

Pharmaceutical Services Provider Guide



Supplemental information for
Oregon Medicaid providers

- Point of Sale and ProDUR
- Prior authorization
- Paper billing
- Forms and other resources



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NOTE: DMAP provides the Information and instructions contained in this booklet as a supplement to the program policies found in the current Pharmaceutical Services Oregon Administrative Rules (Chapter 410 Division 121). See current Pharmaceutical Services rulebook for official policies regarding billing.

Eligibility and coverage

Client eligibility and enrollment

DMAP General Rule 410-120-1140 Verification of Eligibility and Coverage requires all enrolled providers to verify eligibility on the date of service.

- DMAP will not pay claims for clients who are not eligible on the date of service.
- For clients enrolled in an OHP managed care plan, DMAP will not pay for services covered by the managed care plan, except as provided by statute and included in Oregon Administrative Rule (OAR).

Resources

To determine client eligibility and enrollment, verify with one of the following. For more information, go to www.oregon.gov/OHA/healthplan/tools_prov/electronverify.shtml.

- Automated Voice Response (AVR): Call 866-692-3864. A quick reference for verifying client eligibility via AVR is available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/OE3162.pdf>.
- Provider Web Portal: Go to <https://www.or-medicaid.gov>.
- 270/271 transaction: Available to approved Electronic Data Interchange (EDI) providers.

Client copayment information *See OAR 410-120-1230 for more information*

Copayments are excluded for the following clients:

- Eligible clients younger than 19 years of age;
- Pregnant women;
- Clients in Long Term Care;

- OHP Standard clients (KIT);
- OYA foster clients over the age of 19;
- American Indian/Alaska Native clients;

The following services are exempt from copayment:

- Mail order pharmacy claims;
- Indian Health Services (Tribal) claims;
- 96 hour emergency supplies, as defined in OAR 410-120-0000;
- Immunizations;
- Infant formulas;
- Nutritional supplements;
- Family planning drugs (Therapeutic Classes 36 and 63).

How to determine client copayments

When using AVR to verify client eligibility, a message beginning with, “Some clients will be responsible for copayments” will only play when the client being inquired upon has a copayment. For more information about copayments, go to the [Copayment FAQ](#) page.

NOTE: DMAP is the payer of last resort. When the claim is for a service DMAP covers, you can only collect DMAP copayments (if applicable) from the clients. Do not collect primary copayments or deductibles.

Client coverage information

Medicare Part B clients

Claims for Oregon Medicaid clients with Part B coverage are billed to Medicare. The remaining balance is paid by DMAP up to the Medicaid allowed amount.

Medicare Part D dual eligibles

Oregon Medicaid clients may have Part D coverage (Dual Eligibles).

Part D dual eligible clients in Oregon are identified in the enrollment file by benefit package of BMM and BMD.

Claims for covered Part D medications for Dual Eligibles will deny with edit 2514, as NCPDP 70, NDC not covered.

Oregon Medicaid does not cover Part D drugs and pharmacies cannot coordinate benefit or split bill for co-payment between Part D and Medicaid benefit coverage.

For Part D coverage information, call the MMA Hotline at 877-585-0007.

See the Appendix for a listing of Oregon Medicare Part D plans, billing information and contact numbers.

Fee-for-Service (FFS) dual eligibles drug coverage

The following categories are covered:

- Selected agents used for symptomatic relief of cough/cold
- Selected vitamins and minerals
- Selected OTC drugs
- Barbiturates
- Benzodiazepines with quantity limit of 15 tablets/capsules per rolling 30 day period. Higher quantities deny with edit 6830 (Plan Limitations Exceeded), and require prior authorization. Benzodiazepine sedatives with quantity limits include:
 - ✓ estazolam
 - ✓ flurazepam
 - ✓ quazepam
 - ✓ temazepam
 - ✓ triazolam

Prepaid Health Plan dual eligible coverage

In instances where the patient has Part D coverage and Prepaid Health Plan coverage, the following rules apply:

- DMAP covers benzodiazepines in Therapeutic Class (TC) 7.
- All other drugs are billed to the client's Prepaid Health Plan (PHP).

Long Term Care (LTC) clients

LTC claims for certain drugs are not covered through the pharmacy benefit and are considered part of the per diem paid to the institution.

For information regarding LTC clients, refer to OAR 410-121-0148 and OAR 410-121-0625 in the in the Pharmaceutical Services Administrative Rulebook.

Pharmacy Management Program *See OAR 410-121-0135 for more information*

When Pharmacy Management Program (lock-in) clients attempt to fill their prescription elsewhere than their designated pharmacy, the claim will reject with edit #2603 "Recipient Lock in (NCPDP Reject Code M2)

Providers may call the Oregon Pharmacy Call Center for override consideration. Override is for DOS only.

PMP clients may receive drugs from a different pharmacy if the client urgently needs to fill a prescription and the enrolled pharmacy:

- Is not available;
- Does not have the prescribed drug in stock; or
- Is more than 50 miles away from client's location at the time the prescription needs to be filled.

However, DMAP may deny coverage if the client frequently fills prescriptions out of the area of the enrolled pharmacy.

Prepaid Health Plan (PHP) coverage *See OAR 410-141-0070 for more information*

DMAP covers only the following (carve out) drugs for OHP clients enrolled in a Prepaid Health Plan (fully-capitated health plan or physician care organization):

- Therapeutic Class/Code (TC): 7 and 11
- Depakote and generic equivalents
- Lamictal and generic equivalents

For a listing of current carve-out drugs, go to www.oregon.gov/OHA/healthplan/tools_prov/711carveout.xls.

Drug coverage information

Coverage exclusions

- Expired drug products;
- Drug products without an assigned NDC;
- Drug products that are not FDA approved;
- Drug Efficacy Study Implementation (DESI) drugs:
 - ✓ The DESI list is available on the CMS Web site at www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp.
 - ✓ For more information regarding DESI, please refer to OAR 410-121-0420 in the Pharmaceutical Services Administrative Rulebook.
- Drugs for non-funded conditions on the Oregon Health Plan (OHP) Health Services Commission (HSC) prioritized list: For more information regarding the HSC, go to the HSC Web site at www.oregon.gov/OHPPR/HSC/index.shtml.
- Home pregnancy kits;
- Fluoride for clients 19 years of age and older.
- Drug products dispensed for Citizen/Alien-Waived Emergency Medical (CAWEM) client benefit type;
- Written (non-electronic) prescriptions that are not executed on a tamper-resistant pad.

- Medicare Part D covered drugs or classes of drugs for fully dual eligible clients: See pages 3-4 for more information.
- Claims for clients enrolled in a managed care plan, with the exception of drugs carved out for DMAP payment as outlined in OAR 410-141-0070.
- Non-rebatable drugs: Drugs not listed on the Medicaid Drug Rebate List are not covered for Medicaid clients. Drug claims will also deny if the date of service exceeds the CMS Termination Date on the Medicaid Drug Rebate file.

Covered non-rebatable drugs

DMAP covers some drugs not listed on the Medicaid Drug Rebate List, including:

- Oral nutritional supplements used for total nutrition
- Selected vitamins
- Vaccines
- Infant formulas
- One pill splitter/cutter per client per twelve month period billed via POS with a valid NDC number.

Age limits *See OAR 410-121-0147 for more information*

- Fluoride (excluding vitamin combinations) is not covered if client is 19 or older.
- Plan B (emergency contraception) requires a prescription for female clients under 17 years of age. Plan B may be dispensed OTC for female clients age 17 and over. Refer to OAR 410-121-0160 for more Plan B information.
- Pharmacist-administered immunizations: Client must be 11 years or older. DMAP covers up to three immunizations for one date of service. For information about the Vaccines For Children (VFC) Program please visit the Medical Surgical provider guidelines at www.dhs.state.or.us/policy/healthplan/guides/medsurg/main.html.

Provider payment information *See OAR 410-121-0155 for more information*

The major source of updating the drug reference data is from the commercial First DataBank (FDB) drug files. The weekly file updates from FDB update information on the drug reference database, including items such as:

- Wholesale pricing
- Federal Upper Limit (FUL) pricing
- Drug Efficacy Study Implementation (DESI) data,
- CMS rebate-related information.

Federal Upper Limit *See OAR 140-121-0300 for more information*

In 1987, regulations limited the amount which Medicaid could reimburse for drugs with available generic drugs under the Federal Upper Limit (FUL) Program. These limits are intended to ensure that the federal government acts as a prudent buyer of drugs, and achieve savings by taking advantage of the current market prices. FUL pricing is updated weekly from FDB drug file update information.

For more information concerning CMS FULs go to the Pharmaceutical Services provider guidelines at www.dhs.state.or.us/policy/healthplan/guides/pharmacy/main.html (click on “Billing information”).

Note: FUL price can be overridden if the provider enters a “1” in the DAW field, but this requires prior authorization from the prescriber.

Average Actual Acquisition Cost *See OAR 410-121-0155 for more information*

This is the maximum price DMAP will pay for a specific NDC. AAAC lists for brand-name and generic drugs are available in the Pharmaceutical Services provider guidelines at www.dhs.state.or.us/policy/healthplan/guides/pharmacy/main.html (click on “Billing information”).

AAAC reimbursement rate reviews

If the AAAC price for a specific NDC is below the pharmacy’s usual cost, the pharmacy should submit a Reimbursement Rate Review request to Myers and Stauffer, LC, for review. For more information, go to <http://or.mslc.com/RequestRateReview.aspx>.

A copy of this form and instructions are also in the Forms section of this supplement.

340B program

The federal 340B Public Health Services (PHS) program allows eligible safety net providers to buy drugs at very low prices. Eligible providers include federally-qualified health centers, disproportionate share hospitals, and urban Indian organizations.

For more information about the 340B program, go to www.hrsa.gov/opa/introduction.htm.

For information about billing as a 304B provider, see the Billing Information section of this document.

Billing information

Billing for pharmacy services

Pharmacy providers are encouraged to submit pharmacy claims via Point of Sale (POS) to access real time ProDUR information and claim adjudication. See page 15 for information.

For information about submitting claims using the Provider Web Portal, go to www.oregon.gov/OHA/healthplan/webportal.shtml.

Whenever possible, only use the NCPDP 5.1 Universal Claim Form (UCF) when billing for medications that cannot be billed electronically via Point-of-Sale or Web portal, such as:

- Claims more than a year old (from the date of service);
- Death with Dignity claims: See OAR 410-121-0150 (8) (a-d).

See the Forms section of this supplement for a sample UCF and how to complete and submit UCF claims.

Dispensing limits

- Dispensing Fees: See OAR 410-121-0160.
- Days Supply Limits: See OAR 410-121-0146.
- Dose/Duration: See OAR 410-121-0040-2.
- Metric Quantity: See OAR 410-121-0280.

Diabetic supplies and pill splitters/cutters

Pharmacies can bill POS for diabetic supplies (e.g., test strips, lancets, insulin syringes) and one pill splitter/cutter with a valid NDC number per client in a twelve month period.

Diabetic supplies prescribed in excess of DMAP's utilization guidelines require prior authorization (PA) from DMAP's Medical Management Unit (see the Prior Authorization section of this guide).

Pharmacy-based immunization delivery *See 410-121-0185 for more information*

When administering immunizations for adults (ages 19 and older), the pharmacy can bill POS with the serum's NDC. DMAP will automatically apply the administration fee equivalent to Current Procedural Terminology (CPT) codes 90470- 90474.

For current administration fee rates, refer to the OHP FFS Fee Schedule Web page at www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml. This rate is subject to change, based on DMAP's annual Relative Value Unit weight adjustments.

Emergency dispensing procedures

Refer to OAR 410-121-0060 in the in the Pharmaceutical Services Rulebook.

340B claims

340B providers must be enrolled with provider specialty 408, using the provider IDs (DMAP provider ID and NPI) they use for 340B purchasing.

- These IDs should be on the federal Medicaid Exclusion file. For more information about the Medicaid Exclusion file, go to www.hrsa.gov/opa/medicaidexclusion.htm#tutorial.
- Only use these IDs when billing DMAP for 340B drugs.
- **340B pharmacies are expected to bill actual acquisition cost for 340B drugs.** Reimbursement is the lesser of the acquisition cost, the Federal Upper Limit, or federal 340B pricing.

340B providers who choose to dispense drugs outside the 340B program (*i.e.*, “carve out” drugs) must bill for those drugs under a separate Medicaid ID and NPI.

Indian Health (Tribal) claims

Tribal pharmacies enroll with provider specialty 404. A patient attribute of HNA is required. Copays are excluded.

Long Term Care (LTC) clients

LTC clients are exempt from copays. All PA and ProDUR alerts apply. The dispensing pharmacy must be enrolled with provider specialty 402. For CII partial fills:

- RX # will be valid for 60 days from the date of fill.
- After the 60 day time period, the claim will deny and return a supplemental message indicating that a new RX # is required.
- The provider receives the usual dispensing fee paid for each fill.

Billing for professional services

Providers must bill for the following services using the professional claim format (837P electronic transaction, CMS-1500, or DMAP 505 paper claim form).

- For information about how to complete and submit CMS-1500 and DMAP 505 claims, refer to the DMAP Billing Tips available at www.oregon.gov/OHA/healthplan/tools_prov/tips/main.shtml.
- For information about how to submit the 837P transaction, refer to the *Oregon Medicaid 837 Professional Companion Guide - Fee-for-Service* at www.oregon.gov/OHA/edi/resources.shtml.
- For information about submitting claims using the Provider Web Portal, go to www.oregon.gov/OHA/healthplan/webportal.shtml.

Clozapine supervision *See OAR 410-121-0190 for more information*

Clozapine supervision is the management and record keeping of clozapine dispensings as required by the manufacturer of clozapine. Clozapine is covered only for the treatment of clients who have failed therapy with at least two anti-psychotic medications.

Use the appropriate CPT procedure code and modifier. Indicate the ICD-9 diagnosis code to the 5th digit. Document all of the following:

- Exact date and results of White Blood Counts (WBCs), upon initiation of therapy and at recommended intervals per the drug labeling;
- Notations of current dosage and change in dosage;
- Evidence of an evaluation at intervals recommended per the drug labeling requirements approved by the FDA;
- Dates provider sent required information to manufacturer. Only one provider, either pharmacist or physician, may bill per week per client (limited to five units per 30 days per client);

Bill for Clozapine Therapy (the actual drug product) as a pharmacy claim.

Durable Medical Equipment (DME) and medical supplies

DME and medical supplies are not billed POS, except for diabetic supplies and one pill splitter/cutter with a valid NDC number per client in a twelve month period.

For information on how to request prior authorization and bill for Durable Medical Equipment and Supplies, refer to the DMEPOS provider guidelines at www.dhs.state.or.us/policy/healthplan/guides/dme/main.html.

Enteral-Parenteral and IV (EPIV) Services

For information on how to request prior authorization and bill for EPIV services (e.g., oral nutritional supplements), refer to the Home EPIV provider guidelines at www.dhs.state.or.us/policy/healthplan/guides/homeiv/main.html.

Vaccines for Children (VFC) *See OAR 410-121-0185 for more information*

The VFC Program covers immunizations for clients younger than 19 years of age. When billing for VFC services:

- Use the appropriate CPT code (90470-90474) for the administration plus the appropriate vaccine code(s) (90476-90749):
- Include an ICD-9 diagnosis code to the highest degree of specificity.

Medication Therapy Management (MTM)

Pharmacists must enroll with DMAP as a professional provider to bill for MTM services. Services must be provided based on referral from a physician, licensed provider, or a Prepaid Health Plan (PHP). Use the following codes to bill for MTM services:

Code	Description	DMAP rate
99605	Initial 15 minutes, new patient	\$28.22
99606	Initial 15 minutes, established patient	\$26.34
99607	Each additional 15 minutes.	\$13.17

For documentation requirements, refer to Guideline Note 64 of the Prioritized List of Health Services. For specific information on when to bill for MTM services, refer to CPT coding guidelines.

Coordination of benefits *See OAR 410-120-1280 and 140- 120-1340*

Medicaid (DMAP) must be the payer of last resort whenever possible. Before billing DMAP, find out if the client has other health coverage (third party liability, or TPL). If the client has TPL (including Medicare), you must bill the TPL first before billing DMAP.

If any part of a claim is paid by a TPL:

- You must not charge the client for TPL copayment, coinsurance or deductible.
- DMAP will pay the remainder up to the DMAP allowed amount, less any DMAP copayment that applies. If TPL pays more than DMAP's allowable, then DMAP would pay zero and no DMAP copayment applies. That is considered "payment in full." You must not charge the client for the remainder.

When billing DMAP as secondary (after billing TPL):

- List all TPL payments already paid for the claim.
- If TPL denies or "zero pays," do not use Other Coverage Code 5,6 or 8.

Note: Intentional misuse of TPL coding is fraudulent and DMAP will recoup all resulting overpayments.

Remittance advice

The paper remittance advice (RA) tells you about payment, denial, or other actions taken on a claim. If you are expecting a paper check, you will find it on the third page of your RA. Claims “in process” (suspended) will also appear on your RA.

- The information you see on the RA is the information our system used to process your claim. If you receive an incorrect payment, you must adjust the claim using the Individual Adjustment Request (DMAP 1036) or Provider Web Portal. If DMAP made no payment, your RA will tell you to resubmit or adjust the claim.
- It is important to distinguish between a claim and an RA. You may receive one RA for many clients. Each line on the RA indicates an individual claim. One problem claim will not delay payment for the other claims listed on the RA.

For more information about the remittance advice, go to DMAP’s Remittance Advice Web page at www.oregon.gov/OHA/healthplan/tools_prov/read-ra.shtml.

Electronic remittance advice

Providers who submit electronic claims in the 837 format can choose to receive the 835 Fee for Service Payment/Advice transaction. Like the paper RA, the 835 transaction displays the number of claims and the adjudication status of your claims in Oregon’s Medicaid system. It does not contain suspended claim information.

The 835 contains HIPAA Claim Adjustment Reason Codes. A list of these codes can be found on the Washington Publishing Web site www.wpc-edi.com/content/view/180/223/. For more detailed codes, refer to the paper RA.

To sign up for the 835 transaction, contact EDI Support Services.

Web portal claim search

Instead of waiting for the paper Remittance Advice to come in the mail, authorized providers can review previously submitted claims on the Provider Web Portal at <https://www.or-medicaid.gov> and adjust, void, or resubmit claims as needed.

For more information, go to the Provider Web Portal resources page at www.oregon.gov/OHA/healthplan/webportal.shtml.

Correcting claims

You have three options to adjust a claim that you submitted and DMAP processed:

- Send a paper DMAP 1036 Individual Adjustment Request (see the Forms section);
- Adjust the claim electronically using the Provider Web Portal; or
- Submit the 837P transaction (refer to the 837 Companion Guide).

If DMAP denied your claim, you can submit a corrected claim on paper, Web, or the 837.

Point of sale

Accepted electronic claim formats

DMAP accepts two forms of electronic pharmacy claim submissions: The NCPDP 5.1 Point of Sale (POS) transaction for fee-for-service pharmacies; and the NCPDP .1 format for all batch submissions from OHP contracted managed care organizations (MCOs).

- For more information about the NCPDP 1.1, go to the EDI Web site at www.oregon.gov/OHA/edi (click on “Resources,” then “Companion Guides”).
- A listing of NCPDP v5.1 reject codes crosswalked to edits and EOB codes is available in Appendix C.

DMAP is currently preparing for NCPDP D.0 implementation. For links to recent announcements and resources about this change, go to the Pharmacy Program’s BillingInformation page at www.dhs.state.or.us/policy/healthplan/guides/pharmacy/billing.html#pos.

Value Added Networks (“switches”)

A Value Added Network (VAN) is a third party service that transmits and stores EDI data in an “electronic mailbox” until it is picked up by the appropriate party. A VAN serves as a middleman, so that neither party can access the other’s private network. A VAN must have a current Trading Partner Agreement with DHS/OHA in order to exchange EDI data.

DMAP accepts pharmacy POS claims from the following approved VANs:

Emdeon (formerly WebMD, Envoy)	24 Hour Assistance: 1-615-231-4610 Help Desk: 800-333-6869
ERx	24 Hour Assistance: 866-erxnetwork (answering service) or itoncallpager@erxnetwork.com (on-call pager)
QS1	24 Hour Assistance: 864-253-8600 ext 7734 (pager)
RelayHealth (formerly Per-Se, NDC)	24-hour General Customer Service: 800-895-0333 24-hour Technical Assistance: 1-404-728-2570.

POS transaction types

The following transaction codes are defined according to the standards established by the NCPDP. Ability to use these transaction codes will depend upon the pharmacy's software.

At a minimum, all providers should have the capability to submit original claims (Transaction Code B1) and reversals (Transaction Code B2). Additionally EDS will also accept re-bill claims (Transaction Code B3).

Full Claims Adjudication (Transaction Code B1)

This transaction captures and processes the claim and returns to the pharmacy the dollar amount allowed under the DMAP reimbursement formula.

Claims Reversal (Transaction Code B2)

This transaction is used by the pharmacy to cancel a claim that was previously processed.

- To submit a reversal, the provider must void a claim that has received a Paid status.
- To reverse a claim, the provider selects the Reversal (Void) option in the pharmacy's computer system.
- The following fields must match on the original paid claim and on the void request for a successful claim reversal:
 - ✓ NPI provider number
 - ✓ Prescription number
 - ✓ Date of service (date filled)

Claims Re-Bill/Adjustments (Transaction Code B3)

This transaction is used by the pharmacy to adjust and resubmit a claim that has previously been processed and received a Paid status. A "claims re-bill" voids the original claim and resubmits the claim within a single transaction .

Required data elements

Each NCPDP transaction has **mandatory/required**, **optional** and **not sent** data elements specific to Oregon Medicaid. For more information, refer to the Oregon Medicaid Pharmacy Payer Sheet at www.dhs.state.or.us/policy/healthplan/guides/pharmacy/payer-sheet.pdf.

Client date of birth

DMAP requires the client's/recipient's date of birth (DOB) in the Patient Segment, 304-C4, of all B1 and B3 transactions.

Days Supply information *See OAR 410-121-0146 for more information*

Days supply information is critical to the edit functions of the ProDUR system. Submitting incorrect days supply information in the days supply field can cause false ProDUR alerts or claims denial for that particular claim or drug claims that are submitted in the future.

For Federally-Qualified Health Center (340B), Indian Health Services (tribal), and mail-order pharmacy claims:

- A 100 day supply is allowed on maintenance drugs (FDB Maintenance Indicator = 1).
- The maximum day supply quantity is limited to 34 days on prescriptions for ataractics, tranquilizers (TC 07), muscle relaxants (TC 08), CNS stimulants (TC 10), psychostimulants, antidepressants (TC 12), narcotic analgesics (TC 40), sedative barbiturates (TC 46), and sedative non-barbiturates (TC 47).

Metric Quantity

The true metric decimal quantity must be submitted as the QUANTITY DISPENSED (NCPDP field 442-E7). Do not round off any quantity amounts.

National Provider Identifier requirements

Pharmacies must include a valid NPI for the prescriber when submitting a POS claim. The pharmacy is responsible for obtaining the NPI if it is not provided by the prescriber. To obtain a valid NPI, contact the prescriber first.

If you are unable to obtain the NPI from the prescriber, you can search for the NPI using the free National Plan and Provider Enumeration System (NPPES) NPI Registry at <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>.

- All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice.
- You can search by NPI, Legal Business Name, or other simple searches.

If you have exhausted all NPI resources and cannot identify the prescriber NPI, call the Oregon Pharmacy Call Center at 888-202-2126.

Important reminders:

Do not use 999999 as a prescriber ID. Instead, use the prescribing provider's NPI.

When dispensing Plan B to female clients over 17 years of age, do not use BBBB as a prescriber ID. Instead, use the dispensing pharmacy's NPI for OTC products. If prescribed, use the prescriber's NPI.

When dispensing vaccinations, use the dispensing pharmacy's NPI as the prescriber ID. If the vaccination is prescribed, use the prescriber's NPI.

Other Coverage Codes

On Coordination of Benefit (COB) claims, indicate any denial code received from the primary or secondary payer by using an OCC override code in the Other Coverage field (308-C8).

DMAP will only accept the following values:

Value	Description	When to use this value
1	No other valid pharmacy coverage in effect.	The provider has confirmed that the client does not have valid pharmacy coverage. ◆ Submit the claim with an OCC 1, a valid Other Payer Denial Date and the Other Payer ID returned on the original claim.
2	An amount is collected from another payer.	When any positive amount of money is collected from another payer. ◆ Submit the claim with an OCC 2, the amount collected, the date the claim was adjudicated by the primary payer, and the Other Payer ID.

Value	Description	When to use this value
3	Primary payer does not cover the specific drug being submitted.	<p>The primary payer returned a NCPDP 70 (NDC Not Covered) denial; a DMAP covers the drug; and the claim's Coordination of Benefits (COB) segment (NCPDP Field 472-6E) contains a valid Other Payer Reject Code.</p> <ul style="list-style-type: none"> ◆ Submit an OCC 3, Other Payer ID and a valid Other Payer Denial Date. ◆ POS claims that do not meet the criteria will return NCPDP Reject Code 6E (M/I Other Payer Reject Code). <p>If the primary carrier requires a Prior Authorization (NCPDP 75), follow the primary carrier's PA procedures prior to submitting the claim to DMAP for payment.</p> <p>If you receive other error codes, take action to resolve the problem (such as re-directing the client to a different pharmacy or contact the doctor's office). Use another OCC only if appropriate.</p>
	Plan limitations exceeded (NCPDP Reject Code 76)	There has been an attempt to resolve the problem with the primary payer, particularly if the plan limit is only a certain "days supply" quantity.
4	Client has yet to meet their primary payer's deductible.	<p>The client has not met their primary payer's deductible, and the primary payer payment is zero.</p> <ul style="list-style-type: none"> ◆ Submit claim with an OCC 4, a zero amount collected from the primary payer, the Other Payer ID, and the date the claim was adjudicated by the primary payer.
	Total cost of the claim is less than the client's primary payer's co-payment.	<p>The total cost of the claim is less than the client's primary payer's co-payment, and the adjudication of the claim by the primary payer resulted in zero payment.</p> <ul style="list-style-type: none"> ◆ Submit claim with an OCC 4, a zero amount collected from the primary payer, the Other Payer ID, and the date the claim was adjudicated by the primary payer.
	Client's primary insurance requires the client to pay for medications.	<p>Client's primary insurance requires the client to pay for the medications at the time of dispensing and submit receipts for reimbursement.</p> <ul style="list-style-type: none"> ◆ Submit claim with an OCC 4, a zero amount collected from the primary payer, the Other Payer ID, and the date of service in the Other Payer date field. ◆ In these cases, DMAP will be responsible for collecting the payment from the primary payer.

Value	Description	When to use this value
7	Client has a break in insurance coverage.	For situations where the provider has confirmed that the client's pharmacy coverage is not yet in effect for the date of service on the claim. ◆ Submit claim with an OCC7, Other Payer ID, and valid Other Payer Denial Date.

Claim-specific transaction requirements

Claims subject to ProDUR review

For claims that may trigger Early Refill (ER), Drug-Pregnancy (PG) or High Dose (HD) ProDUR alerts and denials, pharmacies may enter the appropriate Submission Clarification Code in NCPDP field 420-DK for informational purposes.

- 02 - Other Override
- 03 - Vacation Supply
- 04 - Lost Prescription
- 05 - Therapy Change
- 06 - Starter Dose
- 07 - Medically necessary

Compound prescription requirements

Make sure to process compound claims using “multiple ingredient functionality.” Fields marked with an asterisk (*) are required on all compound claims. Compounds are limited to a maximum of 25 ingredient components.

All POS edits apply to each NDC on the claim. EDS will review and price all drugs within the compound based on established pricing criteria.

- In the claim segment, enter “000000000000” as the Product ID and “00” as the Product ID Qualifier to identify the claim as a compound claim.
- In the compound segment, report the National Drug Code (NDC) and quantity for each ingredient detail.
- If DMAP doesn't cover one of the NDCs listed in the compound segment, or if any of the NDCs require prior authorization (PA), the claim will deny.
- If the claim denies, resubmit the claim with Submission Clarification code “08” in field 420-DK. This tells the system to process the compound for approved ingredients.

Field	Name	Required values
Claim segment		
406-D6	Compound Code*	02
420-DK	Submission Clarification Code	08
436-E1	Product/Service ID Qualifier*	00
407-D7	Product/Service ID*	00000000000
442-E7	Quantity Dispensed	(Sum of all ingredient quantities in Compound Segment)
Pricing segment		
430-DU	Gross Amount Due	(Sum of all ingredient drug costs in Compound Segment)
Compound segment		
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*	(Up to 25; this number may be automatically filled in by your POS software)
488-RE	Compound Product ID Qualifier*	03 (this may be automatically filled in by your POS software)
489-TE	Compound Product ID*	(NDC of each ingredient component)
448-ED	Compound Ingredient Quantity*	(Quantity of each ingredient component)
449-EE	Compound Ingredient Drug Cost*	(Cost of each ingredient component)

Medicare Part B claims

When a client is Part A and B eligible, but not Part D eligible, the claim will return EOB 0389, 0154, or 0091 (see the NCPDP-EOB Edit Crosswalk on page 56 for more information) .

When this happens, bill DMAP using the appropriate OTHER COVERAGE CODE in NCPDP field 308-C8, OTHER PAYER DATE in NCPDP field 443-E8, and OTHER PAYER AMOUNT PAID in NCPDP field 431-DV.

System availability

The Oregon Medicaid POS system will be available 24 hours a day, 7 days a week, except for weekly maintenance during non-peak hours over the weekend.

The system's server counters and controls reset nightly at approximately midnight, which may cause a brief period of unavailability (less than 5 minutes).

If for any reason the POS system is not available, wait to submit claims until the system is back online. To facilitate this process, make sure your POS software has the capability to submit backdated claims.

POS system error messages

Occasionally providers may receive a message that indicates their network is having technical problems communicating with the Oregon Medicaid POS system.

NCPDP	Message	Description
90	Host hung up	Host disconnected before session completed.
92	System Unavailable/ Host Unavailable	Processing host did not accept transaction or did not respond within time out period.
99	Host Processing Error	Do not retransmit claims.
93	Planned Unavailable	Transmission occurred during scheduled downtime.

If you get one of these messages, follow these steps. If these steps don't solve your problem, contact the Oregon Pharmacy Call Center.

Make sure your power is on and that the telephone line is working.

Call the telephone number your modem is dialing into.

- Note the information heard (i.e., fast busy, steady busy, recorded message).
- Contact your software vendor if unable to access this information in the system.

If you have technical support staff in your organization or through a VAN, refer the problem to them.

The technical support staff will coordinate with the Oregon Pharmacy Call Center to resolve the problem.

Timely filing limits

Most providers submit their POS claims at the time of dispensing. However, there may be mitigating reasons that require a claim to be submitted after the fact.

For more information regarding timely submission of claims and/or appeals/claims reconsideration, please refer to OAR 410-120-1300 and OAR 410-120-1570 in the General Rules Program Rulebook.

B1 transactions	For all original claims, the timely filing limit for this program is 366 days from the date of service. ◆ POS claims that exceed this limit will deny.
B2 and B3 transactions	Reversals, re-bills and adjusted claims may be submitted 366 days from date of service plus the days supply on the original claim. ◆ Prescriptions for 30 days supply can be reversed through POS up to 396 days from the date of service. After these time limits have expired, you must rebill or adjust the POS claim on paper: ◆ Adjustments require an Individual Adjustment Request form (DMAP 1036). See Forms section of this supplement for instructions and a sample copy of this form. ◆ Denied claims that are 366 days from date of service require the NCPDP 5.1 Universal Claim Form.

Data Integrity Audit Program

Based on POS data, the Oregon Pharmacy Call Center will audit inaccurate days supply entries, metric quantities, credit return frequency, and frequent use of early refill and Pharmacy Management Program (also known as lock-in) overrides. The Call Center will report findings and recommend further investigation to DMAP.

Prospective Drug Utilization Review (ProDUR)

Overview

Fully integrated with the Oregon Medicaid Point of Sale system and general claims processing system, the ProDUR subsystem performs Prospective Drug Utilization Review (ProDUR) against pharmacy claims, alerting the pharmacist of potentially inappropriate prescriptions before the medication is dispensed.

- The POS system's real-time edits use criteria supplied by both First DataBank (FDB) and the Oregon DUR Board. Standard NCPDP alerts are supported by the claims processing system.
- The ProDUR system reviews drug claims against the client's previous claims and medical history for therapeutic appropriateness, focusing on those clients at the highest severity of risk for harmful outcome, and intervening and/or counseling when appropriate

After this review, the system determines if any ProDUR alerts should be returned to pharmacy providers. These real-time alerts describe conflict and severity, and provide references during the claims adjudication process.

Pharmacy providers can use this information to alter the medications they choose to dispense, cancel a claim based on the information received or override the alert with NCPDP override codes if such overrides are permitted by the State.

DMAP has used reasonable care to accurately compile ProDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their clients

ProDUR alert criteria

A ProDUR alert can be triggered on a POS claim in three ways:

- By information supplied directly on the POS pharmacy claim (Drug – Pregnancy, Drug Age – Pediatric and Geriatric and High Dose/Low Dose);
- Based on prior claim history (Drug to Drug Interaction, Late Refill, Early Refill, Therapeutic Duplication and Ingredient Duplication);
- Based on a Client Profile created from any paid claim (except dental) submitted for a client (Drug – Pregnancy, Maximum Duration of Therapy, Minimum Duration of Therapy, Drug –Allergy, Drug – Disease (reported) or Drug – Disease (inferred)).

ProDUR alert sequence

The order in which the ProDUR alerts are performed is as follows. Make sure to read and resolve ProDUR alerts on the **initial prescription response**.

Attempts to re-process or transmit the prescription after the initial ProDUR response must include the appropriate Conflict Reason, Professional Service Intervention, and Result of Service/Outcome codes.

Alerts requiring override

The following ProDUR alerts require the pharmacist to respond and override to avoid claim denial.

Code	Description	Trigger	EOB
PG	Drug-Pregnancy	A pregnancy condition is indicated by either of the following methods: <ul style="list-style-type: none">◆ Pregnancy indicator on the pharmacy claim set in the “affirmative,” or◆ An active pregnancy record is found on the recipient’s profile.	3543
ER	Overutilization (Early Refill)	The days supply for the last-filled prescription conflicts with the prescription being filled. <ul style="list-style-type: none">◆ Various situations can cause this alert, including but not limited to dose changes, lost or stolen prescriptions, vacation supply, fill at another location not picked up and incorrect days supply calculation on the offending claim.	3539

Code	Description	Trigger	EOB
HD	High Dose	The maximum daily dose (quantity dispensed divided by days supply) has been exceeded for the following drugs: <ul style="list-style-type: none"> ◆ CNS- Stimulants ◆ Oxycodone-Narcotic Long Acting ◆ Narcotic Combinations with Aspirin and Acetaminophen 	3541

Informational messaging on ER alerts

The ER alert advises the pharmacy of the reason for the alert, if based on a check against the client's drug claim history. For example, a non-narcotic claim submitted before 75% of the previous days supply has been used will trigger a denied claim status, and display the following messages:

- An "Other Pharmacy" indicator that shows if the previous days supply is from the same pharmacy or a different pharmacy;
- A message including the dispense date in MMMDD format (*e.g.*, JUL27) and the first 11 to 25 characters of the generic drug name. If the previous days supply is from a different pharmacy, this message will also contain the other pharmacy's telephone number.

Informational alerts

All other ProDUR alerts are informational only. These codes do not require override codes.

Code	Description	EOB
TD	Therapeutic Duplication	3536
NF	Non-Formulary Drug	3578
ID	Ingredient Duplication	3535
DD	Drug-Drug Interaction	3537
PA	Drug-Age Geriatric	3534

Code	Description	EOB
PA	Drug-Age Pediatric	3534
MC	Drug-Disease	3546
DA	Drug Allergy	3533
DC	Drug-Disease (inferred)	3546
MX	Excessive Duration	3544
LR	Underutilization	3545

ProDUR alert overrides

When you receive ProDUR alerts ER, HD, or PG, the claim will deny with EOB 7000.

- To override the ProDUR denial, you must submit the appropriate override codes (listed below for PG, ER and HD alerts).
- Claims submitted without these three codes will return EOB 7002, which requires correcting and resubmitting the claim with the appropriate override codes.

Conflict Reason Code		Intervention Codes		Outcome Codes	
NCPDP Field 439-E4		Field 440-E5		Field 441-E6	
PG	Drug Pregnancy - Major to Moderate Severity	M0	Prescriber Consulted	1A	Filled - False Positive
		P0	Patient Consulted	1B	Filled - As Is
				1C	Filled - Different Dose
ER	Early Refill/Over-Utilization	R0	Pharmacist Consulted-Other Source	1D	Filled - Different Directions
				1E	Filled - Different Drug
		00	No Intervention	1F	Filled - Different Quantity
				1G	Filled - Prescriber Approval

Conflict Reason Code		Intervention Codes		Outcome Codes	
HD	High Dose	M0	Prescriber Consulted	2A	Not Filled
		P0	Patient Consulted		
		R0	Pharmacist Consulted-Other Source	2B	Not Filled - Directions Clarified
		00	No Intervention		

High Dose override

Some pharmacy software programs automatically calculate the days supply, sometimes in excess of established dose limits (*e.g.*, more than 4.0 grams of acetaminophen or more than 8.0 grams of aspirin per day) and trigger the HD ProDUR alert.

- In this situation, use Intervention Code M0, P0, or R0 and Outcome Code 2A.
- DMAP will deny the claim, allowing you to retransmit the claim within allowed dose limits. Common excessive dose limits include:
 - ✓ Product containing 325mg of Acetaminophen = 12 maximum quantity per day
 - ✓ Product containing 500mg of Acetaminophen = 8 maximum quantity per day
 - ✓ Product containing 650mg of Acetaminophen = 6 maximum quantity per day
 - ✓ Product containing 750mg of Acetaminophen = 5 maximum quantity per day

In all other circumstances, PA is required to obtain a High Dose override.

Resubmitting claims denied for ProDUR edits

If you fail to enter ProDUR override codes after receiving EOB 7000 on the claim, DMAP will reject the claim with EOB 7002. You have two options for resubmitting the claim:

- Resubmit the claim using the same prescription number, with the proper override codes; or
- Cancel the denied claim using Outcome Code 2A or 2B. Submit a new claim with the same prescription number and any necessary data corrections (*e.g.*, days supply).

When you need help

Alert message information is available from the Oregon Pharmacy Call Center after the message appears. If you need assistance with any alert or denial messages, it is important to contact the Pharmacy Call Center at the time of dispensing.

The Call Center can provide claims information on all error messages sent by the ProDUR system. This information includes NDCs and drug names of the affected drugs, dates of service, days supply and whether the calling pharmacy is the dispensing pharmacy of the conflicting drug or the drug was dispensed by another pharmacy.

Prior authorization

Overview

For drugs that require prior authorization (PA) on Point of Sale (POS) claims:

- A new evaluation feature of the Oregon Medicaid POS system, DUR Plus, reviews incoming POS claims and issues PA when the drug meets appropriate clinical criteria.
- For drugs that do not pass DUR Plus review, pharmacies must contact the prescribing provider, who then requests PA from the Oregon Pharmacy Call Center.

Drugs requiring PA *See OAR 410-121-0400 for more information*

DMAP may require PA for individual drugs and categories of drugs to ensure that the drugs prescribed are indicated for conditions funded by the Oregon Health Plan (OHP) and consistent with the Prioritized List of Health Services and its corresponding treatment guidelines (see OAR 410-141-0480 and 410-141-0520).

For information regarding drugs requiring prior authorization, please refer to Oregon Medicaid PA Criteria at www.dhs.state.or.us/policy/healthplan/guides/pharmacy/clinical.html#pa.

DUR Plus review

The Oregon Medicaid POS system initially evaluates incoming pharmacy claims for basic edits and audits. If the drug on the claim requires prior authorization (PA) and requires DUR Plus evaluation, the claim passes through a series of clinical criteria rules to determine whether DUR Plus can issue PA and allow dispensing the drug to the client.

DUR Plus checks the current drug claim as well as the client's medical and claims history for the appropriate criteria.

- If suitable criteria are found, a prior authorization will be systematically created, applied to the claim, and the claim will be paid. This interactive process occurs with no processing delays and no administrative work for the pharmacy or prescribing provider.
- If all criteria are not met, the claim will be denied and PA will be required. The prescriber will be responsible for requesting PA, using procedures outlined in OAR 410-121-0060.

How to request prior authorization (PA)

For clients enrolled in an OHP managed care plan, contact the plan for their PA procedures.

For OHP fee-for-service (“open card”) clients, and 7/11 carveout prescriptions for managed care clients, use the following contact information:

For prescriptions and oral nutritional supplementss

The Oregon Pharmacy Call Center is available 24 hours per day, seven days a week, 365 days a year, and processes PA requests within 24 hours. When calling in a PA request, have the diagnosis code ready.

Phone: 888-202-2126

Fax: 888-346-0178

Refer to PA procedures outlined in OAR 410-121-0060. See the Forms section of this manual for forms prescribers should use when submitting PA requests to the Call Center.

For emergent or urgent prescriptions that require PA

The Oregon Pharmacy Call Center may authorize up to a 96 hour emergency supply for drugs that require PA, but have no PA on file. Refer to 410-121-0060(4) Emergency Need:

The Pharmacist may request an emergent or urgent dispensing from the Pharmacy Call Center when the client is eligible for covered fee-for-service drug prescriptions.

(a) Clients who do not have a PA pending may receive an emergency dispensing for a 96-hour supply.

(b) Clients who do have a PA pending may receive an emergency dispensing up to a seven-day supply.

For diabetic supplies (lancets, test strips, syringe and glucose monitor supplies)

Diabetic supplies in excess of DMAP's utilization guidelines require PA from DMAP:

DMAP – Medical Management Unit

500 Summer St NE, E44

Salem, OR 97301-1078

503-945-6821 (direct)

800-642-8635 (in-state only)

Use the DHS 3971 form to submit PA requests. Fax the completed form using an EDMS Coversheet (DHS 3970) to one the following fax numbers:

- Routine requests: 503-378-5814
- Immediate/urgent requests: 503-378-3435

See Forms section for sample forms and instructions.

Client hearings and exception requests

For any PA requests that are denied due to DMAP criteria not being met, the right of a client to request a contested case hearing is otherwise provided by statute or rule, including OAR 410-141-0264(10).

- This rule describes when a client may request a state hearing. Clients may request a hearing based upon information included in the PA denial notice.
- Information on how to file an appeal is attached to all PA notices to clients and providers from the Oregon Pharmacy Call Center.

Providers may contact Provider Services at 800-336-6016 to file an exception request on a PA denial. For information regarding OAR 410-120-1860, refer to the General Rules at www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html.

Forms

All DMAP forms are available electronically on the Web at www.oregon.gov/OHA/healthplan/forms/omapforms.shtml.

DMAP 3978 - Pharmacy Prior Authorization Request

Prescribers should submit their PA requests for fee-for-service prescriptions and oral nutritional supplements with required documentation to:

Oregon Pharmacy Call Center

888-202-2126

Fax: 888-346-0178

This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/OE3978.pdf>.

Information needed to request PA

Complete the form as follows. The Oregon Pharmacy Call Center may ask for some or all of the following information, depending upon the class of the drug requested:

DMAP 3978 section	Information needed
Section I:	Requesting provider name and National Provider Identifier. ◆ FQHC/RHC and AI/AN providers - Also enter the pharmacy or clinic NPI for your facility.
Section II	Type of PA Request: Mark "Pharmacy." ◆ FQHC/RHC and AI/AN providers -Mark "Other," followed by provider type (FQHC, RHC, IHS or Tribal 638).
Section III:	Client name and recipient ID number;
Section IV:	Diagnosis code (ICD-9-CM);
Section V:	Drug name, strength, size and quantity of medication. ◆ Participating pharmacy: Include the dispensing pharmacy's name and phone number (if available).
Section VI:	Date of PA Request Begin and End Dates of Service
Section VII:	Complete for EPIV and oral nutritional supplements only.
Section VIII:	Complete for oral nutritional supplements only.



Prior Authorization Request for Prescriptions & Oral Nutritional Supplements

To: Oregon Pharmacy Call Center
888-346-0178 (fax); 888-202-2126 (phone)

Confidentiality Notice:

The information contained in this Prior Authorization Request is confidential and legally privileged. It is intended only for use of the recipient(s) named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax document- except its direct delivery to the intended recipient - is strictly prohibited.

Complete all fields marked with an asterisk (*), if applicable.

I Requesting Provider

* Name * NPI
Contact Name Contact Phone
Contact Fax Processing Time Frame: [] Routine
Supporting Justification for Urgent/Immediate Processing: [] Urgent [] Immediate

II PA Request - Assignment Code (check appropriate box)

* [] Pharmacy [] Home EPIV [] Other

III Client Information

* Client ID DOB / /
* Last Name * First Name, MI

IV Service Information

Estimated length of treatment Frequency
Primary diagnosis * Primary ICD-9 diagnosis code
Other pertinent diagnosis
(For prescriptions and oral nutritional supplements, list all applicable ICD-9 codes or contributing factors)

V Drug/Product Information

* Name * Strength
* Quantity * NDC

Participating Pharmacy:

Name Phone Number - - Date / /

VI Date Information

* Date of Request / / * Expected Service Begin Date / /
* Expected Service End Date / /

VII Code and Cost Information – Required for EPIV and oral nutritional supplements

Line Item	Procedure Code	Modifier	Description	Units	U&C	MSRP	Total Dollars
1					0.00	0.00	0.00
2					0.00	0.00	0.00
3					0.00	0.00	0.00
4					0.00	0.00	0.00
5					0.00	0.00	0.00
			Total Units	0			\$0.00

VIII Patient Questionnaire – Complete for oral nutritional supplements only

Question	Yes	No
Is the patient fed via G-tube?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient currently on oral nutritional supplements? - If Yes, date product started: _____ - How is it supplied (e.g., self-pay, friends/family supply, etc)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have Failure to Thrive (FTT)?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have a long history (more than one year) of malnutrition and cachexia?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient reside in a: - Long-term care facility? - Chronic home care facility? - If Yes, list name of residence: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Does the patient have: - Increased metabolic need from severe trauma (e.g., severe burn, major bone fracture)? - Malabsorption difficulties (e.g., Crohn’s Disease, cystic fibrosis, bowel resection/removal, Short Gut Syndrome, gastric bypass, renal dialysis, dysphagia, achalasia)? - A diagnosis that requires additional calories and/or protein intake (e.g., cancer, AIDS, pulmonary insufficiency, MS, ALS, Parkinson’s, cerebral palsy, Alzheimer’s)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Date of last MD assessment for continued use of supplements: _____

Date of Registered Dietician assessment indicating adequate intake is not obtainable through regular or liquefied pureed foods: _____

- Serum Protein level: _____ Date taken: _____
- Albumin level: _____ Date taken: _____
- Current weight: _____ Normal weight: _____

Written Justification and Attachments:

Requesting Physician’s signature: _____

DHS 3971 - Oregon DHS Prior Authorization Request

Only use this form when requesting PA for diabetic supplies in excess of DMAP's utilization guidelines. Fax to DMAP at one of the following numbers with required documentation and a completed EDMS Coversheet:

- Routine requests: 503-378-5814
- Immediate/urgent requests: 503-378-3435

This form is also available on the DHS/OHA Web site at <http://dhsforms.hr.state.or.us/Forms/Served/DE3971.pdf>.

Information needed to request PA

DMAP may automatically deny requests that do not include one or more of the following pieces of information. Information in **bold** is required for correct processing.

Information needed	New PA	Existing PA
Section I - Provider number - Enter the NPI.	X	
Section II - Type of PA request - Mark the "Supplies" box.	X	
Section III Client ID - The 8-digit Medicaid ID number. ◆ Client's name	X	X
Section IV ◆ ICD-9-CM Diagnosis Code – obtained from the treating practitioner – The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records.	X	
Section V ◆ Description - Enter the 11-digit NDC of the supply) ◆ Units of service ◆ Usual and customary charge (U&C)	X	
Section IX ◆ Date of request ◆ Expected service begin date - Beginning date of service ◆ Expected service end date - Ending date of service	X	
Notes ◆ The needed change ◆ Reason for change		X
Attachments - Describe and attach the following: ◆ A proper written order from the prescribing practitioner ◆ Any other required documentation (see OAR 410-122-0520 in the DMEPOS administrative rulebook).	X	X



Oregon DHS Prior Authorization Request Form

For Internal Use Only: PA Number

I

Requesting Provider Name _____ Provider # _____

Contact Name _____ Contact Phone # _____

Contact Fax # _____ Processing Time Frame: Routine
 Urgent
 Immediate

Supporting Justification for Urgent/Immediate Processing Time Frame:

II

Type of PA Request

Assignment Code (check appropriate box)

- | | | |
|---|---|---|
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Home Health | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Chemical Dependency Treatment Services | <input type="checkbox"/> Imaging | <input type="checkbox"/> SPD – CIIS (MFCU, CHN and Nursing) |
| <input type="checkbox"/> Dental Hospital Referral | <input type="checkbox"/> Inpatient Rehab | <input type="checkbox"/> Speech Services |
| <input type="checkbox"/> DME | <input type="checkbox"/> Medical Transportation | <input type="checkbox"/> Supplies |
| <input type="checkbox"/> Gambling Treatment Services | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Home EPIV | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Other _____ | | |

III

Client ID _____ DOB _____

Last Name _____ First Name, MI _____

IV

Service Information

Estimated length of treatment _____ Frequency _____

Length of time per session _____

Explain primary diagnosis _____ Primary ICD-9 diagnosis code _____

Other pertinent ICD-9 diagnosis codes _____

Facility: Name _____ Provider # _____

Revenue Center Codes _____

Please attach appropriate dental/medical/clinical justification for services requested (attach any plan of treatment, progress notes, invoices, etc. as needed).

V							
Line Item	Procedure Code	Modifier	Description	Units	U&C	MSRP	Total Dollars
1						\$	\$ 0.00
2							0.00
3							0.00
4							0.00
5							0.00
6							0.00
7							0.00
8							0.00
9							0.00
10							0.00
Total Units				0	Total Cost		\$ 0.00

VI DENTAL

Tooth Number _____ Quad _____

VII *Fax all pharmacy PA requests to the Oregon Pharmacy Call Center at 888-346-0178.*

Pharmacy: Drug Name _____ Strength _____
 Quantity _____ NDC _____

Directions:

VIII

Performing Provider _____ Provider # _____

Contact Name _____ Contact Phone # _____

Contact Fax # _____ Billing Provider # _____

IX Date Information

Date of Request (MM/DD/CCYY) ____ / ____ / ____

Expected Service Begin Date ____ / ____ / ____

Expected Service End Date ____ / ____ / ____

Notes:

Attachments:

Document Control Number (DCN) _____

Report Type _____

Description of attachments:

DHS 3970 - EDMS Coversheet

DMAP now requires this sheet as the cover for PA requests sent to DMAP. To avoid delays:

- **Submit each PA request you send to DMAP with its own EDMS Coversheet.** This allows DMAP to track each request as a separate document. You cannot send multiple requests under a single coversheet or combine document types.

This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/DE3970.pdf>.

How to complete the DHS 3970

This sheet allows DMAP to scan your correspondence into the Electronic Document Management System (EDMS). To ensure appropriate processing of your PA request:

- **Always enter your National Provider Identifier and the client's ID number in the "Documentation Identification Numbers" section of this form.**
- **Always mark the "Prior Authorization" box in the "Document Type" section of this form for all PA-related submissions.** This is the only way the EDMS will recognize your PA request for automatic entry into the system.
- **For requests to revise existing PAs, enter the PA number in the "Documentation Identification Numbers" section of this form.** This is the only way EDMS will know to associate your revised PA request with an existing PA.

Requests for expedited PA

If you want to expedite your initial or revised request, mark the expedited timeframe you are requesting on the EDMS Coversheet and DHS 3971:

- "Urgent" processing (within 72 hours)
- "Immediate" processing (within 24 hours)

In addition to required information for the initial or revised request, submit written justification for expedited processing. A space to write this information is at the top of the EDMS Coversheet and DHS 3971.

NCPDP 5.1 Universal Claim Form

The 5.1 Universal Claim Form is available through CommuniForm, LLC, through agreement with the National Council for Prescription Drug Programs (NCPDP).

You can place UCF orders on the Web at www.communiform.com/ncpdp or by calling 800-869-6508.

Where to mail claims

Death with Dignity claims

DMAP
PO Box 992
Salem, OR 97308-0992

Claims less than a year old

DMAP
PO Box 14951
Salem, OR 97309

Claims more than a year old

DMAP Provider Services
500 Summer St NE, E44
Salem, OR 97301-1079

Instructions for 5.1 Universal Claim Form

Shaded boxes indicate the fields DMAP uses to process your claim (shaded on next page). Your claim may suspend or deny if one or more of these fields are empty or incorrectly completed. Unshaded fields are optional or required only in certain circumstances.

1.	Cardholder ID: Enter the 8-digit Recipient ID number found on the Medical Care ID.
2.	Patient Name: Enter the client's name as printed on the Medical Care ID.
3.	Other Coverage Code: Enter a code from the "Other Coverage Code" list on page 22 to indicate response received from other resources. ◆ If the client has other health insurance coverage, and no payment was received from that resource, this space must be used to explain why no payment was made.
4.	Service Provider ID: In the first half of this field, enter the DMAP Provider ID. In the second half this field, enter the 10-digit National Provider Identifier (NPI). Separate the DMAP Provider ID from the NPI with a slash.
5.	Workers Comp Information: Only complete this section when the claim is for a workers compensation injury.
6.	Prescription ID: Enter the unique 7-digit number assigned by the pharmacy to the prescription. Compound prescriptions must have a unique prescription number for each compound. ◆ For compounded prescriptions, bill each component separately. Each component must have a unique 7-digit prescription number. DMAP allows a dispensing fee for each component billed in this manner.
7.	Date Written: Enter the date written on the prescription (MMDDYYYY).
8.	Date of Service: Enter the date you dispensed the drug (MMDDYYYY).

(PERF)

TYPE OR PRINT ALL INFORMATION NEATLY AND COMPLETELY IN APPROPRIATE SPACES

GROUP I.D. (1)

NAME PLAN NAME

PATIENT NAME (2) OTHER COVERAGE CODE (1) (3) PERSON CODE (2)

PATIENT DATE OF BIRTH MM DD CCYY PATIENT (3) PATIENT (4) GENDER CODE RELATIONSHIP CODE

PHARMACY NAME

ADDRESS SERVICE PROVIDER I.D. (4) QUAL (5) FOR OFFICE USE ONLY

CITY PHONE NO ()

STATE & ZIP CODE FAX NO ()

WORKERS COMP. INFORMATION EMPLOYER NAME (5)

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.

ADDRESS 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 1

PREScription / SERV. REF. # (6)	QUAL (8)	DATE WRITTEN (7) MM DD CCYY	DATE OF SERVICE (8) MM DD CCYY	FILL# (9)	QTY DISPENSED (8)	DAYS SUPPLY (11)

PRODUCT / SERVICE I.D. (12)	QUAL (10)	DAW CODE (13)	PRIOR AUTH # SUBMITTED (14)	PA TYPE (11)	PREScriBER I.D. (15)	QUAL (12)

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

OTHER PAYER DATE (17) MM DD CCYY	OTHER PAYER I.D. (17)	QUAL (17)	OTHER PAYER REJECT CODES (18)	USUAL & CUST. CHARGE (17)

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

2 2

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

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

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

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

	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

9.	Fill #: Enter “0” for a new prescription; enter “1” for first refill, “2” for second refill, and so on.
10.	Quantity Dispensed: Enter the quantity dispensed as a whole number. If you need to bill decimal quantities, bill electronically (POS or Provider Web Portal). <ul style="list-style-type: none"> ◆ Do not include descriptive designations such as “ml,” “gm,” or “each.” ◆ For additional information, refer to OAR 410-121-0280 Billing Quantities, Metric Quantities and Package Sizes.
11.	Days Supply: Estimate in days the duration of this prescription supply.
12.	Product/Service ID: Enter the 11-digit National Drug Code (NDC) code for the product being billed. <ul style="list-style-type: none"> ◆ If you cannot find an NDC number for an item that is prescribed and eligible for payment under this program, contact the Oregon Pharmacy Call Center..
13.	Prior Authorization: For diabetic supply billing, enter the 10-digit prior authorization number received from DMAP.
14.	DAW Code: Enter “1” to indicate substitution not allowed by prescriber when the drug is a brand-name product and the proper documentation is on file with the pharmacy. PA is required. <ul style="list-style-type: none"> ◆ To be “Dispensed as Written (DAW),” the prescription must have “Medically necessary,” “Brand medically necessary,” or “Brand necessary” written on it by the prescriber. ◆ Initials or checked boxes are not acceptable.
15.	Prescriber ID: Enter the 10-digit NPI for the physician who prescribed the product. You can search for the provider’s NPI at https://nppes.cms.hhs.gov .
16.	Diagnosis Code: Enter the ICD-9 CM diagnosis code obtained from the treating practitioner – The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records.
17.	Other Payer Reject Codes: Enter the 2-digit NCPDP reject codes returned by other payers.
18.	Usual and Customary Charge
19.	Ingredient Cost Submitted: Enter costs for compound drugs only.
20.	Gross Amount Due Submitted: Enter the sum of all charges for the prescription.
21.	Other Payer Amount Paid: Enter the total amount paid by any other resource. Do not include DMAP copayments in this field. If the client has other insurance and this amount is zero, you must enter a code in the “Other Coverage” field.
22.	Net Amount Due: Subtract the Other Payer Amount Paid from the Gross Amount Due Submitted to get the total for this field.

UCF 5.1 code definition/values

Use the following codes as indicated on the back of the NCPDP Universal Claim Form 5.1.

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	7 = Other coverage exists not in effect at time of service
Patient Gender Code	
0 = Not specified	1 = Male 2 = Female
Patient Relationship Code	
0 = Not specified 1 = Cardholder 2 = Spouse	3 = Child 4 = Other
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
Prescription Service Reference # Qualifier	
Blank = Not specified	1 = Rx billing 2 = Service billing
Product Service ID Qualifier	
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. Services (DUR/PPS)	

Product Service ID Qualifier (continued)	
07 = Common Procedure Terminology (CPT4)	
08 = Common Procedure Terminology (CPT5)	
09 = CMS 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	
Prior authorization type code	
0 = Not specified	5 = Exemption from Rx limits
1 = Prior Authorization	6 = Family Planning Indicator
2 = Medical Certification	7 = Aid to Families with dependent Children
3 = Early Periodic Screening Diagnosis Treatment	8 = Payer defined exemption
4 = Exemption from copay	
DUR/Professional Service Codes	
For values, refer to current NCPDP data dictionary.	
A = Reason for service	C = Result of Service
B = Professional Service code	
Basis of Cost Determination	
Blank = Not specified	04 = EAC (Estimated Acquisition Cost)
00 = Not specified	05 = Acquisition
01 = AWP (average wholesale price)	06 = MAC (Maximum Allowable Cost)
02 = Local Wholesale	07 = Usual and Customary
03 = Direct	09 = Other
Provider ID Qualifier	
Blank = Not specified	04 = Name
01 = Drug Enforcement Administration (DEA)	05 = National Provider Identifier (NPI)
02 = State License	06 = Health Industry Number (HIN)
03 = Social Security Number (SSN)	07 = State issued
	99 = Other
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	
05 = Common Dental Term (CDT)	

Diagnosis Code Qualifier (continued)

06 = Medi-Span Diagnosis Code

07 = American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders
(DSM/V)

99 = Other

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

DMAP 1036 - Individual Adjustment Request

Overpayments, underpayments and payments received after DMAP has paid a claim can be resolved through the adjustment process.

- Use the DMAP 1036 only to request adjustments for *adjudicated* claims. Do not use the DMAP 1036 for *denied* claims. If DMAP denied a claim that you think DMAP should have paid, you must correct and re-submit the claim for processing.
- To order the Individual Adjustment Request (DMAP 1036) form, complete and submit the DMAP 2420 (Provider Forms Request) to: DHS/OHA Forms Distribution, 550 Airport Rd SE, Salem, OR 97310.
- This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/OE1036.pdf>.

How to complete the Individual Adjustment Request (DMAP 1036)

Most required information is printed on the RA. You must have an RA for the claim in order to fill out the form. You can also submit documentation to support your request.

1. Check the appropriate box if this request is an underpayment (DMAP paid too little) or an overpayment (DMAP paid too much).
4. Enter the 13-digit Internal Control Number (ICN).
5. Enter the date printed at the top of the RA.
6. Enter the client's name. Use the same name as is shown on the Medical Care ID.
7. Enter the client's recipient ID number.
8. This space is for your provider name.
9. Enter your 6- or 9-digit provider number.
10. Enter your 10-digit National Provider Identifier (NPI), if available.
11. This column contains possible areas you might want to correct. Only check the box you want to change.
 - ◆ Other - Use this box if none of the above boxes address your problems.
12. Use the line number from the original claim you are adjusting.
13. Enter the date you performed the service.
14. Enter the incorrect information submitted on your original claim.
15. Enter the corrected information.
16. Give additional information or explain your request, if necessary.
17. The signature of the provider or other authorized person must be in this space.

Individual Adjustment Request

DMAP Use Only

- ✓ Complete this form to request an adjustment.
- ✓ Please keep a copy and do not use red ink.

- ① **Type of Adjustment:** Underpayment – Request additional payment
 Overpayment – Please deduct from subsequent payment

- ② **Attach the following:**
- ✓ Claim (corrected copy)
 - ✓ Remittance Advice (copy)
 - ✓ Financial planner (NH only)

③ **Return nursing home adjustment requests to:**
 DMAP – NH
 PO Box 14954
 Salem, OR 97309

Return all other adjustment requests to:
 DMAP
 PO Box 14952
 Salem, OR 97309

Enter the following data from your Remittance Advice (RA):

④ Internal Control Number		⑤ RA Date	
⑥ Recipient Name	⑦ Recipient ID Number		
⑧ Provider Name	⑨ Provider Number		
⑩ NPI			

⑪ Description of original error	⑫ Line No.	⑬ Service Date	⑭ Wrong Information	⑮ Right Information
<input type="checkbox"/> Place of Service				
<input type="checkbox"/> Procedure Code/NDC/Rev Code				
<input type="checkbox"/> Modifier				
<input type="checkbox"/> Quantity/Unit				
<input type="checkbox"/> Diagnosis				
<input type="checkbox"/> Prescribing/Rendering Provider				
<input type="checkbox"/> Billed Amount/Total Billed				
<input type="checkbox"/> Medicare Payment				
<input type="checkbox"/> Other Insurance/Patient Liability				
<input type="checkbox"/> Co-Insurance				
<input type="checkbox"/> Other				

⑯ **Remarks**

⑰ Requester's Name	Phone #	Date
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DHS 8708 - Insurance Notification Form

Use this form to update third party insurance information for DMAP clients. Interactive versions of this form are available on the DHS/OHA Web site at the following links:

- <https://apps.state.or.us/Forms/Served/DE8708.pdf>
- http://dhsresources.hr.state.or.us/WORD_DOCS/DE8708.doc

Submit by fax, e-mail or mail to:

Health Insurance Group

PO Box 14023

Salem, OR 97309-9919

Fax: 503-373-0358

E-mail: tpr.referrals@state.or.us

Insurance Notification Form

Providers and Plans: Use this form to report information about Medicaid clients (including Oregon Health Plan) who are covered by other insurance.

Date: _____

Client (policyholder) name: _____ Date of birth: _____

Insurance company name: _____ Phone: () _____

Insurance company address: _____

Policyholder's ID no. (include any alpha prefix): _____

Group number: _____ Policyholder's SSN: _____

Policy effective date: _____ End date: _____

People covered by this insurance (use additional sheets if necessary):

Name	Medicaid Case #	Date of Birth	Social Security No. (if available)

Name of provider or plan submitting this report: _____

Contact Person: _____ Phone: () _____

Comments: _____

Please return this form to the DHS Health Insurance Group:

By E-mail - Tprref@DHS.state.or.us By fax - (503) 373-0358

Or by mail - P.O. Box 14023 , Salem, Oregon 97309-9919

If you have questions, contact the Health Insurance Group at (503) 378-2220 (Salem)

Additional copies of this form are available by going to www.dhs.state.or.us and clicking on "Forms," then "Find a Form," and entering "8708"

Reimbursement Review Request Form

This form is also available as an online submission form at <http://or.mslc.com/RequestForm.aspx>. Pharmacy providers should use this form to report changes in drug pricing.

- Please print and fax this form to Myers and Stauffer at 317-571-8481 (attention: Pharmacy Unit) or e-mail this form to pharmacy@mslc.com.
- Be sure to include copies of your purchase records that illustrate your costs..

Notations such as “product availability” and/or “not available to purchase at listed price” are acceptable.

Once complete information is received, Myers and Stauffer will evaluate your inquiry and respond within 24 hours.

AVERAGE ACQUISITION COST PROGRAM - REQUEST FOR MEDICAID REIMBURSEMENT REVIEW

Pharmacy providers should use this form to report changes in drug pricing.

NOTE: ALL FIELDS MARKED WITH AN ASTERISK (*) MUST BE COMPLETED FOR PROPER SUBMISSION OF THIS FORM

Pharmacy Provider Information

Pharmacy Name			
Medicaid Provider Number			
City		State	
Phone		Email	

Drug Information: Please enter information for one (1) drug only per submitted form.

Drug Name			
National Drug Code (NDC)			

(e.g., 12345-6789-10)

Provider Cost Information

Cost Per Package				
Package Size		Is this a recent change in reimbursement?	Y / N	*
Date of Purchase		Are you able to purchase alternate NDCs?	Y / N	*
		Are there availability issues?	Y / N	*
		Has there been a recent increase in acquisition cost?	Y / N	*

Claim Information

Dispense Date		Comments:
Quantity Dispensed		
Total Reimbursement for claim		
	\$	

Please print and fax this form to 317-571-8481 (attention: Pharmacy Unit) or e-mail this form to pharmacy@mslc.com.

Be sure to include copies of your purchase records that illustrate your costs.

Once complete information is received, we will evaluate your inquiry and respond within 24 hours. For questions or to check the status of an inquiry, please contact us by e-mail at pharmacy@mslc.com or by phone at **800-591-1183**.

Person Submitting This Request

Appendix

NCPDP-EOB edit crosswalk

Last updated September 2011.

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
0201	05	M/I Service/ Provider Number	0099	PROVIDER NUMBER IS MISSING, INVALID OR NOT IN THE CORRECT FIELD ON THE CLAIM FORM. CORRECT AND RESUBMIT
0202	05	M/I Service/ Provider Number	0099	PROVIDER NUMBER IS MISSING, INVALID OR NOT IN THE CORRECT FIELD ON THE CLAIM FORM. CORRECT AND RESUBMIT
0203	07	M/I Cardholder ID	0032	RECIPIENT NUMBER MISSING. REFER TO THE MEDICAL CARE IDENTIFICATION (DMAP1417) FOR VALID RECIPIENT NUMBER THEN CORRECT AND RESUBMIT.
0205	25	M/I Prescriber ID	0152	PRESCRIBING PHYSICIAN NUMBER MISSING OR NOT USABLE. CORRECT AND RESUBMIT.

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
0206	56	Non-Matched Prescriber ID	0152	PRESCRIBING PHYSICIAN NUMBER MISSING OR NOT USABLE. CORRECT AND RESUBMIT.
0208	2C	M/I Pregnancy Indicator	3213	PREGNANCY INDICATOR INVALID
0211	17	M/I Fill Number	1012	INVALID REFILL INDICATOR VALUE
0212	16	M/I Prescription/Service Reference Number	0033	PRESCRIPTION NUMBER IS MISSING. CORRECT AND RESUBMIT.
0214	28	M/I Date Prescription Written	1030	DATE PRESCRIBED IS INVALID
0215	15	M/I Date of Service	0034	DATE DISPENSED MISSING. CORRECT AND RESUBMIT.
0216	15	M/I Date of Service	0436	DATE DISPENSED IS NON-NUMERIC OR INVALID. CORRECT AND RESUBMIT.
0217	21	M/I Product/Service ID	1014	MISSING DRUG CODE
0218	21	M/I Product/Service ID	1015	INVALID DRUG CODE
0219	E7	M/I Quantity Dispensed	0437	METRIC QUANTITY IS NON-NUMERIC OR INVALID. CORRECT AND RESUBMIT.
0220	E7	M/I Quantity Dispensed	0437	METRIC QUANTITY IS NON-NUMERIC OR INVALID. CORRECT AND RESUBMIT.
0221	19	M/I Days Supply	1017	MISSING DAYS SUPPLY
0222	19	M/I Days Supply	0441	ESTIMATED DAYS SUPPLY IS NON-NUMERIC OR INVALID. CORRECT AND RESUBMIT.
0227	DV	M/I Other Payer Amount Paid	0014	AMOUNT PAID BY OTHER INSURANCE IS NON-NUMERIC. CORRECT AND RESUBMIT.

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
0238	CB	M/I Patient Last Name	0252	RECIPIENT NAME IS MISSING OR INCOMPLETE
0250	21	M/I Product/ Service ID	0167	CLAIM SUBMITTED WITHOUT ANY SERVICES BILLED. COMPLETE FORM AND RESUBMIT.
0259	15	M/I Date of Service	0116	BILLING DATE IS NON-NUMERIC, INVALID, LATER THAN DATE RECEIVED OR PRIOR TO DATE
0268	DQ	M/I Usual and Customary Charge	0428	SPECIFIC SERVICE CHARGE MISSING/ INVALID. CORRECT AND RESUBMIT OR ADJUST AS APPROPRIATE.
0269	DQ	M/I Usual and Customary Charge	0428	SPECIFIC SERVICE CHARGE MISSING/ INVALID. CORRECT AND RESUBMIT OR ADJUST AS APPROPRIATE.
0270	DU	M/I Gross Amount Due	0037	TOTAL CHARGE AMOUNT EQUALS ZERO OR IS INVALID. CORRECT AND RESUBMIT.
0271	DU	M/I Gross Amount Due	0037	TOTAL CHARGE AMOUNT EQUALS ZERO OR IS INVALID. CORRECT AND RESUBMIT.
0351	73	Refills are not covered	3336	REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS.
0500	EP	M/I Associated Prescription/ Service Date	1030	DATE PRESCRIBED IS INVALID
0502	AB	Date Written is After Date Filled	1075	DATE DISPENSED EARLIER THAN DATE PRESCRIBED
0503	PV	Non-Matched Associated Prescription/ Service Date	1074	DATE DISPENSED AFTER BILLING DATE

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
0505	74	Other carrier Payment Meets or Exceeds Payable	1136	NO PAYMENT MADE-TPL IS MORE THAN THE ALLOWED AMOUNT.
0506	15	M/I Date of Service	0116	BILLING DATE IS NON-NUMERIC, INVALID, LATER THAN DATE RECEIVED OR PRIOR TO DATE OF SERVICE. CORRECT AND RESUBMIT
0513	52	Non-Matched Cardholder ID	0028	RECIPIENTS NAME AND NUMBER DISAGREE AND DMAP CANNOT RESOLVE. CORRECT AND RESUBMIT BILLING
0545	81	Claim too old	0076	CLAIM PAST FILING TIME LIMIT. SEE GENERAL RULE 410-120-1300 FOR INSTRUCTIONS.
0554	EP	M/I Associated Prescription/ Service Date	0013	FROM OR THRU DATE OF SERVICE IS MISSING OR INVALID. CORRECT AND RESUBMIT OR ADJUST AS APPROPRIATE
0565	74	Other carrier Payment Meets or Exceeds Payable	1135	HEADER PAID AMOUNT IS GREATER THAN BILLED AMOUNT
0576	4C	M/I Coordination of Benefits/Other Payments Count	1042	CLAIM HAS THIRD-PARTY PAYMENT
0643	5C	M/I Other Payer Coverage Type	1643	INVALID OTHER COVERAGE CODE
0652	5C	M/I Other Payer Coverage Type	1652	MISSING OR INVALID OTHER PAYER COVERAGE TYPE
1000	05	M/I Service/ Provider Number	0099	PROVIDER NUMBER IS MISSING, INVALID OR NOT IN THE CORRECT FIELD ON THE CLAIM FORM. CORRECT AND RESUBMIT

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
1001	40	Pharmacy Not Contracted with Plan on Date of Service	0004	PROVIDER WAS NOT ENROLLED ON SPECIFIED DATE OF SERVICE OR DATE OF SERVICE IS NOT VALID. CORRECT AND RESUBMIT
1003	40	Pharmacy Not Contracted with Plan on Date of Service	1086	PROVIDER INELIGIBLE ON DATE OF SERVICE
1016	70	Product/Service Not covered	1100	NON-PARTICIPATING MANUFACTURER
1026	25	M/I Prescriber ID	1048	PRESCRIBING PROVIDER NOT ON FILE
1032	AD	Billing Provider Not Eligible To Bill This claim Type	0044	CLAIM FORM INCONSISTENT WITH PROVIDER TYPE. RESUBMIT ON CORRECT CLAIM FORM.
1036	AD	Billing Provider Not Eligible To Bill This claim Type	0044	CLAIM FORM INCONSISTENT WITH PROVIDER TYPE. RESUBMIT ON CORRECT CLAIM FORM.
1049	40	Pharmacy Not Contracted with Plan on Date of Service	0156	OUR RECORDS SHOW PERFORMING PROVIDER INELIGIBLE ON DOS. IF BILLING WAS IN ERROR, CORRECT AND RESUBMIT OR ADJUST AS APPROPRIATE.
1927	05	M/I Service/ Provider Number	0099	PROVIDER NUMBER IS MISSING, INVALID OR NOT IN THE CORRECT FIELD ON THE CLAIM FORM. CORRECT AND RESUBMIT
1936	05	M/I Service/ Provider Number	0099	PROVIDER NUMBER IS MISSING, INVALID OR NOT IN THE CORRECT FIELD ON THE CLAIM FORM. CORRECT AND RESUBMIT

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
1945	05	M/I Service/ Provider Number	0099	PROVIDER NUMBER IS MISSING, INVALID OR NOT IN THE CORRECT FIELD ON THE CLAIM FORM. CORRECT AND RESUBMIT
1995	05	M/I Service/ Provider Number	1999	BILLING PROVIDER ID SUBMITTED UNDER OLD FORMAT
1999	05	M/I Service/ Provider Number	1999	BILLING PROVIDER ID SUBMITTED UNDER OLD FORMAT
2001	52	Non-Matched Cardholder ID	0145	THE RECIPIENT NUMBER LISTED IS NOT IN OUR RECORDS. CONTACT THE APPROPRIATE DMAP/SPD BRANCH FOR ASSISTANCE
2002	65	Patient is not covered	0003	OUR RECORDS SHOW RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE.
2003	65	Patient is not covered	0003	OUR RECORDS SHOW RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE.
2009	65	Patient is not covered	0003	OUR RECORDS SHOW RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE.
2017	70	Product/Service Not covered	0090	SERVICE IS COVERED BY A MANAGED CARE PLAN. CLAIM MUST BE BILLED TO THE APPROPRIATE MANAGED CARE PLAN. Call (888) 202-2126
2037	65	Patient is not covered	1113	RECIPIENT NUMBER HAS BEEN DEACTIVATED
2077	65	Patient is not covered	1041	RECIPIENT IS NOT ELIGIBLE ALL DATES OF SERVICES
2507	41	Submit Bill to Other Processor or Primary payer	0092	OUR RECORDS SHOW CLIENT HAS MULTIPLE INSURANCE. YOUR CLAIM MUST REFLECT EITHER PAYMENT OR 2 DIGIT DENIAL CODE FROM ALL POTENTIAL INSURANCES.
2508	41	Submit Bill to Other Processor or Primary payer	1035	INSURANCE DENIAL REQUIRED

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
2509	AE	QMB (Qualified Medicare Beneficiary) - Bill Medicare	0389	PATIENT HAS MEDICARE COVERAGE ONLY. THIS SERVICE IS NOT COVERED BY MEDICAID
2603	M2	Recipient Locked in	0227	RESTRICTED RECIPIENT. SERVICES NOT PROVIDED BY PRIMARY PHARMACY. Call (888) 202-2126
2804	62	Patient/Card Holder ID Name Mismatch	2804	CASE NUMBER NOT ON FILE
2805	70	Product/Service Not covered	2805	DRUG IS NOT COVERED FOR RECIPIENT
2808	09	M/I Date of Birth	7278	INVALID DATE (DATE OF BIRTH)
2809	09	M/I Date of Birth	7278	INVALID DATE (DATE OF BIRTH)
3000	64	Claim Submitted Does Not Match Prior Authorization	0344	THE QUANTITY AND/OR AMOUNT BILLED EXCEEDS PRIOR AUTHORIZATION. IF THE QUANTITY BILLED WAS IN ERROR, CORRECT AND RESUBMIT YOUR CLAIM.
3002	75	Prior Authorization Required	1056	THIS DRUG REQUIRES PRIOR AUTHORIZATION. Call (888) 202-2126
3019	75	Prior Authorization Required	1094	REVIEW EDITS 4005/4006/4009/4084 PRIOR TO CUTBACK. Call (888) 202-2126
3022	75	Prior Authorization Required	1056	PRIOR AUTHORIZATION REQUIRED. CALL (888) 202-2126
3023	N/A	N/A	3429	NON-PREF DRUG, CONSIDER OPTIONS AT WWW.ORPDL.ORG

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
3025	AD	Billing Provider Not Eligible To Bill This Claim Type	3296	HEMOPHILIA FACTOR RESTRICTED BILLING
3326	73	Refills are not covered	3336	REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS
3329	AD	Billing Provider Not Eligible To Bill This Claim Type	0044	CLAIM FORM INCONSISTENT WITH PROVIDER TYPE. RESUBMIT ON CORRECT CLAIM FORM.
3330	70	Product/Service Not covered	0590	NOT COVERED. CLASSIFIED AS A DESI OR RELATED PRODUCT BY THE FDA AND/OR MANUFACTURER.
3343	41	Submit bill to other processor or primary payer.	1343	QUESTIONABLE THIRD PARTY LIABILITY (PLEASE CALL PBM AT 888-202-2126, IF PAYMENT UNDER \$2.00 IS A VALID TPL PAYMENT FOR ASSISTANCE)
3556	85	Claim Not Processed	4014	NO PRICING SEGMENT IS ON FILE.
4002	70	Product/Service Not covered	0091	NON-COVERED SERVICE.
4004	54	Non-Matched Product/Service ID Number	0403	DRUG CODE NOT ON FILE. CORRECT AND RESUBMIT.
4007	77	Discontinued Product/Service ID Number	1062	NDC IS DEACTIVATED AND NOT PAYABLE ON DATE FILLED
4014	85	M/I Request Pricing Segment	0589	NO PRICING ON FILE PLEASE CALL MYERS & STAUFFER AT 800-591-1183
4023	61	Product/Service Not Covered For Patient Gender	0012	PROCEDURE OR DIAGNOSIS NOT PAYABLE FOR RECIPIENT OF THIS SEX. IF BILL WAS IN ERROR, CORRECT AND RESUBMIT OR ADJUST AS APPROPRIATE.

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
4025	60	Product/Service Not Covered for Patient Age	0091	NON-COVERED SERVICE.
4026	76	Plan Limitations Exceeded	0148	QUANTITY DISPENSED EXCEEDS THE MAXIMUM QUANTITY ALLOWED BY OMAP.
4084	R9	Value In Gross Amount Due Does Not Follow Pricing Formula	0069	ALLOWED AMOUNT REDUCED TO REFLECT PROGRAM LIMITATIONS
4113	70	Product/Service Not covered	0091	NON-COVERED SERVICE
4117	70	Product/Service Not covered	0091	NON-COVERED SERVICE
4127	M6	Host Processing Error	1124	CANNOT PRIORITIZE RECIPIENT'S PROGRAMS
4130	99	Host Processing Error	1011	INTERNAL ERROR
4131	99	Host Processing Error	1011	INTERNAL ERROR
4164	70	Product/Service Not covered	1063	INACTIVE DRUG
4165	76	Plan Limitations Exceeded	0030	DAYS SUPPLY GREATER THAN MAX ALLOWED.
4200	R9	Value In Gross Amount Due Does Not Follow Pricing Formula	1085	ZERO AMOUNT TO PAY
4888	70	Product/Service Not covered	0154	NDC NOT COVERED ON DATE DISPENSED
4889	70	Product/Service Not covered	0154	NDC NOT COVERED ON DATE DISPENSED

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
4890	70	Product/Service Not covered	0154	NDC NOT COVERED ON DATE DISPENSED
4891	70	Product/Service Not covered	0154	NDC NOT COVERED ON DATE DISPENSED
4999	41	Submit Bill to Other Processor or Primary payer	1109	THIS DRUG NOT COVERED BY MEDICARE PART D
5000	83	Duplicate Paid/ Captured Claim	0015	SERVICE IS A DUPLICATE OF A SERVICE PREVIOUSLY PROCESSED/PAID.
5001	83	Duplicate Paid/ Captured Claim	0015	SERVICE IS A DUPLICATE OF A SERVICE PREVIOUSLY PROCESSED/PAID.
6501	N/A	N/A	0148	QUANTITY DISPENSED EXCEEDS THE MAXIMUM QUANTITY ALLOWED BY DMAP.
6502	76	Plan Limitations Exceeded	0634	Prior Authorization Required Program Limitation Exceeded. Please contact Prior Authorization Authority 800-642-8635
6503	76	Plan Limitations Exceeded	0634	Prior Authorization Required - Program Limitation Exceeded. Please contact Prior Authorization Authority 800-642-8635
6504	76	Plan Limitations Exceeded	0634	Prior Authorization Required - Program Limitation Exceeded. Please contact Prior Authorization Authority 800-642-8635
6505	76	Plan Limitations Exceeded	0634	Prior Authorization Required - Program Limitation Exceeded. Please contact Prior Authorization Authority 800-642-8635
6506	76	Plan Limitations Exceeded	0634	Prior Authorization Required - Program Limitation Exceeded. Please contact Prior Authorization Authority 800-642-8635
6830	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6831	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
6832	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6833	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6834	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6835	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6836	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6837	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6838	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6839	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6840	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6841	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6842	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6843	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6844	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6845	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6846	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6847	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
6848	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6849	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6850	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6851	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6852	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6853	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6854	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6855	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6856	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6857	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6858	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6859	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6870	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6871	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6872	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6873	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
6874	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6875	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6876	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6877	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6878	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6879	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6880	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6881	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6882	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6883	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6884	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6885	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6886	76	Plan Limitations Exceeded	1056	Prior Authorization Required. Call (888) 202-2126
6891	75	Prior Auth Required	1056	Prior Authorization Required. Call (888) 202-2126
6892	75	Prior Auth Required	1056	Prior Authorization Required. Call (888) 202-2126
7000	88	DUR Reject Error	0040	DUR Reject Error. Call (888) 202-2126

MMIS Error	NCPDP Error Code	NCPDP Description	EOB Code	EOB Description
7001	88	DUR Alert	0040	DUR Alert
7002	88	DUR Reject Error	0040	DUR Reject Error
7024	70	Product/Service Not Covered	0075	Payment for this drug not allowed for nursing facility resident. Considered part of all inclusive rate paid to facility.

Key terms

American National Standards Institute (ANSI)	A private non-profit organization that oversees the development of voluntary consensus standards for products, services, processes, systems, and personnel in the United States.
Carve-Outs	Drugs covered by DMAP when a client is enrolled in a Prepaid Health Plan.
Centers for Medicare and Medicaid Services (CMS)	A federal program which mandates quality health care coverage for beneficiaries.
Claim	A request for payment of health care services administered to a DHS/OHA client.
Coordination of Benefits (COB)	Determination of payer. DMAP is the payer of last resort on claims for OHP clients with other insurance coverage.
Current Procedural Terminology (CPT)	A code, issued and published by the AMA, designating a health service provided
Date of Service (DOS)	The date on which a drug is dispensed or a service is provided.
Diagnosis code	A numeric code that documents the client's medical condition, symptom or complaint as determined by the Provider and is the basis for rendering service(s). The diagnosis coding structure uses the International Classification of Disease– Ninth Revision, Clinical Modification (ICD-9-CM).
Electronic Data Interchange (EDI)	A method of transmitting batch claims electronically.
Federally-Qualified Health Center (340B) Providers	Pharmacies and health clinics enrolled with DMAP and dispensing 340B-purchased drugs.

Fee For Service (FFS)	Claims or services rendered that are paid individually and not included in other service payments.
Fully Capitated Health Plan (FCHP)	Prepaid health plans (PHPs) that contract with DMAP to provide capitated services under the Oregon Health Plan (OHP). The distinguishing characteristic of FCHPs is the coverage of hospital inpatient services.
Healthcare Common Procedural Coding System (HCPCS)	A code, issued and published by the AMA, designating a health service provided.
Health Maintenance Organization (HMO)	A public or private health care organization which is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.
Internal Control Number (ICN)	A unique 13-digit identification number assigned to every claim in order to distinguish it from all other claims received by the system. The ICN is comprised of multiple components that identify critical information about the claim.
Long Term Care (LTC)	Refers to institutional settings that include skilled nursing facilities and intermediate care facilities with the exclusions found in ORS 443.400 to 443.455.
Managed Care Organization (MCO)	Contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law.
Medicaid Management Information System (MMIS)	A fully-integrated Medicaid claims processing system.
National Drug Code (NDC)	A number found on a drug product. For purposes of meeting CMS billing requirements, NDCs must be configured in what is referred to as a '5-4-2' format.
National Council for Prescription Drug Programs (NCPDP)	A not-for-profit ANSI-accredited Standards Development Organization.
National Provider Identifier (NPI)	A numeric value assigned by the National Plan and Provider Enumeration System (NPPES) to eligible health care providers.
Oregon State Pharmacy Association (OSPA)	A group of pharmacists providing Oregon Board of Pharmacy-approved pharmacy services to Medicaid clients.

Pharmacy Benefit Management (PBM)	Provides claims management, ProDUR, and Drug Rebate services. HP is DMAP's contracted PBM administrator.
Physician Care Organization (PCO)	A group of physicians providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law.
Point of Sale (POS)	On-line, real-time claim adjudication.
Prepaid Health Plan (PHP)	A contracted health delivery system providing capitated or prepaid health services.
Prior Authorization (PA)	Requested by a provider in order to render specified services to a designated beneficiary. The authorization is given prior to the services being performed.
Procedure Codes (CPT and HCPCS)	Codes entered on claim forms to designate services provided.
Prospective Drug Utilization Review (ProDUR)	Clinical messages accompanying an adjudicated claim.
Provider Web Portal	A secure self-service Web site (https://www.or-medicaid.gov) that allows authorized providers access to current client eligibility, claims, prior authorization, and HSC prioritized list information.
Third Party Liability/Resource (TPL/TPR)	Third Party Resource is a term for other insurance that should be the primary payer. A medical or financial resource which, under law, is available and applicable to pay for Medical Services and items for a DMAP client. This includes, but is not limited to, private health insurance, any applicable Medicare coverage, worker's compensation, and accident-related liability.
Vaccines For Children (VFC)	A federal program providing vaccines for children 18 years of age and younger
Value-Added Networks (VANs)	A third party service that transmits and stores EDI data in an "electronic mailbox" until it is picked up by the appropriate party.

Provider enrollment information

For information about how to enroll as an OHP provider, go to the Provider Enrollment Web page at www.oregon.gov/OHA/healthplan/tools_prov/providerenroll.shtml.

Pharmacy Provider Specialty Types

106 - Pharmacist

400 – Retail Pharmacy

- 402 – Long Term Care/Nursing Facility
- 404 – Indian Health Service (Tribal) Provider
- 405 – Mail Order Provider
- 406 – Specialty Pharmacy Provider
- 407 – Rural Health Clinic
- 408 – Public Health Service (340B) Provider

Pharmacy news & updates

Information pertaining to billing and drug therapy problems is delivered to providers by various medium including:

- OSU College of Pharmacy fax blasts and DUR Newsletters.
 - ✓ To view past and current issues of the DUR Newsletter, go to the OSU College of Pharmacy Web site at http://pharmacy.oregonstate.edu/drug_policy/index.php?nav=newsletter.
 - ✓ To receive the DUR Newsletter and other updates via e-mail, subscribe to the OSU College of Pharmacy listserv at <http://lists.oregonstate.edu/mailman/listinfo/osupharmdi>.
- DMAP provider announcements: remittance advice (RA) banner messages or inserts, direct provider mailings. The direct link for OHP announcements is www.oregon.gov/OHA/healthplan/notices_providers/main.shtml (search for “pharmacy” to find all pharmacy updates)
- eSubscribe: To receive automatic e-mail updates whenever DMAP updates pharmacy information on the Web, eSubscribe to “Pharmacy Program Announcements” and the Pharmacy program policies, rules and guidelines. Go to www.oregon.gov/DHS/govdelivery.shtml to sign up for this free service.

Keep your information updated

DMAP relies on current pharmacy contact information when helping clients and providers resolve urgent pharmacy issues. You can provide updates two ways:

- Complete and submit the DMAP 3035 (Provider Information Update) form at <https://apps.state.or.us/Forms/Served/OE3035.pdf>; or
- Enter and submit your changes on the Web using the Provider Demographic panels at <https://www.or-medicaid.gov>. For information about this feature, see the Web Portal Account Administration handbook at www.oregon.gov/OHA/healthplan/docs/web-admin.pdf.

DMAP General Rule 410-120-1260(10) (Provider Enrollment Required Updates) states that enrolled providers must report such changes within 30 days of the change.

Contact information

For current contact information, refer to the Provider Contacts List at www.oregon.gov/OHA/healthplan/data_pubs/add_ph_conts.pdf.

This includes current information for provider enrollment, eligibility verification, billing assistance, prior authorization, and more.

Oregon Pharmacy Call Center

The Oregon Pharmacy Call Center is available 24 hours per day, seven days per week, 365 days per year to assist with claims processing, coordination of benefits, ProDUR overrides, and claim questions related to fee-for-service prescriptions (including 7/11 carveout prescriptions for managed care clients).

The Call Center is not intended to replace or supplement the professional judgment of the dispensing pharmacist. If a provider question requires a clinical response, staff pharmacists are available for consultation.

Phone: 888-202-2126

Fax: 888-346-0178

Reimbursement inquiries and reviews

Providers with questions about pharmacy reimbursement rates, requests to review rates for specific drugs, or billing errors due to no pricing on file may contact Myers and Stauffer in writing by e-mail, regular mail, fax, toll free telephone, or online.

Myers and Stauffer, LC
Pharmacy Unit
9265 Counselors Row, Suite 200
Indianapolis, IN 46240

Phone: 800-591-1183

Fax: 317-571-8481

E-mail: pharmacy@mslc.com

Medicare Part D plan information

If you need assistance resolving Medicare Part D billing issues, contact the DHS Medicare Hotline at 877-585-0007. Hotline hours are 8 a.m. to 5 p.m., Monday through Friday.

You can also visit the department's Medicare Modernization Act Web site at www.oregon.gov/DHS/mma for more information.

Company/Plan Name	BIN	PCN	Pharmacy Contact Number
AARP Medicare RX	610097	9999	877-889-6481
Aetna	610502	00670000	800-238-6279
Asuris Medicare Script	610502	02110000	800-732-9157
ATRIO/MyAdvantage	003585	98829	800-681-9571 (MedImpact)
CareOregon Advantage	012189	5016	888-439-1696
CareSource	003585	38060	800-788-2949
CIGNA HealthCare/ Signature Rx	012353	03490000	800-222-6700
Clear Choice	3858	A4	888-437-7728; 800-824-0898 (Express Scripts)
Coventry/Advantra	610029	CMK	800-421-2342
Envision Rx	012312	PARTD	800-361-4542
Family Care/Premier Care	012189	5006	n/a
Fox Value Plan	004336	ADV	800-361-4542
Health Net	600428	03330000	800-806-8811 800-693-8951 (Argus) 888-802-7001 (PA requests)
HealthSpring	012353	03590000	800-971-1581
Humana	610649	03200000	800-865-8715
Marion Polk Community Health	610415	PCS	800-364-6331
Medco/YOURx	610014	MEDDPRIME	800-922-1557
Member Health/Community Care	012304	MPD	866-684-5395
National Medical Health Card	610011	NMHCPDP	866-443-1095
ODS Advantage	003585	38600	888-786-7509 (ODS Pharmacy Services) or 800- 681-9576 (MedImpact)
Pennsylvania Life Insurance	610468	n/a	800-777-1023

Company/Plan Name	BIN	PCN	Pharmacy Contact Number
Providence	012353	03300000	877-216-3644
Regence BlueCross BlueShield	610623	02100000	800-732-9157
Rx America	012189	5000	877-279-0372
Samaritan Advantage	012189	5005	n/a
Secure Horizons	610097	9999	877-889-6510
Sierra Health/Sierra Rx	007382	SHS	800-443-8197
Silverscript Insurance	004336	ADV	866-275-8072
Sterling Life	004336	ADV	866-364-6931
Torchmark/United American	610014	MEDDPRIME	800-922-1557
Trillium Advantage	012189	5027	800-910-3906
Unicare Value & Standard	610053	n/a	866-841-8953
United HealthCare/Walgreens	603286	01410000	888-492-2952
United Health Rx	610097	9999	877-889-6481
United Medicare Rx	610097	9999	877-889-6481
Wellcare	603286	141000	866-800-6111

OHP Prepaid Health Plan information

4-digit Plan ID codes and telephone numbers are available in the COB PHP Contract Service Area Element Definitions Crosswalk posted at www.oregon.gov/OHA/edi/docs/cob-php-crosswalk.pdf.

Other third-party carrier information

The Carrier Codes List provides the carrier name and contact information for each insurance carrier code on file with DHS/OHA. You can access the list on the DHS/OHA Web site at www.oregon.gov/OHA/edi/resources.shtml.

To report new third-party information for a DMAP client:

- Submit a completed DHS 8708 form to the Health Insurance Group.
- See the Forms section of this supplement for a copy of the form and instructions for completing the form.