SECTION 3 PHARMACY CLAIM FILING INSTRUCTIONS

All pharmacy claims must be submitted electronically either through a clearinghouse, billing agent or the MO HealthNet Web site at emomed.com for billing and to maintain the business relationship with the MO HealthNet Division (MHD).

MANAGED CARE HEALTH PLAN PHARMACY "CARVE OUT"

Effective October 1, 2009, the MO HealthNet managed care health plans no longer provide pharmacy services for their members. Pharmacy claims for all MO HealthNet Managed Care members are processed by the MO HealthNet Fee-for-Service Pharmacy Program. Existing Fee-for-Service Pharmacy Program clinical editing parameters and Preferred Drug List criteria apply for coverage of pharmacy claims, and can be found at the following link.

http://dss.mo.gov/mhd/cs/pharmacy/pages/clinedit.htm

The carve out of pharmacy services in relation to physicians and private medical clinics (including FQHCs and provider based RHCs) includes all injections and birth control devices administered in the physician's office or a private clinic setting. Note – injection administrations, including VFC vaccine administrations, must still be billed to the participant's managed care health plan and not MO HealthNet.

MEDICATION BILLING

The quantity to be billed for pharmacy items (e.g. birth control devices and systems) and injectable medications dispensed to MHD patients must be calculated as follows:

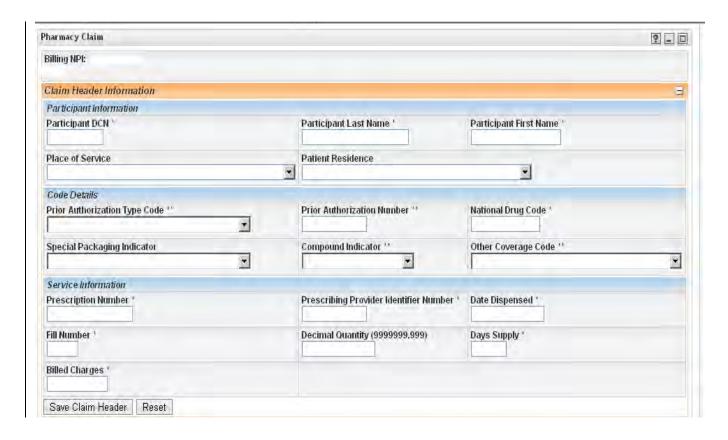
- Containers of medication in solution (for example, ampules, bags, bottles, vials, syringes) must be billed by the exact cubic centimeters or milliliters (cc or ml), even if the quantity includes a decimal (i.e., if three (3) 0.5 ml vials are dispensed, the correct quantity to bill would be 1.5 mls).
- Single dose syringes and single dose vials must be billed per cubic centimeters or milliliters (cc or ml), rather than per syringe or per vial.
- Powder filled vials and syringes that require reconstitution must be billed by the number of vials.
- The product Herceptin, by Genentech, must be billed by milligram (mg) rather than by vial.
- Immunizations and vaccines must be billed by the cubic centimeters or milliliters (cc or ml) dispensed, rather than per dose.

Claims billed incorrectly are identified through a dispute resolution process. When these claims are identified, providers are notified and required to file adjustments to accurately reflect the quantity dispensed.

Reimbursement for pharmacy items and injectable medications is made on the basis of the lower of the following:

- 1. Applicable Federal Upper Limit;
- 2. Applicable Missouri Maximum Allowable Cost (MAC);
- 3. Applicable Wholesaler Acquisition Cost (WAC), plus 10%; or,
- 4. Usual and customary charge.

For specific questions concerning pharmacy items and injectable medication billing, contact the Pharmacy and Clinical Services Administration Unit at (573) 751-6963.



Electronic Pharmacy Claim Form Filing Instructions

NOTE: * These fields are required on all Pharmacy claim submissions.

**These fields are required only in specific situations, as described below. NPIs with alpha characters are case sensitive.

Participant's DCN* Enter the participant's eight digit MO HealthNet

identification number (DCN).

Participant's Last Name* Enter the participant's last name.

Participant's First Name* Enter the participant's first name.

Place of Service Required only for pharmacy providers.

Patient Residence Required only for pharmacy providers.

Prior Authorization Type**

Code.

The valid values are:

0 Not Specified

1 Prior Authorization2 Medical Certification

3 EPSDT

4 Exemption from Co-pay

5 Exemption from Prescription

6 Family Plan

7 AFDC

8 Payer Defined Exemption

Prior Authorization Number Enter the Prior Authorization number, if applicable.

Otherwise, leave blank.

National Drug Code Enter the precise National Drug Code (NDC) assigned to

the product dispensed or administered as it appears on the package. If the drug code on the package is not in 5-4-2 format, enter zeroes in front of the numbers listed for each field. For example: NDC 45-143-20 is listed as

00045-0143-20.

Special Packaging Indicator Indicate the type of unit dose dispensing. The valid

values are:

0 Not Specified

1 Not Unit Dose

2 Manufacturer Unit Dose

3 Pharmacy Unit Dose

FIELD

INSTRUCTIONS FOR COMPLETION

Compound Indicator**

billing for a compound drug, the first ingredient of a compound must be billed with a compound indicator of 0-First Ingredient. All other ingredients must be billed with a compound indicator of 1-Additional Ingredient... Otherwise, leave blank.

Other Coverage Code**

Indicate whether the patient has a secondary health insurance plan. If so, choose the appropriate value. The valid values are:

- 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

Other Coverage Amount**

Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and co-pay amounts are **not** to be entered in this field. This field is required if the Other Coverage Code field has a value.

Patient Responsibility Amount** Enter the total amount the other payer identified as patient's responsibility.

Prescription Number*

Enter the number assigned by the physician's office or the clinic. Enter a sequential identification number in this field. If the billing provider chooses to use a patient account number, an additional unique identifying character must be added to identify different injection administered on the same date of service. NOTE – This number is used to sort claims submitted electronically on the pharmacy remittance pages.

Prescribing Provider Identifier Number*

Enter the prescribing provider's NPI

Date Dispensed*

Enter the date the drug was dispensed or administered.

Fill Number*

The code indicating whether the prescription is an original or a refill. Enter a two-digit value. 00 = Original dispensing, 01-99 = Refill number

Decimal Quantity* Enter the decimal quantity dispensed or used in

Administration. Note: Use the guidelines outlined on page 3.1 of this billing booklet, titled Medication Billing.

Day's supply* Enter the estimated duration of the prescription

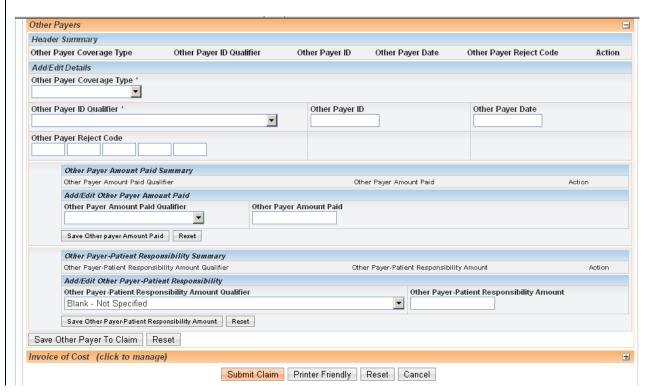
supply in days. If billing for an administration in a physician's office/clinic, the value must always be 1.

Billed Charges* Enter the charge for this medication.

Save Claim Header (button) Click Save Claim Header to save the Pharmacy Claim

Header information.

Pharmacy Other Payer Attachment



FIELD <u>INSTRUCTIONS FOR COMPLETION</u>

Other Payer Coverage Type* Determines the order in which the claim was paid by other payers

Other Paver ID Qualifier* Choose from the options that best describes the Other

> Payer, options are: 01 National Payer ID 1C Medicare Number 1D Medicare Number

02 Health Industry Number (HIN) 03 Bank Information Number (BIN)

04 National Association of Insurance Commissioners

(NAIC)

05 Medicare Carrier Number

99 Other

Other Payer ID Determines the ID of prior payers, not a required field

Other Payer Date The date prior payer processed the claim, not a required

field

Other Payer Reject code Indicate the reason the prior payer did not pay the claim.

> Up to 5 reject codes can be entered. This field will be required if the Other Coverage Code is populated with 3 Other Coverage Exists- This Claim Not Covered. A list of NCPDP reject codes can be located on pages 3.8 and

3.9 of this training booklet.

Other Payer Amount Paid Qualifier Indicates the type of payment made by a prior

payer. This is a required field if other payer amount paid

is populated for the corresponding occurrence. The

options are: 01 Delivery

02 Shipping

03 Postage

04 Administrative

05 Incentive

06 Cognitive Service

07 Drug Benefit

09 Compound Preparation Cost

Note: Only the Other Payer Amount Paid Qualifier value of 07- Drug Benefit will be used to determine

the Third Party Liability amount that will be

considered for payment.

Other Payer Amount Paid Indicated the amount paid by a prior payer. This is a

required field if the Other Coverage Code is populated

with 2 or 4.

Save Other Payer Amount Paid (button)

Click to Save Other Payer Amount Paid

Patient Responsibility **Amount Qualifier**

The type of patient responsibility amount returned by prior payer. This is required if Other Payer Patient Responsibility Amount is populated. The options are:

01 Amount Applied to Periodic Deductible

02 Amount Attributed to Product Selection/Brand Drug

03 Amount Attributed to Sales Tax

04 Amount Exceeding Periodic Benefit Maximum

05 Amount of Copay 06 Patient Pay Amount

07 Amount of Coinsurance

08 Amount Attributed to Product Selections/Non-Preferred Formulary Selection

09 Amount Attributed to Health Plan Assistance Amount

10 Amount Attributed to Provider Network Selection

11 Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection

12 Amount Attributed to Coverage Gap

13 Amount Attributed to Processor Fee

Note: Only the Patient Responsibility Amount Qualifier value of 06- Patient Pay Amount will be considered for payment.

Patient Responsibilit Amount**

Indicates the patient responsibility amount returned by prior payer. This will be required when there is a 2 or 4 in the Other Coverage Code field.

Save Other Payer-Patient Responsibility Amount (button)

Click to Save Other Payer-Patient Responsibility Amount

Save Other Payer To

Claim (button) Click to Save Other Payer to claim

Reset/Cancel (button) Click on reset or cancel to remove any data entered and

revert to the previous values or blank form.

Submit Claim (button) Click Submit Claim to submit the claim.

Printer Friendly (button) Click Printer Friendly to open the claim in a printer

friendly PDF format.

Reset (button) Click Reset to discard all claim information entered.

Cancel (button) Click Cancel to discard all claim information entered and

return to Claim Management.

NCPDP Valid Other Payer Reject Codes

Reject Code	Code Description
40	Pharmacy Not Contracted With Plan On Date Of Service
60	Product/Service Not Covered For Patient Age
61	Product/Service Not Covered For Patient Gender
65	Patient is not covered
66	Patient Age Exceeds Maximum Age
67	Filled Before Coverage Effective
68	Filled After Coverage Expired
69	Filled After Coverage Terminated
70	Product/Service Not Covered – Plan/Benefit Exclusion
71	Prescriber Is Not Covered
72	Primary Prescriber Is Not Covered
73	Refills Are Not Covered
74	Other Carrier Payment Meets Or Exceeds Payable
76	Plan Limitations Exceeded
78	Cost Exceeds Maximum
80	Drug-Diagnosis Mismatch
81	Claim Too Old
88	DUR Reject Error
569	Provide Beneficiary with CMs Notice of Appeal Rights
3Y	Prior Authorization Denied
4Y	Patient Residence not supported by plan
4Z	Place of Service Not Support By Plan
6Z	Provider Not Eligible To Perform Service/Dispense Product
7W	Refills Exceed allowable Refills
7X	Days Supply Exceeds Plan Limitation
7Y	Compounds Not Covered,
9G	Quantity Dispensed Exceeds Maximum Allowed,
9K	Compound Ingredient Component Count Exceeds Number Of ingredients Supported
9N	Compound Ingredient Quantity Exceeds Maximum Allowed
9Q	Route Of Administration Submitted Not Covered
A5	Not Covered Under Part D Law
AC	Product Not Covered Non-Participating Manufacturer

Reject Code	Code Description
AD	Billing Provider Not Eligible To Bill This Claim Type
AG	Days Supply Limitation For Product/Service
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients
AJ	Generic Drug Required
E7	M/I Quantity Dispensed
G6	Pharmacy Not Contracted in Specialty Network
G7	Pharmacy Not Contracted in Home Infusion Network
G8	Pharmacy Not Contracted in Long Term Care Network
M1	Patient Not Covered In This Aid Category
M2	Recipient Locked In
M4	Prescription/Service Reference Number/Time Limit Exceeded
MR	Drug Not on Formulary
N1	No patient match found.
PA	PA Exhausted/Not Renewable
RN	Plan Limits Exceeded On Intended Partial Fill Field Limitations