PROVIDER BULLETIN

BT200706 FEBRUARY 13, 2007

To: All Pharmacy Providers

Subject: Updated Drug Claim Form and Compounded Prescription Claim Form Requirements

The following information does not apply to providers rendering services in the Risk Based Managed Care (RBMC) delivery system. These providers should contact the Managed Care Organization (MCO) with whom they are contracted for information about paper claim form transition.

Overview

The Indiana Health Coverage Programs (IHCP) will discontinue acceptance of the current versions of the *Indiana Medicaid Drug Claim Form* and the *Indiana Medicaid Compounded Prescription Claim Form* effective May 23, 2007. Beginning May 23, 2007, only the revised versions will be accepted. Paper claims received on or after May 23, 2007, must meet the new claim form requirements. Non-compliant paper claims submitted on or after May 23, 2007, will be returned to the provider.

Note: The information in this bulletin supersedes information that has been previously communicated through bulletins, banner pages, or workshop training materials.

Drug Claim Form and Compounded Prescription Paper Claim Form Changes and Requirements

This section provides a brief overview of the changes required for completion of the *Indiana Medicaid Drug Claim Form* and the *Indiana Medicaid Compounded Prescription Claim Form*. Both of these forms will be available on the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com as of May 16, 2007.

These instructions are effective for paper claim submission starting May 23, 2007. Paper claims received on or after May 23, 2007, must meet the new claim form requirements. Non-compliant paper claims submitted on or after May 23, 2007, will be returned to the provider. There is no transition period for these forms.

All providers must first report the National Provider Identifier (NPI) and taxonomy code(s) via the NPI Reporting Tool available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/NPITool/npi_logon.aspx or by using the *NPI Reporting Form* available on the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp. The *National Provider Identifier (NPI)* page, located at http://www.indianamedicaid.com/ihcp/ProviderServices/npi.asp, contains information about the IHCP NPI Implementation Plan and instructions for obtaining an NPI.

Definitions

Legacy Provider Identifier (LPI)	The provider number issued by the IHCP.
National Provider Identifier (NPI)	New identifier issued through the NPPES developed by CMS. NPI will replace all IHCP provider numbers (legacy provider identifier (LPI)) currently used for billing purposes.

Drug Claim Form and Compounded Prescription Claim Form Fields

This section explains completion of the Drug claim form and Compounded Prescription claim form. Some information is required to complete the claim form, while other information is optional.

The Drug claim form and Compounded Prescription Claim Form Locator Descriptions table uses bold type to indicate if a field is **Required** or **Required, if applicable**. Specific instructions applicable to a particular provider type are noted as well. The instructions describe each form locator by referring to the number found in the left corner of each box on the drug claim form and the compounded prescription claim form. These boxes contain the data elements.

Samples of the new claim forms are included in this bulletin.

All form locator fields with a change are noted with an asterisk (*) in the following table.

Indiana Medicaid Drug Claim Form Locator Descriptions

Form Locator	Explanation
01	**MEMBER NAME: LAST, FIRST -** Enter the last name and first name of the member. **Required**.
02*	**PRESCRIBER'S NPI -** Enter the prescriber's 10-digit NPI. The prescriber is not required to be an enrolled IHCP provider for the pharmacy to be reimbursed by the IHCP for a pharmacy claim, but is required to have a valid NPI. **Required**. Note: If the prescriber is a non-IHCP provider, a web-tool will be available to report the NPI. Information specific to this process is forthcoming in a future publication. For assistance in obtaining the prescriber's NPI: • Call the prescriber • Call EDS
03	**EMERGENCY -** Emergency indicator; valid values are **Yes** and **No**. **Required**.
04	**PREGNANT** - Pregnancy indicator; valid value is **Yes** if patient is pregnant and this medication is related to the pregnancy. Leave this field **blank** for **No**. **Required**, **if applicable.**
05	**PATIENT LOCATION CODE -** Nursing facility indicator. **Required, when applicable**. Valid program values are: **00** – Not specified **03** – Nursing home **04** – Long term/extended care **11** – Hospice
06	**RID NO. -** Enter the 12-digit IHCP member identification number. **Required**.

Indiana Medicaid Drug Claim Form Locator Descriptions

Form Locator	Explanation
07	**PRESCRIPTION NUMBER -** Enter the prescription number. Field accommodates 10 alphanumeric characters. **Required**.
08	**DAW CODE** - Brand medically necessary (BMN) indicator. **Required**. Valid program values are: **0** – No product selection indicated. This value is used when the prescriber has prescribed either by brand name or generic name, signed either on the *dispense as written (DAW)* or *may substitute* line, but has not properly indicated *brand medically necessary*. This value is also used for brand name products that are not generically available and for items prescribed generically. This value is the only value used for covered over the counter (OTC) drugs, and is to be reported by providers for all such prescriptions. **5** – Substitution allowed-brand drug dispensed as a generic. In some cases, providers can purchase brand name drugs at a reduced price that allows them to dispense the brand name drug instead of the generic and the brand name is no more costly to the program than the generic. Use of this value does not penalize a provider when the brand name drug is **no more costly to the program than the generic.** **6** – Override. This value is reported **only** when the prescriber, in accordance with Indiana and federal laws, has specified *brand medically necessary* and signed on the *Dispense as Written* line of the prescription. *Override* requires prior authorization in most all dispensing circumstances, and use by pharmacy providers of this code are closely monitored by Medicaid auditing contractors. **8** – Substitution allowed-generic drug not available in market. This value is allowed when a generic substitution is not available in the marketplace. Proper use of this code is closely monitored by Medicaid auditing contractors.
09	**REFILL NUMBER -** Refill indicator. If this is an original prescription, enter **00**. If this is a prescription refill, indicate the number of the refill. **Required**. Valid values in the two-digit field are **00** to **99**.
10	**QUANTITY DISPENSED -** Indicate the quantity of the item or drug dispensed using the appropriate metric decimal quantity, such as ea, gm, or ml. Maximum field capacity is 10 digits. **Required**.
11	**DAYS SUPPLY -** Indicate the approximate number of days supply (DS) for the quantity of the drug dispensed. The field accommodates three numeric characters, for up to 999 days. **Required**.
12	**USUAL AND CUSTOMARY CHARGE -** Enter the total amount charged for the prescription including any dispensing fee. **Required**.
13	**DATE PRESCRIBED -** Enter the date prescribed. MMDDYY **Required**.
14	**DATE DISPENSED -** Enter the date dispensed. MMDDYY **Required**.
15	**NDC NUMBER -** Enter the 11-digit National Drug Code (NDC) for the drug(s) dispensed. **Required**.
16	**TPL AMOUNT PAID -** Providers are required to bill pharmacy claims to private insurance companies prior to submitting claims to IHCP. **Required, if applicable**. If another insurance company was billed, but paid nothing, refer to the IHCP provider manual, Chapter 9, Section 3 for instructions about billing when only a copayment is required under the insurance plan.

Indiana Medicaid Drug Claim Form Locator Descriptions

Form Locator	Explanation
17	**OTHER COVERAGE CODE -** Enter the two-digit value associated with member's other coverage. **Required, if applicable.** Valid values are: **Blank** – Not specified **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 date of service (DOS) **08** – Claim is billing for copay
18	**OTHER AMOUNT CLAIMED SUBMITTED -** Used when billing for third party liability (TPL) copay only. Enter total copay amount. **Required, if applicable**.
19	**GROSS AMOUNT DUE -** Used when billing for Third Party Liability (TPL) copays only. Enter total copay amount. **Required, if applicable**. Field #18 and #19 must agree.
20	**PROVIDER'S NAME AND ADDRESS -** Enter the provider name and address. The address entered in this field must correspond to the location code entered in field 22. **Required**.
21*	**BILLING PROVIDER NPI -** Enter the appropriate 10-character billing provider NPI number. **Required.**
22	**PROVIDER TYPE -** Indicate the appropriate provider type by checking the box preceding value. **Required.**
23	**SIGNATURE OF PROVIDER OR REPRESENTATIVE -** Read the statement above the signature line and sign the claim form. The provider or an authorized person designated by the agency or organization must sign and date the claim. A signature stamp is acceptable; however, a typed signature is not acceptable. **Required**. Note: **Required, unless the *Signature on File* form has been completed and is included in the provider enrollment file**. If on file please indicate by putting "Signature on File" in this field.
24	**DATE BILLED -** Enter the date the claim was completed. MMDDYY **Required**.

Indiana Medicaid Drug Claim Form, Effective May 23, 2007

[redacted]

Table A.19

PLEASE PRINT CLEARLY
The claim information below is an example for illustrative purposes only.

Indiana Medicaid
DRUG CLAIM FORM

1	MEMBER NAME: LAST, FIRST 01			PRESCRIBER NPI 02		EMERGENCY 03		PREG 04		PATIENT LOCATION CODE 05		
	RID NO. 06	PRESCRIPTION NUMBER 07		DAW CODE 08	REFILL NUMBER 09	QUANTITY DISPENSED 10		DAYS SUPPLY 11		USUAL & CUSTOMARY CHARGE 12		
	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	TPL AMOUNT PAID 16		OTHER COVERAGE CODE 17		OTHER AMOUNT CLAIMED SUBMITTED 18			GROSS AMOUNT DUE 19	
2	MEMBER NAME: LAST, FIRST 01			PRESCRIBER NPI 02		EMERGENCY 03		PREG 04		PATIENT LOCATION CODE 05		
	RID NO. 06	PRESCRIPTION NUMBER 07		DAW CODE 08	REFILL NUMBER 09	QUANTITY DISPENSED 10		RID NO. 06		PRESCRIPTION NUMBER 07		
	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	TPL AMOUNT PAID 16		OTHER COVERAGE CODE 17		DATE PRESC 13			DATE DISP 14	
3	MEMBER NAME: LAST, FIRST 01			PRESCRIBER NPI 02		EMERGENCY 03		PREG 04		PATIENT LOCATION CODE 05		
	RID NO. 06	PRESCRIPTION NUMBER 07		DAW CODE 08	REFILL NUMBER 09	QUANTITY DISPENSED 10		DAYS SUPPLY 11		USUAL & CUSTOMARY CHARGE 12		
	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	TPL AMOUNT PAID 16		OTHER COVERAGE CODE 17		OTHER AMOUNT CLAIMED SUBMITTED 18			GROSS AMOUNT DUE 19	
4	MEMBER NAME: LAST, FIRST 01			PRESCRIBER NPI 02		EMERGENCY 03		PREG 04		PATIENT LOCATION CODE 05		
	RID NO. 06	PRESCRIPTION NUMBER 07		DAW CODE 08	REFILL NUMBER 09	QUANTITY DISPENSED 10		DAYS SUPPLY 11		USUAL & CUSTOMARY CHARGE 12		
	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	TPL AMOUNT PAID 16		OTHER COVERAGE CODE 17		OTHER AMOUNT CLAIMED SUBMITTED 18			GROSS AMOUNT DUE 19	
5	MEMBER NAME: LAST, FIRST 01			PRESCRIBER NPI 02		EMERGENCY 03		PREG 04		PATIENT LOCATION CODE 05		
	RID NO. 06	PRESCRIPTION NUMBER 07		DAW CODE 08	REFILL NUMBER 09	QUANTITY DISPENSED 10		DAYS SUPPLY 11		USUAL & CUSTOMARY CHARGE 12		
	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	TPL AMOUNT PAID 16		OTHER COVERAGE CODE 17		OTHER AMOUNT CLAIMED SUBMITTED 18			GROSS AMOUNT DUE 19	

PROVIDER'S NAME AND ADDRESS
☐ 20

BILLING PROVIDER NPI
21

PROVIDER TYPE
☐ PHARMACY
☐ PHYSICIAN
☐ DENTIST
☐ OTHER
22

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any falsification of claims, statements or documents, or concealment of material fact may be prosecuted under applicable federal or state laws.

I, the undersigned, being aware of restricted funds in the IHCP Program, agree to accept as full payment for services enumerated on this claim form, for this IHCP patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient. I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

SIGNATURE OF PROVIDER OR REPRESENTATIVE
☐ 23

DATE BILLED
24

MAIL COMPLETED CLAIM FORM TO:

EDS Pharmacy Claims
P.O. Box 7268
Indianapolis, IN 46207-7268

Effective: May 23, 2007

Form Number: PRX???

Indiana Medicaid Compounded Prescription Claim Form Locator Descriptions

Form Locator	Explanation
01	**MEMBER NAME: LAST, FIRST** - Enter the last name and first name of the member. **Required**.
02	**RID NO**. - Enter the IHCP 12-digit member identification number. **Required**.
03*	**PRESCRIBER'S NPI** - Enter the prescriber's 10-digit NPI. The prescriber is not required to be an enrolled IHCP provider for the pharmacy to be reimbursed by the IHCP for a pharmacy claim, but is required to have a valid NPI. **Required**. Note: If the prescriber is a non-IHCP provider, a web-tool will be available to report the NPI. Information specific to this process is forthcoming in a future publication. For assistance in obtaining the prescriber's NPI: • Call the prescriber • Call EDS
04	**EMERGENCY** - Emergency indicator, valid values are **Y** for yes and **N** for no. **Required**.
05	PREG: Pregnancy indicator; valid value is **Yes** if patient is pregnant and this medication is related to the pregnancy. Leave this field **blank** for **No**. **Required, if applicable.**
06	**PATIENT LOCATION CODE** - Nursing facility indicator. **Required, when applicable**. Valid program values are: **00** – Not specified **03** – Nursing home **04** – Long term/extended care **11** – Hospice
07	**DAW CODE** - Brand medically necessary (BMN) indicator. **Required**. Valid program values are: **0** – No product selection indicated. This value is used when the prescriber has prescribed either by brand name or generic name, signed either on the dispense as written (DAW) or may substitute line, but has not properly indicated *brand medically necessary*. This value is also used for brand name products that are not generically available and for items prescribed generically. This value is the only value used for covered over the counter (OTC) drugs, and is to be reported by providers for all such prescriptions. **5** – Substitution allowed-brand drug dispensed as a generic. In some cases, providers can purchase brand name drugs at a reduced price that allows them to dispense the brand name drug instead of the generic and the brand name is no more costly to the program than the generic. Use of this value does not penalize a provider when the brand name drug is no more costly to the program than the generic. **6** – Override. This value is reported **only** when the prescriber, in accordance with Indiana and federal laws, has specified *brand medically necessary* and signed on the *Dispense as Written* line of the prescription. *Override* requires prior authorization in most all dispensing circumstances, and use by pharmacy providers of this code is closely monitored by Medicaid auditing contractors. **8** – Substitution allowed-generic drug not available in market. This value is allowed when a generic substitution is not available in the marketplace. Proper use of this code is closely monitored by Medicaid auditing contractors.

Indiana Medicaid Compounded Prescription Claim Form Locator Descriptions

Form Locator	Explanation
08	**REFILL NUMBER** - Refill indicator. If this is an original prescription, enter 00. If this is a prescription refill, indicate the number of the refill. **Required.** Valid values in the two-digit field are **00** to **99**.
09	**PRESCRIPTION NUMBER** - Enter the prescription number. Field accommodates 10 alphanumeric characters. **Required**.
10	**DATE PRESCRIBED** - Enter the date prescribed. MMDDYY **Required**.
11	**DATE DISPENSED** - Enter the date dispensed. MMDDYY **Required**.
12	**TOTAL QUANTITY DISPENSED** - Indicate the total quantity of the compounded prescription. Use the appropriate metric decimal quantity, such as ea, gm, or ml. Maximum field capacity is 10 digits. **Required**.
13	**DAYS SUPPLY** - Indicate the approximate number of days supply (DS) for the quantity of the drug dispensed. The field accommodates three numeric characters, for up to 999 days. **Required**.
14	**USUAL AND CUSTOMARY CHARGE** - Enter the total amount charged for the prescription including any dispensing fees. **Required**.
15	**ROUTE OF ADMINISTRATION CODE** - Enter the one or two-digit code for the route of administration. **Required.** Valid route of administration codes are: **0** – Not Specified **1** – Buccal **2** – Dental **3** – Inhalation **4** – Injection **5** – Intraperitoneal **6** – Irrigation **7** – Mouth/Throat **8** – Mucous Membrane **9** – Nasal **10** – Ophthalmic **11** – Oral **12** – Other/Miscellaneous **13** – Otic **14** – Perfusion **15** – Rectal **16** – Sublingual **17** – Topical **18** – Transdermal **19** – Translingual **20** – Urethral **21** – Vaginal **22** – Enteral
16	**SUBMISSION CLARIFICATION CODE** - This code is used when requesting that the compound be processed for approved ingredients only. **Required, if applicable.** **00** – Not Specified **08** – Process compound for approved ingredients *Failure to use this code will cause a compound to deny if it contains any non covered ingredients.*

Indiana Medicaid Compounded Prescription Claim Form Locator Descriptions

Form Locator	Explanation
17	**OTHER COVERAGE CODE** - Enter the two-digit value associated with member's other coverage. **Required, if applicable**. Valid values are: **Blank** – not specified **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 date of service (DOS) **08** – Claim is billing for copay
18	**TPL AMOUNT PAID** - Providers are required to bill pharmacy claims to private insurance companies prior to submitting claims to IHCP. **Required, if applicable**. If another insurance company was billed, but paid nothing, refer to the IHCP provider manual, Chapter 9, Section 3 for instructions about billing when only a copayment is required under the insurance plan.
19	**OTHER AMOUNT CLAIMED SUBMITTED** - Used when billing for third party liability (TPL) copay only. Enter total copay amount. **Required, if applicable**.
20	**GROSS AMOUNT DUE** - Used when billing for Third Party Liability (TPL) copays only. Enter total copay amount. **Required, if applicable**. Field #19 and #20 must agree.
21	**NDC NUMBER** - Enter the 11-digit National Drug Code (NDC) for the drug(s) dispensed. **Required.**
22	**DESCRIPTION OF INGREDIENT** - If there is not an NDC, health-related items (HRI), or universal product code (UPC) for an ingredient used, the provider can enter a narrative description of the ingredient. However, it is necessary for a product to have an NDC or UPC on file with First DataBank (FDB) in order for the product to be reimbursed as part of a compound. **Required**.
23	**INGREDIENT QUANTITY** - Indicate the quantity of the item or drug dispensed using the appropriate metric decimal quantity, such as ea, gm, or ml. Maximum field capacity is 10 digits. **Required**.
24	**PROVIDER'S NAME AND ADDRESS** - Enter the provider name and address. The address entered in this field must correspond to the location code entered in field 25. **Required**.
25*	**BILLING PROVIDER NPI** - Enter the appropriate 10-character billing provider NPI. **Required**.
26	**PROVIDER TYPE** - Indicate the appropriate provider type by checking the box preceding value. **Required**.

Indiana Medicaid Compounded Prescription Claim Form Locator Descriptions

Form Locator	Explanation
27	**SIGNATURE OF PROVIDER OR REPRESENTATIVE** - Read the statement above the signature line and sign the claim form. The provider or an authorized person designated by the agency or organization must sign and date the claim. A signature stamp is acceptable; however, a typed signature is not acceptable. **Required**. Note: **Required, unless the *Signature on File* form has been completed and is included in the provider enrollment file**. If on file please indicate by putting "Signature on File" in this field.
28	**DATE FILED** - Enter the date the claim was completed. MMDDYY **Required**.

Indiana Medicaid Compounded Prescription Claim Form, Effective May 23, 2007

[redacted]

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Indiana Medicaid
COMPOUNDED PRESCRIPTION CLAIM FORM

MEMBER NAME: LAST, FIRST 1	RID NO. 2	PRESCRIBER NPI 3	EMERGENCY 4	PREG 5	PATIENT LOCATION CODE 6

DAW CODE 7	REFILL NUMBER 8	PRESCRIPTION NUMBER 9	DATE PRESCRIBED 10	DATE DISPENSED 11	TOTAL QUANTITY DISPENSED 12	DAYS SUPPLY 13

USUAL & CUSTOMARY CHARGE 14	ROUTE OF ADMINISTRATION CODE 15	SUBMISSION CLARIFICATION CODE 16	OTHER COVERAGE CODE 17	TPL AMOUNT PAID 18	OTHER AMOUNT CLAIMED SUBMITTED 19	GROSS AMOUNT DUE 20

LINE NUMBER	21 NDC NUMBER	22 DESCRIPTION OF INGREDIENT	23 INGREDIENT QUANTITY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

BILLING PROVIDER'S NAME AND ADDRESS
24

BILLING PROVIDER NPI
25

PROVIDER TYPE
☐ PHARMACY
☐ PHYSICIAN
☐ DENTIST
☐ OTHER
26

This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements or documents, or concealment of material fact may be prosecuted under applicable Federal or State laws.

I, the undersigned, being aware of restricted funds in the Medicaid Program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient. I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of Provider or Representative ☐ 27

Date Filed 28

MAIL COMPLETED CLAIM FORM TO:
EDS Pharmacy Claims
P.O. Box 7268
Indianapolis, IN 46207-7268

Effective: May 23, 2007

Form Number: PRX005