First Health
Services Corporation

Pharmacy Provider Manual

South Carolina Medicaid

Administered By:
FIRST HEALTH SERVICES CORPORATION
Glen Allen, Virginia

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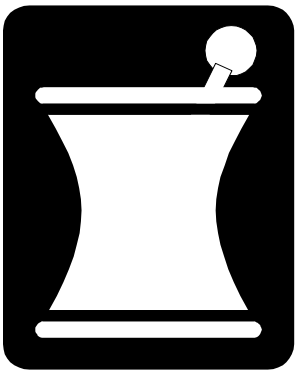

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Section 1: Introduction

As the pharmacy claims processor, FIRST HEALTH SERVICES introduced a new computerized point of sale (POS) system in order to meet Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance requirements for standardized transactions. The new system was implemented on September 10, 2003.

As with the previous program, the new system allows participating pharmacies real-time access to beneficiary eligibility, drug coverage, pricing and payment information, and prospective drug utilization review (ProDUR) across all network pharmacies. Pharmacy providers must be enrolled through South Carolina Medicaid and have an active status for any dates of service submitted. This manual is intended to provide pharmacy claims submission guidelines to the users of the FIRST HEALTH SERVICES on-line system as well as to alert pharmacy providers to new or changed program information. Additionally, it contains instructions for claims submissions via paper media using the Universal Claim Form (UCF). Providers who submit claims via batch media must use the National Council for Prescription Drug Programs (NCPDP) Batch 1.1 format. Batch specifications may be obtained directly from NCPDP via their website: NCPDP.org.

The FIRST HEALTH SERVICES on-line system is used in conjunction with the pharmacy's existing system. While there are a variety of different operating pharmacy systems, the information contained in this manual addresses only the response messages related to the interaction with the FIRST HEALTH SERVICES on-line system, not the technical operation of the pharmacy-specific system.

FIRST HEALTH SERVICES provides assistance through the **Technical Call Center**, which is **available 24 hours a day, seven days a week** and is located in Richmond, Virginia**.** For answers to questions that are not addressed in this manual or if additional information is needed, contact FIRST HEALTH SERVICES at:

1- 866-254-1669
(Nationwide Toll-Free Number)

1.1 Help Desks Telephone Numbers

Responsibility	Help Desk Function	Phone Numbers	Availability
Beneficiary Inquiries			
SCDHHS Beneficiaries' Services	**Medicaid Client Services**	**888-549-0820 (toll-free)**	**Monday – Thursday: 8:00AM – 6:00PM Friday: 8:00AM – 5:00PM**
First Health Services	**Beneficiary Call Line**	**800-834-2680 (toll-free)**	**24/ 7/ 365**
Provider Inquiries			
MCCS	**Provider Enrollment Unit**	**803-788-7622 Ext. 41650**	**Monday –Friday: 8:30AM – 5:00PM**
First Health Services	**Provider Relations**	**804-965-7729**	**Monday – Friday: 7:30AM – 6:00PM**
First Health Services	**Technical Call Center** Non-clinical Prior Authorization ProDUR	**866-254-1669 (toll-free)**	**24/ 7/ 365**
First Health Services	**MAP Clinical Call Center** Clinical Prior Authorization	**866-247-1181 (toll-free)**	**Monday – Friday: 8:00AM – 10:00PM** After hours: Calls roll over to Technical Call Center; on-call clinical staff is contacted via cell phone.
SCDHHS	**Pharmacy Services Medicaid Program** Policy/Procedures	**803-898-2876**	**Monday – Friday: 8:30AM – 5:00PM**
SCDHHS	**DME Medicaid Program** Policy/Procedures	803-898-2882	**Monday – Friday: 8:30AM – 5:00PM**

IMPORTANT NOTE→: If you have any questions regarding your current NCPDP (formerly NABP) Provider Number, or if you need to obtain an NCPDP Provider Number, please contact the NCPDP offices directly at 480-477-1000. The **NCPDP Provider Number** must be submitted as the SERVICE PROVIDER ID NUMBER (field # 201-B1) for all pharmacy claim submissions.

1.2 Important Addresses

Provider EMC Billing Address (Cartridges):
First Health Services Corp.
Media Control/South Carolina EMC Processing Unit
4300 Cox Road
Glen Allen, VA 23060

Format
NCPDP Batch 1.1

Provider EMC Billing Address (Diskettes):
First Health Services Corp.
Operations Department/South Carolina Medicaid
4300 Cox Road
Glen Allen, VA 23060

Format
NCPDP Batch 1.1

Provider Paper Claims Billing Address:
First Health Services Corp.
South Carolina Paper Claims Processing Unit
P.O. Box C-85042
Richmond, VA 23261-5042

Format
5.1 Universal Claim Form (UCF)

A FIRST HEALTH SERVICES Transmittal Form must accompany all electronic non-POS submissions.

Durable Medical Equipment (DME):

- The CMS 1500 claim form should be completed for all supplies, with the exceptions of insulin, insulin needles and syringes; those specified items are reimbursable through the SC Medicaid Pharmacy Services Program. DME claims should be sent directly to:

Medicaid Claims Receipt
P.O. Box 1412
Columbia, SC 29202-1412

- Claims for all non-oral route nutritional supplements should be processed as DME. Policy or claims processing questions related to the DME program should be directed to 803-898-2882.

1.3 Service Support

On-line Certification:

All POS claims must be submitted using NCPDP version 5.1. Providers must have their software vendors certified through FIRST HEALTH SERVICES prior to any claims submission. *Individual pharmacies are not required to be certified.* Providers should contact FIRST HEALTH SERVICES or their software vendor to determine if the vendor is certified with FIRST HEALTH SERVICES. The SOFTWARE VENDOR/ CERTIFICATION NUMBER (NCPDP field #110-AK) is required for claim submission in the NCPDP version 5.1.

IMPORTANT NOTE→: For assistance with software vendor certification, please call 804-934-4247 or e-mail: vendor_certification@fhsc.com.

On-line System Not Available:

If for any reason the on-line system is not available, providers should submit claims when the on-line capability resumes. In order to facilitate this process, the provider's software should have the capability to submit backdated claims.

Technical Problem Resolution:

In order to resolve technical problems, providers should follow the steps outlined below:

1. Check the terminal and communications equipment to ensure that electrical power and telephone services are operational. Call the telephone number the modem is dialing and note the information heard (i.e., fast busy, steady busy, recorded message). Contact the software vendor if unable to access this information in the system.

2. If the pharmacy provider has an internal Technical Support Department, the provider should forward the problem to that department. The pharmacy's technical support staff will coordinate with FIRST HEALTH SERVICES to resolve the problem.

3. If the pharmacy provider's network is experiencing technical problems, the pharmacy provider should contact the network's technical support area. The network's technical support staff will coordinate with FIRST HEALTH SERVICES to resolve the problem.

4. If unable to resolve the problem after following the steps outlined above, the pharmacy provider should contact the FIRST HEALTH SERVICES Technical Call Center at:

1-866-254-1669
(Nationwide Toll-Free Number)

Section 2: Program Set Up

2.1 Claim Format

- Effective September 10, 2003, FIRST HEALTH SERVICES began accepting NCPDP v.5.1; providers *may not* send v.3.2/3C.
- NCPDP Batch 1.1 format will be required for any/all batch submissions.
- The Universal Claim Form (5.1 UCF) is required for paper submissions. See *Appendix A* for sample UCF and instructions.

2.2 NCDPD V.5.1 Enhanced Functionality

FIRST HEALTH SERVICES v.5.1 functionality has fully implemented. See Payer Specifications.

2.3 Media Options

While FIRST HEALTH SERVICES strongly recommends claims submission via POS, the following alternative media will be accepted:

- Electronic media claims (batch) submission via FTP
- Paper (5.1 UCF)

2.4 Networks

National Data Corporation (NDC) 1-800-388-2316	QS1 1-800-845-7558	WebMD 1-615-885-3700

2.5 Transaction Types

The following transaction codes are defined according to the standards established by the NCPDP. Ability to use these transaction codes will depend on the pharmacy's software. At a minimum, all providers should have the capability to submit original claims (Transaction Code B1) and reversals (Transaction Code B2). Additionally FIRST HEALTH SERVICES will also accept re-bill claims (Transaction Code B3).

Full Claims Adjudication (Transaction Code B1)
This transaction captures and processes the claim and returns to the pharmacy the dollar amount allowed under the South Carolina Medicaid reimbursement formula. B1 corresponds to the "01-04" Transactions supported by version 3.2/3C.

Claims Reversal (Transaction Code B2)
This transaction is used by the pharmacy to cancel a claim that was previously processed. To submit a reversal, the provider must void a claim that has received a **Paid** status. To reverse a claim, the provider selects the Reversal (Void) option in the pharmacy's computer system. B2 corresponds to the "11" Transaction supported by version 3.2/3C.

IMPORTANT NOTE→: The following fields must match on the original paid claim and on the void request for a successful claim reversal:

- NCPDP /NABP provider number
- PRESCRIPTION NUMBER
- DATE OF SERVICE (date filled)
- NDC

Claims Re-bill (Transaction Code B3)
This transaction is used by the pharmacy to adjust and resubmit a claim that has previously been processed and received a **Paid** status. A "claims re-bill" voids the original claim and resubmits the claim within a single transaction. B1 corresponds to the "31-34" transactions supported by version 3.2/3C. A complete listing of all transactions supported in NCPDP v.5.1 is located on page 7.

2.6 Version 5.1 Transactions

Please review the following for program requirements; some transactions may be required at a future date to be determined**:**

NCPDP Lower Version Transaction Code	NCPDP Lower Version Transaction Name	NCPDP V.5.1 Transaction Code	NCPDP V.5.1 Transaction Name	Transaction Support Requirements
00	Eligibility Verification	E1	Eligibility Verification	Required **<future date>**.
01 – 04	Rx Billing	B1	Billing	Required **<9/10/03>**.
11	Rx Reversal	B2	Reversal	Required **<9/10/03>**.
21 – 24	Rx Downtime Billing	N/A	N/A	Not supported in v.5.1.
31 – 34	Rx Re-billing	B3	Re-bill	Required **<9/10/03>**.
41	Prior Authorization Request with Request for Payment	P1	Prior Authorization Request and Billing	Required **<future date>**.
45	Prior Authorization Inquiry	P3	Prior Authorization Inquiry	Required **<future date>**.
46	Prior Authorization Reversal	P2	Prior Authorization Reversal	Required **<future date>**.
51	Prior Authorization Request Only	P4	Prior Authorization Request Only	Required **<future date>**.
81 – 84	Rx DUR	N1	Information Reporting	No planned requirements at this time; **may be required at a future date.**
91 – 94	Rx Refill	N/A		Not supported in v.5.1.
N/A	N/A	N2	Information Reporting Reversal	No planned requirements at this time; **may be required at a future date.**
N/A	N/A	N3	Information Reporting Re-bill	No planned requirements at this time; **may be required at a future date.**
N/A	N/A	C1	Controlled Substance Reporting	No planned requirements at this time; **may be required at a future date.**
N/A	N/A	C2	Controlled Substance Reporting Reversal	No planned requirements at this time; **may be required at a future date.**
N/A	N/A	C3	Controlled Substance Reporting Re-bill	No planned requirements at this time; **may be required at a future date.**

2.7 Version 5.1 Segments

Data in NCPDP v.5.1 is grouped together in segments. Please review the following for program requirements; some segments may be required at a future date to be determined.

NCPDP Request Segment Matrix									**Segment Support Requirements**
Transaction Code	**E1**	**B1**	**B2**	**B3**	**P1**	**P2**	**P3**	**P4**	
Segment									
Header	M	M	M	M	M	M	M	M	Required <**9/10/03**>.
Patient	O	O	O	O	O	O	O	O	Required <**9/10/03**>.
Insurance	M	M	O	M	M	O	M	M	Required <**9/10/03**>.
Claim	N	M	M	M	M	M	M	M	Required <**9/10/03**>.
Pharmacy Provider	O	O	N	O	O	O	O	O	No planned requirements at this time; **may be required at a future date.**
Prescriber	N	O	N	O	O	O	O	O	Required <**9/10/03**>.
COB/ Other Payments	N	O	N	O	O	N	O	O	Required <**9/10/03**>.
Worker's Comp	N	O	N	O	O	O	O	O	Not required.
DUR/ PPS	N	O	O	O	O	O	O	O	Required <**9/10/03**>.
Pricing	N	M	O	M	M	O	O	O	Required <**9/10/03**>.
Coupon	N	O	N	O	O	O	O	O	No planned requirements at this time; **may be required at a future date.**
Compound	N	O	N	O	O	O	O	O	Required <**future date**>.
PA	N	O	N	O	M	O	M	M	Required <**future date**>.
Clinical	N	O	N	O	O	N	N	O	Required <**future date**>.

NCPDP Designations:

M = Mandatory (required at all times)
O = Optional (required in designated conditions)
N = Not Sent (not necessary)

- **NOTE:** Some segments designated as "Optional" by NCPDP may be "Required" to support specific transactions for this program.

2.8 Required Data Elements

The FIRST HEALTH SERVICES system has program-specific "mandatory/ required," "situational" and "not sent" data elements for each transaction. The pharmacy provider's software vendor will need the Payer Specifications before setting up the plan in the pharmacy's computer system. This will allow the provider access to the required fields. Please note the following descriptions regarding data elements:

Mandatory	=	Designated as **MANDATORY** in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. These fields must be sent if the segment is required for the transaction.
Situational	=	Designated as **SITUATIONAL** in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. It is necessary to send these fields in noted situations. Some fields designated as situational by NCPDP may be required for all South Carolina Medicaid.
M or S***R***	=	The "R***" indicates that the field is repeating. One of the other designators, Mandatory "M" or Situational "S," will precede it.

South Carolina Medicaid claims will not be processed without all the required data elements. Required fields may or may not be used in the adjudication process. The complete South Carolina Medicaid Payer Specifications, including NCPDP field number references, is in *Appendix B*. Fields "not required for this program" at this time may be required at a future date.

IMPORTANT NOTE→: The following list provides important identification numbers for this program:

- ANSI BIN # ØØ9745
- Processor Control # PØØ6ØØ9745
- Group # SCMEDICAID
- Provider ID # NCPDP/ NABP Number (7-byte, all numeric)
- Cardholder ID # SC Beneficiary ID Number (10-byte Medicaid Health Insurance Number) SSN for SILVERxCARD beneficiaries
- Prescriber ID # State Medical License Number in the specified format
- Product Code National Drug Code (NDC) (11 digits)

2.9 Timely Filing Limits

Most providers who utilize the POS system submit their claims at the time of dispensing. However, there may be mitigating reasons that require a claim to be submitted retroactively.

- For all original claims, reversals and adjustments, the timely filing limit is **365 days** from the date of service (DOS).
- Claims that exceed the specified timely filing limit will deny.
- When appropriate (i.e., retroactive Medicaid eligibility determination), contact DHHS Pharmacy Services staff for consideration of an override to timely filing limits.
- Overrides will be considered ONLY if SCDHHS grants approval for same.

Section 3: Program Policies

3.1 Dispensing Limits

- **Days' Supply:**
  - South Carolina Medicaid will allow a per claim maximum of a **34 days' supply** for each new (original) or refill non-controlled substance prescription.
  - Claims will **deny** if the days' supply limit is exceeded.
- **Quantity:**
  - **Tobacco Cessation Products***:* Reimbursement is available for bupropion sustained release products and Nicotine Replacement Therapy (NRT) pharmaceutical products (i.e., legend and OTC patches and gum) for a single 12 week course of treatment consisting of 90 days (three consecutive months) per beneficiary per calendar year. Prior authorization is not required except where indicated.
  - **Quantity Limits for Certain Drugs:** Additional drugs with quantity limits can be located at http://southcarolina.fhsc.com. The quantity limitations listing will be updated periodically; therefore, providers may find it beneficial to refer to the website for the most current information.
- **Age Limitations**
  - **Influenza Vaccine:** Beneficiary must be >/= 21 years of age. Limit is one vaccine per flu season. Only in-store administered influenza vaccines or those administered to a LTC beneficiary may be considered for Medicaid reimbursement through the Pharmacy Services program. NOTE: For dually eligible Medicare/Medicaid beneficiaries, Medicare Part B must be billed as primary.
  - **Pneumococcal Vaccine:** Beneficiary must be >/= 21 years of age. Limit is one vaccine every 5 years. Only in-store administered pneumococcal vaccines or those administered to a LTC beneficiary may be considered for Medicaid reimbursement through the Pharmacy Services program. NOTE: For dually eligible Medicare/Medicaid beneficiaries, Medicare Part B must be billed as primary.
  - **Oral Hydration:** Beneficiary must be < 21 years of age. Claims for adults will be denied with NCPDP error code 60, 'Drug Not Covered for Patient Age.'
- **Provider Specific Limitations:**
  - **Hepatitis-B Vaccine:**
    - Hepatitis-B vaccine is excluded from coverage for all pharmacy providers except those authorized by SCDHHS.
    - Claim will deny for NCPDP error code 70, 'Drug Not Covered.'
    - After the initial series of hepatitis-B vaccines, Medicaid coverage of any necessary re-vaccination will be considered on a case-by-case basis.
    - Combination products (e.g., A/B, B/HIB) are included in this edit.
  - **Anti-hemophilia Agents:**
    Coverage is limited to the state governmental agency, which provides services to the Medicaid beneficiaries enrolled in the South Carolina Hemophilia Program.

Maximum Prescriptions/ Month:

Program Name	Number of Rx per Month
Children (∅ to the date of 21st birthday)	No limit
Adult beneficiaries	4
Elderly and Disabled Waiver Program patients	4
HASCI Waiver Program patients	7
HIV/AIDS Waiver Program patients	6
VENT Waiver Program patients	6
MR/RD Waiver Program patients	6
SILVERxCARD	4

Exceptions to Monthly Limit

Routine exceptions to the monthly prescription limit for adult beneficiaries are:

- Insulin syringes used in the administration of home parenteral therapies
- Home-administered parenteral therapies (however, insulin counts toward monthly limit)
- Aerosolized pentamidine
- Clozapine therapy
- Family planning pharmaceuticals, supplies and devices

Monthly Prescription Limit Override

Pharmacists may utilize an override code to exceed the monthly prescription limit for adult Medicaid and SILVERxCARD beneficiaries if certain criteria are met. However, it is inappropriate for pharmacy providers to generally promote this particular billing process since all prescriptions cannot meet the override criteria. Pharmacists must NOT use the override code for a given prescription until after the adult patient's monthly prescription limit has been reached. Additionally, since children from birth to the date of their 21st birthday are eligible for an unlimited number of Medicaid-covered prescriptions per month, the override mechanism must NOT be utilized when submitting claims for children.

IMPORTANT NOTE→: Pharmacists should submit a "5" in the PRIOR AUTHORIZATION TYPE CODE field if *all* of the following criteria have been met:

- Monthly prescription limit has been met, and
- Adult patient has one of the following medical conditions and
- The prescription is for an essential drug used in the patient's treatment plan for one of the following conditions:

1. Acute sickle cell disease
2. Behavioral health disorder
3. Cancer
4. Cardiac disease (including hyperlipidemia)
5. Diabetes
6. End stage lung disease
7. End stage renal disease (ESRD)
8. HIV/AIDS
9. Hypertension

10. Life-threatening illness (not otherwise specified)
11. Organ transplant
12. Terminal stage of an illness

Note: The monthly prescription limit override code will be systematically restricted for those therapeutic classes that normally do not meet the override criteria. If, in the pharmacist's judgment, a prescription for a medication in a restricted therapeutic class meets the stipulated criteria below, he/she may call the **FIRST HEALTH SERVICES Clinical Call Center** at **1-866-247-1181** (toll-free) to request prior authorization.

- **Refills:**
  - All refills must be dispensed in accordance with State and Federal requirements.
  - Refill prescriptions for non-controlled substances must be dispensed pursuant to the orders of the prescriber, but not more than two years from the date of the original prescription.
  - CIIs (DEA code = '2') may not be refilled; a new prescription is required for each total fill. However, ***CIIs may be partially filled at the pharmacist's discretion and in compliance with Controlled Substance regulations and partial fill procedures.***
  - Controlled substances other than CIIs may be refilled according to the prescriber's instructions up to 5 refills (plus the original) or six months, whichever comes first.

- **Partial Fills:**

- When a pharmacy files a partial fill prescription to SC Medicaid, the beneficiary's co-payment and the pharmacy's dispensing fee will be "prorated" based on the fractional percentage of the quantity dispensed compared to the quantity prescribed.
- Partial fill functionality cannot be used when submitting Multi-Ingredient Compound claims.
- Partial fills may not be transferred from one pharmacy to another.
- Two Partial Fill transactions may not be submitted on the same day; the Service Date must be different for each of the partial fill transactions and the completion transaction.
- When submitting Usual and Customary (U&C) charge for partial fills, the amount should represent the U&C for the "quantity intended to be dispensed" as opposed to the "quantity dispensed".

PARTIAL FILL FIELDS
Fields listed below which are required for Partial Fill claims submission: • 456-EN ASSOCIATED PRESCRIPTION SERVICE REFERENCE #. • 457-EP ASSOCIATED PRESCRIPTION/SERVICE DATE. • 343-HD DISPENSING STATUS. • 344-HF QUANTITY INTENDED TO BE DISPENSED. • 345-HG DAYS SUPPLY INTENDED TO BE DISPENSED.

- **Initial Fill – On-line Process:**

•Enter actual QUANTITY DISPENSED (NCPDP Field 442-E7).
•Enter actual DAYS SUPPLY (NCPDP Field 405-D5).
•Enter DISPENSING STATUS (NCPDP Field 343-HD) = "P".
•Enter QUANTITY INTENDED TO BE DISPENSED
(NCPDP Field 344-HF) = the total prescribed amount for the prescription.
•Enter DAYS SUPPLY INTENDED TO BE DISPENSED (NCPDP Field 345-HG) = the total days supply from the prescription.

- **Subsequent Partial Fill – On-line Process:**
  •Enter ASSOCIATED PRESCRIPTION/SERVICE REFERENCE #
  (NCPDP Field 456-EN) = the prescription number from the initial partial fill.
  •Enter ASSOCIATED PRESCRIPTION/SERVICE DATE
  (NCPDP Field 457-EP) = the date of service of the most recent partial fill in the series.
  •Enter actual QUANTITY DISPENSED (NCPDP Field 442-E7).
  •Enter actual DAYS SUPPLY (NCPDP Field 405-D5).
  •Enter DISPENSING STATUS (NCPDP Field 343-HD) = "P".
  •Enter QUANTITY INTENDED TO BE DISPENSED
  (NCPDP Field 344-HF) = the total prescribed amount for the prescription.
  •Enter DAYS SUPPLY INTENDED TO BE DISPENSED
  (NCPDP Field 345-HG) = the total days supply from the prescription.

- **Completion of Partial Fill – On-line Process:**
  •Enter ASSOCIATED PRESCRIPTION/SERVICE REFERENCE #
  (NCPDP Field 456-EN) = the prescription number from the initial partial fill.
  •Enter ASSOCIATED PRESCRIPTION/SERVICE DATE
  (NCPDP Field 457-EP) = the date of service of the most recent partial fill in the series.
  •Enter actual QUANTITY DISPENSED (NCPDP Field 442-E7).
  •Enter actual DAYS SUPPLY (NCPDP Field 405-D5).
  •Enter DISPENSING STATUS (NCPDP Field 343-HD) = "C".
  •Enter QUANTITY INTENDED TO BE DISPENSED
  (NCPDP Field 344-HF) = the total prescribed amount for the prescription.
  •Enter DAYS SUPPLY INTENDED TO BE DISPENSED
  (NCPDP Field 345-HG) = the total days supply from the prescription.

General Exclusions:

The following is a listing of products excluded from Medicaid coverage. These items are considered non-covered, regardless of circumstance.

- Weight control products (except lipase inhibitors).
- Investigational pharmaceuticals or products.
- Immunizing agents (except for influenza, pneumococcal, and hepatitis-B vaccines administered to a Medicaid-only beneficiary in a long term care facility or in an in-pharmacy setting). Note: Hepatitis-B vaccine is excluded from coverage for all pharmacy providers except those specifically authorized by SCDHHS.
- Pharmaceuticals determined by the FDA to be less than effective and identical, related, or similar drugs (frequently referred to as "DESI" drugs).
- Injectable pharmaceuticals administered by the practitioner in the office, in an outpatient clinic or infusion center, or in a mental health center. [Note: Medicaid reimbursement for Synagis®, Respigam®, or Cerezyme® is limited solely to physician providers, hospital providers, and infusion centers through their respective Medicaid programs.]
  NOTE: Risperdal Consta® may be billed via point of sale by the Pharmacy Services provider if administered in a SC Department of Mental Health outpatient clinic – see section 3.6 Provider Level Overrides.
- Products used as flushes to maintain patency of indwelling peripheral or central venipuncture devices.
- Fertility products.
- Pharmaceuticals that are not rebated.
- Nutritional supplements [Note: Enteral nutrition therapy administered through a feeding tube and total parenteral nutritional (TPN) therapy may be covered through DHHS' Department of Durable Medical Equipment; neither program reimburses for oral nutritional supplements.]
- Oral hydration therapies for adults.
- Pharmaceuticals used for cosmetic purposes or hair growth.
- Anti-hemophilia factor products [except for those patients enrolled in South Carolina DHEC's hemophilia program]
- Devices and supplies (e.g., glucometers, diabetic supplies such as test strips and lancets, infusion supplies, etc.).
- Erectile dysfunction (E/D) products prescribed to treat impotence.

Zidovudine (AZT) Syrup for Newborns

- In an effort to ensure timely access to critical AZT therapy for at-risk newborns and to maximize patient compliance, the DHHS will allow the pharmacy provider to bill Medicaid using the mother's Medicaid Health Insurance Number when dispensing the initial six weeks' supply of AZT syrup. Billing this drug to the mother's Medicaid identification number is permissible only in those instances where the newborn has not yet been assigned a Medicaid Health Insurance Number at the time of dispensing. This special billing policy pertains only to the initial dispensing of AZT syrup and is limited to a lifetime maximum of a 34-day supply. A relationship code of "3" must also be used to identify the patient as a newborn. Other medications dispensed to newborns may not be billed to Medicaid in such a manner.

3.2 Provider Reimbursement

Reimbursement Algorithms:

- The pharmacy provider should submit the pharmacy's usual and customary (U&C) charge when billing.
- The amount reimbursed by Medicaid for a drug dispensed **shall not exceed the lowest of**:
  - FUL or SCMAC minus 10% plus dispensing fee of $4.05; or
  - AWP minus 10% plus dispensing fee of $4.05; or
  - The provider's usual and customary charge to the general public for the prescription as written for the product actually dispensed.

3.3 Generic Substitution Policy

- Unless otherwise excluded from coverage, all generic drugs included on the South Carolina Medicaid Drug File are considered reimbursable, provided ***they are rebated.***
- If the prescriber certifies in his/her own writing that a specific brand product is medically necessary (*by handwriting the phrase "brand medically necessary" on the face of the prescription)* and a restricted FUL/SCMAC price exists, the pharmacy provider may enter a value of '6' in the DAW field. However, the claim may then deny for 'PA Required.' The prescriber should be instructed to call the First Health Services Clinical Call Center (1-866-247-1181) for prior authorization consideration.
- It should be noted that brand name products for the following do not require prior authorization in order to be billed as "Brand Medically Necessary," provided the necessary requirements outlined above are met:

digoxin	levothyroxine	theophylline (controlled release)	carbamazepine
warfarin	phenytoin	Pancrelipase	

3.4 Special Beneficiary Conditions

- **Medicaid Hospice Services:**
  - A beneficiary who elects the hospice benefit must waive all rights to other Medicaid services related to the treatment of the terminal condition for the duration of the hospice care. Services (including prescriptions) available for illnesses or conditions ***not*** related to the terminal illness of the beneficiary require prior authorization from the hospice provider, not FIRST HEALTH SERVICES.
  - The provider will submit these claims with a customer location code of 11 (hospice) and "8" in the PRIOR AUTHORIZATION TYPE CODE field (NCPDP field 461-EU).
  - For paper claim submission, the provider will write "Hospice" in the upper right hand corner of the claim form. Data entry staff will key the designated customer location code and PRIOR AUTHORIZATION TYPE CODE values in the appropriate fields.
  - Co-pay information is on page 22

Medicare Covered Drugs For Dually Eligible Beneficiaries

- For those Medicare/Medicaid dually eligible transplant and cancer patients, Medicare Part B should be billed for certain specified drugs until the pharmacist receives a Medicare denial of coverage. If the Medicaid patient also has Medicare Part B coverage, any claims submitted to Medicaid as primary for the products on the following page will deny. However, pharmacists may continue to obtain a prior authorization if any of the following criteria are met:
  - The drug is being used for non-transplant reasons (e.g., the patient has rheumatoid arthritis, lupus, etc.).
  - The drug is being used for a non-Medicare sponsored transplant or the transplant was not an organ transplant (e.g., bone marrow transplant).
  - It is an oral cancer drug and is not being used for cancer treatment.
  - It is an oral anti-emetic drug and it is not used as part of a cancer chemotherapy regimen. NOTE: Medicare Part B is the primary payer if the oral anti-emetic replaces an intravenous anti-emetic and the initial oral anti-emetic is administered within 2 hours of chemotherapy administration.
  - It is an inhalation drug and it is not used for the management of: obstructive pulmonary disease, cystic fibrosis, HIV/pneumocystosis, complications of organ transplants, or persistent pulmonary secretions.

IMPORTANT NOTE→: Providers should refer to detailed Medicare Part B drug coverage policy at www.palmettogba.com.

3.5 Medicare Covered Drugs

Drug Name	Dosage Form
IMMUNOSUPPRESSIVES	
Imuran® (Azathioprine)	Oral, Inj.
Cellcept® (Mycophenolate Mofetil)	Oral
Neoral®, Sandimmune® (Cyclosporine)	Oral, Inj.
Prograf® (Tacrolimus)	Oral, Inj.
Rapamune® (Sirolimus)	Oral
Orthoclone OKT3® (Muromonab-CD3)	Inj.
Zenapax® (Daclizumab)	Inj.
Atgam® (Lymphocyte Immune Globulin)	Inj.
ORAL CHEMOTHERAPY	
Cytoxan® (Cyclophosphamide)	Oral
Alkeran® (Melphalan)	Oral
VePesid® (Etoposide)	Oral
Rhumatrex® (Methotrexate)	Oral
Myleran® (Busulfan)	Oral
Temodar® (Temozolomide)	Oral
Xeloda® (Capecitabine)	Oral
INHALATION THERAPY	
Mucomyst® (Acetylcysteine)	Inhalation Solution
Proventil® (Albuterol)	Inhalation Solution
Xopenex® (Levalbuterol)	Inhalation Solution
Tornalate® (Bitolterol)	Inhalation Solution
Pulmicort® (Budesonide)	Inhalation Solution
Intal® (Cromolyn)	Inhalation Solution
Pulmozyme® (Dornase Alfa)	Inhalation Solution
Duo-Neb® (Ipratropium/Albuterol) *	Inhalation Solution
Atrovent® (Ipratropium)	Inhalation Solution
Isoetharine	Inhalation Solution
Alupent® (Metaproterenol)	Inhalation Solution
NebuPent® (Pentamidine)	Inhalation Solution
TOBI® (Tobramycin)	Inhalation Solution
Brethine® (Terbutaline)	Inhalation Solution
Robinul® (Glycopyrrolate)	Inhalation Solution
Atropine	Inhalation Solution
Isuprel® (Isoproterenol)	Inhalation Solution
ANTIEMETIC AGENTS	
Anzemet® (Dolasetron)	Oral
Marinol® (Dronabinol)	Oral
Kytril® (Granisitron)	Oral
Zofran® (Ondansetron)	Oral
MULTIPLE SCLEROSIS THERAPY	
Avonex® (Interferon Beta-A)	Injection

Five digit carrier code for Medicare = 90798

Claims For Long Term Care Beneficiaries

- LTC/ NH beneficiaries are identified by having an LTC segment on the enrollment file.
- The only OTC product covered by Pharmacy Services for LTC/NH beneficiaries is insulin. All other OTC products (regardless of whether they are payable on the drug file or not) will deny.
- LTC/NH beneficiaries are not subject to co-payment requirements.
- LTC/NH beneficiaries are limited to four fee-for-service prescriptions per month, unless the specified monthly prescription limit override criteria are applicable.
- Pneumococcal and influenza vaccines are covered for Medicaid-only LTC patients.
- Exceptions to the monthly prescription limit for fee-for-service LTC/NH patients are:
- Parenteral therapies (excluding insulin)
- Aerosolozed pentamidine
- Clozapine
- Family planning pharmaceuticals and devices

3.6 Prior Authorization Protocols

FIRST HEALTH SERVICES' prior authorization (PA) process is designed to provide rapid, timely responses to prior authorization requests. Prior authorizations will be managed for South Carolina Medicaid by one of three methods:

1. Provider level overrides
2. FIRST HEALTH SERVICES Clinical Call Center
3. FIRST HEALTH SERVICES Technical Call Center

The following tables provide the products, criteria, and billing instructions for each prior authorization method.

PROVIDER LEVEL OVERRIDES		
Product	**Criteria**	**Billing Instructions**
Home-Administered Injectable Products	In order to be considered for reimbursement, injectable products must be rebated and must be administered in the patient's home (including long term care facilities). Unless otherwise noted below, injectables administered in the prescriber's office, emergency room, or clinic are excluded from coverage through Pharmacy Services.	Dispensing pharmacist will enter "1" in the PRIOR AUTHORIZATION TYPE CODE field (data element #461) and "01" in the Customer Location field (data element #307). **The submission of a Medicaid pharmacy claim for an injectable product signifies that the pharmacist has verified the beneficiary's self- or home-administration of that product.**
Risperdal Consta® administered in a South Carolina Department of Mental Health Out-Patient Clinic	In addition to home-administration situations, Risperdal Consta® may be considered for reimbursement if administered in a South Carolina Department of Mental Health Out-Patient Clinic.	Dispensing pharmacist will enter "1" in the PRIOR AUTHORIZATION TYPE CODE field (data element #461) and "10" in the Customer Location field (data element #307). **The submission of a Medicaid pharmacy claim according to this procedure signifies that the pharmacist has verified the DMH Out-Patient Clinic administration.**
Amphetamines for adult patients (> age 21)	Drug is rebated, and dispensing pharmacist determines that usage is appropriate.	Dispensing pharmacist will enter "1" in the PRIOR AUTHORIZATION TYPE CODE field (data element #461)
Lactulose	Drug is rebated, and dispensing pharmacist determines that usage is appropriate.	Dispensing pharmacist will enter "1" in the PRIOR AUTHORIZATION TYPE CODE field (data element #461)
Tretinoin for adult patients (> age 21)	Drug is rebated, and dispensing pharmacist determines that usage is appropriate.	Dispensing pharmacist will enter "1" in the PRIOR AUTHORIZATION TYPE CODE field (data element #461)

3.6.1 Clinical Call Center Prior Authorizations

Product/Edit Type	Billing Instructions
Growth Hormones	In order to receive prior authorization for the product, the pharmacist should ask the prescriber to contact FIRST HEALTH SERVICES Clinical Call Center.
Lipase Inhibitors (orlistat)	In order to receive prior authorization for the product, the pharmacist should ask the prescriber to contact FIRST HEALTH SERVICES Clinical Call Center.
Panretin® (alitretinoin)	In order to receive prior authorization for Panretin®, the pharmacist should ask the prescriber to contact FIRST HEALTH SERVICES Clinical Call Center. **Note:** There is a limit of one tube of Panretin® gel on the initial prescription.
Targretin® (bexarotene)	In order to receive prior authorization for Targretin®, the pharmacist should ask the prescriber to contact FIRST HEALTH SERVICES Clinical Call Center. **Note:** If approved, on the initial prescription there is a limit of one tube of Targretin® gel OR a one month's supply of oral medication.
COX 2 Inhibitors for patients less than 60 years of age	In order to receive prior authorization for the product, the pharmacist should ask the prescriber to contact FIRST HEALTH SERVICES Clinical Call Center.
Anti-Ulcer Medications: • **PPIs for adult patients** • **PPI/H2RA Concurrent Therapy**	In order to receive prior authorization for the product, the pharmacist should ask the prescriber to contact FIRST HEALTH SERVICES Clinical Call Center. Approval period may vary, depending on patient's diagnosis and other patient-specific clinical information.
Tobacco Cessation Products	In order to receive prior authorization for NRT lozenges, nasal inhalers, or sprays, the pharmacist should ask the prescriber to contact FIRST HEALTH SERVICES Clinical Call Center. Documentation verifying the patient's inability to use the patches or gum and the medical necessity for these products will be required.
"Brand Medically Necessary" Designated Products	In order to receive prior authorization for the brand name product, the pharmacist should ask the prescriber to contact FIRST HEALTH SERVICES Clinical Call Center. **Note:** See PA exceptions on page 15.
Maximum Quantity Limitations	Products subject to quantity limitations may be found at **http://southcarolina.fhsc.com**. Quantities exceeding the established per month limitation will require prior authorization for the product; the pharmacist should ask the prescriber to contact FIRST HEALTH SERVICES Clinical Call Center.
Preferred Drug List	In order to receive prior authorization for a non-preferred product, the pharmacist should ask the prescriber to contact FIRST HEALTH SERVICES Clinical Call Center.

3.6.2 Technical Call Center Prior Authorizations

Product/Edit Type	Criteria	Billing Instructions
Medicare Part B Covered Drugs	**See Medicare section, page 17.**	**See Medicare section, page 17.**
Early Refill (ProDUR)	The claim submitted is evaluated to determine if at least 75% of the previous fill of the same drug product has been used. Claims will deny at the POS if the utilization requirement has not been met.	Providers may contact the Technical Call Center at 1-866-254-1669 to request an override.

- For all Clinical Call Center prior authorization requests, the pharmacist should request the prescriber to contact FIRST HEALTH SERVICES' Clinical Call Center (1-866-247-1181, toll-free) in order to provide the necessary patient-specific medical information
- The prescriber is required to initiate clinical prior authorization requests. Ideally this should occur at the point the prescription is being written. If this does not occur, the claim will deny at POS with a message that the prescriber should contact FIRST HEALTH SERVICES for prior authorization consideration.
- Upon receiving a call from the prescriber, FIRST HEALTH SERVICES will work with the prescriber to determine the outcome of the prior authorization request. Often, a change to the patient's drug therapy regimen will be made. In some cases, the requested drug may be authorized; in some instances, the requested drug may be denied. If FIRST HEALTH SERVICES has knowledge regarding which pharmacy services provider is involved, FIRST HEALTH SERVICES will contact that pharmacist with information pertaining to the PA request.
- FIRST HEALTH SERVICES clinical staff is available on site from 8:00 a.m. – 10:00 p.m. Monday through Friday. After normal business hours, and on weekends and holidays, calls to the Clinical Call Center will be forwarded to the Technical Call Center. A Technical Call Center representative will contact an on-call pharmacist if clinical intervention is required.
- FIRST HEALTH SERVICES will respond to all prior authorization requests within 24 hours of initiation of the request by the prescriber.
- If the prescriber cannot be contacted within a reasonable period of time, FIRST HEALTH SERVICES will authorize a 72-hour emergency fill.
- Prior authorization records are entered for a reasonable time based on the nature of the drug/ drug class and any follow-up activity that needs to occur.
- It is not necessary to enter a PA number when the claim is transmitted. An active PA record in the FIRST HEALTH SERVICES system is all that is necessary in order for the claim to be submitted.
- Prior authorization edits will apply to all claim types and claims media.

3.7 Beneficiary Financial Requirements

- **<u>Co-payments:</u>**
  - Except as specified below, South Carolina Medicaid beneficiaries age 19 and older are subject to a $3.00 per prescription/refill co-payment.
  - Co-payments for "partial fills" are prorated based on quantity dispensed vs. quantity prescribed for the month's supply – refer to Section 3.1 of this POS Manual.

- The following beneficiaries and/or services are exempt from the co-payment requirement:
  - Beneficiaries from birth to the date of 19th birthday
  - Beneficiaries residing in a long term care facility
  - Beneficiaries who are pregnant (verified by either the patient or prescriber) Providers should enter a value of "2" in the PRIOR AUTHORIZATION TYPE CODE field
  - Family planning pharmaceuticals and devices
  - Beneficiaries enrolled in the Elderly/Disabled, HASCI, HIV/AIDS, VENT, SC Choice, or MR/RD waiver programs
  - Beneficiaries receiving hospice care

- **SILVERxCARD Co-payment Amounts:**
  - Generic drugs $10
  - Brand name drugs $15
  - Drugs requiring PA $21

- **ANNUAL DEDUCTIBLE:**
  - SILVERxCARD enrollees $500.00

3.8 Coordination of Benefits (COB)/Third Party Liability (TPL)

- Claims for **Coordination of Benefits (COB)** where the SOUTH CAROLINA Medicaid is not the primary payer will be processed on-line. In those cases where the SOUTH CAROLINA Medicaid beneficiary has other insurance coverage, pharmacy providers will be required to bill all other insurance carriers (including Medicare) before billing South Carolina Medicaid. NCPDP override conditions will be supported.
- No primary insurer co-payments or deductibles should be collected from beneficiaries if the claim is for a covered South Carolina Medicaid product. **Only the South Carolina Medicaid co-payment (if applicable) should be collected from the beneficiary.**
- OTHER COVERAGE CODE (NCPDP field 308-C8) = "1" *No other coverage identified* (I.e., primary insurance carrier indicates patient has *never* had coverage). *Note: See OCC "7" definition below if primary insurance has been "terminated".*
- OTHER COVERAGE CODE (NCPDP field 308-C8) = "2" *Other coverage exists - payment collected* should be submitted when payment was collected from the primary insurance carrier(s).
- OTHER COVERAGE CODE (NCPDP field 308-C8) = "3" *Other coverage exists – claim not covered* should only be submitted if the primary insurance carrier returned a NCPDP 70 – *NDC Not Covered* denial. If the primary carrier requires a Prior Authorization (NCPDP 75), then the primary carrier's prior authorization procedures must be followed prior to submitting the claim to South Carolina Medicaid for secondary payment.
- OTHER COVERAGE CODE (NCPDP field 308-C8) = "4" *Other coverage exists - payment not collected* should only be submitted if the primary insurance carrier did not cover any portion of the claim due to a beneficiary's deductible or co-payment obligation.
- OTHER COVERAGE CODE (NCPDP field 308-C8) = "7" *Other coverage exists – not in effect on DOS* (i.e., primary insurance coverage has lapsed).
- OTHER COVERAGE CODE (NCPDP field 308-C8) = "5", "6" or "8" will not be allowed for overrides.
- HIPAA has not named a standard identifier for the OTHER PAYER ID. Consequently, FIRST HEALTH SERVICES typically uses the South Carolina specific IDs. If there is payment received from multiple other carriers, FIRST HEALTH SERVICES will require the **total amount paid** from **all valid carriers** in the OTHER PAYER AMOUNT field.
- Even if **no** "other insurance" is indicated on the eligibility file, FIRST HEALTH SERVICES will **process the claim as a TPL claim if the pharmacist submits TPL data as indicated in the TPL Processing Grid (see below).**
- If other insurance is indicated on the eligibility file, then FHS will **process as TPL. All required TPL values must be submitted for claim processing.**
- In all cases, FIRST HEALTH SERVICES will use the SOUTH CAROLINA Medicaid **"Allowed Amount"** when calculating payment. Note that in some cases, this may result in a "0" payment.
- South Carolina will allow providers to override days' supply limitations and/or Drug requires Prior Authorization conditions by entering a value of "**5**" (exemption from monthly prescription limit) in the *Prior Authorization Type Code* field (NCPDP field # 461-EU) when the *Other Coverage Code* = 2 (NCPDP field # 308-C8).

○ Note - This override situation applies to TPL/COB processing only and is ONLY allowed when the Other Coverage Code = "2" (*Other coverage exists-payment collected*).

3.8.1 Change and Updates for Beneficiary Insurance

- Pharmacies are required to keep updated primary insurance information for beneficiaries to ensure appropriate claims submission to Medicaid. When the pharmacist becomes aware that there has been a change in a beneficiary's primary insurance, they are asked to complete a HEALTH INSURANCE INFORMATION REFERRAL FORM and fax it to Medicaid Insurance Verification Services at (803) 252-0870. This form may be obtained from http://southcarolina.fhsc.com. (Choose PROVIDERS then DOCUMENTS)

COB GRID

	Other Coverage Code (field # 308-C8)	Other Payer Amount Paid (field # 431-DV)	Other Coverage indicated on SC Medicaid Recipient Record	Other Payer Date (field # 443-E8)	Other Payer ID (field # 340-7C)	Claim Disposition	Comments
1	**0 = Not Specified**	0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date*	**This code will not override TPL.**
2	**0 = Not Specified**	0	No	Null	Null	Pay	
3	**0 = Not Specified**	>0	No	M/I or null	M/I or null	Deny, *M/I Other Payer Date*	
4	**0 = Not Specified**	>0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer Amount*	
5	**1 = No other coverage identified**	0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date*	
6	**1 = No other coverage identified**	0	Yes	Valid Date	Valid TPL Carrier Code	Pay	**Use when primary does not show coverage.**
7	**1 = No other coverage identified**	0	No	M/I or null	M/I or null	Pay	
8	**1 = No other coverage identified**	>0	No	M/I or null	M/I or null	Deny, *Primary, M/I Other Payer Date*	
9	**1 = No other coverage identified**	>0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer Amount*	
10	**1 = No other coverage identified**	0	Yes	Valid Date	M/I or null	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payor ID*	
11	**1 = No other coverage identified**	0	No	Valid Date	M/I or null	Deny, *M/I Other Payer Date*	
12	**1 = No other coverage identified**	0	No	M/I or null	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
13	**1 = No other coverage identified**	0	Yes	M/I or null	Valid TPL Carrier Code	Deny,*M/I Other Payer Date*	
14	**1 = No other coverage identified**	0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, *Bill Primary*	
15	**1 = No other coverage identified**	0	Yes	Date > Adjudication Date	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	

	Other Coverage Code (field # 308-C8)	Other Payer Amount Paid (field # 431-DV)	Other Coverage indicated on SC Medicaid Recipient Record	Other Payer Date (field # 443-E8)	Other Payer ID (field # 340-7C)	Claim Disposition	Comments
16	**2 = Other coverage exists, payment collected**	> 0	Yes or No	Valid Date	Valid TPL Carrier Code	Pay (Will pay when all Carriers have been overridden)	**Will pay the difference between the SC Medicaid Allowed Amount and the Other PayerAmount**
17	**2 = Other coverage exists, payment collected**	>0	No	Valid Date	M/I or null	Deny, *M/I Other Payer Date, M/I Other Payer ID*	
18	**2 = Other coverage exists, payment collected**	>0	Yes	Valid Date	M/I or null	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer ID*	
19	**2 = Other coverage exists, payment collected**	>0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
20	**2 = Other coverage exists, payment collected**	0	No	M/I or null	M/I or null	Deny, *M/I Other Payer Date, MI Other Payer Amount*	
21	**2 = Other coverage exists, payment collected**	0	Yes	N/A	N/A	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer Amount*	
22	**2 = Other coverage exists, payment collected**	>0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, *Bill Primary*	
23	**2 = Other coverage exists, payment collected**	>0	Yes	Denial > Adjudication Date	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
24	**3 = Other coverage exists, this claim not covered**	0	Yes or No	Valid Date	Valid TPL Carrier Code	Pay	**Pay the SC Medicaid Allowed Amount.**

	Other Coverage Code (field # 308-C8)	Other Payer Amount Paid (field # 431-DV)	Other Coverage indicated on SC Medicaid Recipient Record	Other Payer Date (field # 443-E8)	Other Payer ID (field # 340-7C)	Claim Disposition	Comments
25	**3 = Other coverage exists, this claim not covered**	0	No	Valid Date	M/I	Deny, *M/I Other Payer Date, M/I Other Payer ID*	
26	**3 = Other coverage exists, this claim not covered**	0	Yes	Valid Date	M/I	Deny, *Bill Primary*	
27	**3 = Other coverage exists, this claim not covered**	0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
28	**3 = Other coverage exists, this claim not covered**	>0	No	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date*	
29	**3 = Other coverage exists, this claim not covered**	>0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer Amount*	
30	**3 = Other coverage exists, this claim not covered**	>0	Yes or No	Valid	Valid	Deny, *M/I Other Payer Amount*	
31	**3 = Other coverage exists, this claim not covered**	>0	Yes	Valid	Invalid	Deny, *Bill Primary, M/I Other Payer Amount*	
32	**3 = Other coverage exists, this claim not covered**	>0	No	Valid	Invalid	Deny, *M/I Other Payer Amount*	
33	**3 = Other coverage exists, this claim not covered**	>0	Yes or No	Invalid	Valid	Deny, *M/I Other Payer Date, M/I Other Payer Amount*	
34	**3 = Other coverage**	0	Yes	Valid Date	Invalid TPL	Deny, *Bill Primary Payer*	

	Other Coverage Code (field # 308-C8)	Other Payer Amount Paid (field # 431-DV)	Other Coverage indicated on SC Medicaid Recipient Record	Other Payer Date (field # 443-E8)	Other Payer ID (field # 340-7C)	Claim Disposition	Comments
	exists, this claim not covered				Carrier Code		
35	**3 = Other coverage exists, this claim not covered**	0	Yes	Denial > Adjudication Date	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
36	**4 = Other coverage exists, payment not collected**	>0	No	M/I or null	M/I or null	Deny, *M/I Other Payer Date, M/I Other Payer Amount*	
37	**4 = Other coverage exists, payment not collected**	>0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer Amount*	
38	**4 = Other coverage exists, payment not collected**	>0	Yes or No	Valid	Valid	Deny, *M/I Other Payer Amount*	
39	**4 = Other coverage exists, payment not collected**	>0	Yes	Valid	Invalid	Deny, *Bill Primary, M/I Other Payer Amount*	
40	**4 = Other coverage exists, payment not collected**	>0	No	Valid	Invalid	Deny, *M/I Other Payer Amount*	
41	**4 = Other coverage exists, payment not collected**	>0	Yes or No	Invalid	Valid	Deny, *M/I Other Payer Date, M/I Other Payer Amount*	
42	**4 = Other coverage exists, payment not collected**	0	Yes	Valid Date	Valid TPL Carrier Code	Pay	**Use if primary is full deductible or 100% copay.**
43	**4 = Other coverage exists, payment not collected**	0	Yes	Valid Date	M/I or null	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer ID*	

	Other Coverage Code (field # 308-C8)	Other Payer Amount Paid (field # 431-DV)	Other Coverage indicated on SC Medicaid Recipient Record	Other Payer Date (field # 443-E8)	Other Payer ID (field # 340-7C)	Claim Disposition	Comments
44	**4 = Other coverage exists, payment not collected**	0	No	Valid Date	M/I or null	Deny, *M/I Other Payer Date*	
45	**4 = Other coverage exists, payment not collected**	0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
46	**4 = Other coverage exists, payment not collected**	0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, *Bill Primary*	
47	**4 = Other coverage exists, payment not collected**	0	Yes	Date > Adjudication Date	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
48	**New 5.1 codes:**						
49	**5 = Managed care plan denial**					Deny, *Drug Not Covered* Additional Message: *OCC 5/ 6/ 8 Not Allowed for Override*	**Not allowed for override. NCPDP 70/ with message**
50	**6 = Other coverage denied – not a participating provider**					Deny, *Drug Not Covered* Additional Message: *OCC 5/ 6/ 8 Not Allowed for Override*	**Not allowed for override. NCPDP 70/ with message**
51	**7 = Other coverage exists – not in effect on DOS**						**Use if TPL expired; edits mirror OCC = 1.**
52	**8 = Claim is billing for copay**					Deny, *Drug Not Covered* Additional Message: *OCC 5/ 6/ 8 Not Allowed for Override*	**Not allowed for override. NCPDP 70/ with message**

3.9 Special Processing Conditions

- **Compound Claims:**

The following method will be used for compound claim processing:

- Each compound ingredient will **undergo all edits** relative to the NDC.
- Compounds will be counted as one prescription and applied to the adult beneficiary's monthly limit as one prescription.
- The claims will pay according to the designated payment logic.

- **Routine Compounds - Procedures for claim submission**

- The claim segment product ID (i.e., NDC) is defined as a mandatory field and therefore must be submitted for all claims, including multi-ingredient compounds. A non-space value is expected in this field for field validation. A claim for a multi-ingredient compound must be submitted with all zeroes in this field. For compound segment transactions, the claim will reject if all zeroes are not submitted as the product ID.

- A Submission Clarification Code value of "8" will allow a claim to continue processing if at least one ingredient is covered.

CLAIMS SUBMISSION INSTRUCTIONS FOR MULTI-INGREDIENT COMPOUND PRESCRIPTIONS

Providers must submit the actual NDC *listed on the package* for each ingredient used to compound the prescription. Multi-ingredient compound claims submitted with inaccurate NDC's for the actual ingredients dispensed are subject to post-payment review and recoupment of Medicaid monies.

Compounds:

Compounds should be processed on-line using "multiple ingredient functionality." All edits apply to each NDC. Providers should enter the following:

On Claim Segment:

- SUBMISSION CLARIFICATION CODE (NCPDP field # 420-DK) = 8.
  A value of 8 ("Process Compound for Approved Ingredients") allows a claim to continue processing if at least one ingredient is covered.
- Enter PRODUCT/SERVICE ID QUALIFIER (NCPDP field # 436-E1) as "03" (= NDC)
- Enter PRODUCT CODE/NDC (NCPDP field # 407-D7) as "00000000000" on the claim segment to identify the claim as a multi-ingredient compound.
- Enter COMPOUND CODE (NCPDP field # 406-D6) of "2".
- Enter QUANTITY DISPENSED (NCPDP field # 442-E7) of entire product.
- Enter GROSS AMOUNT DUE (NCPDP field # 430-DU) for entire product.

On Compound Segment:

- Enter COMPOUND DOSAGE FORM DESCRIPTION CODE (NCPDP field # 450-EF).
- COMPOUND DISPENSING UNIT FORM INDICATOR (NCPDP field # 451-EG).
- COMPOUND ROUTE OF ADMINISTRATION (NCPDP field # 452-EH).
- COMPOUND INGREDIENT COMPONENT COUNT (NCPDP field # 447-EC) (Maximum of 25).

For Each Line Item:

- COMPOUND PRODUCT ID QUALIFIER (NCPDP field # 488-RE).
- COMPOUND PRODUCT ID (NCPDP field # 489-TE); (I.e., NDC).
- COMPOUND INGREDIENT QUANTITY (NCPDP field # 448-ED).
- COMPOUND INGREDIENT DRUG COST (NCPDP field # 449-EE).

- NOTE: Partial fill functionality cannot be used when submitting Multi-Ingredient Compound claims.

➢ **Procedures for Submitting Alternate Reimbursement Methodology (ARM) Claims for Rebate Data Reporting**

- Quarterly claims data submitted by ARM providers for rebate reporting-only purposes must be transmitted to FIRST HEALTH SERVICES via diskette (3.5in, unzipped) in NCPDP Batch v1.1 format. *Such claims rebate data may not be submitted via the POS system.* The ARM rebate data diskettes should be sent to:

FIRST HEALTH Services
Attn: Rebate Dept.
4300 Cox Road
Glen Allen, VA 23060

- Diskettes must be accompanied by an ARM Transmittal Slip. Questions regarding proper diskette formatting, specifications, etc., should be directed to First Health Services Provider Relations Department at 1-800-884-2822, ext. 7729.

If you require additional assistance with this process, contact FIRST HEALTH SERVICES at:

1-866-254-1669

Section 4: Prospective Drug Utilization Review

Prospective drug utilization review (ProDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of FIRST HEALTH SERVICES assists the pharmacist in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may NOT have been previously available.

Because FIRST HEALTH SERVICES' ProDUR system examines claims from all participating pharmacies, drugs which interact or are affected by previously dispensed medications can be detected. FIRST HEALTH SERVICES recognizes that the pharmacist uses his/her education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacist in performing his/her professional duties.

4.1 ProDUR Problem Types

- Listed below are ALL ProDUR conflict types within the FIRST HEALTH SERVICES system for the SOUTH CAROLINA Medicaid program.

1. Drug to Drug Interaction (DD)
2. Early Refill (ER)
3. Late Refill (LR)
4. Therapeutic Duplication (TD)
5. Duplicate Ingredient (ID)
6. Drug to Pregnancy Precaution (PG)
7. Minimum/Maximum Daily Dosing (LD, HD)
8. Drug to Pediatric Precaution (PA)
9. Drug to Geriatric Precaution (PA)
10. Drug to Disease (MC)
11. Drug to Inferred Disease (DC)
12. Prerequisite Drug Therapy (SR)

- Drug to Drug Interactions and Therapeutic Duplication edits that deny may be overridden by the pharmacy provider at the POS using the NCPDP DUR override codes listed on pages 45.
- For Early Refill denials, providers should contact the FIRST HEALTH Technical Call Center (866-254-1669) to request an override.
- For Prerequisite Drug Therapy denials, providers should contact the FIRST HEALTH Clinical Call Center (866.257.1181) to request a prior authorization.

4.2 Days' Supply

Days' supply information is critical to the edit functions of the ProDUR system. Submitting incorrect days' supply information in the days' supply field can cause false positive ProDUR messages or claim denial for that particular claim or for drug claims that are submitted in the future.

4.3 Technical Call Center

FIRST HEALTH SERVICES Technical Call Center is available 24 hours per day, seven days per week. The telephone number is 866.254.1669. Alert message information is available from the Call Center after the message appears. If you need assistance with any alert or denial messages, it is important to contact the Call Center about FIRST HEALTH SERVICES ProDUR messages at the time of dispensing. The Call Center can provide claims information on all error messages which are sent by the ProDUR system. This information includes: NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days supply.

The Technical Call Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. FIRST HEALTH SERVICES has used reasonable care to accurately compile ProDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their patients.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, FIRST HEALTH SERVICES staff pharmacists are available for consultation.

4.4 ProDUR Alert/Error Messages

- All ProDUR alert messages appear at the end of the claims adjudication transmission. Alerts will appear in the following format:

FORMAT	FIELD DEFINITIONS
REASON FOR SERVICE:	Up to 3 characters. Code transmitted to pharmacy when a conflict is detected. (e.g., ER, HD, TD, DD).
SEVERITY INDEX CODE:	1 character. Code indicates how critical a given conflict is.
OTHER PHARMACY INDICATOR:	1 character. Indicates if the dispensing provider also dispensed the first drug in question. 1 = Your pharmacy. 3 = Other pharmacy
PREVIOUS DATE OF FILL:	8 characters. Indicates previous fill date of conflicting drug in YYYYMMDD format.
QUANTITY OF PREVIOUS FILL:	5 characters. Indicates quantity of conflicting drug previously dispensed.
DATA BASE INDICATOR:	1 character. Indicates source of ProDUR message. 1 = First DataBank 4 = Processor Developed
OTHER PRESCRIBER	1 character. Indicates the prescriber of conflicting prescription. 0 = No Value 1 = Same Prescriber 2 = Other Prescriber

Section 5: Edits

5.1 On Line Claims Processing Messages

Following an on-line claim submission by a pharmacy, the system will return a message to indicate the outcome of processing. If the claim passes all edits, a "Paid" message will be returned with SOUTH CAROLINA Medicaid's allowed amount for the paid claim. A claim that fails an edit and is rejected (denied) will also return a message. Following is a list of the program's error codes with their corresponding NCPDP rejection codes.

As shown below, an NCPDP error code is returned with an NCPDP message. Where applicable, the NCPDP field that should be checked is referenced. Check the "Solutions" box if you are experiencing difficulties. For further assistance, contact FIRST HEALTH SERVICES at:

TECHNICAL CALL CENTER
1-866-254-1669
(Nationwide Toll-Free Number)

POINT OF SALE REJECT CODES AND MESSAGES
~ All edits may not apply to this program ~
~ All submitted data elements will be edited for valid format and valid values ~

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
ØØ	("M/I" Means Missing/Invalid)		
Ø1	M/I Bin	1Ø1	Use ØØ9745
Ø2	M/I Version Number	1Ø2	Use 51
Ø3	M/I Transaction Code	1Ø3	Transactions allowed = B1, B2, B3.
Ø4	M/I Processor Control Number	1Ø4	Use PØØ62 ØØ9745.
Ø5	M/I Pharmacy Number	2Ø1	Use NCPDP (formerly NABP) number only; do not send SC Medicaid ID. Must be actively enrolled with SC Medicaid on DOS. Check with software vendor to ensure appropriate number has been set up in your system.
Ø6	M/I Group Number	3Ø1	Use SCMEDICAID only.
Ø7	M/I Cardholder ID Number	3Ø2	Use SC Medicaid beneficiary ID number; for SILVERxCARD enrollees, use SSN. Do not use any other type of patient ID. Do not enter any dashes. **Providers should always examine a beneficiary's Medicaid ID card before services are rendered. It is the provider's responsibility to establish the identity of the individual and to verify the effective date of coverage for the card presented.**
Ø8	M/I Person Code	3Ø3	
Ø9	M/I Birth Date	3Ø4	Format = CCYYMMDD.
1C	M/I Smoker/Non-Smoker Code	334	
1E	M/I Prescriber Location Code	467	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
1Ø	M/I Patient Gender Code	3Ø5	Values = 0/ not specified; 1/ male and 2/ female.
11	M/I Patient Relationship Code	3Ø6	Allowed value = 1/ cardholder
12	M/I Patient Location	3Ø7	Allowed values = 3/ nursing home, 4/ long term/ extended care or 11/ hospice.
13	M/I Other Coverage Code	3Ø8	See *Coordination of Benefits* section.
14	M/I Eligibility Clarification Code	3Ø9	
15	M/I Date of Service	4Ø1	
16	M/I Prescription/Service Reference Number	4Ø2	Ensure all appropriate codes on refill are same as original fill.
17	M/I Fill Number	4Ø3	
19	M/I Days Supply	4Ø5	
2C	M/I Pregnancy Indicator	335	
2E	M/I Primary Care Provider ID Qualifier	468	
2Ø	M/I Compound Code	4Ø6	
21	M/I Product/Service ID	4Ø7	
22	M/I Dispense As Written (DAW)/Product Selection Code	4Ø8	
23	M/I Ingredient Cost Submitted	4Ø9	
25	M/I Prescriber ID	411	
26	M/I Unit Of Measure	6ØØ	
28	M/I Date Prescription Written	414	
29	M/I Number Refills Authorized	415	
3A	M/I Request Type	498-PA	
3B	M/I Request Period Date-Begin	498-PB	
3C	M/I Request Period Date-End	498-PC	
3D	M/I Basis Of Request	498-PD	
3E	M/I Authorized Representative First Name	498-PE	
3F	M/I Authorized Representative Last Name	498-PF	
3G	M/I Authorized Representative Street Address	498-PG	
3H	M/I Authorized Representative City Address	498-PH	
3J	M/I Authorized Representative State/Province Address	498-PJ	
3K	M/I Authorized Representative Zip/Postal Zone	498-PK	
3M	M/I Prescriber Phone Number	498-PM	
3N	M/I Prior Authorized Number Assigned	498-PY	
3P	M/I Authorization Number	5Ø3	
3R	Prior Authorization Not Required	4Ø7	
3S	M/I Prior Authorization Supporting Documentation	498-PP	
3T	Active Prior Authorization Exists Resubmit At Expiration Of Prior Authorization		
3W	Prior Authorization In Process		
3X	Authorization Number Not Found	5Ø3	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
3Y	Prior Authorization Denied		
32	M/I Level Of Service	418	
33	M/I Prescription Origin Code	419	
34	M/I Submission Clarification Code	42Ø	
35	M/I Primary Care Provider ID	421	
38	M/I Basis Of Cost	423	
39	M/I Diagnosis Code	424	Do not enter any names in this field.
4C	M/I Coordination Of Benefits/Other Payments Count	337	
4E	M/I Primary Care Provider Last Name	57Ø	
4Ø	Pharmacy Not Contracted With Plan On Date Of Service		
41	Submit Bill To Other Processor Or Primary Payer		Refer to additional messaging in Additional Message field for Other Payer ID, name and policy # (if available).
5C	M/I Other Payer Coverage Type	338	
5E	M/I Other Payer Reject Count	471	Must equal the number of Other Payer Reject Codes if submitted.
5Ø	Non-Matched Pharmacy Number	2Ø1	
51	Non-Matched Group ID	3Ø1	
52	Non-Matched Cardholder ID	3Ø2	Validate patient's first and last names.
53	Non-Matched Person Code	3Ø3	
54	Non-Matched Product/Service ID Number	4Ø7	
55	Non-Matched Product Package Size	4Ø7	
56	Non-Matched Prescriber ID	411	
58	Non-Matched Primary Prescriber	421	
6C	M/I Other Payer ID Qualifier	422	Enter 99/ other.
6E	M/I Other Payer Reject Code	472	Ensure validly formatted codes are sent.
6Ø	Product/Service Not Covered For Patient Age	3Ø2, 3Ø4, 4Ø1, 4Ø7	
61	Product/Service Not Covered For Patient Gender	3Ø2, 3Ø5, 4Ø7	
62	Patient/Card Holder ID Name Mismatch	31Ø, 311, 312, 313, 32Ø	Validate patient's first and last names.
63	Institutionalized Patient Product/Service ID Not Covered		
64	Claim Submitted Does Not Match Prior Authorization	2Ø1, 4Ø1, 4Ø4, 4Ø7, 416	
65	Patient Is Not Covered	3Ø3, 3Ø6	
66	Patient Age Exceeds Maximum Age	3Ø3, 3Ø4, 3Ø6	
67	Filled Before Coverage Effective	4Ø1	
68	Filled After Coverage Expired	4Ø1	
69	Filled After Coverage Terminated	4Ø1	
7C	M/I Other Payer ID	34Ø	Must be appropriate SC Other Payer ID.
7E	M/I DUR/PPS Code Counter	473	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
7Ø	Product/Service Not Covered	4Ø7	
71	Prescriber Is Not Covered	411	
72	Primary Prescriber Is Not Covered	421	
73	Refills Are Not Covered	4Ø2, 4Ø3	
74	Other Carrier Payment Meets Or Exceeds Payable	4Ø9, 41Ø, 442	
75	Prior Authorization Required	462	
76	Plan Limitations Exceeded	4Ø5, 442	
77	Discontinued Product/Service ID Number	4Ø7	
78	Cost Exceeds Maximum	4Ø7, 4Ø9, 41Ø, 442	
79	Refill Too Soon	4Ø1, 4Ø3, 4Ø5	
8C	M/I Facility ID	336	
8E	M/I DUR/PPS Level Of Effort	474	
8Ø	Drug-Diagnosis Mismatch	4Ø7, 424	
81	Claim Too Old	4Ø1	Claim exceeds filing limit; validate DOS.
82	Claim Is Post-Dated	4Ø1	DOS is greater than submittal date.
83	Duplicate Paid/Captured Claim	2Ø1, 4Ø1, 4Ø2, 4Ø3, 4Ø7	
84	Claim Has Not Been Paid/Captured	2Ø1, 4Ø1, 4Ø2	
85	Claim Not Processed	None	
86	Submit Manual Reversal	None	
87	Reversal Not Processed	None	Reversals must match on Provider #, Rx #, DOS and NDC.
88	DUR Reject Error		
89	Rejected Claim Fees Paid		Response Not In Appropriate Format To Be Displayed
9Ø	Host Hung Up		Processing Host Did Not Accept Transaction/Did Not Respond Within Time Out Period
91	Host Response Error		
92	System Unavailable/Host Unavailable		
*95	Time Out		
*96	Scheduled Downtime		
*97	Payer Unavailable		
*98	Connection To Payer Is Down		
99	Host Processing Error		Do Not Retransmit Claim(s)
AA	Patient Spend-down Not Met		
AB	Date Written Is After Date Filled		
AC	Product Not Covered Non-Participating Manufacturer		
AD	Billing Provider Not Eligible To Bill This Claim Type		
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
AF	Patient Enrolled Under Managed Care		
AG	Days Supply Limitation For Product/Service		
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients		
AJ	Generic Drug Required		
AK	M/I Software Vendor/Certification ID	11Ø	
AM	M/I Segment Identification	111	
A9	M/I Transaction Count	1Ø9	
BE	M/I Professional Service Fee Submitted	477	
B2	M/I Service Provider ID Qualifier	2Ø2	
CA	M/I Patient First Name	31Ø	
CB	M/I Patient Last Name	311	
CC	M/I Cardholder First Name	312	
CD	M/I Cardholder Last Name	313	
CE	M/I Home Plan	314	
CF	M/I Employer Name	315	
CG	M/I Employer Street Address	316	
CH	M/I Employer City Address	317	
CI	M/I Employer State/Province Address	318	
CJ	M/I Employer Zip Postal Zone	319	
CK	M/I Employer Phone Number	32Ø	
CL	M/I Employer Contact Name	321	
CM	M/I Patient Street Address	322	
CN	M/I Patient City Address	323	
CO	M/I Patient State/Province Address	324	
CP	M/I Patient Zip/Postal Zone	325	
CQ	M/I Patient Phone Number	326	
CR	M/I Carrier ID	327	
CW	M/I Alternate ID	33Ø	
CX	M/I Patient ID Qualifier	331	
CY	M/I Patient ID	332	
CZ	M/I Employer ID	333	
DC	M/I Dispensing Fee Submitted	412	
DN	M/I Basis Of Cost Determination	423	
DQ	M/I Usual And Customary Charge	426	
DR	M/I Prescriber Last Name	427	
DT	M/I Unit Dose Indicator	429	
DU	M/I Gross Amount Due	43Ø	
DV	M/I Other Payer Amount Paid	431	
DX	M/I Patient Paid Amount Submitted	433	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
DY	M/I Date Of Injury	434	
DZ	M/I Claim/Reference ID	435	
EA	M/I Originally Prescribed Product/Service Code	445	
EB	M/I Originally Prescribed Quantity	446	
EC	M/I Compound Ingredient Component Count	447	
ED	M/I Compound Ingredient Quantity	448	
EE	M/I Compound Ingredient Drug Cost	449	
EF	M/I Compound Dosage Form Description Code	45Ø	
EG	M/I Compound Dispensing Unit Form Indicator	451	
EH	M/I Compound Route Of Administration	452	
EJ	M/I Originally Prescribed Product/Service ID Qualifier	453	
EK	M/I Scheduled Prescription ID Number	454	
EM	M/I Prescription/Service Reference Number Qualifier	445	
EN	M/I Associated Prescription/Service Reference Number	456	
EP	M/I Associated Prescription/Service Date	457	
ER	M/I Procedure Modifier Code	459	
ET	M/I Quantity Prescribed	46Ø	
EU	M/I Prior Authorization Type Code	461	
EV	M/I Prior Authorization Number Submitted	462	
EW	M/I Intermediary Authorization Type ID	463	
EX	M/I Intermediary Authorization ID	464	
EY	M/I Provider ID Qualifier	465	
EZ	M/I Prescriber ID Qualifier	466	
E1	M/I Product/Service ID Qualifier	436	
E3	M/I Incentive Amount Submitted	438	
E4	M/I Reason For Service Code	439	Enter appropriate DUR problem type (e.g., 'ER' = Early Refill) for override consideration.
E5	M/I Professional Service Code	44Ø	Enter appropriate DUR intervention type (e.g., 'M0' = prescriber consulted) for override consideration.
E6	M/I Result Of Service Code	441	Enter appropriate DUR outcome type (e.g., '1A' = filled as is, false positive) for override consideration.
E7	M/I Quantity Dispensed	442	Enter appropriate metric decimal quantity.
E8	M/I Other Payer Date	443	Used for COB. Enter valid date Other Payer paid or denied the primary claim. Date must be =/< DOS of claim to Medicaid.
E9	M/I Provider ID	444	
FO	M/I Plan ID	524	
GE	M/I Percentage Sales Tax Amount Submitted	482	
HA	M/I Flat Sales Tax Amount Submitted	481	
HB	M/I Other Payer Amount Paid Count	341	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
HC	M/I Other Payer Amount Paid Qualifier	342	
HD	M/I Dispensing Status	343	
HE	M/I Percentage Sales Tax Rate Submitted	483	
HF	M/I Quantity Intended To Be Dispensed	344	
HG	M/I Days Supply Intended To Be Dispensed	345	
H1	M/I Measurement Time	495	
H2	M/I Measurement Dimension	496	
H3	M/I Measurement Unit	497	
H4	M/I Measurement Value	499	
H5	M/I Primary Care Provider Location Code	469	
H6	M/I DUR Co-Agent ID	476	
H7	M/I Other Amount Claimed Submitted Count	478	
H8	M/I Other Amount Claimed Submitted Qualifier	479	
H9	M/I Other Amount Claimed Submitted	48Ø	
JE	M/I Percentage Sales Tax Basis Submitted	484	
J9	M/I DUR Co-Agent ID Qualifier	475	
KE	M/I Coupon Type	485	
M1	Patient Not Covered In This Aid Category		
M2	Recipient Locked In		
M3	Host PA/MC Error		
M4	Prescription/Service Reference Number/Time Limit Exceeded		
M5	Requires Manual Claim		
M6	Host Eligibility Error		
M7	Host Drug File Error		
M8	Host Provider File Error		
ME	M/I Coupon Number	486	
MZ	Error Overflow		
NE	M/I Coupon Value Amount	487	
NN	Transaction Rejected At Switch Or Intermediary		
PA	PA Exhausted/Not Renewable		
PB	Invalid Transaction Count For This Transaction Code	1Ø3, 1Ø9	
PC	M/I Claim Segment	111	
PD	M/I Clinical Segment	111	
PE	M/I COB/Other Payments Segment	111	
PF	M/I Compound Segment	111	
PG	M/I Coupon Segment	111	
PH	M/I DUR/PPS Segment	111	
PJ	M/I Insurance Segment	111	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
PK	M/I Patient Segment	111	
PM	M/I Pharmacy Provider Segment	111	
PN	M/I Prescriber Segment	111	
PP	M/I Pricing Segment	111	
PR	M/I Prior Authorization Segment	111	
PS	M/I Transaction Header Segment	111	
PT	M/I Workers' Compensation Segment	111	
PV	Non-Matched Associated Prescription/Service Date	457	
PW	Non-Matched Employer ID	333	
PX	Non-Matched Other Payer ID	34Ø	
PY	Non-Matched Unit Form/Route of Administration	451, 452, 6ØØ	
PZ	Non-Matched Unit Of Measure To Product/Service ID	4Ø7, 6ØØ	
P1	Associated Prescription/Service Reference Number Not Found	456	
P2	Clinical Information Counter Out Of Sequence	493	
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions	447	
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions	337	
P5	Coupon Expired	486	
P6	Date Of Service Prior To Date Of Birth	3Ø4, 4Ø1	
P7	Diagnosis Code Count Does Not Match Number Of Repetitions	491	
P8	DUR/PPS Code Counter Out Of Sequence	473	
P9	Field Is Non-Repeatable		
RA	PA Reversal Out Of Order		
RB	Multiple Partials Not Allowed		
RC	Different Drug Entity Between Partial & Completion		
RD	Mismatched Cardholder/Group ID-Partial To Completion	3Ø1, 3Ø2	
RE	M/I Compound Product ID Qualifier	488	
RF	Improper Order Of "Dispensing Status" Code On Partial Fill Transaction		
RG	M/I Associated Prescription/service Reference Number On Completion Transaction	456	
RH	M/I Associated Prescription/Service Date On Completion Transaction	457	
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	4Ø1	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
RN	Plan Limits Exceeded On Intended Partial Fill Values	344, 345	
RP	Out Of Sequence “P” Reversal On Partial Fill Transaction		
RS	M/I Associated Prescription/Service Date On Partial Transaction	457	
RT	M/I Associated Prescription/Service Reference Number On Partial Transaction	456	
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	478, 48Ø	
R2	Other Payer Reject Count Does Not Match Number Of Repetitions	471, 472	
R3	Procedure Modifier Code Count Does Not Match Number Of Repetitions	458, 459	
R4	Procedure Modifier Code Invalid For Product/Service ID	4Ø7, 436, 459	
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals Ø6	4Ø7, 436	
R6	Product/Service Not Appropriate For This Location	3Ø7, 4Ø7, 436	
R7	Repeating Segment Not Allowed In Same Transaction		
R8	Syntax Error		
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae	43Ø	
SE	M/I Procedure Modifier Code Count	458	
TE	M/I Compound Product ID	489	
UE	M/I Compound Ingredient Basis Of Cost Determination	49Ø	
VE	M/I Diagnosis Code Count	491	
WE	M/I Diagnosis Code Qualifier	492	
XE	M/I Clinical Information Counter	493	
ZE	M/I Measurement Date	494	

5.2 Host System Problems

Occasionally providers may receive a message that indicates their network is having technical problems communicating with FIRST HEALTH SERVICES.

NCPDP	Message
90	Host Hung Up

Host disconnected before session completed.

NCPDP	Message
92	System Unavailable/Host Unavailable

Processing host did not accept transaction or did not respond within time out period.

NCPDP	Message
93	Planned Unavailable

Transmission occurred during scheduled downtime. Scheduled downtime for file maintenance is Saturday 11:00 p.m.- 6:00 a.m. ET.

NCPDP	Message
99	Host Processing Error

Do not retransmit claims.

5.3 DUR Fields

Following are the ProDUR edits that will deny for SOUTH CAROLINA Medicaid:

- Drug /Drug Interactions - (Severity level 1) - provider override allowed
- Early Refill - contact FIRST HEALTH SERVICES Technical Call Center to request an override.
- Therapeutic Duplication - (selected therapeutic classes) - provider override allowed
- Prerequisite Drug Therapy (COX-2 PA Edit) - contact the FIRST HEALTH SERVICES Clinical Call Center to request prior authorization.

NCPDP	*Message*
88	DUR Reject Error

Also note that the following ProDUR edits will return a warning message only (i.e., an override is not necessary).

- Drug /Drug Interactions - (Severity levels 2, 3)

- Late Refill
- Duplicate Ingredient
- Drug to Pregnancy Precaution - (Severity level 1)
- Minimum/Maximum Daily Dosing
- Drug to Pediatric Precautions - (Severity level 1)
- Drug to Geriatric Precautions - (Severity level 1)
- Drug to Known Disease - (Severity level 1)
- Drug to Inferred Disease - (Severity level 1)
- Therapeutic Duplication - (selected therapeutic classes)

IMPORTANT NOTE→: Provider overrides are processed on a per claim (date of service only) basis. For quality of care purposes, pharmacists are required to retain documentation relative to these overrides.

DUR Reason for Service (Conflict) Code:

The DUR Conflict Code is used to define the type of utilization conflict that was detected (NCPDP field 439).

Valid DUR Reason for Service (Conflict) Codes for the South Carolina Medicaid Program are:

- DD - DRUG /DRUG INTERACTIONS
- ER - EARLY REFILL
- TD - THERAPEUTIC DUPLICATION
- LR - LATE REFILL
- ID - DUPLICATE INGREDIENT
- PG - DRUG TO PREGNANCY PRECAUTION
- LD/HD - MINIMUM/MAXIMUM DAILY DOSING
- PA - DRUG TO PEDIATRIC PRECAUTIONS
- PA - DRUG TO GERIATRIC PRECAUTIONS
- MC - DRUG TO KNOWN DISEASE
- DC - DRUG TO INFERRED DISEASE
- SR - PRE-REQUISITE DRUG THERAPY: COX-2 PA EDIT

NCPDP	***Message***
E4	M/I DUR conflict/reason for service code

DUR Professional Service (Intervention) Code:

The DUR Reason for Service (Intervention) Code is used to define the type of interaction or intervention that was performed by the pharmacist (NCPDP field 440).

Valid DUR Professional Service (Intervention) Codes for the South Carolina Medicaid Program are:

- 00 NO INTERVENTION
- CC COORDINATION OF CARE
- M0 PRESCRIBER CONSULTED
- PE PATIENT EDUCATION/ INSTRUCTION
- PH PATIENT MEDICATION HISTORY
- P0 PATIENT CONSULTED
- R0 PHARAMACIST CONSULTED OTHER SOURCE

NCPDP	***Message***
E5	M/I DUR intervention/professional service code

DUR Result of Service (Outcome) Code:

The DUR Result of Service (Outcome) Code is used to define the action taken by the pharmacist in response to a ProDUR Conflict code or the result of a pharmacist's professional service (NCPDP field 441).

Valid DUR Result of Service (Outcome) Codes for the South Carolina Medicaid Program are:

- 1A FILLED AS IS, FALSE POSITIVE
- 1B FILLED PRESCRIPTION AS IS
- 1C FILLED WITH DIFFERENT DOSE
- 1D FILLED WITH DIFFERENT DIRECTIONS
- 1F FILLED WITH DIFFERENT QUANTITY
- 1G FILLED WITH PRESCRIBER APPROVAL
- 2A PRESCRIPTION NOT FILLED
- 3B RECOMMENDATION NOT ACCEPTED
- 3C DISCONTINUED DRUG

NCPDP	***Message***
E6	M/I DUR outcome/ result of service code

APPENDIX A: UNIVERSAL CLAIM FORM

How to complete a UCF 5.1:

1. Fill in all applicable areas on the front of the form.
2. Verify patient information is correct and that patient named is eligible for benefits.
3. If this claim is for a worker's compensation injury, the appropriate section on the front side must be completed.
4. Patient signs certification on front side for prescription(s) received.
5. Enter Compound Rx in the Product Service ID area and list each ingredient name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
6. Worker's Compensation information is conditional. It should be completed only for a Worker's Compensation Claim.
7. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
8. Limit 1 set of DUR/PPS codes per claim.
9. Each area is numbered. Complete each area using the following codes:

DEFINITION / VALUES

1. OTHER COVERAGE CODE

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 copay

2. PERSON CODE

Code assigned to a specific person within a family

3. PATIENT GENDER CODE

0=Not specified	1=Male	2=Female

4. PATIENT RELATIONSHIP CODE

0=Not specified	1=Cardholder	2=Spouse
3=Child	4=Other	

5. SERVICE PROVIDER ID QUALIFIER

Blank=Not specified	01=National Provider Identifier (NPI)	02=Blue Cross
03=Blue Shield	04=Medicare	05=Medicaid
06=UPIN	07=NCPDP Provider ID	08=State license
09=Champus	10=Health Industry number (HIN)	11=Federal Tax ID
12=Drug Enforcement Administration (DEA)	13=State Issued	14=Plan Specific
99=other		

6. CARRIER ID

Carrier code assigned in Worker's Compensation Program.

7. CLAIM/REFERENCE ID

Identifies the claim number assigned by Worker's Compensation Program.

8. PRESCRIPTION SERVICE REFERENCE # QUALIFIER

Blank=Not specified	1=Rx billing	2=Service billing

9. QUANTITY DISPENSED

Quantity dispensed expressed in metric decimal units (shaded areas for decimal values)

10. PRODUCT SERVICE ID QUALIFIER
Code qualifying the value in Product/Service ID (407-07)

Blank=Not specified	00= Not specified	01=Universal Product Code (UPC)
02=Health Related Item (HRI)	03=National Drug Code (NDC)	04= Universal Product Number (UPN)
05=Department of Defense (DOD)	06=Drug Use Review Professional Pharm. Services (DUR/PPS)	07=Common Procedure Terminology (CPT4)
08=Common Procedure Terminology (CPT5)	09=HCFA Common Procedural Coding System (HCPSCS)	10=Pharmacy Practice Activity Classification (PPAC)
11=National Pharmaceutical Product Interface Code (NAPPI)	12=International Article Numbering System (EAN)	13=Drug Identification Number (DIN)
99=Other		

11. PRIOR AUTHORIZATION TYPE CODE

0=Not specified	1=Prior Authorization	2=Medical Certification
3=EPSDT (Early Periodic Screening, Diagnosis, and Treatment)	4=Exemption from copay	5=Exemption from Rx limits
6=Family Planning Indicator	7=Aid to Families with Dependent Children (AFDC)	8=Payer defined exemption

12. PRESCRIBER ID QUALIFIER
Use service provider ID values

13. DUR/PROFESSIONAL SERVICE CODES
For values refer to current NCPDP data dictionary.

A=Reason for service	B=Professional Service code	C=Result of Service

14. BASIS OF COST DETERMINATION

Blank=Not specified	00=Not specified	01=AWP (average wholesale price)
02=Local Wholesale	03=Direct	04= EAC (Estimated Acquisition Cost)
05=Acquistion	06=MAC (Maximum Allowable Cost)	07=Usual and Customary
09=Other		

15. PRODUCT SERVICE ID QUALIFIER

Blank=Not specified	01=Drug Enforcement Administration (DEA)	02=State License
03=Social Security Number (SSN)	04=Name	05=National Provider Identifier (NPI)
06=Health Industry Number (HIN)	07=State issued	99=Other

16. DIAGNOSIS CODE QUALIFIER

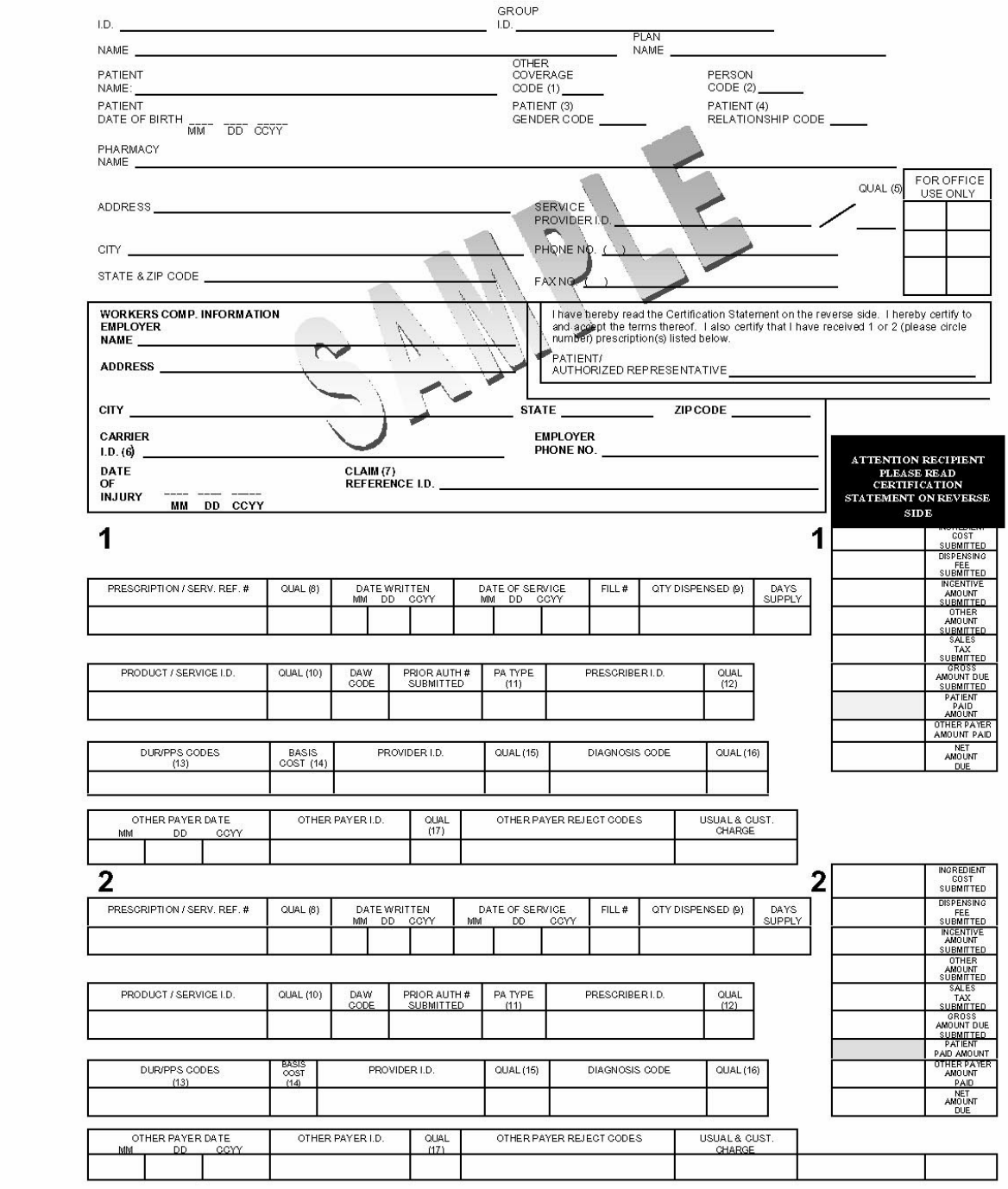
Blank=Not specified	00=Not specified	01=International Classification of Diseases (ICD9)
02= International Classification of Diseases (ICD10)	03=National Criteria Care Institute (NDCC)	04=Systemized Nomenclature of Human and Veterinary Medicine (SNDMED)
05=Common Dental Term (CDT)	06=Medi-Span Diagnosis Code	07=American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM/V)
99=Other		

17. OTHER PAYER ID QUALIFIER

Blank=Not specified
01= National Payer ID
02=Health Industry Number (HIN)
03=Bank Information Number (BIN)
04=National Association of Insurance Commissioners (NAIC)
09=Coupon
99=Other

18. ADD INFORMATION ON COMPOUND PRESCRIPTIONS IF NECESSARY – LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM

Name	NDC	Quantity	Cost



I.D. _____ GROUP I.D. _____

NAME _____ PLAN NAME _____

PATIENT NAME: _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH ____ ____ _____ MM DD CCYY

PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____

CITY _____ PHONE NO. ( ) _____

STATE & ZIP CODE _____ FAX NO. ( ) _____

FOR OFFICE USE ONLY

WORKERS COMP. INFORMATION
EMPLOYER NAME _____
ADDRESS _____
CITY _____ **STATE** _____ **ZIP CODE** _____
CARRIER I.D. (6) _____
DATE OF INJURY ____ ____ _____ MM DD CCYY
EMPLOYER PHONE NO. _____
CLAIM (7) REFERENCE I.D. _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT/ AUTHORIZED REPRESENTATIVE _____

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

1

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

2

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE