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OREGON MEDICAID
MANAGEMENT INFORMATION
SYSTEM

Pharmacy Point of Sale and Prospective Drug Utilization Review Training Manual v1.2

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1 Introduction

1.1 The Oregon MMIS POS and ProDUR System

The Oregon Division of Medical Assistance Programs (DMAP) contracts Pharmacy Benefit Management (PBM) services out to Electronic Data Systems (EDS.) EDS supports and operates a Point of Sale (POS) System that contains all of DMAP's drug claim edits and a database of MMIS eligibility data. EDS also provides a PBM Technical and Prior Authorization Center.

The new Oregon MMIS is a fully integrated claims processing system, thus eliminating the need for the claim processing, claims history and financial interfaces with DMAP. The system uses real-time adjudication and eligibility verification to determine claim status and respond to ProDUR alerts. All prescription drug claims submitted to the OR MMIS will be submitted using approved National Council for the Prescription Drug Program (NCPDP) standard formats regardless of media type.

Providers can submit POS claims in batches or interactively through direct connectivity from value-added networks (VANs). Additionally the OR MMIS supports prescription drug claim submissions through the Provider Web Portal and EDI.

1.2 About this manual

This manual is intended to provide pharmacy claims submission guidelines using the new EDS on-line system and alert pharmacy providers to new and changed program information.

This manual is also available for download from the DHS training Web site.

www.oregon.gov/DHS/mmis/training-info.shtml

1.3 Rule references

This manual refers frequently to Oregon Administrative Rules (OARs) found in the Pharmaceutical Services administrative rulebook. This rulebook is available on the Pharmaceutical Services provider guidelines Web page at

<http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/main.html>.

Additionally, this manual refers to OARs found in the General Rules Program Rulebook. This rulebook is available on the provider guidelines General Rules Web page at

<http://www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html>

2 Key terms

Centers for Medicare and Medicaid Management Services (CMS)

- A federal program which mandates quality health care coverage for beneficiaries.

Claim

- A request for payment of health care services to a DHS client.

Coordination of Benefits (COB)

- Determination of payer. DMAP is the payer of last resort on claims for OHP clients with other insurance coverage.

Diagnosis code

- A numeric code that documents the client's medical condition, symptom or complaint as determined by the Provider and is the basis for rendering service(s). The diagnosis coding structure uses the International Classification of Disease– Ninth Revision, Clinical Modification (ICD-9-CM).

Electronic Data Interchange (EDI)

- A method of transmitting batch claims electronically.

Internal Control Number (ICN)

- A unique 13-digit identification number assigned to every claim in order to distinguish it from all other claims received by the system. The ICN is comprised of multiple components that identify critical information about the claim.
 - The first two characters represent the region code that identifies the source (paper, electronic, claim adjustments, etc) of the claim submission.

- The ICN also represents the date the claim was received in the year and Julian date portion of the field. This facilitates control reporting of claims for the receipt date, as well as other downstream processing, such as edit disposition.
- The batch range portion identifies the claim type assigned to the claim, and the sequence number of its relative position within a process cycle.

Long Term Care (LTC)

- Refers to institutional settings that include skilled nursing facilities and intermediate care facilities with the exclusions found in ORS 443.400 to 443.455.

MMIS

- Medicaid Management Information System.

National Council for Prescription Drug Programs (NCPDP)

- A not-for-profit ANSI-accredited Standards Development Organization.

National Provider Identifier (NPI)

- A numeric value assigned by the National Plan and Provider Enumeration System (NPPES) to a eligible health care providers.

Oregon Maximum Allowable Cost (OMAC)

- A list of multiple source generic drugs covered by DMAP at a lower reimbursement price.

Pharmacy Benefit Management (PBM)

- Provides claims management, ProDUR, and Drug Rebate services. EDS is DMAP's contracted PBM administrator.

Point of Sale (POS)

- On-line, real-time claim adjudication.

Prior Authorization (PA)

- Requested by a provider in order to render specified services to a designated beneficiary. The authorization is given prior to the services being performed.

Prospective Drug Utilization Review (ProDUR)

- Clinical messages accompanying an adjudicated claim.

Provider Web Portal

- A secure self-service Web site (see the [Web Portal Enrollment](#) section of this manual) that allows authorized providers access to the following functionality:
 - Verify and view current client eligibility information.
 - Submit and view individual claims online.
 - Track claims, resubmit denied claims, and adjust paid claims.
 - Request and view prior authorization requests.
 - Perform OHP HSC prioritized list inquiries.
 - Submit and track the status of provider enrollment forms and attachments.

Third-Party Liability

- Third-Party Liability (TPL) provides cost containment of the Medicaid program through the identification of services for which other insurance should be the primary payer. This includes, but is not limited to, private health insurance, any applicable Medicare coverage, worker's compensation, and accident-related liability insurance.

Value-Added Networks (VANs)

- A third party service that transmits and stores EDI data in an "electronic mailbox" until it is picked up by the appropriate party.

3 Contact information

With the implementation of the replacement MMIS, many important phone numbers and addresses will change. This section includes important contact information.

3.1 Telephone and Fax Numbers

With the implementation of the replacement MMIS, the following telephone and fax numbers will change. Upon implementation of the replacement MMIS, you should begin using the following contact numbers.

PBM Technical and Prior Authorization Center <ul style="list-style-type: none">✓ Prior Authorization for providers calling for prescriptions✓ Answers billing questions✓ Processes provider appeals✓ Discusses claim status✓ Reviews out-of-state claims	888-202-2126 Fax: 888-346-0178
Client Eligibility <ul style="list-style-type: none">• AVR	866-692-3864
Client Services Unit (CSU) <ul style="list-style-type: none">• This number is for clients to call for assistance.	1-800-273-0557

<p>DMAP Provider Services</p> <ul style="list-style-type: none"> • State-specific policy information 	<p>Phone : 800-336-6016</p> <p>E-mail : dmap.providerservices@state.or.us</p>
<p>Provider Enrollment</p>	<p>Phone: 800-422-5047</p> <p>E-mail: provider.enrollment@state.or.us</p>
<p>OSU College of Pharmacy Drug Use Research & Management (DURM)</p> <ul style="list-style-type: none"> • Polypharmacy • Referrals, e.g. lock-in Pharmacy Management • General information about DUR Newsletter, DUR Board, Prescriber Tools, etc. 	<p>Phone: 503-945-6513</p> <p>Website: http://pharmacy.oregonstate.edu/drug_policy</p>
<p>EDI Support Services</p>	<p>888-690-9888</p> <p>e-mail: dhs.edisupport@state.or.us</p>

3.2 Mailing Addresses

Upon implementation of the replacement MMIS, you should begin sending correspondence to the following addresses.

<p>Pharmacy paper claims billing address</p> <p>(Format: Universal Claim Form 5.1)</p>	<p>Division of Medical Assistance Programs</p> <p>Drug Invoice</p> <p>P.O. Box 14951</p> <p>Salem, Oregon 97309</p>
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Paper PA Requests	EDS-MAPAC 248 Chapman Road, Suite 100 Newark, DE 19702
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3.3 Provider Enrollment

Providers can apply to enroll with DHS in one of the following ways:

3.3.1 Web Portal Enrollment

Providers may submit an enrollment application via the provider Web portal at: www.or-medicaid.gov

For instructions on how to submit a Web portal application, please view the Web Portal Handbook, available for download on the DHS training information Web site.

www.oregon.gov/DHS/mmis/training-info.shtml

3.3.2 Contact DHS and request an enrollment packet

To request an enrollment packet, contact Provider Enrollment at: 800-422-5047.

3.3.3 Download enrollment forms from the DHS Web site

To download the provider enrollment forms, search for form number **0739** on the Find A Form Web site.

http://dhsforms.hr.state.or.us/forms/databases/FMPRO?-db=FormTbl.fp5&-lay=Main&-format=Findforms_FMP.htm&-findany

3.4 Client Eligibility

The following eligibility verification methods are available to providers:

3.4.1 Eligibility verification via the provider secure Web portal

The secure provider Web portal enables providers to verify eligibility over the Internet. Providers can also review eligibility information such as benefit plans, third-party coverage, managed care information, service limitations, and OHP HSC prioritized list information.

For more information on Web portal eligibility verification, see the Web Portal Handbook at: www.oregon.gov/DHS/mmis/training-info.shtml

3.4.2 Eligibility verification via AVR

Providers may access eligibility information using the EDS Automated Voice Response (AVR) system at 866-692-3864.

3.4.3 Electronic Eligibility Verification System (EEVS)

A fee-based system called EEVS is currently supported [maintained] by DMAP.

For additional information regarding EEVS go to the OHP electronic eligibility verification Web page at http://www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml#eevs

3.5 DMAP Provider Services

DMAP Provider Services is available from 8:00 AM to 5:00 PM PT, Monday through Friday, for provider calls related to:

- State-specific policy information
- Eligibility issues not resolved through the AVR

DMAP Provider Services can be reached at: 800-336-6016

4 Point-of-Sale (POS)

The EDS POS/ProDUR program is a fully-integrated subsystem of the Oregon MMIS claims processing system. Using DMAP-approved criteria, the ProDUR system includes reviewing claims for therapeutic appropriateness before the medication is dispensed, reviewing the MMIS medical history, focusing on those clients at the highest severity of risk for harmful outcome, and intervening and/or counseling when appropriate.

On receipt of POS pharmacy claims, the system determines if any Pro-DUR alerts should be returned to pharmacy providers based on State requirements. These real-time, clinically significant alerts describe conflict and severity, in addition to providing available references during the claims adjudication process. Pharmacy providers use this information to alter the medications they choose to dispense, cancel a claim based on the information received or override the alert with NCPDP override codes if such overrides are permitted by the State.

1. A ProDUR alert can be triggered on a POS pharmacy claim in three ways: By information supplied directly on the POS pharmacy claim (Drug – Pregnancy, Drug Age – Pediatric and Geriatric and High Dose/Low Dose);
2. Based on prior claim history (Drug to Drug Interaction, Late Refill, Early Refill, Therapeutic Duplication and Ingredient Duplication);
3. Based on a Client Profile created from any paid claim (except dental) submitted for a client (Drug – Pregnancy, Maximum Duration of Therapy, Minimum Duration of Therapy, Drug – Allergy, Drug – Disease (reported) or Drug – Disease (inferred)).

4.1 PBM Technical and Prior Authorization Center

The PBM Technical and Prior Authorization Center is available 24 hours per day, seven days per week, 365 days per year to assist with claims processing, coordination of benefits, ProDUR overrides, pricing and paper/Web claim questions. See [section 3](#) of this document for the PBM Technical and Prior Authorization Center phone number.

If you need assistance with any alert or denial messages, it is important to contact the PBM Technical and Prior Authorization Center about EDS ProDUR alerts at the time of dispensing. The PBM Technical and Prior Authorization Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, EDS staff pharmacists are available via the PBM Technical and Prior Authorization Center for consultation.

4.2 Technical Problem Resolution

In order to resolve technical problems, providers should follow these steps:

1. Check the terminal and communications equipment to ensure that electrical power and telephone services are operational. Call the telephone number the modem is dialing and note the information heard (i.e. fast busy, steady busy, recorded message). Contact your software vendor if unable to access this information in the system.
2. If the pharmacy provider has an internal Technical Support Department, the problem should be forwarded to that department. The pharmacy's technical support staff will coordinate with EDS to resolve the problem.
3. If the pharmacy provider's network is experiencing technical problems, the pharmacy provider should contact the network's

technical support area. The network's technical support staff will coordinate with EDS to resolve the problem.

4. If unable to resolve the problem after following the steps outline above, the pharmacy provider should contact the PBM Technical and Prior Authorization Center. See [section 3](#) of this document for the PBM Technical and Prior Authorization Center phone number.

4.2.1 System Availability

The PBM/POS system will be available 24 hours a day 7 days a week with the exception of a maintenance window. This window will occur no more frequently than weekly and will be scheduled for non-peak hours over the weekend. This period of maintenance will be scheduled between the hours of 10:00 PM and 2:00 AM on a weekend night (Saturday or Sunday).

Additionally, the PBM/POS server counters and controls are reset nightly at approximately midnight. This may cause a brief period of unavailability (less than 5 minutes).

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

4.2.2 Host System Problems

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

NCPDP	Message
90	Host hung up

Host disconnected before session completed.

NCPDP	Message
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92	System Unavailable/Host Unavailable
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Processing host did not accept transaction or did not respond within time out period.

NCPDP	Message
99	Host Processing Error

Do not retransmit claims.

NCPDP	Message
93	Planned Unavailable

Transmission occurred during schedule downtime.

4.3 POS Specifications

4.3.1 Claim Format

- NCPDP v5.1 for POS claims
- NCPDP Batch v1.1 format for all batch submissions
- The 5.1 Universal Claim Form (UCF) is required for paper submissions. Please see [Appendix A](#) for sample UCF and instructions.

4.3.2 Media Options

EDS recommends claim submission via POS or the provider Web portal for their immediate response benefits. In addition, some claims can be submitted through paper and Electronic Data Interchange (EDI) batch billing.

Note: EDI claims are subject to all prior authorization requirements and ProDUR alerts.

Note: NCPDP V. 5.1 has an expanded dollar field and allows for submitted amounts up to \$999,999.99

4.3.3 Paper Claims

For faster claims processing, providers are encouraged to bill electronically using POS or the secure Provider Web Portal when appropriate. For both of these options, claims enter directly into the MMIS claims processing system, with real-time acknowledgment of claim submissions.

See [Appendix A](#) for an example of the Universal Claim Form.

Note: Paper claims are subject to all prior authorization requirements and ProDUR alerts.

4.3.4 NCPDP V.5.1

For information regarding NCPDP V.5.1, please see the NCPDP Companion Guides for more information.

Companion Guides for production transactions are available at

http://www.oregon.gov/DHS/admin/hipaa/guides_man.shtml

4.3.5 Value Added Networks

A Value Added Network (VAN) is a third party service that transmits and stores EDI data in an "electronic mailbox" until it is picked up by the appropriate party. A VAN serves as a "middle man," so that neither party can access the other's private network. A VAN must have a current Trading Partner Agreement with DHS in order to exchange EDI data with DHS.

For a list of VANs currently authorized to exchange EDI data with DHS, please contact DHS EDI Support Services.

See [section 3](#) of this document for DHS EDI Support Services contact information.

4.3.6 On-Line Claims Testing

Pharmacy vendors should contact DHS EDI Support Services for information regarding pharmacy testing.

See [section 3](#) of this document for DHS EDI Support Services contact information.

4.3.7 Transaction Types

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

A. Full Claims Adjudication (Transaction Code B1)

This transaction captures and processes the claim and returns to the pharmacy the dollar amount allowed under the Oregon Division of Medical Assistance reimbursement formula. B1 corresponds to the “01-04” Transactions supported by version 3.2/3C.

B. Claims Reversal (Transaction Code B2)

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

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

- NPI provider number
- Prescription number
- Date of service (date filled)
- NDC

C. Claims Re-Bill/Adjustments (Transaction Code B3)

This transaction is used by the pharmacy to adjust and resubmit a claim that has previously been processed and received a Paid status. A “claims re-bill” voids the original claim and resubmits the claim within a single transaction. B3 corresponds to the “31-34” Transactions supported by version 3.2/3C. A complete listing of all transactions supported in NCPDP v.5.1 is on the following page.

4.3.8 Required Data Elements

The EDS system has program-specific “mandatory/required”, “optional” and “not sent” data elements for each transaction. For more information, please see the NCPDP Companion Guides.

Companion Guides for production transactions are available at

http://www.oregon.gov/DHS/admin/hipaa/guides_man.shtml

The following list provides important identification numbers for this program:

ANSI BIN #	009729
Processor Control #	P007009729
Group #	ORMEDICAID
Provider ID #	NPI Number
Cardholder ID #	DMAP ID Number
Prescriber ID #	NPI Number
Product Code	National Drug Code (NDC)

Note:

- 999999 can no longer be used as a prescriber ID. Instead, use the prescribing provider's NPI as the prescriber ID.
- After exhausting all NPI resources, if a prescriber NPI is not available, please call the PBM Technical and Prior Authorization Center at 888-202-2126.
- Prescriber ID BBBBBB can no longer be used when dispensing Plan B. When dispensing Plan B, use the dispensing pharmacy's NPI as the prescriber ID.
- When dispensing vaccinations, use the dispensing pharmacy's NPI as the prescriber ID.

If you have any questions regarding your current NPI, you can call the NPI Enumerator at 800-465-3203, or look it up in the online NPI Registry at <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>.

4.4 Prior Authorization

DMAP prior authorization policies are applied to appropriate drug claims in the adjudication process. Prescribing providers, upon notification from the pharmacy attempting to dispense a drug, may request prior authorization over the phone, fax, mail or EDS Web Portal. Prior authorization of prescription drug services will also be performed systematically, using an integrated drug authorizing tool called EDS DUR Plus, following DMAP-established clinical rules, with the submission of the claims. Authorization of prescription drugs will be managed under a contract between the Oregon Department of Human Services (DHS) and Electronic Data Systems (EDS).

When a pharmacy claim is submitted to the EDS POS system, it is initially evaluated for basic edits and audits. If the drug on the claim requires Prior Authorization and is set up for EDS DUR Plus evaluation, it is passed through a series of clinical criteria rules to determine the appropriateness of issuing a Prior Authorization to allow dispensing the drug to the client. EDS DUR Plus checks the current drug claim as well as the medical and claims history for the appropriate criteria. If suitable criteria are found, a prior authorization will be systematically created, applied to the claim, and the claim will be paid. This interactive process occurs with no processing delays and no administrative work for the pharmacy or prescribing provider. If all criteria are not met, the claim will be denied and a prior authorization will be required. The prescriber will then be responsible for requesting the prior authorization from the PBM Technical and Prior Authorization Center, using procedures required in OAR 410-121-0060.

For information regarding OAR 410-121-0060, please refer to the [Pharmaceutical Services administrative rulebook](#).

Please refer to [Section 3](#) of this document for prior authorization contact information.

Please refer to [Appendix B](#) for a copy of the universal prior authorization form and coversheet.

Note: EDS has used reasonable care to accurately compile ProDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their clients.

4.4.1 PBM Technical and Prior Authorization Center

The PBM Technical and Prior Authorization Center is available 24 hours a day, seven days a week, 365 days a year. The PBM Technical and Prior Authorization Center receives calls related to prior authorization and processes PA requests within 24 hours. PA's can also be faxed, mailed or received via the Web portal. If a PA request does not meet selected criteria requirements for coverage, the request is forwarded to the PBM Technical and Prior Authorization Center clinical pharmacist for review and response. An example of the DHS Universal PA form is included in [Appendix B](#). Please refer to the Contact Information in [Section 3](#) of this document.

4.4.2 Drugs Requiring PA

DHS may required prior authorization for individual drugs and categories of drugs to ensure that the drugs prescribed are indicated for conditions funded by the Oregon Health Plan (OHP) and consistent with the Prioritized List of Health Services and its corresponding treatment guidelines (see OAR 410-141-0480). Specific criteria related to drugs requiring prior authorization for Medically Appropriate Use are included in OAR 410-141-0500 and 410-141-0520:

Please refer to OAR 410-121-0040, 410-141-0500 and 410-141-0520 for generic and brand names, dose and duration criteria association with drugs requiring prior authorization.

For information regarding OAR 410-121-0040-1 and OAR 410-121-0040-2, please refer to the [Pharmaceutical Services administrative rulebook](#).

4.4.3 Emergency PA Protocol

- If the doctor is not available; EDS may authorize up to a 96 hour emergency supply as authorized under CMS guidelines.

4.4.4 Filing Client PA Appeals

For any prior authorization requests that are denied due to criteria not being met, the client may appeal the decision on the grounds of PA denial, reduction or claim denial.

For information regarding OAR 410-120-1860, please refer to the [General Rules Program rulebook](#).

4.5 Timely filing limits

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

- For all original claims, (NCPDP Transaction 01-04/B1), the timely filing limit for this program is **365 days** from the date of service (DOS).
- Reversal, Re-Bill and Adjusted Claims (NCPDP Transaction 11/B2 and 31-34/B3) **365 days** from date of service (DOS).
- Claims that exceed the timely filing limit will deny.

For information regarding timely submission of claims and/or appeals/claims reconsideration, please refer - OAR 410-120-1300 and OAR 410-120-1570 in the [General Rules Program rulebook](#).

4.6 Dispensing Limits

4.6.1 Days Supply Limits

For information regarding days supply limits, please refer to OAR 410-121-0146 in the [Pharmaceutical Services administrative rulebook](#).

4.6.2 Dose/Duration

For information regarding dose/duration, please refer to OAR 410-121-0040-2 in the [Pharmaceutical Services administrative rulebook](#).

4.6.3 Metric Quantity

Note: The true metric decimal quantity must be submitted as the QUANTITY DISPENSED (NCPDP field #442-E7). Do not round off any quantity amounts.

For information regarding metric quantity, please refer to OAR 410-121-0280 in the [Pharmaceutical Services administrative rulebook](#).

4.6.4 Age Limits

- Fluoride (excluding vitamin combinations) are not covered if client is older than 18.

For information regarding age limits, please refer to OAR 410-121-0147 in the [Pharmaceutical Services administrative rulebook](#).

4.6.5 Plan B (Emergency Contraception)

Plan B requires a prescription for clients under the age of 18. Plan B may be dispensed OTC for clients age 18 and over.

For information regarding Plan B, please refer to OAR 410-121-0150 in the [Pharmaceutical Services administrative rulebook](#).

4.7 Dispensing Fees

For information regarding dispensing fees, please refer to OAR 410-121-0160 in the [Pharmaceutical Services administrative rulebook](#).

4.8 Administering Vaccines and Immunizations

4.8.1 Billing Instructions

- The dispensing pharmacy's valid NPI should be input in the prescriber ID field.
- Designated Immunization products are associated with a special dispensing fee. Client must be 19 or older.
- In order to receive the additional fee for dispensing designated immunization products, you must enter a value of "1" in the PRIOR AUTHORIZATION TYPE CODE (416-DG) field if it is the first immunization claim of the day for that client.
- Additionally, if it is the first claim of the day for that client and any designated immunization product, enter "\$14.25" in the INCENTIVE AMOUNT SUBMITTED (438-E3) field.
- If you are submitting claims for more than one designated immunization product for the same client on the same day, enter "\$7.80" in the INCENTIVE AMOUNT SUBMITTED (438-e3) field and **do not** enter any value in the PRIOR AUTHORIZATION TYPE CODE field.

For information regarding immunizations, please refer to OAR 410-121-0185 in the [Pharmaceutical Services administrative rulebook](#).

4.9 Drug Coverage

4.9.1 Terminated NDCs

- EDS uses the CMS Termination Date on the drug file. The claim will deny if the date is exceeded.

4.9.2 Durable Medical Equipment (DME) and Medical Supplies

- DME and medical supply claims can be submitted via the secure provider Web portal. For more information on submitting claims via the Web portal, see the Pharmacy Web billing modules at: www.oregon.gov/DHS/mmis/training-info.shtml
- DME is billed on a CMS 1500 or DMAP 505 (for Medicare-eligible clients) form and forwarded to DMAP. This applies to non-senior programs. For more information about billing for DME and medical supplies, refer to the DME provider guidelines at www.dhs.state.or.us/policy/healthplan/dme/main.html.

4.9.3 DMAP coverage exclusions

- Drugs for non-funded conditions on the Oregon Health Plan (OHP) Health Services Commission (HSC) prioritized list.

For more information regarding the HSC, go to the HSC Web site at <http://www.oregon.gov/OHPPR/HSC/index.shtml>.

- Non-rebatable drugs .
- Drug Efficacy Study Implementation (DESI) program.

The DESI list can be obtained from the following Web site:

http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp

For information regarding DESI, please refer to OAR 410-121-0420 in the in the [Pharmaceutical Services administrative rulebook](#).

For information regarding coverage exclusions, please refer to OAR 410-121-0147 in the [Pharmaceutical Services administrative rulebook](#).

4.10 Client Payment Information

Medicaid copays may apply in certain circumstances.

For information regarding client copay information, please refer to OAR 410-120-1230 in the [General Rules Program rulebook](#).

NOTE: When DMAP is the payer of last resort, and the claim is for a service DMAP covers, you can only collect DMAP copayments (if applicable) from the clients. Do not collect primary copayments or deductibles.

4.11 Provider Payment Information

The drug reference data is the basis for pharmacy claims processing. The major source of updating is from the commercial First DataBank (FDB) files.

The weekly file updates from FDB update information on the drug reference database including items such as:

- Wholesale pricing
- Federal Upper Limit (FUL) pricing
- Drug Efficacy Study Implementation (DESI) data,
- CMS rebate related information.

For information regarding reimbursement information, please refer to OAR 410-121-0155 in the in the [Pharmaceutical Services administrative rulebook](#).

Note: NCPDP V. 5.1 has an expanded dollar field and allows for submitted amounts up to \$999,999.99

4.11.1 Federal Upper Limit (FUL)

Note: FUL price can be overridden if the provider enters a “1” in the DAW field, but this requires a prior authorization from the prescriber.

In 1987, regulations limited the amount which Medicaid could reimburse for drugs with available generic drugs under the Federal Upper Limit (FUL) Program. These limits are intended to assure that the Federal government acts as a prudent buyer of drugs. The concept of the upper limits program is to achieve savings by taking advantage of the current market prices. For more information concerning FULs go to:

<http://www.cms.hhs.gov/FederalUpperLimits/>

The most recent FUL listing can be obtained from the following Web site:
http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/ul_lists/

For information regarding FUL, please refer to OAR 410-121-0300 in the in the [Pharmaceutical Services administrative rulebook](#).

4.11.2 OMAC

Note: OMAC price can be overridden if the provider enters a “1” in the DAW field, but this requires a prior authorization from the prescriber.

For information regarding OMAC, please refer to OAR 410-121-0320 in the [Pharmaceutical Services administrative rulebook](#).

The OMAC list is also available on the Pharmaceutical Services provider guidelines page at <http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/main.html>.

4.11.3 OMAC Dispute Resolution

A Pharmacy Provider may dispute OMAC pricing if the price is below their cost. Providers should submit a Dispute Resolution Request form to the PBM Technical and Prior Authorization Center for a review of the OMAC pricing for a particular NDC. The form must be signed and provider should supply a document containing the products(s) that are of concern and include the challenge related to the OMAC.

See [Appendix E](#) for a sample OMAC Dispute Resolution Request form.

Dispute resolution forms and an invoice documenting how much the NDC(s) in question costs should be faxed to the PBM Technical and Prior Authorization Center. Notations such as “product availability” and/or “not available to purchase at listed OMAC” are acceptable.

See [section 3](#) of this document for the PBM Technical and Prior Authorization Center fax number.

PBM Technical and Prior Authorization Center will research each request. When the issue has been resolved, EDS will contact the pharmacy provider who initiated the dispute request and inform them of the resolution to their dispute. This should be within 5 business days of the initial request.

4.12 Compound Prescription Procedures

A compound drug claim is submitted as a single claim with all ingredients of the compound available for review under a single claim number. All drugs within the compound will be reviewed and priced based on established pricing criteria from DHS. Providers submitting compound drug claims should input a "2" in the 406-D6 field.

4.13 Emergency Dispensing Procedures

For information regarding emergency dispensing procedures, please refer to OAR 410-121-0060 in the in the [Pharmaceutical Services administrative rulebook](#).

4.14 Coordination of Benefits (COB)

DMAP is the payer of last resort on claims for OHP clients who have other insurance coverage for prescription drugs. Please review the rules and regulations surrounding COB claims: OAR 410-120-1280 or 42 CFR 433.135 through 433.154. Compliance with these rules may be subject to audit.

DMAP will pay POS claims billed with Other Coverage Code 3 (“Other coverage exists, claim not covered”) when all of the following are true:

- A drug product is not covered by the beneficiary’s other insurance.
- DMAP covers the drug.
- The claim’s COB segment contains a valid Other Payer Reject Code (NCPDP Field 472-6E).

DMAP will reject claims with Other Coverage Code 3 that do not meet all of the criteria listed above (NCPDP Reject code 6E — “M/I other payer reject code”).

The following is the approved list of Oregon DHS Division of Medical Assistance Programs (DMAP) descriptions and acceptable values for third party liability (TPL) denials. These are to be used in claim processing for the Other Coverage field. DMAP will audit transactions to ensure policy is strictly followed and only the following approved Other Coverage Codes (OCC) are properly used in claims processing. Please submit any denial code received from the primary or secondary payer when submitting the claim to DMAP using an OCC override code.

1. No other valid pharmacy coverage in effect.

OCC 1 is for situations where the provider has confirmed that the client does not have valid pharmacy coverage. Submit the claim with an OCC 1, along with a valid Other Payer Denial Date and Other Payer ID returned on the original claim to override the TPL denial.

2. An amount is collected from another payer.

OCC 2 is used when any positive amount of money is collected from another payer. Submit the claim with an OCC 2, the amount collected from the primary payer, along with the date the claim was adjudicated by the primary payer and the Other Payer ID to override the TPL denial.

3. Primary payer does not cover the specific drug being submitted.

OCC 3 is used when the primary payer does not cover the specific drug being submitted. Submit an OCC 3 and Other Payer ID along with a valid Other Payer Denial Date to override the TPL denial.

OCC 3 is submitted only if the primary insurance carrier returned a NCPDP 70 - NDC Not Covered - denial.

*** If the primary carrier requires a Prior Authorization (NCPDP 75), the primary carrier's Prior Authorization procedures must be followed prior to submitting the claim to DMAP for secondary payment. If you receive other error codes, take action to resolve the problem (such as re-directing the client to a different pharmacy or contact the doctor's office). Use another OCC only if appropriate.

4. Plan limitation exceeded

OCC 3 now also allows NCPDP Reject Codes of 3Y - Prior Authorization Denied and 76 - Plan Limitations Exceeded. The Plan Limitation Exceeded situation needs to have had an attempt at resolution, particularly if the plan limit is only a certain "days supply" quantity.

5. Client has yet to meet their primary payer's deductible.

OCC 4 - If the client has not met their primary payer's deductible, and the primary payer payment is zero, submit the claim with an OCC 4, a zero amount collected from the primary payer, the Other Payer ID, along with the date the claim was adjudicated by the primary payer to override the TPL denial.

6. Total cost of the claim is less than the client's primary payer's co-payment.

OCC 4 - If the total cost of the claim is less than the client's primary payer's co-payment and the adjudication of the claim by the primary payer resulted in zero payment, submit the claim with an OCC 4, a zero amount collected from the primary payer, the Other Payer ID, along with the date the claim was adjudicated by the primary payer for an override.

7. Client's primary insurance requires the client to pay for medications.

OCC 4 - If the client's primary insurance requires the client to pay for the medications at the time of dispensing and submit receipts for reimbursement submit the claim with an OCC 4, a zero amount collected from the primary payer, the Other Payer ID, along with the date of service in the other payer date field to override the TPL denial. In these cases, DMAP will be responsible for collecting the payment from the primary payer.

8. Client's pharmacy coverage is not yet in effect for the date of service.

OCC 7 is reserved for situations where the provider has confirmed that the client's pharmacy coverage is not yet in effect for the date of service on the claim. In this case, submitting the claim with an OCC 7, Other Payer ID, along with a valid Other Payer Denial Date will override the TPL denial.

NOTE: When DMAP is the payer of last resort, and the claim is for a service DMAP covers, you can only collect DMAP copayments (if applicable) from the clients. Do not collect primary copayments or deductibles.

4.15 Data integrity audit program

Based on POS data, EDS will audit inaccurate days supply entries and frequent use of the following overrides: vacation, early refill, lost prescriptions, credit returns, etc. EDS will alert DMAP of any suspicious findings and recommend further investigation.

4.16 Special Client Conditions

4.16.1 Long Term Care (LTC) Clients

- The pharmacy needs to be enrolled with DMAP with NPI taxonomy of 3336L0003X (LTC).
- Designated drugs are not covered through the pharmacy benefit for specific LTC claims; they are considered part of the per diem paid to the institution.
- All PA and ProDUR alerts apply.

- To submit LTC claims, a value of “04” is entered in field #307, Patient Location.
- CII partial fills for LTC clients on DOS:
 - RX # will be valid for 60 days from the date of fill.
 - After the 60 day time period, the claim will deny and return a supplemental message indicating that a new RX # is required.
 - The provider receives the usual dispensing fee paid for each fill.

For information regarding LTC clients, please refer to OAR 410-121-0148 and OAR 410-121-0625 in the in the [Pharmaceutical Services administrative rulebook](#).

4.16.2 Pharmacy Management Program Clients

- Pharmacy information is available from DMAP Provider Services or on-line upon claim adjudication.
- Providers may call the PBM Technical and Prior Authorization Center for override consideration. Override is for DOS only. Approved override criteria:
 - Out of town
 - Changing pharmacy
 - Cannot get the drug at the primary pharmacy
 - Hospital care

For information regarding pharmacy management programs, please refer to OAR 410-121-0135 in the in the [Pharmaceutical Services administrative rulebook](#).

4.16.3 Public Health Service (340B) Claims

- The pharmacy must be enrolled with DMAP as 340B pharmacy specialty (408).
- To submit a 340B claim, enter a “09” (other) in field #423, Basis of Cost Determination.

5 Prospective Drug Utilization Review (ProDUR)

The EDS POS/ProDUR program is a fully-integrated subsystem of the Oregon MMIS claims processing system. Using DMAP-approved criteria, the ProDUR system includes reviewing claims for therapeutic appropriateness before the medication is dispensed, reviewing the MMIS medical history, focusing on those clients at the highest severity of risk for harmful outcome, and intervening and/or counseling when appropriate.

The ProDUR subsystem performs Prospective Drug Utilization Review (ProDUR) against pharmacy claims, alerting the pharmacist of potentially inappropriate prescriptions. Criteria, supplied by both First Data Bank (FDB) and the State, are used in the real-time editing of the Point of Service (POS) drug claims. Standard NCPDP alerts are supported by the Oregon MMIS.

On receipt of POS pharmacy claims, the system determines if any Pro-DUR alerts should be returned to pharmacy providers based on State requirements. These real-time, clinically significant alerts describe conflict and severity, in addition to providing available references during the claims adjudication process.

5.1 ProDUR alert sequence

The order in which the ProDUR alerts are performed is as follows:

1. Drug Pregnancy
2. Drug Age - Pediatric
3. Drug Age - Geriatric
4. High Dose
5. Low Dose
6. Maximum Duration
7. Minimum Duration
8. Drug Allergy
9. Drug/Drug (Audit)
10. Under Utilization (Audit)
11. Over Utilization (Audit)
12. Therapeutic Duplication (Audit)
13. Ingredient Duplication (Audit)
14. Drug Disease

5.1.1 Days Supply

Days supply information is critical to the edit functions of the ProDUR system. Submitting incorrect days supply information in the days supply field can cause false ProDUR alerts or claims denial for that particular claim or drug claims that are submitted in the future. See [section 4.7.1](#) for additional details regarding days supply.

5.2 PBM Technical and Prior Authorization Center

The PBM Technical and Prior Authorization Center is available 24 hours per day, seven days per week. Alert message information is available from the Call Center after the message appears. If you need assistance with any alert or denial messages, it is important to contact the PBM Technical and Prior Authorization Center at the time of dispensing. The PBM Technical and Prior Authorization Center can provide claims information on all error messages sent by the ProDUR system. This information includes NDCs and drug names of the affected drugs, dates of service, days supply and

whether the calling pharmacy is the dispensing pharmacy of the conflicting drug.

See [section 3](#) of this document for the PBM Technical and Prior Authorization Center phone number.

5.3 ProDUR Alerts/Error Messages

CODE	Description	EOB	EOB Description
DA	Drug Allergy	3533	PDUR DRUG-ALLERGY INTERACTION
DC	Drug-Disease (Inferred)	3546	DRUG DISEASE MARKER
DD	Drug-Drug Interaction	3537	PDUR DRUG-TO-DRUG INTERACTION
ER	Overutilization (Early Refill)	3539	PDUR EARLY REFILL ON PRESCRIPTION
HD	High Dose	3541	PDUR DOSING PRECAUTION-HIGH DOSE
ID	Ingredient Duplication	3535	PDUR INGREDIENT DUPLICATION
LD	Low Dose	3542	PDUR DOSING PRECAUTION-LOW DOSE
LR	Underutilization (Late Refill)	3545	PDUR LATE REFILL ON PRESCRIPTION
MC	Drug-Disease	3546	DRUG DISEASE MARKER
MN	Insufficient Duration	3540	PDUR MINIMUM DURATION OF THERAPY
MX	Excessive Duration	3544	PDUR MAXIMUM DURATION OF THERAPY

CODE	Description	EOB	EOB Description
PA	Drug-Age	3534	PRODUR DRUG-AGE INTERACTION
PG	Drug Pregnancy	3543	PDUR BREAST FEEDING/PREGNANCY PRECAUTION
TD	Therapeutic Duplication	3536	PDUR THERAPEUTIC DUPLICATION

5.4 RX Clarification Codes

Intervention and Outcome codes are not required for early refill overrides.

- 02 = other override
- 03 = vacation supply
- 04 = lost prescription

6 NPI Requirements

Pharmacies must include a valid NPI for the prescriber when submitting a POS claim. The pharmacy is responsible for obtaining the NPI if it is not provided by the prescriber. Pharmacies should contact the prescriber or use the following resource to obtain a valid NPI.

6.1 Searching for an NPI

National Plan and Provider Enumeration System (NPPES)

The NPPES NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. You may run simple queries to retrieve this read-only data. For example, users may search for a provider by the NPI or Legal Business Name. There is no charge to use the NPI Registry.

<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

7 PBM News & Updates

Information pertaining to billing and drug therapy problems will be delivered to providers by various medium including:

- Contact with the PBM Technical and Prior Authorization Center
- Blast faxes
- Remittance Advice (RA) banner messages or inserts
- DHS Web site
- Contact with PBM Technical and Prior Authorization Center personnel
- Direct provider mailings
- Newsletters

Providers are encouraged to watch for news and update messages and to visit the DHS Tools for Pharmacy Providers web page.

http://www.oregon.gov/DHS/healthplan/notices_providers/pharmacies.shtml

8.1 Appendix A: Universal Claim Form

Universal Claim Form:

- The Universal Claim Form (UCF) will be required for all paper claims.
- The UCF should be submitted to
Division of Medical Assistance Programs
Drug Invoice
P.O. Box 14951
Salem, Oregon 97309
- UCFs may be obtained through agreement with the National Council for Prescription Drug Programs (NCPDP) from Moore North America, Inc. (R.R. Donnelley) : FAX: (800) 635-9533
- UCFs are available online from NCPDP. Information about purchasing this form is available at:
www.NCPDP.org/standards_purchase.asp

Instructions and a sample copy of this form follow.

How to complete a UCF:

1. Fill in all applicable areas on the front of the form.
2. Verify client information is correct and that the client named is eligible for benefits.
3. If this claim is for a works compensation injury, verify that the appropriate section on the front side has been completed.
4. Client signs certification on front side for prescription(s) received.
5. Enter Compound RX in the Product Service ID area and list each ingredient name, NDC, quantity and cost in the area below. Please use a separate claim form for each compound prescription.
6. Workers Compensation information is conditional. It should be completed only for a Workers Compensation claim.
7. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
8. Limit 1 set of DUR/PPS codes per claim.

9. Each area is numbered. Fill in each area using the following codes:

DEFINITION / VALUES

1. OTHER COVERAGE CODE

0=Not specified	5=Managed care plan denial
1=No other coverage identified	6=Other coverage denied not a participating provider
2=Other coverage exists payment collected	7=Other coverage exists not in effect at time of service
3=Other coverage exists this claim not covered	8=Claim is billing for a copay
4=Other coverage exists payment not collected	

2.PERSON CODE

Code assigned to a specific person within a family

3.CLIENT GENDER CODE

0=Not specified	1=Male
	2=Female

4. CLIENT RELATIONSHIP CODE

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

5. SERVICE PROVIDER ID QUALIFIER

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

6. CARRIER ID

Carrier code assigned in Worker's Compensation Program.

7. CLAIM/REFERENCE ID

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

8. PRESCRIPTION SERVICE REFERENCE # QUALIFIER

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

9. QUANTITY DISPENSED

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

10. PRODUCT SERVICE ID QUALIFIER

Code qualifying the value in Product/Service ID (407-07)

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

11. PRIOR AUTHORIZATION TYPE CODE

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

12. PRESCRIBER ID QUALIFIER

Use service provider ID values

13. DUR/PROFESSIONAL SERVICE CODES

For values refer to current NCPDP data dictionary.

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

14. BASIS OF COST DETERMINATION

00=Not specified Blank=Not specified	04= EAC (Estimated Acquisition Cost)
01=AWP (average wholesale price)	05=Acquisition
02=Local Wholesale	06=MAC (Maximum Allowable Cost)
03=Direct	07=Usual and
	09=Other (340B)

15. PRODUCT SERVICE ID QUALIFIER

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

16. DIAGNOSIS CODE QUALIFIER

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

17. OTHER PAYER ID QUALIFIER

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

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

Name	NDC	Quantity	Cost

I.D. _____ GROUP I.D. _____ PLAN NAME _____
 NAME _____
 PATIENT NAME: _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____
 PATIENT DATE OF BIRTH MM DD CCYY _____ PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____
 PHARMACY NAME _____
 ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (8) _____
 CITY _____ PHONE NO. () _____
 STATE & ZIP CODE _____ FAX NO. () _____

FOR OFFICE USE ONLY	

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

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

**ATTENTION RECIPIENT
 PLEASE READ
 CERTIFICATION
 STATEMENT ON REVERSE
 SIDE**

1

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

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

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

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

2

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

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

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

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

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

	INCREMENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	RELEVANT AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

8.2 Appendix B: Universal Prior Authorization Form



Oregon DHS Prior Authorization Request Form

For Internal Use Only: PA Number

I

Requesting Provider Name <input style="width: 80%;" type="text"/>	Provider # <input style="width: 40%;" type="text"/>
Contact Name <input style="width: 40%;" type="text"/>	Contact Phone # <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/> - <input style="width: 10%;" type="text"/>
Contact Fax # <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/> - <input style="width: 10%;" type="text"/>	Processing Time Frame: Routine Urgent Immediate

Supporting Justification for Urgent/Immediate Processing Time Frame:

II

Type of PA Request and Date Information

Assignment Code (check appropriate box)

<input type="checkbox"/> <u>Audiology</u>	<input type="checkbox"/> Home Health Division	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Chemical Dependency Treatment Services	<input type="checkbox"/> Skilled Nursing Svcs.	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Dental Hospital Referral	<input type="checkbox"/> Imaging	<input type="checkbox"/> Physician
<input type="checkbox"/> DME	<input type="checkbox"/> Inpatient Rehab	<input type="checkbox"/> Speech Services
<input type="checkbox"/> Gambling Treatment Services	<input type="checkbox"/> Medical Transportation	<input type="checkbox"/> Surgery
<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Transplant
<input type="checkbox"/> Home EPIV	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Vision
<input type="checkbox"/> Other <input style="width: 50px;" type="text"/>		

III

Client ID <input style="width: 80%;" type="text"/>	DOB <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 20%;" type="text"/>
	MM DD CCYY
Last Name <input style="width: 80%;" type="text"/>	First Name, MI <input style="width: 80%;" type="text"/>

IV

Service Information

Estimated length of treatment <input style="width: 80%;" type="text"/>	Frequency <input style="width: 80%;" type="text"/>
Primary diagnosis <input style="width: 80%;" type="text"/>	Primary diagnosis code <input style="width: 80%;" type="text"/>
Other pertinent diagnosis <input style="width: 90%;" type="text"/>	
Facility: Name <input style="width: 80%;" type="text"/>	Provider # <input style="width: 80%;" type="text"/>

Revenue Center Codes	
<i>Please attach appropriate dental/medical/clinical justification for services requested (attach any plan of treatment, progress notes, invoices, etc. as needed).</i>	

V							
Line Item	Procedure Code	Modifier	Description	Units	U&C	MSRP	Total Dollars
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
Total Units						Total Cost	

VI							
DENTAL							
Tooth Number			Quad				

VII							
Pharmacy:		Drug Name			Strength		
Quantity				NDC			
Directions:							

VIII							
Performing Provider				Provider #			
Contact Name			Contact Phone #				
Contact Fax #			Billing Provider #				

IX							
Date Information							
Date of Request (MM/DD/CCYY) / /							

Expected Service Begin Date	■	/	■	/	■				
Expected Service End Date									

Notes:

■

Attachments:

Control Number

Report Type

Description of attachments:

■

8.3 Appendix C: POS Error Codes and Messages

NCPDP Error Code	MMIS Edit/Audit	MMIS Edit - Short Description	EOB Code (on RA)
05	201	Billing provider ID number missing	0099
05	202	Billing provider ID in invalid format	0099
07	203	Recipient ID number missing	0145
25	205	Prescribing provider ID missing	0152
56	206	Prescribing provider ID invalid	0152
2C	208	Pregnancy indicator invalid	3213
22	210	Brand medically necessary indicator invalid	9999
17	211	Refill indicator invalid	1012
16	212	Prescription number is missing	0033
28	214	Date prescribed is invalid	1030
15	215	Date dispensed is missing	0034
15	216	Date dispensed is invalid	0436
21	217	NDC missing	1014
21	218	NCD invalid format	1015
E7	219	Quantity dispensed is missing	0034
18	220	Quantity dispensed is invalid	0437
19	221	Days supply missing	1017
19	222	Days supply invalid	0441
DV	227	Other insurance amount is invalid	0014
CA	238	Recipient name is missing	0252
39	242	Secondary diagnosis code invalid format	0020
39	244	Third diagnosis code invalid	0021
39	246	Fourth diagnosis code not on file or inactive	0022
21	250	Claim has no details	0167
15	259	Date billed is missing/invalid	0019
DQ	268	Billed amount missing	0428
DQ	269	Detail billed amount invalid	0428

NCPDP Error Code	MMIS Edit/Audit	MMIS Edit - Short Description	EOB Code (on RA)
DU	270	Header total billed amount invalid	0037
39	272	Primary diagnosis code invalid	0054
73	351	Refill not allowed for narcotic drugs	3336
39	355	Fifth diagnosis code invalid	0047
39	356	Sixth diagnosis code invalid	3313
39	357	Seventh diagnosis code invalid	3313
39	358	Eighth diagnosis code invalid	3313
EP	500	Invalid attachment type (HDR)	9999
AB	502	Date dispensed earlier than date prescribed	1075
PV	503	Date dispensed after billing date	1074
R9	505	Third party payment amount more than claim charge	1136
15	506	ICN Date prior to date billed	0116
CA/CB	513	Recipient name and number disagree	0028
PV	536	Billed date is prior to dates of service	1007
81	545	Filling Limit Exceeded	0076
PV	554	Header billed date is prior to dates of service	9999
74	565	Header paid amount is greater than billed amount	1117
4C	576	Claim has third-party payment	1042
5C	643	Invalid other coverage code	1111
5C	652	Missing or invalid other payer coverage type	1652
25	1000	Billing provider ID not on file	0099
40	1001	Billing provider has no contracts for DOS	0004
PM	1003	Billing prov not elig at serv LOC for prog billed	1086
65	1016	Non-Participating manufacturer	1100

NCPDP Error Code	MMIS Edit/Audit	MMIS Edit - Short Description	EOB Code (on RA)
25	1026	Prescribing physician ID not on file	1048
AD	1032	Billing provider not eligible to bill this claim type	0479
AD	1036	Performing provider type/claim type mis-match	0479
PM	1049	Billing provider is suspended or terminated	9999
70	1050	Service not referred by primary care case manager	1051
PM	1927	NPI required healthcare = Y billing provider	9999
PM	1936	Invalid billing provider specified	1051
PM	1945	Mult SAK Prov LOCS for billing Prov Spec	1051
PM	1995	Render/Dispensing/Performing Provider ID in old format - HDR	1999
PM	1999	Header billing provider ID in old format	1999
52	2001	Recipient ID number not on file	0145
68	2002	Recipient not eligible for header DOS	0003
67	2003	Recipient ineligible on detail DOS	0003
68	2009	Recipient ineligible on header DOS	0003
70	2017	Recipient services covered by HMO	0090
52	2037	Recipient ID is inactive	1113
65	2043	Review Indicator error	0432
68	2077	Recipient not eligible on all dates of service	1041
41	2507	Recipient has more than one insurance carrier	0467
41	2508	Recipient covered by private insurance	1035
65	2509	Recipient covered by Medicare	0389
M2	2603	Recipient lockin	0216

NCPDP Error Code	MMIS Edit/Audit	MMIS Edit - Short Description	EOB Code (on RA)
65	2804	Case number not on file	2804
52	2999	Claim billed with inactive BID	1115
75	3000	Units exceed authorized units on PA master file	0100
75	3001	Emergency indicator = Y - PA is required	0006
75	3002	NCD requires PA	1056
75	3019	PA cutback performed	1094
70	3326	CII LTC participant require new RX#	3006
70	3329	DME Drug not covered	2175
85	3556	No dispensing fee found	4014
70	4002	Non-Covered Drug	0320
21	4004	NDC not on file	0403
R9	4005	Allowed amount high variance	3352
R9	4006	Allowed amount low variance	3351
70	4007	Non-Covered NCD due to CMS termination	1062
R9	4009	Allowed amount less than drug charge variance	1061
PP	4014	No pricing segment on file	4014
AJ	4023	Gender restriction for covered NDC	9998
60	4025	Age is not allowed for NDC	0091
76	4026	Drug quantity per day limit has been exceeded	3148
39	4040	Primary diagnosis code not on file	0054
39	4041	Secondary diagnosis code not on file	0020
39	4042	Third diagnosis code not on file or inactive	0021
39	4043	Fourth diagnosis code not on file or inactive	0022

NCPDP Error Code	MMIS Edit/Audit	MMIS Edit - Short Description	EOB Code (on RA)
39	4047	5th diagnosis code not on file or inactive	0047
39	4048	Sixth diagnosis code not on file	3313
39	4049	7th diagnosis code not on file	3313
39	4050	8th diagnosis code not on file	3313
R9	4084	Drug CHG to allowed CHG exceeds percent	1060
70	4113	Unit dose packaging covered for LTC residents only	3320
70	4117	Family planning restriction for billed NDC	3320
99	4127	Cannot prioritize recipients programs	1124
99	4130	Payer hierarchy not found	1134
99	4131	No benefit plans associated to payer	1134
70	4164	Inactive drug	1063
76	4165	Days supply more than allowed for covered NDC	3030
R9	4200	Claim priced at zero	1085
70	4213	Re-Used NCD codes	3320
70	4222	Med Review restriction for covered NDC	3320
18	4224	Quality less than minimum allowed	0102
70	4999	Prov Location restriction for covered rev code	1109
83	5000	Possible Duplicate	0032
83	5001	Exact Duplicate	0015
78	5036	No more than 15 drugs allowed	5036
75	6550	Prescription Limit Exceeded	TBD
78	6831	Toradol there is a maximum of one Rx filling	6831
78	6832	All ORAL PPIs require PA AFTER 60 days	6832

NCPDP Error Code	MMIS Edit/Audit	MMIS Edit - Short Description	EOB Code (on RA)
88	7001	Drug-Age	3534
88	7001	Drug-Drug Interaction	3537
88	7001	Therapeutic Duplications	3536
88	7001	Drug Pregnancy	3543
88	7001	Drug-Disease	3546
88	7001	High Dose	3541
88	7001	Drug Allergy	3533
88	7001	Excessive Duration	3544
88	7001	Ingredient Duplication	3535
88	7001	Drug-Disease (Inferred)	3546
88	7001	Underutilization (Late Refill)	3545
88	7001	Insufficient Duration	3540
88	7001	Low Dose	3542
88	7002	Overutilization-Early Refill	3539
70	7024	LTC recipient - Non-Compound drug billed	0075
PM	7500	Billing provider on prepayment review	1050

8.4 Appendix D: Other Carrier Codes

Code	Name
9316	AARP
A829	ADVANCED PCS / P C S
G207	AETNA PHARMACY MANGMT CLM
K123	ALLSTATE/AMERICAN HERITGE
B114	AMERIBEN SOLUTIONS/ABS
G740	ANTHEM BC/BS
Q968	ANTHEM PRESCRIPTION MGMT
K528	ANTHEM PRESCRIPTION MNGMT
G324	ARGUS (REGENCE LIFE & HEALTH, Nelson Trust)
9483	Asante/Health Future Inc.
K099	AVIA PARTNERS
K715	B/C B/S OF GEORGIA
9198	BC BS OF MINNESOTA
K810	BC of Minnesota
9203	BC/BS
K815	BC/BS OF ALABAMA
9248	BC/BS OF TN
Q988	BI MART A/R ATTN ELNA
A808	BLUE CARD CUST SERV DEPT
B215	BLUE CROSS FEDERAL EMPLOY
B809	BLUE CROSS OF CALIFORNIA
9139	BLUE CROSS OF IDAHO
G794	BLUE CROSS OF MINNESOTA
0105	BLUE CROSS OF OREGON
G697	BLUE SHIELD OF CALIFORNIA
9127	BLUE SHIELD OF WA & ALASK
A646	Boise Cascade
K713	BS of Cal
B607	CAREMARK
G106	CAREMARK
G434	CAREMARK
K191	CAREMARK

Code	Name
K905	CAREMARK
U977	CAREMARK
G043	CAREMARK / JOINT LABOR MAN RET TRUST
K611	CATALYST RX/MEMB REIMBURS
9008	CHAMPVA-CENTER
G627	CIGNA PHARM SERV CENTER
B692	CIGNA Pharmacy Services Center
B779	CIGNA Pharmacy Services Center
K900	CLEAR CHOICE PREFERRED
U219	CLEAR CHOICE RX REIMBURSE
G250	DPS/Express Scripts
B353	EMPLOYEE BENE MGMT SERV
G866	EXPRESS SCRIPT ATTN CLAIM
B425	EXPRESS SCRIPTS
K928	EXPRESS SCRIPTS
U521	EXPRESS SCRIPTS
U255	EXPRESS SCRIPTS INC/TRICARE SPECIFIC
K826	FEDERAL BC/BSRX
K668	FIRST HEALTH
B298	First Health RX
9221	Great-West Life Assurance
U849	HEALTH TRANS
U205	INNOVANT
K513	KAISER - ATTN:ADMIN
9134	KAISER OF NORTHERN CALIF
A383	KIPP & COMPANY / Advance Benefit Admin.
K774	Les Schwab Employee Benefit
9681	LINECO
0110	LOOMIS BENEFITS WEST
U135	MAIL HANDLERS RX CLAIMS
K088	MED IMPACT
A087	MEDCO HEALTH SERVICES
K272	N W P S
K521	NAT'L MED HEALTH CARD
G443	NAT'L MEDICAL HEALTH CARE

Code	Name
U200	NMHC RX
U005	NORTH AMERICA INSURANCE
9500	NORTHWEST ADMINISTRATORS
G429	ODS PHARMACY NETWORK
9813	OEA CHOICE TRUST
9725	OPET / WILLIAM C EARHART
A664	PACIFIC CARE HMO
U139	PACIFIC CARE PPO
B830	PCS/HEALTH NET OREGON REP
G484	Pequot RX
G419	PHARMACARE
K685	PHARMALINK
9717	Premera BC
U144	PREMERA BLUE CROSS
G572	PRESCRIPTION SOLUTIONS
Q771	PRIME THERAPEUTICS/PAPER
B212	Principal Financial Group
K196	PROV HLTH PLN PO BOX 3125
0115	Regence Life and Health
G159	RESTAT
G495	RX AMERICA
G547	RX SOLUTIONS
K882	SAMARITAN CHOICE PLAN
U063	SAMARITAN HEALTH SERVICES
A235	Secure Horizons of Oregon
G031	SELECT BENEFIT ADMIN
K906	SELECT BENEFITS ADMIN
G462	SHASTA ADMIN SERVICES
B314	SRC INSURANCE SERVICES
G200	STAR ADMINISTRATIVE SERVS
U963	SXC
9111	TIMBER PRODUCTS MANUFACT
B209	UHC Regional Service Center
K014	UHC REGIONAL SERVICE CTR
A959	Uniform Medical Plan

Code	Name
9551	United Health Care
A312	United HealthCare/RR Medicare
A376	US BENEFITS
K859	WAL-GREENS HLTH INITIATIV
G463	Wal-Mart Health Plan
G533	WELL POINT PHARM MANAGEMT
K830	WELL POINT PHARMACY
B234	WELL POINT PHARMACY MGMT
U541	WELLPOINT PHARMACY MGMNT
K374	WELLPOINT PHARMACY MNGMT
9253	WILLIAM C EARHART CO

For information regarding managed care carrier codes, please see the EB05 and MSG01 Element Definitions Companion Guide.

Companion Guides for production transactions are available at

http://www.oregon.gov/DHS/admin/hipaa/guides_man.shtml

8.5 Appendix E: OMAC Dispute Resolution Request Form



OMAC Dispute Resolution Form



Date: _____

To: _____

Fax: _____

E-mail: _____

Provider Name*: _____

Provider Phone*: - -

Provider Fax*: - -

Provider NABP #:

Provider Contact*: _____

Drug Name, Strength, & Dosage Form*: _____

NDC#*: - -

Member ID #: _____ **Rx#:** _____

Price*: _____

Comments:

Response Date: _____

Response: _____

*Required Field (red)

Signature _____