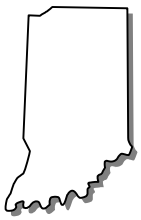
Indiana Health Coverage Programs



PROVIDER BULLETIN

BT200361 SEPTEMBER 19, 2003

To: **All Pharmacy Providers**

Subject: **Indiana Health Coverage Programs (IHCP) Transition to the National Council for Prescription Drug Programs (NCPDP) Version 5.1 Claim Format**

Overview

This bulletin announces changes and enhancements for the National Council for Prescription Drug Programs (NCPDP) Version 5.1 claim format. On October 1, 2003, the IHCP will begin accepting pharmacy claims using the NCPDP Version 5.1 claim format.

Indiana Health Coverage Programs (IHCP) pharmacy providers can continue to submit claims using the NCPDP Version 3.2 (3C) claim format until October 15, 2003. Beginning October 16, 2003, all pharmacy providers are required to submit claims using only the NCPDP Version 5.1 claim format, as mandated by the Health Insurance Portability and Accountability Act (HIPAA).

IHCP pharmacy providers who believe they will not be ready to submit claims in the NCPDP Version 5.1 claim format on October 16, 2003, should contact ACS by sending an email to Indiana.Providerrelations@acs-inc.com or call the ACS Call Center Helpdesk at 1-866-645-8344.

A copy of the NCPDP Version 5.1 Claim Format Payer Sheet should be used in conjunction with this bulletin. Please use this *Payer Sheet* to ensure that your software is compliant with IHCP requirements for billing Version 5.1 claims. To print a NCPDP Version 5.1 Claim Format Payer Sheet, visit the IHCP Web site at www.indianamedicaid.com. Use the *Payer Sheet* as a companion to this bulletin.

NCPDP Version 5.1 Claim Format

The NCPDP Version 5.1 claim format is a variable format and will allow providers to transmit up to four transactions per transmission, with a few exceptions. Of the 86 new data fields in the NCPDP Version 5.1 claim format, the IHCP will use 23. Additionally, there are several existing data fields that have been expanded in the NCPDP Version 5.1.

Claims for Compound Drug Prescriptions

A new feature available under the NCPDP 5.1 claim format is the submission of compound drug claims at point of sale (POS). ACS Prescription Drug Claim Processing (PDCSX2) will allow up to 40 separate ingredients to be submitted on a single transaction. Each line of the compound drug claim

will be adjudicated separately and will be subject to all applicable edits. If one ingredient in the compound drug claim requires a prior authorization (PA), the entire compound drug claim requires a PA. **There is only one PA required for a compound even when more than one ingredient requires a PA.**

While NCPDP Version 5.1 generally supports up to four separate transactions per transmission, a transmission that contains a compound drug claim must consist of only that single compound drug claim transaction.

To submit a claim for a compound drug, providers must verify with their software vendors that their software is set up to do the following transaction:

- Auto-populate field 407-D7 (Product/Service ID) with all zeros when field 406-D6 (Compound Code) is populated with a 2.

When submitting a POS claim for a compound drug, providers must complete the following steps:

In the Claims segment:

- Indicate the claim is a compound drug by populating field 406-D6 (Compound Code) with a 2, which denotes a compound drug claim.
- Indicate a value of *8 – Process compound for approved ingredients* in field 420DK (Submission Clarification Code). If an 8 is not indicated in this field the claim will deny.

In the Pricing segment:

- At this time, providers will not be required to submit individual ingredient costs for each ingredient of the compound drug prescription. Providers must continue to submit their usual and customary charge for the entire compound in field 426-DQ (Usual and Customary Charge) of the pricing segment.

In the Compound Segment:

- Providers must complete the following fields:
  111-AM, Segment Identifier
  450-EF, Compound Dosage Form Description Code
  451-EG, Compound Dispensing Unit Form Indicator
  452-EH, Compound Route of Administration
  447-EC, Compound Ingredient Component Count
  488-RE, Compound Product Id Qualifier
  489-TE, Compound Product Code
  448-ED, Compound Ingredient Quantity

Fields 489-TE and 448-ED are repeating fields that must be completed for each ingredient of the compound drug.

Claims for Compound Drugs over $200

Current IHCP policy requires that all compound drug claims having a submitted charge of greater than $200 be reviewed by an ACS pharmacist. The purpose of the review of compound drug claims above $200 is to ensure that the compound prescription is necessary and the amount charged is reasonable for the service rendered. This policy will remain in effect for compound claims submitted by any claims submission method. Claims submitted electronically (by POS or batch) will suspend for review. All suspended claims will be reviewed and adjudicated within State guidelines.

Note: While NCPDP Version 5.1 will be available for use on October 1, 2003, providers must continue to submit compound drug claims with a submitted charge greater than $200 by paper until November 1, 2003.

NCPDP Version 5.1 Claim Format Segments

Please refer to the *Payer Sheet* for detailed information on the claim segments.

NCPDP Version 5.1 Claim Format Definitions

- **Mandatory** – This is denoted by an **M** in the status column on the NCPDP Version 5.1 Payer Sheet. These fields must be populated for the claim to process per the NCPDP Standard. If a provider fails to put a valid value in these fields the claim will deny.
- **Required** – This status is denoted by an **R** in the status column. These fields are required by the IHCP.
- **Required When** – This status is denoted by an **RW** in the status column. These fields are dependent on other fields or member information to determine if they are required for the claim to process.
- **Repeating** – These fields are denoted by **(repeating)** under the status of the field. These fields will allow more than one valid value to be populated to satisfy the requirements of the claim.
- **Segment Identifier** – This is a new field in Version 5.1. Because this format is a variable format, the segment identifier tells PDCSX2 which segment and information is coming next.
- **Field Qualifier** – This is a new field for the Version 5.1. It describes the type of number that is going to follow in the next field. The qualifier aids the system by directing it where to look for the information to validate and process the claim. For example, if field 436, Product/Service ID Qualifier, is populated with an 03 = NDC, then the system knows that the pharmacy must enter the NDC number of the medication dispensed in the next field, 407 (Product/Service ID). If a field is mandatory or required, the field qualifier is mandatory or required as well.

Claim Segments

Transaction Header Segment

The Transaction Header Segment tells the system where to send the claim, what type of submission it is, how many transactions, who is submitting the claim, what the dates of service are and what the vendor certification number is.

The Transaction Header Segment is mandatory on all transmissions and all fields within the segment are mandatory.

Patient Segment

The Patient Segment is required on every IHCP claims transmission. For other payers, this segment would be used to differentiate between the patient to whom the service was provided and the cardholder identified in the Insurance Segment.

Since each IHCP member has a unique member identification number (RID), the only required fields are the Segment Identification and Patient First and Last Name. Additionally, there are two *required when* fields that must be populated if applicable to the member for which the claim is being billed:

- The Patient Location field, 307-C7, must be used when the member resides in a nursing facility. A 3 in the field indicates nursing facility residency.
- The Pregnancy Indicator field, 335-2C, is used when the pharmacy is indicating the patient is pregnant and therefore exempt from co-pay. To indicate pregnancy, enter the value 2.

If neither of the listed situations exists, these fields should be left blank.

Insurance Segment

The Insurance Segment is mandatory on Bill (B1) and Re-bill (B3) transactions.

This segment contains data describing the insured cardholder or IHCP member. The three fields that are required to be submitted in this segment are the Segment Identification, Cardholder ID and Group ID.

Claim Segment

The Claim Segment is mandatory for pharmacy claims processing. This segment contains data relating to the actual prescription dispensed or the professional service performed. The claim segment is also used to identify compound prescriptions. Please refer to the compound segment below for complete instructions on filing POS claims for compound drugs.

Additionally, there have been changes to the Other Coverage Code fields, please see the coordination of benefits (COB)/Other Coverage Segment for instructions for submitting a claim with third party liability (TPL).

Pharmacy Segment

IHCP pharmacy providers do not use this segment.

Prescriber Segment

The Prescriber Segment contains data about the prescribing physician and is required on incoming transmissions except reversals. The required fields are the Segment Identification, Prescriber ID Qualifier and Prescriber ID. This segment is mandatory for IHCP providers.

Coordination of benefits (COB)/Other Payment Segment

The COB/Other Payment Segment contains information related to the presence of other payers or insurers, as well as the dates, amounts and status of any claim filed with those payers for the current service. It is a *required when* segment.

This segment will be required when the member eligibility file indicates the presence of other insurance coverage. If the member eligibility file indicates other insurance coverage and this segment is not included on the transmission, the claim will deny.

If other coverage exists, the provider must enter one of the following values in 308 of the **Claims Segment**:

- *2 = Other coverage exists – payment collected* – Use this code when other insurance coverage exists and payment is collected.

> *Note: This code was optional under NCPDP Version 3.2. It is a required field under NCPDP Version 5.1 when the member eligibility file indicates other insurance coverage.*

- *3 = Other coverage exists – this claim not covered* – This code should be used to communicate non-coverage by a third party insurer. For example, the service billed could be outside of the member's scope of coverage or the member may have exceeded their annual benefit limitation.
- *4 = Other coverage exists – payment not collected* – This code should be used to communicate any other valid reasons for non-payment.

> *Note: Previously providers were instructed to use this code when members no longer have coverage that is indicated on the file. For this situation the provider must now use code 7.*

- *5 = Managed care plan detail* – This code should be used to communicate any denial associated with a managed care TPL plan.
- *6 = Other coverage denied – not a participating provider* – This code should be used if the claim is denied by the insurer because the provider dispensing the drug or the provider prescribing the drug is not part of the insurer's network.
- *7 = Other coverage exists – not in effect at this time of service* – Providers should use this code when an insurer denies a claim because the policy is no longer in effect on the date of service.
- *8 = Billing for co-pay* – To bill the IHCP for a co-payment required by another insurer, the provider must indicate the National Drug Code (NDC) for which the co-payment is being billed in conjunction with override code 8. The provider may bill only one unit per NDC with a maximum reimbursement allowable of $20. Previously, providers were able to bill for multiple co-payments on one claim. Since each co-payment is NDC specific, providers may bill for one co-payment per claim.

> *Note: This represents a change from previous billing policy. Previously, providers were instructed to bill IHCP for co-payment amounts covered by an insurance plan that would otherwise be paid by the member by utilizing the 99999-9999-11 co-payment code. This will not be allowed under NCPDP Version 5.1.*

When the pharmacy enters a code *2 = Other coverage exists – payment collected*, *3 = Other coverage exists – this claim not covered,* or *4 = Other coverage exists – payment not collected* in field 308 (Other Coverage Code), the system will automatically look to the COB Segment. The required fields in the COB Segment are:

- Coordination of Benefits/Other Payer Count, 337-4C
- Other Payer Date, 443-E8
- Other Payer Coverage Type, 338-5C
- Other Payer Amount Paid, 431-DV

If these fields are not populated, the claim will reject.

Worker's Compensation Segment

This segment will not be used by the IHCP.

Drug Utilization Review (DUR)/Prospective Payment System (PPS) Segment

The DUR/PPS Segment contains data pertinent to the DUR conflict being resolved. If the edits or alert is not resolved, the claim will deny.

The following fields are presently being used in NCPDP Version 3.2 (3C) but the names have changed in the NCPDP Version 5.1 claim format:

- DUR Conflict Code is now referred to as DUR Reason for Service Code
- DUR Intervention Code is now referred to as DUR Professional Service Code
- DUR Outcome Code is now referred to as DUR Result of Service Code.

These fields are used to enter information that explains why a service was done, what type of service was provided and what happened as a result of that service. These three fields are repeating fields to allow for more than one response per element. Some conflicts require more than one response to be able to process the claim.

Please refer to the *Payer Sheet* on www.indianamedicaid.com for the valid values that are accepted for this segment. The valid values have not changed from the values currently accepted.

Pricing Segment

The Pricing Segment is mandatory on all transactions. This segment contains data describing how the product is to be priced. The only mandatory/required fields are the Segment Identification and Usual and Customary Charge.

Coupon Segment

This segment is not used by the IHCP.

Compound Segment

As noted above, this segment is required for the submission of compound drug claims. The Compound Segment may only be submitted on Billing and Re-billing. This segment is not required on claim reversals.

Prior Authorization Segment

While the use of this segment is not required at this time, the IHCP is evaluating the use of it for the future.

Clinical Segment

This segment is not required by the IHCP at this time.

Additional Information

Please direct any questions regarding the content of the bulletin to the ACS Call Center Helpdesk at 1-866-645-8344.