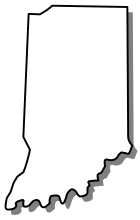
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

B T 2 0 0 3 1 7 M A R C H 1 4 , 2 0 0 3

To: All Pharmacy Providers

Subject: Pharmacy Processor Change Reminders

Note: The information in this document is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.

Overview

On March 23, 2003, the Indiana Health Coverage Program (IHCP) Pharmacy Benefits Manager (PBM), ACS State Healthcare, will assume processing of IHCP pharmacy claims. The purpose of this bulletin is to give providers information on issues related to the change in pharmacy claims processors, as well as information about other pharmacy program changes.

Direct questions about the information in this bulletin in an e-mail that includes a detailed description of the questions to: Indiana.ProviderRelations@acs-inc.com, or by calling the ACS PBM Call Center at 1-866-645-8344.

Instructions for Claims Submission

Point of Sale

EDS will continue to accept point of sale (POS) claims through midnight March 22, 2003. After midnight March 22, 2003, the pharmacy claim processing system will be down for no more than 12 hours in order to transfer files necessary for the change of processor. During the downtime, providers may still determine member eligibility through the automated voice-response system (AVR) and OMNI. If a prescription is filled during the downtime, providers can choose to wait until POS is available to submit the claim or the claim can be submitted on paper. Please remember that prescriptions filled during the downtime will still be subject to all applicable edits.

At present, all POS pharmacy claim transactions will continue to follow the National Council for Prescription Drug Programs (NCPDP) version 3.2(3C) standard. The IHCP will implement the NCPDP 5.1 standard with the implementation of changes related to the Health Insurance Portability and Accountability Act (HIPAA) during 2003. As of October 16, 2003, the NCPDP 5.1 standard is required. Providers will receive a revised *IHCP Provider Manual* during 2003 that will address any changes. In addition, provider training will be offered to familiarize providers with the enhancements included in the NCPDP 5.1 format.

The complete NCPDP claim format for the 3C transaction set to be used to submit POS pharmacy Claims to ACS is included with this bulletin. The significant changes are highlighted and they must be implemented in POS software **prior to** submitting claims to ACS on March 23, 2003. **Providers**

should consult with their software vendors to determine when it is appropriate to make these changes. If a provider fails to implement any or all of these changes, POS claims could be rejected.

The following table contains the significant changes to the 3C transaction set:

Field	Transaction	Changes
Field 101	**BIN Number**	Change the BIN number to 61ØØ84 to ensure that ACS can receive your claim.
Field 104	**Processor Control Number**	The PCN field is critical and required. The PCN and the Group Number are required for the Prescription Drug Claim System (PDCS) to determine eligibility and plan parameters. Submit either of the following: DRRXPROD for production claims DRRXTEST for test claims.
Field 301	**Group Number**	ACS uses the Group Number field in conjunction with the PCN to determine eligibility and plan parameters. Always submit Group Number INCAID1ØØ for IHCP pharmacy claims.
Field 308	**Other Coverage Code**	The Other Coverage Code is used by the provider to indicate whether the patient (member) has other insurance coverage. This field's status has changed from *Not Used* to *Conditional*.
Field 404	**Metric Quantity**	The Metric Quantity will no longer be used. Submit quantities in the Metric Decimal Quantity Field.
Field 431	**Other Payor Amount**	The dollar amount of any payment known by the pharmacy from other sources. For IHCP pharmacy claims, this field will indicate the amount paid by other primary insurance. The status of this field has changed from *Not Used* to *Conditional*.
Field 442	**Metric Decimal Quantity**	The Metric Decimal Quantity is required. Use of the Metric Decimal Quantity allows for accurate fractional drug unit pricing. Quantity rounding is no longer accepted.
Field 443	**Other Payor Date**	The payment or denial date of the claim submitted to the other payor. This field is used for coordination of Other Third Party Liability. This field's status has changed from *Not Used* to *Conditional*.

Additionally, POS responses will now include text messaging in addition to explanation of benefits (EOB) codes when applicable. It is important for all pharmacy providers to ensure that their POS software is configured to receive these enhanced POS responses.

Provider Electronic Solutions

Currently, *Provider Electronic Solutions* can be used to verify eligibility, submit pharmacy batch claims, and submit POS claims. Effective March 23, 2003, the IHCP will not accept pharmacy claims submissions from *Provider Electronic Solutions*. *Provider Electronic Solutions* is custom configured for Indiana*AIM* and is not compatible with the ACS claim processing system. Providers may continue to use *Provider Electronic Solutions*, that is custom software available only through EDS, for all claim types other than pharmacy. Providers using this software for the submission of pharmacy batch or POS claims are encouraged to contact one of the many commercial pharmacy software vendors. For additional information about commercial pharmacy software vendors, providers should contact their drug wholesaler or pharmacy association. Although the IHCP does not endorse any one software vendor, the following is a partial list of software vendors from which providers can purchase software or services:

Tech RX
530 Lindbergh Drive
Coropolis, PA 15108
1-800-860-2372
www.techrx.com
info@techrx.com

QS1 Data Systems
P.O. Box 6052
Spartanburg, SC 29304
1-800-882-3815
www.qs1.com

SpeedScript – Digital Simplistics
14807 W 95th Street
Lenexa, KS 66215
1-800-569-1175
www.speedscript.com

PDX-NHIN
101 Jim Write Freeway South
Suite 200
Fort Worth, TX 76108
1-817-246-6760
www.pdxinc.com
info@pdxinc.com

Healthcare Computer Corp.
2601 Scott Avenue, #600
Fort Worth, TX 76106
1-888-727-5422
www.hcc-care.com

Rescot Systems Group
One Neshaminy Interplex
Suite 207
Trevose, PA 19053
1-888-737-2681
www.rescot.com

Providers using *Provider Electronic Solutions* to submit pharmacy batch claims, should refer to the *Batch Claims* section of this bulletin. Providers are encouraged to share this information with either a software vendor or in-house programming department. Providers using *Provider Electronic Solutions* to submit POS pharmacy claims need to communicate the information found in the *Point of Sale* section of this bulletin to their software vendor.

National Electronic Claims Submission

Currently, National Electronic Claims Submission (NECS) can be used to verify eligibility, submit pharmacy batch claims, and submit pharmacy POS claims. Effective March 23, 2003, the IHCP will not accept pharmacy claims submitted from NECS. NECS is custom configured for Indiana*AIM* and is not compatible with the ACS claim processing system. Providers using this software to submit pharmacy batch or pharmacy POS claims are encouraged to contact one of the many commercial pharmacy software vendors for assistance in submitting IHCP pharmacy claims. Although the IHCP does not endorse any one software vendor, a partial list of software vendors is provided in the *Provider Electronic Solutions* section of this bulletin.

Providers using NECS to submit batch claims, should refer to the *Batch Claims* section of this bulletin. Providers are encouraged to share this information with either a software vendor or in-house programming department. Providers using NECS to submit POS pharmacy claims need to communicate the information found in the *Point of Sale* section of this bulletin to their software vendor.

Batch Claims

EDS will continue to accept electronic pharmacy batch claims through 5 p.m., March 22, 2003. Effective 12 p.m., March 23, 2003, batch formatted pharmacy claims must be submitted to ACS using the NCPDP 1.1 batch format. This format is included in this bulletin.

> *Note: Pharmacy claims submitted from* Provider Electronic Solutions *and NECS will reject after 5 p.m., March 22, 2003.*

Batch claim files can be submitted using either of the following two methods beginning March 23, 2003:

- **Providers can submit claims using a secure Web site transmission. For this method, a personal computer (PC) connected to the Internet is required along with Internet Explorer version 5.0 or higher.**

- **Claims may also be accepted via tape cartridge.**

> *Note: Asynchronous and bisynchronous communication methods for submitting batch pharmacy claims are discontinued as of 5 p.m. March 22, 2003.*

All providers wishing to submit batch claims to ACS need to register with ACS to obtain a secure ID and password for the Web-based submission method. Those wishing to submit cartridges must also register with ACS. To submit batch claims after March 22, 2003, please notify ACS by e-mail at Indiana.ProviderRelations@acs-inc.com or by calling 1-866-645-8344 no later than March 13, 2003. Include the complete provider name, address, IHCP provider number, contact name, and phone number. Providers should indicate their preference for Web file transfer or cartridge submission. ACS will confirm the notification by e-mail with a provider ID, password, and detailed instructions for submission.

For more information, see the reference document for the NCPDP 1.1 batch claim format included with this bulletin.

Paper Claims Using the Indiana Family and Social Services Administration Drug Claim Form

For paper claim submission, providers will continue to use the current *Indiana Family and Social Services Administration (IFSSA) Drug Claim Form* and the *IFSSA Compound Claim Form* as outlined in *Chapter 9* of the *IHCP Provider Manual*. However, as of March 13, 2003, the following address should be used to submit paper claims to ACS:

Indiana Pharmacy Claims
C/O ACS
P.O. Box 502327
Atlanta, GA 31150

Paper claims that are sent to EDS after March 13, 2003 will be forwarded to ACS until April 15. After April 15, any paper claims sent to EDS will be returned to the provider for proper handling.

Adjustments

The guidelines and forms for submitting paid claims adjustments as outlined in *Chapter 11* of the *IHCP Provider Manual* remain the same. However all requests for adjustments of paid pharmacy claims must now be directed to:

Indiana Pharmacy Adjustments
C/o ACS
PO Box 502327
Atlanta, GA 31150

Claim Reimbursement and Administrative Review and Appeal Procedures

The process providers must follow if they are dissatisfied with the adjudication of a claim is outlined in *Chapter 10, Section 6,* of the *IHCP Provider Manual*. However, pharmacy providers must direct any requests for administrative review to:

Indiana Administrative Review
C/o ACS
PO Box 502327
Atlanata, GA 31150

Other Pharmacy Related Program Information

Third Party Liability Cost Avoidance Procedures

When members are identified as having pharmacy insurance coverage, providers must bill the pharmacy insurance carrier prior to submitting the claim to the IHCP. To satisfy this requirement, providers must routinely ask IHCP members whether a secondary insurance that covers pharmacy services is applicable. If a provider fails to ask the member, the IHCP claim could be denied. When a POS submitted claim is denied because a member has secondary insurance, the provider receives a message identifying the insurance carrier. When a claim is submitted on paper or by electronic batch and it denies for TPL, the provider will need to contact the AVR or use OMNI to identify the insurance carrier.

For POS billing purposes, beginning March 23, 2003, the NCPDP reject code of 41 – *Submit Bill to Other Processor or Primary Payor,* is changing from an information edit to a denial edit. This means if a claim is submitted for a member having pharmacy TPL coverage and there is no evidence of TPL collection on the claim, the claim will be denied with reject code 41.

IHCP recognizes there will be times when, despite the provider's efforts, a TPL payment is not collected. To accommodate these situations, override codes are available that will bypass the TPL edits when appropriate. TPL-related codes, including override codes, are available to POS billers only and follow the NCPDP version 3.2 (3C) standard. The following TPL-related codes are available for POS billers:

Other Insurance Indicator Field 308

- Code 2 – Other coverage exists – payment collected
- Code 3 - Other coverage exists – NDC not covered (overrides the TPL edit)
- Code 4 – Other coverage exists – payment not collected (overrides the TPL edit)

It is important that TPL override codes are used responsibly. Providers are required to maintain documentation that confirms proper use of override codes. For example, if *Code 3 – NDC not covered*, is used by the provider, the provider must maintain documentation from the insurance carrier that the code billed is a non-covered service. If *Code 4 – Payment not Collected*, is used, the provider must maintain documentation that the service was billed but not collected. Proper use of override codes will be subject to post-payment audit.

Restricted Card (Lock-in)

As part of a larger initiative to improve health outcomes and control program expenditures, the OMPP has identified IHCP members using an inappropriate volume of services. This program is called Restricted Card or Lock-in. The OMPP has determined that usage for these members should be controlled by restricting the member to specific providers. This restricted card program is administered by Health Care Excel (HCE). Restricted card members are locked-in to one physician, one pharmacy and one hospital. Members that require services from other sources are permitted to receive these services with the authorization of their physician.

Filing Claims for Member in the Restricted Card Program

For pharmacy claims to pay for a restricted member, the prescription must be written by the lock-in provider or a valid referring doctor, and be presented at the lock-in pharmacy. Claims can be submitted via POS, electronic batch, or paper. If a member in the Restricted Card Program is locked-in to a pharmacy and presents a prescription from a prescriber that is not the primary lock-in provider or a valid referral, the claim will deny.

If the pharmacy does receive a denial indicating the prescriber is not a valid lock-in provider (*EOB 7501*), and the member insists he or she has a valid referral from that prescriber, the lock-in pharmacy should contact HCE to confirm the referral. All referrals are kept on file by HCE. If it is determined the prescription has been written by an appropriate prescriber, HCE will authorize an override to allow payment.

Additionally, any claims submitted for a restricted or lock-in member with an out-of-state prescriber number will deny for an invalid lock-in prescriber. If the member indicates an out-of-state prescriber is a valid referral, the pharmacy must call HCE to receive an override for payment of the claim.

Direct questions about the Restricted Card or Lock-in Program or to request confirmation of a valid prescriber information from HCE at (317) 347-4527 in the Indianapolis local area or 1-800-457-4515.

Medical Supplies

Effective March 17, 2003, providers will be required to submit claims for medical supplies on the HCFA-1500 claim form using Health Care Procedure Coding System (HCPCS) codes. All claims for medical supplies should be sent to EDS in paper format or electronically using *Provider Electronic Solutions* software.

Additionally, all claims for medical supplies for dates of service on or after March 17, 2003, that are submitted on the pharmacy claim form, using National Drug Codes (NDCs), Health Related Item (HRI) codes, Universal Package Codes (UPC), or Universal Product Identification Numbers (UPIN) will deny. POS claims will return with NCPDP reject *code 70 – NDC not covered,* and a text message instructing providers to bill these items on a HCFA-1500 form and submit to EDS. All denied claims will post an *EOB 7510*. This service must be billed to EDS on the HCFA-1500 using the appropriate HCPCS code.

> *Note: POS devices cannot be used to submit HCFA-1500 claims electronically. Providers must bill the HCFA-1500 claims on paper or electronically via batch submission. If the provider chooses to submit the HCFA-1500 electronically, an IHCP approved software vendor or clearinghouse must be used.*

The IHCP provides *Provider Electronic Solutions* software free of charge as a means to submit batch claims electronically and verify member eligibility. This software can be downloaded from the IHCP Web site at www.indianamedicaid.com. CD-ROM or diskette versions of *Provider Electronic Solutions* are also available upon request. A shipping and handling fee of $15.50 is charged for CD-ROM and diskette mailing.

A list of approved software vendors and clearinghouses is also available by contacting the EDS Electronic Solutions Help Desk at (317)488-5160 in the Indianapolis local area.

For complete information about all IHCP changes for medical and surgical supplies, please refer to IHCP provider bulletin, *BT200308,* dated January 31, 2003.

Nutritional Supplements

In accordance with HIPAA, only drugs and biologicals can be billed using an NDC on a pharmacy claim form. Consequently, as nutritional supplements are not considered drugs or biologicals, effective April 3, 2003, providers must bill the IHCP for such services using HCPCS codes on the HCFA-1500 claim form. These claims must be submitted to the IHCP. As of April 3, 2003, nutritional supplements billed with NDCs on the pharmacy claim form will deny.

Refer to the section on *Medical Supplies* for information on billing options.

Forms

Effective March 23, 2003, the *Forms* section of www.indianamedicaid.com will contain separate forms for pharmacy inquiries and non-pharmacy inquiries. The forms may be found under the heading *Provider Correspondence Forms* under the **Forms** link. Pharmacy inquiries should be sent to ACS at the address provided on the pharmacy inquiry form; non-pharmacy inquiries should be sent to EDS at the address provided on the non-pharmacy inquiry form. The pharmacy form is to be used if a provider has a complex issue about a pharmacy claim, and has exhausted other avenues of resolution.

Hospice

As a reminder, palliative drugs that are related to the palliation or management of the member's terminal illness are included in the hospice per diem *405 IAC 5-34-8*. Claims submitted by POS to the IHCP for individuals under hospice care will receive an informational message for the provider to contact the hospice provider for authorization. While claims submitted to the IHCP for members under hospice care will not deny, it is the responsibility of the pharmacy provider to coordinate with the hospice provider to determine if the drug is related to the terminal illness. If a drug is related to the member's terminal illness, the pharmacy must bill the hospice provider and not the IHCP. Pharmacy claims for hospice members are subject to retrospective review. The pharmacy must have a contract with each hospice provider that the pharmacy may bill. For more information refer to IHCP banner pages, *BR200040, BR200041, BR200042,* and *BR200043*. Direct questions about hospice members to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-557-1278.

IHCP Pharmacy Claim Format - NCPDP 3.2(3C)

Effective March 23, 2003, the highlighted fields in the following tables are required software modifications.

Table 1 – Required Header Information

Field Number	Name of Field	Format	Field Length	Start Position	Valid Value/Format	Required Status
101	**Bin Number**	**A/N**	**6**	**1**	**61ØØ84**	**Required**
102	Version/Release Number	A/N	2	7	3C	Required
103	Transaction Code	N	2	9	ØØ Eligibility Verification Ø1-Ø4 Rx Billing 11 Rx Reversal 24 Rx Downtime Billing 31-34 Rx Re-Billing	Required
104	**Processor Control Number**	**A/N**	**8**	**11**	**DRRXPROD (if using Webmd/envoy switch refer to Webmd/envoy for PCN)**	**Required**
201	Pharmacy Number	A/N	12	21	10-character provider number. Must include nine-digit number and one-byte location field	Required
301	**Group Number**	**A/N**	**15**	**33**	**9 digit group number "INCAID1ØØ"**	**Required**
302	Cardholder ID Number	A/N	18	48	12-character member ID number.	Required
303	Person Code	A/N	3	66		Not used
304	Date of Birth	N	8	69		Not used
305	Sex Code	N	1	77		Not used
306	Relationship Code	N	1	78		Not used
308	**Other Coverage Code**	**N**	**1**	**79**		**Conditional**
401	Date Filled	N	8	80	CCYYMMDD	Required

Table 2 – Optional Header Information

Field Number	Name of Field	Format	Field Length	Start Position	Valid Value/Format	Required Status
307	Customer Location	N	2	91	00 = default 03 = Nursing Home	Required
309	Eligibility Clarification Code	N	1	96		Not used
310	Patient First Name	A/N	12	100		Required
311	Patient Last Name	A/N	15	115		Required

Table 3 – Required Claim Information

Field Number	Name of Field	Format	Field Length	Start Position	Valid Value/Format	Required Status
402	Prescription Number	N	7	131		Required
403	New/Refill Code	N	2	138	ØØ = New Prescription Ø1 to 99 = Number of Refill	Required
404	**Metric Quantity**	**N**	**5**	**140**	**Metric Quantity no longer used. Please submit the Metric Decimal Quantity in field 442.**	**Not Used**
406	Compound Code	*N*	1	148		Not Used
407	NDC Number	*N*	11	149		Required
408	Dispense as Written (DAW)	*A/N*	1	160	0 = default 1 = Sub not allowed by Prescriber 5 = Brand Drug used as generic 6 = BMN price override (Indiana Medicaid specific)	Required
409	Ingredient Cost	*D*	6	161	s$$$$cc	Optional
411	Prescriber ID	*A/N*	10	167	8 character state license number of the prescriber For out of state prescribers, please input on of the following: 91111111 = Illinois 92222222 = Kentucky 93333333 = Ohio 94444444 = Michigan 95555555 = All other states	Required
414	Date Prescription Written	*N*	8	177	CCYYMMDD	Required
426	Usual & Customary Charge	*D*	6	185	s$$$$cc	Required

Table 4 – Optional Claim Information

Field	Name of Field	Format	Field	Start	Valid Value/Format	Required
416	Prior Authorization /Medical Certification Code and Number	N	12	194	000000000000 = default 600000000000 = family planning 800000000000 = pregnancy	Required
418	Level of Service	A/N	2	209	00 = default 03 = emergency	Required
424	Diagnosis Code	A/N	6	214		Not used
429	Unit Dose Indicator	N	1	223		Not used
430	Gross Amount due	D	6	227	S$$$cc	Optional
431	**Other Payor Amount**	**D**	**6**	**236**	**S$$$cc**	**Conditional**
433	Patient Paid Amount	D	6	245	S$$$cc	Not used
438	Incentive Amount Submitted	D	6	254	S$$$cc	Not used
439	DUR Conflict Code	A/N	2	263	See net page for valid values	Conditional
440	DUR Intervention Code	A/N	2	268	See next page for valid values	Conditional
441	DUR Outcome Code	A/N	2	273	See next page for valid values	Conditional
442	**Metric Decimal Quantity**	**N**	**8**	**278**	**Use in place of fiele 404 (Metric Quantity) 99999.999**	**Required**
443	**Other Payor Date**	**N**	**8**	**289**	**CCYYMMDD Submit if other coverage code is equal to 2, 3, or 4**	**Conditional**

IHCP Pharmacy Batch Claim Format – NCPDP 1.1 Batch

Effective March 23, 2003

Table 5 – Required Transaction Header Section

Field	Field Name	Type	Length	Start	End	Value
880-K4	Text Indicator	A/N	1	1	1	Start of Text (Stx) = X'02'
701	Segment Identifier	A/N	2	2	3	00 = File Control (header)
880-K6	Transmission Type	A/N	1	4	4	T = Transaction R = Response E = Error
880-K1	Sender ID	A/N	24	5	28	To be defined by processor/switch.
806-5C	Batch Number	N	7	29	35	Matches Trailer
880-K2	Creation Date	N	8	36	43	Format = CCYYMMDD
880-K3	Creation Time	N	4	44	47	Format = HHMM
702	File Type	A/N	1	48	48	P = production T = test
102-A2	Version /Release Number	A/N	2	49	50	Version/Release of Header Data
880-K7	Receiver ID	A/N	24	51	74	To be defined by processor/switch.
880-K4	Text Indicator	A/N	1	75	75	End of Text (Etx) = X'03'

Table 6 – Detail Data Record

Field	Field Name	Type	Length	Start	End	Value
880-K4	Text Indicator	A/N	1	1	1	Start of Text (Stx) = X'02'
701	Segment Identifier	A/N	2	2	3	G1 = Detail Data Record
880-K5	Transaction Reference Number	A/N	1Ø	4	13	
	NCPDP Data Record V 3.2		varies	14	varies	See Note below*.
880-K4	Text Indicator	A/N	1	varies	varies	End of Text (Etx) = X'03'

Table 7 – Trailer Record

Field	Field Name	Type	Length	Start	End	Value
880-K4	Text Indicator	A/N	1	1	1	Start of Text (STX) = X'02'
701	Segment Identifier	A/N	2	2	3	99 = File Trailer
806-5C	Batch Number	N	7	4	10	Matches header
751	Record Count	N	10	11	20	
504-F4	Message	A/N	35	21	55	
880-K4	Text Indicator	A/N	1	56	56	End of Text (ETX) = X'03'

Note: At this point in the batch layout, insert the NCPDP 3C transaction set. The ACS specific 3C fixed length transaction set is listed in the previous section (IHCP Claim Format).