



Ohio Department of Job & Family Services

Pharmacy Provider Manual Policy and Procedure Guide

**Administered By:
ACS State Healthcare
PBM Division**



**Northridge Center 1
365 Northridge Road
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Section 1: Introduction

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

The system allows participating pharmacies real-time access to consumer eligibility, drug coverage, pricing and payment information, and prospective drug utilization review (ProDUR) across all network pharmacies. Pharmacy providers must be enrolled through ODJFS and have an active status for any dates of service submitted. This manual is intended to provide pharmacy claims submission guidelines to the users of the ACS on-line system as well as to alert pharmacy providers to new or changed program information. Additionally, it contains instructions for claims submissions via paper media using the Universal Claim Form (UCF). **Batch media submissions are no longer accepted as of July 1, 2006.**

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

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

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

1.1 Help Desk Telephone Numbers

ACS Technical Helpdesk and Technical Prior Authorizations	1-877-518-1545 Available 24 hours a day, seven days a week
ACS Clinical Prior Authorizations	1-877-518-1546 Fax: 1-800-396-4111 Monday – Friday 7am – 7pm (ET)
ODJFS Provider Enrollment Unit	1-800-686-1516 (in state) 614-728-3288 (out of state) Monday – Friday, 8am – 4:30pm (ET)
ODJFS IVR Eligibility	1-800-686-1516 (in state) 614-728-3288 (out of state) Available 24 hours a day, seven days a week
ODJFS Remittance Advice (835)	1-800-686-1516 (in state) 614-728-3288 (out of state) Monday – Friday, 8am – 4:30pm (ET)
Ohio Medicaid Consumer Hotline	1-800-324-8680 TTY 1-800-292-3572 Monday – Friday, 7am – 8pm (ET); Saturday – Sunday, 8am – 5pm (ET)

ODJFS Web Site Addresses:

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

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

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

1.2 Mailing Addresses

Provider Paper Claims Billing Address:

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

PA Appeals (consumers only):

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

1.3 Service Support

On-line Certification:

Providers must submit claims using NCPDP v.5.1

On-line System Not Available:

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

Technical Problem Resolution:

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

1. Check the terminal and communications equipment to ensure that electrical power and telephone services are operational. Call the telephone number the modem is dialing and note the information heard (i.e. fast busy, steady busy, recorded message). Contact the software vendor if unable to access this information in the system.
2. If the pharmacy provider has an internal Technical Support Department, the provider should forward the problem to that department. The pharmacy's technical support staff will coordinate with ACS to resolve the problem.
3. If the pharmacy provider's network is experiencing technical problems, the pharmacy provider should contact the network's technical support area. The network's technical support staff will coordinate with ACS to resolve the problem.
4. If unable to resolve the problem after following the steps outlined above, the pharmacy provider should contact the **ACS Technical Call Center: 1-877-518-1545** (Nationwide Toll Free Number).

Section 2: Program Setup

2.1 Claim Format

- ACS will accept only NCPDP v.5.1. See *Appendix B* for Payer Specifications.
- The 5.1 Universal Claim Form (UCF) is required for paper submissions. See *Appendix A* for sample UCF and instructions.

2.2 Media Options

ODJFS no longer accepts Batch Claim submissions effective July 1, 2006. Mandatory POS submission is required for all providers except:

- Dispensing doctors
- LTC facilities
- Other providers with prior approval from ACS

2.3 Networks

NDC 404-728-2570	WebMD / Envoy 866-288-9761	QS1 800-845-7558	ERX 817-887-0300
Medco 800-251-7690	BioScrip 800-677-4323	Caremark 866-270-0545	

2.4 Transaction Types

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

- **Full Claims Adjudication (Transaction Code B1)**
This transaction captures and processes the claim and returns to the pharmacy the dollar amount allowed under the ODJFS reimbursement formula.
- **Claims Reversal (Transaction Code B2)**
This transaction is used by the pharmacy to cancel a claim that was previously processed. To submit a reversal, the provider must void a claim that has received a **Paid** status. To reverse a claim, the provider selects the Reversal (Void) option in the pharmacy's computer system.

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

- Service Provider ID
 - Prescription number
 - Date of service (date filled)
 - NDC
-

- **Claims Re-bill (Transaction Code B3)**
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. A complete listing of all transactions supported in NCPDP v.5.1 is on the following page.
- **Eligibility Verification (Transaction Code E1)**
This transaction is used by the pharmacy to transmit patient billing number and receive a real time response verifying eligibility.

2.5 Version 5.1 Transactions

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

NCPDP V.5.1 Transaction Code	NCPDP V.5.1 Transaction Name	Transaction Support Requirements
E1	Eligibility Verification	Supported
B1	Billing	Required
B2	Reversal	Required
B3	Re-bill	Required
P1	Prior Authorization Request and Billing	No planned requirements at this time; may be required at a future date.
P3	Prior Authorization Inquiry	No planned requirements at this time; may be required at a future date.
P2	Prior Authorization Reversal	No planned requirements at this time; may be required at a future date.
P4	Prior Authorization Request Only	No planned requirements at this time; may be required at a future date.
N1	Information Reporting	No planned requirements at this time; may be required at a future date.
N2	Information Reporting Reversal	No planned requirements at this time; may be required at a future date.
N3	Information Reporting Re-bill	No planned requirements at this time; may be required at a future date.
C1	Controlled Substance Reporting	No planned requirements at this time; may be required at a future date.
C2	Controlled Substance Reporting Reversal	No planned requirements at this time; may be required at a future date.
C3	Controlled Substance Reporting Re-bill	No planned requirements at this time; may be required at a future date.

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

2.6 Version 5.1 Segments

Data in NCPDP v.5.1 is grouped together in segments. Please review the following for program requirements.

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

NCPDP Designations:

M = Mandatory per the NCPDP Version 5.1 Claim Format Standard. The fields must be populated in order for the claim to be processed.

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

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

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

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

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

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

2.7 Required Data Elements

The ACS system has program-specific requirements for data elements for each transaction. The pharmacy provider's software vendor will need the Payer Specifications before setting up the plan in the pharmacy's computer system. This will allow the provider access to the required fields. Please note the following descriptions regarding data elements:

- M** = Mandatory per the NCPDP Version 5.1 Claim Format Standard. The fields must be populated in order for the claim to be processed.
- R** = Required above the Standard. The fields must also be populated in order to have the claim processed.
- RW** = Required When. The fields depend on other claim information or eligibility information to determine if they are required.
- NA** = Not Applicable. The fields do not have to be populated for the claim to be processed.
- NS** = Not Supported. The fields are not supported by ACS and do not have to be populated.

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

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

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

2.8 Timely Filing Limits

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

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

Claim Type	Timely Filing Limit
Original Claims (B1 transaction)	Within 365 days of the date of service. Denied claims may be re-submitted beyond 365 days if the re-submission is within 90 days of the original claim denial.
Re-bills (B3 transactions)	Within 365 days of the date of service or beyond 365 days if the re-bill is within 90 days of the original claim payment.
Reversals (B2 transactions)	Within 545 days of the date of original claim payment.

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

Section 3: Program Policies

3.1 Requirement for Tamper-Resistant Prescription Forms

Tamper-Resistant Prescription Forms

- All written prescriptions billed to Medicaid must be on tamper-resistant forms beginning April 1, 2008.
- Prescriptions transmitted to the pharmacy via telephone, fax, or e-prescribing are exempt from this requirement.
- To be considered tamper resistant on April 1, 2008, a prescription form must contain at least one required tamper-resistant characteristic. To be considered tamper-resistant beginning October 1, 2008, a prescription form must contain all three tamper-resistant characteristics.
- Tamper-Resistant Characteristics:

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

The tamper-resistant requirement applies in the following situations:

- All written prescriptions presented at the pharmacy on or after April 1, 2008, regardless of the date the prescription was written.
- All written prescriptions when ODJFS pays any part of the claim, including when ODJFS is not the primary payer.

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

- Refills of written prescriptions presented at the pharmacy before April 1, 2008.
- Prescriptions transmitted to the pharmacy via e-prescribing, fax, or telephone.
- Prescriptions for which payment will be made by an ODJFS-contracting managed care plan.
- Orders for medications administered in a provider setting and billed by the administering provider.
- Orders for medications administered in a long-term care facility (LTCF), provided the order is written in the patient's medical record and given by medical staff directly to the pharmacy. A prescription for a LTCF resident is considered tamper resistant if the patient does not have opportunity to handle the written order.

Emergency Fill of Non-Tamper-Resistant Prescription

- If a written prescription that is not tamper resistant is presented at the pharmacy on or after April 1, 2008, the pharmacy may fill the prescription on an emergency basis and obtain a compliant tamper-resistant replacement from the prescriber within 72 hours of dispensing.
- The pharmacist should use professional judgment to define an emergency situation.
- The replacement may be a compliant written prescription, a fax copy, or an electronically transmitted copy. The replacement should be filed with the original, non-tamper-resistant prescription.
- Alternatively, the pharmacy may verify the prescription by telephone. In this case, the verification must be documented on the prescription including the name of the prescriber or prescriber's office staff member verifying the prescription, date of verification, and identification of the pharmacy staff member requesting verification.

Retroactive Eligibility

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

3.2 Dispensing Limits**Days Supply:**

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

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

Dose/Duration:

- Oxycontin: limit 120 tablets (all strengths) for rolling 26-day period.
- Acetaminophen-containing products: limit 4 gram acetaminophen per day combined products
- Tablet Splitting: Lexapro[®] 10mg, hydrochlorothiazide 12.5mg, and metoclopramide 5mg require prior authorization. Prior authorization may be granted for patients who are unable to split tablets due to physical or other limitations, or for patients requiring complicated dosing regimens during dose titrations. Otherwise, use ½ tablet of higher-strength product.
- Other dose-per-day limits are online at <http://jfs.ohio.gov/ohp/bhpp/omdp/POS.stm>.

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

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

Refills:

- All refills must be dispensed in accordance with State and Federal requirements.
- Refill prescriptions must be dispensed pursuant to the orders of the physician, but not more than one year from the DATE Rx WRITTEN (NCPDP field #414-DE).
- **CII Controlled Drugs** (DEA code = “II”) **may not be refilled**, a new prescription is required for each fill.
- **CIII and CIV Controlled drugs** (DEA code = “III”, “IV”) may be refilled, pursuant to the order of the physician, up to 5 refills (plus one original) or 6 months, whichever comes first.
- **Non-controlled drugs and CV Controlled drugs** (DEA = “0”, “V”) may be refilled, pursuant to the order of the physician, up to 99 refills (plus one original) or one year, whichever comes first.

3.3 Provider Dispensing Fees

Dispensing Fee:

- Standard: \$3.70
- Flu vaccine: \$0.50
- Compound (standard): \$6.00 per prescription
- Total Parenteral Nutrition (TPN): \$15.00 per days supply, capped at \$150.00
- Infusion Compounds non-TPN: \$10.00 per days supply, capped at \$70.00

3.4 Generic Substitution Policy

All drugs included on the ODJFS Drug File are considered reimbursable, regardless of their brand or generic designation. There are no DAW requirements with the following exceptions: Depakene[®] 250mg and 250mg/5ml, Mysoline[®] 250mg, Tegretol[®] 100mg and 200mg, and Clozaril[®] 25mg and 100mg. These drugs must be noted “brand medically necessary” (BMN) on the original prescription.

3.5 Drug Coverage

DME/DMS:

- Durable Medical Equipment (DME) and Disposable Medical Supplies (DMS) are not covered through the pharmacy program. Equipment and supplies, including enteral nutrition products, should be billed as DME. Contact ODJFS Provider Network Management at 1-800-686-1516 for more information. Claims submitted to ACS will be denied.

Medicare Part B:

- Drugs that may be covered by Medicare Part B will be denied for consumers who have Medicare coverage. Cost sharing only for the drugs in the table below can be billed using Coordination of Benefits (COB) functionality outlined in Section 3.7 of this manual. There are no overrides or prior authorizations allowed for Medicare Part B-covered products even if drug is not being used for a Medicare-approved indication. The Medicare Part D Prescription Drug Plan should be contacted for coverage.

Medicare Part B Drugs

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

Medicare Part D Dual Eligibles

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

3.6 Consumer Payment Information

Co-payments:

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

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

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

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

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

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

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

3.7 Prior Authorization

Technical Call Center Prior Authorizations:

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

<i>NCPDP</i>	<i>Message</i>
M2	Not Filled By Lock-in Pharmacy
81	DOS Not Within Filing Limits
88	Early Refill Call 1-877-518-1545
75	Living Arrangement/Nursing Home Criteria Not Met
75	Bill MCO with message including the plan ID and MCO phone for the pharmacy to bill when a claim is submitted for a patient enrolled in a Medicaid Managed Care plan.

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

Clinical Call Center:

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

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

- The prescriber should initiate prior authorization requests. Ideally this should occur at the time the prescription is being written. If this does not occur, the claim will deny at POS with a message that the prescriber should contact ACS for prior authorization consideration.
- Upon a call from the prescriber, ACS will work with the prescriber to determine the outcome of the prior authorization request. Often, a change will be made to the drug. The requested drug may be authorized or denied. The consumer will be contacted if the prior authorization request is denied.
- Prior authorization may also be requested by using the Request For Prior Authorization form and faxing to 1-800-396-4111. (See *Appendix C* for PA request form)
- ACS clinical staff are available on site from 7am – 7pm (ET) Monday through Friday.

- ACS will respond to all prior authorization requests within 24 hours of initiation of the request by the prescriber.
- If the prescriber cannot be contacted within a reasonable period of time, ACS may authorize a 72-hour emergency fill if appropriate.
- Prior authorizations are entered for a reasonable time based on the nature of the drug/drug class and any follow-up activity that needs to occur.
- It is not necessary to enter a PA Number when the claim is transmitted. An active PA record in the ACS system is all that is necessary.
- Prior authorization edits will apply to all claim types and claims media.

3.8 Coordination of Benefits (COB)

- On-line COB is a part of the Medicaid cost-avoidance program.
- If ODJFS is the consumer's secondary carrier, claims for COB will be accepted.
- ODJFS is always the payer of last resort. The **exception** to this is when the consumer is covered concurrently by Medicaid and the Bureau for Children with Medical Handicaps (BCMh). In that case, Medicaid will take precedence.
- Other coverage will be identified by the presence of other carrier information on the consumer's ODJFS eligibility file and/or information communicated by the provider on the claim.
- If the consumer shows other coverage on the DOS, ACS will deny the claim. ACS will **return a unique ODJFS carrier code identifying the other carrier, the consumer's policy number and the carrier name** in the additional message field. It is possible that a consumer may have more than one active other carrier; in that case, ACS will return Other Payer codes with the exception of Medicare Part D Prescription Drug Plan (PDP) carriers. Providers will be required to submit this code in OTHER PAYER ID (NCPDP field #340-7C) as part of the claim submission process for all COB related transactions (*see the TPL Processing Grid*).
- Even if **no** "other insurance" is indicated on the ODJFS eligibility file, ACS will **process the claim as a third party liability (TPL) claim if the pharmacist submits TPL data as indicated in the TPL Processing Grid**.
- If other insurance is indicated on the ODJFS eligibility file, then ACS will **process as TPL regardless of what TPL codes the pharmacist submits as indicated on the TPL Processing Grid**.
- In all cases, ACS will use the ODJFS "**Allowed Amount**" when calculating payment. In some cases, this **may result in a zero payment**.
- In order to facilitate the TPL/COB process, ODJFS will allow providers to override days supply limits and/or Drug Requires PA conditions by entering a value of "**5**" (exemption from prescription limits) as the PRIOR AUTHORIZATION TYPE CODE (NCPDP field #461-EU).
- The ODJFS ID Card indicates if the consumer has other insurance and provides the ODJFS carrier code identifying the other payer.
- If the provider determines that the consumer no longer has other coverage as identified by the ODJFS eligibility file, the ODJFS Cost Avoidance Unit (614-752-5768) will accept calls from pharmacy providers. The ACS Call Center will transfer the provider to the Cost Avoidance Unit if requested. **NOTE:** Voicemail is available.

- The minimum allowed amount for the OTHER PAYER AMOUNT PAID (NCPDP field #431-DV) is \$2.00. If the amount in the OTHER PAYER AMOUNT PAID field is <\$2.00, the claim will deny with NCPDP EC 41/ *Submit bill to other processor or primary payer*. Additional messaging (TPL Payer Amount is less than \$2.00) will advise provider to validate amount. If an override is needed, contact ACS Technical Call Center at 1-877-518-1545.
- The following are values and claim dispositions based on pharmacist submission of the standard NCPDP TPL codes:

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

TPL PROCESSING GRID:							
	Other Coverage Code (field # 308-C8)	Other Payer Amount Paid (field # 431-DV)	Other Coverage indicated on ODJFS Eligibility Record	Other Payer Date (field # 443-E8)	Other Payer ID (field # 340-7C)	Claim Disposition	Comments
15.	1 = No other coverage identified	0	Yes	Date > Adjudication Date	Valid TPL Carrier Code	Deny, <i>M/I Other Payer Date</i>	
16.	2 = Other coverage exists, payment collected	>0	Yes or No	Valid Date	Valid TPL Carrier Code	Pay (Will pay when all Carriers have been overridden.)	Will pay the difference between the ODJFS Allowed Amount and the Other Payer Amount.
17.	2 = Other coverage exists, payment collected	>0	No	Valid Date	M/I or null	Deny, <i>M/I Other Payer Date</i>	
18.	2 = Other coverage exists, payment collected	>0	Yes	Valid Date	M/I or null	Deny, <i>Bill Primary, M/I Other Payer Date</i>	
19.	2 = Other coverage exists, payment collected	>0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, <i>M/I Other Payer Date</i>	
20.	2 = Other coverage exists, payment collected	0	No	M/I or null	M/I or null	Deny, <i>M/I Other Payer Date, M/I Other Payer Amount</i>	
21.	2 = Other coverage exists, payment collected	0	Yes	N/A	N/A	Deny, <i>Bill Primary, M/I Other Payer Date, M/I Other Payer Amount</i>	
22.	2 = Other coverage exists, payment collected	>0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, <i>Bill Primary</i>	
23.	2 = Other coverage exists, payment collected	>0	Yes	Date Adjudication Date	Valid TPL Carrier Code	Deny, <i>M/I Other Payer Date</i>	
24.	3 = Other coverage exists, this claim not covered	0	Yes or No	Valid Date	Valid TPL Carrier Code	Pay	Pay ODJFS Allowed Amount.
25.	3 = Other coverage exists, this claim not covered	0	No	Valid Date	00000	Deny, <i>M/I Other Payer Date</i>	
26.	3 = Other coverage exists, this claim not covered	0	Yes	Valid Date	M/I	Deny, <i>Bill Primary, M/I Other Payer Date</i>	
27.	3 = Other coverage exists, this claim not covered	0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, <i>M/I Other Payer Date</i>	
28.	3 = Other coverage exists, this claim not covered	>0	No	M/I or null	M/I or null	Deny, <i>Bill Primary, M/I Other Payer Date</i>	

TPL PROCESSING GRID:							
	Other Coverage Code (field # 308-C8)	Other Payer Amount Paid (field # 431-DV)	Other Coverage indicated on ODJFS Eligibility Record	Other Payer Date (field # 443-E8)	Other Payer ID (field # 340-7C)	Claim Disposition	Comments
29.	3 = Other coverage exists, this claim not covered	>0	Yes	M/I or null	M/I or null	Deny, <i>Bill Primary, M/I Other Payer Date, M/I Other Payer Amount</i>	
30.	3 = Other coverage exists, this claim not covered	>0	Yes or No	Valid Date	Valid TPL Carrier Code	Deny, <i>M/I Other Payer Amount</i>	
31.	3 = Other coverage exists, this claim not covered	>0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, <i>Bill Primary, M/I Other Payer Amount</i>	
32.	3 = Other coverage exists, this claim not covered	>0	No	Valid Date	Invalid TPL Carrier Code	Deny, <i>M/I Other Payer Amount</i>	
33.	3 = Other coverage exists, this claim not covered	>0	Yes or No	Invalid Date	Valid TPL Carrier Code	Deny, <i>M/I Other Payer Date, M/I Other Payer Amount</i>	
34.	3 = Other coverage exists, this claim not covered	0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, <i>Bill Primary Payer</i>	
35.	3 = Other coverage exists, this claim not covered	0	Yes	Date Adjudication Date	Valid TPL Carrier Code	Deny, <i>M/I Other Payer Date</i>	
36.	4 = Other coverage exists, payment not collected	>0	No	M/I or null	M/I or null	Deny, <i>M/I Other Payer Date, M/I Other Payer Amount</i>	
37.	4 = Other coverage exists, payment not collected	>0	Yes	M/I or null	M/I or null	Deny, <i>Bill Primary, M/I Other Payer Date, M/I Other Payer Amount</i>	
38.	4 = Other coverage exists, payment not collected	>0	Yes or No	Valid Date	Valid TPL Carrier Code	Deny, <i>M/I Other Payer Amount</i>	
39.	4 = Other coverage exists, payment not collected	>0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, <i>Bill Primary, M/I Other Payer Amount</i>	
40.	4 = Other coverage exists, payment not collected	>0	No	Valid Date	Invalid TPL Carrier Code	Deny, <i>M/I Other Payer Amount</i>	
41.	4 = Other coverage exists, payment not collected	>0	Yes or No	Invalid Date	Valid TPL Carrier Code	Deny, <i>M/I Other Payer Date, M/I Other Payer Amount</i>	
42.	4 = Other coverage exists, payment not collected	0	Yes	Valid Date	Valid TPL Carrier Code	Pay	Use if primary is full deductible or 100% co-pay.

TPL PROCESSING GRID:							
	Other Coverage Code (field # 308-C8)	Other Payer Amount Paid (field # 431-DV)	Other Coverage indicated on ODJFS Eligibility Record	Other Payer Date (field # 443-E8)	Other Payer ID (field # 340-7C)	Claim Disposition	Comments
43.	4 = Other coverage exists, payment not collected	0	Yes	Valid Date	M/I or null	Deny, <i>Bill Primary, M/I Other Payer Date</i>	
44.	4 = Other coverage exists, payment not collected	0	No	Valid Date	M/I or null	Deny, <i>M/I Other Payer Date</i>	
45.	4 = Other coverage exists, payment not collected	0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, <i>M/I Other Payer Date</i>	
46.	4 = Other coverage exists, payment not collected	0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, <i>Bill Primary</i>	
47.	4 = Other coverage exists, payment not collected	0	Yes	Date > Adjudication Date	Valid TPL Carrier Code	Deny, <i>M/I Other Payer Date</i>	
48.	5 = Managed care plan denial					Deny, Drug Not Covered Additional Message: <i>OCC 5/8 Not Allowed for Override</i>	Not allowed for override; returns NCPDP 70/ with message.
49.	6 = Other coverage denied – not a participating provider						Use if provider is not in network for primary payer.
50.	7 = Other coverage exists – not in effect on DOS						Use if TPL expired; edits mirror OCC = 1.
51.	8 = Claim is billing for copay					Deny, Drug Not Covered Additional Message: <i>OCC 5/8 Not Allowed for Override</i>	Not allowed for override; returns NCPDP 70/with message.

3.9 Long Term Care (LTC) Claims

Limited dispensing fee:

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

PA and ProDUR edits will apply unless specifically noted otherwise.

There is no repackaging fee.

3.10 HMO/MCO Consumers

- There may be some situations where the patient shows managed care organization (MCO) coverage on the ODJFS eligibility file, but they also have a valid Medicaid card. The pharmacist may call ACS to request assistance in processing the claim through Medicaid.

3.11 Lock-In Consumers (PACT Program)

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

3.12 Medicare-Covered Drugs

- If a Medicaid consumer has Medicare Part A or B coverage, ACS will deny claims for Medicare-covered drugs with NCPDP error code *70/ NDC Not Covered* and detailed messaging to “Bill Medicare”.
- The ACS Technical Call Center may NOT override a rejection if the consumer is identified as a Medicare beneficiary on the ODJFS eligibility file. The pharmacy provider should contact the client’s Medicare Prescription Drug Plan for assistance. If the consumer indicates that he does not have Medicare, he should be advised to call his county eligibility caseworker.
- Medicare Part B Crossover claims for dually eligible consumers should be submitted on-line after the Medicare Part B carrier has been billed.
 - Submit with OTHER COVERAGE CODE (NCPDP field #308-C8) = 2 (other coverage exists, payment collected);
 - Submit with OTHER PAYER ID (NCPDP field #340-7C) = 88888 (Medicare);
 - Submit with OTHER PAYER DATE (NCPDP field #443-E8) = the date Medicare paid the claim; and
 - Submit the amount received from Medicare in the OTHER PAYER AMOUNT PAID (NCPDP field #431-DV).

3.13 Qualified Medicare Beneficiary (QMB)

- Consumers with a QMB card are eligible only for payment of cost sharing associated with Medicare Part B-covered drugs (see section 3.4 of this document).
- Other Claims for QMB consumers will deny with NCPDP error code *70/ Drug Not Covered*.
- The ACS Technical Call Center may NOT override a rejection if the consumer is identified as a QMB on the ODJFS eligibility file. The pharmacy provider should contact the client’s Medicare Prescription Drug Plan for assistance.
- Medicare crossover claims for QMB consumers for Medicare Part B-covered drugs should be billed on-line. On-line claims should be submitted after Medicare has been billed. Use the following protocols:
 - Submit with OTHER COVERAGE CODE (NCPDP field #308-C8) = 2 (other coverage exists, payment collected);
 - Submit with OTHER PAYER ID (NCPDP field #340-7C) = 88888 (Medicare);
 - Submit with OTHER PAYER DATE (NCPDP field #443-E8) = the date Medicare paid or denied the claim; and
 - Submit the amount received from Medicare in the OTHER PAYER AMOUNT PAID (NCPDP field #431-DV).

3.14 Compounds

There are three types of compounds:

1. Standard compounds:

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

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

- Use multi-ingredient single claim functionality.
- All edits apply to each NDC except for age and gender restriction and living arrangement.
- Claim requirements:
 - COMPOUND ROUTE OF ADMINISTRATION (NCPDP field #452-EH) = “12” (other/miscellaneous); and
 - NDC is within Home IV list; then
 - Dispensing fee = \$10.00 per day with dispensing fee maximum of \$70.00.

NOTE: Days supply is normal days supply maximum (i.e., not limited to 7 days just because dispensing fee is capped at \$70.00).

3. TPN compounds:

- Use multi-ingredient single claim functionality.
- All edits apply to each NDC except for age and gender restriction and living arrangement.
- Claim requirements:
 - COMPOUND ROUTE OF ADMINISTRATION (NCPDP field #452-EH) = “12” (other/miscellaneous); and
 - NDC is within TPN list; then
 - Dispensing fee = \$15.00 per day with dispensing fee maximum of \$150.00.

NOTE: Days supply is normal days supply maximum (i.e., not limited to 10 days just because dispensing fee is capped at \$150.00).

NOTES:

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

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

Section 4: Prospective Drug Utilization Review (ProDUR)

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

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

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

4.1 Therapeutic Edits

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

4.2 Technical Call Center

The ACS Technical Call Center is available 24 hours per day, 7 days per week. The telephone number is 1-877-518-1545. Alert message information is available from the Technical Call Center after the message appears. For assistance with any alert or denial messages, it is important to contact the Technical Call Center about ACS ProDUR messages at the time of dispensing. The Technical Call Center can provide claims information on all error messages that are sent by the ProDUR system. This information includes: NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days supply.

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

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, ACS staff pharmacists are available for consultation during clinical call center business hours.

4.3 ProDUR Alert / Error Messages

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

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

Section 5: Edits

5.1 On-Line Claims Processing Messages

Following an on-line claim submission by a pharmacy, the system will return a message to indicate the outcome of processing. If the claim passes all edits, a **“Paid”** message will be returned with the ODJFS allowed amount for the paid claim. A claim that fails an edit and is rejected (denied) will also return a message.

As shown below, an NCPDP error code is returned with an NCPDP message. Where applicable, the NCPDP field that should be checked is referenced. Check the “Possible Solutions” box if you are experiencing difficulties. For further assistance contact ACS:

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

POINT OF SALE REJECT CODES AND MESSAGES			
All edits may not apply to this program			
Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
ØØ	("M/I" Means Missing/Invalid)		
Ø1	M/I Bin	1Ø1	Use 61ØØ84.
Ø2	M/I Version Number	1Ø2	Version allowed 5.1.
Ø3	M/I Transaction Code	1Ø3	Transactions allowed = B1, B2, B3 and E1.
Ø4	M/I Processor Control Number	1Ø4	Use DROHPROD = Production DROHACCP = Test
Ø5	M/I Pharmacy Number	2Ø1	Use National Provider Identifier (NPI). Must have contract with Ohio Medicaid for DOS. Check with software vendor to ensure appropriate number has been set up in your system.
Ø6	M/I Group Number	3Ø1	Use OHMEDICAID only.
Ø7	M/I Cardholder ID Number	3Ø2	Use 12 digit Ohio Medicaid Recipient ID number only; do not use any other patient ID. Do not enter any dashes. Providers should always examine a consumer's Medicaid ID card before services are rendered. It is the provider's responsibility to establish the identity of the consumer and to verify the effective date of coverage for the card presented.
Ø8	M/I Person Code	3Ø3	
Ø9	M/I Birth Date	3Ø4	Format = YYYY/MM/DD.
1C	M/I Smoker/Non-Smoker Code	334	
1E	M/I Prescriber Location Code	467	
1Ø	M/I Patient Gender Code	3Ø5	Values = 0 (not specified), 1 (male) and 2 (female).
11	M/I Patient Relationship Code	3Ø6	Allowed value = 1 (cardholder).

POINT OF SALE REJECT CODES AND MESSAGES			
All edits may not apply to this program			
Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
12	M/I Patient Location	3Ø7	Enter if needed to identify a patient's living arrangement. Required when needed to override co-payment. Acceptable Values are: 3 = Nursing Home 4 = Long Term/Extended Care 7 = Skilled Care 11 = Hospice
13	M/I Other Coverage Code	3Ø8	See <i>Coordination of Benefits</i> section.
14	M/I Eligibility Clarification Code	3Ø9	
15	M/I Date of Service	4Ø1	Format = YYYY/MM/DD. A future date is not allowed in this field.
16	M/I Prescription/Service Reference Number	4Ø2	Format = NNNNNNN.
17	M/I Fill Number	4Ø3	Enter "ØØ" for a new prescription. Acceptable values for a refill prescription range from Ø1 to 99.
19	M/I Days Supply	4Ø5	Format = NNN. Enter the days supply, "PRN" not allowed.
2C	M/I Pregnancy Indicator	335	Required when needed to override a co-payment on a claim for a pregnant consumer. 2=Pregnant
2E	M/I Primary Care Provider ID Qualifier	468	
2Ø	M/I Compound Code	4Ø6	
21	M/I Product/Service ID	4Ø7	Use 11-digit NDC only for non-compound claims. Do not enter any dashes. Use "Ø" for compound claims.
22	M/I Dispense As Written (DAW)/Product Selection Code	4Ø8	
23	M/I Ingredient Cost Submitted	4Ø9	
25	M/I Prescriber ID	411	Use Ohio Medicaid ID number or National Provider Identifier (NPI). Do not use any other number.
26	M/I Unit Of Measure	6ØØ	
28	M/I Date Prescription Written	414	
29	M/I Number Refills Authorized	415	
3A	M/I Request Type	498-PA	
3B	M/I Request Period Date-Begin	498-PB	
3C	M/I Request Period Date-End	498-PC	
3D	M/I Basis Of Request	498-PD	
3E	M/I Authorized Representative First Name	498-PE	
3F	M/I Authorized Representative Last Name	498-PF	
3G	M/I Authorized Representative Street Address	498-PG	
3H	M/I Authorized Representative City Address	498-PH	
3J	M/I Authorized Representative State/Province Address	498-PJ	
3K	M/I Authorized Representative Zip/Postal Zone	498-PK	
3M	M/I Prescriber Phone Number	498-PM	

POINT OF SALE REJECT CODES AND MESSAGES			
All edits may not apply to this program			
Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
3N	M/I Prior Authorized Number Assigned	498-PY	
3P	M/I Authorization Number	5Ø3	
3R	Prior Authorization Not Required	4Ø7	
3S	M/I Prior Authorization Supporting Documentation	498-PP	
3T	Active Prior Authorization Exists Resubmit At Expiration Of Prior Authorization		
3W	Prior Authorization In Process		
3X	Authorization Number Not Found	5Ø3	
3Y	Prior Authorization Denied		
32	M/I Level Of Service	418	Required when needed to identify emergency conditions. 3 = Emergency.
33	M/I Prescription Origin Code	419	
34	M/I Submission Clarification Code	42Ø	
35	M/I Primary Care Provider ID	421	
38	M/I Basis Of Cost	423	
39	M/I Diagnosis Code	424	
4C	M/I Coordination Of Benefits/Other Payments Count	337	
4E	M/I Primary Care Provider Last Name	57Ø	
4Ø	Pharmacy Not Contracted With Plan On Date Of Service	None	Use National Provider Identifier (NPI) number only; check DOS. Call the Provider Enrollment Department if necessary (1-800-686-1516).
41	Submit Bill To Other Processor Or Primary Payer	None	Indicates patient has other coverage. See the <i>Additional Message</i> field for details.
5C	M/I Other Payer Coverage Type	338	
5E	M/I Other Payer Reject Count	471	
5Ø	Non-Matched Pharmacy Number	2Ø1	Use National Provider Identifier (NPI). Check lock-in status.
51	Non-Matched Group ID	3Ø1	Use OHMEDICAID only.
52	Non-Matched Cardholder ID	3Ø2	Use 12-digit Ohio Medicaid ID number only; do not use any other patient ID. Do not enter any dashes.
53	Non-Matched Person Code	3Ø3	
54	Non-Matched Product/Service ID Number	4Ø7	Use 11-digit NDC for non-compound claims. Use 'Ø' if a compound.
55	Non-Matched Product Package Size	4Ø7	
56	Non-Matched Prescriber ID	411	Use Ohio Medicaid ID number or National Provider Identifier (NPI).
58	Non-Matched Primary Prescriber	421	
6C	M/I Other Payer ID Qualifier	422	Use '99'.
6E	M/I Other Payer Reject Code	472	
6Ø	Product/Service Not Covered For Patient Age	3Ø2, 3Ø4, 4Ø1, 4Ø7	

POINT OF SALE REJECT CODES AND MESSAGES			
All edits may not apply to this program			
Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
61	Product/Service Not Covered For Patient Gender	302, 305, 407	
62	Patient/Card Holder ID Name Mismatch	310, 311, 312, 313, 320	
63	Institutionalized Patient Product/Service ID Not Covered		
64	Claim Submitted Does Not Match Prior Authorization	201, 401, 404, 407, 416	
65	Patient Is Not Covered	303, 306	
66	Patient Age Exceeds Maximum Age	303, 304, 306	
67	Filled Before Coverage Effective	401	Use 12-digit Ohio Medicaid ID number only; do not use any other patient ID. Do not enter any dashes. Check DOS. Check Group Number.
68	Filled After Coverage Expired	401	Use 12-digit Ohio Medicaid ID number only; do not use any other patient ID. Do not enter any dashes. Check DOS. Check Group Number.
69	Filled After Coverage Terminated	401	
7C	M/I Other Payer ID	340	Use Ohio Medicaid Other Payer ID (ODJFS Carrier Code) only.
7E	M/I DUR/PPS Code Counter	473	
70	Product/Service Not Covered	407	Use 11-digit NDC. Drug not covered.
71	Prescriber Is Not Covered	411	
72	Primary Prescriber Is Not Covered	421	
73	Refills Are Not Covered	402, 403	
74	Other Carrier Payment Meets Or Exceeds Payable	409, 410, 442	
75	Prior Authorization Required	462	Validate 11-digit NDC. Drug requires PA. Non-PDL; try preferred agent.
76	Plan Limitations Exceeded	405, 442	Check days supply and metric decimal quantity. NDCs may have minimum and/or maximum quantity limits or quantity per days supply limits.
77	Discontinued Product/Service ID Number	407	Validate 11-digit NDC. NDC is obsolete.
78	Cost Exceeds Maximum	407, 409, 410, 442	
79	Refill Too Soon	401, 403, 405	
8C	M/I Facility ID	336	
8E	M/I DUR/PPS Level Of Effort	474	
80	Drug-Diagnosis Mismatch	407, 424	Check DOS.
81	Claim Too Old	401	Check DOS.
82	Claim Is Post-Dated	401	
83	Duplicate Paid/Captured Claim	201, 401, 402, 403, 407	
84	Claim Has Not Been Paid/Captured	201, 401, 402	
85	Claim Not Processed	None	

POINT OF SALE REJECT CODES AND MESSAGES			
All edits may not apply to this program			
Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
86	Submit Manual Reversal	None	
87	Reversal Not Processed	None	Provider number, DOS and Rx number must equal original claim.
88	DUR Reject Error		If Early Refill, 75% day's supply of previous claim has not been utilized. Looks at all network providers.
89	Rejected Claim Fees Paid		Response not in appropriate format to be displayed.
90	Host Hung Up		Processing host did not accept transaction/did not respond within time out period.
91	Host Response Error		
92	System Unavailable/Host Unavailable		
95	Time Out		
96	Scheduled Downtime		
97	Payer Unavailable		
98	Connection To Payer Is Down		
99	Host Processing Error		Do not retransmit claim(s).
AA	Patient Spend-down Not Met		
AB	Date Written Is After Date Filled		
AC	Product Not Covered Non-Participating Manufacturer		
AD	Billing Provider Not Eligible To Bill This Claim Type		
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare		
AF	Patient Enrolled Under Managed Care		
AG	Days Supply Limitation For Product/Service		
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients		
AJ	Generic Drug Required		
AK	M/I Software Vendor/Certification ID	110	
AM	M/I Segment Identification	111	
A9	M/I Transaction Count	109	
BE	M/I Professional Service Fee Submitted	477	
B2	M/I Service Provider ID Qualifier	202	
CA	M/I Patient First Name	310	
CB	M/I Patient Last Name	311	
CC	M/I Cardholder First Name	312	
CD	M/I Cardholder Last Name	313	
CE	M/I Home Plan	314	
CF	M/I Employer Name	315	
CG	M/I Employer Street Address	316	

POINT OF SALE REJECT CODES AND MESSAGES			
All edits may not apply to this program			
Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
CH	M/I Employer City Address	317	
CI	M/I Employer State/Province Address	318	
CJ	M/I Employer Zip Postal Zone	319	
CK	M/I Employer Phone Number	320	
CL	M/I Employer Contact Name	321	
CM	M/I Patient Street Address	322	
CN	M/I Patient City Address	323	
CO	M/I Patient State/Province Address	324	
CP	M/I Patient Zip/Postal Zone	325	
CQ	M/I Patient Phone Number	326	
CR	M/I Carrier ID	327	
CW	M/I Alternate ID	330	
CX	M/I Patient ID Qualifier	331	
CY	M/I Patient ID	332	
CZ	M/I Employer ID	333	
DC	M/I Dispensing Fee Submitted	412	
DN	M/I Basis Of Cost Determination	423	
DQ	M/I Usual And Customary Charge	426	
DR	M/I Prescriber Last Name	427	
DT	M/I Unit Dose Indicator	429	
DU	M/I Gross Amount Due	430	
DV	M/I Other Payer Amount Paid	431	
DX	M/I Patient Paid Amount Submitted	433	Do not submit any value > 0.
DY	M/I Date Of Injury	434	
DZ	M/I Claim/Reference ID	435	
EA	M/I Originally Prescribed Product/Service Code	445	
EB	M/I Originally Prescribed Quantity	446	
EC	M/I Compound Ingredient Component Count	447	
ED	M/I Compound Ingredient Quantity	448	
EE	M/I Compound Ingredient Drug Cost	449	
EF	M/I Compound Dosage Form Description Code	450	
EG	M/I Compound Dispensing Unit Form Indicator	451	
EH	M/I Compound Route Of Administration	452	
EJ	M/I Originally Prescribed Product/Service ID Qualifier	453	
EK	M/I Scheduled Prescription ID Number	454	

POINT OF SALE REJECT CODES AND MESSAGES			
All edits may not apply to this program			
Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
EM	M/I Prescription/Service Reference Number Qualifier	445	
EN	M/I Associated Prescription/Service Reference Number	456	
EP	M/I Associated Prescription/Service Date	457	
ER	M/I Procedure Modifier Code	459	
ET	M/I Quantity Prescribed	460	
EU	M/I Prior Authorization Type Code	461	
EV	M/I Prior Authorization Number Submitted	462	
EW	M/I Intermediary Authorization Type ID	463	
EX	M/I Intermediary Authorization ID	464	
EY	M/I Provider ID Qualifier	465	
EZ	M/I Prescriber ID Qualifier	466	
E1	M/I Product/Service ID Qualifier	436	
E3	M/I Incentive Amount Submitted	438	
E4	M/I Reason For Service Code	439	
E5	M/I Professional Service Code	440	
E6	M/I Result Of Service Code	441	
E7	M/I Quantity Dispensed	442	
E8	M/I Other Payer Date	443	Must be =< Medicaid DOS.
E9	M/I Provider ID	444	
FO	M/I Plan ID	524	
GE	M/I Percentage Sales Tax Amount Submitted	482	
HA	M/I Flat Sales Tax Amount Submitted	481	
HB	M/I Other Payer Amount Paid Count	341	
HC	M/I Other Payer Amount Paid Qualifier	342	
HD	M/I Dispensing Status	343	
HE	M/I Percentage Sales Tax Rate Submitted	483	
HF	M/I Quantity Intended To Be Dispensed	344	
HG	M/I Days Supply Intended To Be Dispensed	345	
H1	M/I Measurement Time	495	
H2	M/I Measurement Dimension	496	
H3	M/I Measurement Unit	497	
H4	M/I Measurement Value	499	
H5	M/I Primary Care Provider Location Code	469	
H6	M/I DUR Co-Agent ID	476	
H7	M/I Other Amount Claimed Submitted Count	478	

POINT OF SALE REJECT CODES AND MESSAGES			
All edits may not apply to this program			
Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
H8	M/I Other Amount Claimed Submitted Qualifier	479	
H9	M/I Other Amount Claimed Submitted	480	
JE	M/I Percentage Sales Tax Basis Submitted	484	
J9	M/I DUR Co-Agent ID Qualifier	475	
KE	M/I Coupon Type	485	
M1	Patient Not Covered In This Aid Category		
M2	Recipient Locked In		
M3	Host PA/MC Error		
M4	Prescription/Service Reference Number/Time Limit Exceeded		
M5	Requires Manual Claim		
M6	Host Eligibility Error		
M7	Host Drug File Error		
M8	Host Provider File Error		
ME	M/I Coupon Number	486	
MZ	Error Overflow		
NE	M/I Coupon Value Amount	487	
NN	Transaction Rejected At Switch Or Intermediary		
PA	PA Exhausted/Not Renewable		
PB	Invalid Transaction Count For This Transaction Code	103, 109	
PC	M/I Claim Segment	111	
PD	M/I Clinical Segment	111	
PE	M/I COB/Other Payments Segment	111	
PF	M/I Compound Segment	111	
PG	M/I Coupon Segment	111	
PH	M/I DUR/PPS Segment	111	
PJ	M/I Insurance Segment	111	
PK	M/I Patient Segment	111	
PM	M/I Pharmacy Provider Segment	111	
PN	M/I Prescriber Segment	111	
PP	M/I Pricing Segment	111	
PR	M/I Prior Authorization Segment	111	
PS	M/I Transaction Header Segment	111	
PT	M/I Workers' Compensation Segment	111	
PV	Non-Matched Associated Prescription/Service Date	457	

POINT OF SALE REJECT CODES AND MESSAGES			
All edits may not apply to this program			
Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
PW	Non-Matched Employer ID	333	
PX	Non-Matched Other Payer ID	340	
PY	Non-Matched Unit Form/Route of Administration	451, 452, 600	
PZ	Non-Matched Unit Of Measure To Product/Service ID	407, 600	
P1	Associated Prescription/Service Reference Number Not Found	456	
P2	Clinical Information Counter Out Of Sequence	493	
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions	447	
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions	337	
P5	Coupon Expired	486	
P6	Date Of Service Prior To Date Of Birth	304, 401	
P7	Diagnosis Code Count Does Not Match Number Of Repetitions	491	
P8	DUR/PPS Code Counter Out Of Sequence	473	
P9	Field Is Non-Repeatable		
RA	PA Reversal Out Of Order		
RB	Multiple Partial Not Allowed		
RC	Different Drug Entity Between Partial & Completion		
RD	Mismatched Cardholder/Group ID-Partial To Completion	301, 302	
RE	M/I Compound Product ID Qualifier	488	
RF	Improper Order Of "Dispensing Status" Code On Partial Fill Transaction		
RG	M/I Associated Prescription/Service Reference Number On Completion Transaction	456	
RH	M/I Associated Prescription/Service Date On Completion Transaction	457	
RJ	Associated Partial Fill Transaction Not On File		
RK	Partial Fill Transaction Not Supported		
RM	Completion Transaction Not Permitted With Same "Date Of Service" As Partial Transaction	401	
RN	Plan Limits Exceeded On Intended Partial Fill Values	344, 345	

POINT OF SALE REJECT CODES AND MESSAGES			
All edits may not apply to this program			
Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
RP	Out Of Sequence "P" Reversal On Partial Fill Transaction		
RS	M/I Associated Prescription/Service Date On Partial Transaction	457	
RT	M/I Associated Prescription/Service Reference Number On Partial Transaction	456	
RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment		
R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions	478, 480	
R2	Other Payer Reject Count Does Not Match Number Of Repetitions	471, 472	
R3	Procedure Modifier Code Count Does Not Match Number Of Repetitions	458, 459	
R4	Procedure Modifier Code Invalid For Product/Service ID	407, 436, 459	
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals 06	407, 436	
R6	Product/Service Not Appropriate For This Location	307, 407, 436	
R7	Repeating Segment Not Allowed In Same Transaction		
R8	Syntax Error		
R9	Value In Gross Amount Due Does Not Follow Pricing Formula	430	
SE	M/I Procedure Modifier Code Count	458	
TE	M/I Compound Product ID	489	
UE	M/I Compound Ingredient Basis Of Cost Determination	490	
VE	M/I Diagnosis Code Count	491	
WE	M/I Diagnosis Code Qualifier	492	
XE	M/I Clinical Information Counter	493	
ZE	M/I Measurement Date	494	

5.2 Host System Problems

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

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

5.3 DUR Fields

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

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

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

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

All other therapeutic categories of medications will only message.

Section 6: Provider Reimbursement

6.1 Provider Payment Algorithms

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

6.2 Provider Reimbursement Schedule

Contact ODJFS Provider Network Management (1-800-686-1516) for questions regarding payment and Remittance Advices.

APPENDIX A: Universal Claim Form

Universal Claim Form (UCF):

- The UCF will be required for all paper claims.
- The UCF should be submitted to ACS for processing.
- UCFs may be obtained from your wholesaler.
- Paper claims are allowed for:
 - Dispensing doctors
 - LTC facilities
 - Other providers with prior approval from ACS

How to Complete 5.1 UCF Form:

1. Fill in all applicable areas on the front of the form.
2. Verify patient information is correct and that patient named is eligible for benefits.
3. If this claim is for a Workers' Compensation injury, the appropriate section on the front side has been completed.
4. Patient signs certification on front side for prescription(s) received.
5. Enter Compound Rx in the Product Service ID area and list each ingredient name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
6. 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 each area using the following codes:

DEFINITION/VALUES:

1. OTHER COVERAGE CODE

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

2. PERSON CODE

Code assigned to a specific person within a family.

3. PATIENT GENDER CODE

0	Not specified
1	Male
2	Female

4. PATIENT RELATIONSHIP CODE

0	Not specified
1	Cardholder
2	Spouse
3	Child
4	Other

5. SERVICE PROVIDER ID QUALIFIER

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

6. CARRIER ID

Carrier code assigned in Workers' Compensation Program.

7. CLAIM/REFERENCE ID

Identifies the claim number assigned by Workers' Compensation Program.

8. PRESCRIPTION SERVICE REFERENCE # QUALIFIER

0	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

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

11. PRIOR AUTHORIZATION TYPE CODE

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

12. PRESCRIBER ID QUALIFIER

Use service provider ID values.

13. DUR/PROFESSIONAL SERVICE CODES

For values refer to current NCPDP data dictionary

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

14. BASIS OF COST DETERMINATION

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

15. PRODUCT SERVICE ID QUALIFIER

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

16. DIAGNOSIS CODE QUALIFER

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

17. OTHER PAYER ID QUALIFIER

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

NOTE: Compound prescriptions – limit 1 compound prescription per claim form.

Universal Claim Form Sample

I.D. _____ GROUP I.D. _____
 NAME _____ PLAN NAME _____
 PATIENT NAME: _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____
 PATIENT DATE OF BIRTH MM DD CCYY _____ PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____
 PHARMACY NAME _____
 ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____
 CITY _____ PHONE NO. () _____
 STATE & ZIP CODE _____ FAX NO. () _____

FOR OFFICE USE ONLY	

WORKERS COMP. INFORMATION
 EMPLOYER NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 CARRIER I.D. (6) _____ 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)

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

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

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

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

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

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

APPENDIX B: Payer Specification

NCPDP VERSION 5 PAYER SHEET – B1/B3 Transactions

GENERAL INFORMATION

Payer Name: Ohio Medicaid	Date: April 13, 2007
Plan Name/Group Name: Ohio Medicaid	
Effective as of: May 23, 2007	Version/Release #: 5.1
ACS Help Desk: 1-877-518-1545	
Other versions supported:	

** OTHER TRANSACTIONS SUPPORTED **

Payer: Please list each transaction supported with the segments, fields, and pertinent information on each transaction.

Transaction Code	Transaction Name
B1	Billing
B3	Rebill

BILLING TRANSACTION:

Transaction Header Segment: Mandatory in all cases

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	61ØØ84	M	
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B1 = Billing B2 = Reversals B3 = Rebill	M	
1Ø4-A4	Processor Control Number	DROHPROD = Production DROHACCP = Test	M	
1Ø9-A9	Transaction Count	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	
2Ø2-B2	Service Provider ID Qualifier	Ø1=National Provider Identifier (NPI)	M	NPI effective 05/23/2007
2Ø1-B1	Service Provider ID	NPI Number	M	NPI effective 05/23/2007
4Ø1-D1	Date of Service	CCYYMMDD	M	
11Ø-AK	Software Vendor/Certification ID		N/A	Not used, populate with all zeros

Patient Segment: Required

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø1	M	Patient segment
331-CX	Patient ID Qualifier	Blank = Not Specified Ø 1=Social Security Number Ø 2=Driver's License Number Ø 3=U.S. Military ID 99=Other	NA	Not used
332-CY	Patient ID		NA	Not used
3Ø4-C4	Date of Birth	CCYYMMDD	R	
3Ø5-C5	Patient Gender Code	Ø =Not specified 1=Male 2=Female	NA	Not used
31Ø -CA	Patient First Name		NA	Not used
311-CB	Patient Last Name		NA	Not used
322-CM	Patient Street Address		NA	Not used
323-CN	Patient City Address		NA	Not used
324-CO	Patient State/Province Address		NA	Not used
325-CP	Patient Zip/POSTAL Zone		NA	Not used
326-CQ	Patient Phone Number		NA	Not used
3Ø7-C7	Patient Location	Ø=Not specified 1=Home 2=Inter-Care 3=Nursing Home 4=Long Term/Extended Care 5=Rest Home 6=Boarding Home 7=Skilled Care Facility 8=Sub-Acute care Facility 9=Acute Care Facility 1Ø=Outpatient 11=Hospice	RW	Required when needed to override co-payment. Acceptable fields are: 3 = Nursing Home 4 = Long Term/Extended Care 7 = Skilled Care 11 = Hospice
333-CZ	Employer ID		NS	Not supported
334-1C	Smoker/Non-Smoker Code		NS	Not supported
335-2C	Pregnancy Indicator	Blank=Not Specified 2=Pregnant	RW	2=Pregnant Required when needed to override a co-payment on a claim for a pregnant member

Insurance Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø4	M	Insurance segment
3Ø2-C2	Cardholder ID	Medicaid ID = 12 digits	M	
312-CC	Cardholder First Name		NA	Not used
313-CD	Cardholder Last Name		NA	Not used
314-CE	Home Plan		NS	Not supported
524-FO	Plan ID		NA	Not used
3Ø9-C9	Eligibility Clarification Code	Ø=Not specified 1=No Override 2=Override 3=Full Time Student 4=Disabled Dependent 5=Dependent Parent 6=Significant Other	NA	Not used
336-8C	Facility ID		NS	Not supported
3Ø1-C1	Group ID	OHMEDICAID	R	

Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø7	M	Claim segment
455-EM	Prescription/Service Reference Number Qualifier	1=Rx Billing	M	
4Ø2-D2	Prescription/Service Reference Number	Number assigned by the pharmacy	M	
436-E1	Product/Service ID Qualifier	Ø3=National Drug Code	M	
4Ø7-D7	Product/Service ID	NDC Number	M	
456-EN	Associated Prescription/Service Reference #		RW	Required when submitting a partial fill
457-EP	Associated Prescription/Service Date		RW	Required when submitting a partial fill
458-SE	Procedure Modifier Count		NA	Not used
459-ER	Procedure Modifier Code Count		NA	Not used
442-E7	Quantity Dispensed	Metric Decimal Quantity	M	
4Ø3-D3	Fill Number	Ø=Original Dispensing 1-99=Number of refills	M	
4Ø5-D5	Days Supply		M	
4Ø6-D6	Compound Code	Ø=Not specified 1=Not a compound 2=Compound	M	
4Ø8-D8	Dispense as Written (DAW)		NA	Not used
414-DE	Date Prescription Written	CCYYMMDD	R	
415-DF	Number of Refills Authorized	Ø=Not specified 1-99=Number of refill	M	
419-DJ	Prescription Origin Code	Ø=Not specified 1=Written 2=Telephone 3=Electronic 4=Facsimile	NA	Not used
42Ø -DK	Submission Clarification Code	Ø=Not specified, default 1=No override 2=Other override 3=Vacation Supply 4=Lost Prescription 5=Therapy Change 6=Starter Dose 7=Medically Necessary 8=Process compound for approved Ingredients 9=Encounters 99=Other	RW	Required when needed to provide additional information for coverage purposes 8=Process compound for approved ingredients
46Ø -ET	Quantity Prescribed		RW	Required when submitting a partial fill

Field #	NCPDP Field Name	Value	M/R/RW	Comment
308-C8	Other Coverage Code	Ø=Not specified 1=No other coverage identified 2=Other coverage exists-payment collected 3=Other coverage exists-this claim not covered 4=Other coverage exists-payment not collected 5=Managed care plan denial 6=Other coverage exists, not a participating provider 7=Other coverage exists-not in effect at time of service 8=Claim is a billing for a copay	RW	Required for COB
429-DT	Unit Dose Indicator	Ø=Not specified 1=Not unit dose 2=Manufacturer unit dose 3=Pharmacy unit dose	NA	Not used
453-EJ	Original Prescribed Product/Service ID Qualifier	Ø3=National Drug Code (NDC)	NA	Not used
445-EA	Originally Prescribed Product/Service Code		NA	Not used
446-EB	Originally Prescribed Quantity		NA	Not used
330-CW	Alternate ID		NS	Not supported
454-EK	Scheduled Prescription ID Number		NS	Not supported
418-DI	Level of Service		NA	Not used
461-EU	Prior Authorization Type Code	Ø5=Exemption from RX	RW	Required for billing COB
462-EV	Prior Authorization Number Submitted		NA	Not used
463-EW	Intermediary Authorization Type ID	Replace PA/MC field	NA	Not used
464-EX	Intermediary Authorization ID	Replaced PA/MC field	NA	Not used
343-HD	Dispensing Status	P=initial fill C=Completion fill	RW	Required when submitting a partial fill or the completion of a partial fill
344-HF	Quantity Intended to be Dispensed		RW	Required when submitting a partial fill or the completion of a partial fill
345-HG	Days Supply Intended to be Dispensed		RW	Required when submitting a partial fill or the completion of a partial fill
600-28			NS	Not supported

Pharmacy Provider Segment: Not used

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø2	NA	Pharmacy provider segment
465-EY	Provider ID Qualifier	Blank=Not specified Ø1=Drug Enforcement Administration (DEA) Ø2=State License Ø3=Social Security Number (SSN) Ø4=Name Ø5=National Provider Identifier (NPI) Ø6=Health Industry Number (HIN) Ø7=State Issued 99=Other	NA	Not used
444-E9	Provider ID		NA	Not used

Prescriber Segment: Required

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø3	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	Ø1=National Identifier Ø5=Medicaid ID	R	NPI effective 05/23/2007
411-DB	Prescriber ID	NPI Number Medicaid ID (Prescriber specific)	R	NPI effective 05/23/2007
467-1E	Prescriber Location Code		NS	Not Supported
427-DR	Prescriber Last Name		NA	Not used
498-PM	Prescriber Phone Number		NA	Not used
468-2E	Primary Care Provider ID Qualifier	Blank=Not Specified Ø1=National Provider ID (NPI) Ø2=Blue Cross Ø3=Blue Shield Ø4=Medicare Ø5=Medicaid Ø6=UPIN Ø7=NCPDP Provider ID Ø8=State License Ø9=Champus 1Ø=Health Industry Number (HIN) 11=Federal Tax ID 12=Drug Enforcement Administration (DEA) 13=State Issued 14=Plan Specific 99=Other	NA	Not used
421-DL	Primary Care Provider ID		NA	Not used
469-H5	Primary care Provider Location Code		NS	Not Supported
47Ø- 4E	Primary Care Provider Last Name		NS	Not Supported

COB/Other Payments Segment: Required when there is other payer information

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø5	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count		M	Max = 3
338-5C	Other Payer Coverage Type	Ø1= Primary Ø2= Secondary Ø3= Tertiary	M Max = 3	
339-6C	Other Payer ID Qualifier	Blank=Not Specified Ø1=National Payer ID Ø2=Health Industry Number Ø3=Bank Information Number (BIN) Ø4=National Association of Insurance Commissioners (NAIC) Ø9=Coupon 99=Other	M	Required for this program 99 = Other
34Ø -7C	Other Payer ID		RW Max = 3	Use proprietary program codes for the Other Payer ID (Carrier Code)
443-E8	Other Payer Date	CCYYMMDD	RW Max = 3	Required when billing for COB
341-HB	Other Payer Amount Paid Count		RW Max = 3	Required when billing for COB
342-HC	Other Payer Amount Paid Qualifier	Blank=Not specified Ø1=Delivery Ø2=Shipping Ø3=Postage Ø4=Administrative Ø5=Incentive Ø6=Cognitive Service Ø7=Drug Benefit Ø8=Sum of all Reimbursement 98=Coupon 99=Other	RW (Repeating) Max = 3	Required when billing for COB
431-DV	Other Payer Amount Paid	S\$\$\$\$\$cc	RW Max = 3	Required when billing for COB
471-5E	Other Payer Reject Count		NA	Not used
472-6E	Other Payer Reject Code		NA	Not used

Workers' Compensation Segment: Not used

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø6	NA	Workers' Compensation Segment
434-DY	Date of Injury		NA	
315-CF	Employer Name		NS	Not Supported
316-CG	Employer Street Address		NS	Not Supported
317-CH	Employer City Address		NS	Not Supported
318-CI	Employer State/Province ID		NS	Not Supported
319-CJ	Employer Zip/Postal Zone		NS	Not Supported
32Ø-CK	Employer Phone Number		NS	Not Supported
321-CL	Employer Contact Name		NS	Not Supported
327-CR	Carrier ID		NS	Not Supported
435-DZ	Claim/Reference ID		NS	Not Supported

DUR/PPS Segment: Optional

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø8	NA	DUR/PPS Segment
473-7E	DUR/PPS Code counter		M	Required when submitting this segment
439-E4	Reason For Service Code	See Attached list of valid values	RW (Repeating) Max = 9	Required when there is a conflict to resolve or reason for service to be explained
44Ø-E5	Professional Service Code	See Attached list of valid values	RW (Repeating) Max = 9	Required when there is a professional service to be identified
441-E6	Result of Service Code	See Attached list of valid values	RW (Repeating) Max = 9	Required when there is a result of service to be submitted
474-8E	DUR/PPS Level of Effort		NA	Not used
475-J9	DUR Co-Agent ID Qualifier		NA	Not used
476-H6	DUR Co-Agent ID		NA	Not used

Pricing Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	11	M	Pricing Segment
4Ø9-D9	Ingredient Cost Submitted		M	Zero is a valid value
412-DC	Dispensing Fee Submitted		NA	Not used
477-BE	Professional Service Fee Submitted		NA	Not used
433-DX	Patient Paid Amount		NA	Not used
438-E3	Incentive Amount Submitted		NA	Not used
478-H7	Other Amount Claimed Submitted Count		NA	Not used
479-H8	Other Amount Claimed Submitted		NA	Not used
481-HA	Flat Sales Tax Amount Submitted		NA	Not used
48Ø-H9	Other Amount Claimed Submitted		R	
482-GE	Percentage Sales Tax Amount Submitted		NA	Not used
483-HE	Percentage Sales Tax Rate Submitted		NA	Not used

Field #	NCPDP Field Name	Value	M/R/RW	Comment
484-JE	Percentage Sales Tax Basis Submitted	Blank=Not specified Ø1=Gross Amount Due Ø2=Ingredient Cost Ø3=Ingredient Cost + Dispensing Fee	NA	Not used
426-DQ	Usual and Customary Charge		R	
43Ø-DU	Gross Amount Due	s9(6)v99	R	
423-DN	Basis of Cost Determination	Blank=Not specified ØØ=Not specified Ø1=AWP (Average Wholesale Price) Ø2=Local Wholesaler Ø3=Direct Ø4=EAC (Estimated Acquisition Cost) Ø5=Acquisition Ø6=MAC (Maximum Allowable Cost) Ø7=Usual & customary Ø9=Other	NA	Not used

Coupon Segment: Segment is not supported

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø9	NS	Coupon Segment
485-KE	Coupon Type		NS	
486-ME	Coupon Number		NS	
487-NE	Coupon Value Amount		NS	

Compound Segment: Required if claim is for a compound

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	1Ø	M	Compound Segment
45Ø-EF	Compound Dosage Form Description Code	Ø1=Capsule Ø2=Ointment Ø3=Cream Ø4=Suppository Ø5=Powder Ø6=Emulsion Ø7=Liquid 1Ø=Tablet 11=Solution 12=Suspension 13=Lotion 14=Shampoo 15=Elixir 16=Syrup 17=Lozenge 18=Enema	M	
451-EG	Compound Dispensing Unit Form Indicator	1=Each 2=Grams 3=Milliliters	M	

Field #	NCPDP Field Name	Value	M/R/RW	Comment
452-EH	Compound Route of Administration	1=Buccal 2=Dental 3=Inhalation 4=Injection 5=Intraperitoneal 6=Irrigation 7=Mouth/Throat 8=Mucous Membrane 9=Nasal 10=Ophthalmic 11=Oral 12=Other/Miscellaneous 13=Otic 14=Perfusion 15=Rectal 16=Sublingual 17=Topical 18=Transdermal 19=Translingual 20=Urethral 21=Vaginal 22=Enteral	M	
447-EC	Compound Ingredient Component (Count)		M (Repeating)	MAX=25
488-RE	Compound Product ID Qualifier	03=National Drug Code (NDC)	M (Repeating)	
489-TE	Compound Product ID		M (Repeating)	
448-ED	Compound Ingredient Quantity		M (Repeating)	
449-EE	Compound Ingredient Drug Cost		NA	Not used
490-UE	Compound Ingredient Basis of Cost Determination	Blank=Not specified 01=AWP 02=Local Wholesaler 03=Direct 04=EAC 05=Acquisition 06=MAC 07=Usual & customary 09=Other	NA	Not used

Prior Authorization Segment: Not Used

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	12	NA	Prior Authorization Segment
498-PA	Request Type		NA	
498-PB	Request Period Date-Begin		NA	
498-PC	Request Period Date-End		NA	
498-PD	Basis of Request		NA	
498-PE	Authorized Representative First Name		NA	
498-PF	Authorized Representative Last Name		NA	
498-PG	Authorized Representative Street Address		NA	
498-PH	Authorized Representative City Address		NA	
498-PJ	Authorized Representative State/Province Address		NA	
498-PK	Authorized Representative Zip/Postal Code		NA	
498-PY	Prior Authorization Number Assigned		NA	
503-F3	Authorization Number		NA	
498-PP	Prior Authorization Supporting Documentation		NA	

Clinical Segment: Not Used

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	13	NA	Clinical Segment
491-VE	Diagnosis Code Count		NA	
492-WE	Diagnosis Code		NA	
424-DO	Diagnosis Code		NA	
493-XE	Clinical Information Counter		NA	
494-ZE	Measurement Date		NA	
495-H1	Measurement Time		NA	
496-H2	Measurement Dimension		NA	
497-H3	Measurement Unit		NA	
499-H4	Measurement Value		NA	

Additional Claim Information

- **M = Mandatory per the NCPDP Version 5.1 Claim Format Standard. These fields must be populated in order for the claim to be processed.**
- **R = Required above the Standard. These data fields must also be populated in order to have the claim processed.**
- **RW = Required When. These fields depend on other claim information or eligibility information to determine if they are required.**
- **NA = These fields are not applicable and do not have to be populated for the claim to be processed.**
- **NS = Not Supported. These fields are not supported by ACS and do not have to be populated**
- **ACS POS Help Desk: 1-877-518-1545**

DUR Codes

Reason for Service Codes (DUR Conflict Codes)

Code	Meaning	Code	Meaning
AT	Additive Toxicity	LD	Low Dose Alert
CH	Call Help Desk	LR	Under Use Precaution
DA	Drug Allergy Alert	MC	Drug Disease Precaution
DC	Inferred Drug Disease Precaution	MN	Insufficient Duration Alert
DD	Drug-Drug Interaction	MX	Excessive Duration Alert
DF	Drug Food Interactions	OH	Alcohol Precaution

Code	Meaning	Code	Meaning
DI	Drug Incompatibility	PA	Drug Age precaution
DL	Drug Lab conflict	PG	Drug Pregnancy alert
DS	Tobacco use precaution	PR	Prior Adverse Drug reaction
ER	Over Use precaution	SE	Side Effect alert
HD	High Dose alert	SX	Drug Gender alert
IC	Iatrogenic Condition alert	TD	Therapeutic Duplication
ID	Ingredient Duplication		

Professional Service Codes (Intervention Codes)

Code	Meaning	Code	Meaning
MØ	MD Interface	RØ	Pharmacist reviewed
PØ	Patient Interaction		

Result of Service Codes (DUR Outcome Codes)

Code	Meaning	Code	Meaning
1A	Filled – False Positive	1F	Filled – Different quantity
1B	Filled as is	1G	Filled after prescriber approval
1C	Filled with different dose	2A	Not Filled
1D	Filled with different directions	2B	Not Filled – Directions Clarified

NCPDP Version 5.1 Payer Sheet – B2 Transactions

****GENERAL INFORMATION****

Payer Name: Ohio Medicaid	Date: April 25, 2007
Plan Name/Group Name: Ohio Medicaid	
Processor: ACS, Inc.	Help Desk: 1-877-518-1545
Effective as of: May 23, 2007	Version/Release #: 5.1

Transaction Code	Transaction Name
B2	Reversals

Transaction Header Segment: Mandatory in all cases

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	61ØØ84	M	
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B2	M	
1Ø4-A4	Processor Control Number	DROHPROD = Production DROHACCP = Test	M	
1Ø9-A9	Transaction Count	1 = One Occurrence	M	
2Ø2-B2	Service Provider ID Qualifier	Ø1 = National Provider Identifier (NPI) Ø5 = Medicaid Provider ID	M	NPI is required starting 05/23/2007
2Ø1-B1	Service Provider ID	NPI Number Medicaid Provider ID	M	NPI is required starting 05/23/2007
4Ø1-D1	Date of Service	CCYYMMDD	M	
M	Software Vendor/Certification ID		N/A	Not used, populate with all zeros

Insurance Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID	Medicaid ID = 12 digits	M	
3Ø1-C1	Group ID	OHMEDICAID	R	

Patient Segment: Not Supported for B2 Transactions

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø1	NS	Patient Segment

Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Ø1= RX Billing	M	
4Ø2-D2	Prescription/Service Reference Number	Number assigned by pharmacy	M	
436-E1	Product/Service ID Qualifier	Ø3= NDC	M	
4Ø7-D7	Product/Service ID	NDC Number	M	

Pharmacy Provider Segment: Not Supported for B2 Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø2	NS	Pharmacy Provider Segment

Prescriber Segment: Not Supported for B2 Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø3	NS	Prescriber Segment

COB/Other Payments Segment: Not Supported for B2 Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø5	NS	COB/Other Payments Segment

Workers' Compensation Segment: Not Supported for B2 Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø6	NS	Workers' Compensation Segment

DUR/PPS Segment: Not Supported for B2 Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø8	NS	DUR/PPS Segment

Pricing Segment: Not Supported for B2 Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	11	NS	Pricing Segment

Coupon Segment: Not Supported for B2 Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø9	NS	Coupon Segment

Compound Segment: Not Supported for B2 Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	1Ø	NS	Compound Segment

Prior Authorization Segment: Not Supported for B2 Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	12	NS	Prior Authorization Segment

Clinical Segment: Not Supported for B2 Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	13	NS	Clinical Segment

APPENDIX C: Request For Prior Authorization

Prior Authorization Form on next page.

Request For Prior Authorization Can be Made by:

- **Fax:** 1-800-396-4111
- **Phone:** 1-877-518-1546
- **Fillable Prior Authorization Form available at:**
<http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>