State of Nebraska Medicaid Pharmacy Claims Submission Manual

Version 2.7

October 1, 2024

Revision History

Document Version	Date	Name	Comments
1.0	05/2008	Documentation Mgmt. Team; Implementations and Planning Dept.	Initial creation of document
1.1	05/2008	Documentation Mgmt. Team; Implementations and Planning Dept.	Updated Appendix A
1.2	07/2008	Documentation Mgmt. Team; Implementations and Planning Dept.	Updated Appendix A and Section 8.1.1
1.3	09/2008	Documentation Mgmt. Team; Implementations and Planning Dept.	Updated Appendix B – Universal Claim Form (UCF)
1.4	10/2008	Documentation Mgmt. Team; Implementations and Planning Dept.	Updated Appendix B – Universal Claim Form (UCF)
1.5	02/2010	Documentation Mgmt. Team; Implementations and Planning Dept.	Updated Prime Therapeutics Management's address in Appendix E
1.6	05/2010	Documentation Mgmt. Team; Implementations and Planning Dept.	Standardized
1.7	04/14/2011	Documentation Mgmt. Team; Account Management	Updated sections 2.3, 3.0, 3.1, 3.2, 5.2, 7.3, 7.4, 7.6, 7.7.2, 8.2.4, Appendix C.1, C.2, D.1, and D.2
1.8	06/09/2011	Glenn Sharp	Updated
1.9	11/04/2011	Documentation Mgmt. Team; Linwood Schools	Updated section 7.5 Client Co-Pays table
2.0	03/23/2012	Documentation Mgmt. Team; Linwood Schools	Updated all references to NCPD version 5.1 to NCPDP version D.0 Updated payer specs and Universal Claim Form for D.0 requirements; removed reference to OCC 5, 6, 7, and 8 Removed reference to Prescription Origin code 0 and added prescription Origin code 5
2.1	04/19/2012	Linwood Schools	Updated sections 7.2.1, 7.4.1, 7.9
2.2	08/17/2012	Documentation Mgmt. Team; Glenn Sharp	Updated vendor certification contact information and paper claims mailing address

Document Version	Date	Name	Comments
2.3	01/01/2013	Documentation Mgmt. Team; Linwood Schools	Updated procedure for cusp claims for spend down patients
2.4	01/17/2013	Documentation Mgmt. Team; Linwood Schools	Updated *Section 7.4.3 – SMAC Pricing or Appeal/Raise Issues*
2.5	07/16/2013	Documentation Mgmt. Team; Linwood Schools	Update all references to timely filing to 180 days
2.6	10/03/2013	Communication & Documentation Mgmt Team; Glenn Sharp	Added UCF key and updated the UCF form
2.7	10/01/2024	Account Team; ShaLeigh Hammons	Rebranded to Prime Therapeutics State Government Solutions LLC.

Table of Contents

1.0 Introduction

1.1 Nebraska Department of Health and Human Services Pharmacy Program

This manual provides claims submission guidelines for the Medicaid pharmacy program administered by the Nebraska Department of Health and Human Services (NE DHHS).

Important NE DHHS coverage and reimbursement policies are available in this *State of Nebraska Pharmacy Claims Submission Manual*. The Prime Therapeutics Management website for NE DHHS contains a link to this document. Subsequent revisions to this document will be available by accessing the link.

For the most current version of this manual, refer to the Prime Therapeutics Management website at http://nebraska.fhsc.com.

1.2 Pharmacy Benefit Manager (PBM) – Prime Therapeutics Management

NE DHHS contracts with Prime Therapeutics Management as its pharmacy benefit manager to

- Adjudicate claims;
- Provide Pharmacy Support Center and Clinical Support Center services for providers;
- Review and adjudicate prior authorization requests;
- Perform prospective drug utilization review (ProDUR) and retrospective drug utilization review (RetroDUR); and
- Provide clinical consultation.

2.0 Billing Overview

2.1 Enrolling as a DHHS-Approved Pharmacy

The Nebraska Medicaid pharmacy provider network will consist of DHHS-contracted pharmacies. To enroll as a Medicaid pharmacy provider, contact the Nebraska Provider Enrollment Unit:

- 402-471-9128 (Lincoln Area)
- 877-255-3092 (Outside Lincoln)

All billing providers must have an active National Provider Identifier (NPI). Providers must submit the NPI only in the Service Provider ID field (NCPDP Field # 2Ø1-B1).

2.2 Claim Formats and DHHS – Specific Values

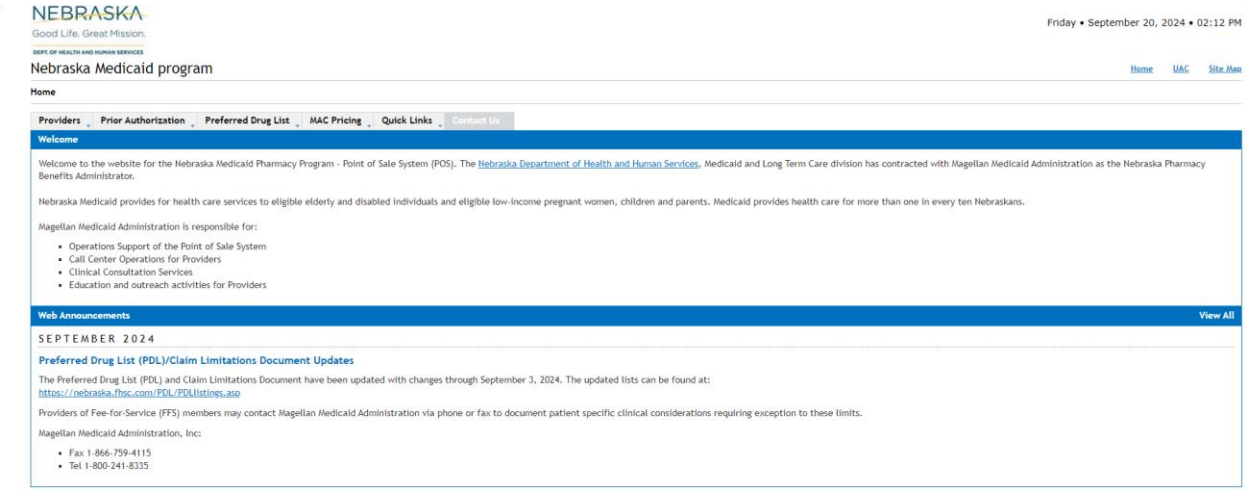
Pharmacy claims may be submitted online by point-of-sale (POS), by web claims submission, or by paper using the following National Council for Prescription Drug Programs (NCPDP) standards:

- POS: NCPDP version D.0
- Paper: Universal Claim Form (Version 1.1 for Standard Version D.0)
- Web Claims: NCPDP version D.0

Refer to *Section 4.1 – Claim Format* for further details on acceptable claim formats and specifications.

2.3 Prime Therapeutics Management's Website for Nebraska

Announcements, provider forms, drug information, provider manuals, Medicaid policies, and bulletins are posted on the Prime Therapeutics Management website at http://nebraska.fhsc.com/.



2.4 Important Contact Information

Refer to *Appendix E – Directory* at the end of this manual for important phone numbers, mailing addresses, and websites.

3.0 Prime Therapeutics Management's Support Centers

Prime Therapeutics Management has support centers to assist pharmacists and prescribers. *Appendix E – Directory* at the end of this manual lists their phone numbers along with the hours of operation.

3.1 Pharmacy Support Center

1-800-368-9695 (Nationwide Toll-Free Number)

Prime Therapeutics Management provides a toll-free number for pharmacies available 7 days a week, 24 hours a day, and 365 days a year. The Pharmacy Support Center responds to questions on coverage, claims processing, and client eligibility.

Examples of issues addressed by Pharmacy Support Center staff include, but are not limited to, the following:

- **Questions on Claims Processing Messages** – If a pharmacy needs assistance with alert or denial messages, it is important to contact the Pharmacy Support Center at the time of dispensing drugs. Prime Therapeutics Management staff is able to provide claim information on all error messages, including messaging from the ProDUR system.
- **After Hours Emergency Fills**
- **Non-Clinical Overrides by the Pharmacy Support Center** – The Pharmacy Support Center will address non-clinical overrides as they will be the first point of contact for pharmacy providers requesting emergency overrides for covered drugs. If the pharmacy provider's request is received after normal DHHS business hours or on a weekend or a holiday, then an override will be granted for up to 72 hours for covered drugs. The Pharmacy Support Center staff is required to quote the emergency definitions as supplied by DHHS and will require the pharmacist's and physician's first and last name per the guidelines established by DHHS.
- **Clinical Issues** – The Pharmacy Support Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. However, a second level of assistance is available if a pharmacist's question requires a clinical response. To address these situations, Prime Therapeutics Management pharmacists are available for consultation. Prime Therapeutics Management uses reasonable care to accurately compile its ProDUR information. Since 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.

3.2 Clinical Support Center

1-800-241-8335 (Nationwide Toll-Free Number)

Prime Therapeutics Management provides a toll-free telephone line for providers to contact our Clinical Consultation Services support staff. This toll-free telephone line will be staffed Monday through Friday from 8:00 a.m. to 7:00 p.m. (Central Time [CT]), and Saturday, 8:00 a.m. to 1:00 p.m. (CT). After hours, weekends, and holiday calls will be routed to our 24/7/365 Pharmacy Support Center, where emergency fills can be authorized.

Prescribers and Pharmacy – The Clinical Support Center handles prior authorization requests for

- Drugs requiring prior authorization;
- Quantity limit overrides; and
- Early refill for controlled substances.

A pharmacy technician initially responds to callers. Requests not meeting established criteria or requiring an in-depth review are forwarded to a Prime Therapeutics Management clinical pharmacist.

Prior authorization forms are available to prescribers and pharmacy providers via the website at http://nebraska.fhsc.com.

4.0 Program Setup

4.1 Claim Format

While Prime Therapeutics Management strongly recommends claims submission by POS or web claims submission. Paper claims are only acceptable in special circumstances where POS or web submission is not possible. The following standard formats are accepted (see Table 4.1.1). Each is explained in subsequent sections.

Table 4.1.1 – Claim Formats Accepted by Prime Therapeutics Management

Billing Media	NCPDP Version	Comments
POS	Version D.0	Online POS and web claims submission is preferred.
Paper Claims	Universal Claim Form (D.0)	Version 1.1 for Standard D.0
Web Claims Submission	NCPDP D.0	

4.2 Point-of-Sale – NCPDP Version D.0

As part of claims processing, Prime Therapeutics Management uses an online POS system to provide submitters with real-time online information regarding

- Client eligibility;
- Drug coverage;
- Dispensing limits;
- Pricing;
- Payment information; and
- ProDUR.

The POS system is used in conjunction with a pharmacy's in-house operating system. While there are a variety of different pharmacy operating systems, the information contained in this manual specifies only the response messages related to the interactions with the Prime Therapeutics Management online system and not the technical operation of a pharmacy's in-house-specific system. Pharmacies should check with their software vendors to ensure their system is able to process as per the payer specifications listed in *Appendix A – Payer Specifications* of this manual.

4.2.1 Supported POS Transaction Types

Prime Therapeutics Management has implemented the following NCPDP Version D.0 transaction types. A pharmacy's ability to use these transaction types will depend on its software. At a minimum, pharmacies should have the capability to submit original claims

(B1), reversals (B2), and re-bills (B3). Other transactions listed in *Table 4.2.1.1* are also supported.

- **Full Claims Adjudication (Code B1)** – This transaction captures and processes the claim and returns the dollar amount allowed under the program's reimbursement formula. The B1 transaction will be the prevalent transaction used by pharmacies.
- **Claims Reversal (Code B2)** – This transaction is used by a pharmacy to cancel a claim that was previously processed. To submit a reversal, a pharmacy must void a claim that has received a PAID status and select the REVERSAL (Void) option in its computer system.
- **Claims Re-Bill (Code B3)** – This transaction is used by the pharmacy to adjust and resubmit a claim that has received a PAID status. A "claim re-bill" voids the original claim and resubmits the claim within a single transaction. The B3 claim is identical in format to the B1 claim with the only difference being that the transaction code (Field # 1Ø3) is equal to B3.

Note: The following fields must match the original paid claim for a successful transmission of a B2 (reversal) or B3 (re-bill):

- Service Provider ID - NPI Number
- Prescription Number
- Date of Service (Date Filled)

Table 4.2.1.1 – NCPDP Version D.0 Transaction Types Supported

NCPDP D.0 Transaction Code	Transaction Name
E1	Eligibility Verification
B1	Billing
B2	Reversal
B3	Re-Bill
P1	Prior Authorization Request & Billing
P3	Prior Authorization Inquiry
P2	Prior Authorization Reversal
P4	Prior Authorization Request Only
N1	Information Reporting
N2	Information Reporting Reversal
N3	Information Reporting Re-Bill
C1	Controlled Substance Reporting
C2	Controlled Substance Reversal
C3	Controlled Substance Reporting Re-Bill

4.2.2 Required Data Elements

A software vendor will need the Prime Therapeutics Management Payer Specifications (see *Appendix A – Payer Specifications*) to set up a pharmacy's computer system, to allow access to the required fields, and to process claims. The Prime Therapeutics Management claims processing system has program-specific field requirements; e.g., mandatory, situational, and not sent. Table 4.2.2.1 lists abbreviations that are used throughout the Payer Specifications to depict field requirements.

Table 4.2.2.1 – Definitions of Field Requirement Indicators Used in Payer Specifications

Code	Description
M	MANDATORY Fields with this designation according to NCPDP standards must be sent if the segment is required for the transaction.
R	REQUIRED Fields with this designation according to this program's specifications must be sent if the segment is required for the transaction.
S	SITUATIONAL It is necessary to send these fields in noted situations. Some fields designated as situational by NCPDP may be required for all Nebraska Medicaid transactions. Some fields designated as situational by NCPDP may be required for Nebraska Medicaid transactions where specific conditions are met.
R***	REPEATING The "R***" indicates that the field is repeating. One of the other designators, "M" or "S" will precede it.

Claims will not be processed without all the required (or mandatory) data elements. Required (or mandatory) fields may or may not be used in the adjudication process. Also, fields not required at this time may be required at a future date.

Claims will be edited for valid format and valid values on not required fields. If data are submitted in fields not required for processing as indicated by the Payer Specifications, the data will be subjected to valid format/value checks. Failure to pass those checks will result in claim denials.

- **Required Segments** – The transaction types implemented by Prime Therapeutics Management have NCPDP-defined request formats or segments. Table 4.2.2.2 lists NCPDP segments used.

Table 4.2.2.2 – Segments Supported For B1, B2, and B3 Transaction Types

Segment	Transaction Type Codes		
	B1	B2	B3
Header	M	M	M

Segment	Transaction Type Codes		
	B1	B2	B3
Patient	S	S	S
Insurance	M	S	M
Claim	M	M	M
Pharmacy Provider	S	N	S
Prescriber	S	N	S
COB/Other Payments	S	N	S
Worker's Comp	S	N	S
DUR/PPS	S	S	S
Pricing	M	S	M
Coupon	S	N	S
Compound	S	N	S
Prior Authorization	S	N	S
Clinical	S	N	S
M = Mandatory S = Situational N = Not Used			

- **Payer Specifications** – A list of transaction types and their field requirements is available in *Appendix A – Payer Specifications*. These specifications list B1, B2, and B3 transaction types with their segments, fields, field requirement indicators (mandatory, situational, optional), and values supported by Prime Therapeutics Management.
- **Program Setup** – Table 4.2.2.3 lists required values unique to Nebraska programs.

Table 4.2.2.3 – Important Required Values for Program Setup

Fields	Description	Comments
ANSI BIN #	013766	
Processor Control #	P063013766	
Group #	NEBMEDICAID	
Provider ID #	National Provider Identifier (NPI)	10 bytes
Cardholder ID #	Medicaid ID Number	11 bytes (numeric)
Prescriber ID #	National Provider Identifier (NPI)	10 bytes Beginning with adjudication date 01/01/2012, all claims must be submitted with Prescriber NPI, even claims with a date of service prior to 01/01/2012.
Product Code	National Drug Code (NDC)	11 digits

4.2.3 Tamper-Resistant Prescription Pad (Prescription Origin Code)

Effective October 1, 2008, NE DHHS requires providers to report the type of prescription presented at the pharmacy. This change is in compliance with the Centers for Medicare & Medicaid Services (CMS) tamper-resistant prescription pad mandate. The NCPDP Prescription Origin Code (NCPDP Field # 419-DJ) identifies the type of prescription that was presented at the pharmacy. Pharmacy providers must report one of the following NCPDP values for the Prescription Origin Code:

- 1 = Written
- 2 = Telephone
- 3 = Electronic
- 4 = Facsimile
- 5 = Pharmacy

NCPDP Error Code 33 – *Missing/Invalid Prescription Origin Code* will occur if one of the above values is not reported on the claim.

When submitting a value of 1 (Written), the provider is validating that the prescription was submitted in accordance with all tamper-resistant prescription pad guidelines.

Note: **This was a required field at go-live on June 11, 2008, though the edit did not start until October 1, 2008.**

4.3 Paper Claim – Universal Claim Form (UCF)

All paper pharmacy claims must be submitted to Prime Therapeutics Management on a Universal Claim Form (UCF, version 1.1). *Appendix E – Directory* at the end of this manual specifies

- An alternative source for obtaining UCFs; and
- The address that pharmacies must use when sending completed UCF billings.

Completion instructions for the UCF are listed in *Appendix B – Universal Claim Form*. For certain billings outside the norm, Prime Therapeutics Management may accept UCF submissions.

Examples of claims that require a UCF include, but are not limited to, the following:

- **Prescriptions Exceeding the Timely Filing Limit** – Claims with dates of service past 180 days from date written must be authorized by DHHS. Information sent to DHHS should include reason claims were not submitted electronically within the allowed timeframe. DHHS will enter an override if appropriate. Claims submitted without authorization will deny.

  Note: Effective 09/01/2013, Timely Filing Limit has changed from 366 days to 180 days.

- **Split Claims for Spend-Down Clients** – A split claim for a Medicaid client who is subject to spend-down requirements should be submitted at POS or using web claim submission using the procedure below.

1. Client fills prescription to meet share of cost obligation and prescription cost is greater than share of cost (spend-down) amount.
2. Complete share of cost form and collect share of cost amount from client. Pharmacy cannot collect an amount from the client greater than the stated share of cost obligation on the client form. Fax completed form to Medicaid for processing at 1-402-471-8703.
3. Call the Inquiry Line (1-877-255-3092 option 1) to verify share of cost form has been met for a particular month and client eligibility is now open.
4. Submit claim electronically to Prime Therapeutics Management with the patient pay field (DX) populated. Claim will deny as a duplicate. Call the Prime Therapeutics Management Help Desk at 1-800-368-9695 to obtain an override. Advise agent that you need an override to process a share of cost claim with a remaining balance due to the pharmacy.
5. Resubmit claim electronically to receive payment.

- Web Claims Submission

Refer to the *Web Claims Submission User Guide* for more information.

5.0 Service Support

5.1 Online Certification

The Software Vendor/Certification Number (NCPDP Field # 11Ø-AK) of the Transaction Header Segment is required for claims submission under NCPDP version D.0; providers should submit the value = "0000000000."

Prime Therapeutics Management certifies software vendors, not an individual pharmacy's computer system. A pharmacy should contact its vendor or Prime Therapeutics Management to determine if the required certification has been obtained. For assistance with software vendor certification, contact Prime Therapeutics Management. Refer to *Appendix E – Directory* at the end of this manual for other contact information.

5.2 Solving Technical Problems

Pharmacies will receive one of the following messages when Prime Therapeutics Management's POS system is down (see *Table 5.2.1*).

Table 5.2.1 – Host System Problem Messages and Explanations

NCPDP	Message	Explanation
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. Scheduled downtime for file maintenance is Sunday, 10:00 p.m.–5:00 a.m. (CT).
99	Host Processing Error	Do not retransmit claims.

Prime Therapeutics Management strongly encourages that a pharmacy's software has the capability to submit backdated claims. Occasionally, a pharmacy may also receive messages that indicate its own network is having problems communicating with Prime Therapeutics Management. If this occurs or if a pharmacy is experiencing technical difficulties connecting with the Prime Therapeutics Management system, pharmacies should follow the steps outlined below:

1. Check the terminal and communications equipment to ensure that electrical power and telephone services are operational.
2. Call the telephone number the modem is dialing and note the information heard (i.e., fast busy, steady busy, recorded message).

3. Contact the software vendor if unable to access this information in the system.
4. If the pharmacy has an internal technical staff, forward the problem to that department, then internal technical staff should contact Prime Therapeutics Management to resolve the problem.
5. If unable to resolve the problem after following the steps outlined above, directly contact the Prime Therapeutics Management Pharmacy Support Center. Refer to *Appendix E – Directory* at the end of this manual for contact information.

6.0 Online Claims Processing Edits

6.1 Paid, Denied, and Rejected Responses

After online claims submission is made by a pharmacy, the POS 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 allowed reimbursement amount. A claim that fails an edit and is REJECTED (or DENIED) will also return with an NCPDP rejection code and message. Refer to *Appendix D – POS Reject Codes and Messages* for a list of POS rejection codes and messages.

6.2 Duplicate Responses

A duplicate disposition occurs when there is an attempt to submit a claim that has already gone through the adjudication process with either some or all of the previous claims information. An exact match on the following fields will result in a duplicate disposition:

- Same Patient/Client
- Same Service Provider ID
- Same Date of Service
- Same Product/Service ID
- Same Prescription/Service Reference Number
- Same Fill Number (only if Rx Billing)

In situations where there are matches on some of the above data elements, Prime Therapeutics Management will return an NCPDP Error Code 83 – *Duplicate Paid Claim* to indicate a possible suspected duplicate.

There are situations in which the provider sends the transaction request and Prime Therapeutics Management receives the request and processes the transaction. Then, due to communication problems or interruptions, the response is never received by the provider. In these cases, the provider should resubmit the transaction request. Prime Therapeutics Management will respond with the same information as the first response, but the transaction response will be marked as duplicate.

7.0 Program Specifications

7.1 Timely Filing Limits

Most pharmacies that utilize the POS system submit their claims at the time of dispensing drugs. However, there may be mitigating reasons that require a claim to be submitted retroactively. For all original claims and adjustments, the timely filing limit is **180 days** from the date of service (DOS). For reversals, the filing limit is unlimited. **Claims that exceed the timely filing limit will deny.** Claims with dates of service past 180 days from date written must be submitted on paper to DHHS for authorization. Information sent to DHHS should include reason claims were not submitted electronically within the allowed timeframe. DHHS will forward authorized paper claims to Prime Therapeutics Management for processing. Claims submitted directly to Prime Therapeutics Management will deny.

Note: Effective 09/01/2013, the Timely Filing Limit has changed from 366 days to 180 days.

7.1.1 Overrides

For overrides on claims, reversals, and adjustments billed past the timely filing limits of 180 days or more, pharmacies must send a UCF to NE DHHS. Refer to *Appendix E – Directory* at the end of this manual for contact information. Approved criteria for NE DHHS to override the denials include

- Retroactive client eligibility;
- Third-party liability (TPL) delay;
- Retroactive disenrollment from Medicaid Health Plan; and
- Claims recovered through rebate dispute resolution as identified and agreed upon by the rebate manufacturers and the NE DHHS staff. Prime Therapeutics Management may also override claims discovered through rebate dispute resolution as identified and agreed upon by Prime Therapeutics Management Rebate and NE DHHS staff.

7.2 Dispensing Limitations/Claim Restrictions

For current detailed information specifically regarding dispensing limitations and/or claim restrictions, refer to the Prime Therapeutics Management website at http://nebraska.fhsc.com.

7.2.1 Days' Supply

The standard days' supply maximum is 90 days per prescription with the following exceptions:

7.2.1.1 Exceptions

- 100 tablets or capsules of prenatal vitamins taken once daily
- 1 intact package that exceeds standard days' supply
- **31-day supply of any injectable medication** except insulin, Lupron Depot® 4 month, Depo-Provera® Contraceptive 50 mg, Vitamin B12
- **93-day supply of** Seasonale®
- **Effective 03/30/2012, there is a 31-day limit on all controlled medications (schedule II through V)**

7.2.2 Quantity

7.2.2.1 Minimum Quantity Limits

- There are no minimum quantity limits with the exception of OxyContin®.
  - OxyContin® 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, and 80 mg have a minimum quantity of 6 tablets per claim.

7.2.2.2 Maximum Quantity Limits, Quantity Per Day, Quantity over Time, and Maximum Daily Dose

For current detailed information specifically regarding these dispensing limitations, refer to the Prime Therapeutics Management website at http://nebraska.fhsc.com.

7.2.3 Minimum/Maximum Age Limits

For current detailed information specifically regarding these dispensing limitations, refer to the Prime Therapeutics Management website at http://nebraska.fhsc.com.

7.2.4 Physicians Certified for Buprenorphine (Suboxone® and Subutex®) Treatment

- Only designated prescribers are authorized to write prescriptions for Buprenorphine (Suboxone® and Subutex®) treatment. Claims submitted with a non-authorized prescriber for Suboxone® and Subutex® will deny.

7.3 Refills

- **Schedule 0**: Original plus up to 99 refills within 366 days from original date Rx written.
- **Schedule II**: No refills.

7.3.1 Exception

Schedule II refills are allowed for long-term care (LTC) and/or terminal conditions. LTC are identified in enrollment data from NE DHHS. To be eligible for refill status, these claims must be submitted within 60 days from date written for CII drugs if patient is in an LTC facility.

Contact the Clinical Support Center for override when patient condition is terminal.

- **Schedule III-IV-V:** Original plus 5 fills within 183 days from original Date Rx Written.

7.4 Provider Reimbursement

7.4.1 Provider Reimbursement Rates

Providers are reimbursed as follows (FUL = Federal Upper Limit, EAC = Estimated Acquisition Cost (WAC + 6.8%); SMAC = State Maximum Allowed Cost):

Note: Claims for medications without a WAC, SMAC, or FUL will deny for NCPDP-70 *Product/Service Not Covered* with a message *Products w/o a Wholesale Acquisition Cost (WAC) are not cvrd.*

Compounds, Legends, and LTC
Lesser of: ▪ (SMAC/FUL/EAC) + Dispensing Fee, or – If SMAC and FUL exist, always take SMAC (even if it is higher). ▪ Usual & Customary, or ▪ Gross Amount Due
Over-the-Counter and Family Planning Drugs
Lesser of: ▪ (SMAC/FUL/EAC)+ Dispensing Fee, or – If SMAC and FUL exist, always take SMAC (even if it is higher). ▪ U+C/Shelf Price, or ▪ (SMAC/FUL/EAC) + 50%, or ▪ Gross Amount Due

7.4.2 SMAC Rates

NE DHHS has SMAC reimbursement levels generally applied to multi-source brand and generic products. However, SMAC reimbursement may also be applied to single-source drugs or drug classifications.

The Prime Therapeutics Management website at http://nebraska.fhsc.com provides links to new or changed SMAC rates. The files on the website are provided as a convenience only to

pharmacies to assist them with pre-POS adjudication decision making. **The presence of a particular drug on the website SMAC lists does not guarantee payment or payment level.** The POS system provides up-to-date SMAC information as part of the claims processing response.

7.4.3 SMAC Pricing or Appeal/Raise Issues

As referenced in Chapter 16-000 of Pharmacy Services, the determination of which products are assigned SMAC limits is the direct responsibility of the Medicaid division in conjunction with the Nebraska Pharmacists Association Medicaid Advisory Committee. Providers may submit a *MAC Price Research Request Form* if there are concerns with current rates established. This form can also be obtained online at nebraska.fhsc.com and can be submitted via e-mail to StateMACProgram@magellanhealth.com or faxed to 1-888-656-1951. A copy of the purchasing invoice for the medication must accompany the *MAC Price Research Request Form* in order to evaluate a MAC price inquiry.

7.4.4 SMAC Overrides/MC-6 Form Process

For consideration of a SMAC override, an MC-6 form signed by the prescriber must be submitted to Prime Therapeutics Management. Upon approval, the claim may be reversed and resubmitted by the provider in order for the branded price to be reimbursed for the inclusive dates noted by the prescriber, but not longer than 12 months from the original date of service.

Providers must enter a time range for the override request on the MC-6 form. The Prime Therapeutics Management support center is authorized to backdate up to 45 days; if request for backdate is greater than 45 days, please contact DHHS for consideration.

Note that SMAC overrides are allowed only an on innovator product (as identified on First DataBank [FDB] drug file) where there is an active SMAC or FUL on the NDC. If an MC-6 request is received for a product that does not meet this condition, it will be returned to the requester.

MC-6 forms will not be processed for OTC drugs, barbiturates, benzodiazepines, cough and cold, or vitamins.

An MC-6 override will only override pricing; it will not override any coverage-type edits.

MC-6 forms for lock-in clients must come from the designated lock-in doctor only; if received from a non-lock-in doctor, the MC-6 form will be returned to the submitter.

7.4.5 Additional Pill Splitting Fee

An additional fee is paid when a provider splits tablets at the time of dispensing and submits a claim for pill splitting, using PA Type Code (NCPDP Field # 461-EU) = “8” (Payer Defined Exemption). The calculation used equals the quantity on the claim

multiplied by 0.15. This amount is noted as an incentive fee. The drugs in the *Table 7.4.5.1* are subject to this additional fee.

Table 7.4.5.1 – Drugs Subject to Additional Pill Splitting Fee

Drug Code	Drug Name
GSN 046206	Celexa 10 mg tablet
GSN 046203	Celexa 20 mg tablet
GSN 046204	Celexa 40 mg tablet
GSN 047478	Flexeril 5 mg tablet
GSN 004681	Flexeril 10 mg tablet
GSN 051642	Lexapro 5 mg
GSN 050712	Lexapro 10 mg
GSN 050760	Lexapro 20 mg
GSN 029967	Lipitor 10 mg
GSN 029968	Lipitor 20 mg
GSN 029969	Lipitor 40 mg
GSN 045772	Lipitor 80 mg
GSN 046222	Paroxetine (Paxil and Paroxetine) 10 mg
GSN 046223	Paroxetine (Paxil and Paroxetine) 20 mg
GSN 046225	Paroxetine (Paxil and Paroxetine) 40 mg
GSN 046227	Zoloft 25 mg tablet
GSN 046228	Zoloft 50 mg tablet
GSN 046229	Zoloft 100 mg tablet

7.4.6 LTC – Additional Dispense Fee

Dispense fees are limited to 1 fee per patient per generic sequence number (GSN) per 24 days for LTC clients (regardless of the number of providers), excluding Schedule II drugs and co-pay only claims submitted with Other Coverage Code (OCC) = 8, and including

- Drugs in Route Codes = B (buccal), S (sublingual), T (transdermal), or H (inhalation);
- Drugs with Route Code = 1 (oral);
- Drugs with Route Code = 4 (mucous membranes); and
- Prescription and OTC products.

Situational exclusions to this limit will be handled by provider submission of PA Type code = 2 (used for any/all authorized conditions in which a provider is entitled to an additional dispensing fee). Criteria for overriding include

- Death of patient;

- Patient discharged or transferred to different LTC facility; and
- Duplicate (NCPDP EC # 83 may be overridden by support center).

7.5 Client Co-Pays

Description	Standard	Exceptions
Medicaid co-pay	$2.00 for generic and $3.00 for brand. **Note:** If the calculated amount is < $2.00 or $3.00, the co-pay is equal the calculated amount. **Note:** Brand medications that are preferred will return the generic co-pay.	Exceptions ($0 co-pay): ▪ Claims for family planning drugs ▪ LTC client ▪ Unborn client ▪ Children < 19

7.6 Prior Authorization (PA)

7.6.1 Clinical Prior Authorizations

Review of prior authorization requests are handled by Prime Therapeutics Management's Clinical Support Center and Nebraska Medicaid. Early refill overrides for non-controlled substances are performed by the pharmacy provider. If the drug is a controlled substance, tramadol, or carisoprodol, the pharmacy provider will contact Prime Therapeutics Management's Clinical Support Center, which will provide the override.

If a drug is a controlled substance, the Pharmacy Support Center will forward the request to the Clinical Support Center.

- During regular business hours, the Clinical Support Center will apply state-specific criteria for approval/change/denial.
- After hours, the emergency protocol listed below will be in effect.

7.6.2 Emergency Protocols

Only registered pharmacists and licensed prescribers may certify that the situation is a medical emergency. A *medical emergency* is defined by DHHS as "Emergency care is defined as medically necessary services provided to an individual who requires immediate medical attention to sustain life or to prevent any condition which could cause permanent disability to body functions." Emergency override requires that registered pharmacist's (or licensed prescriber's) first and last name be documented by support center staff. This

protocol allows for override of all applicable drug coverage edits, with the exception of plan-excluded products.

- The prior authorization is entered by Prime Therapeutics Management's Pharmacy Support Center for the date of service with the appropriate supply to last until the next business day of DHHS. This could be from one to four days, depending upon the day and time of the call and the DHHS holiday schedule.

7.7 Conditional Eligibility Situations

7.7.1 Ineligible Mother of an Eligible Unborn Child

Individuals covered under this Medicaid-defined category include those women whose Nebraska Medicaid Card, the Nebraska Medicaid Eligibility System (NMES), or the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X 12N 270/271) indicates eligibility for the unborn/newborn but not for the mother. This Medicaid coverage ends on the last day of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

Examples:
Delivery Date 07/04/2008 – mother's coverage extends through 09/30/2008.
Delivery Date 07/01/2008 – mother's coverage extends through 08/31/2008.

Covered drug products include those prescribed during pregnancy (through the postpartum period) when necessary for treatment of existing and pre-existing conditions that affect the health of the mother or unborn child. Nebraska Medicaid covers drug products prescribed during the postpartum period for new conditions directly related to the pregnancy, delivery, and family planning.

Beginning 03/01/2010–12/31/2011, these claims edit on gender, DOB, and first and last names.

On 02/01/2011, NEUNBORN group coverage is extended to 12/31/2011.

Note all coverage for the NEUNBORN group ended effective 12/31/2012.

7.7.2 Lock-In Clients

Details related to lock-in providers can be found on the patient monthly Nebraska Medicaid ID document or by calling the NMES line. If the pharmacy claim rejects with "Not prescribed by Lock-In Physician" during normal business hours, then the pharmacy provider should contact the lock-in physician for authorization. If the pharmacy claim rejects with "Not dispensed by Lock-In Pharmacy" during normal business hours, the patient should be instructed to take the prescription to the lock-in pharmacy.

For override of lock-in during normal DHHS business hours, the pharmacy provider should contact DHHS at 1-877-255-3092. If the rejection occurs outside the normal DHHS business hours and the pharmacy provider feels the patient's life will be threatened and/or compromised without the benefit of the drug, then the pharmacist must call Prime Therapeutics Management's Pharmacy Support Center.

7.7.3 Spend-down

Medicaid clients are not eligible for pharmacy claims until they have met their spend-down. Once a client has met their spend-down obligation, enrollment information will be sent to Prime Therapeutics Management, and pharmacy claims may be processed and paid if all standard processing edits are passed.

7.7.4 Split Claim Process

A Nebraska Medicaid client who is subject to spend-down requirements is given a form by their caseworker that indicates the dollar amount that is the responsibility of that client before DHHS begins paying for their claims. The client takes the form to the pharmacy along with any prescriptions to be filled. Once the pharmacy has determined that the client spend-down amount has been satisfied, the claim (split claim) that completes the spend-down amount is split so that the client pays their portion; the remainder is submitted at POS using the following procedure:

1. Client fills prescription to meet share of cost obligation and prescription cost is greater than share of cost (spend-down) amount.
2. Complete share of cost form and collect share of cost amount from client. Pharmacy cannot collect an amount from the client greater than the stated share of cost obligation on the client form. Fax completed form to Medicaid for processing at 1-402-471-8703.
3. Call the Inquiry Line (1-877-255-3092 option 1) to verify share of cost form has been met for a particular month and client eligibility is now open.
4. Submit claim electronically to Prime Therapeutics Management with the patient pay field (DX) populated. Claim will deny as a duplicate. Call the Prime Therapeutics Management help desk at 1-800-368-9695 to obtain an override. Advise agent that you need an override to process a share of cost claim with a remaining balance due to the pharmacy.
5. Resubmit claim electronically to receive payment.

In addition, DHHS modifies client eligibility so that further claims for the month do not deny for spend-down requirements.

7.8 Managed Care Plans

Currently, there are four managed care plans:

- Share Advantage (standard and additional drug exclusions)
- Coventry (standard and additional drug exclusions)
- Primary Care (standard drug exclusions)
- Prime Therapeutics(standard drug exclusions)

If a client is a member of Share Advantage or Coventry, in addition to the standard list of excluded products, any medication intended for administration in the physician's office will not be covered.

7.9 Compound Claims

NE DHHS processes compounds using the Multi-Ingredient Compound functionality as provided by NCPDP v.D.0. All compounds must contain at least two ingredients, and at least one ingredient must be a covered product. Single-ingredient compound claims will not be accepted.

There must be some cost associated with at least one of the covered products. Claims will be denied if no associated cost is submitted: NCPDP Error Code 7Ø – *Product/Service Not Covered* will be returned.

- Message to be returned in such cases: Calculated reimbursement is <$0.01. Please verify ingredient quantities.

The total ingredient cost submitted must be equal to the sum of the ingredients' cost, or the claim will deny. The Submission Clarification Code (NCPDP Field # 42Ø-DK) = "8" (process compound for approved ingredients) may be submitted at POS to override coverage conditions. This will ensure only covered ingredients within the compound are paid. Multiple instances of the same NDC within a compound are not allowed.

Prior authorization edits are applicable to ingredients within a compound.

Note: SCC 8 will not bypass denial on medications that do not have a valid price type on file with Prime Therapeutics Management. Claims for medications without a WAC, SMAC, or FUL will deny for NCPDP-70 *Product/Service Not Covered* with a message *Products w/o a Wholesale Acquisition Cost (WAC) are not cvrd.*

7.9.1 Exception

- When used in compounding for clients < 5 years of age, Prevacid® 30 mg and Omeprazole® 20 mg capsules will not require a prior authorization.

Dispensing fees for compounds are the same as the legend dispensing fee.

All products that are compounded must be submitted as a compound claim. In some cases, providers are submitting supplemental ingredients in the compound (e.g., recipients) that do not have NDCs.

- To allow for submission of these products within a compound claim, providers should submit the following:
  - **99999999999** = use for scheduled product (CII – CV)
  - **99999999996** = use for non-scheduled product
- Each dummy NDC can be used only once in a claim; i.e., "99999999999" cannot be used twice to represent two different products.
- No more than two dummy numbers will be allowed per compound claim; i.e., there can be one "99999999999" and one "99999999996" only.
- If a compound contains more than one scheduled or non-scheduled ingredient without NDCs, the appropriate NDC ("99999999999" or "99999999996") should be submitted with the sum of the quantities of all ingredients without NDCs.

8.0 Coordination of Benefits (COB)

Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments.

TPL refers to

- An insurance plan or carrier;
- A program; and
- A commercial carrier.

The plan or carrier can be

- An individual;
- A group;
- Employer-related;
- Self-insured; and
- Self-funded plan.

The program can be Medicare, which has liability for all or part of a client's medical or pharmacy coverage.

The terms *third-party liability* and *other insurance* are used interchangeably to mean any source other than Medicaid that has a financial obligation for health care coverage.

8.1 COB General Instructions

8.1.1 COB Process

All third-party resources (TPRs) available to a Medicaid client must be utilized for all or part of their medical costs before billing to Medicaid. A third-party resource is any individual, entity, or program that is, or may be, contractually or legally liable to pay all or part of the cost of any medical services furnished to a client. The provider shall resolve all TPRs before Medicaid can consider paying a claim even when Medicaid prior authorization has been given. The Department may deny payment of a provider's claims if the provider fails to apply third-party payments to medical bills, to file necessary claims, or to cooperate in matters necessary to secure payment by insurance or other liable third parties. Providers must comply with all policies of a patient's insurance coverage, including, but not limited to, prior authorization, quantity, and days' supply limits. Prime Therapeutics Management will assist DHHS in monitoring this process for compliance on all claims.

Prime Therapeutics Management supports the use of the COB segment as per the NCPDP D.0 claim transaction. Nebraska Medicaid does not require the Other Payer ID (NCPDP Field # 34Ø-7C) to be submitted in the COB segment.

The following COB edits will be applied when **a non-Medicare TPL payer exists** for the client on the NE DHHS enrollment file for the claim date of service. OTCs are not subject to COB editing, with the exception of insulin.

8.1.2 COB Denial Edits

Claims will deny when the client has TPL coverage on the NE DHHS enrollment file received with either of the following conditions:

- The claim is received with no COB segment or **Other Coverage Code, (NCPDP Field # 3Ø8-C8)** code
- **Other Coverage Code, (NCPDP Field # 3Ø8-C8)** = "Ø" or "1" (with or without a payer payment amount)
- **Other Coverage Code, (NCPDP Field # 3Ø8-C8)** = "2" and the Other Payer Amount is = $0

Claims will deny when the client has TPL coverage on the NE DHHS enrollment file and a COB segment was received on the NCPDP D.0 claim transaction with any of the following conditions:

- **Other Coverage Code, (NCPDP Field # 3Ø8-C8)** = "2" and the Other Payer Amount is = $0
- **Other Coverage Code, (NCPDP Field # 3Ø8-C8)** = "3," or "4" and the Other Payer Amount > $0

8.1.3 COB Approval Edits

If the pharmacy submits a claim with a valid COB segment for a client who has TPL coverage on the NE DHHS enrollment file, Prime Therapeutics Management will adjudicate the claim as follows:

- When **Other Coverage Code, (NCPDP Field # 3Ø8-C8)** = "2" and Other Payer Paid amount > $0, the claim is approved for payment, and the net amount to be paid will be the NE DHHS Medicaid allowable less other payer payment amount.
- When **Other Coverage Code, (NCPDP Field # 3Ø8-C8)** = "3" or "4," and Other Payer Paid amount = $0, the claim is approved for payment, and the net amount to be paid will be the NE DHHS Medicaid allowable.

Note: Other Coverage Code 3 is used when the primary plan has excluded the drug from coverage. It should not be used when the primary plan requires prior authorization or has other limitations (e.g., quantity). Authorization MUST be requested from the primary plan.

- When **Other Coverage Code, (NCPDP Field # 3Ø8-C8)** = "2" and Medicare TPL Payer exists for the client, see *Section 8.2 – Special Instructions for Medicare Clients*.

If the pharmacy submits a claim with a COB segment for a client who does not have TPL coverage on the NE DHHS enrollment file, Prime Therapeutics Management will adjudicate the claim as follows:

- When **Other Coverage Code, (NCPDP Field # 3Ø8-C8)** = "2" and Other Payer Paid amount > $0, the claim is approved for payment, and the net amount to be paid will be the NE DHHS Medicaid allowable less other payer payment amount. Prime Therapeutics Management will report to Medicaid Management Information System (MMIS) that potential other coverage exists.
- When **Other Coverage Code, (NCPDP Field # 3Ø8-C8)** = "Ø," "1," "3," or "4," and Other Payer Paid amount = $0, the claim is approved for payment, and the net amount to be paid will be the NE DHHS Medicaid allowable.
- When **Other Coverage Code, (NCPDP Field # 3Ø8-C8)** = "2" and Medicare TPL Payer exists for the client, see *Section 8.2 – Special Instructions for Medicare Clients*.

8.1.4 TPL Processing Grid

The following table displays the values and claim dispositions based on pharmacist submission of the standard NCPDP TPL codes. Where applicable, it has been noted which OTHER COVERAGE CODE (NCPDP Field # 3Ø8-C8) should be used based on the error codes received from the primary.

Other Coverage Code (Field # 3Ø8-C8)	Other Payer Amount Paid (Field # 431-DV)	Notes
0 = Not specified	must = 0	Not allowed for override
1 = No other coverage identified	must = 0	Not allowed for override
2 = Other coverage exists, payment collected	must be > 0	Used when payment is collected from the primary. Also accepted for certain Medicaid D co-pays that DHHS had agreed to cover.
3 = Other coverage exists, claim not covered	must = 0	Used when the primary denies the claim
4 = Other coverage exists, payment not collected	must = 0	Used when the primary pays the claim but does not receive anything from the primary due to deductible or co-pay.

8.2 Special Instructions for Medicare Clients

- Medicare Part D edits will be applied when a Medicare TPL payer exists on the NE DHHS enrollment file for the client and claim date of service.

8.2.1 Medicare and Non-LTC

Claims Submitted for Over-the-Counter, Certain Vitamins, and Cough and Cold

- Claims submitted with the Other Coverage Code, (NCPDP Field # 3Ø8-C8) = "2" are not allowed and will deny with NCPDP Error Code 41 – *Submit Bill to Other Processor or Primary Payer*.
- Claims submitted without a COB segment or claims submitted where the Other Coverage Code, (NCPDP Field # 3Ø8-C8) is not equal to "2" will be processed using all standard edits and are subject to payment if the claim passes all edits.

Claim Submitted, not Over-the-Counter, Certain Vitamins, and Cough and Cold

- Claims submitted without a COB segment or claims submitted where the Other Coverage Code, (NCPDP Field # 3Ø8-C8) is not equal to "2" will be processed using all standard edits and will deny for NCPDP Error Code 41 – *Submit Bill to Other Processor or Primary Payer* with the supplemental message "Bill Medicare."
- If the Other Coverage Code, (NCPDP Field # 3Ø8-C8) = "2," the client is exempt from Medicaid co-pay, and the Other Payer-Patient Responsibility Amount (NCPDP Field # 353 NQ) is less than or equal to the Medicare co-pay, the claim will process using all standard edits and be eligible for payment.
- If the Other Coverage Code, (NCPDP Field # 3Ø8-C8) = "2" and the Other Payer-Patient Responsibility Amount (NCPDP Field # 353 NQ) is NOT less than or equal to the Medicare co-pay, the claim will deny for NCPDP Error Code 13 – *Missing/Invalid Other Coverage Code* with a supplemental message of "Co-pay exceeds Maximum."

8.2.2 Medicare and LTC

Claims Submitted for Over-the-Counter, Certain Vitamins, and Cough and Cold

- Claims submitted with the Other Coverage Code, (NCPDP Field # 3Ø8-C8) = "2" are not allowed and will deny with NCPDP Error Code 41 – *Submit Bill to Other Processor or Primary Payer*.
- Claims submitted without a COB segment or claims submitted where the Other Coverage Code, (NCPDP Field # 3Ø8-C8) is not equal to "2" will be processed using all standard edits and are subject to payment if the claim passes all edits.

Claim Submitted, not Over-the-Counter, Certain Vitamins, and Cold and Cough

- Claims submitted without a COB segment or claims submitted where the Other Coverage Code, (NCPDP Field # 3Ø8-C8) is not equal to "2" will be processed using all

standard edits and will deny for NCPDP Error Code 41 – *Submit to Primary Payer* with the supplemental message "Bill Medicare."

- Claims submitted with the Other Coverage Code, (NCPDP Field # 3Ø8-C8) = "2" are not allowed and will deny with NCPDP Error Code 41 – *Submit Bill to Other Processor or Primary Payer*.

8.2.3 Medicare and Assisted Living (on the NE DHHS Enrollment File)

Claim Submitted for Over-the-Counter, Certain Vitamins, and Cold and Cough

- Claims submitted with the Other Coverage Code, (NCPDP Field # 3Ø8-C8) = "2" are not allowed and will deny with NCPDP Error Code 41 – *Submit Bill to Other Processor or Primary Payer*.
- Claims submitted without a COB segment or claims submitted where the Other Coverage Code, (NCPDP Field # 3Ø8-C8) is not equal to "2" will be processed using all standard edits and are subject to payment if the claim passes all edits.

Claim Submitted, not Over-the-Counter, Certain Vitamins, and Cold and Cough

- Claims submitted without a COB segment or claims submitted where the Other Coverage Code, (NCPDP Field # 3Ø8-C8) is not equal to "2" will be processed using all standard edits and will deny for NCPDP Error Code 41 – *Submit to Primary Payer* with the supplemental message "Bill Medicare."
- If the Other Coverage Code, (NCPDP Field # 3Ø8-C8) = "2" and the Other Payer-Patient Responsibility Amount (NCPDP Field # 353-NQ) is less than or equal to the Medicare co-pay, the claim will process using all standard edits and be eligible for payment.
- If the Other Coverage Code, (NCPDP Field # 3Ø8-C8) = "2" and the Other Payer-Patient Responsibility Amount (NCPDP Field # 353-NQ) is NOT less than the Medicare co-pay, the claim will deny for NCPDP Error Code 13 – *Missing/Invalid Other Coverage Code* with a supplemental message of "Co-pay exceeds Maximum."

8.2.4 Medicare Co-Pays

Year	Low/Generic	Low/Brand	High/Generic	High/Brand
2006	$1.00	$3.00	$2.00	$5.00
2007	$1.00	$3.10	$2.15	$5.35
2008	$1.05	$3.10	$2.25	$5.60
2009	$1.10	$3.20	$2.40	$6.00
2010	$1.10	$3.30	$2.50	$6.30
2011	$1.10	$3.30	$2.50	$6.30
2012	$1.10	$3.30	$2.50	$6.50
2013	$1.15	$3.50	$2.65	$6.60
2014	$1.15	$3.60	$2.65	$6.35
2015	$1.15	$3.60	$2.65	$6.60
2016	$1.15	$3.60	$2.65	$7.40

Note: Medicaid covers the Medicare co-pay on the following supplies for individuals not in a nursing home who are exempt from Medicaid co-pays:

- Insulin Syringes
- Alcohol Swabs

Appendix A – Payer Specification

Please find the Nebraska D.0 Payer Specification Sheet at this location:

http://mmadocs.fhsc.com/Rx/NE/downloads/NE_D0_Payer_Spec.pdf

Appendix B – Universal Claim Form (UCF)

All paper pharmacy claims must be submitted to Prime Therapeutics Management on a UCF, which may be obtained from a pharmacy's wholesaler. *Appendix E – Directory* at the end of this manual specifies (1) an alternative source for UCFs and (2) Prime Therapeutics Management's address to which pharmacies should mail UCF billings.

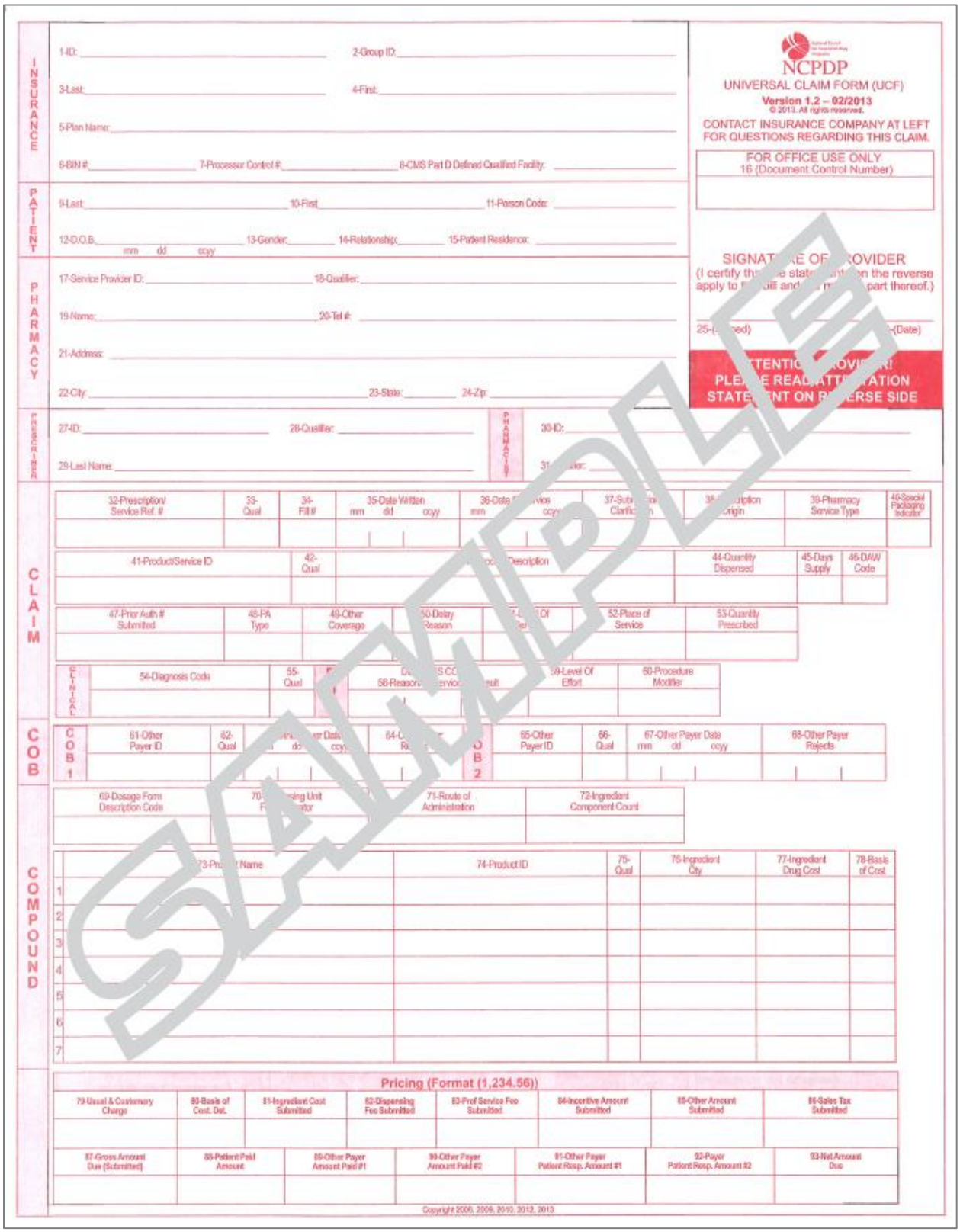
Field Legend for Columns

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	R	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	RW	"Required when." The situations designated have qualifications for usage ("Required if x," "Not required if y").	Yes

Section	Field Number	Field Description	Value
Insurance	1	ID	M
	2	Group ID	R
	3	Last	
	4	First	
	5	Plan Name	NEB01
	6	Bin Number	M (013766)
	7	Processor Control Number	M (P063013766)
	8	CMS Part D Defined Qualified Facility	
Patient	9	Last	R
	10	First	R
	11	Person Code	
	12	Date of Birth – mm dd ccyy	R R R
	13	Gender	R
	14	Relationship	
	15	Patient Residence	RW
Pharmacy	17	Service Provider ID	M
	18	Qualifier	M
	19	Name	
	20	Telephone Number	
	21	Address	
	22	City	

Section	Field Number	Field Description	Value
	23	State	
	24	Zip Code	
Prescriber	27	ID	R
	28	Qualifier	R
	29	Last Name	R
Pharmacist	30	ID	
	31	Qualifier	
Claim	32	Prescription/Service Reference Number	M
	33	Qualifier	M
	34	Fill Number	R
	35	Date Written – mm dd ccyy	R R R
	36	Date of Service – mm dd ccyy	M M M
	37	Submission Clarification Code(s)	RW
	38	Prescription Origin Code	R
	39	Pharmacy Service Type	
	40	Special Packaging Indicator	
	41	Product/Service ID	M
	42	Qualifier	M
	43	Product Description	
	44	Quantity Dispensed	R
	45	Days Supply	R
	46	DAW Code	R
	47	Prior Authorization Number Submitted	
	48	PA Type	RW
	49	Other Coverage	RW
	50	Delay Reason	RW
	51	Level of Service	RW
	52	Place of Service	RW
	53	Quantity Prescribed	
Claim Clinical	54	Diagnosis Code	RW
	55	Qualifier	RW
Claim DUR	56	DUR/PPS Codes – Reason	RW
	57	DUR/PPS Codes – Service	RW
	58	DUR/PPS Codes – Result	RW
	59	Level of Effort	RW
	60	Procedure Modifier	
COB COB 1	61	Other Payer ID	RW
	62	Qualifier	RW

Section	Field Number	Field Description	Value
	63	Other Payer Date – mm dd ccyy	RW RW RW
	64	Other Payer Rejects	RW RW RW
COB COB 2	65	Other Payer ID	RW
	66	Qualifier	RW
	67	Other Payer Date – mm dd ccyy	RW RW RW
	68	Other Payer Rejects	RW RW RW
Compound	69	Dosage Form Description Code	M
	70	Dispensing Unit Form Indicator	M
	71	Route of Administration	RW
	72	Ingredient Component Count	M
	73	Product Name (Lines 1 – 7)	
	74	Product ID (Lines 1 – 7)	M
	75	Qualifier (Lines 1 – 7)	M
	76	Ingredient Quantity (Lines 1 – 7)	M
	77	Ingredient Drug Cost (Lines 1 – 7)	RW
	78	Basis of Cost (Lines 1 – 7)	RW
Pricing	79	Usual and Customary Charge	R
	80	Basis of Cost Determination	RW
	81	Ingredient Cost Submitted	R
	82	Dispensing Fee Submitted	RW
	83	Prof Service Fee Submitted	
	84	Incentive Amount Submitted	RW
	85	Other Amount Submitted	RW
	86	Sales Tax Submitted	
	87	Gross Amount Due Submitted	R
	88	Patient Paid Amount	RW
	89	Other Payer Amount Paid #1	RW
	90	Other Payer Amount Paid #2	RW
	91	Other Payer Patient Resp. Amount #1	RW
	92	Other Payer Patient Resp. Amount #2	RW
	93	Net Amount Due	


INSURANCE
1-ID:
2-Group ID:
3-Last:
4-First:
5-Plan Name:
6-BIN #:
7-Processor Control #:
8-CMS Part D Defined Qualified Facility:
PATIENT
9-Last:
10-First:
11-Person Code:
12-D.O.B.:
13-Gender:
14-Relationship:
15-Patient Residence:
PHARMACY
17-Service Provider ID:
18-Qualifier:
19-Name:
20-Tel #:
21-Address:
22-City:
23-State:
24-Zip:
PRESCRIBER
27-ID:
28-Qualifier:
29-Last Name:
30-ID:
CLAIM
COB
COMPOUND
NCPDP
UNIVERSAL CLAIM FORM (UCF)
Version 1.2 – 02/2013
© 2013. All rights reserved.
CONTACT INSURANCE COMPANY AT LEFT
FOR QUESTIONS REGARDING THIS CLAIM.
FOR OFFICE USE ONLY
16 (Document Control Number)
SIGNATURE OF PROVIDER
(Date)
ATTENTION PROVIDER!
PLEASE READ ATTESTATION
STATEMENT ON REVERSE SIDE
32-Prescription/ Service Ref. #
33-Qual
34-Fill #
35-Date Written
41-Product/Service ID
42-Qual
44-Quantity Dispensed
45-Days Supply
46-DAW Code
47-Prior Auth.# Submitted
48-PA Type
49-Other Coverage
50-Delay Reason
52-Place of Service
53-Quantity Prescribed
54-Diagnosis Code
55-Qual
59-Level Of Effort
60-Procedure Modifier
61-Other Payer ID
62-Qual
65-Other Payer ID
66-Qual
67-Other Payer Date
68-Other Payer Rejects
69-Dosage Form Description Code
71-Route of Administration
72-Ingredient Component Count
74-Product ID
75-Qual
76-Ingredient Qty
77-Ingredient Drug Cost
78-Basis of Cost
Pricing (Format (1,234.56))
79-Usual & Customary Charge
80-Basis of Cost Det.
81-Ingredient Cost Submitted
82-Dispensing Fee Submitted
83-Prof Service Fee Submitted
84-Incentive Amount Submitted
85-Other Amount Submitted
86-Sales Tax Submitted
87-Gross Amount Due (Submitted)
88-Patient Paid Amount
89-Other Payer Amount Paid #1
90-Other Payer Amount Paid #2
91-Other Payer Patient Resp. Amount #1
92-Payer Patient Resp. Amount #2
93-Net Amount Due
Copyright 2006, 2008, 2010, 2012, 2013

Universal Claim Form (Reverse)

The provider agrees to the following:

- Certifies that required beneficiary signatures, or legally authorized signatures of beneficiaries, are on file;
- That the submitted claim is accurate, complete, and truthful; and
- That it will research and correct claim discrepancies.

For more instructions on this form, see the NCPDP *Manual Claim Forms Reference Implementation Guide* available where forms are ordered or with NCPDP membership at www.ncpdp.org.

Code List

For fields not listed below, or more values which may be available, see the *NCPDP Manual Claim Forms Reference Implementation Guide* or the NCPDP *External Code List*.

8 - CMS Part D Defined Qualified Facility
- "Y" - Yes
- "N" - No

13 - Patient Gender Code
- "0" - Not Specified
- "1" - Male
- "2" - Female

14 - Patient Relationship Code
- "0" - Not Specified
- "1" - Cardholder
- "2" - Spouse
- "3" - Child
- "4" - Other

15 - Patient Residence
- "1" - Home
- "3" - Nursing Facility
- "4" - Assisted Living Facility
- "9" - Intermediate Care Facility/Mentally Retarded
- "11" - Hospice
- "15" - Correctional Institution

18 - Service Provider ID Qualifier
- "blank" - Not Specified
- "01" - NPI
- "05" - Medicaid
- "07" - NCPDP
- "99" - Other

28 - Prescriber ID Qualifier
- "01" - NPI
- "08" - State License
- "12" - DEA
- "99" - Other

31 - Provider ID Qualifier
- "01" - DEA
- "02" - State License
- "03" - Social Security Number
- "04" - Name
- "05" - NPI
- "06" - HIN
- "07" - State issued
- "99" - Other

33 - Prescription/Service Reference # Qualifier
- "1" - Rx Billing
- "2" - Service Billing

37 - Submission Clarification Code
- "1" - No Override
- "2" - Prior Override
- "3" - Medication Shortage
- "4" - Lost Prescription
- "5" - Therapeutic Substitution
- "6" - Stat Order
- "7" - May Be Necessary
- "8" - Previous Compound Approved Ingredients
- "9" - Encounter
- "10" - Medically Limited Quantity
- "11" - Clarification on Request
- "12" - Replacement Request
- "13" - Payer-Recognized Emergency/Disaster
- "14" - Quantity Request
- "15" - Long Term Care Leave of Absence
- "15" - Long Term Care Replacement Medication
- "16" - Long Term Care Emergency Box or Automated Dispensing Machine
- "17" - Long Term Care Emergency Supply Remainder
- "18" - Long Term Care Patient Admit / Readmit Indicator
- "19" - Split Billing
- "20" - 340B

37 - Submission Clarification Code (Continued)
- "21" - LTC dispensing: 14 days or less not applicable
- "22" - LTC dispensing: 7 days
- "23" - LTC dispensing: 4 days
- "24" - LTC dispensing: 3 days
- "25" - LTC dispensing: 2 days
- "26" - LTC dispensing: 1 day
- "27" - LTC dispensing: 4-3 days
- "28" - LTC dispensing: 2-2-3 days
- "29" - LTC dispensing: daily and 3-day weekend
- "30" - LTC dispensing: Per shift dispensing
- "31" - LTC dispensing: Per med pass dispensing
- "32" - LTC dispensing: PRN on demand
- "33" - LTC dispensing: 7 day or less cycle not otherwise represented
- "34" - LTC dispensing: 14 days dispensing
- "35" - LTC dispensing: 8-14 days dispensing method not listed above
- "36" - LTC dispensing: Dispensed outside short cycle
- "47" - Shortened Days Supply Fill
- "48" - Fill Subsequent to a Shortened Days Supply Fill
- "99" - Other

38 - Prescription Origin
- "0" - Not Known
- "1" - Written
- "2" - Telephone
- "3" - Electronic
- "4" - Facsimile
- "5" - Pharmacy

39 - Pharmacy Service Type
- "1" - Community/Retail Pharmacy Services
- "2" - Compounding Pharmacy Services
- "3" - Home Infusion Therapy Provider Services
- "4" - Institutional Pharmacy Services
- "5" - Long Term Care Pharmacy Services
- "6" - Mail Order Pharmacy Services
- "7" - Managed Care Organization Pharmacy Services
- "8" - Specialty Care Pharmacy Services
- "99" - Other

40 - Special Packaging Indicator
- "1" - Not unit dose
- "2" - Manufacturer Unit Dose
- "3" - Pharmacy Unit Dose
- "4" - Pharmacy Unit Dose Patient Compliance Packaging
- "5" - Pharmacy Multi-drug Patient Compliance Packaging
- "6" - Remote Device Unit Dose
- "7" - Remote Device Multi-drug Compliance
- "8" - Manufacturer Unit of Use Package (not unit dose)

42 & 75 - Product/Service ID Qualifier
- "00" - Not Specified
- "01" - UPC
- "02" - HRI
- "03" - NDC
- "04" - HIBCC
- "06" - DUR/PPS
- "07" - CPT4
- "08" - CPT5
- "09" - HCPCS

42 & 75 - Product/Service ID Qualifier (Continued)
- "10" - PPAC
- "11" - NAPPI
- "12" - GTIN
- "15" - GCN
- "28" - FDB Med Name ID
- "29" - FDB Routed Med ID
- "30" - FDB Routed Dosage Form Med ID

46 - Dispense as Written (DAW) / Product Selection
- "0" - No Product Selection Indicated
- "1" - Substitution Not Allowed by Prescriber
- "2" - Substitution Allowed - Patient Requested Product Dispensed
- "3" - Substitution Allowed - Pharmacist Selected Product Dispensed
- "4" - Substitution Allowed - Generic Drug Not in Stock
- "5" - Substitution Allowed - Brand Drug Dispensed as a Generic
- "6" - Overridden
- "7" - Substitution Not Allowed - Brand Drug Mandated by Law
- "8" - Substitution Allowed - Generic Drug not Available in Marketplace
- "9" - Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to be Dispensed

48 - Prior Authorization Type Code
- "0" - Not Specified
- "1" - Prior Authorization
- "2" - Medical Certification
- "3" - EPSDT
- "4" - Exemption from Copay and/or Coinsurance
- "5" - Exemption from Rx
- "6" - Family Planning Indicator
- "7" - TANF (Temporary Assistance for Needy Families)
- "8" - Payer Defined Exemption
- "9" - Emergency Preparedness

49 - Other Coverage Code
- "0" - Not Specified by patient
- "1" - No Other Coverage
- "2" - Other Coverage Exists - Payment Collected
- "3" - Other Coverage Billed - Claim Not Covered
- "4" - Other Coverage Exists - Payment Not Collected
- "8" - Claim is billing for patient financial responsibility only

50 - Delay Reason Code
- "1" - Proof of eligibility unknown or unavailable
- "2" - Litigation
- "3" - Authorization delays
- "4" - Delay in certifying provider
- "5" - Delay in supplying billing forms
- "5" - Delay in delivery of custom-made appliances
- "7" - Third party processing delay
- "8" - Delay in eligibility determination

- "9" - Original claim rejected or denied due to reasons unrelated to the filing limitations
- "10" - Administrative delay in the prior authorization process

51
- "0" - Not Specified
- "1" - Without Consultation
- "2" - Home Delivery
- "3" - Emergency
- "4" - 24 Hour Service
- "5" - Patient consultation regarding generic product selection
- "6" - In-Home service

52 - Place of Service (For values see https://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html)

55 - Diagnosis Code Qualifier
- "00" - Not Specified
- "01" - ICD9
- "02" - ICD10
- "03" - NCCI
- "04" - SNOMED
- "05" - CDT
- "06" - Medi-Span Product Line Diagnosis Code
- "07" - DSM IV
- "08" - First DataBank Disease Code (FDBDX)
- "09" - First DataBank FML Disease Identifier (FDB DxID)
- "99" - Other

56 - Reason for Service &
57 - Professional Service Code &
58 - Result of Service Code (For values refer to NCPDP Reference Guide or current External Code List)

59 - DUR/PPS Level of Effort
- "0" - Not Specified
- "11" - Level 1 (Lowest)
- "12" - Level 2
- "13" - Level 3
- "14" - Level 4
- "15" - Level 5 (Highest)

60 - Procedure Modifier Code (See http://www.cms.hhs.gov/hcpcsreleasecodesets/anhcpcs/list.asp)

62 - Other Payer ID Qualifier &
66
- "01" - National Payer ID
- "02" - HIN
- "03" - BIN
- "04" - NAIC
- "05" - Medicare Carrier Number
- "99" - Other

64 - Other Payer Reject Codes &
68 - (For values refer to current NCPDP External Code List)

71 - Route of Administration (See SNOMED CT® http://www.snomed.org)

78 - Compound Basis of Cost Determination &
80 - Basis of Cost Determination (For values refer to NCPDP Reference Guide or current External Code List)

Completion Instructions for the Universal Claim Form

1. Complete all applicable areas on the front of the form. Type or print the information legibly. Each area is numbered.
2. Verify patient information is correct and that patient named is eligible for benefits.
3. Ensure that the patient's signature is in the authorization box in the certification section on front side of the form for prescription(s) dispensed.
4. **Compound Prescriptions** – Enter "Compound Rx" in the **Product/Service ID** area and list each ingredient name, NDC, quantity, and cost in the **Product/Service ID** box.

Note: Use a new Universal Claim Form for each compound prescription.

Definition of Values

In addition to the general guidelines above, pharmacies must use the code values listed when completing the following selected fields of the Universal Claim Form.

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

2. **Patient Gender Code**

0	Not specified
1	Male
2	Female

3. **Patient Relationship Code**

1	Cardholder

4. **Service Provider ID Qualifier**

01	National Provider Identifier (NPI)

5. **Prescription Service Reference # Qualifier**

Blank	Not specified
1	Rx billing
2	Service billing

6. **Quantity Dispensed**

   Enter quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

7. **Product/Service ID Qualifier (Qual)**

   This is the code qualifying the value in **Product/Service ID** (NCPDP Field # 4Ø7-Ø7).

   03 National Drug Code (NDC)

   If claim is a compound, use a qualifier = 0 (not specified) and one 0 as the NDC value.

8. **Prior Authorization Type Code (PA Type)**

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

9. **Prescriber Provider ID Qualifier**

   Use Qualifier "01" for the National Provider Identifier (NPI) for the prescriber.

10. **DUR/Professional Service Codes**

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

11. **Provider ID Qualifier**

    Use Qualifier "01" for the National Provider Identifier (NPI) of the pharmacy.

Appendix C – ProDUR

C.1 ProDUR Problem Types

ProDUR encompasses the detection, evaluation, and counseling components of predispensing drug therapy screening. The ProDUR system of Prime Therapeutics Management assists in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing assists the pharmacists to ensure that their patients receive the appropriate medications.

Because the Prime Therapeutics Management ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. Prime Therapeutics Management recognizes that the pharmacists use their education and professional judgments in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacists in performing their professional duties.

Listed below are all the ProDUR Conflict Codes within Prime Therapeutics Management's system for the NE DHHS Medicaid Program.

Deny or Message Only	ProDUR Problem Type	Provider-level Override Allowed (via NCPDP DUR Override Codes)	Prime Therapeutics Management Clinical Support Center Override Required
D	Early Refill (ER) Non-controlled substances – 75% Controlled substances – 90% tramadol and carisoprodol – 90% Must have allowed Submission Clarification Code	Y for non-controlled substances	Y for controlled substances
D, severity 1 M, severity 2, 3	Drug-to-Drug Interactions (DD)	Y	N/A
D	Therapeutic Duplication (TD) TD is not performed on ▪ Cough and/or cold preparations ▪ Laxatives and cathartics ▪ H2S ▪ Lipotropics ▪ Anticoagulants, Coumadin ▪ Glucocorticoids ▪ Bulk Chemicals	Y	NSAIDS only require Prime Therapeutics Management's Clinical Support Center override
D	Duplicate Ingredient (ID)	Y	N/A

Deny or Message Only	ProDUR Problem Type	Provider-level Override Allowed (via NCPDP DUR Override Codes)	Prime Therapeutics Management Clinical Support Center Override Required
D for HD M for LD 115%>FDB criteria	Minimum/Maximum Daily Dosing (LD, HD) *no DUR LD for pill splitting	Y	N/A
D, severity 1 M, severity 2	Drug to Gender (SX) N/A to the Unborn population	N	Y
M	Drug to Disease (MC)	N/A	N/A
M	Drug to Geriatric Precautions (PA)	N/A	N/A
M	Drug to Pediatric Precautions (PA)	N/A	N/A
D M	Drug to Pregnancy Precautions (PG) Deny for NEUNBORN group. Message for NESTANDARD group when Pregnancy Indicator or Pregnancy Diagnosis Code is available.	Y	N/A

C.2 Drug Utilization Review (DUR) Fields

The following are the ProDUR edits that will deny for NE DHHS:

- Drug/Drug Interactions – (Severity Level 1) – Provider overrides allowed.
- Early Refill – Contact Pharmacy Support Center to request an override.
- Therapeutic Duplication – (selected therapeutic classes) – Provider overrides allowed.
- Drug to Gender – Severity 1 – Clinical Support Center may PA.
- Plan Protocol – Anti-Ulcer perquisite.

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

- Late Refill
- Duplicate Ingredient
- Minimum/Maximum Daily Dosing
- Drug to Pediatric Precautions – (Severity Level 1)
- Drug to Geriatric Precautions – (Severity Level 1)
- Drug to Inferred Disease – (Severity Level 1)
- Therapeutic Duplication – (Selected Therapeutic Classes)

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.

C.3 DUR Overrides

The following are the NCPDP interactive Professional Service, Result of Service, Reason for Service, and Submission Clarification codes. These codes may be used to override the following "provider level" ProDUR overrides. See Table C.3.1.

- **Problem/Conflict Type:** The override codes below may be used by providers in any condition where a provider-level override is allowed for ProDUR denials.
- **Professional Service Codes Allowed for Submission:** All codes below allowed.
- **Result of Service Codes Allowed for Submission:** All codes below allowed.

Table C.3.1 – Override Codes

Professional Service Code/Description	Result of Service Code/Description	Reason for Service Code	Submission Clarification Code/Description
Select one: ▪ AS/Patient Assessment ▪ CC/Coordination of Care ▪ DE/Dosing Evaluation/Determination ▪ FE/Formulary Enforcement ▪ GP/Generic Product Selection ▪ M0/Prescriber Consulted ▪ MA/Medication Administration ▪ MR/Medication Review ▪ PH/Patient Medication History ▪ PM/Patient Monitoring ▪ P0/Patient Consulted ▪ PE/Patient Education/Instruction ▪ PT/Perform Laboratory Test ▪ RO/Physician Consulted Other Source ▪ RT/Recommended Laboratory Tests ▪ SC/Self Care Consultation ▪ SW/Literature Search/Review ▪ TC/Payer/Processor Consulted ▪ TH/Therapeutic Product Interchange	Select one: ▪ 1A/filled as is, false positive ▪ 1B/filled prescription as is ▪ 1C/filled, with different dose ▪ 1D/filled, different direction ▪ 1E/filled, with different drug ▪ 1F/filled, different quantity ▪ 1G/filled, prescriber approved ▪ 1H/brand-to-generic change ▪ 1J/Rx-to OTC change ▪ 1K/filled, different dosage form ▪ 2A/prescription not filled ▪ 2B/not filled – direction clarified	Y/ER	Select one: ▪ 03/Vacation supply ▪ 04/Lost prescription ▪ 05/Therapy change ▪ 07/Medically necessary

Professional Service Code/Description	Result of Service Code/Description	Reason for Service Code	Submission Clarification Code/Description
	▪ 3A/recommendation accepted ▪ 3B/recommendation not accepted ▪ 3C/discontinued drug ▪ 3D/regimen changed ▪ 3E/therapy changed ▪ 3F/therapy chg – cost inc accepted ▪ 3G/drug therapy unchanged ▪ 3H/follow-up report ▪ 3J/patient referral ▪ 3K/instructions understood ▪ 3M/compliance aid provided ▪ 3N/medication administered		

Appendix D – POS Reject Codes and Messages

After a pharmacy online claims submission, the Prime Therapeutics Management POS system returns messages that comply with NCPDP standards. Messages focus on ProDUR and POS rejection codes, as explained in the next sections.

D.1 ProDUR Alerts

If a pharmacy needs assistance interpreting ProDUR alert or denial messages from the Prime Therapeutics Management POS system, the pharmacy should contact the Pharmacy Support Center at the time of dispensing. Refer to *Appendix E – Directory* at the end of this manual for contact information.

The Pharmacy Support 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. All ProDUR alert messages appear at the end of the claims adjudication transmission. The following table provides the format that is used for these alert messages.

Table D.1.1 – Record Format for ProDUR Alert Messages

Format	Field Definitions
Reason For Service Code	Up to three characters – Code transmitted to pharmacy when a conflict is detected (e.g., ER, HD, TD, DD)
Severity Index Code	One character – Code indicates how critical a given conflict is
Other Pharmacy Indicator	One character – Indicates if the dispensing provider also dispensed the first drug in question ▪ 1 = Your pharmacy ▪ 3 = Other pharmacy
Previous Date of Fill	Eight characters – Indicates previous fill date of conflicting drug in YYYYMMDD format
Quantity of Previous Fill	Five characters – Indicates quantity of conflicting drug previously dispensed
Data Base Indicator	One character – Indicates source of ProDUR message ▪ 1 = First DataBank ▪ 4 = Processor Developed
Other Prescriber	One character – Indicates the prescriber of conflicting prescription ▪ 0 = No Value ▪ 1 = Same Prescriber ▪ 2 = Other Prescriber

D.2 Point-of-Sale Reject Codes and Messages

The following table lists the rejection codes and explanations, possible B1, B2, B3 fields that may be related to denied payment, and possible solutions for pharmacies experiencing difficulties. All edits may not apply to this program. Pharmacies requiring assistance should call Prime Therapeutics Management's Pharmacy Support Center. Refer to *Appendix E – Directory* at the end of this manual for contact information.

Table D.2.1 – Point-of-Sale Reject Codes and Messages

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
Ø1	M/I Bin	1Ø1-A1	Use 013766
Ø2	M/I Version Number	1Ø2-A2	Version allowed = D.0
Ø3	M/I Transaction Code	1Ø3-A3	Transactions allowed = B1, B2, B3
Ø4	M/I Processor Control Number	1Ø4-A4	Use PØ63013766
Ø5	M/I Pharmacy Number	2Ø1-B1	Use NPI – National Provider Identifier only and do *not* send Nebraska Medicaid ID. Check with your software vendor to ensure appropriate number has been set up in your system. Your pharmacy must be an enrolled provider with Nebraska Medicaid on the DOS.
Ø6	M/I Group Number	3Ø1-C1	Use NEBMEDICAID only
Ø7	M/I Cardholder ID Number	3Ø2-C2	Use NE Medicaid ID Number only and do not use any other patient ID. Do not enter any dashes. Pharmacist should always examine a client's Medicaid ID card before services are rendered. It is the provider's responsibility to establish the identity of the client and to verify the effective date of coverage for the card presented.
Ø8	M/I Person Code	3Ø3-C3	Not required; refer to Payer Specs
Ø9	M/I Birthdate	304-C4	The format is CCYYMMDD.
1C	M/I Smoker/Non-Smoker Code	334-1C	Not required; refer to Payer Specs
1E	M/I Prescriber Location Code	467-1E	Not required; refer to Payer Specs

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
1Ø	M/I Patient Gender Code	3Ø5-C5	Allowed values: ▪ 0 = Not specified ▪ 1 = Male ▪ 2 = Female
11	M/I Patient Relationship Code	3Ø6-C6	Not required; refer to Payer Specs
12	M/I Patient Location	3Ø7-C7	Not required; refer to Payer Specs
13	M/I Other Coverage Code	3Ø8-C8	Allowed values: ▪ ØØ = Not specified ▪ Ø1 = No other coverage identified ▪ Ø2 = Other coverage exists - payment collected ▪ Ø3 = Other coverage exist - this claim not covered ▪ Ø4 = Other coverage exists - payment not collected
14	M/I Eligibility Clarification Code	3Ø9-C9	Not required; refer to Payer Specs
15	M/I Date of Service	4Ø1-D1	▪ The format is CCYYMMDD ▪ A future date is not allowed in this field.
16	M/I Prescription/Service Reference Number	4Ø2-D2	The format is NNNNNNN
17	M/I Fill Number	4Ø3-D3	▪ Enter "ØØ" for a new prescription ▪ Enter from a range of Ø1 to 99 for a refill prescription
19	M/I Days Supply	4Ø5-D5	The format is NNN. Enter the days' supply. "PRN" is not allowed.
2C	M/I Pregnancy Indicator	335-2C	Not required; refer to Payer Specs
2E	M/I Primary Care Provider ID Qualifier	468-2E	Not required; refer to Payer Specs
2Ø	M/I Compound Code	4Ø6-D6	Allowed values: ▪ Ø = Not specified ▪ 1 = Not a compound ▪ 2 = Compound
21	M/I Product/Service ID	4Ø7-D7	▪ Use 11-digit NDC only ▪ Do not enter any dashes
22	M/I Dispense As Written (DAW)/Product Selection Code	4Ø8-D8	Not required; refer to Payer Specs

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
23	M/I Ingredient Cost Submitted	4Ø9-D9	Not required; refer to Payer Specs
25	M/I Prescriber ID	411-DB	Use the prescriber's National Provider Identification (NPI). Do not use any other number.
26	M/I Unit Of Measure	6ØØ-28	Not required; refer to Payer Specs
28	M/I Date Prescription Written	414-DE	The format is CCYYMMDD
29	M/I Number Refills Authorized	415-DF	Enter number of refills authorized by prescriber; must be in compliance with guidelines for drug schedule.
3A	M/I Request Type	498-PA	Not required; refer to Payer Specs
3B	M/I Request Period Date-Begin	498-PB	Not required; refer to Payer Specs
3C	M/I Request Period Date-End	498-PC	Not required; refer to Payer Specs
3D	M/I Basis Of Request	498-PD	Not required; refer to Payer Specs
3E	M/I Authorized Representative First Name	498-PE	Not required; refer to Payer Specs
3F	M/I Authorized Representative Last Name	498-PF	Not required; refer to Payer Specs
3G	M/I Authorized Representative Street Address	498-PG	Not required; refer to Payer Specs
3H	M/I Authorized Representative City Address	498-PH	Not required; refer to Payer Specs
3J	M/I Authorized Representative State/Province Address	498-PJ	Not required; refer to Payer Specs
3K	M/I Authorized Representative Zip/Postal Zone	498-PK	Not required; refer to Payer Specs
3M	M/I Prescriber Phone Number	498-PM	Not required; refer to Payer Specs
3N	M/I Prior Authorized Number Assigned	498-PY	Not required; refer to Payer Specs
3P	M/I Authorization Number	5Ø3	Not required; refer to Payer Specs
3R	Prior Authorization Not Required	4Ø7-D7	Not required; refer to Payer Specs
3S	M/I Prior Authorization Supporting Documentation	498-PP	Not required; refer to Payer Specs

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
3T	Active Prior Authorization Exists Resubmit At Expiration Of Prior Authorization		Not required; refer to Payer Specs
3W	Prior Authorization In Process		
3X	Authorization Number Not Found	5Ø3-F3	Not required; refer to Payer Specs
3Y	Prior Authorization Denied		
32	M/I Level Of Service	418-D1	Not required; refer to Payer Specs
33	M/I Prescription Origin Code	419-DJ	Valid values: ▪ 1 = Written Rx ▪ 2 = Telephone ▪ 3 = Electronic ▪ 4 = Facsimile ▪ 5 = Pharmacy
34	M/I Submission Clarification Code	42Ø-DK	Allowed values: ▪ 03/Vacation supply ▪ 04/Lost prescription ▪ 05/Therapy change ▪ 07/Medically necessary ▪ 08/Process compound for Approved Ingredients
35	M/I Primary Care Provider ID	421-DL	Not required; refer to Payer Specs
38	M/I Basis Of Cost	423-DN	Not required; refer to Payer Specs
39	M/I Diagnosis Code	424-DO	Not required; refer to Payer Specs
4C	M/I Coordination Of Benefits/Other Payments Count	337-4C	
4E	M/I Primary Care Provider Last Name	47Ø-4E	Not required; refer to Payer Specs
4Ø	Pharmacy Not Contracted With Plan On Date Of Service	None	Use NPI only Check the Date of Service; call the Provider Enrollment department, if necessary
41	Submit Bill To Other Processor Or Primary Payer	None	Indicates the individual has other insurance coverage. See the Additional Message field for details, including the Carrier Name.

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
5C	M/I Other Payer Coverage Type	338-5C	▪ 01 – Primary ▪ 02 – Secondary ▪ 03 – Tertiary ▪ 99 – Composite
5E	M/I Other Payer Reject Count	471-5E	Not required; refer to Payer Specs
5Ø	Non-Matched Pharmacy Number	2Ø1-B1	▪ Use NPI only ▪ Check client lock-in status
51	Non-Matched Group Number	301-C1	Use NEBMEDICAID only
52	Non-Matched Cardholder ID	302-C2	▪ Use NE Medicaid ID Number only ▪ Do not use any other patient ID ▪ Do not enter any dashes
53	Non-Matched Person Code	3Ø3-C3	Not required; refer to Payer Specs
54	Non-Matched Product/Service ID Number	4Ø7-D7	Use 11-digit NDC
55	Non-Matched Product Package Size	4Ø7-D7	Use 11-digit NDC
56	Non-Matched Prescriber ID	411-DB	Use the prescriber's National Provider Identification (NPI) Number
58	Non-Matched Primary Prescriber	421-DL	Not required; refer to Payer Specs
6C	M/I Other Payer ID Qualifier	339-6C	Not required; refer to Payer Specs
6E	M/I Other Payer Reject Code	472-6E	Not required; refer to Payer Specs
6Ø	Product/Service Not Covered For Patient Age	3Ø2-C2, 3Ø4-C4, 4Ø1-D1, 4Ø7-D7	
61	Product/Service Not Covered For Patient Gender	3Ø2-C2, 3Ø5-C5, 4Ø7-D7	
62	Patient/Card Holder ID Name Mismatch	31Ø-CA, 311-CB, 312-CC, 313-CD, 32Ø-CK	Enter name exactly as indicated on Medicaid ID Card
63	Institutionalized Patient Product/Service ID Not Covered	4Ø7-D7	Validate NDC; designated drugs are not covered for institutionalized clients
64	Claim Submitted Does Not Match Prior Authorization	2Ø1-B1, 4Ø1-D1, 4Ø4-, 4Ø7-D7, 416-	Not required; refer to Payer Specs
65	Patient Is Not Covered	3Ø3-C3, 3Ø6-C6	Not applicable

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
66	Patient Age Exceeds Maximum Age	3Ø3-C3, 3Ø4-C4, 3Ø6-C6	Not applicable
67	Filled Before Coverage Effective	4Ø1-D1	▪ Use the NE Medicaid ID Number only ▪ Do not enter any dashes ▪ Check the Date of Service ▪ Check the Group Number
68	Filled After Coverage Expired	4Ø1-D1	▪ Use the NE Medicaid ID Number only. ▪ Do not enter any dashes ▪ Check the Date of Service ▪ Check the Group Number
69	Filled After Coverage Terminated	4Ø1-D1	▪ Use the NE Medicaid ID Number only ▪ Do not enter any dashes ▪ Check the Date of Service ▪ Check the Group Number
7C	M/I Other Payer ID	34Ø-7C	Not required; refer to Payer Specs
7E	M/I DUR/PPS Code Counter	473-7E	Must be numeric
7Ø	Product/Service Not Covered	4Ø7-D7	Use 11-digit NDC; drug not covered
71	Prescriber Is Not Covered	411-DB	Validate appropriate National Provider Identifier Number (NPI) is entered for prescriber
72	Primary Prescriber Is Not Covered	421-DL	Not required; refer to Payer Specs
73	Refills Are Not Covered	4Ø2-D2, 4Ø3-D3	Check refill; some drugs are not authorized for refills
74	Other Carrier Payment Meets Or Exceeds Payable	4Ø9-D9, 41Ø, 442-E7	No payment due
75	Prior Authorization Required	462-EV	Use 11-digit NDC; drug requires PA
76	Plan Limitations Exceeded	4Ø5-D5, 442-E7	Check days' supply and metric decimal quantity.
77	Discontinued Product/Service ID Number	4Ø7-D7	Use the 11-digit NDC NDC is obsolete.
78	Cost Exceeds Maximum	4Ø7-D7, 4Ø9-D9, 41Ø, 442-E7	Cannot exceed $9,999.00 Call for prior authorization consideration if greater than $9,999.00.
79	Refill Too Soon	4Ø1-D1, 4Ø3-D3, 4Ø5-D5	75 percent or 90 percent days' supply of previous claim has not been utilized.

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
			Logic includes all claims (batch, POS, and paper).
8C	M/I Facility ID	336-8C	Not required; refer to Payer Specs
8E	M/I DUR/PPS Level Of Effort	474-8E	Not required; refer to Payer Specs
8Ø	Drug-Diagnosis Mismatch	4Ø7-D7, 424-DO	Not required; refer to Payer Specs
81	Claim Too Old	4Ø1-D1	Check the Date of Service
82	Claim Is Post-Dated	4Ø1-D1	Check the Date of Service
83	Duplicate Paid/Captured Claim	2Ø1-B1, 4Ø1-D1, 4Ø2-D2, 4Ø3-D3, 4Ø7-D7	Claim already received and adjudicated.
84	Claim Has Not Been Paid/Captured	2Ø1-B1, 4Ø1-D1, 4Ø2-D2	
85	Claim Not Processed	None	Claim is not able to be reversed as no paid claim exists.
86	Submit Manual Reversal	None	Not applicable
87	Reversal Not Processed	None	Service Provider Number (NPI ID), Date of Service, National Drug Code (NDC), and Rx Number must equal original claim.
88	DUR Reject Error		See DUR Response for details
89	Rejected Claim Fees Paid		Not applicable
9Ø	Host Hung Up		Processing host did not accept transaction or did not respond within time out period. Host disconnected before session completed.
91	Host Response Error		Response not in appropriate format to be displayed
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. Scheduled downtime for file maintenance is Sunday 10:00 p.m.–5:00 a.m. (CT).
95	Time Out		
96	Scheduled Downtime		
97	Payer Unavailable		

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
98	Connection To Payer Is Down		
99	Host Processing Error		Do not re-transmit claim(s)
AA	Patient Spend-down Not Met		Not applicable
AB	Date Written Is After Date Filled		Format = CCYYMMDD DOS cannot be < Date Rx Written
AC	Product Not Covered Non-Participating Manufacturer		Not applicable
AD	Billing Provider Not Eligible To Bill This Claim Type		Not applicable
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare		Not applicable
AF	Patient Enrolled Under Managed Care		Not applicable
AG	Days' Supply Limitation For Product/Service		Not applicable
AH	Unit Dose Packaging Only Payable For Nursing facility Beneficiaries		Not applicable
AJ	Generic Drug Required		Not applicable
AK	M/I Software Vendor/Certification ID	11Ø-AK	Enter "00000000000" only
AM	M/I Segment Identification	111-AM	Refer to software vendor
A9	M/I Transaction Count	1Ø9-A9	Refer to software vendor
BE	M/I Professional Service Fee Submitted	477-BE	Not required; refer to Payer Specs
B2	M/I Service Provider ID Qualifier	2Ø2-B2	Use "Ø1" = NPI ID
CA	M/I Patient First Name	31Ø-CA	Not required; refer to Payer Specs
CB	M/I Patient Last Name	311-CB	Not required; refer to Payer Specs
CC	M/I Cardholder First Name	312-CC	Check the patient's first name
CD	M/I Cardholder Last Name	313-CD	Check the patient's last name
CE	M/I Home Plan	314-CE	Not required; refer to Payer Specs
CF	M/I Employer Name	315	Not required; refer to Payer Specs
CG	M/I Employer Street Address	316	Not required; refer to Payer Specs
CH	M/I Employer City Address	317	Not required; refer to Payer Specs

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
CI	M/I Employer State/Province Address	318	Not required; refer to Payer Specs
CJ	M/I Employer Zip Postal Zone	319	Not required; refer to Payer Specs
CK	M/I Employer Phone Number	32Ø	Not required; refer to Payer Specs
CL	M/I Employer Contact Name	321	Not required; refer to Payer Specs
CM	M/I Patient Street Address	322-CM	Not required; refer to Payer Specs
CN	M/I Patient City Address	323-CN	Not required; refer to Payer Specs
CO	M/I Patient State/Province Address	324-CO	Not required; refer to Payer Specs
CP	M/I Patient Zip/Postal Zone	325-CP	Not required; refer to Payer Specs
CQ	M/I Patient Phone Number	326-CQ	Not required; refer to Payer Specs
CR	M/I Carrier ID	327-CR	Not required; refer to Payer Specs
CW	M/I Alternate ID	33Ø-CW	Not required; refer to Payer Specs
CX	M/I Patient ID Qualifier	331-CX	Not required; refer to Payer Specs
CY	M/I Patient ID	332-CY	Not required; refer to Payer Specs
CZ	M/I Employer ID	333-CZ	Not required; refer to Payer Specs
DC	M/I Dispensing Fee Submitted	412-DC	Not required; refer to Payer Specs
DN	M/I Basis Of Cost Determination	423-DN	Not required; refer to Payer Specs
DQ	M/I Usual And Customary Charge	426-DQ	Enter Usual & Customary charge in numeric format
DR	M/I Prescriber Last Name	427-DR	
DT	M/I Unit Dose Indicator	429-DT	Not required; refer to Payer Specs
DU	M/I Gross Amount Due	43Ø-DU	Numeric value only
DV	M/I Other Payer Amount Paid	431-DV	Enter the amount received from other payer(s) for this claim
DX	M/I Patient Paid Amount Submitted	433-DX	Cannot exceed $0.00 except on share of cost spend-down claims where the patient pays a portion of the claim and Medicaid is responsible for the remainder.
DY	M/I Date Of Injury	434	Not required; refer to Payer Specs
DZ	M/I Claim/Reference ID	435	Not required; refer to Payer Specs
EA	M/I Originally Prescribed Product/Service Code	445-EA	Not required; refer to Payer Specs

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
EB	M/I Originally Prescribed Quantity	446-EB	Not required; refer to Payer Specs
EC	M/I Compound Ingredient Component Count	447-EC	Enter number of ingredients in compound; must be numeric
ED	M/I Compound Ingredient Quantity	448-ED	Enter appropriate quantity for each ingredient in compound; must be numeric
EE	M/I Compound Ingredient Drug Cost	449-EE	Enter appropriate drug cost for each ingredient in compound; must be numeric
EF	M/I Compound Dosage Form Description Code	45Ø-EF	Enter dosage form for completed compounded product
EG	M/I Compound Dispensing Unit Form Indicator	451-EG	Enter dispensing unit form for completed compounded product
EH	M/I Compound Route Of Administration	452-EH	Enter route of administration for completed compounded product
EJ	M/I Originally Prescribed Product/Service ID Qualifier	453-EJ	Not required; refer to Payer Specs
EK	M/I Scheduled Prescription ID Number	454-EK	Not required; refer to Payer Specs
EM	M/I Prescription/Service Reference Number Qualifier	455-EM	Must be "1" (Rx Billing).
EN	M/I Associated Prescription/Service Reference Number	456-EN	Must be numeric
EP	M/I Associated Prescription/Service Date	457-EP	Format = CCYYMMDD
ER	M/I Procedure Modifier Code	459-ER	Not applicable
ET	M/I Quantity Prescribed	46Ø-ET	Not required; refer to Payer Specs
EU	M/I Prior Authorization Type Code	461-EU	Required when needed to identify designated prior authorization and/or override conditions
EV	M/I Prior Authorization Number Submitted	462-EV	Not required; refer to Payer Specs
EW	M/I Intermediary Authorization Type ID	463-EW	Not required; refer to Payer Specs
EX	M/I Intermediary Authorization ID	464-EX	Not required; refer to Payer Specs
EY	M/I Provider ID Qualifier	465	Not required; refer to Payer Specs

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
EZ	M/I Prescriber ID Qualifier	466-EZ	Use NPI Number
E1	M/I Product/Service ID Qualifier	436-E1	Enter "03" for NDC only
E3	M/I Incentive Amount Submitted	438-E3	Not required; refer to Payer Specs
E4	M/I Reason For Service Code	439-E4	Enter allowed codes only
E5	M/I Professional Service Code	44Ø-E5	Enter allowed codes only
E6	M/I Result Of Service Code	441-E6	Enter allowed codes only
E7	M/I Quantity Dispensed	442-E7	The correct format is 9(7).999
E8	M/I Other Payer Date	443-E8	Required when submitting COB; the format is CCYYMMDD
E9	M/I Provider ID	444-E9	Not required; refer to Payer Specs
FO	M/I Plan ID	524-F0	Not required; refer to Payer Specs
GE	M/I Percentage Sales Tax Amount Submitted	482-GE	Not required; refer to Payer Specs
HA	M/I Flat Sales Tax Amount Submitted	481-HA	Not required; refer to Payer Specs
HB	M/I Other Payer Amount Paid Count	341-HB	Must be numeric
HC	M/I Other Payer Amount Paid Qualifier	342-HC	Must be allowed value
HD	M/I Dispensing Status	343-HD	Required when submitting a claim for a partial fill ▪ P = Initial Fill ▪ C = Complete Fill
HE	M/I Percentage Sales Tax Rate Submitted	483-HE	Not required; refer to Payer Specs
HF	M/I Quantity Intended To Be Dispensed	344-HF	Required when submitting a claim for a partial fill
HG	M/I Days Supply Intended To Be Dispensed	345-HG	Required when submitting a claim for a partial fill
H1	M/I Measurement Time	495-H1	Not required; refer to Payer Specs
H2	M/I Measurement Dimension	496-H2	Not required; refer to Payer Specs
H3	M/I Measurement Unit	497-H3	Not required; refer to Payer Specs
H4	M/I Measurement Value	499-H4	Not required; refer to Payer Specs
H5	M/I Primary Care Provider Location Code	469-H5	Not required; refer to Payer Specs

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
H6	M/I DUR Co-Agent ID	476-H6	Not required; refer to Payer Specs
H7	M/I Other Amount Claimed Submitted Count	478-H7	Required when submitting a claim for co-pay only; to be used with Medicare clients only
H8	M/I Other Amount Claimed Submitted Qualifier	479-H8	99 = Other Required when submitting a claim for co-pay only; to be used with Medicare clients only
H9	M/I Other Amount Claimed Submitted	48Ø-H9	Co-pay amount Required when submitting a claim for co-pay only; to be used with Medicare clients only
JE	M/I Percentage Sales Tax Basis Submitted	484-JE	Not required; refer to Payer Specs
J9	M/I DUR Co-Agent ID Qualifier	475-J9	Not required; refer to Payer Specs
KE	M/I Coupon Type	485	Not required; refer to Payer Specs
M1	Patient Not Covered In This Aid Category		Not required; refer to Payer Specs
M2	Beneficiary Locked In		Not required; refer to Payer Specs
M3	Host PA/MC Error		
M4	Prescription/Service Reference Number/Time Limit Exceeded		Not required; refer to Payer Specs
M5	Requires Manual Claim		Not applicable
M6	Host Eligibility Error		
M7	Host Drug File Error		
M8	Host Provider File Error		
ME	M/I Coupon Number	486	Not required; refer to Payer Specs
MZ	Error Overflow		Exceeds 25 errors; resubmit claim
NE	M/I Coupon Value Amount	487	Not required; refer to Payer Specs
NN	Transaction Rejected At Switch Or Intermediary		Resubmit
PA	PA Exhausted/Not Renewable		Not applicable
PB	Invalid Transaction Count For This Transaction Code	1Ø3-A3, 1Ø9-A9	Refer to software vendor
PC	M/I Claim Segment	111-AM	Ø7 = Claim Segment

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
PD	M/I Clinical Segment	111-AM	13 = Clinical Segment
PE	M/I COB/Other Payments Segment	111-AM	Ø5 = Coordination of Benefits/Other Payer Segment
PF	M/I Compound Segment	111-AM	10 = Compound Segment
PG	M/I Coupon Segment	111-AM	Not required; refer to Payer Specs
PH	M/I DUR/PPS Segment	111-AM	Ø8 = DUR/PPS Segment
PJ	M/I Insurance Segment	111-AM	Ø4 = Insurance Segment
PK	M/I Patient Segment	111-AM	Ø1 = Patient Segment
PM	M/I Pharmacy Provider Segment	111-AM	Not required; refer to Payer Specs
PN	M/I Prescriber Segment	111-AM	Ø3 = Prescriber Segment
PP	M/I Pricing Segment	111-AM	11 = Pricing Segment
PR	M/I Prior Authorization Segment	111-AM	Not required; refer to Payer Specs
PS	M/I Transaction Header Segment	111-AM	Refer to software vendor
PT	M/I Workers' Compensation Segment	111-AM	Not required; refer to Payer Specs
PV	Non-Matched Associated Prescription/Service Date	457-EP	Format = CCYYMMDD
PW	Non-Matched Employer ID	333-CZ	Not required; refer to Payer Specs
PX	Non-Matched Other Payer ID	34Ø-7C	Not required; refer to Payer Specs
PY	Non-Matched Unit Form/Route Of Administration	451-EG, 452-EH, 6ØØ-28	Not applicable
PZ	Non-Matched Unit Of Measure To Product/Service ID	4Ø7-D7, 6ØØ-28	Not applicable
P1	Associated Prescription/Service Reference Number Not Found	456-EN	Format = CCYYMMDD
P2	Clinical Information Counter Out Of Sequence	493-XE	Not required; refer to Payer Specs
P3	Compound Ingredient Component Count Does Not Match Number of Repetitions	447-EC	Number of ingredient iterations must equal number in count field
P4	Coordination of Benefits/Other Payments	337-4C	Number of other payment iterations must equal number in count field.

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
	Count Does Not Match Number Of Repetitions		
P5	Coupon Expired	486-	Not required; refer to Payer Specs
P6	Date Of Service Prior To Date of Birth	3Ø4-C4, 4Ø1-D1	Check client date of birth
P7	Diagnosis Code Count Does Not Match Number Of Repetitions	491-VE	Not required; refer to Payer Specs
P8	DUR/PPS Code Counter Out of Sequence	473-7E	Refer to software vendor
P9	Field is Non-Repeatable		Refer to software vendor
RA	PA Reversal Out Of Order		Not applicable
RB	Multiple Partials Not Allowed		Not applicable
RC	Different Drug Entity Between Partial & Completion		Completion drug must be same as original drug on partial fill
RD	Mismatched Cardholder/Group ID-Partial To Completion	3Ø1-C1, 3Ø2-C2	Not applicable
RE	M/I Compound Product ID Qualifier	488-RE	Enter "03" = NDC
RF	Improper Order Of "Dispensing Status" Code On Partial Fill Transaction		Refer to software vendor
RG	M/I Associated Prescription/Service Reference Number On Completion Transaction	456-EN	Format = CCYYMMDD
RH	M/I Associated Prescription/Service Date On Completion Transaction	457-EP	Format = CCYYMMDD
RJ	Associated Partial Fill Transaction Not On File		Partial claims must exist for completion claim to be processed
RK	Partial Fill Transaction Not Supported		Not applicable
RM	Completion Transaction Not Permitted With Same "Date Of Service" As Partial Transaction	4Ø1-D1	Completion date must be different date than original date if partial fill

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
RN	Plan Limits Exceeded On Intended Partial Fill Values	344-HF, 345-HG	Check allowed quantity
RP	Out Of Sequence "P" Reversal On Partial Fill Transaction		Refer to software vendor
RS	M/I Associated Prescription/Service Date On Partial Transaction	457-EP	Format = CCYYMMDD Completion fill must = Partial fill
RT	M/I Associated Prescription/Service Reference Number On Partial Transaction	456-EN	Must be numeric; completion fill must = Partial fill
RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment		Refer to software vendor
R1	Other Amount Claimed Submitted Count Does Not Match Number of Repetitions	478-H7, 48Ø-H9	Not required; refer to Payer Specs
R2	Other Payer Reject Count Does Not Match Number of Repetitions	471-5E, 472-6E	Not required; refer to Payer Specs
R3	Procedure Modifier Code Count Does Not Match Number of Repetitions	458-SE, 459-ER	Not required; refer to Payer Specs
R4	Procedure Modifier Code Invalid For Product/Service ID	4Ø7-D7, 436-E1, 459-ER	Not required; refer to Payer Specs
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals Ø6	4Ø7-D7, 436-E1	Not applicable
R6	Product/Service Not Appropriate For This Location	3Ø7-C7, 4Ø7-D7, 436-E1	Not required; refer to Payer Specs
R7	Repeating Segment Not Allowed In Same Transaction		Refer to software vendor
R8	Syntax Error		Refer to software vendor
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae	43Ø-DU	Gross Amount Due = Ingredient Cost submitted + Dispensing Fee Submitted.
SE	M/I Procedure Modifier Code Count	458-SE	Not required; refer to Payer Specs

Reject Code and Explanation "M/I" Means Missing/Invalid		Possible Field # in Error	Possible Solutions
TE	M/I Compound Product ID	489-TE	Must be numeric
UE	M/I Compound Ingredient Basis Of Cost Determination	49Ø-UE	Not required; refer to Payer Specs
VE	M/I Diagnosis Code Count	491-VE	Not required; refer to Payer Specs
WE	M/I Diagnosis Code Qualifier	492-WE	Not required; refer to Payer Specs
XE	M/I Clinical Information Counter	493-XE	Not required; refer to Payer Specs
ZE	M/I Measurement Date	494-ZE	Not required; refer to Payer Specs

Appendix E – Directory

Contact/Topic	Contact Numbers	Mailing, E-mail, and Web Addresses	Purpose/Comments
Pharmacy Support Center 24/7/365	800-368-9695 **Fax:** 866-759-4115	Prime Therapeutics Management 11013 W. Broad Street Glen Allen, VA 23060	Pharmacy calls for ▪ ProDUR questions; ▪ Non-clinical prior authorization and early refills; ▪ Overrides for the client lock-in program; and ▪ Questions regarding Payer Specifications, etc.
Clinical Support Center 8:00 a.m.–7:00 p.m. (CT) (Monday–Friday) 8:00 a.m.–1:00 p.m. (CT) (Saturday) (After hours calls rollover to Pharmacy Support Center)	800-241-8335 **Fax:** 866-759-4115		Prescriber and pharmacy provider calls for ▪ Drugs requiring prior authorization (PA). Pharmacy calls for ▪ Dollar amount limits; and ▪ Medicare Coinsurance.
Nebraska Medicaid Eligibility (NMES) Line	402-471-9580 (in Lincoln) 800-642-6092 (outside of Lincoln)		
Nebraska Medicaid Provider Line	877-255-3092		
Vendor Software Certification and Testing 8:00 a.m.–5:00 p.m. (CT) Monday–Friday	804-548-0130		For software vendors to test billing transaction sets
UCFs	800-869-6508	Communiform Printing and Promotional Products https://www.asbaces.com/NEWACES/(S(s2nfae3jvzlj5n0whkhxlxfw))/storefront.aspx	To obtain UCFs
NPPES		https://nppes.cms.hhs.gov/NPPES/Welcome.do	To obtain NPI number

Contact/Topic	Contact Numbers	Mailing, E-mail, and Web Addresses	Purpose/Comments
NCPDP 7:00 a.m.–5:00 p.m. (MT) Monday–Friday	480-477-1000 **Fax:** 480-767-1043	National Council for Prescription Drug Programs 9240 East Raintree Drive Scottsdale, AZ 85260-7518 www.NCPDP.org	To obtain a NCPDP number or update addresses

Web Addresses

Prime Therapeutics Management	http://nebraska.fhsc.com
Nebraska DHHS	http://dhhs.ne.gov/Pages/default.aspx

Mailing Addresses for Claims Submission

Paper Claims (UCFs)

Prime Therapeutics Management
Nebraska Paper Claims Processing Unit
P.O. Box 85042
Richmond, VA 23261-5042

Overrides

Nebraska Medicaid Pharmacy Program
P.O. Box 95026
Lincoln, NE 68509-5026