



**Department of
Job and Family Services**

**Pharmacy Provider Manual
Policy and Procedure Guide**

**Administered by:
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Section 1: Introduction

ACS is the claims processor for the Ohio Department of Job & Family Services (ODJFS) Ohio Medicaid fee-for-service Pharmacy Benefit Management Program. ACS uses a computerized point-of-sale (POS) system, utilizing NCPDP standards for claim transactions.

The system allows participating pharmacies real-time access to consumer eligibility, drug coverage, pricing and payment information, and prospective drug utilization review (ProDUR) across all network pharmacies. Pharmacy providers must be enrolled through ODJFS 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 ACS 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). Batch media submissions are not accepted.

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

ACS often provides additional information on the response transactions to include a more detailed explanation regarding a denied claim. Please ensure that your provider software can return NCPDP field number 504-F4 (Message) and number 526-FQ (Additional Message Information) so that you can view this helpful information.

ACS provides assistance through the **Technical Call Center**, which is **available 24 hours per day, seven days per week**. For answers to questions that are not addressed in this manual or if additional information is needed, contact the ACS technical call center at **1-877-518-1545**.

1.1 Help Desk Telephone Numbers

| | |
|--|--|
| ACS Technical Helpdesk and Technical Prior Authorizations | 1-877-518-1545 Available 24 hours a day, seven days a week |
| ACS Clinical Prior Authorizations | 1-877-518-1546 Fax: 1-800-396-4111 Monday – Friday 7am – 7pm (ET) |
| ODJFS Provider Enrollment Unit | 1-800-686-1516 Monday – Friday, 8am – 4:30pm (ET) |
| ODJFS IVR Eligibility | 1-800-686-1516 Available 24 hours a day, seven days a week |
| ODJFS Remittance Advice (835) | 1-800-686-1516 Monday – Friday, 8am – 4:30pm (ET) |
| Ohio Medicaid Consumer Hotline | 1-800-324-8680 TTY 1-800-292-3572 Monday – Friday, 7am – 8pm (ET); Saturday, 8am – 5pm (ET) Voice mail is available at other times with calls returned the next business day |

ODJFS Web Site Addresses:

<http://www.jfs.ohio.gov/ohp/> The Ohio Medicaid Program

<http://www.jfs.ohio.gov/ohp/bhpp/meddrug.stm> The Ohio Medicaid Drug Program

<http://medlist.ohio.gov> Searchable database of covered drugs

1.2 Mailing Addresses

Provider Paper Claims Billing Address:

ACS
P.O. Box 967
Henderson, NC 27536-0967
Attn: Claims

PA Appeals (consumers only):

Ohio Department of Job and Family Services
Bureau of State Hearings
P.O. Box 182825
Columbus, OH 43218-2825

1.3 Service Support

On-line Certification:

Providers must submit claims using NCPDP format. NCPDP v5.1 will be accepted through March 31, 2012. NCPDP vD.0 is now accepted and will be required beginning April 1, 2012.

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 ACS 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 ACS to resolve the problem.
4. If unable to resolve the problem after following the steps outlined above, the pharmacy provider should contact the **ACS Technical Call Center: 1-877-518-1545** (Nationwide Toll Free Number).

Section 2: Program Setup

2.1 Claim Format

- ACS will accept NCPDP v5.1 through March 31, 2012. NCPDP vD.0 is now accepted and will be required beginning April 1, 2012. Payer sheets are posted at <http://jfs.ohio.gov/ohp/bhpp/omdp/POS.stm>.
- The D.0 Universal Claim Form (UCF) is required for paper submissions. Information about the UCF is available from NCPDP at <http://www.ncpdp.org/products.aspx>.

2.2 Media Options

ODJFS does not accept Batch Claim submissions. Mandatory POS submission is required for all providers except:

- Clinics
- Other providers with prior approval from ACS

2.3 Networks

| | | |
|---------------------|-----------------|-----------------|
| Relay Health | Emdeon | QS1 |
| 866.735.2963 | 866-288-9761 | 800-845-7558 |
| Medco | BioScrip | Caremark |
| 800-251-7690 | 800-677-4323 | 866-270-0545 |

2.4 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 ACS 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 ODJFS reimbursement formula.
- **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.
NOTE: The following fields must match on the original paid claim and on the void request for a successful claim reversal:
 - Service Provider ID
 - Prescription number
 - Date of service (date filled)
 - NDC
- **Claims Re-bill (Transaction Code B3)**
Use this transaction 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.
- **Eligibility Verification (Transaction Code E1)**
Use this transaction to transmit patient billing number and receive a real time response verifying eligibility.

2.5 NCPDP Version D.0 Transactions

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

| Transaction Code | Transaction Name | Transaction Support Requirements |
|------------------|---|----------------------------------|
| E1 | Eligibility Verification | Supported |
| B1 | Billing | Required |
| B2 | Reversal | Required |
| B3 | Re-bill | Required |
| P1 | Prior Authorization Request and Billing | No planned requirements |
| P3 | Prior Authorization Inquiry | No planned requirements |
| P2 | Prior Authorization Reversal | No planned requirements |
| P4 | Prior Authorization Request Only | No planned requirements |
| N1 | Information Reporting | No planned requirements |
| N2 | Information Reporting Reversal | No planned requirements |
| N3 | Information Reporting Re-bill | No planned requirements |
| C1 | Controlled Substance Reporting | No planned requirements |
| C2 | Controlled Substance Reporting Reversal | No planned requirements |
| C3 | Controlled Substance Reporting Re-bill | No planned requirements |

NOTE: Providers should send only the B1, B2, B3 and E1 transactions until further notice. Other transactions will be denied.

2.6 Version D.0 Segments

Data in NCPDP vD.0 is grouped together in segments. Please review the following for program requirements.

| NCPDP Request Segment Matrix | | | | | Segment Support Requirements |
|------------------------------|----|----|----|----|--|
| Transaction Code | E1 | B1 | B2 | B3 | |
| Segment | | | | | |
| Header | M | M | M | M | Required |
| Insurance | M | M | M | M | Required |
| Patient | RW | R | NS | R | Required |
| Claim | NA | M | M | M | Required |
| Pricing | NA | M | NS | M | Required |
| Pharmacy Provider | RW | NA | NS | NA | No planned requirements at this time; may be required at a future date |
| Prescriber | NA | R | NS | R | Required |
| COB/Other Payments | NA | RW | NS | RW | Required |
| Worker's Comp | NA | NA | NS | NA | Not Applicable |
| DUR/PPS | NA | RW | NS | RW | Required |
| Coupon | NA | NS | NS | NS | No planned requirements at this time; may be required at a future date |
| Compound | NA | RW | NS | RW | Required When claim is a compound |
| Clinical | NA | NA | NS | NA | No planned requirements at this time; may be required at a future date |

NCPDP Designations:

M = Mandatory per the NCPDP Version D.0 Claim Format Standard. The fields must be populated in order for the claim to be processed.

R = Required above the Standard. The fields must also be populated in order to have the claim processed.

RW = Required When. The fields depend on other claim information or eligibility information to determine if they are required.

NA = Not Applicable. The fields do not have to be populated for the claim to be processed.

NS = Not Supported. The fields are not supported by ACS and do not have to be populated

ACS POS Help Desk: 1-877-518-1545

NOTE: Some segments indicated as “Required When” by NCPDP may be “Required” to support specific transactions for this program.

2.7 Required Data Elements

The ACS system has program-specific requirements for 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.

ODJFS 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 ODJFS Payer Specifications, including NCPDP field number references, are in the payer sheet, posted online at <http://jfs.ohio.gov/ohp/bhpp/omdp/POS.stm>. Fields "not required for this program" at this time may be required at a future date.

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

- ANSI BIN #610084
- Processor Control # DROHPROD
- Group # OHMEDICAID
- Provider ID # National Provider Identifier (NPI) Number
- Cardholder ID # Ohio Medicaid ID Number
- Prescriber ID # NPI
- Product Code National Drug Code (NDC)

2.8 Timely Filing Limits

Most providers submitting point-of-sale submit their claims at the time of dispensing. There may be mitigating reasons that require a claim to be submitted after the fact.

For all original claims, reversals and adjustments, the timely filing limits are:

| Claim Type | Timely Filing Limit |
|--|--|
| Original Claims (B1 transaction) | Within 365 days of the date of service. Denied claims may be re-submitted beyond 365 days if the re-submission is within 90 days of the original claim denial. |
| Re-bills (B3transaction) | Within 365 days of the date of service or beyond 365 days if the re-bill is within 90 days of the original claim payment. |
| Reversals (B2 transaction) | Within 545 days of the date of original claim payment. |

- Claims that exceed the prescribed timely filing limit will deny.
- When appropriate, contact ACS for consideration of an override to timely filing limits.
- **ACS staff** may override the timely filing limits for the following reasons:
 - Retroactive consumer eligibility
 - Third Party Liability (TPL) delay

Section 3: Program Policies

3.1 Requirement for Tamper-Resistant Prescription Forms

Tamper-Resistant Prescription Forms

- All written prescriptions billed to Medicaid must be on tamper-resistant forms.
- Prescriptions transmitted to the pharmacy via telephone, fax, or e-prescribing are exempt from this requirement.
- To be considered tamper resistant a prescription form must contain all three of the following tamper-resistant characteristics.
- Tamper-Resistant Characteristics:

| Required characteristic: | Examples include but not limited to: |
|--|---|
| 1. One or more features designed to prevent unauthorized copying of a completed or blank prescription form | <ul style="list-style-type: none"> • Text that appears when photocopied or scanned (e.g., "void" or "illegal") • Microprint borders that cannot be copied |
| 2. One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber | <ul style="list-style-type: none"> • Erasure or use of solvents will discolor background • Check-off boxes to indicate the quantity prescribed (e.g., 1-24, 25-49, 50-74, etc.) |
| 3. One or more features designed to prevent the use of counterfeit prescription forms | <ul style="list-style-type: none"> • Thermo-chromic ink • High security watermark • Sequentially numbered • Duplicate or triplicate blanks |

The tamper-resistant requirement applies in the following situations:

- All written prescriptions presented at the pharmacy.
- All written prescriptions when ODJFS pays any part of the claim, including when ODJFS is not the primary payer.

The tamper-resistant requirement does not apply in the following situations:

- Prescriptions for which payment will be made by an ODJFS-contracting managed care plan.
- Prescriptions transmitted to the pharmacy via e-prescribing, fax, or telephone.
- Orders for medications administered in a provider setting and billed by the administering provider.
- Orders for medications administered in a long-term care facility (LTCF), provided the order is written in the patient's medical record and given by medical staff directly to the pharmacy. A prescription for a LTCF resident is considered tamper resistant if the patient does not have opportunity to handle the written order.

Emergency Fill of Non-Tamper-Resistant Prescription

- If a written prescription that is not tamper resistant is presented, the pharmacy may fill the prescription on an emergency basis and obtain a compliant tamper-resistant replacement from the prescriber within 72 hours of dispensing.
- The pharmacist should use professional judgment to define an emergency situation.
- The replacement may be a compliant written prescription, a fax copy, or an electronically transmitted copy. The replacement should be filed with the original, non-tamper-resistant prescription.

- Alternatively, the pharmacy may verify the prescription by telephone. In this case, the verification must be documented on the prescription including the name of the prescriber or prescriber's office staff member verifying the prescription, date of verification, and identification of the pharmacy staff member requesting verification.

Retroactive Eligibility

- If a consumer is determined to be retroactively eligible for Medicaid coverage, and the pharmacy has filled a prescription for a date of service that falls into the retroactive eligibility period, the pharmacy must verify that the original prescription was tamper resistant.
- If the original prescription was not tamper resistant, the pharmacy may follow the procedures listed above to obtain a replacement tamper-resistant prescription or verify the prescription by phone, prior to billing the claim to ODJFS.

3.2 Dispensing Limits

Days Supply:

- There is a per claim days supply maximum of 34 days for most drugs.
- The following maintenance drug classes allow 102-day-supply:

| | |
|----------------------------------|------------------------------|
| Allergy and Asthma Preparations | Anticonvulsants |
| Antiparkinson Agents | BPH Preparations |
| Cardiovascular Preparations | Contraceptives |
| Diabetic Therapy | Digestants |
| Electrolytes | Endocrine Preparations |
| Glucocorticoids | Hematinics |
| Hyperuricemia Preparations | Lipotropics |
| Psychostimulants/Antidepressants | Urinary Tract Antispasmodics |
| Vitamins | |

Dose/Duration:

- Acetaminophen-containing products: limit 4 gram acetaminophen per day combined products
- Other dose-per-time period limits are online at <http://jfs.ohio.gov/ohp/bhpp/omdp/POS.stm>.

Date Rx Written to Date of Service (DOS) Edits:

- The DOS cannot be > 183 days from the DATE Rx WRITTEN (NCPDP field #414-DE) for the first fill.
- The DOS cannot be > 366 days from the DATE Rx WRITTEN (NCPDP field #414-DE) for all subsequent fills (non-controlled drugs).

Refills:

- All refills must be dispensed in accordance with State and Federal requirements.
- Refill prescriptions must be dispensed pursuant to the orders of the physician, but not more than one year from the DATE Rx WRITTEN (NCPDP field #414-DE).
- **CII Controlled Drugs** (DEA code = "II") **may not be refilled**, a new prescription is required for each fill.
- **CIII and CIV Controlled drugs** (DEA code = "III", "IV") may be refilled, pursuant to the order of the physician, up to 5 refills (plus one original) or 6 months, whichever comes first.

- **Non-controlled drugs and CV Controlled drugs** (DEA = "0", "V") may be refilled, pursuant to the order of the physician, up to 99 refills (plus one original) or one year, whichever comes first.

3.3 Provider Dispensing Fees

Dispensing Fee:

- Standard: \$1.80
- Flu vaccine for LTCF patient: \$0.50
- Compound (standard): \$6.00 per prescription
- Total Parenteral Nutrition (TPN): \$15.00 per days supply, capped at \$150.00
- Infusion Compounds non-TPN: \$10.00 per days supply, capped at \$70.00

3.4 Generic Substitution Policy

All drugs included on the ODJFS Drug File are considered reimbursable, regardless of their brand or generic designation. There are no DAW requirements with the following exceptions: Depakene[®] 250mg and 250mg/5ml, Mysoline[®] 250mg, and Tegretol[®] 100mg and 200mg. These drugs must be noted "brand medically necessary" (BMN) by the prescriber on the original prescription.

3.5 Drug Coverage

DME/DMS:

- Limited durable Medical Equipment (DME) and Disposable Medical Supplies (DMS) are covered through the pharmacy program. Only pharmacy providers are able to bill for the supplies listed in the table below. These supplies should be billed using the NDC on the package through the pharmacy POS claim system. Claims billed to Medicare Part B or a Medicare Advantage plan as the primary payer will continue to be paid when billed on a medical claim (CMS-1500 claim form or 837P EDI claim transaction). Other equipment and supplies not listed below, including enteral nutrition products, should be billed as DME. Contact ODJFS Provider Network Management at 1-800-686-1516 for more information. Claims submitted to ACS for services not listed in the table below will be denied.

| HCPCS Code* | Description |
|--------------------|--|
| A4245 | Alcohol wipes or swabs |
| E2101 | Blood glucose monitor with integrated lancing/blood sample (PA required) |
| E2100 | Blood glucose monitor with voice (PA required) |
| A4253 | Blood glucose test or reagent strips for home blood glucose monitor |
| A4252 | Blood ketone test or reagent strip |
| A4268 | Contraceptive supply, condom, female |
| A4267 | Contraceptive supply, condom, male |
| E0607 | Home blood glucose monitor complete |
| S5560 | Insulin delivery device, reusable pen; 1.5ml size |
| S5561 | Insulin delivery device, reusable pen; 3ml size |
| A4259 | Lancets |
| A4215 | Needles only, sterile, any size, including pen needles |
| A4256 | Normal, low high calibration solutions/chips |
| A4614 | Peak Expiratory Flow Rate Meter |
| A4627 | Spacer, bag, or reservoir, with or without mask, for use with metered dose inhaler |
| A4258 | Spring powered device for lancet |
| A4206 | Syringe with needle, sterile less than or equal to 1 cc |
| A4250 | Urine test or reagent strips or tablets |

*The Healthcare Common Procedure Coding System (HCPCS) code is listed in the table for reference only. These supplies will be paid by the NDC number instead of the HCPCS code.

Medicare Part B:

- Drugs that may be covered by Medicare Part B will be denied for consumers who have Medicare coverage. Cost sharing for drugs covered by Medicare Part B must not be billed to the Medicaid consumer. Medicaid will pay the claim through the standard Medicare crossover process. If payment has not been received from Medicaid within 90 days, follow the billing instructions found at <http://jfs.ohio.gov/ohp/provider.stm> (click on "billing instructions"). There are no overrides or prior authorizations allowed for Medicare Part B-covered products even if drug is not being used for a Medicare-approved indication. The Medicare Part D Prescription Drug Plan should be contacted for coverage.

Example Medicare Part B Drugs

| | |
|--------------------------|----------------------------|
| Acetylcysteine | Albuterol |
| Aprepitant | Atropine |
| Azathioprine | Bitolterol |
| Budesonide | Busulfan |
| Capecitabine | Cromolyn Sodium |
| Cyclophosphamide | Cyclosporine |
| Daclizumab | Dexamethasone |
| Dolasetron | Dornase Alfa |
| Dronabinol | Etoposide |
| Glycopyrrolate | Granisetron |
| Hemophilia blood factors | Hydroxyzine Pamoate |
| Iloprost | Insulins |
| Ipratropium | Ipratropium/Albuterol |
| Isoetharine | Isoproterenol |
| Levalbuterol | Lymphocyte Immune Globulin |
| Melphalan | Metaproterenol |
| Methotrexate | Muromonab-CD3 |
| Mycophenolate | Ondansetron |
| Pentamidine | Perphenazine |
| Prednisolone | Prednisone |
| Prochlorperazine | Promethazine |
| Sirolimus | Tacrolimus |
| Temozolomide | Terbutaline |
| Thiethylperazine | Tobramycin |
| Trimethobenzamide | |

Medicare Part D Dual Eligibles

Drugs covered under Ohio Medicaid for dually eligible Medicare/Medicaid consumers include barbiturates, benzodiazepines, vitamins (except prenatal vitamins, fluoride, and potassium), cough suppressants, and selected over-the-counter drugs that do not have a therapeutic equivalent that may be covered under a Medicare Prescription Drug Plan. A list of covered products can be found in Appendix A of Ohio Administrative Code (OAC) Rule 5101:3-9-12 or by searching at <http://medlist.ohio.gov/>.

3.6 Consumer Payment Information

Co-payments:

- There will be a \$3.00 co-payment for medications that require prior authorization.
- There will be a \$2.00 co-payment for selected trade name medications.
- Details and exclusions can be found in OAC 5101:3-9-09.

Co-payments **must not be charged** by the pharmacy, and co-payments are not applicable if the consumer is:

- under age 21, or
- pregnant or in the post-partum period (The post-partum period is the immediate post-partum period that begins on the last day of pregnancy and extends through the end of the month in which the sixty-day period following termination of pregnancy ends), or
- in a nursing home or intermediate care facility for the mentally retarded, or
- receiving hospice care.

Co-payments **must not be charged** by a pharmacy, and co-payments are not applicable, if:

- the prescription medication is a trade name medication the department has exempted from co-payment (e.g., the department has indicated the trade name medication should be dispensed rather than the generic), or
- the prescription is for family planning (contraceptive, oxytocic, or prenatal vitamin).

Contact the ACS Technical Call Center at 1-877-518-1545 for appropriate override if a consumer indicates that one of the above categories applies but the system has applied a co-payment. Living arrangement, hospice, and pregnancy may be indicated as part of the online claim to override co-payments when appropriate. See Section 5.1 of this document for details.

Medications administered to a consumer in a hospital, emergency department, office, clinic, or other facility, are not subject to co-payments.

Consumers subject to co-payment, who indicate that they are unable to pay their co-payment at the time their medication is dispensed, may indicate their inability to pay and obtain their prescription medication without paying the co-payment. The consumer remains liable for the co-payment and the pharmacy provider may bill the consumer for the co-payment or request payment for a prior uncollected co-payment.

If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid Medicaid co-payment imposed by the co-payment program from a prior transaction as an outstanding debt and may refuse service to a Medicaid consumer who owes the provider an outstanding debt. If the provider intends to refuse service to a Medicaid consumer who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services.

3.7 Prior Authorization

Technical Call Center Prior Authorizations:

To request prior authorization for the edits below, the pharmacist may call the ACS Technical Call Center at **1-877-518-1545**.

| <i>NCPDP</i> | <i>Message</i> |
|--------------|--|
| M2 | Not Filled By Lock-in Pharmacy |
| 81 | DOS Not Within Filing Limits |
| 88 | Early Refill Call 1-877-518-1545 |
| 75 | Living Arrangement/Nursing Home Criteria Not Met |

A pharmacist may request prior authorization for an alternative dosage form of a drug to be administered through a tube for patients who are tube fed, if no comparable drugs listed in Appendix A to OAC rule 5101:3-9-12 can be administered through a tube.

If a pharmacy claim is rejected at the pharmacy because prior authorization is required, and the prescriber's office is closed, the pharmacy may call ACS to request payment of up to a 72-hour supply of medication. This will give time for the prescriber to request prior authorization. This emergency override is available only when the prescriber's office is closed (evenings, holidays, and weekends).

Clinical Call Center:

To request prior authorization for the edits below, the ***prescribing provider*** must call ACS Prior Authorization Unit at **1-877-518-1546**.

| <i>NCPDP</i> | <i>Message</i> |
|--------------|---|
| 76 | Plan Limitation Exceeded. Qty Submitted Exceeds Allowed. |
| 76 | Quantity exceeds max |
| 76 | Days supply exceeds max |
| 76 | Refills exceed max |
| 75 | PA required, Call ACS at 1-877-518-1546 |
| 75 | Non-PDL. Try Preferred Agent. Call ACS at 1-877-518-1546. |
| 75 | No indication of continuation therapy |
| 75 | Patient must try generic equivalent first |
| 75 | Age requirement not met |
| 75 | Max quantity allowed is exceeded |

- The prescriber should initiate prior authorization requests. Ideally this should occur at the time the prescription is being written. If this does not occur, the claim will deny at POS with a message that the prescriber should contact ACS for prior authorization consideration.
- Upon a call from the prescriber, ACS will work with the prescriber to determine the outcome of the prior authorization request. Often, a change will be made to the drug. The requested drug may be authorized or denied. The consumer will be contacted if the prior authorization request is denied.
- Prior authorization may also be requested by using the Request For Prior Authorization form and faxing to 1-800-396-4111. (See *Appendix A* for PA request form.)

- ACS clinical staff are available on site from 7am – 7pm (ET) Monday through Friday. ACS 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, ACS may authorize a 72-hour emergency fill if appropriate.
- Prior authorizations 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 ACS system is all that is necessary.
- Prior authorization edits will apply to all claim types and claims media.

3.8 Coordination of Benefits (COB)

- On-line COB is a part of the Medicaid cost-avoidance program.
- If ODJFS is the consumer's secondary carrier, claims for COB will be accepted.
- ODJFS is always the payer of last resort. The **exception** to this is when the consumer is covered concurrently by Medicaid and the Bureau for Children with Medical Handicaps (BCMHS). In that case, Medicaid will take precedence.
- Other coverage will be identified by the presence of other carrier information on the consumer's ODJFS eligibility file and/or information communicated by the provider on the claim.
- If the consumer shows other coverage on the DOS, ACS will deny the claim. ACS will **return a unique ODJFS carrier code identifying the other carrier, the consumer's policy number and the carrier name** in the additional message field. It is possible that a consumer may have more than one active other carrier; in that case, ACS will return Other Payer codes with the exception of Medicare Part D Prescription Drug Plan (PDP) carriers.
- Even if **no** "other insurance" is indicated on the ODJFS eligibility file, ACS will **process the claim as a third party liability (TPL) claim if the pharmacist submits TPL data as indicated in the TPL Processing Grid.**
- If other insurance is indicated on the ODJFS eligibility file, then ACS will **process as TPL regardless of what TPL codes the pharmacist submits as indicated on the TPL Processing Grid.**
- In all cases, ACS will use the ODJFS "**Allowed Amount**" when calculating payment. In some cases, this **may result in a zero payment.**
- In order to facilitate the TPL/COB process, ODJFS will allow providers to override days supply limits and/or Drug Requires PA conditions (NCPDP reject 75 or 76), or age and gender edits (NCPDP reject 60 or 61) by entering a value of "**5**" (exemption from prescription limits) as the PRIOR AUTHORIZATION TYPE CODE (NCPDP field #461-EU).
- If the provider determines that the consumer no longer has other coverage as identified by the ODJFS eligibility file, the ODJFS Cost Avoidance Unit (614-752-5768 or TPL@jfs.ohio.gov) will accept calls or emails from pharmacy providers. The pharmacist should provide the Medicaid billing ID, consumer name, and insurance information. The Cost Avoidance Unit is not able to return phone calls or emails but will verify and update records based on the information received. The update may take up to 48 hours.
- The minimum allowed amount for the OTHER PAYER AMOUNT PAID (NCPDP field #431-DV) is \$2.00. If the amount in the OTHER PAYER AMOUNT PAID field is <\$2.00, the claim will deny with NCPDP EC 41/ *Submit bill to other processor or primary payer.* Additional messaging (TPL Payer Amount is less than \$2.00) will advise provider to validate amount. If the pharmacy has verified a primary payment of less than \$2.00 and an override is needed, contact ACS Technical Call Center at 1-877-518-1545.

- The following are values and claim dispositions based on pharmacy submission of the standard NCPDP TPL codes:

| TPL PROCESSING GRID: | | | | | | |
|-----------------------------|---|---|--|--------------------------------------|--|--|
| | Other Coverage Code (field # 308-C8) | Other Payer Amount Paid (field # 431-DV) | Other Coverage indicated on ODJFS Eligibility Record | Other Payer Date (field # 443-E8) | Claim Disposition | Comments |
| 1 | 0 = Not Specified | 0 | Yes | M/I or null | Deny (Bill Primary, M/I Other Payer Date) | OCC 0 will not override TPL |
| 2 | 0 = Not Specified | 0 | Yes | Valid Date | Pay | |
| 3 | 0 = Not Specified | 0 | Yes | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 4 | 0 = Not Specified | 0 | No | M/I or null | Pay | |
| 5 | 0 = Not Specified | 0 | No | Valid Date | Pay | |
| 6 | 0 = Not Specified | 0 | No | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 7 | 0 = Not Specified | >0 | Yes | M/I or null | Deny (Bill Primary, M/I Other Payer Date, M/I Other Payer Amountt) | |
| 8 | 0 = Not Specified | >0 | Yes | Valid Date | Pay | |
| 9 | 0 = Not Specified | >0 | Yes | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 10 | 0 = Not Specified | >0 | No | M/I or null | Pay | |
| 11 | 0 = Not Specified | >0 | No | Valid Date | Pay | |
| 12 | 0 = Not Specified | >0 | No | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 13 | 1= No Other Coverage Identified | 0 | Yes | M/I or null | Deny (Bill Primary, M/I OP date) | Use OCC 1 when primary does not show coverage |
| 14 | 1= No Other Coverage Identified | 0 | Yes | Valid Date | Pay | |
| 15 | 1= No Other Coverage Identified | 0 | Yes | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 16 | 1= No Other Coverage Identified | 0 | No | M/I or null | Pay | |
| 17 | 1= No Other Coverage Identified | 0 | No | Valid Date | Pay | |
| 18 | 1= No Other Coverage Identified | 0 | No | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 19 | 1= No Other Coverage Identified | >0 | Yes | M/I or null | Deny (Bill Primary, M/I Other Payer Date) | |
| 20 | 1= No Other Coverage Identified | >0 | Yes | Valid Date | Pay | |
| 21 | 1= No Other Coverage Identified | >0 | Yes | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 22 | 1= No Other Coverage Identified | >0 | No | M/I or null | Pay | |
| 23 | 1= No Other Coverage Identified | >0 | No | Valid Date | Pay | |
| 24 | 1= No Other Coverage Identified | >0 | No | Date > Adjudication Date | Deny (M/I Other Payer Date) | |

| TPL PROCESSING GRID: | | | | | | |
|-----------------------------|---|---|--|--------------------------------------|--|---|
| | Other Coverage Code (field # 308-C8) | Other Payer Amount Paid (field # 431-DV) | Other Coverage indicated on ODJFS Eligibility Record | Other Payer Date (field # 443-E8) | Claim Disposition | Comments |
| 25 | 2 - other COB exists, payment collected | 0 | Yes | M/I or null | Deny (Bill Primary, M/I OP date) | |
| 26 | 2 - other COB exists, payment collected | 0 | Yes | Valid Date | Deny (TPL payment < \$2) | Call for override if other payer amount is correct; Will pay the difference between the ODJFS Allowed Amount and the Other Payer Amount |
| 27 | 2 - other COB exists, payment collected | 0 | Yes | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 28 | 2 - other COB exists, payment collected | 0 | No | M/I or null | Pay | |
| 29 | 2 - other COB exists, payment collected | 0 | No | Valid Date | Pay | |
| 30 | 2 - other COB exists, payment collected | 0 | No | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 31 | 2 - other COB exists, payment collected | >0 | Yes | M/I or null | Deny (M/I Other Payer Date) | |
| 32 | 2 - other COB exists, payment collected | >0 | Yes | Valid Date | Pay | Will pay the difference between the ODJFS Allowed Amount and the Other Payer Amount |
| 33 | 2 - other COB exists, payment collected | >0 | Yes | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 34 | 2 - other COB exists, payment collected | >0 | No | M/I or null | Deny (M/I Other Payer Date) | |
| 35 | 2 - other COB exists, payment collected | >0 | No | Valid Date | Pay | Will pay the difference between the ODJFS Allowed Amount and the Other Payer Amount |
| 36 | 2 - other COB exists, payment collected | >0 | No | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 37 | 3 - other coverage exists; this claim not covered | 0 | Yes | M/I or null | Deny (Bill Primary, M/I Other Payer Date) | Use OCC 3 when Primary requires mail order or has other requirements that the pharmacy does not meet |
| 38 | 3 - other coverage exists; this claim not covered | 0 | Yes | Valid Date | Pay | Pay ODJFS allowed amount |
| 39 | 3 - other coverage exists; this claim not covered | 0 | Yes | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 40 | 3 - other coverage exists; this claim not covered | 0 | No | M/I or null | Deny (M/I Other Payer Date) | |
| 41 | 3 - other coverage exists; this claim not covered | 0 | No | Valid Date | Pay | Pay ODJFS allowed amount |
| 42 | 3 - other coverage exists; this claim not covered | 0 | No | Date > Adjudication Date | Deny (M/I Other Payer Date) | |

| TPL PROCESSING GRID: | | | | | | |
|-----------------------------|---|---|--|--------------------------------------|---|---|
| | Other Coverage Code (field # 308-C8) | Other Payer Amount Paid (field # 431-DV) | Other Coverage indicated on ODJFS Eligibility Record | Other Payer Date (field # 443-E8) | Claim Disposition | Comments |
| 43 | 3 - other coverage exists; this claim not covered | >0 | Yes | M/I or null | Deny (Bill Primary, M/I Other Payer Date) | |
| 44 | 3 - other coverage exists; this claim not covered | >0 | Yes | Valid Date | Pay | Will pay the difference between the ODJFS Allowed Amount and the Other Payer Amount |
| 45 | 3 - other coverage exists; this claim not covered | >0 | Yes | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 46 | 3 - other coverage exists; this claim not covered | >0 | No | M/I or null | Pay | Will pay the difference between the ODJFS Allowed Amount and the Other Payer Amount |
| 47 | 3 - other coverage exists; this claim not covered | >0 | No | Valid Date | Pay | Will pay the difference between the ODJFS Allowed Amount and the Other Payer Amount |
| 48 | 3 - other coverage exists; this claim not covered | >0 | No | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 49 | 4 - other COB exists, payment not collected | 0 | Yes | M/I or null | Deny (M/I Other Payer Date) | Use OCC 4 if primary is full deductible or 100% copay |
| 50 | 4 - other COB exists, payment not collected | 0 | Yes | Valid Date | Pay | Pay ODJFS allowed amount |
| 51 | 4 - other COB exists, payment not collected | 0 | Yes | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 52 | 4 - other COB exists, payment not collected | 0 | No | M/I or null | Deny (M/I Other Payer Date) | |
| 53 | 4 - other COB exists, payment not collected | 0 | No | Valid Date | Pay | Pay ODJFS allowed amount |
| 54 | 4 - other COB exists, payment not collected | 0 | No | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 55 | 4 - other COB exists, payment not collected | >0 | Yes | M/I or null | Deny (Bill Primary, M/I Other Payer Date) | |
| 56 | 4 - other COB exists, payment not collected | >0 | Yes | Valid Date | Deny (M/I Other Coverage Code) | |
| 57 | 4 - other COB exists, payment not collected | >0 | Yes | Date > Adjudication Date | Deny (M/I Other Payer Date) | |
| 58 | 4 - other COB exists, payment not collected | >0 | No | M/I or null | Pay | Will pay the difference between the ODJFS Allowed Amount and the Other Payer Amount |

| TPL PROCESSING GRID: | | | | | | |
|-----------------------------|--|---|--|--------------------------------------|--------------------------------|---|
| | Other Coverage Code (field # 308-C8) | Other Payer Amount Paid (field # 431-DV) | Other Coverage indicated on ODJFS Eligibility Record | Other Payer Date (field # 443-E8) | Claim Disposition | Comments |
| 59 | 4 - other COB exists, payment not collected | >0 | No | Valid Date | Pay | Will pay the difference between the ODJFS Allowed Amount and the Other Payer Amount |
| 60 | 4 - other COB exists, payment not collected | >0 | No | Date > Adjudication Date | Deny (M/I Other Payer Date) | |

3.9 Long Term Care (LTC) Claims

Limited dispensing fee:

- One dispensing fee per patient/per drug/per provider/per rolling 25 days.
- Providers may override the dispensing fee limit by entering a value of “5” (exemption from prescription limits) as the PRIOR AUTHORIZATION TYPE CODE (NCPDP field #461-EU).
- Acceptable criteria for provider-level override:
 - Cases where the physician has prescribed a second round of medication within the 25-day period.
 - Cases where the physician has increased the dose.
 - Cases where the medication did not last for the intended days supply.
 - Cases where the drug has been compromised by accident (e.g., contaminated or destroyed).
 - Controlled substances (limited to two dispensing fees per month).
- PA and ProDUR edits will apply unless specifically noted otherwise.
- There is not a special dispensing fee or repackaging fee for LTC.

Over-the-counter (OTC) drugs billed to Medicaid for residents of nursing facilities (NF):

Coverage responsibility for certain over-the-counter drugs is included in the NF's per diem rate and cannot be billed directly to Medicaid for payment. Please note that this applies only to residents of nursing facilities, and not to residents of intermediate care facilities for the mentally retarded (ICF-MR).

The OTC drugs that are not separately billable to Medicaid when prescribed for a consumer who resides in a nursing facility are those that are classified into one of the following drug classes:

- a) Analgesics, including urinary analgesics;
- b) Compounding vehicles and bulk chemicals;
- c) Cough and cold preparations and antihistamines, except cetirizine and loratadine;
- d) Ear preparations;
- e) Gastrointestinal agents, except histamine-2 receptor antagonists, proton pump inhibitors, and loperamide;
- f) Hemorrhoidal preparations;
- g) Nasal preparations;
- h) Ophthalmic agents, except antihistamines;
- i) Saliva substitutes;
- j) Sedatives;
- k) Topical agents, except antifungals and acne preparations; or
- l) Vitamins and minerals, except prenatal vitamins and fluoride.

Instructions for pharmacies that serve NF residents:

- Claims for the OTC drugs listed above will be denied for patients whose Medicaid eligibility records show they reside in a NF.
- OTC drugs listed above should not be billed directly to Medicaid for NF residents.
- The NF is responsible for providing OTC drugs to its residents.

Instructions for pharmacies that do not serve NF residents:

- Claims for the OTC drugs listed above will be denied for patients whose Medicaid eligibility records show they reside in a NF.
- If the pharmacy has knowledge that the patient does not reside in a NF, the pharmacy should call ACS at 1-877-518-1545 to request an override.
- The patient or patient's representative should be advised to have their Medicaid eligibility caseworker change the living arrangement in the eligibility record.

3.10 Managed Care Plan (MCP) Consumers

Beginning with date of service October 1, 2011, MCPs are responsible for pharmacy benefits for their members. See <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm> for pharmacy information for managed care plan members.

3.11 Lock-In Consumers (Coordinated Services Program [CSP])

- ACS edits for pharmacy lock-in only.
- Providers should call ACS Technical Call Center (1-877-518-1545) for override consideration.
- Criteria for overrides:
 - Dispensing provider has identified that the lock-in provider cannot dispense the medication (e.g., pharmacy closed or drug out of stock), *and*
 - The dispensing pharmacist has determined the situation to be an emergency.

3.12 Medicare-Covered Drugs

- If a Medicaid consumer has Medicare Part A or B coverage, ACS will deny claims for Medicare-covered drugs with NCPDP error code *70/ NDC Not Covered* and detailed messaging to "Bill Medicare".
- The ACS Technical Call Center will NOT override a rejection if the consumer is identified as a Medicare beneficiary on the ODJFS eligibility file. The pharmacy provider should contact the client's Medicare Prescription Drug Plan for assistance. If the consumer indicates that he does not have Medicare, he should be advised to call his county eligibility caseworker.

3.13 Qualified Medicare Beneficiary (QMB)

- Consumers with a QMB card are eligible only for payment of cost sharing associated with Medicare Part B-covered drugs (see section 3.5 of this document).
- The ACS Technical Call Center will NOT override a rejection if the consumer is identified as a having Medicare Part B on the ODJFS eligibility file. The pharmacy provider should contact the client's Medicare Prescription Drug Plan for assistance.

3.14 Compounds

There are three types of compounds:

1. Standard compounds:

- Use multi-ingredient single claim functionality.
- All edits apply to each NDC except for age and gender restriction.
- Dispensing fee = \$6.00 per prescription.

2. Infusion Compound non-TPN (for IV chemo/pain management/antibiotics):

- Use multi-ingredient single claim functionality.
 - All edits apply to each NDC except for age and gender restriction and living arrangement.
 - Claim requirements:
 - COMPOUND ROUTE OF ADMINISTRATION (NCPDP field #995-E2) should be submitted using the Systematized Nomenclature of Medicine (SNOMED) route of administration code specifying IV infusion. The SNOMED route codes that will trigger the higher dispensing fee are 47625008 (IV), 419993007 (IV peripheral), and 418114005 (IV central); and
 - NDC within Home IV list (bulk solutions); then
 - Dispensing fee = \$10.00 per day with dispensing fee maximum of \$70.00.
- NOTE:** Days supply is normal days supply maximum (i.e., not limited to 7 days just because dispensing fee is capped at \$70.00).

3. TPN compounds:

- Use multi-ingredient single claim functionality.
 - All edits apply to each NDC except for age and gender restriction and living arrangement.
 - Claim requirements:
 - COMPOUND ROUTE OF ADMINISTRATION (NCPDP field #995-E2)) should be submitted using the SNOMED route of administration code specifying IV infusion. The SNOMED route codes that will trigger the higher dispensing fee are 47625008 (IV), 419993007 (IV peripheral), and 418114005 (IV central); and
 - NDC within TPN list; then
 - Dispensing fee = \$15.00 per day with dispensing fee maximum of \$150.00.
- NOTE:** Days supply is normal days supply maximum (i.e., not limited to 10 days just because dispensing fee is capped at \$150.00).

NOTES:

Compound claims will not deny for duplicate if one of the compound ingredients is also submitted as a single ingredient claim for the same DOS. There will be a denial for Early Refill; the provider should contact ACS for an override request.

If an ingredient in a compound is not payable in the ODJFS drug file, the pharmacy may receive payment for only the covered products by submitting “8” as the SUBMISSION CLARIFICATION CODE (NCPDP field #420-DK).

3.15 Influenza Vaccine Administration

Pharmacies may bill for administration of both pandemic and seasonal influenza vaccine through May 31 of each influenza season. Payment for influenza vaccine administration will be made to pharmacies only for Medicaid consumers who do not reside in long-term care facility (LTCF).

Reimbursement for the pandemic influenza vaccine will be limited to an administration fee of no more than \$10.00. The pandemic influenza vaccine is supplied by the Ohio Department of Health at no cost to the provider, so no reimbursement will be made for the vaccine itself. Reimbursement for the seasonal influenza vaccine will include product cost and an administration fee of no more than \$10.00. No dispensing fee will be paid when the administration fee is billed. Influenza vaccine may be dispensed to LTCF residents for administration by LTCF staff. Claims for influenza vaccine dispensed to residents of LTCFs are eligible for a dispensing fee of \$0.50.

3.16 Newborns Without an Assigned Medicaid ID

Newborns should have an ID card showing the newborn's Medicaid billing ID. If a card is not presented, call ACS to determine if an ID number has been assigned. If a Medicaid ID has not been assigned for the baby, newborns will be covered for prescriptions for the first 365 days after birth under their mother's Medicaid billing ID. The claim for the newborn should be submitted using the mother's Medicaid ID and the baby's date of birth. As soon as a Medicaid ID is assigned to the newborn it should be used for billing claims.

Section 4: Prospective Drug Utilization Review (ProDUR)

Prospective Drug Utilization Review (ProDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system 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 the ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. ACS 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.

Individual ingredients in compound claims will be evaluated for ProDUR consideration.

4.1 Therapeutic Edits

- Point of Sale Denials
 - Early Refill
 - Therapeutic Duplication: Only one drug from each of the following categories may be dispensed in any three-week period:
 - Antihistamines
 - Non-steroidal anti-inflammatory drugs (NSAIDs)
 - Proton Pump Inhibitors (PPIs)
 - Sedative/Hypnotics
 - Selective Serotonin Reuptake Inhibitors (SSRIs)Pharmacy overrides using standard NCPDP intervention and outcome codes will be permitted for these therapeutic duplication edits and should be used only when the pharmacist believes it is clinically appropriate.
- The system will automatically override an increase in dose when the prescription is submitted with a new prescription number.
- Submitting correct days supply information is critical to the edit functions of the ProDUR system. Submitting incorrect information in the days supply field may cause false ProDUR messages or claim denial.
- ProDUR edits apply to all claims media types.
- The pharmacy provider must contact the ACS Technical Call Center (1-877-518-1545) for any other override reasons.

4.2 Technical Call Center

The ACS Technical Call Center is available 24 hours per day, 7 days per week. The telephone number is 1-877-518-1545. Alert message information is available from the Technical Call Center after the message appears. For assistance with any alert or denial messages, it is important to contact the Technical Call Center about ACS ProDUR messages at the time of dispensing. The Technical Call Center can provide claims information on all error messages that 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. ACS 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, ACS staff pharmacists are available for consultation during clinical call center business hours.

4.3 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 YYYY/MM/DD 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 the ODJFS allowed amount for the paid claim. A claim that fails an edit and is rejected (denied) will also return a message.

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 “Possible Solutions” box if you are experiencing difficulties. For further assistance contact ACS:

Technical Call Center
1-877-518-1545
(Nationwide Toll Free Number)

| POINT OF SALE REJECT CODES AND MESSAGES | | | |
|--|---|---------------------------------------|--|
| Edits may not all apply to this program | | | |
| ("M/I" Means Missing/Invalid) | | | |
| Reject Code | Explanation | Field Number Possibly In Error | Possible Solutions |
| Ø1 | M/I Bin | 1Ø1 | Use 61ØØ84. |
| Ø2 | M/I Version Number | 1Ø2 | Version allowed 5.1 through March 31, 2012 or D.0. |
| Ø3 | M/I Transaction Code | 1Ø3 | Transactions allowed = B1, B2, B3 and E1. |
| Ø4 | M/I Processor Control Number | 1Ø4 | Use DROHPROD = Production DROHACCP = Test |
| Ø5 | M/I Pharmacy Number | 2Ø1 | Use National Provider Identifier (NPI). Must have contract with Ohio Medicaid for DOS. Check with software vendor to ensure appropriate number has been set up in your system. |
| Ø6 | M/I Group Number | 3Ø1 | Use OHMEDICAID only. |
| Ø7 | M/I Cardholder ID Number | 3Ø2 | Use 12 digit Ohio Medicaid Recipient ID number only; do not use any other patient ID. Do not enter any dashes. Providers should always examine a consumer’s Medicaid ID card before services are rendered. It is the provider’s responsibility to establish the identity of the consumer and to verify the effective date of coverage for the card presented. |
| Ø9 | M/I Birth Date | 3Ø4 | Format = YYYY/MM/DD. Date of birth is printed on the Medicaid card. |
| 1Ø | M/I Patient Gender Code | 3Ø5 | Values = 0 (not specified), 1 (male) and 2 (female). |
| 13 | M/I Other Coverage Code | 3Ø8 | See <i>Coordination of Benefits</i> section. |
| 15 | M/I Date of Service | 4Ø1 | Format = YYYY/MM/DD. A future date is not allowed in this field. |
| 16 | M/I Prescription/Service Reference Number | 4Ø2 | Format = NNNNNNN. |
| 17 | M/I Fill Number | 4Ø3 | Enter “ØØ” for a new prescription. Acceptable values for a refill prescription range from Ø1 to 99. |
| 19 | M/I Days Supply | 4Ø5 | Format = NNN. Enter the days supply, “PRN” not allowed. |
| 2C | M/I Pregnancy Indicator | 335 | Required when needed to override a co-payment on a claim for a pregnant consumer. 2=Pregnant |

| POINT OF SALE REJECT CODES AND MESSAGES | | | |
|--|---|---------------------------------------|---|
| Edits may not all apply to this program | | | |
| ("M/I" Means Missing/Invalid) | | | |
| Reject Code | Explanation | Field Number Possibly In Error | Possible Solutions |
| 2E | M/I Primary Care Provider ID Qualifier | 468 | |
| 2Ø | M/I Compound Code | 4Ø6 | |
| 21 | M/I Product/Service ID | 4Ø7 | Use 11-digit NDC only for non-compound claims. Do not enter any dashes. Use "Ø" for compound claims. |
| 22 | M/I Dispense As Written (DAW)/Product Selection Code | 4Ø8 | |
| 23 | M/I Ingredient Cost Submitted | 4Ø9 | |
| 25 | M/I Prescriber ID | 411 | Use National Provider Identifier (NPI). Do not use any other number. |
| 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 | |
| 3P | M/I Authorization Number | 5Ø3 | |
| 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 | |
| 3Y | Prior Authorization Denied | | |
| 33 | M/I Prescription Origin Code | 419 | |
| 34 | M/I Submission Clarification Code | 42Ø | |
| 39 | M/I Diagnosis Code | 424 | |
| 4C | M/I Coordination Of Benefits/Other Payments Count | 337 | |
| 4Ø | Pharmacy Not Contracted With Plan On Date Of Service | None | Use National Provider Identifier (NPI) number only; check DOS. Call the Provider Enrollment Department if necessary (1-800-686-1516). |
| 41 | Submit Bill To Other Processor Or Primary Payer | None | Indicates patient has other coverage. See the <i>Additional Message</i> field for details. |
| 5C | M/I Other Payer Coverage Type | 338 | |
| 5E | M/I Other Payer Reject Count | 471 | |

| POINT OF SALE REJECT CODES AND MESSAGES | | | |
|--|--|---------------------------------------|---|
| Edits may not all apply to this program | | | |
| ("M/I" Means Missing/Invalid) | | | |
| Reject Code | Explanation | Field Number Possibly In Error | Possible Solutions |
| 5Ø | Non-Matched Pharmacy Number | 2Ø1 | Use National Provider Identifier (NPI). Check lock-in status. |
| 51 | Non-Matched Group ID | 3Ø1 | Use OHMEDICAID only. |
| 52 | Non-Matched Cardholder ID | 3Ø2 | Use 12-digit Ohio Medicaid ID number only; do not use any other patient ID. Do not enter any dashes. |
| 54 | Non-Matched Product/Service ID Number | 4Ø7, 489 | Use 11-digit NDC for non-compound claims. Use 'Ø' if a compound. |
| 56 | Non-Matched Prescriber ID | 411 | Use National Provider Identifier (NPI). |
| 6C | M/I Other Payer ID Qualifier | 339 | |
| 6E | M/I Other Payer Reject Code | 472 | |
| 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 | |
| 63 | Institutionalized Patient Product/Service ID Not Covered | | |
| 66 | Patient Age Exceeds Maximum Age | 3Ø4 | |
| 67 | Filled Before Coverage Effective | 4Ø1 | Use 12-digit Ohio Medicaid ID number only; do not use any other patient ID. Do not enter any dashes. Check DOS. Check Group Number. |
| 68 | Filled After Coverage Expired | 4Ø1 | Use 12-digit Ohio Medicaid ID number only; do not use any other patient ID. Do not enter any dashes. Check DOS. Check Group Number. |
| 69 | Filled After Coverage Terminated | 4Ø1 | |
| 7C | M/I Other Payer ID | 34Ø | |
| 7E | M/I DUR/PPS Code Counter | 473 | |
| 7Ø | Product/Service Not Covered | 4Ø7 | Use 11-digit NDC. Drug not covered. |
| 71 | Prescriber Is Not Covered | 411 | |
| 73 | Refills Are Not Covered | 4Ø2, 4Ø3 | |
| 74 | Other Carrier Payment Meets Or Exceeds Payable | 4Ø9, 41Ø, 442 | |
| 75 | Prior Authorization Required | 462 | Validate 11-digit NDC. Drug requires PA. Non-PDL; try preferred agent. |
| 76 | Plan Limitations Exceeded | 4Ø5, 442 | Check days supply and metric decimal quantity. NDCs may have minimum and/or maximum quantity limits or quantity per days supply limits. |
| 77 | Discontinued Product/Service ID Number | 4Ø7 | Validate 11-digit NDC. NDC is obsolete. |
| 78 | Cost Exceeds Maximum | 4Ø7, 4Ø9, 41Ø, 442 | |
| 79 | Refill Too Soon | 4Ø1, 4Ø3, 4Ø5 | |
| 8C | M/I Facility ID | 336 | |
| 81 | Claim Too Old | 4Ø1 | Check DOS. |
| 82 | Claim Is Post-Dated | 4Ø1 | Check DOS. |
| 83 | Duplicate Paid/Captured Claim | 2Ø1, 4Ø1, 4Ø2, 4Ø3, 4Ø7 | |

| POINT OF SALE REJECT CODES AND MESSAGES | | | |
|--|--|---------------------------------------|--|
| Edits may not all apply to this program | | | |
| ("M/I" Means Missing/Invalid) | | | |
| Reject Code | Explanation | Field Number Possibly In Error | Possible Solutions |
| 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 | Provider number, DOS and Rx number must equal original claim. |
| 88 | DUR Reject Error | | If Early Refill, 75% day's supply of previous claim has not been utilized. Looks at all network providers. |
| 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 | | |
| 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 | | |
| AM | M/I Segment Identification | 111 | |
| A9 | M/I Transaction Count | 1Ø9 | |
| B2 | M/I Service Provider ID Qualifier | 2Ø2 | |
| CX | M/I Patient ID Qualifier | 331 | |
| DC | M/I Dispensing Fee Submitted | 412 | |
| DQ | M/I Usual And Customary Charge | 426 | |
| DU | M/I Gross Amount Due | 43Ø | |
| DV | M/I Other Payer Amount Paid | 431 | |
| EC | M/I Compound Ingredient Component Count | 447 | |
| ED | M/I Compound Ingredient Quantity | 448 | |
| EF | M/I Compound Dosage Form Description Code | 45Ø | |

| POINT OF SALE REJECT CODES AND MESSAGES | | | |
|--|---|---------------------------------------|---|
| Edits may not all apply to this program | | | |
| ("M/I" Means Missing/Invalid) | | | |
| Reject Code | Explanation | Field Number Possibly In Error | Possible Solutions |
| EG | M/I Compound Dispensing Unit Form Indicator | 451 | |
| E2 | M/I Route Of Administration | 995 | |
| EM | M/I Prescription/Service Reference Number Qualifier | 455 | |
| EN | M/I Associated Prescription/Service Reference Number | 456 | |
| EP | M/I Associated Prescription/Service Date | 457 | |
| ET | M/I Quantity Prescribed | 460 | |
| EU | M/I Prior Authorization Type Code | 461 | |
| 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 | |
| E5 | M/I Professional Service Code | 440 | |
| E6 | M/I Result Of Service Code | 441 | |
| E7 | M/I Quantity Dispensed | 442 | |
| E8 | M/I Other Payer Date | 443 | Must be =< Medicaid date of service and adjudication. |
| FO | M/I Plan ID | 524 | |
| HB | M/I Other Payer Amount Paid Count | 341 | |
| 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 | |
| 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 | | |
| MZ | Error Overflow | | |
| NN | Transaction Rejected At Switch Or Intermediary | | |
| PA | PA Exhausted/Not Renewable | | |
| PB | Invalid Transaction Count For This Transaction Code | 103, 109 | |
| PC | M/I Claim Segment | 111 | |

| POINT OF SALE REJECT CODES AND MESSAGES | | | |
|--|--|---------------------------------------|---------------------------|
| Edits may not all apply to this program | | | |
| ("M/I" Means Missing/Invalid) | | | |
| Reject Code | Explanation | Field Number Possibly In Error | Possible Solutions |
| 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 | |
| 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 | |
| PX | Non-Matched Other Payer ID | 34Ø | |
| PY | Non-Matched Unit Form/Route of Administration | 451, 452, 6ØØ | |
| P1 | Associated Prescription/Service Reference Number Not Found | 456 | |
| 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 | |
| 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 Partial 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 | |

| POINT OF SALE REJECT CODES AND MESSAGES | | | |
|--|---|---------------------------------------|---------------------------|
| Edits may not all apply to this program | | | |
| ("M/I" Means Missing/Invalid) | | | |
| Reject Code | Explanation | Field Number Possibly In Error | Possible Solutions |
| 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 | 401 | |
| 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, 480 | |
| R2 | Other Payer Reject Count Does Not Match Number Of Repetitions | 471, 472 | |
| R5 | Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals 06 | 407, 436 | |
| R6 | Product/Service Not Appropriate For This Location | 307, 407, 436 | |
| R7 | Repeating Segment Not Allowed In Same Transaction | | |
| R8 | Syntax Error | | |
| R9 | Value In Gross Amount Due Does Not Follow Pricing Formula | 430 | |
| TE | M/I Compound Product ID | 489 | |
| VE | M/I Diagnosis Code Count | 491 | |
| WE | M/I Diagnosis Code Qualifier | 492 | |
| XE | M/I Clinical Information Counter | 493 | |

5.2 Host System Problems

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

| <i>NCPDP</i> | <i>Message</i> | <i>Explanation</i> |
|--------------|---|--|
| 90 | Host Hung Up | Host disconnected before session completed. |
| 92 | System Unavailable/ Host Unavailable | Processing host did not accept transaction or did not respond within time out period. |
| 93 | Planned Unavailable | Transmission occurred during scheduled downtime. ACS will provide system availability 7 days per week during regular business hours. Scheduled maintenance will occur during low volume and non-peak times, generally limited to Sundays midnight to 2 AM. |
| 99 | Host Processing Error | Do not retransmit claims. |

5.3 DUR Fields

Direct requests for ProDUR Early Refill overrides to the ACS Technical Call Center.

| <i>NCPDP</i> | <i>Message</i> |
|--------------|------------------|
| 88 | DUR Reject Error |

When denials for ProDUR edits are received, providers may override these denials using the appropriate NCPDP intervention and outcome codes as described in the payer sheet. Following are the ProDUR edits that will deny for any Therapeutic Duplication DUR that are dispensed in any 3 week period for Ohio Medicaid:

- Antihistamines
- NSAIDs
- PPIs
- Sedative/Hypnotics
- SSRIs

All other therapeutic categories of medications will only message.

Section 6: Provider Reimbursement

6.1 Provider Payment Algorithms

- Payment is always the allowed amount minus any applicable co-payment. The allowed amount is the least of:
 - ODJFS maximum amount + dispensing fee, or
 - GROSS AMOUNT DUE (NCPDP field #430-DU) (submitted), or
 - USUAL AND CUSTOMARY CHARGE (U/C) (NCPDP field #426-DQ) (submitted)

6.2 Provider Reimbursement Schedule

Contact ODJFS Provider Network Management (1-800-686-1516) or log on to the MITS web portal (<https://portal.ohmits.com/public/Providers/tabid/43/Default.aspx>) for questions regarding payment and Remittance Advices.

APPENDIX A: Request For Prior Authorization

Prior Authorization Form on next page.

Request For Prior Authorization Can be Made by:

- **Fax:** 1-800-396-4111
- **Phone:** 1-877-518-1546
- **Fillable Prior Authorization Form available at:**
<http://jfs.ohio.gov/ohp/bhpp/meddrug.stm> or through ODJFS Forms Central at
<http://www.odjfs.state.oh.us/forms/interfind.asp?formnum=03523>

