DLTSS)	(225) 219-0200 (800) 660-0488	Recipients may request assistance regarding Elderly and Disabled Adults (EDA), Adult Day Health Care (ADHC) and Long Term Personal Care Services (LT-PCS).
Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports & Services (WSS)	(225) 219-0200 (800) 660-0488	Recipients may request assistance regarding waiver services.

APPENDIX A – REJECT CODE MESSAGES

Following is a list of the National Council Prescription Drug Program (NCPDP) two-digit rejection codes. An explanation follows with the Medicaid fiscal intermediary corresponding three-digit Explanation of Benefits (EOB) code. Reference page 54 for the description of the Medicaid fiscal intermediary EOB codes. 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	002 289	Provider Number Missing or Not Numeric Invalid Provider Number When Deny Applied
*06	Missing or Invalid Group Number		
07	Missing or Invalid Cardholder ID Number	003	Recipient Number Invalid or Less Than 13 Digits

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*08	Missing or Invalid Person Code		
09	Missing or Invalid Birthdate	134 224	DOB Mismatch for CCN Invalid Birthdate on Recipient File
*1C	Missing or Invalid Smoker/Non-Smoker Code		
*1E	Missing or Invalid Prescriber Location Code		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
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		
*2E	Missing or Invalid Primary Care Provider ID Qualifier		
20	Missing or Invalid Compound Code	431	Missing or Invalid Compound Code
21	Missing or Invalid Product/Service ID	127	NDC Code Missing or Incorrect
22	Missing or Invalid Dispense As Written (DAW)/Product Selection Code	128	The MAC Override Indicator Must be a “C”
		576	Missing or Invalid PA/MC Code and Number
*23	Missing or Invalid Ingredient Cost Submitted		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
25	Missing or Invalid Prescriber Identification	121	A Prescribing Physician Medicaid ID Must be Supplied
		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		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*3X	Authorization Number Not Found		
*3Y	Prior Authorization Denied		
*32	Missing or Invalid Level of Service		
*33	Missing or Invalid Prescription Origin Code		
*34	Missing or Invalid Submission Clarification Code		
*35	Missing or Invalid Primary Care Provider ID		
38	Missing or Invalid Basis of Cost	238 239 458	Invalid PAC Action Code/Call Help Desk Price missing on p/f/Call help desk Does Not Have Valid Price for DOS MAC/FUL Cost Zero/Call help desk
39	Missing or Invalid Diagnosis Code	020 575	Invalid or Missing Diagnosis Code Missing/Invalid ICD-9-CM Diagnosis Code
*4C	Missing or Invalid Coordination Of Benefits/Other Payments Count		
*4E	Missing or Invalid Primary Care Provider Last Name		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
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 D
		536	Bill Medicare D
		932	Please bill third party carrier first
		988	Item Covered by Medicare
*42-49	(Reserved for Future Use)		
*5C	M/I Other Payer Coverage Type		
*5E	M/I Other Payer Reject Count		
50	Non-Matched Pharmacy Number	200	Provider/Attending Provider Not on File
*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

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

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*64	Claim Submitted Does Not Match Prior Authorization		
65	Patient is Not Covered	135	Patient not Covered for Pharmacy Service
		216	Recipient Not Eligible on Date of Service
		293	Recycled Recipient Ineligible on DOS
		295	Recipient Ineligible Recycled three Times
*66	Patient Age Exceeds Maximum Age		
*67	Filled Before Coverage Effective		
*68	Filled After Coverage Expired		
69	Filled After Coverage Terminated	364	Recipient Ineligible/Deceased
*7C	Missing or Invalid Other Payer ID		
*7E	Missing or Invalid DUR/PPS Code Counter		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
70	Product/Service Not Covered	099	Item Covered Under Durable Medical Equipment Program Only
		299	Proc/Drug Not Covered by Medicaid
		233	Proc/NDC Not Covered for Service Date Given
		439	Manufacturer has identified product as food supplement
		459	Deny for File review/Call help desk
71	Prescriber is Not Covered	213	Provider Not Covered for Services Rendered By Medicaid
		262	Provider's Adjustments on Review
		514	Prescribing Provider Does not Have Prescriptive Authority
*72	Primary Prescriber is Not Covered		
73	Refills Are Not Covered	452	Schedule 2 Narcotic Cannot Be Refilled
		461	Refills not Payable
*74	Other Carrier Payment Meets Or Exceeds Payable		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
75	Prior Authorization Required	484 485 486 487	New RX will require PA PA Required – MD must Call ULM Operations Staff PA Expired – MD Must Call ULM Operations Staff Emergency Override of a Drug that Requires PA
*76	Plan Limitations Exceeded		
77	Discontinued Product/Service ID Number	438 460	Manufacturer Notified Us That NDC is Obsolete NDC Probably Obsolete. Check Label/Computer
		462 465	CMS Notified Us that NDC is Obsolete Invalid NDC – not on CMS File
78	Cost Exceeds Maximum	650 660 918	Payment Reduced to State Maximum Payment Reduced to LMAC Maximum Medicaid Allowable Amount Reduced by Other Insurance
*79	Refill Too Soon		
*8C	Missing or Invalid Facility ID		
*8E	M/I DUR/PPS Level Of Effort		
80	Drug Diagnosis Mismatch	668	No Patient History of Insulin Requirements

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
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
		898	Exact Dup. Same ICN- Dropped
84	Claim Has Not Been Paid/Captured	280	Manual Pricing Required
		250	Diag/Proc Requires Review
*85	Claim Not Processed		
*86	Submit Manual Reversal		
87	Reversal Not Processed	516	Cannot Adjust Due to Previous Financial Transaction
		796	Adj./Void Billing Provider Mismatch
		797	Duplicate Adjustment Records Entered
		798	History Record Already Adjusted
		799	No History Record on File for This Adjustment

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
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 with sildenafil and nitrate
		482	Therapeutic Duplication Denial
		483	Pregnancy Precaution-Denial-FDA Category X
		529	Exceed Maximum Daily Dose
		531	Drug Use Not Warranted Cox-2 Inhibitor
		656	Exceeds maximum Duration of Therapy
* 89	Rejected Claim Fees Paid		
*90	Host Hung Up		
*91	Host Response Error		
*92	System Unavailable/Host Unavailable		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*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		
*CZ	Missing or Invalid Employer ID		
*DC	Missing or Invalid Dispensing Fee Submitted		
*DN	Missing or Invalid Basis Of Cost Determination		

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

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*EC	Missing or Invalid 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 Compound Dispensing Unit Form Indicator		
*EH	Missing or Invalid 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		
*EV	Missing or Invalid Prior Authorization Number Submitted		
*EW	Missing or Invalid I Intermediary Authorization Type ID		
*EX	Missing or Invalid Intermediary Authorization ID		
*EY	Missing or Invalid Provider ID Qualifier		
*EZ	Missing or Invalid Prescriber ID Qualifier		
*E1	Missing or Invalid Product/Service ID Qualifier		
*E3	Missing or Invalid Incentive Amount Submitted		
*E4	Missing or Invalid Reason For Service Code		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*E5	Missing or Invalid Professional Service Code		
*E6	Missing or Invalid Result Of Service Code		
E7	Missing or Invalid Quantity Dispensed	120	Quantity Invalid/Missing
*E8	Missing or Invalid Other Payer Date		
*E9	Missing or Invalid Provider ID		
*FO	Missing or Invalid Plan ID		
*GE	Missing or Invalid Percentage Sales Tax Amount Submitted		
*HA	Missing or Invalid Flat Sales Tax Amount Submitted		
*HB	Missing or Invalid Other Payer Amount Paid Count		
*HC	Missing or Invalid Other Payer Amount Paid Qualifier		
*HD	Missing or Invalid Dispensing Status		
*HE	Missing or Invalid Percentage Sales Tax Rate Submitted		
*HF	Missing or Invalid Quantity Intended To Be Dispensed		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*HG	Missing or Invalid Days Supply Intended To Be Dispensed		
*H1	Missing or Invalid Measurement Time		
*H2	Missing or Invalid Measurement Dimension		
*H3	Missing or Invalid Measurement Unit		
*H4	Missing or Invalid Measurement Value		
*H5	Missing or Invalid Primary Care Provider Location Code		
*H6	Missing or Invalid DUR Co-Agent ID		
*H7	Missing or Invalid Other Amount Claimed Submitted Count		
*H8	Missing or Invalid Other Amount Claimed Submitted Qualifier		
*H9	Missing or Invalid Other Amount Claimed Submitted		
*JE	Missing or Invalid Percentage Sales Tax Basis Submitted		
*J9	Missing or Invalid DUR Co-Agent ID Qualifier		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*KE	Missing or Invalid Coupon Type		
*M1	Patient not covered in this aid category	524	Capitated Service Must Be Authorized/Paid by PACE Provider
M2	Recipient Locked-In	218	Recipient is MD, Pharm Restricted-MD Invalid
		389	Invalid Provider Number When Deny Applied
*M3	Host PA/MC Error		
M4	Prescription Number/Time Limit Exceeded	453	Schedule 2 Narcotic Cannot Be Refilled
		454	New Prescription Not Filled Within six Months of Date Prescription
		455	Refill Not Filled Within six Months
		498	Number of prescriptions greater than limit
		577	Override Prescription Exceeds 8 Scripts Per Month Limit
		920	Greater than five refills per script not reimbursable

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
M5	Requires Manual Claim	242 448 466 966	110-MNP Required for Recip Liability Amount Transplant Discharge Date or other Dx needed Hard Copy Required-Fertility Preparation 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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*PF	Missing or Invalid Compound Segment		
*PG	Missing or Invalid Coupon Segment		
*PH	Missing or Invalid DUR/PPS Segment		
*PJ	Missing or Invalid Insurance Segment		
*PK	Missing or Invalid Patient Segment		
*PM	Missing or Invalid Pharmacy Provider Segment		
*PN	Missing or Invalid Prescriber Segment		
*PP	Missing or Invalid Pricing Segment		
*PR	Missing or Invalid Prior Authorization Segment		
*PS	Missing or Invalid Transaction Header Segment		
*PT	Missing or Invalid Workers' Compensation Segment		
*PV	Non-Matched Associated Prescription/Service Date		
*PW	Non-Matched Employer ID		
*PX	Non-Matched Other Payer ID		
*PY	Non-Matched Unit Form/Route of Administration		

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

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*RC	Different Drug Entity Between Partial & Completion		
*RD	Mismatched Cardholder/Group ID-Partial To Completion		
*RE	M/I Compound Product ID Qualifier		
*RF	Improper Order Of 'Dispensing Status' Code On Partial Fill Transaction		
*RG	M/I Associated Prescription/service Reference Number On Completion Transaction		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*RP	Out Of Sequence 'P' Reversal On Partial Fill Transaction		
*RS	M/I Associated Prescription/Service Date On Partial Transaction		
*RT	M/I Associated Prescription/Service Reference Number On Partial Transaction		
*RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment		
*R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions		
*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		

NCPDP REJECTION CODE	EXPLANATION	EOB CODE	DESCRIPTION
*R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals Ø6		
*R6	Product/Service Not Appropriate For This Location		
*R7	Repeating Segment Not Allowed In Same Transaction		
*R8	Syntax Error		
*R9	Value In Gross Amount Due Does Not Follow Pricing Formulae		
*SE	Missing or Invalid Procedure Modifier Code Count		
*TE	Missing or Invalid Compound Product ID		
*UE	Missing or Invalid Compound Ingredient Basis Of Cost Determination		
*VE	Missing or Invalid Diagnosis Code Count		
*WE	Missing or Invalid Diagnosis Code Qualifier		
*XE	Missing or Invalid Clinical Information Counter		
*ZE	Missing or Invalid Measurement Date		

APPENDIX B – EXPLANATION OF BENEFITS (EOB) TRANSLATION

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

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

EOB CODE	DESCRIPTION
201	Provider Not Eligible on Dates of Service
202	Provider Cannot Submit This Claim Type
211	Date of Service Less Than Date of Birth
213	Provider Not Covered for Services Rendered by Medicaid
215	Recipient Not on File - Make Copy of Card
216	Recipient Not Eligible on Date of Service - Make Copy of Card
217	Name/Number Mismatch - Copy Card
218	Recipient is MD, Pharm Restricted-MD Invalid
223	Recycled Recipient Not on File
224	Invalid Birthdate on Recipient File
231	NDC Code Not on File
233	Proc/NDC not covered for service date given
234	P/F Age Restriction
235	P/F Sex Restriction
238	Invalid PAC/ Call help desk
239	Price missing of p/f/Call help desk
242	110-MNP Required for Recipient Liability Amount
250	Diagnosis/Procedure Requires Review
262	Provider's Adjustments on Review
272	Claim Exceeds 1 Year Filing Limit
275	Recipient is Medicare Eligible
276	High Variance Error
277	Low Variance Error
280	Manual Pricing Required
289	Invalid Provider Number When Deny Applied
293	Recycled Recipient Ineligible on DOS
294	Recipient Not on File Recycled 3 Times
295	Recipient Ineligible Recycled 3 Times
299	Proc/Drug Not Covered by Medicaid
330	QMB Not Medicaid Eligible
364	Recipient Ineligible/Deceased
385	Diabetic Supplies not covered for LTC recipient
389	Recipient is MD, Pharm Restricted-Pharmacy Invalid
431	Missing or Invalid Compound Code
432	Quantity Exceeds Package Size
434	Bill Medicare Nebulizer Med
436	Days Supply > 100 Exceeds Program Maximum

EOB CODE	DESCRIPTION
438	Manufacturer Notified Us That NDC is Obsolete
439	Manufacturer Has Identified Product as Food Supplement
441	Outcome 2A or 2B- RX not Filled – Transaction Reporting
442	Drug/Drug Interaction
443	Therapeutic Overlay
445	Duplicate Drug Therapy
446	Pregnancy Precaution
447	Compliance Monitoring/Early or Late Refill
448	Transplant Discharge Date or other Dx needed
449	Date of service is within transplant window, bill Medicare
450	Prescribing Provider Not on File - Status = O
452	Schedule 2 Narcotic Cannot Be Refilled
453	Schedule 2 Narcotic Not Filled Within 5 Days
454	New Prescription Not Filled Within 6 Months of Date Prescription
455	Refill Not Filled Within 6 Months
457	Quantity and/or Days Supply Exceeds Program Maximum
458	MAC/FUL Cost is Zero/Call help desk
459	Deny for file review/ Call help desk
460	NDC Probably Obsolete. Check Label/Computer
461	Refills not Payable_____
462	CMS Notified Us that NDC is Obsolete
463	Drug Does Not Need MAC Override
466	Hard Copy Required-Fertility Preparation
471	Drug to Drug Interaction with sildenafil and nitrate
472	Manufacturer has not entered into CMS rebate agreement
479	DUR data Unnecessary for Conflict, Intervention, Outcome
482	Therapeutic Duplication Denial
483	Pregnancy Precaution-Denial-FDA Category X
484	New RX will require PA
485	PA Required – MD must call ULM Operations Staff
486	PA Expired – MD Must Call ULM Operations Staff
487	Emergency Override of a Drug that Requires PA
489	Provider Type Not Authorized to Prescribe
491	Prescriber Number Not For Individual Prescriber

EOB CODE	DESCRIPTION
498	Number of prescriptions greater than limit
514	Prescribing Provider Does not Have Prescriptive Authority
516	Cannot Adjust Due to Previous Financial Transaction
521	Precribing Provider is Group Using Indiviual Prescriber Number
524	Capitated Service Must Be Authorized/Paid by PACE Provider
529	Exceeds Maximum Daily Dose
530	Recipient was Reimbursed for This Service
531	Drug Use Not Warranted Cox-2 Inhibitor
535	Bill Medicare Part D
536	Bill Medicare Part D
537	Educational – OBRA 90 Excluded Drug
575	Edit 575 **-** Missing/Invalid ICD-9-CM Diagnosis Code
576	Missing or invalid PA/MC code or number for RX override
577	Override/prescription exceeds 8 scripts per month limit
650	Payment Reduced to State Maximum
656	Exceeds Maximum Duration of Therapy
660	Payment Reduced to LMAC Maximum
662	Payment Reduced by COPAY
668	No Patient History of Insulin Requirements
796	Adj./Void Billing Provider Mismatch
797	Duplicate Adjustment Records Entered
798	History Record Already Adjusted
799	No History Record on File For This Adjustment
843	Exact Duplicate Error: Identical Pharmacy Claims
898	Exact Dupe Same ICN –Dropped
918	Medicaid Allowable Amount Reduced by Other Insurance
920	GT 5 Refills Per Script Not Reimbursed
932	Please Bill Third Party Carrier First
966	Submit hard copy claim
978	Calculated pricing is zero/ Call help desk
988	Item Covered by Medicare

* Other exceptions are constantly being added and changed. If providers receive an exception that is not listed, call the Unisys POS Help Desk **at 1-800-648-0790 or 1-225-216-6381**.