Pharmacy Billing Manual

Revision Table

Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
7/1/02	2.2	Removed the word "not" from the first sentence of the third bullet.
8/1/02	2.4	Clarification was added to the required field titled Prescriber ID.
8/1/02	Added Section 2.6	Added the DMAC Pricing Inquiry Worksheet form.
2/27/04	1.0 and 2.2	Changing POS DUR timely filing limit from 14 days to 100 days.
9/8/04	2.2, 2.4 and Appendix A	Pharmacies must give the DMAP credit for reusable medications returned to the dispensing pharmacy by a long term care facility. Information added on billing a client's primary insurance prior to billing the DMAP. Appendix A added to give the NCPDP Other Coverage Codes.
5/5/05	2.3.1 and 2.3.2	Added two new sections entitled 'NCPDP 5.1 Layouts – Request Reversals' and 'NCPDP 5.1 Layouts – Request Segments'.
12/13/05	1.3 and 2.2-2.7	Electronic and paper claim submission has changed for Medicare Part D. A new section has been created for Medicare Part D billing in section 2.6. The DMAC pricing inquiry worksheet has been moved to section 2.7
5/25/06	1.3	Modified the process for calculating co-payments.
9/18/06	1.3	Update to Delaware Prescription Assistance Program benefit amount based on Senate Bill # 297, 143rd General Assembly (signed into State law on July 6, 2006). Also clarifying existing policy.
9/18/06	2.2, 2.3.2, 2.4, 2.6, and 3.0	Adding clarification to existing policy.
10/25/06	2.2 and Appendix A	Added the option of providing a license number instead of a DEA number when applicable. Added language directing providers to bill Medicare Part B for covered medications or devices and clarified correct use of NCPDP coverage codes.
3/10/07	2.2, and 2.4	Added instructions for the prescriber id field of the paper pharmacy claim form to include the National Provider Identifier (NPI).
3/25/07	2.3.1 and 2.3.2	Updated the NCPDP 5.1 layouts for NPI billing.

6/22/07	2.2.7, 2.3.2, 2.4 and 2.6	Clarification for billing after primary insurance. Update to data field 110-AK and clarification for billing compounds.
8/30/07	2.4, 2.6.1	Clarification has been made to the billing instructions.

Pharmacy Billing Instructions

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1.0 Introduction

The Delaware Division of Medicaid and Medical Assistance (DMMA) establishes all policies and procedures governing the Delaware Medical Assistance Program (DMAP) that includes Medicaid, The Delaware Healthy Children Program, The Chronic Renal Disease Program (CRDP) and the Delaware Prescription Assistance Program (DPAP). The General Policy and Provider Specific Policy manuals are to be referenced for all program guidelines.

EDS is the Delaware Medical Assistance Program Fiscal Agent. Providers are to bill EDS for the care and services rendered to DMAP clients.

The Pharmacy Billing Instructions section is designed as a reference tool to be utilized by DMAP providers when submitting claims for payment. This manual should be used in conjunction with the General Policy and Provider Specific Policy sections. Participation in the POS program is mandatory for any pharmacy provider serving ambulatory clients. The POS-DUR program will have a 100-day timely filing limit, with the exception of claims submitted to a primary insurance. These claims can be submitted up to 120 days after the date of service. Claims adjudicated via the POS system will be reimbursed with a check or by Electronic Funds Transfer (EFT) on the next financial cycle. The submission of proper and complete billing documents by providers is essential for timely and accurate claims processing and payment. Providers are responsible for the accuracy of all data elements submitted on their claims including, but not limited to the metric quantity, days supply, diagnosis and correct identification of the prescriber.

Delaware is part of the CMS national drug rebate program. It is vital that claims are submitted with the NDC of the product actually dispensed. Only medications that were actually dispensed should be billed. (If a medication is not in stock, the claim should not be submitted.)

Initially, providers should carefully read this manual to become familiar with the contents. The manual should then be referenced when completing billing documents or forms. EDS will periodically update the Billing Manual on the DMAP Web site. Providers can opt to have paper updates sent through the mail. Revised pages should be promptly inserted into the manual for quick and accurate future reference.

1.1 Delaware Medical Assistance Program (DMAP) and the Delaware Healthy Children Program (DHCP)

The DMAP and the DHCP coverage is based on criteria as stated in the General Policy and the provider-specific sections of the manual. Medicaid's clinical staff will review any prescriptions over $500.00.

1.2 Chronic Renal Disease Program (CRDP)

The CRDP has some coverages that are unique to the program. Eligible clients will have their own benefits package that may include a co-payment and a maximum benefit limit.

1.3 Delaware Prescription Assistance Program (DPAP)

The DPAP has some requirements that are unique. Clients are required to pay a co-pay for each prescription. DMMA will cover a portion of drugs covered by Part D if it is part

of the deductible or coverage gap The PDP co-payment is the client's responsibility and based on the PDP transaction information
For claims that are 100% covered by DMMA the co-pay will be equal to 25% of the allowed amount for the prescription or $5.00, whichever is greater. There is no maximum on the amount of a co-pay.

The co-pay calculation on claims with a primary insurance payment takes the DMMA allowed amount and compares it to the sum of all other insurance payments. If the balance between DMMA's allowed amount and the total other insurance payment is less than DMMA's 25% of maximum allowed or $5.00, the co-pay will be reduced. The co-pay will be calculated to be the difference between DMMA's allowed amount and the sum of the other insurance payments or $0.00, whichever is greater.

The NCPDP response transaction will state the amount of co-pay required to be paid to the pharmacy prior to the medication being dispensed.

Eligible clients are limited to a $3,000 benefit each calendar year effective July 6,2006. If a client exceeds the maximum benefit the co-pay will be increased by the total amount that could not be covered by the program.

The DPAP cannot cover medications for Medicare covered clients except as noted above unless the medication is in an excluded Medicare category such as OTC products, benzodiazepines, barbiturates, cough and cold products or vitamins and minerals. There are detailed billing instructions for submitting a claim that needs a coordination of benefits in the Medicare Part D Billing Instructions section of this manual.

Medication coverage will also be based on the manufacturer's willingness to pay a rebate to the Department of Health and Social Services. Products labeled by non-participating manufacturers will not be covered.

Clients who obtain other prescription benefit coverage or no longer reside in Delaware or whose income exceeds 200% of poverty will no longer be eligible for the program. Providers are cautioned to verify eligibility before dispensing any medications.

2.0 Billing Instructions

2.1 Introduction

POS-DUR on-line adjudication has eliminated most paper claims. Pharmacy claims must be submitted using the Health Insurance Portability and Accountability Act (HIPAA) of 1996 required transactions for pharmacy services. This is the NCPDP Version 5.1 transaction and code set. The Delaware Medical Assistance Programs uses NCPDP Version 5.1 in conjunction with the approved data dictionary from September 1999 to determine the specifications and definitions for transaction creation and submission. Additionally, should it be necessary to submit a paper claim, DMAP pharmacy services must be submitted on the NCPDP national standard claim form.

The provider should keep documentation of all authorization numbers to serve as a reference for on-line adjudication. The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important.

2.2 General Procedures

2.2.1 Eligibility should be verified via the POS device regardless of the type of claim. The authorization number will serve as proof of eligibility.

2.2.2 National Provider Identifier

2.2.2.1 The prescriber ID field must include the prescribing practitioner's NPI number.

2.2.2.2 If an NPI number is being submitted and the claim still rejects, the prescriber's information will need to be provided to EDS. The practitioner's full name and either address or phone must be included with the NPI number. This information can be faxed to 302-454-0224 or can be provided to EDS pharmacy provider call center at 800-999-3371. The information on the prescription must match the information submitted on the claim. If audited and discrepancies are found, monies may be recouped.

2.2.2.3 If a prescription is written by a prescriber with an NPI that has been removed from DMMA network, the claim will be denied and should not be submitted with an alternate identifier. If audited and such claims are found, monies may be recouped.

2.2.2.4 If the pharmacy is unable to obtain the physician's NPI number a temporary identifier may be provided by EDS.

2.2.2.5 If the physician is from an emergency department in order for the prescription to be considered valid, the prescribing provider's NPI must be submitted in the prescriber ID field..

2.2.2.6 If the prescriber's NPI is not available and it is after business hours and the pharmacist considers the medication to be critical, then DMMA will honor one emergency 72 hour supply. In order to process the claim the pharmacy can submit an emergency identifier of "NPI0000001" in the prescriber ID field. If you experience difficulties processing this type of claim, call EDS pharmacy provider call center at 800-999-3371.

2.2.3 The NCPDP submission clarification code is to be used only for a change in therapy. Inappropriate use of this code may result in monies being recouped.

2.2.4 Submit POS claims within 100 days of the dates of service. Paper claims should be submitted within time limits specified in the General Policy Manual.

2.2.5 Claims for prescriptions that are not dispensed and are returned to the pharmacy stock should be credited by reversing the claims. Medications that are returned by LTC facilities that can be issued to another resident must be credited. Reversal transactions can be submitted up to 120 days after initial submission.

2.2.6 Claims billed for clients with a primary insurance that covers drugs, or a Medicare segment (for a Medicare covered drug), should be billed to the primary insurance prior to billing the DMAP. When billing DMAP the pharmacy will receive a reject error that states, “Bill other insurance or primary payer”. The pharmacy will enter one of the NCPDP Other Coverage Codes on the claim to let Medicaid know when (and if) the claim was submitted to the other insurance carrier. Appendix A lists the NCPDP Other Coverage Codes that are currently accepted by DMAP to allow for full payment Claims for clients with Medicare Part D coverage must include a Coordination of Benefit segment that includes information received from the PDP.

2.2.7 Providers must bill Medicare Part B first for any medications or devices that are covered by the federal program. The coinsurance and co-payment must be submitted to EDS on a CMS1500 claim form. Please refer to the CMS1500 Billing Manual for instructions.

2.2.8 POS Claims: Formats for claims submitted via POS will differ based on the software system in use. Certified vendors comply with NCPDP 5.1 specifications.

2.2.9 Any provider who has dramatic and long-term system problems must contact EDS Provider Relations within 13 days of discovery of the problem. Indicating “System Problem” in the remarks section of a Pharmacy claim form is not a valid exception from POS-DUR claim submission. The information must be submitted in writing identifying the problem; action plan and estimate of the duration the system will be down.

2.2.10 Mail the completed invoices to the following address:

EDS

P.O. Box 909, Manor Branch

New Castle, Delaware 19720-0909

2.3 POS Transactions (Submitting a Claim)

A standard claim is transaction code B1, compliance with the Delaware specifications.

A claim payable response will include total amount paid as well as the claim number. Claims submitted for the DPAP program will be reduced by the amount of the co-pay. Clients are expected to remit that amount prior to receiving their prescription.

A claim that is not adjudicated will contain a response status of **D** (duplicate billing), **R** (rejected) or **C** (captured). You will also receive all of the DUR conflict information and a message further defining the problem.

Claim reversal, transaction code B2, is used to cancel a prescription that has been paid within 120 days after initial submission. A reversal claim requires a version, bin number, processor control number, pharmacy provider number, date of service, transaction code B2, and prescription number. The DUR codes are optional. The EDS Help Desk cannot reverse a claim. The correct procedure for reversing a claim from both the pharmacy computer and DMAP should be well documented from the pharmacy's software vendor for the pharmacy staff to apply. The EDS Help Desk is unable to clarify problems associated with the software vendor.

2.3.1 NCPDP 5.1 Layouts – Request Reversal

If you do not receive confirmation that the reversal has been accepted, contact your software vendor or helpdesk. The EDS Pharmacy Team cannot reverse a claim.

Data elements not listed in the table below are not required by the DMAP.

Transaction Header Segment- Reversal			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
1Ø1-A1	Bin Number	Card Issuer ID or Bank ID Number used for network routing.	**Required field:** 610452
1Ø2-A2	Version/Release Number	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	**Required field:** 5.1
1Ø3-A3	Transaction Code	Code identifying the type of transaction.	**Required field:** B2 = Reversal
1Ø4-A4	Processor Control Number	Number assigned by the processor.	Part D = 'PDMAPPARTD' if routed through TrOOP Facilitator Non Part D = 'PDE610452'
1Ø9-A9	Transaction Count	Count of transactions in the transmission.	1= One Occurrence
2Ø2-B2	Service Provider ID Qualifier	Code qualifying the 'Service Provider ID' (2Ø1-B1).	**Required field:** Ø1=National Provider Identifier (NPI)
2Ø1-B1	Service Provider ID	ID assigned to a pharmacy or provider.	**Required field:** 10 digit assigned NPI
4Ø1-D1	Date of Service	Identifies date the prescription was filled or professional service rendered.	**Required field:** Format = CCYYMMDD
11Ø-AK	Software Vendor/Certification ID	ID assigned by the switch or processor to identify the software source.	Test = 154 Production = 5529
Patient Segment - Reversal			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
This segment is not required for a claim reversal.			
Insurance Segment - Reversal			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
This segment is not required for a claim reversal.			

Claim Segment - Reversal			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
111-AM	Segment Identification	Identifies the segment in the request and/or response.	**Required field**: Ø7=Claim
455-EM	Prescription/Service Reference Number Qualifier	Indicates the type of billing submitted.	**Required field:** 1=Rx Billing 2=Service Billing
4Ø2-D2	Prescription/Service Reference Number	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	**Required field:** Enter the seven digit numeric prescription number. The number must be identical to the initial claim.
436-E1	Product/Service ID Qualifier	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	**Required field:** Ø3 = National Drug Code (NDC) Ø6 = Drug Use Review/Professional Pharmacy Service (DUR/PPS)
4Ø7-D7	Product/Service ID	ID of the product dispensed or service provided.	**Required field when 436-E1 is a Ø3:** When the Prescription/Service Reference Number Qualifier is a '1',enter the 11-digit national drug code for the drug dispensed. If the Product/Service Id Qualifier is an 'Ø6' or the compound code is a 2, this field should contain a '0'.
4Ø6-D6	Compound Code	Code indicating whether or not the prescription is a compound.	**Optional field:** Ø=Not Specified 1=Not a Compound 2=Compound
414-DE	Date Prescription Written	Date prescription was written.	**Required field:** Format = CCYYMMDD

DUR/PPS Segment - Reversal			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
This segment is not required for a claim reversal.			

Pricing Segment - Reversal			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
This segment is not required for a claim reversal.			

2.3.2 NCPDP 5.1 Layouts – Request Segments

Data elements not listed in the table below are not required by the DMAP.

Transaction Header Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
1Ø1-A1	Bin Number	Card Issuer ID or Bank ID Number used for network routing.	**Required field:** 610452
1Ø2-A2	Version/Release Number	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	**Required field:** 5.1
1Ø3-A3	Transaction Code	Code identifying the type of transaction.	**Required field:** B1 = Billing B3 = Rebill N1 = Information Reporting
1Ø4-A4	Processor Control Number	Number assigned by the processor.	Part D = 'PDMAPPARTD' if routed through TrOOP Facilitator Non Part D = 'PDE610452'
1Ø9-A9	Transaction Count	Count of transactions in the transmission.	1= One Occurrence
2Ø2-B2	Service Provider ID Qualifier	Code qualifying the 'Service Provider ID' (2Ø1-B1).	**Required field:** Ø1=National Provider Identifier (NPI)
2Ø1-B1	Service Provider ID	ID assigned to a pharmacy or provider.	**Required field:** 10 digit assigned NPI
4Ø1-D1	Date of Service	Identifies date the prescription was filled or professional service rendered.	**Required field:** Format = CCYYMMDD
11Ø-AK	Software Vendor/Certification ID	ID assigned by the switch or processor to identify the software source.	Test = **check with your carrier** Production = **check with your carrier**
Patient Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
3Ø7-C7	Patient Location	Code identifying the location of the patient when receiving pharmacy services.	**Required field:** Required.
335-2C	Pregnancy Indicator	Code indicating the patient as pregnant or non-pregnant.	**Optional field:** Blank=Not Specified 1=Not pregnant 2=Pregnant
Insurance Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
111-AM	Segment Identification	Identifies the segment in the request and/or response.	**Required field:** Ø4=Insurance
3Ø2-C2	Cardholder ID	Insurance ID assigned to the cardholder.	**Required field**: Enter the 10 digit DMAP client ID number.
312-CC	Cardholder First Name	Individual first name.	**Required field:** Enter the clients first name. Alpha only.
313-CD	Cardholder Last Name	Individual last name.	**Required field:** Enter the clients last name. Alpha only.

Claim Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
111-AM	Segment Identification	Identifies the segment in the request and/or response.	**Required field**: Ø7=Claim
455-EM	Prescription/Service Reference Number Qualifier	Indicates the type of billing submitted.	**Required field:** 1=Rx Billing 2=Service Billing
4Ø2-D2	Prescription/Service Reference Number	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	**Required field:** Enter the seven digit numeric prescription number.
436-E1	Product/Service ID Qualifier	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	**Required field:** Ø3 = National Drug Code (NDC) Ø6 = Drug Use Review/Professional Pharmacy Service (DUR/PPS)
4Ø7-D7	Product/Service ID	ID of the product dispensed or service provided.	**Required field when 436-E1 is a Ø3:** When the Prescription/Service Reference Number Qualifier is a '1',enter the 11-digit national drug code for the drug dispensed. If the Product/Service Id Qualifier is an 'Ø6' or the compound code is a 2, this field should contain a '0'.
442-E7	Quantity Dispensed	Quantity dispensed expressed in metric decimal units.	**Required field:** Enter the ten digit metric decimal quantity of the drug dispensed in this field
4Ø3-D3	Fill Number	The code indicating whether the prescription is an original or a refill.	**Required field:** Ø=Original dispensing 1 to 99 = Refill number
4Ø5-D5	Days Supply	Estimated number of days the prescription will last.	**Required field:** Enter the estimated days supply of the drug dispensed.
4Ø6-D6	Compound Code	Code indicating whether or not the prescription is a compound.	**Required field:** Ø=not specified 1 = not a compound 2 = compound
4Ø8-D8	Dispense As Written (DAW)/Product Selection Code	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	**Required field:** Default to ØØ if nothing entered. Ø=No Product Selection Indicated 1=Substitution Not Allowed by Prescriber 6=Override
42Ø-DK	Submission Clarification Code	Code indicating that the pharmacist is clarifying the submission.	**Optional field:** 5=Therapy Change A code of 5 should be entered for a change in therapy with regard to the medication claims denying for therapeutic duplication. Inappropriate use of this code may result in monies being recouped

Claim Segment - Request			
3Ø8-C8	Other Coverage Code	Code indicating whether or not the patient has other insurance coverage.	**Required field:** Default to Ø1 if nothing entered. Ø1=No other coverage Ø2=Other coverage exists-payment collected Ø3=Other coverage exists- claim not covered Ø4=Other coverage exists-payment not collected Ø5=Managed care plan denial Ø6=Other coverage denied-not participating provider Ø8=Claim is billing for copay
462-EV	Prior Authorization Number Submitted	Number submitted by the provider to identify the prior authorization.	**Optional Field:** Enter the ten digit prior authorization number assigned.

Pharmacy Provider Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
Data elements not listed in this segment are not required by the DMAP.			

Prescriber Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
111-AM	Segment Identification	Identifies the segment in the request and/or response.	**Required field:** Ø3=Prescriber
466-EZ	Prescriber ID Qualifier	Code qualifying the 'Prescriber ID' (411-DB).	**Required field:** Ø1=National Provider Identifier (NPI) 12**=** DEA
411-DB	Prescriber ID	ID assigned to the prescriber.	**Required field:** 10 digit assigned NPI

COB/Other Payments Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
111-AM	Segment Identification	Identifies the segment in the request and/or response.	**Required field if there is a COB payment:** Ø5=Coordination of Benefits/Other Payments
337-4C	Coordination of Benefits/Other Payments Count	Count of other payment occurrences.	1 = 1 occurrence 2 = 2 occurrences 3 = 3 occurrences
338-5C	Other Payer Coverage Type	Code identifying the type of 'Other Payer ID' (34Ø-7C).	**Required field if there is a COB payment:** Ø1=Primary Ø2=Secondary Ø3=Tertiary
339-6C	Other Payer ID Qualifier	Code qualifying the 'Other Payer ID' (34Ø-7C).	must be '99' when Payer is Part D PDP Any valid NCPDP value if non-Part D PDP
34Ø-7C	Other Payer ID	ID assigned to the payer.	must be 'PDP9999999' when Payer is Part D PDP value of payer ID when non-Part D PDP
443-E8	Other Payer Date	Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.	**Required field if there is a COB payment:** Format=CCYYMMDD

COB/Other Payments Segment - Request			
341-HB	Other Payer Amount Paid Count	Count of the payer amount paid occurrences.	1 = one occurrence allowed
342-HC	Other Payer Amount Paid Qualifier	Code qualifying the 'Other Payer Amount Paid' (431-DV).	**Required field if there is a COB payment:** Ø8=Sum of All Reimbursement
431-DV	Other Payer Amount Paid	Amount of any payment known by the pharmacy from other sources (including coupons).	Enter the total payment amount related to the occurrence for this payer Length of eight.
471-5E	Other Payer Reject Count	Count of 'Other Payer Reject Code' (472-6E) occurrences	1 = one occurrence allowed
472-6E	Other Payer Reject Code	The error encountered by the previous "Other Payer" in 'Reject Code' (511-FB)	Must be present when Part D PDP rejected claim
Workers Compensation Segment - Request			
Data elements not listed in this segment are not required by the DMAP.			
DUR/PPS Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
111-AM	Segment Identification	Identifies the segment in the request and/or response.	**Required field if there is a DUR alert:** Ø8=DUR/PPS
473-7E	DUR/PPS Code Counter	Counter number for each DUR/PPS set/logical grouping.	1 = 1 occurrence allowed
439-E4	Reason for Service Code	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	**Required field if there is a DUR alert:** DC = Drug Disease (inferred) DD = Drug-Drug Interaction ER = Overuse HD = High Dose LD = Low Dose LR = Underuse MC = Drug-Disease (Reported) MN = Insufficient Duration MX = Excessive Duration PA = Drug-Age PG = Drug-Pregnancy TD = Therapeutic
44Ø-E5	Personal Service Code	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	**Required field if there is a DUR alert:** ØØ = No intervention MØ = Prescriber consulted PØ = Patient consulted RØ = Pharmacist consulted other source

COB/Other Payments Segment - Request			
441-E6	Result of Service Code	Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	**Required field if there is a DUR alert:** 1A = Filled As is, False Positive 1B = Filled Prescription As is 1C = Filled, With Different Dose 1D = Filled, With Different Directions 1E = Filled, With Different Drug 1F = Filled, With different quantity 1G = Filled, With Prescriber Approval 2A = Prescription Not Filled 2B = Not Filled, Directions Clarified

Pricing Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
111-AM	Segment Identification	Identifies the segment in the request and/or response.	**Required field:** 11=Pricing
426-DQ	Usual and Customary Charge	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.	**Required field when the Prescription/Service Reference Number Qualifier is a '1' in the claim segment:** Format = $$$$$$cc.
43Ø-DU	Gross Amount Due	Total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (4Ø9-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted'(481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (48Ø-H9). For service claim request, field represents a sum of 'Professional Services Fee Submitted' (477-BE), 'Flat Sales Tax Amount Submitted'(481-HA), 'Percentage Sales Tax Amount Submitted'(482-GE), 'Other Amount Claimed' (48Ø-H9).	**Required field:** Format = $$$$$$cc.

Coupon Segment - Request
Data elements not listed in this segment are not required by the DMAP.

Compound Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
111-AM	Segment Identification	Identifies the segment in the request and/or response.	**Required field when the claim is a compound:** 1Ø=Compound
45Ø-EF	Compound Dosage Form Description Code	Dosage form of the complete compound mixture.	**Optional field:**
451-EG	Compound Dispensing Unit Form Indicator	NCPDP standard product billing codes.	**Required field when the claim is a compound:** Enter the appropriate indicator which represents the total compound metric decimal quantity.
452-EH	Compound Route of Administration	Code for the route of administration of the complete compound mixture.	**Optional field:**
447-EC	Compound Ingredient Compound Count	Count of compound product IDs (both active and inactive) in the compound mixture submitted.	**Required field when the claim is a compound:** A count of 1 to 10 allowed for interactive submission. A count of 1 to 25 allowed for batch submission.
488-RE	Compound Product ID Qualifier	Code qualifying the type of product dispensed.	**Required field when the claim is a compound:** Ø3 = National Drug Code One to ten occurrences allowed.
489-TE	Compound Product ID	Product identification of an ingredient used in a compound.	**Required field when the claim is a compound:** Enter the 11 digit NDC number. One to ten occurrences allowed.

Compound Segment - Request			
448-ED	Compound Ingredient Quantity	Amount expressed in metric decimal units of the product included in the compound mixture.	**Required field when the claim is a compound:** Enter the metric decimal quantity of the drug dispensed. Field length of 10 One to ten occurrences allowed.
449-EE	Compound Ingredient Drug Cost	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	**Required field when the claim is a compound:** Enter the ingredient cost. One to ten occurrences allowed.
Prior Authorization Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
Data elements not listed in this segment are not required by the DMAP.			
Clinical Segment - Request			
Field	**Field Name**	**Definition of Field**	**Delaware Requirements**
111-AM	Segment Identification	Identifies the segment in the request and/or response.	**Required field when the segment is used:** 13=Clinical
491-VE	Diagnosis Code Count	Count of diagnosis occurrences.	1 occurrence allowed
424-DO	Diagnosis Code	Code identifying the diagnosis of the patient.	**Required field when the segment is used:** If a prescriber has provided an ICD-9 code on a prescription, that code must be entered while entering the prescription information. The ICD-9 code is essential to the prior authorization process. Without an appropriate ICD-*9* diagnosis code, claims for medications requiring prior authorization will not pay. Co-payment exemption **V22**—client is pregnant, can be by declaration. **V771—**for use on claim for glucose monitor only. **V24**—post partum for 90 days after delivery. **V60**--when DMMA coverage policy requires two strengths of one medication be used instead of multiple smaller doses.

2.4 Completion of the Pharmacy Claim Form - Non-POS

This section provides specific instructions for completing the NCPDP Pharmacy claim form for the DMAP. A sample of the Pharmacy claim form is included for your reference.

Include only what is required in the following instructions (e.g., no stickers, no stamps, no unnecessary handwritten comments).

Field Name	Instructions for Completion
Header Information	
ID	Required Field. Enter the client's 10-digit Medicaid client id number.
Group ID	Not required
Name	Not required

Field Name	Instructions for Completion
Plan Name	Not required
Patient Name	Required field. Enter the client's last name, first name, and middle initial
Other Coverage Code	Required field. Enter the value from the back of the claim form or Appendix A. Code **0** – Not specified should be used when no specific primary insurance information is available.
Person Code	Not required
Patient Date of Birth	Not required
Patient Gender Code	Not required
Patient Relationship Code	Not required
Pharmacy Name	Required field. Enter the name of the pharmacy providing the service
Address	Required field. Enter the pharmacy address including the city, state, and ZIP code
Service Provider ID	Required field. Enter the 10-digit NPI
Qual	Required field. Valid code is **01** – Medicaid
Phone No.	Enter the provider's phone number
FAX number	Enter the provider's FAX number
Workers Comp Information	Not required
Certification Statement	Not required
Claim #1	
Prescription/serv. Ref#	Required field. Enter the 7-digit prescription number assigned to this prescription
Qual	Required field. Valid code is **1** – RX billing
Date Written	Not required
Date of Service	Required field. Enter the month, day, and year of the date of service in MMDDCCYY format.
Fill#	Required field
QTY Dispensed	Required field. Enter the metric quantity dispensed including the decimal. Do not indicate ounces, pounds, or number of packages. Indicate the metric quantity in numbers only. Do not use letters such as cc, ml, caps, tab, etc. Do not round, e.g., if dispensing 25 (2.5 mil) vials = 60. Lyphized powder is per vial. Questions related to quantity definitions can be verified via the Web/VRS or by contacting EDS Provider Relations.
Days Supply	Required field. Enter the number of days the dispensed quantity will last the client when consumed at the prescribed rate.

Field Name	Instructions for Completion
	The Days Supply must be entered as a numeric value greater than **0**.
Product/Service ID	Required field. Enter the 11-digit NDC for the product that was dispensed. Use modified NDC numbers for over-the-counter items
Qual	Required field. Use code **03** – National Drug Code (NDC)
DAW Code	Required field. Enter code **1** – Substitution not allowed by subscriber
Prior Auth# Submitted	Optional field. Enter the prior authorization number
PA Type	Optional field. If a prior authorization number is enter, use code **1** – Prior authorization
Prescriber ID	Required field. Enter the prescribing practitioner's NPI number. Please refer to section 2.2.2 for additional information.
Qual	Required field – Valid Prescriber ID qualifiers are **01 NPI and 12 DEA**
DUR/PPS Codes	Optional field – refer to Section 5.0 of the Pharmacy Provider Specific Manual
Basis Cost	Not applicable
Provider ID	Not applicable
Qual	Not applicable
Diagnosis Code	Optional field – If a prescriber has provided an ICD-9 code on a prescription, that code must be entered while entering the prescription information. The ICD-9 code is essential to the prior authorization process. Without an appropriate ICD-9 diagnosis code, claims for medications requiring prior authorization will not pay. Co-payment exemption **V22**—client is pregnant, can be by declaration. **V771—**for use on claim for glucose monitor only. **V24**—post partum for 90 days after delivery. **V60**--when DMMA coverage policy requires two strengths of one medication be used instead of multiple smaller doses.
Qual	Optional field unless a diagnosis code is entered. Valid code is **01** – International

Field Name	Instructions for Completion
	Classification of Diseases (ICD9)
Other Payer Date	Optional field. Enter the date the other insurance processed the claim using a MMDDCCYY format.
Other Payer ID	Must be 'PDP9999999' when Payer is Part D PDP Any valid NCPDP value if non-Part D PDP
Qual	Must be '99' when Payer is Part D PDP Any valid NCPDP value if non-Part D Payer
Other Payer Reject Codes	Value must be present if Part D PDP denied claim
Usual & Customary Charge	Required field. Refer to Section 4.0 of the Pharmacy Provider Specific Manual
Fee	Enter the amount in the following fields: Gross Amount Due, Other Payer Amount Paid, and Net Amount Due
Compound Prescription	If you are billing a compound, print the words COMPOUND RX in the product service id field. The compound information is located on the back of the claim form. The claim definitions are the same as Claim #1 section.
Name	Required field. Enter the name of the drug for each ingredient
NDC	Required field. Enter the 11-digit NDC for each ingredient
Quantity	Required field. Enter the metric quantity for each ingredient including the decimal
Cost	Required field. List the cost of the product. Refer to Section 4.0 of the Pharmacy Provider Specific section of the manual
Claim #2	Same as Claim #1

2.5 Pharmacy Claim Form

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 ____

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 ____

CITY ____ **STATE** ____ **ZIP CODE** ____

CARRIER I.D. (6) ____ **EMPLOYER PHONE NO.** ____

DATE OF INJURY ____ **MM** ____ **DD** ____ **CCYY** **CLAIM (7) REFERENCE I.D.** ____

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

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

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

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

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

1

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

2

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

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

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

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

2

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

IMPORTANT I certify that the patient information entered on the front side of this form is correct, that the patient named is eligible for the benefits and that I have received the medication described. If this claim is for a workers compensation injury, the appropriate section on the front side has been completed. I hereby assign the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsor, policyholder and the employer.

PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

1. Fill in all applicable areas on the front of this form.
2. Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient, name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
3. Worker's Comp. Information is conditional. It should be completed only for a Workers Comp. Claim.
4. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
5. Limit 1 set of DUR/PPS codes per claim.

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE

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

2. PERSON CODE: Code assigned to a specific person within a family.

3. PATIENT GENDER CODE

0=Not Specified
1=Male
2=Female

4. PATIENT RELATIONSHIP CODE

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

5. SERVICE PROVIDER ID QUALIFIER

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

6. CARRIER ID: Carrier code assigned in Worker's Compensation Program.

7. CLAIM/REFERENCE ID: Identifies the claim number assigned by Worker's Compensation Program.

8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER

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

9. QUANTITY DISPENSED: Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

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

Blank=Not Specified
00=Not Specified
01=Universal Product Code (UPC)
02=Health Related Item (HRI)
03=National Drug Code (NDC)
04=Universal Product Number (UPN)
05=Department of Defense (DOD)
06=Drug Use Review/Professional Pharm. Service (DUR/PPS)
07=Common Procedure Terminology (CPT4)
08=Common Procedure Terminology (CPT5)
09=HCFA 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: Reason for Service, Professional Service Code, and Result of Service. For values refer to current NCPDP data dictionary.

A=Reason for Service
B=Professional Service Code
C=Result of Service

14. BASIS OF COST DETERMINATION

Blank=Not Specified
00=Not Specified
01=AWP (Average Wholesale Price)
02=Local Wholesaler
03=Direct
04=EAC (Estimated Acquisition Cost)
05=Acquisition
06=MAC (Maximum Allowable Cost)
07=Usual & Customary
09=Other

15. PROVIDER ID QUALIFIER

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

16. DIAGNOSIS CODE QUALIFIER

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

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM.

Name	NDC	Quantity	Cost

2.6 Medicare Part D Billing Instructions

2.6.1 This section provides instructions for submitting claims related to Medicare Part D.

- **If a client has Part D, the Part D PDP must always be billed first.**
- If the Part D PDP approves the claim, a COB segment must be completed with a '99' Payer ID qualifier, a 'PDP9999999' Other Payer ID, and an other payer amount paid must be present, even if the paid amount is $0.00.
- If the Part D PDP denies the claim, a COB segment must be completed with a '99' Payer ID qualifier, a 'PDP9999999' Payer ID, and an other payer reject code must be present. Pharmacies should not use the NCPDP other coverage codes listed in Appendix A to mask that the claim was rejected by the PDP.
- If the claim is routed through the TrOOP Facilitator, the PCN value must be '**PDMAPPARTD** '.
- For paper claims, if a client has Part D, the Part D qualifier must be completed in field 'QUAL (17)' and the Part D payer ID must be completed in field 'other payer ID'. Either the Part D reject code must be completed in field 'other payer reject codes' or the 'other payer amount paid' field must contain the Part D approved amount, which can be $0.00 if the PDP approved the claim at $0.00.
- For paper claims, if a reject code is present, it will be associated with the payer ID and qualifier from the claim.
- For paper claims, if both a reject code and an 'other payer amount paid' is present on the claim, only the reject code will be associated with the payer ID and qualifier from the claim. The paid amount will not be associated to the payer ID and qualifier.
- For paper claims, if the client has both Part D and TPL:
  - If the Part D PDP paid/approved the claim and the TPL carrier denied the claim, complete the form with the PDP information and include the TPL denial.
  - If the Part D PDP denied the claim and the TPL carrier denied the claim, complete the form with the PDP information and include the TPL denial.

- If the Part D PDP denied the claim and the TPL carrier paid the claim, complete the form with the PDP information and place only the TPL payment in the 'other payer amount paid' field on the claim. Include the TPL payment voucher.
- If the Part D PDP paid the claim and the TPL carrier paid the claim, complete the form with the PDP information. Only indicate the PDP payment in the 'other payer amount paid' field on the claim. Include the TPL payment voucher indicating the TPL payment.

2.6.2 The pharmacy is required to bill all active insurances before submitting a claim to CRDP.

- Primary coverage + Medicare Part D both pay on claim
  - If both the primary coverage and Medicare Part D coverage pay on the claim:

    The pharmacy will need to bill the claim showing two Coordination of Benefit (COB) segments with paid amounts. The NCPDP other coverage code will need to be "02", other coverage exists payment collected.
- Primary coverage pays and Medicare Part D rejects claim
  - The pharmacy will need to submit claim with two COB segments. The first COB segment will need to show primary payer with paid amount on claim. The second COB segment will need to show Medicare Part D information with reject code. The NCPDP code will need to be "02", other coverage exists payment collected.
- Primary coverage rejects claim and Medicare Part D pays on claim.
  - The pharmacy will need to submit the COB segment for Medicare Part D with a paid amount and the NCPDP other coverage code "03", other coverage exists payment not collected, showing the primary coverage rejected the claim.

2.6.3 If a client is eligible for a Medicare Part D PDP and has not yet enrolled and has just become eligible for DMMA services, **WELLPOINT (transitional enrollment)** must be billed. 1-800-622-0210

2.7 DMAC Pricing Inquiry Worksheet

Instructions

The DMAC Pricing Inquiry Worksheet provides the opportunity for a pharmacy to indicate any difficulty that has been experienced in obtaining a specific drug at the price listed on the Delaware Maximum Allowable Cost list (DMAC) provided by the Delaware Medical Assistance Program. To ensure a timely response to comments for each drug that the pharmacy is not able to purchase at the State's MAC, the pharmacy must complete the attached form and include the following:

- NDC Code for the lowest priced product available
- Drug label name
- Generic name and strength
- Lowest price for which the pharmacy can obtain the drug
- Source of the product
- NDC(s) for other products that were researched
- Purchase invoice to document pricing

The form must be **faxed to EDS Pharmacy Services at (302) 454-0224**. Failure to include all of the required information will result in the inability to respond to pricing issues. Each inquiry will be researched and reviewed, and upon completion, a written response will be provided within 10 business days.

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2.7.1 DMAC Pricing Inquiry Worksheet

NDC	Label Name	Generic Name	Strength	Source	Lowest Price	Date of Price Search
- -						
- -						
- -						
- -						

Submitted by: ______________________________

Pharmacy ________________________________

Contact information:

Phone ______________________________

Fax: _______________________________

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3.0 Appendix A – NCPDP Other Coverage Codes

Code	Description
01	No other coverage
02	Other coverage exists – payment collected
03	Other coverage exists – claim not covered
04	Other coverage exists – payment not collected
05	Managed care plan denial
06	Other coverage denied – not participating provider
07	Other coverage exists – not in effect on DOS
08	Claim is billing for a copay

The exception codes should only be used for commercial plans that do not have an open network or where Medicare B has rejected the claim. Providers must bill Medicare B first for any medications or devices that are covered by the federal program. Providers may not use the NCPDP coverage codes if they do not have the ability or choose not to bill the primary carrier to use DMMA as a primary coverage.

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