MAGELLAN
MEDICAID
ADMINISTRATION℠

Pharmacy Billing Manual

for Nevada Medicaid and Nevada Check Up

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To keep file sizes manageable for Internet downloads, the appendices for this manual are listed separately on the Magellan Medicaid Administration website at http://nevada.fhsc.com (select "Billing Information" the "Pharmacy" menu).

The appendices are:

Appendix A: Instructions for Completing the Universal Claim Form, v 5.1
Appendix B: Specifications for NCPDP, v 5.1
Appendix C: Other Carrier Code List

Section 1: Introduction

Magellan Medicaid Administration maintains this manual to provide Nevada Medicaid pharmacy providers with claim submission guidelines. This manual discusses interaction with the Magellan Medicaid Administration Point of Sale (POS) system, rather than the technical operation of pharmacy-specific software.

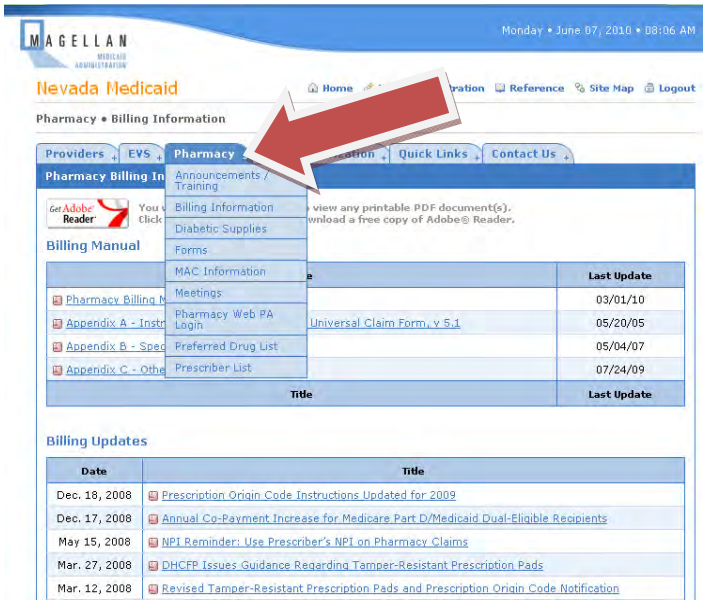
This manual is provided solely for convenience and reference; it does not have the effect of law or regulation. Magellan Medicaid Administration has made every effort to ensure accuracy, however, should there be any conflicts between material in this manual and pertinent laws, regulations, or contracts, the latter will prevail.

1.1 System Capabilities

Magellan Medicaid Administration processes all Nevada Medicaid pharmacy claims using a computerized POS system.

The POS system used in conjunction with a pharmacy's existing system gives pharmacy providers real-time access to:

- Recipient eligibility
- Drug coverage
- Pricing and payment information
- Prospective drug utilization review (ProDUR) across all network pharmacies



1.2 System Availability

The POS system is available Monday-Saturday, 2:00 a.m.-12:00 a.m. and Sunday, 2:00a.m.-9:00 p.m., PT.

If the POS system is down for any reason, hold your claims until online capability resumes. Pharmacy software should have the capability to submit backdated claims.

1.3 Provider Enrollment

Providers must have an active enrollment status with Nevada Medicaid to submit claims. Enrollment forms are at http://nevada.fhsc.com.

If you have enrollment questions, contact the Provider Enrollment Unit at **(877) 638-3472,** Monday-Friday, 8:00 a.m.-5:00 p.m., PT.

1.4 E-prescribing

Nevada Medicaid encourages prescribers to submit electronic prescriptions. Recipient pharmacy claims history, eligibility, drug coverage data and the indication of the need for a PA are also available to prescribers who use electronic prescribing systems.

Prescribers who use electronic prescribing systems can arrange for appropriate access to this data by contacting their software vendors.

For more information, see the Magellan Medicaid Administration website (select "E-prescribing" from the "Providers" menu).

1.5 State Policy

Nevada Medicaid State policy is in Chapter 1200 of the Medicaid Services Manual (MSM). The MSM is on the Division of Health Care Financing and Policy (DHCFP) website at http://dhcfp.nv.gov.

1.6 Magellan Medicaid Administration Web Site

Announcements, meeting dates and policy updates are posted to the Magellan Medicaid Administration web site as they become available. It is recommended that users visit http://nevada.fhsc.com weekly to view the latest information. Pharmacy information is under the "Pharmacy" menu.

1.7 Service and Support

The Technical Call Center handles questions on coverage, claims and recipient eligibility and is available 24 hours per day, 7 days per week, 365 days per year.

Technical Call Center
Phone: (800) 884-3238

The Clinical Call Center handles requests for prior authorization or ProDUR overrides and is available Monday-Friday, 5:00 a.m.-7:00 p.m., PT (after hours, calls roll over to the Technical Call Center). Pharmacists are available if your question requires a clinical response. Magellan Medicaid Administration responds to all prior authorization requests within 24 hours.

Clinical Call Center
Phone: (800) 505-9185
Fax: (800) 229-3943

The Pharmacy Clinical Manager can answer questions regarding the Preferred Drug List (PDL).

Pharmacy Clinical Manager
Phone: (775) 784-3905
Email: pharmacy@magellanhealth.com

The DHCFP Pharmacy Program Specialist handles questions or concerns regarding state policy. The DHCFP Pharmacy Program Specialist is available Monday - Friday, 8:00 a.m.-5:00 p.m., PT.

DHCFP Pharmacy Program Specialist
(775) 684-3751

1.8 Solving Technical Problems

If you are experiencing technical difficulties, first check the terminal and communications equipment to ensure that electrical power and telephone services are operational.

Next, call the telephone number the modem is dialing and note the information heard (e.g., fast busy, steady busy, recorded message). Contact the software vendor if your modem is unable to connect to your vendor.

If you have internal technical staff, forward the problem to their department. They can coordinate with the Technical Call Center to resolve the problem.

1.9 POS System is Down

If the POS system is down, you will receive one of the following messages. Do not submit claims until the POS system comes back online.

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

Section 2: Setup

2.1 Vendor Certification

Software vendors (not individual pharmacies) must be certified through Magellan Medicaid Administration using the National Council for Prescription Drug Programs (NCPDP) version 5.1 claims format.

Contact Magellan Medicaid Administration or the software vendor to determine if the vendor is certified.

The Software Vendor/ Certification Number is required in Field 110-AK.

2.2 Switching Companies

Magellan Medicaid Administration contracts with the following Point of Sale (POS) switching companies for Nevada Medicaid claims:

- National Data Corporation (NDC): (800) 388-2316
- QS1: (800) 845-7558
- WebMD: (615) 885-3700

2.3 Claim Formats

POS claims must be submitted in the **NCPDP version 5.1** format. Lower NCPDP versions are not accepted.

The accepted batch format is **NCPDP Batch 1.1**.

The accepted paper claim is the **Universal Claim Form (UCF), version 5.1**.

Claim submission via the POS system is recommended for its immediate response benefits. Providers not capable of sending claims via the POS system must contact the DHCFP Pharmacy Program Specialist at (775) 684-3751 to request "POS exemption."

See Appendix A of this manual for instructions on completing and submitting a UCF paper claim form.

2.4 Transaction Codes

Transaction codes B1, B2 and B3 are NCPDP standard codes. The ability to use these transaction codes will depend on your pharmacy's software.

At a minimum, all providers should have the capability to submit original claims using transaction code B1 and reversals using transaction code B2. The POS system can accept re-billed claims (also referred to as claim adjustments) with transaction code B3.

Transaction code B1 (Full Claims Adjudication) captures the claim, processes it and informs the provider of the payment amount.

Transaction code B2 (Claims Reversal) To void a previously paid claim, select the Reversal (Void) option in the pharmacy's computer system and complete the following fields:

- NPI-pharmacy
- Prescription number
- Date of service (date filled)

Transaction code B3 (Claims Re-bill) adjusts a previously paid claim by voiding the original claim and resubmitting a new claim with a single transaction.

2.5 Transaction Header Segment

There are required data elements for each POS transaction. Claims are not processed unless the required data elements are complete.

The pharmacy's software vendor must use Appendix B of this manual, Nevada Medicaid Payer Specifications, to set up the pharmacy system with the required data elements.

The following table shows the Transaction Header Segment. This segment and all fields in this segment must be submitted on each claim. "Mandatory" fields are used to adjudicate the claim. "Required" fields may or may not be used in the adjudication process.

Field Name	Supported Values	Field Number	Requirement
ANSI BIN #	009646	101-A1	Mandatory
Processor Control #	P009009646 Medicaid Claims P031009646 Medicare Part D Claims	104-A1	Mandatory
Group #	NVMEDICAID	301-C1	Required
Service Provider ID #	National Provider Identifier (NPI) <Pharmacy NPI>	201-B1	Mandatory
Service Provider ID Qualifier	01 = National Provider Identifier (NPI)	202-B2	Mandatory
Cardholder ID #	Recipient ID	302-C2	Mandatory
Prescriber ID #	Prescriber NPI	411-DB	Mandatory
Prescriber ID Qualifier	01 = National Provider Identifier (NPI)	466-EZ	Mandatory
Product Code	National Drug Code (NDC)	407-D7	Mandatory

The Centers for Medicare & Medicaid Services (CMS) has made available National Plan and Provider Enumeration System (NPPES) health care provider data via the Internet. The NPI Registry and the NPPES Downloadable File are tools Nevada Medicaid pharmacy providers may use to obtain a physician's National Provider Identifier (NPI) when entering the prescriber's ID on claims.

NPI Registry: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do
NPPES Downloadable File: http://nppesdata.cms.hhs.gov/cms_NPI_files.html

Section 3: Coverage and Limitations

Bill all outpatient drugs in accordance with the NCPDP "Billing Unit Standard Format." This standard provides for billing in units of "each," "milliliter (ml)," and "gram (g)."

See the Medicaid Services Manual, Chapter 1200, section 1203.1D.6.a for specific drug units.

Prior authorization is required to exceed pertinent age, gender, diagnosis, quantity and/or clinical limitations as described in this manual and in MSM Chapter 1200.

Some drugs require prior authorization to exceed certain limitations as shown in this manual and in MSM Chapter 1200.

There is no maximum dollar limit for recipient pharmacy benefits.

3.1 Covered Drugs

Covered drugs include:

- Legend drugs from companies participating in the federal Medicaid Drug Rebate Program (unless the drug is listed in the "Non-Covered Drugs" section).
- Drugs on the Nevada Medicaid Preferred Drug List (PDL).
- Drugs prescribed for a medically accepted indication.
- Family planning items such as diaphragms, condoms, foams and jellies.
- Over-the-counter (OTC) drugs from companies participating in the federal Medicaid Drug Rebate Program (unless the drug is listed in the next section, "Non-Covered Drugs."

3.2 Non-Covered Drugs

Medicaid does not cover:

- Agents used for weight loss
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Agents used for impotence/erectile dysfunction
- DESI drugs
- "Experimental" drugs
- Drugs from companies that do not participate in the federal Medicaid Drug Rebate Program

3.3 Days Supply Limitations

The maximum days supply is 34 days for medications. Quantity dispensed should be commensurate to this limit. **Exception:** The maximum days supply for maintenance medications is 100 days. Maintenance medications are:

- Antianginals
- Antiarrhythmics
- Anticonvulsants
- Antidiabetics
- Antihypertensives
- Cardiac Glycosides
- Contraceptives, oral and topical
- Diuretics
- Estrogens
- Progesterone
- Thyroid Preparations

Days supply information on a claim is critical to edit on the ProDUR system (see "Section 10: Prospective Drug Utilization Review").

Incorrect days supply information can cause incorrect ProDUR alerts and claim denials.

3.4 Quantity and Clinical Limitations

The following drugs have quantity limits. Prior authorization (PA) is required for quantities greater than those listed below.

Submit the Metric Decimal Quantity as the QUANTITY DISPENSED in Field 442-E7 on your claim.

Drug Class	Drug	Maximum Dispensing Quantity
Anticholingerics - Inhaled	Duoneb All other agents in this class	6 bottles per month One agent per rolling 30 days
Anticoagulants Lovenox®	30mg/0.3ml Lovenox® 40mg/0.4ml Lovenox® 60mg/0.6ml Lovenox® 80mg/0.8ml Lovenox® 100mg/ml Lovenox® 120mg/0.8ml Lovenox® 150mg/ml	18 per prescription 24 per prescription 36 per prescription 48 per prescription 60 per prescription 48 per prescription 60 per prescription
Antiemetics - Oral 5-T3s	Anzemet® 50mg Anzemet® 100mg Emend® 80mg Emend® 125mg Granisetron 1mg Ondansetron ODT 4mg Ondansetron ODT 8mg Ondansetron 4mg Ondansetron 8mg Ondansetron 24mg Ondansetron Solution	4 per prescription 2 per prescription 2 per prescription 1 per prescription 2 per prescription 12 per prescription 6 per prescription 12 per prescription 6 per prescription 1 per prescription 1 bottle (50ml) per prescription
Beta Adrenergics - Long Acting	Serevent® Diskus	1 box (60 inhalations) per month
Beta Adrenergics - Short Acting	Xopenex® (all strengths)	4 boxes (288ml) per month
Corticosteroids - Inhaled	Flovent® Rotadisk 50mcg Flovent® Rotadisk 100mcg Flovent® Rotadisk 250mcg	1 box per month 1 box per month 1 box per month
Diabetic Supplies	Glucometers	1 per rolling 732 days

Drug Class	Drug	Maximum Dispensing Quantity
Hematopoietic Agents	Darbepoetin Alfa Epoetin Alfa Neupogen®	1200 mcg per rolling 30 days 400,000 units per rolling 30 days 15 ml per prescription
Monoclonal Antibodies	Synagis® 100mg vial	4 per prescription
Muscular Dystrophy Agents	Copaxone® 20mg Kit Rebif®	1 per prescription 6 per prescription
Narcotics	Actiq® Avinza® Butorphanol nasal spray Duragesic® Fentora® Kadian® Morphine Sulfate Sustained Release Formulations Oxycontin® (including generic)	120 units per rolling 30 days 1 capsule per day. Quantity may be exceeded for a diagnosis of terminal cancer (ICD-9 140-239). 2 units per rolling 30 days 15 per prescription 120 units per rolling 30 days 2 capsules per day. Quantity may be exceeded for a diagnosis of terminal cancer (ICD-9 140-239). 3 tablets per day of any one strength. Quantity may be exceeded for a diagnosis of terminal cancer (ICD-9 140-239). 3 tablets per day of any one strength. Quantity may be exceeded for a diagnosis of terminal cancer (ICD-9 140-239).
Non-Steroidal Anti-Inflammatory Agents	Toradol®	20 tablets per rolling 180 days
Sedative Hypnotics	Chloral Hydrate Syrup All other agents in this class	150 ml per rolling 30 days 30 tablets per month of only one strength
Smoking Cessation Products		180 days supply per year
Triptans	Amerge® tablets Axert® tablets Frova® tablets Maxalt® tablets Maxalt® MLT tablets Sumatriptan 25mg tablets Sumatriptan 50mg tablets Sumatriptan 100mg tablets Sumatriptan 6mg injection Sumatriptan 5mg nasal spray Sumatriptan 20mg nasal spray Relpax® tablets Zomig® 2.5mg tablets Zomig® 5mg tablets Zomig® ZMT tablets Zomig® 5mg nasal spray	9 per rolling 30 days 6 per rolling 30 days 9 per rolling 30 days 12 per rolling 30 days 12 per rolling 30 days 18 per rolling 30 days 9 per rolling 30 days 9 per rolling 30 days 4 per rolling 30 days 12 units per rolling 30 days 6 units per rolling 30 days 12 per rolling 30 days 12 per rolling 30 days 6 per rolling 30 days 12 per rolling 30 days 12 units per rolling 30 days

The following drugs/drug classes have clinical prior authorization requirements as stated in MSM Chapter 1200, Appendix A.

- Altace® - Ramipril
- Antifungals – Onychomycosis Agents
- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)
- Byetta®
- CNS Stimulants
- COX-11 Inhibitors
- Growth Hormone
- Immunomodulators – Injectable
- Psychotropic medications for children and adolescents
- Symlin®

The following drugs/drug classes have quantity and clinical prior authorization requirements.

- **Actiq®/Fentora® (Fentanyl Citrate):** Quantity limit of 120 units per rolling 30 days. Prior authorization will not be granted for four units per day of multiple strengths.
- **Duragesic® (Fentanyl Transdermal):** 1 per 72 hours
- **Hematopoietic/Hematinic Agents:** Claims documenting doses exceeding the Center for Medicare and Medicaid Services (CMS) maximum threshold ESAs will be denied.
- **Immunomodulators (Topical):** Elidel® 1% cream is limited to 30g per 30 rolling days with a 25% tolerance for refills. Protopic® 0.03% and 0.1% Ointment is limited to 30 mg per 30 rolling days with a 25% tolerance for refills.
- **Regranex®:** Original prescription (15 grams maximum/prescription) plus one refill (15 grams maximum/prescription) **OR** a total lifetime dose of 30 grams per recipient.
- **Xopenex®:** Xopenex 0.31mg and 0.63mg cannot be dosed more than every 6 hours or as needed. Xopenex 1.25 mg cannot be dosed more than every 8 hours or as needed. Maximum quantity per month = 4 boxes (288ml).

3.5 Drugs with Age Limitations

The following items are subject to age limits. PA is required for exception to limitations.

Drug	Age Limitations
Acne Medications (Rx and OTC products are covered with a prescription)	Covered for recipients under age 21.
Actiq®/Fentora®	Covered for recipients age 16 and older. PA is required.
Exenatide Injection (Byetta®)	Covered for recipients age 18 or older. PA required.
Fluoride Preparations and Vitamins with Fluoride	Covered for recipients under age 21.
Gardasil® (HPV) (limited to females)	PA not required for females ages 19-26.
Omalizumab (Xolair®)	Covered for recipients age 12 years and older. PA is required.
Pramlinitide Injection (Symlin®)	Covered for recipients age 15 or older. PA required.
Pulmicort Respules®	No PA required for recipients under age 4
Regranex®	Covered for recipients age 16 and older. PA is required.
Synagis®	Covered without prior authorization October 1st through April 30th for recipients under age 2. PA is required for recipients age 2 and older. Between May 1st and September 30th, PA is required for all recipients regardless of age.
Tretinoic Acid Cream/Ointment/Gel	Covered for recipients under age 21.
Zantac® Syrup	PA required for < 12 years old.
Zyrtec® Syrup	No PA required for < 2 years old.

3.6 Gender Limitations

Antiandrogenic agents, Flomax® and transdermal testosterone are covered for males only. Gardasil® (HPV), hormone therapy, prenatal vitamins and oral and topical contraceptives are covered for females only.

3.7 Diagnosis Limitations

The following drugs require a certain diagnosis. Submit an ICD-9 code on the claim (the ICD-9 code must also be written on the prescription from the prescriber).

Drug	ICD-9 Code and Diagnosis
Bystolic®	490-496: Chronic Obstructive Pulmonary Disease
Chorionic Gonadotropin	752.51; 257.2: Prepubital chryptorchidism, *or* Hypogonadism
Cymbalta®	356.9: Peripheral Neuropathy
Diabetic Supplies/Glucometers	250.00-250.93; 648.80-648.84: Diabetes
Dypyridamole	424.1; 746.9: Cardiac valve replacement
Long-Acting Narcotics	140-239: Cancer
Lyrica®	345: Epilepsy and/or seizure disorder 780.3: Convulsions 250.6: Diabetic Peripheral Neuropathy 053.1: Posttherpetic Neuropathy 729.1: Fibromyalgia
Proton Pump Inhibitors	530.11 or 530.81: Gastric Esophageal Reflux Disease (GERD) 531-534: Gastric/Duodenal/Peptic/Gastrojejunal Ulcer Disease 530.85: Barrett's Esophagus 251.5: Zollinger-Ellison 578: GI Hemorrhage
Provigil®	347.00; 347.01; 347.10; 347.11; 780.53; 780.57: Narcolespy or Sleep Apnea
Rozerem®	307.42: Persistent disorder of initiating or maintaining sleep
Sildenfil (Revatio® & Viagra®)	416.0, 416.8: Pulmonary Hypertension or Pulmonary Arterial Hypertension

3.8 Family Planning Drugs

You may submit claims for family planning drugs directly to Medicaid without billing a primary insurance carrier first.

3.9 Intravenous (I.V.) Therapy Drugs

Intravenous (I.V.) therapy drug claims must be submitted through the pharmacy POS system using the Multi-Ingredient Functionality (see Section 4: Compound Drugs).

Dispensing Fees

For **outpatient antibiotic therapy**, a daily dispensing fee of $22.40 will be applied to the claim.

For recipients in **Long Term Care**, a daily dispensing fee of $16.80 will be applied to the claim. This fee will be multiplied by the number of days the therapy was provided.

Supplies

I.V. therapy supplies, enteral nutrition/supplies, Standard Total Parenteral Nutrition (TPN) solution and supplies are billed on a CMS-1500 claim form or through the 837P electronic transaction. Medications added to TPN Solution immediately prior to administration are billed through the pharmacy POS system.

For coverage and limitations, see the Billing Guidelines for Provider Type 33, MSM Chapter 1200, Section 1203.2 and MSM Chapter 1300.

3.10 Hospice Drugs

As stated in MSM Chapter 3200, drugs, supplies and durable medical equipment prescribed for conditions other than for the palliative care and management of the terminal illness are not covered benefits under the Nevada Medicaid hospice program and are to be billed in accordance with the appropriate Medicaid Services Manual chapter for those services.

Hospice recipients can be identified by:

- Information on the recipient's Medicaid enrollment file, ***or***
- The PATIENT LOCATION code (Field 307-C7) on the inbound claim contains a code '11' (Hospice)

To bill for a drug that is unrelated to the terminal illness, use override code "08" in Field 461-EU (Payer Defined Exemption).

3.11 Long Term Care (LTC) Drugs

Medicaid provides coverage for legend drugs in LTC. See Medicaid Services Manual, Chapter 500 for complete information on LTC coverage.

Identify claims for recipients in an LTC facility by entering '"04" (Long Term/ Extended Care) in Field 307-C7 (PATIENT LOCATION).

Non-Billable Items

I.V. hydration therapy of standard fluids without additives (e.g., antibiotics, potassium and heparin) and supplies associated with I.V. therapy, enteral nutrition and TPN administration are a part of the LTC or Nursing Facility per diem rate and may not be billed as a separate charge.

The following items are not billable for recipients in an LTC facility (they are considered covered through the per diem rate).

- Dental supplies
- Disposable supplies
- Emollient supplies
- Endocrine supplies
- Fluid and electrolyte supplies
- Metabolic, nutritional and temperature supplies
- Respiratory supplies
- Supplements (see MSM Chapter 1300)
- Urological supplies
- Wound care supplies

Billable Items

I.V. drugs/TPN may be billed as a separate charge for recipients in LTC facilities.

Unit Dose Repackaging Incentive

An incentive plan is available to pharmacies who repackage non-unit dose products (tablets and capsules) to recipients in a LTC facility. Email pharmacy@magellanhealth.com for enrollment and program details.

Enrolled pharmacies are entitled to a per claim incentive fee of $0.43. Submit this fee in the INCENTIVE AMOUNT SUBMITTED field (Field 438 E3). Additionally, submit a value of '3' (Pharmacy Unit Dose) in the UNIT DOSE INDICATOR field (Field 429 DT).

In accordance with the Centers for Medicare and Medicaid Services (CMS), State Director Memo (SMD) 06-005, repackaging of pharmaceuticals must be in compliance with the Nevada State Board of Pharmacy.

In addition, nursing facilities must properly credit the Medicaid program for the return of unused prescription medicines upon discontinuance of the prescription or transfer, discharge or death of a Medicaid beneficiary. This is to assure there is no double billing of medication.

Drugs Indicated as Unit Dose

As indicated by FDB, most unit dose drugs are covered for recipients in LTC facilities only. The following unit dose drugs, though, are covered for both LTC and non-LTC recipients. PA may be required.

- Accutane®
- Albuterol
- Aldara®
- Budesonide
- Cenogen-OB®
- Cromolyn
- Cyclosporin
- Ferrous Sulfate/ Vit C/ FA
- Ipratropium
- Metaproterenol
- Micardis®
- Micardis® HCT
- Prenatal Vit/Fe-P-Sac Complex FA
- Prevacid Solutabs
- PrimaCare®
- NA CL
- Natafort®
- Nephro-Vite+FE
- Nimotop®
- Precare®
- Precare® Conceive
- Prenatal RX
- Remeron® Soltabs
- Testosterone Gel
- Tolfrinic®
- Vinatal-Forte®
- VitaFol®
- Xopenex®
- Zomig® ZMT 5 mg

3.12 Diabetic Supplies

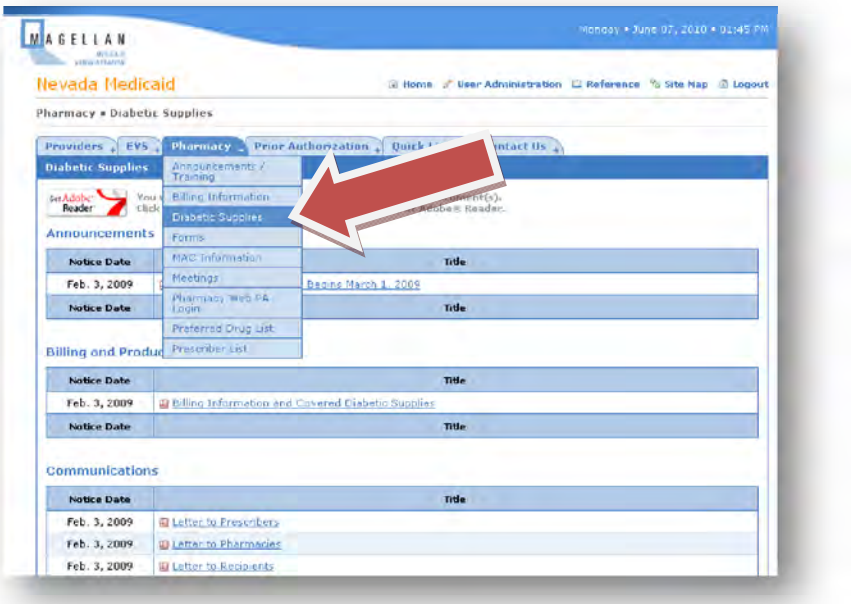
Nevada Medicaid has two preferred diabetic supply vendors.

Click here for a list of covered monitors and test strips.

Please refer to the Magellan Medicaid Administration website for additional information (select "Diabetic Supplies" from the "Pharmacy" menu).

Diabetic supplies such as syringes, test strips, lancets and glucometers must be billed through the POS system. The corresponding ICD-9 code must be entered for diabetic supplies.

Please refer to Section 6.2 in this manual for prior authorization requirements.



Section 4: Compound Drugs

NCPDP Version 5.1 Multi-Ingredient Compound functionality is required to submit POS claims for all compound prescriptions, including IV compounds.

Partial fill functionality cannot be used with Multi-Ingredient Compound claims.

4.1 Submit Only One Claim

Submit one claim to bill for a compound drug (do not submit a separate claim for each ingredient).

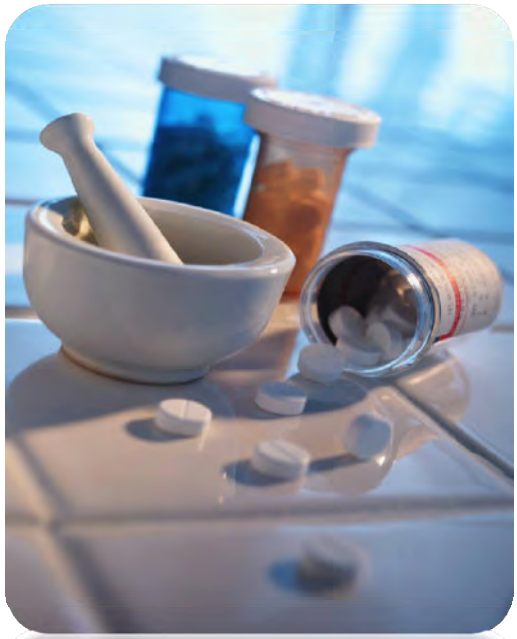
For example, when billing for a compound with 10gm Salicylic Acid, 3ml Lactic Acid and 40ml Flexible Collodion qs, enter the required fields for the Claim and Compound segments.

Next, complete Fields 448, 449, 488 and 489 for each ingredient, i.e., Salicylic Acid, Lactic Acid and Flexible Collodion qs.

This methodology applies to all compound prescriptions, e.g., ointments, liquids, tablets.+++`

4.2 Dispensing Fee

A $4.76 dispensing fee applies to all compound claims except home I.V. antibiotics.



4.3 The Claim Segment

Fields below are required in the Claim segment.

Submission Clarification Code (Field 420-DK)

You may enter an "8" in this field or leave it blank. It is recommended that you leave the field blank when submitting the claim for the first time. If any of the ingredients require prior authorization and prior authorization has not been obtained, the POS system will tell you which ingredient(s) needs prior authorization. Contact the prescriber and request him/her to obtain authorization for the ingredient(s). After the ingredient(s) have been prior authorized, you may re-submit your claim for full payment.

If you enter an "8" in this field and the POS system denies one or more ingredients because prior authorization is required, ask the prescriber to obtain authorization for that ingredient. Once authorization is obtained, void the previous claim and resubmit a new claim for full payment.

If you know an ingredient is not covered and you wish to be paid for only the covered ingredients, enter an "8" in this field and the POS system will pay for the covered ingredients only. Likewise, if prior authorization was required but not obtained, entering an "8" in this field instructs the POS system to pay for only the covered ingredients that do not require prior authorization.

Product Code/NDC (Field 407-D7)

Enter 11 zeros ("00000000000") to identify the claim as a multi-ingredient compound.

Compound Code (Field 406-D6)

Enter "2" or "yes" in this field.

- Quantity Dispensed (Field 442-E7)
- Enter the total quantity of all ingredients dispensed (entire product).
- Gross Amount Due (Field 430-DU)
- Enter the amount due to the pharmacy for all ingredients (the entire product).

4.4 The Compound Segment

The NCPDP fields below are required in the Compound segment.

Compound Dosage Form Description Code (Field 450-EF)

Valid values for this field are:

01 = Capsule
02 = Ointment
03 = Cream
04 = Suppository
05 = Powder
06 = Emulsion
07 = Liquid
10 = Tablet
11 = Solution
12 = Suspension
13 = Lotion
14 = Shampoo
15 = Elixir
16 = Syrup
17 = Lozenge
18 = Enema

Compound Dispensing Unit Form Indicator (Field 451-EG)

Valid values for this field are:

01 = Each
02 = Grams
03 = Milliliters

Compound Ingredient Component Count (Field 447-EC)

A maximum of 25 ingredients are allowed.

Compound Route of Administration (Field 452-EH)

Enter the route of administration.

1 = Buccal
2 = Dental
3 = Inhalation
4 = Injection
5 = Intraperitoneal
6 = Irrigation
7 = Mouth/Throat
8 = Mucous Membrane
9 = Nasal
10 = Ophthalmic
11 = Oral Ingredient
12 = Other/Miscellaneous
13 = Otic
14 = Perfusion
15 = Rectal
16 = Sublingual
17 = Topical
18 = Transdermal
19 = Translingual
20 = Uretal
21 = Vaginal
22 = Enteral Compound

Required Fields for Each Ingredient

Complete the following fields for each ingredient, i.e., if there are three ingredients, complete each field three times–once for each ingredient.

Compound Product ID Qualifier (Field 488-RE)

Enter the compound product ID qualifier.

Compound Product ID (Field 489-TE)

Enter the NDC number from the container being used to compound the medication.

Compound Ingredient Quantity (Field 448-ED)

Enter the ingredient quantity.

Compound Ingredient Drug Cost (Field 449-EE)

Enter the ingredient cost.

Section 5: Partial Fill Functionality

Partial fill functionality allows pharmacies to bill for partial quantities of a single prescription. The following rules apply:

- Partial fills must be billed via the POS system.
- The dispensing fee is prorated according to the quantity dispensed.
- Partial fill functionality cannot be used with Multi-Ingredient Compound claims.
- Partial fills may not be transferred from one pharmacy to another.
- You may not submit two partial fill transactions for the same prescription on the same day; the service date must be different for each partial fill.

The following sections list the NCPDP fields that are required to submit initial, subsequent and final claims using the partial fill functionality.

5.1 Initial Claims

Complete these fields on an initial partial fill claim.

- **Quantity Dispensed (Field 442-E7):** Enter the actual quantity dispensed for this claim.
- **Days Supply (Field 405-D5):** Enter the number of days supply that was dispensed for this claim.
- Dispensing Status (Field 343-HD): Enter "P" in this field.

Quantity Intended To Be Dispensed (Field 344-HF): Enter the total quantity that was prescribed.

Days Supply Intended To Be Dispensed (Field 345-HG): Enter the total days supply that was prescribed.

5.2 Subsequent Claims

Complete these fields on a subsequent partial fill claim.

Associated Prescription/Service Reference # (Field 456-EN): Enter the prescription number from the initial partial fill.

Associated Prescription/Service Date (Field 457-EP): Enter the date of service of the most recent partial fill in the series.

Quantity Dispensed (Field 442-E7): Enter the actual quantity dispensed for this claim.

Days Supply (Field 405-D5): Enter the number of days supply that was dispensed.

Dispensing Status (Field 343-HD): Enter "P" in this field.

Quantity Intended To Be Dispensed (Field 344-HF): Enter the total quantity that was prescribed.

Days Supply Intended To Be Dispensed (Field 345-HG): Enter the total days supply that was prescribed.

5.3 Final Claim

Complete these fields on a final partial fill claim.

- Associated Prescription/Service Reference # (Field 456-EN): Enter the prescription number from the initial partial fill.
- **Associated Prescription/Service Date (Field 457-EP):** Enter the date of service of the most recent partial fill in the series.
- **Quantity Dispensed (Field 442-E7):** Enter the actual quantity dispensed for this claim.
- **Days Supply (Field 405-D5):** Enter the number of days supply dispensed.
- Dispensing Status (Field 343-HD): Enter "C" in this field.
- Quantity Intended To Be Dispensed (Field 344-HF): Enter the total quantity that was prescribed.
- Days Supply Intended To Be Dispensed (Field 345-HG): Enter the total days supply that was prescribed.

Section 6: Prior Authorization

When required, the prescriber may request prior authorization by:

- Calling the Clinical Call Center at **(800) 505-9185**.
- Faxing their paper PA request to **(800) 229-39439**.
- Using the Web PA tool (select "Pharmacy Web PA Login" from the "Pharmacy" menu at http://nevada.fhsc.com). For assistance with the Web PA tool, call the Web Support Call Center at **(800) 241-8726**.

Prior authorization requirements apply regardless of media (e.g., paper, POS) and/or recipient location (e.g., LTC vs. non-LTC).

Prior authorization must be requested prior to dispensing the drug; however there may be situations in which an authorization request is considered after the fact (e.g., retroactive eligibility).

Ideally, prior authorization should be requested (if needed) when the prescription is written. If the prescriber has not contacted Magellan Medicaid Administration and prior authorization is required, the claim will deny with a message for the prescriber to contact Magellan Medicaid Administration.

Magellan Medicaid Administration may request additional information from the prescriber to make a determination for the prior authorization. The physician has three business days to respond to any such requests. After that, the request will be denied.

An Authorization Number is not required on paper or electronic claims; however, Magellan Medicaid Administration must activate authorization in the POS system prior to claim submission.

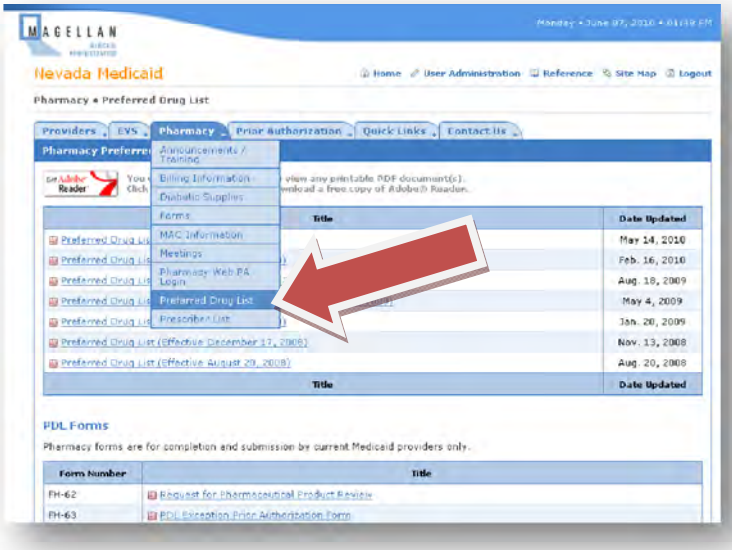
The following drugs and drug classes require prior authorization:

- Actiq®/Fentora®
- Agents used for the treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)
- Anti-cholinergic Agents
- Antifungals: Onychomycosis Agents
- COX IIs
- Exenatide Injection (Byetta®)
- Fentanyl Transdermal (Duragesic®) Patches
- Gastrointestinal Agents: Proton Pump Inhibitors (PPIs)
- Growth Hormones
- Hematopoietic Hematinics
- Immunomodulators: Injectable and Topical
- Lyrica®
- Pramlinitide Injection (Symlin®)
- Psychotropic medications for children and adolescents
- Ramipril (Altace)
- Regranex®

6.1 The Preferred Drug List (PDL)

Nevada Medicaid and Nevada Check Up utilize a Preferred Drug List (PDL). Non-preferred drugs in the listed classes require prior authorization.

The PDL is at http://nevada.fhsc.com. To access, select "Preferred Drug List" from the Pharmacy menu as shown below. Visit this website to ensure you have the most recent version of the PDL as it is updated periodically.



6.2 Diabetic Supplies

Prior authorization is required for diabetic supply quantities greater than those listed below.

- Alcohol Swabs – 200/month
- Battery for Monitor – 1/year
- Blood Glucose Monitor – 1 every 2 years (not to exceed $55/monitor)
- Blood Glucose Strips – 200/month
- Control Solution – 1/month
- Insulin Syringes – 100/month
- Keto-Stix – 100/month
- Lancets – 200/month

6.3 Compound Drugs

Prior authorization requirements apply to each individual ingredient in a compound prescription.

Ingredients that require prior authorization will not be paid until authorized by Magellan Medicaid Administration.

For billing information, see Section 4 in this manual, Compound Drugs.

6.4 Medicare Drugs

Prior authorization is required for Medicare drugs that are used for non-Medicare covered indications. For example, if methotrexate is being used for arthritis, prior authorization is required.

6.5 Protocol for Emergencies

If the prescriber is not available and the pharmacist feels the recipient needs to receive the prescribed drug, the pharmacist should contact the Clinical Call Center at **(800) 505-9185**.

Per CMS guidelines, Magellan Medicaid Administration may authorize a 72-hour, emergency supply.

6.6 Denied Prior Authorization Requests

If a request is denied, the recipient will receive notification by mail along with information on how to appeal the denied request.

Section 7: Program Particulars

7.1 Refills (DEA Codes 0-5)

Dispense refills pursuant to the orders of the physician, but not more than one year from the date of the original prescription.

Early refills may be dispensed only when 80% of the prescription is used for non-controlled drugs and 90% for controlled drugs. Recipients must use drugs in accordance with the prescriber's orders.

- Non-controlled drugs (DEA code '0') may be refilled pursuant to the order of the physician. Up to 11 refills (plus one original) or one year, whichever comes first.
- CIIs (DEA code '2') may not be refilled. A new prescription is required for each fill.
- Controlled drugs other than CIIs (DEA code '3', '4' or '5') may be refilled pursuant to the order of the physician. Up to 5 refills (plus one original) or 6 months, whichever comes first.

7.2 Lost Medications

The recipient is responsible for payment to replace lost, stolen or otherwise destroyed medications even if a physician writes a new prescription for the drug. Prior authorization may be granted in life-threatening situations for maintenance medications (refer to Medicaid Services Manual, Chapter 1200).

7.3 Maximum Prescriptions per Month

Recipients are not restricted to a maximum number of prescriptions per month, however, Over-The-Counter (OTC) drugs require prior authorization if more than two drugs per each Standard Therapeutic Class per each rolling 30 days is prescribed. For example, more than two OTC cough preparations require prior authorization. All OTC drugs require a doctor's prescription.

7.4 Mandatory Generic Policy

If the prescriber has not indicated that generic substitution is prohibited, the pharmacy must dispense the least expensive generic drug available. The only exception is PDL-mandated brand name drugs. Claims for multi-source brand drugs may deny as brand drug based on brand classification provided by FDB.

Effective April 14, 2010, the DISPENSE AS WRITTEN (DAW) CODE "1" (Field 408-D8) will override the generic requirement only when the prescriber has obtained prior authorization. Without prior authorization, a brand name drug may be dispensed, but the claim will be reimbursed per the Maximum Allowable Cost (MAC) + dispensing fee algorithm listed in Section 12.2 of this manual.

7.5 Timely Filing

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

For original claims, reversals (voids) and adjustments, the timely filing limit is **180 days** from the Date of Service (DOS) or the Date of Eligibility Decision when Medicaid is the primary payer and **365 days** from the DOS or Date of Eligibility Decision when the recipient has a primary insurance carrier other than Medicaid or the provider is outside the state of Nevada. Claims that exceed these timely filing limits will be denied.

An exception to the timely filing limitation may be granted if you document delays due to errors on the part of the primary insurance carrier, the Division of Welfare and Supportive Services (DWSS), DHCFP or Magellan Medicaid Administration. If you have any questions, contact the Technical Call Center at **(800) 884-3238**.

7.6 Tamper Resistant Prescription Pads

Federal law requires that all written prescriptions for Medicaid Fee For Service outpatient drugs must contain at least three tamper resistant features.

See the Magellan Medicaid Administration Web Announcement 215 for detailed specifications.

7.7 Prescription Origin Code (NCPDP Field 419-DJ)

Effective on claims with dates of service on and after October 1, 2008, one of the NCPDP standard values of 0 = Not Specified, 1 = Written, 2 = Telephone, 3 = Electronic or 4 = Facsimile will be required in the Prescription Origin Code field. Claims submitted with a null value will be rejected.

Section 8: Coordination of Benefits (COB)

Medicaid is the payer of last resort except as defined in Medicaid Services Manual, Chapter 100. Medicaid manages COB, also referred to as cost avoidance or TPL, as described below.

A recipient's primary coverage is identified by the presence of other carrier information in the recipient's eligibility file and/or information communicated by the pharmacy on the claim. If other insurance is indicated on the recipient's eligibility file, Magellan Medicaid Administration will process the claim as a COB claim regardless of which COB codes the pharmacist submits. If a primary insurance carrier is not indicated on the recipient's eligibility file and the pharmacist submits COB data, the claim will be processed as a COB claim.

If the pharmacy bills Medicaid before the recipient's primary carrier, Magellan Medicaid Administration will deny the claim. A unique, carrier code identifying the other carrier, the patient's policy number and the carrier name will be returned to the pharmacy with the claim denial.

To facilitate COB, Medicaid allows providers to override days supply limits and/or "Drug Requires Prior Authorization" conditions by entering a value of '5' ("Exemption from Prescription Limits") in Field 461-EU (PA/MC CODE). Pharmacies are required to submit the other carrier code in OTHER PAYER ID, Field 340-7C, as part of the override process. See Appendix C for carrier codes.

Magellan Medicaid Administration uses the Nevada Medicaid maximum allowable amount to calculate payment. In some cases, this may result in a zero payment.

TPL Processing Grid

Following are values and claim dispositions based on pharmacist submission of standard NCPDP TPL codes.

Other Payer Amount Paid (Field 431-DV)	Other Coverage Indicated in Recipient's File	Other Payer Date (Field 443-E8)	Other Payer ID (Field 340-7C)	Claim Disposition	Comments
"0" (Not Specified) in Field 308-C8 (Other Coverage Code)					
0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date*	This code will not override TPL.
0 No Null			Null	Pay	
>0	No	M/I or null	M/I or null	Deny, *M/I Other Payer Date*	
>0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer Amount*	
"1" (No Other Coverage Identified) in Field 308-C8 (Other Coverage Code)					
0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date*	
0 Yes		Valid Date	Valid TPL Carrier Code	Pay	Use when primary does not show coverage.
0	No	M/I or null	M/I or null	Pay	
>0	No	M/I or null	M/I or null	Deny, *M/I Other Payer Date, M/I Other Payer Amount*	
>0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer Amount*	
0	Yes	Valid Date	M/I or null	Deny, *Bill Primary, M/I Other Payer Date*	
0	No	Valid Date	M/I or null	Deny, *M/I Other Payer Date*	
0 No M/I		or null	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	

Other Payer Amount Paid (Field 431-DV)	Other Coverage Indicated in Recipient's File	Other Payer Date (Field 443-E8)	Other Payer ID (Field 340-7C)	Claim Disposition	Comments
0	Yes	M/I or null	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, *Bill Primary*	
0 Yes		Date > Adjudication Date	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
"2" (Other Coverage Exists, Payment Collected) in Field 308-C8 (Other Coverage Code)					
> 0	Yes or No	Valid Date	Valid TPL Carrier Code	Pay (Will pay when all Carriers have been overridden)	Payment is the difference between the Nevada Medicaid Allowed Amount and the Other Payer Amount.
>0	No	Valid Date	M/I or null	Deny, *M/I Other Payer Date*	
>0	Yes	Valid Date	M/I or null	Deny, *Bill Primary, M/I Other Payer Date*	
>0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
0	No	M/I or null	M/I or null	Date, *M/I Other Payer Date, MI Other Payer Amount*	
0 Yes		N/A	N/A	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer Amount*	
>0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, *Bill Primary*	
>0 Yes		Denial > Adjudication Date	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
"3" (Other Coverage Exists, This Claim Not Covered) in Field 308-C8 (Other Coverage Code)					
0	Yes or No	Valid Date	Valid TPL Carrier Code	Pay	Pay the Nevada Medicaid Allowed Amount.
0	No	Valid Date	M/I or null	Deny, *M/I Other Payer Date*	
0	Yes	Valid Date	M/I	Deny, *Bill Primary, M/I Other Payer Date*	
0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
>0	No	M/I or null	M/I or null	Deny, *M/I Other Payer Date, M/I Other Payer Amount*	
>0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer Amount*	
>0	Yes or No	Valid	Valid	Deny, *M/I Other Payer Amount*	
>0	Yes	Valid	Invalid	Deny, *Bill Primary, M/I Other Payer Amount*	
>0 No		Valid	Invalid	Deny, *M/I Other Payer Amount*	
>0	Yes or No	Invalid	Valid	Deny, *M/I Other Payer Date, M/I Other Payer Amount*	
0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, *Bill Primary Payer*	
0 Yes		Denial > Adjudication Date	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	

Other Payer Amount Paid (Field 431-DV)	Other Coverage Indicated in Recipient's File	Other Payer Date (Field 443-E8)	Other Payer ID (Field 340-7C)	Claim Disposition	Comments
"4" (Other Coverage Exists, Payment Not Collected) in Field 308-C8 (Other Coverage Code)					
>0	No	M/I or null	M/I or null	Deny, *M/I Other Payer Date, M/I Other Payer Amount*	
>0	Yes	M/I or null	M/I or null	Deny, *Bill Primary, M/I Other Payer Date, M/I Other Payer Amount*	
>0	Yes or No	Valid	Valid	Deny, *M/I Other Payer Amount*	
>0 Yes		Valid	Invalid	Deny, *Bill Primary, M/I Other Payer Amount*	
>0 No		Valid	Invalid	Deny, *M/I Other Payer Amount*	
>0	Yes or No	Invalid	Valid	Deny, *M/I Other Payer Date, M/I Other Payer Amount*	
0 Yes		Valid Date	Valid TPL Carrier Code	Pay	Use if primary is full deductible or 100% copay.
0	Yes	Valid Date	M/I or null	Deny, *Bill Primary, M/I Other Payer Date*	
0	No	Valid Date	M/I or null	Deny, *M/I Other Payer Date*	
0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, *Bill Primary*	
0 Yes		Date > Adjudication Date	Valid TPL Carrier Code	Deny, *M/I Other Payer Date*	
Version 5.1 Codes					
"5" (Managed Care Plan Denial) in Field 308-C8 (Other Coverage Code)					
				Deny, *Drug Not Covered* Additional Message: *OCC 5/ 6 Not Allowed for Override*	Not allowed for override. NCPDP 70/ with message
"6" (Other Coverage Denied: Not a Participating Provider) in Field 308-C8 (Other Coverage Code)					
				Deny, *Drug Not Covered* Additional Message: *OCC 5/ 6 Not Allowed for Override*	Not allowed for override. NCPDP 70/ with message
"7" (Other Coverage Exists: Not in Effect on DOS) in Field 308-C8 (Other Coverage Code)					
					Use if TPL expired; edits mirror OCC = 1.
"8" (Claim is billing for Copay) in Field 308-C8 (Other Coverage Code)					
					Use for Medicare Part D/Medicaid dual-eligible recipient processing only.

Section 9: Recipient Eligibility and Benefits

9.1 Medicare Part D Plan (PDP) and Dual-Eligible Recipients

Recipients eligible for both Medicare and Medicaid benefits ("dual-eligibles") will receive prescription drug coverage through a Medicare Part D Prescription Drug Plan (PDP).

All claims for dual-eligibles must be billed to the recipient's Medicare PDP prior to billing Medicaid. Submit the claim to Medicaid using standard COB processing, i.e., include all required COB processing fields.

Claims for dual-eligibles must include:

- "P031009646" in Field 104-A4 (Processor Control Number).
- "07450" in Field 340-7C (Other Payer ID).

Medicare-Excluded Drugs

Some drugs are not covered by the Medicare PDP. Medicare excluded drug categories are:

- OTC Medications
- Cough and Cold Medications
- Vitamin and Mineral Supplements including Prenatal Vitamins
- Barbiturates
- Benzodiazepines

Submit your claim to Medicaid *after* the Medicare PDP denies the claim as a non-covered benefit. Enter a "3" (Other coverage exists, this claim not covered) in Field 308-C8 (Other Coverage Code).

Medicaid requires a prescription for all drugs, prescribed *and* OTC. All current Medicaid limitations and exclusions apply to claims not covered by a recipient's Medicare PDP.

Co-Payment Claims

Medicaid will cover prescription co-payments ($1.10 for generics, $3.30 for brands) for non-institutionalized dual-eligibles who have an eligibility code of "A" or "B."

Medicaid will cover Part B co-pays for dual-eligibles with an eligibility code of A, B, 5 or S.

Medicaid will not reimburse Part D co-pays for recipients in LTC facilities as these co-pays are waived per federal Medicare regulations.

Medicaid does not cover co-pays ($2.40 for generics, $6.00 for brands) for dual-eligibles with an eligibility code of "5" or "S."

Medicaid co-pay logic does not allow for the reimbursement of a dual-eligible co-pay for an amount greater than $3.30. For Medicare Part B covered drugs, the co-pay amount can and will exceed this amount in most cases. To exceed the current $3.30 co-pay maximum for Part B covered drugs for recipients with Part B and D, bill Medicare Part B as the primary payer. Medicaid can be billed as the secondary payer using standard COB billing practices. For Part B covered drugs, enter the Other Coverage Code of "2" (Field 308-C8). The Gross Amount Due (Field 430-DU) should equal the Medicare allowed amount.

The Part D carrier code, 07450 (Field 340-7C) and Part B carrier code, 04967, are required for processing claims for recipients that are eligible for Medicaid, Medicare Part D and Medicare Part B. Contact the Technical Call Center at (800) 884-3238 to request an override for COB denials if the pharmacy's software prevents entry of these codes.

Below are required NCPDP fields for COB processing specific to Part D co-pays:

- Standard claim information including but not limited to Cardholder ID (Field 302-C2), Prescription/Service Reference Number (Field 402-D2), Usual And Customary Charge (Field 426-DQ) and Gross Amount Due (Field 430-DU)
- Bin Number (Field 102-A2) = 009646
- Processor Control Number (Field 104-A4) = P031009646
- Other Coverage Code (Field 308-C8) = 8
- Other Payer Coverage Type (Field 338-5C)
- Other Payer ID Qualifier (Field 339-6C)
- Other Payer ID (Field 340-7C) = 07450
- Other Payer Date (Field 443-E8)
- Other Payer Amount Paid Count (Field 341-HB)
- Other Payer Amount Paid Qualifier (Field 342-HC) = 99 (Required when Other Payer Amount Paid is used.)

- Other Payer Amount Paid (Field 431-DV) (Required when Other Payer Amount Paid Qualifer is used.)
- Ingredient Cost (Field 409-D9) = $0.00 or null
- Other Amount Claimed Submitted Count (Field 478-H7)
- Other Amount Claimed Submitted Qualifier (Field 479-H8) = 99
- Other Amount Claimed Submitted (Field 480-H9)

Gross Amount Due (Field 430-DU) should equal the Other Amount Claimed Submitted (Field 478-H9).

Diabetic Supplies

Blood glucose testing equipment and supplies, as well as injection devices, are a Part B-covered benefit. These items are not considered Part D drugs and therefore are not a Part D benefit. After billing Medicare Part B for these items, Medicaid can be billed as the secondary payer using standard COB billing practices.

Enter the Other Coverage Code of "2" (Field 308-C8). The Gross Amount Due (Field 430-DU) should equal the Medicare allowed amount. The Part D carrier code, 07450 (Field 340-7C) and Part B carrier code, 04967, are required for processing diabetic supply claims for recipients that are eligible for Medicaid, Medicare Part D and Medicare Part B.

Contact the Technical Call Center at (800) 884-3238 to request override for COB denials if the pharmacy's software prevents entry of these codes.

9.2 Eligible for Medicare Only

If a recipient is eligible for Medicare deductible and co-insurance payment only, Medicaid does not pay the claim unless the drug is on the Medicare covered list.

The Medicare covered drugs are:

Azathioprine Graniseton
Busulfan Mephalen
Capecitabine Methotrexate
Cyclophosphamide Mycophenolate
Cyclosporine Mofetil
Diabetic Supplies Ondansetron
Dolasetron Sirolimus
Dronabinol Tacrolimus
Etoposide Temozolomide

Submit claims for Medicare covered drugs, using standard COB processing entering an Other Coverage Code of "2" in Field 308-C8. The Gross Amount Due (Field 430-DU) should equal the Medicare allowed amount. Include all required COB processing fields including the Part B carrier code, 04967.

9.3 Recipient Lock-in Program

When a recipient shows patterns of abuse/misuse of benefits, the recipient can be "locked in" to a pharmacy. If a claim is submitted for a recipient who is "locked in" to a specific pharmacy, the claim will reject if not submitted by the locked-in pharmacy. A "50" rejection code (Non-matched Pharmacy ID-Check NPI/Locked In-Call 800-505-9185) will be sent to the pharmacy at the time of billing.

Pharmacies may call the Clinical Call Center for override consideration. Overrides are considered when one of the following criteria is met:

- Lock-in provider is out of stock
- Lock-in provider is closed
- Patient is out of town and cannot access the lock-in provider

9.4 Multiple Benefit Plans/ Carve-Out Programs

Description	Drug Coverage and Dispensing Rules	Comments
Cash Assistance - eligible for full Medicaid benefits	Standard Medicaid	
Child Welfare - eligible for full Medicaid benefits	Standard Medicaid	
Medical Only - eligible for full Medicaid benefits	Standard Medicaid	
Medical Only - eligible for Medicaid and Medicare coverage	Dual Eligible	Medicaid covers: • Drugs in the Medicare excluded-drug categories up to the Nevada Medicaid allowed amount. After billing the Medicare PDP, claims for excluded drugs can be submitted to Medicaid for reimbursement. • Co-pay claims for Part D covered drugs ($1.10 generic, $3.30 brand) Refer to Section 9.1 for claims processing requirements.
Cash Assistance - eligible for Medicaid and Medicare coverage	Dual Eligible	Medicaid covers: • Drugs in the Medicare excluded-drug categories up to the Nevada Medicaid allowed amount. After billing the Medicare PDP, claims for excluded drugs can be submitted to Medicaid for reimbursement. • Co-pay claims for Part D covered drugs ($1.10 generic, $3.30 brand) Refer to Section 9.1 for claims processing requirements.
Eligible for Limited Medicaid Services - no nursing services covered, either home or institution	Standard Medicaid	
Eligible for Full Medicare and Limited Medicaid - no nursing services covered, either home or institution	Standard Medicaid	
Eligible for Catastrophic Coverage Only	Medicare (mirrors Standard Medicaid with comments as indicated)	• For all Medicare covered drugs, Medicare must be billed first. • After billing Medicare, submit Medicare covered drugs to Medicaid for reimbursement of the copay/deductible. • Enter a value of '02' (Other payment exists - payment collected) in OTHER COVERAGE CODE, Field308-C8. Complete all required COB processing fields including the Part B carrier code (04967). The Gross Amount Due (Field 430-DU) should equal the Medicare-allowed amount. Medicaid will reimburse the copay/coinsurance/deductible up to the Nevada Medicaid allowed amount.
Eligible for pregnancy Related Medicaid Services Only	Pregnancy	• Standard Medicaid **except** pregnancy contraindicated drugs. • Drugs contraindicated for pregnancy will deny with a ProDUR error and cannot be overridden.
Children's Program - This is separate from Medicaid.	Check-Up	• Plan mirrors Medicaid.

Section 10: Prospective Drug Utilization Review (ProDUR)

The Magellan Medicaid Administration Prospective Drug Utilization Review (ProDUR) system is an integral part of the Nevada Medicaid pharmacy program.

The ProDUR systems alerts pharmacy providers to potential drug problems by reviewing claims for therapeutic appropriateness, reviewing medical history for recipients at risk of harmful outcome, intervening and counseling when appropriate.

Because the ProDUR system examines claims from all participating pharmacies, you can detect drugs that interact with or are affected by previously dispensed medications.

We have made every effort to ensure accuracy in the ProDUR system, but because each clinical situation is unique, pharmacists must use their own discretion in the drug therapy management of recipients.

10.1 ProDUR Alerts

When certain criteria are met (e.g., early refills, therapeutic duplication, drug/drug denials), a ProDUR alert is sent through the POS system. If you have any questions regarding a ProDUR alert, contact the Technical Call Center at **(800) 884-3238**.

ProDUR alerts apply to all media types and appear in the following format at the end of a claim transmission.

ProDUR Format	ProDUR Alert Definition
Reason For Service/ Conflict Code	This code can be up to three characters and is transmitted when a conflict is detected (e.g., ER, HD, TD, DD).
Severity Index Code	This 1-character code indicates how critical a given conflict is. 1= Major 2 = Moderate 3 = Minor
Other Pharmacy Indicator	This 1-character code indicates if your pharmacy also dispensed the first drug in question. 1 = Your pharmacy 3 = Other pharmacy
Previous Date Of Fill	This 8-character code indicates the previous fill date of conflicting drug using YYYYMMDD format.
Quantity Of Previous Fill	This 5-character code indicates the quantity of the conflicting drug that was dispensed.
Data Base Indicator	This 1-character code indicates the source of ProDUR the alert. 1 = First DataBank 4 = Processor Developed
Other Prescriber	This 1-character code indicates the prescriber of conflicting prescription. 0 = No Value 1 = Same Prescriber 3 = Other Prescriber

10.2 ProDUR Overrides

ProDUR alerts can be overridden using the interactive NCPDP DUR override codes. Medicaid policy determines which alerts can be overridden by providers. For example, providers may override early refill alerts as long as the drug is not a controlled substance.

You must retain in-house documentation explaining the reason for any override. When applicable, submit an Rx clarification code with your override code.

In certain circumstances (such as an early refill for a controlled substance), you will need to request an override by contacting the Technical Call Center at (800) 884-3238.

10.3 Controlled Substance Early Refill

For override consideration of a controlled substance, contact the Technical Call Center at **(800) 884-3238**.

10.4 Vacation Fill

To override an Early Refill denial message for a non-controlled substance (Reject Code 88) where the prescriber has authorized a vacation fill, enter '03' as the Submission Clarification Code (Field 420-DK).

10.5 Reason for Service Code (Conflict Code)

A Reason for Service Code (Reject Code E4) defines the type of utilization conflict that was detected (Field 439).

Professional Service codes and Result of Service codes are required for Severity Level One Conflict codes.

Conflict Codes

Code	Description	Comments
DD	Drug to Drug	Severity level 1 only
ER	Early Refill	Controlled substances will continue to require a call to the Technical Call Center for a denial override
SX	Drug to Gender	Severity level 1 only

10.6 Professional Service Code (Intervention Code)

A Professional Service Code (Reject Code E5) defines the type of interaction or intervention that was performed by the pharmacist (Field 440). A Professional Service Code must accompany a Result of Service Code to allow an override.

10.7 Result of Service Code (Outcome Code)

A Result of Service Code (Reject Code E6) defines the action taken by the pharmacist in response to a ProDUR Reason for Service (Conflict) code or as a result of a pharmacist's professional service (Field 441). A Professional Service Code must accompany a Result of Service Code to allow an override.

The ProDUR system sends a claim denial message when it detects a problem with a claim. You may use an override code to override a ProDUR denial message on a per claim, (date of service only) basis. You must retain in-house documentation explaining the reason for any override. When applicable, submit an Rx Clarification code with your override code.

10.8 ProDUR Override Codes

The following tables reflect the listing of available Conflict Codes, Intervention Codes and Outcome Codes.

Intervention Codes

NCPDP External Code List	Field Description
440-E5 - Professional Service Code (Intervention Code)	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.
Code	**Description**
DE Dosing	evaluation/determination
MO	Prescriber consulted
MR	Medication review
PE	Patient education/instruction
PH	Patient medication history
PM	Patient monitoring
RO	Pharmacist consulted other source
SW	Literature search/review

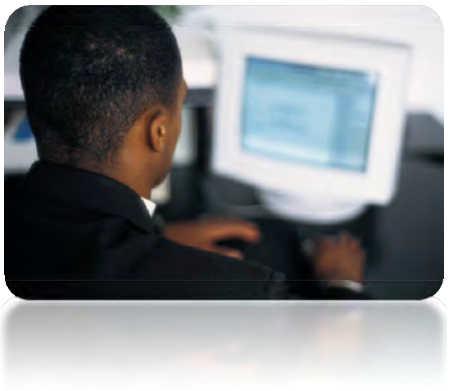
Outcome Codes

NCPDP External Code List	Field Description
441-E6 - Result of Service Code (Outcome Code)	Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.
Code	**Description**
1A	Filled As Is, False Positive
1B	Filled Prescription As Is
1C	Filled, With Different Dose
1D	Filled, With Different Directions
1E	Filled, With Different Drug
1G	Filled, With Prescriber Approval
2A	Prescription Not Filled
3B	Recommendation Not Accepted
3C	Discontinued Drug
3D	Regimen Changed
3E	Therapy Changed

Coding Options		
Intervention Code(s)	**Outcome Code Options**	
DE, MO, MR, PH, RO, SW	1A	Filled As Is, False Positive
DE, MO, MR, PE, PH, PM, RO, SW	1B	Filled Prescription As Is
MO	1C	Filled, With Different Dose
MO	1D	Filled, With Different Directions
MO	1E	Filled, With Different Drug
MO	1G	Filled, With Prescriber Approval
MO, RO	2A	Prescription Not Filled
MO	3B	Recommendation Not Accepted
MO 3C		Discontinued Drug
MO	3D	Regimen Changed
MO 3E		Therapy Changed
MO	3G	Drug Therapy Unchanged

Section 11: Edits

11.1 Online Claims Processing Messages



After the pharmacy provider submits a POS claim, Magellan Medicaid Administration returns an immediate response with the claim adjudication and payment information.

If the claim is denied, use the following table to correct the error(s) on your claim. If you have any questions regarding a denied claim, contact the Technical Call Center at **(800) 884-3238**.

In the table below, "M/I" is the abbreviation for "Missing/Invalid."

Reject Code	Reject Code Description	NCPDP Field	Solution
Ø1	M/I Bin	1Ø	009646
Ø2	M/I Version Number	1Ø2	The NCPDP allowed version is 5.1.
Ø3	M/I Transaction Code	1Ø3	Transactions allowed are B1, B2 and B3.
Ø4	M/I Processor Control Number	1Ø4	P009009646 – Medicaid Claims P031009646 – Medicare Part D Claims
Ø5	M/I Pharmacy Number	2Ø1	Is your NPI entered correctly? Check with software vendor to ensure the correct number has been set up in your system.
Ø6	M/I Group Number	3Ø1	Group ID = NVMEDICAID
Ø7	M/I Cardholder ID Number	3Ø2	Was the recipient's 11-digit Recipient ID entered correctly? Do not use any dashes, hyphens or spaces. Do not use the provider's patient ID number. Examine the recipient's Medicaid Card and verify their Medicaid eligibility each time before providing service.
Ø8	M/I Person Code	3Ø3	
Ø9	M/I Birth Dat	3Ø4	Have you entered the date in the proper format (CYYMMDD)?
1C	M/I Smoker/Non-Smoker Code	334	
1E	M/I Prescriber Location Code	467	
1Ø	M/I Patient Gender Code	3Ø5	Allowed values are: 0 = not specified; 1 = male; 2 = female
11	M/I Patient Relationship Code	3Ø6	Allowed value is 1 (cardholder)
12	M/I Patient Location	3Ø7	Allowed value is 03 (nursing home)
13	M/I Other Coverage Code	3Ø8	See section 8,"Coordination of Benefits."
14	M/I Eligibility Clarification Code	3Ø9	
15	M/I Date of Service	4Ø1	Format is CCYYMMDD.
16	M/I Prescription/Service Reference Number	4Ø2	Format = NNNNNNN.
17	M/I Fill Number	4Ø3	Allowed value varies based on drug DEA code. (Refer to Section 3: Coverage and Limitations). If a value is entered in the Field 415 (Number Of Refills Authorized), the value in the New/ Refill Code field must not exceed the number of refills authorized.
19	M/I Days Supply	4Ø5	Format = NNN. "PRN" not allowed.

Reject Code	Reject Code Description	NCPDP Field	Solution
2C	M/I Pregnancy Indicator	335	
2E	M/I Primary Care Provider ID Qualifier	468	
2Ø	M/I Compound Code	4Ø6	Allowed values are: 0 = not specified; 1 = not a compound; 2 = compound. See Section 4,"Compound Drugs."
21	M/I Product/Service ID	4Ø7	Use 11-digit NDC number. Do not include dashes, hyphens, spaces, etc.
22	M/I Dispense As Written (DAW)/Product Selection Code	4Ø8	
23	M/I Ingredient Cost Submitted	4Ø9	
25	M/I Prescriber ID		Is the prescriber's NPI entered correctly? Do not include dashes, hyphens, spaces, etc.
26	M/I Unit of Measure	6ØØ	
28	M/I Date Prescription Written	414	Was the date entered correctly? The valid format is CCYYMMDD. This date must be on or before the date of service.
29	M/I Number Refills Authorized	415	
3A	M/I Request Type	498-PA	
3B	M/I Request Period Date-Begin	498-PB	
3C	M/I Request Period Date-End	498-PC	
3D	M/I Basis of Request	498-PD	
3E	M/I Authorized Representative First Name	498-PE	
3F	M/I Authorized Representative Last Name	498-PF	
3G	M/I Authorized Representative Street Address	498-PG	
3H	M/I Authorized Representative City Address	498-PH	
3J	M/I Authorized Representative State/Province Address	498-PJ	
3K	M/I Authorized Representative Zip/Postal Zone	498-PK	
3M	M/I Prescriber Phone Number	498-PM	
3N	M/I Prior Authorized Number Assigned	498-PY	
3P	M/I Authorization Number	5Ø3	
3R	Prior Authorization Not Required	4Ø7	
3S	M/I Prior Authorization Supporting Documentation	498-PP	
3T	Active Prior Authorization Exists Resubmit at Expiration of Prior Authorization		
3W	Prior Authorization in Process		
3X	Authorization Number Not Found	5Ø3	
3Y	Prior Authorization Denied		
32	M/I Level of Service	418	
33	M/I Prescription Origin Code	419	
34	M/I Submission Clarification Code	42Ø	
35	M/I Primary Care Provider ID	421	
38	M/I Basis of Cost	423	
39	M/I Diagnosis Code	424	Was the ICD-9 code entered properly?
4C	M/I Coordination of Benefits/Other Payments Count	337	
4E	M/I Primary Care Provider Last Name	57Ø	
4Ø	Pharmacy Not Contracted With Plan on Date of Service	None	Was the pharmacy enrolled with Medicaid on the date of service? Call the Provider Enrollment Unit at (877) 638-3472 to verify enrollment if necessary.
41	Submit Bill to Other Processor or Primary Payer	None	The recipient has other coverage on file. See Section 8, "Coordination of Benefits."

Reject Code	Reject Code Description	NCPDP Field	Solution
5C	M/I Other Payer Coverage Type	338	
5E	M/I Other Payer Reject Count	471	
5Ø	Non-Matched Pharmacy Number	2Ø1	Non-matched Pharmacy ID-Check NPI/Locked In-Call 800-505-9185.
51	Non-Matched Group ID	3Ø1	Group ID = NVMEDICAID
52	Non-Matched Cardholder	3Ø2	Was the recipient's 11-digit Recipient ID entered correctly? Do not include dashes, hyphens, spaces, etc.
53	Non-Matched Person Code	3Ø3	
54	Non-Matched Product/Service ID Number	4Ø7	Was the 11-digit NDC entered correctly?
55	Non-Matched Product Package Size	4Ø7	
56	Non-Matched Prescriber ID	411	Was the prescriber's 10-digit NPI entered correctly? Do not include dashes, hyphens, spaces, etc.
58	Non-Matched Primary Prescriber	421	
6C	M/I Other Payer ID Qualifier	422	Use "99" (Other) only.
6E	M/I Other Payer Reject Code	472	
6Ø	Product/Service Not Covered for Patient Age	3Ø2, 3Ø4, 4Ø1, 4Ø7	
61	Product/Service Not Covered for Patient Gender	3Ø2, 3Ø5, 4Ø7	
62	Patient/Card Holder ID Name Mismatch	31Ø, 311, 312, 313, 32Ø	Was the recipient's name entered as shown on their Medicaid Card?
63	Institutionalized Patient Product/Service ID Not Covered		
64	Claim Submitted Does Not Match Prior Authorization	2Ø1, 4Ø1, 4Ø4, 4Ø7, 461	
65	Patient is Not Covered	3Ø3, 3Ø6	
66	Patient Age Exceeds Maximum Age	3Ø3, 3Ø4, 3Ø6	
67	Filled Before Coverage Effective	4Ø1	Was the recipient eligible for benefits on the date of service?
68	Filled After Coverage Expired	4Ø1	Was the 11-digit Recipient ID entered correctly? Do not include dashes, hyphens, spaces, etc. Verify the date of service.
69	Filled After Coverage Terminated	4Ø1	
7C	M/I Other Payer ID	34Ø	
7E	M/I DUR/PPS Code Counter	473	
7Ø	Product/Service Not Covered	4Ø7	This drug is not covered.
71	Prescriber is Not Covered	411	
72	Primary Prescriber is Not Covered	421	
73	Refills are Not Covered	4Ø2, 4Ø3	Values vary based on drug DEA code.
74	Other Carrier Payment Meets or Exceeds Payable	4Ø9, 41Ø, 442	
75	Prior Authorization Required	462	This drug requires prior authorization.
76	Plan Limitations Exceeded	4Ø5, 442	Check days supply and metric decimal quantity.
77	Discontinued Product/Service ID Number	4Ø7	Was a valid, current 11-digit NDC entered?

Reject Code	Reject Code Description	NCPDP Field	Solution
78	Cost Exceeds Maximum	4Ø7, 4Ø9, 41Ø, 442	Not applicable.
79	Refill Too Soon	4Ø1, 4Ø3, 4Ø5	80% of the days supply of a non-controlled substance (or 90% of the days supply for a controlled substance) from a previous claim has not been utilized. This edit considers all network providers.
8C	M/I Facility ID	336	
8E	M/I DUR/PPS Level Of Effort	474	
8Ø	Drug-Diagnosis Mismatc	4Ø7, 424	
81	Claim Too Old	4Ø1	Was the claim submitted within the timely filing limit? See section 7, "Program Particulars."
82	Claim is Post-Dated	4Ø1	Verify the date of service.
83	Duplicate Paid/Captured Claim	2Ø1, 4Ø1, 4Ø2, 4Ø3, 4Ø7	
84	Claim has Not Been Paid/Captured	2Ø1, 4Ø1, 4Ø2	
85	Claim Not Processed	None	
86	Submit Manual Reversal	None	
87	Reversal Not Processe	None	
88	DUR Reject Error		
89	Rejected Claim Fees Paid		
9Ø	Host Hung Up		Host Disconnected Before Session Completed
91	Host Response Error		Response Not In Appropriate Format To Be Displayed
92	System Unavailable/Host Unavailable		Processing Host Did Not Accept Transaction/Did Not Respond Within Time Out Period
*95	Time Out		
*96	Scheduled Downtime		
*97	Payer Unavailable		
*98	Connection to Payer is Down		
99	Host Processing Error		Do Not Retransmit Claim(s).
AA	Patient Spend-Down Not Met		
AB	Date Written is After Date Filled		
AC	Product Not Covered Non-Participating Manufacturer		
AD	Billing Provider Not Eligible to Bill This Claim Type		
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare		
AF	Patient Enrolled Under Managed Care		
AG	Days Supply Limitation for Product/Service		
AH	Unit Dose Packaging Only Payable for Nursing Home Recipients		
AJ	Generic Drug Required		
AK	M/I Software Vendor/Certification ID	11Ø	
AM	M/I Segment Identification	111	
A9	M/I Transaction Count	1Ø9	
BE	M/I Professional Service Fee Submitted	477	
B2	M/I Service Provider ID Qualifier	2Ø2	
CA	M/I Patient First Name	31Ø	

Reject Code	Reject Code Description	NCPDP Field	Solution
CB	M/I Patient Last Name	311	Is the recipient's last name spelled as it appears on their Medicaid Card?
CC	M/I Cardholder First Name	312	Is the recipient's first name spelled as it appears on their Medicaid Card?
CD	M/I Cardholder Last Name	313	
CE	M/I Home Plan	314	
CF	M/I Employer Name	315	
CG	M/I Employer Street Address	316	
CH	M/I Employer City Address	317	
CI	M/I Employer State/Province Address	318	
CJ	M/I Employer Zip Postal Zone	319	
CK	M/I Employer Phone Number	32Ø	
CL	M/I Employer Contact Name	321	
CM	M/I Patient Street Address	322	
CN	M/I Patient City Address	323	
CO	M/I Patient State/Province Address	324	
CP	M/I Patient Zip/Postal Zone	325	
CQ	M/I Patient Phone Number	326	
CR	M/I Carrier ID	327	
CW	M/I Alternate ID	33Ø	
CX	M/I Patient ID Qualifier	331	
CY	M/I Patient ID	332	
CZ	M/I Employer ID	333	
DC	M/I Dispensing Fee Submitted	412	
DN	M/I Basis of Cost Determination	423	
DQ	M/I Usual and Customary Charge	426	
DR	M/I Prescriber Last Name	427	
DT	M/I Unit Dose Indicator	429	
DU	M/I Gross Amount Due	43Ø	
DV	M/I Other Payer Amount Paid	431	Enter the amount you received from other payer(s) for this claim.
DX	M/I Patient Paid Amount Submitted	433	
DY	M/I Date of Injury	434	
DZ	M/I Claim/Reference ID	435	
EA	M/I Originally Prescribed Product/Service Code	445	
EB	M/I Originally Prescribed Quantity	446	
EC	M/I Compound Ingredient Component Count	447	
ED	M/I Compound Ingredient Quantity	448	
EE	M/I Compound Ingredient Drug Cost	449	
EF	M/I Compound Dosage Form Description Code	45Ø	
EG	M/I Compound Dispensing Unit Form Indicator	451	
EH	M/I Compound Route of Administration	452	
EJ	M/I Originally Prescribed Product/Service ID Qualifier	453	
EK	M/I Scheduled Prescription ID Number	454	
EM	M/I Prescription/Service Reference Number Qualifier	445	
EN	M/I Associated Prescription/Service Reference Number	456	
EP	M/I Associated Prescription/Service Date	457	
ER	M/I Procedure Modifier Code	459	
ET	M/I Quantity Prescribed	46Ø	
EU	M/I Prior Authorization Type Code	461	

EV	M/I Prior Authorization Number Submitted	462	
EW	M/I Intermediary Authorization Type ID	463	
EX	M/I Intermediary Authorization ID	464	
EY	M/I Provider ID Qualifier	465	
EZ	M/I Prescriber ID Qualifier	466	
E1	M/I Product/Service ID Qualifier	436	
E3	M/I Incentive Amount Submitted	438	
E4	M/I Reason for Service Code	439	Enter up to three characters when a conflict is detected (e.g., ER, HD, TD, DD). See Section 10, "ProDUR."
E5	M/I Professional Service Code	44Ø	
E6	M/I Result of Service Code	441	
E7	M/I Quantity Dispensed	442	The correct format is 99999.999.
E8	M/I Other Payer Date	443	
E9	M/I Provider ID	444	
FO	M/I Plan ID	524	
GE	M/I Percentage Sales Tax Amount Submitted	482	
HA	M/I Flat Sales Tax Amount Submitted	481	
HB	M/I Other Payer Amount Paid Count	341	
HC	M/I Other Payer Amount Paid Qualifier	342	
HD	M/I Dispensing Status	343	
HE	M/I Percentage Sales Tax Rate Submitted	483	
HF	M/I Quantity Intended to be Dispensed	344	
HG	M/I Days Supply Intended to be Dispensed	345	
H1	M/I Measurement Time	495	
H2	M/I Measurement Dimension	496	
H3	M/I Measurement Unit	497	
H4	M/I Measurement Value	499	
H5	M/I Primary Care Provider Location Code	469	
H6	M/I DUR Co-Agent ID	476	
H7	M/I Other Amount Claimed Submitted Count	478	
H8	M/I Other Amount Claimed Submitted Qualifier	479	
H9	M/I Other Amount Claimed Submitted	48Ø	
JE	M/I Percentage Sales Tax Basis Submitted	484	
J9	M/I DUR Co-Agent ID Qualifier	475	
KE	M/I Coupon Type	485	
M1	Patient Not Covered in This Aid Category		
M2	Recipient Locked In		
M3	Host PA/MC Error		
M4	Prescription/Service Reference Number/Time Limit Exceeded		
M5	Requires Manual Claim		
M6	Host Eligibility Error		
M7	Host Drug File Error		
M8	Host Provider File Error		
ME	M/I Coupon Number	486	
MZ	Error Overflow		
NE	M/I Coupon Value Amount	487	
NN	Transaction Rejected At Switch or Intermediary		
PA	PA Exhausted/Not Renewable		
PB	Invalid Transaction Count for This Transaction Code	1Ø3, 1Ø9	
PC	M/I Claim Segment	111	
PD	M/I Clinical Segment	111	

PE	M/I COB/Other Payments Segment	111	
PF	M/I Compound Segment	111	
PG	M/I Coupon Segment	111	
PH	M/I DUR/PPS Segment	111	
PJ	M/I Insurance Segment	111	
PK	M/I Patient Segment	111	
PM	M/I Pharmacy Provider Segmen	111	
PN	M/I Prescriber Segm	111	
PP	M/I Pricing Segmen	111	
PR	M/I Prior Authorization Segment	111	
PS	M/I Transaction Header Segment	111	
PT	M/I Workers' Compensation Segment	111	
PV	Non-Matched Associated Prescription/Service Date	457	
PW	Non-Matched Employer I	333	
PX	Non-Matched Other Payer ID	34Ø	
PY	Non-Matched Unit Form/Route of Administration	451, 452, 6ØØ	
PZ	Non-Matched Unit Of Measure to Product/Service ID	4Ø7, 6ØØ	
P1	Associated Prescription/Service Reference Number Not Found	456	
P2	Clinical Information Counter Out of Sequence	493	
P3	Compound Ingredient Component Count Does Not Match Number of Repetitions	447	
P4	Coordination of Benefits/Other Payments Count Does Not Match Number of Repetitions	337	
P5	Coupon Expi	486	
P6	Date of Service Prior to Date of Birth	3Ø4, 4Ø1	
P7	Diagnosis Code Count Does Not Match Number of Repetitions	491	
P8	DUR/PPS Code Counter Out of Sequence	473	
P9	Field is Non-Repeatable		
RA	PA Reversal Out of Order		
RB	Multiple Partials Not Allowed		
RC	Different Drug Entity Between Partial & Completion		
RD	Mis-matched Cardholder/Group ID-Partial to Completion	3Ø1, 3Ø2	
RE	M/I Compound Product ID Qualifier	488	
RF	Improper Order of 'Dispensing Status' Code on Partial Fill Transaction		
RG	M/I Associated Prescription/Service Reference Number on Completion Transaction	456	
RH	M/I Associated Prescription/Service Date on Completion Transaction	457	
RJ	Associated Partial Fill Transaction Not on File		
RK	Partial Fill Transaction Not Supported		
RM	Completion Transaction Not Permitted With Same 'Date of Service' as Partial Transaction	4Ø1	
RN	Plan Limits Exceeded on Intended Partial Fill Values	344, 345	
RP	Out of Sequence 'P' Reversal on Partial Fill Transaction		
RS	M/I Associated Prescription/Service Date on Partial Transaction	457	
RT	M/I Associated Prescription/Service Reference Number on Partial Transaction	456	
RU	Mandatory Data Elements Must Occur Before Optional Data Elements in a Segment		

R1	Other Amount Claimed Submitted Count Does Not Match Number of Repetitions	478, 48Ø	
R2	Other Payer Reject Count Does Not Match Number of Repetitions	471, 472	
R3	Procedure Modifier Code Count Does Not Match Number of Repetitions	458, 459	
R4	Procedure Modifier Code Invalid for Product/Service ID	4Ø7, 436, 459	
R5	Product/Service ID Must be Zero When Product/Service ID Qualifier Equals Ø6	4Ø7, 436	
R6	Product/Service Not Appropriate for This Location	3Ø7, 4Ø7, 436	
R7	Repeating Segment Not Allowed in Same Transaction		
R8	Syntax Error		
R9	Value in Gross Amount Due Does Not Follow Pricing Formulae	43Ø	
SE	M/I Procedure Modifier Code Count	458	
TE	M/I Compound Product ID	489	
UE	M/I Compound Ingredient Basis of Cost Determination	49Ø	
VE	M/I Diagnosis Code Count	491	
WE	M/I Diagnosis Code Qualifier	492	
XE	M/I Clinical Information Counter	493	
ZE	M/I Measurement Date	494	

Section 12: Calculating Payment

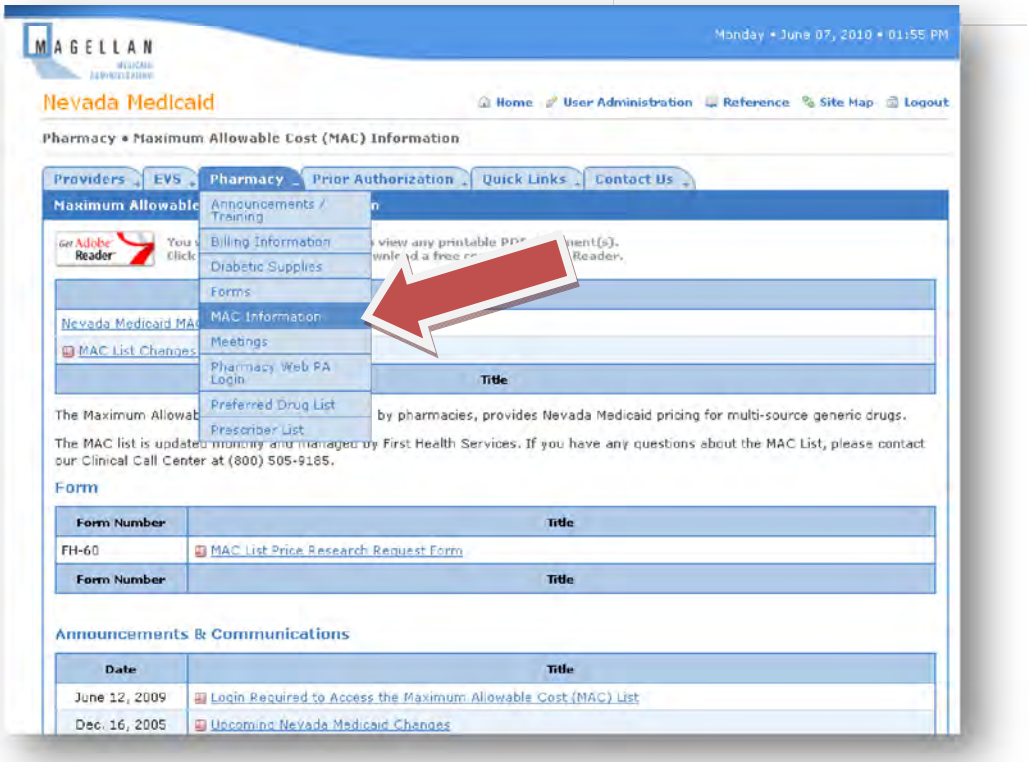
12.1 State Maximum Allowable Cost

The State Maximum Allowable Cost is the lower of (1) the cost established by the Center for Medicaid and Medicare Services (CMS) for multiple source drugs that meet the criteria set forth in 42 CFR 447.332 and 1927 (f)(2) of the Social Security Act, or (2) the cost established by DHCFP for multiple source drugs under the State Maximum Allowable Cost.

MAC List

Nevada Medicaid and Nevada Check Up use a Maximum Allowable Cost (MAC) List to determine drug payment amounts.

The MAC List is available online at http://nevada.fhsc.com. Select "MAC Information" from the "Pharmacy" menu as shown below.



12.2 Payment Algorithms

Medicaid pays for all drugs and supplies except diabetic supplies using the lowest cost algorithm from the list below:

- Estimated Acquisition Cost (EAC) = Average Wholesale Price (AWP) – 15% + dispense fee
- Federal Upper Limit + Dispensing fee
- Maximum Allowable Cost (MAC) + Dispensing fee
- Department Of Justice (DOJ) – 15% + Dispensing fee
- Gross Amount Due (Field 430-DU) (submitted)
- Usual and Customary (Field 426-DQ) (submitted)

Diabetic Supplies

Diabetic supplies are paid using the lowest cost algorithm from the list below:

- Average Wholesale Price (AWP) – 10% + $1.54 *($1.54 is the handling and dispensing fee)*
- Gross Amount Due (Field #430-DU) *(submitted)*
- Usual and Customary (Field #426- DQ) *(submitted)*

Section 13: Claims Appeals

You can appeal a claim that has been **denied**.

If you do not agree with a denial of a claim, please contact our Technical Call Center at (800) 884-3238. We may be able to identify and resolve the issue over the phone or direct you on how to resubmit your claim so it can be paid.

13.1 How to File an Appeal

Appeals must be post marked no later than 30 days from the date on the RA showing the claim as denied.

An appeal must contain the following information:

1. A copy of the most recent RA page(s) showing the denial.
2. Any documentation to support the issue, e.g., prior authorization, physician's notes, ER reports.
3. A cover letter. Your cover letter must state that you are appealing the denial of a claim and include the following information related to the appeal:

- Reason for the appeal
- Provider name and NPI
- Internal Control Number (ICN) of the claim
- Recipient's name and ID
- Date(s) of service
- Prescription Number(s)
- Name and phone number of the person Magellan Medicaid Administration can contact regarding the appeal

Mail your appeal to the following address:

Magellan Medicaid Administration
Attn: Appeals
PO Box 30042
Reno NV 89520-3042

Be sure to include "Attn: Appeals" on the outside of your envelope. Do not send claims in the same envelope with your appeal as this will delay the processing of your claim.

13.2 After You Submit an Appeal

Magellan Medicaid Administration researches and processes all appeals. When a decision has been made, Magellan Medicaid Administration mails a written Notice of Decision to the provider stating the decision regarding the appeal.

If you do not agree with the decision, you may request a Fair Hearing. Instructions for requesting a Fair Hearing are mailed with the written Notice of Decision.