South Carolina
Pharmacy Provider Manual

Version 1.16

July 26, 2019

Revision History

Document Version	Date	Name	Comments
1.0	09/01/2003	Provider Representative	Initial creation of document
1.1	04/01/2010	Lori Ash	Updated sections 1.1, 1.2, 2.2, 2.5, 2.8, 2.10, 3.1–3.4, 3.7, and 3.8
1.2	05/11/2010	Lori Ash	Updated section 1.1
1.3	07/26/2010	Lori Ash	Updated section 3.1
1.4	12/01/2010	Lori Ash	Updated sections 3.4, 3.8, and 3.9.1
1.5	02/25/2011	Lori Ash	Updated sections 3.1, 3.2, and 3.4
1.6	04/25/2011	Lori Ash	Updated section 3.2
1.7	07/08/2011	Lori Ash	Updated sections 3.1, 3.2, 3.4, 3.5, 3.6, and 3.7
1.8	07/08/2011	Lori Ash	Updated section 3.1
1.9	11/01/2011	Lori Ash	Updated sections 3.1, 3.2, and 3.8.1
1.10	03/01/2012	Lori Ash	Updated sections 1.0, 2.0, 3.0, and 5.0
1.11	09/23/2013	Lori Ash	Updated sections 1.1, 3.1, 3.3, 3.5, and 3.5.2
1.12	10/01/2015	Lori Ash	Updated sections 3.1 and 3.4
1.13	05/01/2016	Lori Ash	Updated sections 3.1 and 3.5.1
1.14	05/21/2017	Lori Ash	Updated sections 1.1, 1.2, 2.7, 2.8, 3.1, 3.4, 3.5.1, and 3.5.2
1.15	10/19/2017	Lori Ash	Updated sections 1.1, 3.1, and 3.4
1.16	07/08/2019	Lori Ash; Communication and Documentation Management	Updated sections 1.2, 3.1, and 3.9

Table of Contents

1.0 Introduction

As the pharmacy claims processor, Magellan Medicaid Administration (Magellan), part of the Magellan Rx Management division of Magellan Health, Inc., introduced a computerized point-of-sale (POS) system in order to meet Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance requirements for standardized transactions. The new system was implemented on September 10, 2003.

As with the previous program, the system allows participating pharmacies real-time access to beneficiary eligibility, drug coverage, pricing and payment information, and prospective drug utilization review (ProDUR) across all network pharmacies. Pharmacy providers must be enrolled through South Carolina Medicaid and have an active status for any dates of service submitted. This manual is intended to provide pharmacy claims submission guidelines to the users of the Magellan online system, as well as to alert pharmacy providers to new or changed program information. Providers who submit claims via batch media must use the National Council for Prescription Drug Programs (NCPDP) Batch 1.1 format. Batch specifications may be obtained directly from NCPDP via their website: http://ncpdp.org/.

The Magellan online system is used in conjunction with the pharmacy's existing system. While there are a variety of different operating pharmacy systems, the information contained in this manual addresses only the response messages related to the interaction with the Magellan online system, not the technical operation of the pharmacy-specific system.

Magellan provides assistance through the Pharmacy Support Center, which is available 24 hours a day, 7 days a week and is located in Richmond, Virginia. For answers to questions that are not addressed in this manual, or if additional information is needed, contact Magellan at 1-866-254-1669 (nationwide toll-free number).

1.1 Help Desks Telephone Numbers

Responsibility	Help Desk Function	Phone Numbers	Availability
Beneficiary Inquiries			
South Carolina Department of Health and Human Services (SC DHHS) Beneficiaries' Services	Medicaid client services	1-888-549-0820 (toll-free)	Monday–Thursday: 8:00 a.m.–6:00 p.m. Friday: 8:00 a.m.–5:00 p.m.
Magellan	Beneficiary call line	1-800-834-2680 (toll-free)	24/7/365
Provider Inquiries			
Medicaid Claims Control System (MCCS)	Provider Enrollment Unit	1-888-289-0709	Monday–Friday: 8:30 a.m.–5:00 p.m.
Magellan	Provider Relations	1-804-965-7619	Monday–Friday: 8:00 a.m.–5:00 p.m.
Magellan	Pharmacy Support Center Non-clinical prior authorization ProDUR	1-866-254-1669 (toll-free)	24/7/365
Magellan	MAP Clinical Support Center Clinical prior authorization	1-866-247-1181 (toll-free) Fax 1-888-603-7696 (toll-free)	Monday–Friday: 8:00 a.m.–10:00 p.m. After hours: Calls roll over to Pharmacy Support Center; on-call clinical staff is contacted via cell phone.
Provider Service Center	Durable Medical Equipment (DME) Medicaid Program policy/procedures	1-888-289-0709	Monday–Friday: 8:30 a.m.–5:00 p.m.

1.2 Important Addresses

Address	Format
Provider EMC Billing Address (Cartridges): Magellan Medicaid Administration, Inc. Media Control/South Carolina EMC Processing Unit 11013 W. Broad Street, Suite 500 Glen Allen, VA 23060	NCPDP Batch 1.1
Provider EMC Billing Address (Diskettes): Magellan Medicaid Administration, Inc. Operations Department/South Carolina Medicaid 11013 W. Broad Street, Suite 500 Glen Allen, VA 23060	NCPDP Batch 1.1
Provider Paper Claims Billing Address: Magellan Medicaid Administration, Inc. South Carolina Paper Claims Processing Unit P.O. Box 85042 Richmond, VA 23261-5042	D.0 Universal Claim Form (UCF)

A *Magellan Transmittal Form* must accompany all electronic non-POS submissions.

Durable Medical Equipment (DME)

- The CMS 1500 Claim Form should be completed for all supplies, with the exceptions of insulin, insulin needles and syringes, glucose testing meters and strips; those specified items are reimbursable through the South Carolina Medicaid Pharmacy Services Program. Durable Medical Equipment (DME) claims should be sent directly to

  Medicaid Claims Receipt
  P.O. Box 1412
  Columbia, SC 29202-1412

- Claims for all non-oral route nutritional supplements should be processed as DME. Policy or claims processing questions related to the DME program should be directed to the Provider Service Center (PSC) at 1-888-289-0709.
- Claims for glucose testing meters, strips and lancets must be billed through the POS system or the Magellan Web Claims Submission tool; see *Section 3.8 – Special Processing Conditions* for details.
- Effective November 18, 2011, spacers for Metered Dose Inhalers are covered under the South Carolina Medicaid Pharmacy Program. A quantity limit of two spacers per fiscal year has been established for this device. Requests for more than two spacers per fiscal year will require a prior authorization (PA) by contacting Magellan via phone at 1-866-247-1181 or fax at 888-603-7696.

- Effective with dates of service on or after July 1, 2019, certain Continuous Glucose Monitors (CGMs) will be covered under the pharmacy benefit. Only stand-alone CGMs not requiring the use of a pump will be covered under the pharmacy benefit. All CGMs under the pharmacy benefit will require prior authorization (PA). The physician may request prior authorization by contacting Magellan via phone at 1-866-247-1181 or fax at 888-603-7696.

1.3 Service Support

Online Certification

All POS claims must be submitted using NCPDP version D.0. Providers must have their software vendors certified through Magellan prior to any claims submission. *Individual pharmacies are not required to be certified.* Providers should contact Magellan or their software vendor to determine if the vendor is certified with Magellan. The Software Vendor/Certification Number (NCPDP Field # 11Ø-AK) is required for claim submission in the NCPDP version D.0.

Note: For assistance with software vendor certification, please call 1-804-548-0130.

Online System Not Available

If for any reason the online system is not available, providers should submit claims when the online capability resumes. In order to facilitate this process, the provider's software should have the capability to submit backdated claims.

Technical Problem Resolution

In order to resolve technical problems, providers should follow the steps outlined below:

1. Check the terminal and communications equipment to ensure that electrical power and telephone services are operational. Call the telephone number the modem is dialing and note the information heard (i.e., fast busy, steady busy, recorded message). Contact the software vendor if unable to access this information in the system.
2. If the pharmacy provider has an internal Technical Support Department, the provider should forward the problem to that department. The pharmacy's technical support staff will coordinate with Magellan to resolve the problem.
3. If the pharmacy provider's network is experiencing technical problems, the pharmacy provider should contact the network's technical support area. The network's technical support staff will coordinate with Magellan to resolve the problem.

4. If unable to resolve the problem after following the steps outlined above, the pharmacy provider should contact the Magellan Pharmacy Support Center at 1-866-254-1669 (nationwide toll-free number).

2.0 Program Set Up

2.1 Claim Format

- Effective January 1, 2012, Magellan began accepting NCPDP v.D.0; providers may not send v.3.2/3C or 5.1.
- NCPDP Batch 1.1 format will be required for any/all batch submissions.
- The Universal Claim Form (D.0 UCF) is required for paper submissions. Go to www.ncpdp.org/products.aspx to obtain the UCF.

2.2 NCPDP V.D.0 Enhanced Functionality

Magellan v.D.0 functionality is fully implemented. See *Payer Specifications*.

2.3 Media Options

While Magellan strongly recommends claims submission via POS, the following alternative media will be accepted:

- Electronic media claims (batch) submission via File Transfer Protocol (FTP)
- Paper (D.0 UCF)

2.4 Networks

National Data Corporation (NDC)	QSI	WebMD
1-800-388-2316	1-800-845-7558	1-615-885-3700

2.5 Transaction Types

The following transaction codes are defined according to the standards established by the NCPDP. Ability to use these transaction codes will depend on 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, Magellan 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 South Carolina Medicaid 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 s*tatus. To reverse a claim, the provider selects the *Reversal (Void)* option in the pharmacy's computer system.

Note: The following fields must match on the original paid claim and on the void request for a successful claim reversal:

- National Provider Identifier (NPI) provider number

  Note: NPI may be submitted on reversals for claims originally submitted with NCPDP/National Association of Boards of Pharmacy (NABP).

- Prescription number
- Date of service (date filled)
- National Drug Code (NDC)

Claims Re-bill (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.

2.6 Required Data Elements

The Magellan system has program-specific "mandatory/required," "situational," and "not sent" data elements for each transaction. The pharmacy provider's software vendor will need the *Payer Specifications* before setting up the plan in the pharmacy's computer system. This will allow the provider access to the required fields. Please note the following descriptions regarding data elements:

Data Element	Description
Mandatory	Designated as **MANDATORY** in accordance with the *NCPDP Telecommunication Implementation Guide Version D.0*. These fields must be sent if the segment is required for the transaction.
Situational	Designated as **SITUATIONAL** in accordance with the *NCPDP Telecommunication Implementation Guide Version D.0*. It is necessary to send these fields in noted situations. Some fields designated as situational by NCPDP may be required for all South Carolina Medicaid.
M or S***R***	The "R***" indicates that the field is repeating. One of the other designators, Mandatory "M" or Situational "S," will precede it.

South Carolina Medicaid claims will not be processed without all the required data elements. Required fields may or may not be used in the adjudication process. The complete *South Carolina Medicaid Payer Specifications*, including NCPDP field number references, is available at http://southcarolina.fhsc.com/Downloads/Provider/SCRx_Payer_Specs.pdf. Fields "not required for this program" at this time may be required at a future date.

Note: The following list provides important identification numbers for this program:

- ANSI BIN # ØØ9745
- Processor Control # PØØ6ØØ9745
- Group # SC MEDICAID
- Provider ID # NPI (10-byte, all numeric)
- Cardholder ID # SC Beneficiary ID Number (10-byte Medicaid Health Insurance Number)
- Prescriber ID # National Provider Identifier (NPI)
- Product Code National Drug Code (NDC) (11 digits)

2.7 Timely Filing Limits

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

- For all original claims, reversals, and adjustments, the timely filing limit is 365 days from the date of service (DOS).
- Claims that exceed the specified timely filing limit will deny.
- When appropriate (i.e., retroactive Medicaid eligibility determination), contact Magellan's Technical Call Center for consideration of an override to timely filing limits.
- Overrides will be considered ONLY if SC DHHS grants approval for same.

2.8 Tamper-Resistant Prescription Pads

Effective April 1, 2008, Medicaid-covered outpatient prescription and over-the-counter (OTC) drugs are reimbursable only if non-electronic prescriptions are issued on a tamper-resistant pad. These new federal requirements result from amendments to Section 1903(i) of the Social Security Act, as required by Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007. Electronic prescriptions (ePrescriptions) meeting federal and state requirements are excluded from this requirement. These tamper-resistant requirements do not apply to

- Prescriptions presented at a pharmacy ***before*** April 1, 2008
- Prescriptions sent to the pharmacy electronically (either by ePrescriber or by fax)
- Prescriptions communicated to the pharmacy by telephone
- Prescriptions paid for by a managed care entity

To be considered tamper-resistant, a prescription pad must contain as of April 1, 2008, at least one of the following three characteristics:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

No later than October 1, 2008, a prescription pad must contain all three characteristics to be considered tamper-resistant and Medicaid reimbursable.

This rule does apply to nursing facilities, intermediate care facilities for the mentally retarded, and other like residential facilities where their prescriptions are separately reimbursed by Medicaid and not included in the facility's rate.

To the extent permissible under state and federal law and regulation, this requirement does not restrict emergency fills of non-controlled or controlled substances for which a prescriber provides the pharmacy with a verbal, faxed, electronic, or compliant written prescription(s) within 72 hours after the date on which the prescription(s) was issued.

Future post-payment audits of pharmacy claims for Medicaid reimbursement, whether conducted by the DHHS Division of Program Integrity or any other agent, will review compliance with the above requirements.

3.0 Program Policies

Due to the implementation of Medicare Part D on January 1, 2006, the policies below pertain to non-dually eligible Medicaid beneficiaries unless otherwise specified.

3.1 Dispensing Limits

Days' Supply

- South Carolina Medicaid will allow a per-claim maximum of a **31 days' supply** for each new (original) or refill non-controlled substance prescription.
- Claims will **deny** if the days' supply limit is exceeded.

Quantity

- **Contraceptives:** Effective with dates of service on or after July 25, 2011, with the prescriber's authorization/approval, prescriptions for systemic contraceptives may be filled for a 365-day supply when filled at a SC DHEC pharmacy.
- **Quantity Limits for Certain Drugs**: Quantities exceeding established limitations will require prior authorization for the product; the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center.
- **Dose Optimization Program:** Quantities exceeding established limitations will require prior authorization for the product; the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center.
- **Opioid Quantity Limits:** For initial opioid naïve prescriptions, a maximum dose of 90 Morphine milligram equivalents (MME) per day will be allowed. Doses higher than 90 MME will reject at the point of sale. This dosing limitation is based on the Center for Disease Control (CDC) recommendations.

Age Limitations

- **Influenza Vaccine**: Beneficiary must be 19 years of age or older. Limit is one vaccine per flu season. Only in-store administered influenza vaccines or those administered to a Long-Term Care (LTC) beneficiary may be considered for Medicaid reimbursement through the Pharmacy Services program.
- **Pneumococcal Vaccine**: Beneficiary must be 19 years of age or older. Limit is one vaccine every five years. Only in-store administered pneumococcal vaccines or those administered to an LTC beneficiary may be considered for Medicaid reimbursement through the Pharmacy Services program.
- **Oral Hydration**: Beneficiary must be 21 years of age or younger. Claims for adults will be denied with NCPDP error code 60, "Drug Not Covered for Patient Age."
- **Hepatitis B Vaccine**: Beneficiary must be 19 years of age or older.

Provider-Specific Limitations

- Anti-hemophilia agents
  - Coverage is limited to the state governmental agency, which provides services to the Medicaid beneficiaries enrolled in the South Carolina Hemophilia Program. However, if a beneficiary has primary insurance coverage that pays 70 percent or more, the beneficiary is not limited to receiving services through the Department of Health and Environmental Control (DHEC), and any pharmacy may bill Medicaid as secondary in those cases.
  - For beneficiaries enrolled in a Medicaid managed care organization (MCO), the MCO is responsible for the provision and reimbursement of anti-hemophilia factor.

Refills

Refills are to be provided only if authorized by the prescriber, allowed by law and should be in accordance with the best medical and pharmacological practices. Refills must not exceed the number authorized by the prescriber. Refill documentation must be accurate and easily accessible for post-payment purposes. If a refill authorization is received orally, sufficient documentation must be present on the original prescription. At least 75 percent of the current prescription must be used (according to the prescriber's directions) prior to submitting a refill claim for Medicaid payment. In those instances where a refill requires a new and separate prescription (i.e., controlled substances), a new prescription must be issued in accordance with state and federal requirements. Automatic refill programs shall not be used for South Carolina Medicaid beneficiaries. A pharmacy provider shall not automatically generate refills for South Carolina Medicaid beneficiaries.

Partial Fills

- When a pharmacy files a partial fill prescription to South Carolina Medicaid, the beneficiary's co-payment and the pharmacy's dispensing fee will be prorated based on the fractional percentage of the quantity dispensed compared to the quantity prescribed.
- Partial fill functionality cannot be used when submitting Multi-Ingredient Compound claims.
- Partial fills may not be transferred from one pharmacy to another.
- Two partial fill transactions may not be submitted on the same day; the service date must be different for each of the partial fill transactions and the completion transaction.

Partial Fill Fields
Fields listed below that are required for partial fill claims submission: ▪ 456-EN Associated Prescription Service Reference # ▪ 457-EP Associated Prescription/Service Date ▪ 343-HD Dispensing Status ▪ 344-HF Quantity Intended to be Dispensed ▪ 345-HG Days Supply Intended to be Dispensed

Initial Fill – Online Process

- Enter actual Quantity Dispensed (NCPDP Field # 442-E7).
- Enter actual Days Supply (NCPDP Field # 4Ø5-D5).
- Enter Dispensing Status (NCPDP Field # 343-HD) = "P."
- Enter Quantity Intended to be Dispensed (NCPDP Field # 344-HF) = the total prescribed amount for the prescription.
- Enter Days Supply Intended to be Dispensed (NCPDP Field # 345-HG) = the total days' supply from the prescription.

Subsequent Partial Fill – Online Process

- Enter Associated Prescription/Service Reference # (NCPDP Field # 456-EN) = the prescription number from the initial partial fill.
- Enter Associated Prescription/Service Date (NCPDP Field # 457-EP) = the date of service of the most recent partial fill in the series.
- Enter actual Quantity Dispensed (NCPDP Field # 442-E7).
- Enter actual Days Supply (NCPDP Field # 4Ø5-D5).
- Enter Dispensing Status (NCPDP Field # 343-HD) = "P."
- Enter Quantity Intended to be Dispensed (NCPDP Field # 344-HF) = the total prescribed amount for the prescription.
- Enter Days Supply Intended to be Dispensed (NCPDP Field # 345-HG) = the total days' supply from the prescription.

Completion of Partial Fill – Online Process

- Enter Associated Prescription/Service Reference # (NCPDP Field # 456-EN) = the prescription number from the initial partial fill.
- Enter Associated Prescription/Service Date (NCPDP Field # 457-EP) = the date of service of the most recent partial fill in the series.
- Enter actual Quantity Dispensed (NCPDP Field # 442-E7).

- Enter actual Days Supply (NCPDP Field # 4Ø5-D5).
- Enter Dispensing Status (NCPDP Field # 343-HD) = "C."
- Enter Quantity Intended to be Dispensed (NCPDP Field # 344-HF) = the total prescribed amount for the prescription.
- Enter Days Supply Intended to be Dispensed (NCPDP Field # 345-HG) = the total days' supply from the prescription.

General Exclusions

The following is a listing of products **excluded** from Medicaid coverage. These items are considered non-covered, regardless of circumstance.

- Anti-hemophilia factor products except for those patients enrolled in South Carolina DHEC's Hemophilia Program
- Cough and cold medications
- Devices and supplies (e.g., infusion supplies); however, certain glucometers, test strips, lancets, spacers for metered dose inhalers, and certain (stand-alone) continuous glucose monitors may also be billed through the Pharmacy POS system (refer to *Section 1.2*).
- Sexual Dysfunction products prescribed to treat impotence
- Fertility products
- Immunizing agents except for influenza, pneumococcal, and hepatitis B vaccines administered to a Medicaid-only beneficiary in a long-term care facility or in an in-pharmacy setting.
- Injectable pharmaceuticals administered by the practitioner in the office, in an outpatient clinic or infusion center, or in a mental health center. In certain cases, such as antipsychotics being administered in a Mental Health Center, the pharmacy may bill through the point-of-sale system and the pharmacy must deliver the pharmaceuticals directly to the outpatient Mental Health Clinic. (See *Section 3.5 – Prior Authorization Protocols* for detailed billing information.)
- Investigational pharmaceuticals or products
- Nutritional supplements

Note: Enteral nutrition therapy administered through a feeding tube and total parenteral nutritional (TPN) therapy may be covered through SC DHHS's Department of Durable Medical Equipment; neither program reimburses for oral nutritional supplements.

- Oral hydration therapies for adults
- Pharmaceuticals determined by the Food and Drug Administration (FDA) to be less than effective and identical, related, or similar drugs (frequently referred to as Drug Efficacy Study Implementation (DESI) drugs)
- Pharmaceuticals obtained via a patient assistance program (PAP)
- Pharmaceuticals that are not rebated
- Pharmaceuticals used for cosmetic purposes or hair growth
- Products used as flushes to maintain patency of indwelling peripheral or central venipuncture devices
- Weight control products except lipase inhibitors

Zidovudine (AZT) Syrup for Newborns

In an effort to ensure timely access to critical AZT therapy for at-risk newborns and to maximize patient compliance, the DHHS will allow the pharmacy provider to bill Medicaid using the mother's Medicaid Health Insurance Number when dispensing the initial six weeks' supply of AZT syrup. Billing this drug to the mother's Medicaid identification number is permissible only in those instances where the newborn has not yet been assigned a Medicaid Health Insurance Number at the time of dispensing. This special billing policy pertains only to the initial dispensing of AZT syrup and is limited to a lifetime maximum of a 42 days' supply. A relationship code of "3" must also be used to identify the patient as a newborn. Other medications dispensed to newborns may not be billed to Medicaid in such a manner.

3.2 Provider Reimbursement

Reimbursement Algorithms

- The pharmacy provider should submit the pharmacy's usual and customary (U&C) charge when billing.
- The amount reimbursed by Medicaid for a drug dispensed shall not exceed the lowest of
  - Federal Upper Limit (FUL) plus dispensing fee of $3.00; or
  - South Carolina Maximum Allowable Cost (MAC) plus dispensing fee of $3.00; or
  - Wholesale Acquisition Cost (WAC) plus 0.8% plus dispensing fee of $3.00; or
  - The provider's U&C charge to the general public for the prescription as written for the product actually dispensed; or
  - The patient's primary insurance co-payment responsibility when the other coverage code (OCC) of "2" is submitted.

- 340B providers must be listed on the Health Resources and Services Administration (HRSA) website (http://www.hrsa.gov/opa). Any products obtained at 340B pricing must be submitted with the actual purchased drug price plus the dispensing fee in the Usual and Customary field on prescription claims.

3.3 Generic Substitution Policy

- Unless otherwise excluded from coverage, all generic drugs included on the South Carolina Medicaid Drug File are considered reimbursable, provided ***they are rebated***.
- If the prescriber certifies in his/her own writing that a specific brand product is medically necessary (by handwriting the phrase "brand medically necessary" on the face of the prescription), the pharmacy provider may enter a value of "1" in the dispense as written (DAW) field. However, the claim may then deny for "PA Required." The prescriber should be instructed to call the Magellan Clinical Support Center (1-866-247-1181) for prior authorization consideration.
- It should be noted that brand name products for the following do not require prior authorization in order to be billed as "Brand Medically Necessary," provided the necessary requirements outlined above are met:
  - Digoxin
  - Levothyroxine
  - Theophylline (controlled release)
  - Carbamazepine
  - Warfarin
  - Phenytoin
  - Pancrelipase

Note: In cases where SC DHHS has designated a brand-name drug as preferred over the generic, provider may elect to use a DAW code of "9."

3.4 Special Beneficiary Conditions

Medicaid Hospice Services

- A beneficiary who elects the hospice benefit must waive all rights to other Medicaid services related to the treatment of the terminal condition for the duration of the hospice care. Services (including prescriptions) available for illnesses or conditions not related to the terminal illness of the beneficiary require prior authorization from the hospice provider, not Magellan.
- The provider will submit these claims with a Patient Residence code of "11" (hospice) and "8" in the Prior Authorization Type Code field (NCPDP Field # 461-EU).
- For paper claim submission, the provider will write "Hospice" in the upper right-hand corner of the claim form. Data entry staff will key the designated Patient Residence code and Prior Authorization Type Code values in the appropriate fields.
- Co-pay information is in Section 3.6 – Beneficiary Financial Requirements.

Claims for Long-Term Care Beneficiaries

- Long-term care/nursing home (LTC/NH) beneficiaries are identified by having an LTC segment on the enrollment file.
- The only OTC product covered by pharmacy services for LTC/NH beneficiaries is insulin. All other OTC products (regardless of whether they are payable on the drug file or not) will deny.
- LTC/NH beneficiaries are not subject to co-payment requirements.
- Pneumococcal and influenza vaccines are covered for Medicaid-only LTC patients.

Claims for Family Planning Waiver Beneficiaries

- Family Planning beneficiaries are identified by having waiver information on the enrollment file.
- Only outpatient contraceptive pharmaceuticals and devices and certain antibiotics used to treat sexually transmitted infections (STIs) are covered.
- In order for antibiotics to be considered for reimbursement, the physician must write the ICD diagnosis code on the prescription. The pharmacist must include the actual ICD from the prescription in the Diagnosis Code field (Field # 424-DO), the value "1" in the Diagnosis Qualifier field (Field # 492-WE), and the number of ICD values that are being submitted in the Diagnosis Code Count field (Field # 491-VE).
- All prescriptions written for Family Planning pharmaceuticals, devices, or supplies are exempt from the collection of the $3.40 Medicaid co-payment.
- If the beneficiary is 19 years of age or older, the $3.40 co-payment is applicable for antibiotics used to treat STIs.

Medicare Part B Covered Drugs for Dually Eligible Beneficiaries

- For those Medicare/Medicaid dually eligible beneficiaries, Medicare Part B should be billed for certain specified drugs. If Medicare Part B denies payment because the drug is considered non-covered for the diagnosis indicated, the claim should be submitted to the beneficiary's Medicare Part D prescription drug plan (PDP).
- Effective April 1, 2010, if Medicare Part B reimburses for any portion of the pharmacy service provider's submitted charge (or if the claim paid amount was applied to the Medicare Part B annual deductible), the pharmacist should bill Medicaid secondarily using the Magellan POS system.

  Note: Effective for dates of service January 1, 2007, Medicaid cannot be billed secondarily for Medicare Part B-covered vaccines. In those instances, the beneficiary's Medicare Part D PDP must be billed for any allowable secondary payment.
- When billing a prior authorized claim secondarily to Medicaid, the coordination of benefits (COB) data elements are applicable and must be appropriately populated.

3.5 Prior Authorization Protocols

Magellan's prior authorization process is designed to provide rapid, timely responses to prior authorization requests. Prior authorizations will be managed for South Carolina Medicaid by one of three methods:

- Provider-level overrides
- Magellan Clinical Support Center
- Magellan Pharmacy Support Center

The following tables provide the products, criteria, and billing instructions for each prior authorization method.

Provider Level Overrides

Product	Criteria	Billing Instructions
Amphetamines for adult patients (> age 21)	Drug is rebated and dispensing pharmacist determines that usage is appropriate.	Dispensing pharmacist will enter "1" in the Prior Authorization Type Code field (data element #461)
Lactulose	Drug is rebated and dispensing pharmacist determines that usage is appropriate.	Dispensing pharmacist will enter "1" in the Prior Authorization Type Code field (data element #461)

Product	Criteria	Billing Instructions
Tretinoin for adult patients (> age 21)	Drug is rebated and dispensing pharmacist determines that usage is appropriate.	Dispensing pharmacist will enter "1" in the Prior Authorization Type Code field (data element #461)

3.5.1 Clinical Support Center Prior Authorizations

Product/Edit Type	Billing Instructions
Growth Hormones	In order to receive prior authorization for the product, the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center.
Lipase Inhibitors (orlistat)	In order to receive prior authorization for the product, the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center.
Panretin® (alitretinoin)	In order to receive prior authorization for Panretin®, the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center. **Note:** There is a limit of one tube of Panretin® gel on the initial prescription.
Targretin® (bexarotene)	In order to receive prior authorization for Targretin®, the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center. **Note:** If approved, on the initial prescription there is a limit of one tube of Targretin® gel OR a one-month supply of oral medication.
Xolair® (omalizumab)	In order to receive prior authorization for the product, the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center.
COX 2 Inhibitors for patients 60 years of age or younger	In order to receive prior authorization for the product, the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center.
Anti-Ulcer Medications: ▪ PPIs for adult patients ▪ PPI/H2RA Concurrent Therapy	In order to receive prior authorization for the product, the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center. Approval period may vary, depending on patient's diagnosis and other patient-specific clinical information.
"Brand Medically Necessary" Designated Products	In order to receive prior authorization for the brand name product, the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center. **Note:** See PA exceptions in *Section 3.3 – Generic Substitution Policy*.

Product/Edit Type	Billing Instructions
Maximum Quantity Limitations and Dose Optimization Program	Quantities exceeding established limitations will require prior authorization for the product; the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center.
Preferred Drug List	In order to receive prior authorization for a non-preferred product, the pharmacist should ask the prescriber to contact the Magellan Clinical Support Center.

3.5.2 Pharmacy Support Center Prior Authorizations

Product/Edit Type	Criteria	Billing Instructions
Early Refill (ProDUR)	The claim submitted is evaluated to determine if at least 75 percent of the previous fill of the same drug product has been used. For controlled substances, 85% of the previous fill must be used. Claims will deny at the POS if the utilization requirement has not been met.	Providers may contact the Pharmacy Support Center at 1-866-254-1669 to request an override.

- For all Clinical Support Center prior authorization requests, the pharmacist should request the prescriber to contact Magellan's Clinical Support Center (1-866-247-1181, toll-free) in order to provide the necessary patient-specific medical information.
- The prescriber is required to initiate clinical prior authorization requests. Ideally, this should occur at the point the prescription is being written. If this does not occur, the claim will deny at POS with a message that the prescriber should contact Magellan for prior authorization consideration.
- Upon receiving a call from the prescriber, Magellan will work with the prescriber to determine the outcome of the prior authorization request. Often, a change to the patient's drug therapy regimen will be made. In some cases, the requested drug may be authorized; in some instances, the requested drug may be denied. If Magellan has knowledge regarding which pharmacy services provider is involved, Magellan will contact that pharmacist with information pertaining to the prior authorization request.
- Magellan clinical staff is available on site from 8:00 a.m.–10:00 p.m., Monday through Friday. After normal business hours, and on weekends and holidays, calls to the Clinical Support Center will be forwarded to the Pharmacy Support Center. A Pharmacy Support Center representative will contact an on-call pharmacist if clinical intervention is required.
- Magellan will respond to all prior authorization requests within 24 hours of initiation of the request by the prescriber.
- If the prescriber cannot be contacted within a reasonable period of time, Magellan will authorize a five-day emergency fill. The emergency fill policy for Narcotics will continue to follow South Carolina Controlled Substance Act (CSA) and any applicable State and/or Federal Laws pertaining to controlled substances.
- Prior authorization records are entered for a reasonable time based on the nature of the drug/drug class and any follow-up activity that needs to occur.
- It is not necessary to enter a prior authorization number when the claim is transmitted. An active prior authorization record in the Magellan system is all that is necessary in order for the claim to be submitted.
- Prior authorization edits will apply to all claim types and claims media.

3.6 Beneficiary Financial Requirements

- Co-payments:
  - Except as specified below, South Carolina Medicaid beneficiaries 19 years of age or older are subject to a $3.40 per prescription/refill co-payment.
  - Co-payments for "partial fills" are prorated based on quantity dispensed vs. quantity prescribed for the month's supply – refer to *Section 3.1 – Dispensing Limits* of this manual.
- The following beneficiaries and/or services are **exempt** from the co-payment requirement:
  - Beneficiaries from birth to the date of 19th birthday
  - Institutionalized individuals
  - Beneficiaries who are pregnant (verified by either the patient or prescriber) – Providers should enter a value of "2" in the Prior Authorization Type Code field
  - Beneficiaries enrolled in the Family Planning pay category
  - Beneficiaries enrolled in the Medicaid Hospice benefit
  - Beneficiaries who are members of a Federally Recognized Indian Tribe
  - Beneficiaries enrolled in the Health Opportunity Account (HOA) program

3.7 Coordination of Benefits (COB)/Third-Party Liability (TPL)

- Claims for **COB** where the South Carolina Medicaid is not the primary payer will be processed online. In those cases where the South Carolina Medicaid beneficiary has other insurance coverage, pharmacy providers will be required to bill all other insurance carriers (including Medicare) before billing South Carolina Medicaid. NCPDP override conditions will be supported.
- No primary insurer co-payments or deductibles should be collected from beneficiaries if the claim is for a *covered* South Carolina Medicaid product. **Only the South Carolina Medicaid co-payment (if applicable) should be collected from the beneficiary.**

OCC	Use this value if…	Additional fields to complete…		
		Field name	NCPDP #	Reason
2	Primary payer makes payment	Other Payer Amount Paid	431-DV	Enter payer's payment amount
		Other Payer Patient Responsibility Amt	352-NQ	Enter patient's liability
3	Primary payer does not cover the drug ~OR~ Primary payer denied the claim as the Beneficiary's coverage was not effective on the date of service	Other Payer Reject Code	472-6E	Enter payer's reject reason
4	Primary payer's total payment is applied to the Beneficiary's Deductible or Co-payment	Other Payer Patient Responsibility Amt	352-NQ	Enter patient's liability
		Other Payer Amount Paid	431-DV	Enter payer's payment amount
		Other Payer Amount Paid Qualifier	342-HC	Enter value of "07" (Drug Benefit)

- Other Coverage Code (NCPDP Field # 3Ø8-C8) = "1," "5," "6,", "7," or "8" are no longer accepted data elements in this field.
- HIPAA has not named a standard identifier for the Other Payer ID. Consequently, Magellan typically uses the South Carolina-specific IDs. If there is payment received from multiple other carriers, Magellan will require the **total amount paid** from **all valid carriers** in the Other Payer Amount field.
- Even if no "other insurance" is indicated on the eligibility file, Magellan **will process the claim as a TPL claim if the pharmacist submits TPL data as indicated in the TPL Processing Grid** (see below).
- If other insurance is indicated on the eligibility file, then Magellan **will process as TPL. All required TPL values must be submitted for claim processing.**
- In all cases, Magellan will use the South Carolina Medicaid **"Allowed Amount"** when calculating payment. Note that in some cases, this may result in a "0" payment.
- South Carolina will allow providers to override days' supply limitations and/or drug requires prior authorization conditions by entering a value of "5" (exemption from monthly prescription limit) in the Prior Authorization Type Code field (NCPDP Field # 461-EU) when the Other Coverage Code = "2" (NCPDP Field # 3Ø8-C8).

Note: This override situation applies to TPL/COB processing only and is ONLY allowed when the Other Coverage Code = "2" (*Other coverage exists – payment collected*).

3.7.1 Change and Updates for Beneficiary Insurance

Pharmacies are required to keep updated primary insurance information for beneficiaries to ensure appropriate claims submission to Medicaid. When the pharmacist becomes aware that there has been a change in a beneficiary's primary insurance, he or she is asked to complete a *Health Insurance Information Referral Form* and fax it to Medicaid Insurance Verification Services at 1-803-252-0870. This form may be obtained from http://southcarolina.fhsc.com (choose Providers, then Documents).

TPL Processing Grid

	Other Coverage Code (Field # 3Ø8-C8)	Other Payer Amount Paid (Field # 431-DV)	Other Coverage Indicated on SC Medicaid Recipient Record	Other Payer Date (Field # 443-E8)	Other Payer ID (Field # 34Ø-7C)	Claim Disposition	Comments
1	0 = Not Specified	0	Yes	M/I or null	M/I or null	Deny, Bill Primary, M/I Other Payer Date	This code will not override TPL.
2	0 = Not Specified	0	No	Null	Null	Pay	
3	0 = Not Specified	>0	No	M/I or null	M/I or null	Deny, M/I Other Payer Date	
4	0 = Not Specified	>0	Yes	M/I or null	M/I or null	Deny, Bill Primary, M/I Other Payer Date, M/I Other Payer Amount	
5	1 = No other coverage identified	0	Yes	M/I or null	M/I or null	Deny, Bill Primary, M/I Other Payer Date	
6	1 = No other coverage identified	0	Yes	Valid Date	Valid TPL Carrier Code	Pay	Use when primary does not show coverage.
7	1 = No other coverage identified	0	No	M/I or null	M/I or null	Pay	
8	1 = No other coverage identified	>0	No	M/I or null	M/I or null	Deny, Primary, M/I Other Payer Date	

	Other Coverage Code (Field # 3Ø8-C8)	Other Payer Amount Paid (Field # 431-DV)	Other Coverage Indicated on SC Medicaid Recipient Record	Other Payer Date (Field # 443-E8)	Other Payer ID (Field # 34Ø-7C)	Claim Disposition	Comments
9	1 = No other coverage identified	>0	Yes	M/I or null	M/I or null	Deny, Bill Primary, M/I Other Payer Date, M/I Other Payer Amount	
10	1 = No other coverage identified	0	Yes	Valid Date	M/I or null	Deny, Bill Primary, M/I Other Payer Date, M/I Other Payer ID	
11	1 = No other coverage identified	0	No	Valid Date	M/I or null	Deny, M/I Other Payer Date	
12	1 = No other coverage identified	0	No	M/I or null	Valid TPL Carrier Code	Deny, M/I Other Payer Date	
13	1 = No other coverage identified	0	Yes	M/I or null	Valid TPL Carrier Code	Deny, M/I Other Payer Date	
14	1 = No other coverage identified	0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, Bill Primary	
15	1 = No other coverage identified	0	Yes	Date > Adjudication Date	Valid TPL Carrier Code	Deny, M/I Other Payer Date	

	Other Coverage Code (Field # 3Ø8-C8)	Other Payer Amount Paid (Field # 431-DV)	Other Coverage Indicated on SC Medicaid Recipient Record	Other Payer Date (Field # 443-E8)	Other Payer ID (Field # 34Ø-7C)	Claim Disposition	Comments
16	2 = Other coverage exists, payment collected	> 0	Yes or No	Valid Date	Valid TPL Carrier Code	Pay (Will pay when all Carriers have been overridden)	Will pay the difference between the South Carolina Medicaid Allowed Amount and the Other Payer Amount
17	2 = Other coverage exists, payment collected	>0	No	Valid Date	M/I or null	Deny, M/I Other Payer Date, M/I Other Payer ID	
18	2 = Other coverage exists, payment collected	>0	Yes	Valid Date	M/I or null	Deny, Bill Primary, M/I Other Payer Date, M/I Other Payer ID	
19	2 = Other coverage exists, payment collected	>0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, M/I Other Payer Date	
20	2 = Other coverage exists, payment collected	0	No	M/I or null	M/I or null	Deny, M/I Other Payer Date, MI Other Payer Amount	

	Other Coverage Code (Field # 3Ø8-C8)	Other Payer Amount Paid (Field # 431-DV)	Other Coverage Indicated on SC Medicaid Recipient Record	Other Payer Date (Field # 443-E8)	Other Payer ID (Field # 34Ø-7C)	Claim Disposition	Comments
21	2 = Other coverage exists, payment collected	0	Yes	N/A	N/A	Deny, Bill Primary, M/I Other Payer Date, M/I Other Payer Amount	
22	2 = Other coverage exists, payment collected	>0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, Bill Primary	
23	2 = Other coverage exists, payment collected	>0	Yes	Denial > Adjudication Date	Valid TPL Carrier Code	Deny, M/I Other Payer Date	
24	3 = Other coverage exists, this claim not covered	0	Yes or No	Valid Date	Valid TPL Carrier Code	Pay	Pay the South Carolina Medicaid Allowed Amount.
25	3 = Other coverage exists, this claim not covered	0	No	Valid Date	M/I	Deny, M/I Other Payer Date, M/I Other Payer ID	
26	3 = Other coverage exists, this claim not covered	0	Yes	Valid Date	M/I	Deny, Bill Primary	

	Other Coverage Code (Field # 3Ø8-C8)	Other Payer Amount Paid (Field # 431-DV)	Other Coverage Indicated on SC Medicaid Recipient Record	Other Payer Date (Field # 443-E8)	Other Payer ID (Field # 34Ø-7C)	Claim Disposition	Comments
27	3 = Other coverage exists, this claim not covered	0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, M/I Other Payer Date	
28	3 = Other coverage exists, this claim not covered	>0	No	M/I or null	M/I or null	Deny, Bill Primary, M/I Other Payer Date	
29	3 = Other coverage exists, this claim not covered	>0	Yes	M/I or null	M/I or null	Deny, Bill Primary, M/I Other Payer Date, M/I Other Payer Amount	
30	3 = Other coverage exists, this claim not covered	>0	Yes or No	Valid	Valid	Deny, M/I Other Payer Amount	
31	3 = Other coverage exists, this claim not covered	>0	Yes	Valid	Invalid	Deny, Bill Primary, M/I Other Payer Amount	
32	3 = Other coverage exists, this claim not covered	>0	No	Valid	Invalid	Deny, M/I Other Payer Amount	

	Other Coverage Code (Field # 3Ø8-C8)	Other Payer Amount Paid (Field # 431-DV)	Other Coverage Indicated on SC Medicaid Recipient Record	Other Payer Date (Field # 443-E8)	Other Payer ID (Field # 34Ø-7C)	Claim Disposition	Comments
33	3 = Other coverage exists, this claim not covered	>0	Yes or No	Invalid	Valid	Deny, M/I Other Payer Date, M/I Other Payer Amount	
34	3 = Other coverage exists, this claim not covered	0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, Bill Primary Payer	
35	3 = Other coverage exists, this claim not covered	0	Yes	Denial > Adjudication Date	Valid TPL Carrier Code	Deny, M/I Other Payer Date	
36	4 = Other coverage exists, payment not collected	>0	No	M/I or null	M/I or null	Deny, M/I Other Payer Date, M/I Other Payer Amount	
37	4 = Other coverage exists, payment not collected	>0	Yes	M/I or null	M/I or null	Deny, Bill Primary, M/I Other Payer Date, M/I Other Payer Amount	
38	4 = Other coverage exists, payment not collected	>0	Yes or No	Valid	Valid	Deny, M/I Other Payer Amount	

	Other Coverage Code (Field # 3Ø8-C8)	Other Payer Amount Paid (Field # 431-DV)	Other Coverage Indicated on SC Medicaid Recipient Record	Other Payer Date (Field # 443-E8)	Other Payer ID (Field # 34Ø-7C)	Claim Disposition	Comments
39	4 = Other coverage exists, payment not collected	>0	Yes	Valid	Invalid	Deny, Bill Primary, M/I Other Payer Amount	
40	4 = Other coverage exists, payment not collected	>0	No	Valid	Invalid	Deny, M/I Other Payer Amount	
41	4 = Other coverage exists, payment not collected	>0	Yes or No	Invalid	Valid	Deny, M/I Other Payer Date, M/I Other Payer Amount	
42	4 = Other coverage exists, payment not collected	0	Yes	Valid Date	Valid TPL Carrier Code	Pay	Use if primary is full deductible or 100 percent co-pay.
43	4 = Other coverage exists, payment not collected	0	Yes	Valid Date	M/I or null	Deny, Bill Primary, M/I Other Payer Date, M/I Other Payer ID	
44	4 = Other coverage exists, payment not collected	0	No	Valid Date	M/I or null	Deny, M/I Other Payer Date	

	Other Coverage Code (Field # 3Ø8-C8)	Other Payer Amount Paid (Field # 431-DV)	Other Coverage Indicated on SC Medicaid Recipient Record	Other Payer Date (Field # 443-E8)	Other Payer ID (Field # 34Ø-7C)	Claim Disposition	Comments
45	4 = Other coverage exists, payment not collected	0	Yes or No	M/I or null	Valid TPL Carrier Code	Deny, M/I Other Payer Date	
46	4 = Other coverage exists, payment not collected	0	Yes	Valid Date	Invalid TPL Carrier Code	Deny, Bill Primary	
47	4 = Other coverage exists, payment not collected	0	Yes	Date > Adjudication Date	Valid TPL Carrier Code	Deny, M/I Other Payer Date	
48	**New 5.1 Codes**						
49	5 = Managed care plan denial					Deny, Drug Not Covered Additional Message: OCC 5/6/8 Not Allowed for Override	Not allowed for override. NCPDP 7Ø/with message
50	6 = Other coverage denied – not a participating provider					Deny, Drug Not Covered Additional Message: OCC 5/6/8 Not Allowed for Override	Not allowed for override. NCPDP 7Ø/with message

	Other Coverage Code (Field # 3Ø8-C8)	Other Payer Amount Paid (Field # 431-DV)	Other Coverage Indicated on SC Medicaid Recipient Record	Other Payer Date (Field # 443-E8)	Other Payer ID (Field # 34Ø-7C)	Claim Disposition	Comments
51	7 = Other coverage exists – not in effect on DOS						Use if TPL expired; edits mirror OCC = "1."
52	8 = Claim is billing for co-pay					Deny, Drug Not Covered Additional Message: OCC 5/6/8 Not Allowed for Override	Not allowed for override. NCPDP 7Ø/with message

3.8 Special Processing Conditions

Compound Claims

The following method will be used for compound claim processing:

- Each compound ingredient will **undergo all edits** relative to the NDC.
- Compounds will be counted as one prescription and applied to the adult beneficiary's monthly limit as one prescription.
- The claims will pay according to the designated payment logic.

Compounds: Procedures for Claim Submission

- The Claim Segment Product ID (i.e., NDC) is defined as a mandatory field and therefore must be submitted for all claims, including multi-ingredient compounds. A non-space value is expected in this field for field validation. A claim for a multi-ingredient compound must be submitted with a single zero in this field. For compound segment transactions, the claim will reject if all zeroes are submitted as the product ID.
- A Submission Clarification Code value of "8" will allow a claim to continue processing if at least one ingredient is covered.

3.8.1 Claims Submission Instructions for Multi-Ingredient Compound Prescriptions

Providers must submit the actual NDC listed on the package for each ingredient used to compound the prescription. Multi-ingredient compound claims submitted with inaccurate NDCs for the actual ingredients dispensed are subject to post-payment review and recoupment of Medicaid monies.

Compounds

Compounds should be processed online using "multiple ingredient functionality." All edits apply to each NDC. Providers should enter the following:

- On Claim Segment
  - Submission Clarification Code (NCPDP Field # 42Ø-DK) = "8."
  - A value of "8" ("Process Compound for Approved Ingredients") allows a claim to continue processing if at least one ingredient is covered.
  - Enter Product/Service ID Qualifier (NCPDP Field # 436-E1) as "00" (= Not Specified).

- Enter Product Code/NDC (NCPDP Field # 4Ø7-D7) as "0" on the claim segment to identify the claim as a multi-ingredient compound.
- Enter Compound Code (NCPDP Field # 4Ø6-D6) of "2."
- Enter Quantity Dispensed (NCPDP Field # 442-E7) of entire product.
- Enter Gross Amount Due (NCPDP Field # 43Ø-DU) for entire product.
- Compound Route of Administration (NCPDP Field # 995-E2)

• On Compound Segment
- Enter Compound Dosage Form Description Code (NCPDP Field # 45Ø-EF).
- Compound Dispensing Unit Form Indicator (NCPDP Field # 451-EG)
- Compound Ingredient Component Count (NCPDP Field # 447-EC) (Maximum of 25 ingredients)

• For each line item
- Compound Product ID Qualifier (NCPDP Field # 488-RE)
- Compound Product ID (NCPDP Field # 489-TE) (i.e., NDC)
- Compound Ingredient Quantity (NCPDP Field # 448-ED)
- Compound Ingredient Drug Cost (NCPDP Field # 449-EE)

Note: Partial fill functionality cannot be used when submitting multi-ingredient compound claims.

Entering Time

Effective for claims billed on or after August 17, 2011, pharmacy providers submitting claims for compounding pharmacy products may bill for compounding services using the online claims adjudication system.

The pharmacy provider will use NCPDP Field # 474-8E (DUR/PPS Level of Effort) to enter the appropriate value. The values for this field and resulting compounding fee are as follows:

Value	Number of Minutes	Compounding Fee
11	15 Minutes	$12.50
12	30 Minutes	$25.00
13	45 Minutes	$37.50
14	60 Minutes	$50.00

The compounding fee of $50 per hour is paid based on the level of effort of the product compounded. The maximum number of minutes to be billed is indicated in the chart below.

For dosage forms not included in the chart, pharmacy providers should document actual time spent preparing the compounded product and bill accordingly.

No more than 60 minutes of compounding time will be allowed for any single preparation.

Minutes	Type of Product/Dosage Form
15	Oral Solutions or Suspensions Involving the Combination of Commercially Available Oral Products
	Topical Preparations Compounded by Combining Commercially Available Topical Products
	Enemas
30	Suppositories
	Compounded Capsules
	Topical Preparations Containing Components that are NOT Commercially Available in a Topical Formulation
45	Oral Liquids Containing Components that are NOT Commercially Available in Oral Formulation
	Ophthalmic Preparations
	Chemotherapeutic Topical Agents
60	Sterile Injectable Preparations

3.9 340B

Effective with dates of service on or after July 1, 2019: the following policy will apply regarding the submission of claims for drugs purchased through the 340B program, as described in Section 340B of the Public Health Act of 1992.

For drugs purchased through the 340B program, covered entities must submit a value of "20" in the Submission Clarification Code field (420-DK). When submitting Medicaid fee-for-service (FFS) claims, an amount not exceeding the 340B ceiling price plus an enhanced 340B dispensing fee should be submitted in the usual and customary field.

Claims submitted by covered entities without a value of "20" in the Submission Clarification Code field will be considered eligible for Medicaid rebates. This policy applies to all covered entities, regardless of designation by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs.

Contract pharmacies must carve out Medicaid beneficiaries. For additional information, refer to the SCDHHS Pharmacy Administrative and Billing Guide located at https://www.scdhhs.gov/provider-manual-list.

4.0 Prospective Drug Utilization Review

Prospective drug utilization review (ProDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of Magellan assists the pharmacist in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may NOT have been previously available.

Because Magellan's ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. Magellan recognizes that the pharmacist uses his/her education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacist in performing his or her professional duties.

4.1 ProDUR Problem Types

- Listed below are ALL ProDUR conflict types within the Magellan system for the South Carolina Medicaid program:
  - Drug-to-Drug Interaction (DD)
  - Early Refill (ER)
  - Late Refill (LR)
  - Therapeutic Duplication (TD)
  - Duplicate Ingredient (ID)
  - Drug-to-Pregnancy Precaution (PG)
  - Minimum/Maximum Daily Dosing (LD, HD)
  - Drug-to-Pediatric Precaution (PA)
  - Drug-to-Geriatric Precaution (PA)
  - Drug-to-Disease (MC)
  - Drug-to-Inferred Disease (DC)
  - Prerequisite Drug Therapy (SR)
- Drug-to-Drug Interactions and Therapeutic Duplication edits that deny may be overridden by the pharmacy provider at the POS using the NCPDP DUR override codes listed in *Section 5.3 – DUR Fields*.
- For Early Refill denials, providers should contact the Magellan Pharmacy Support Center (1-866-254-1669) to request an override.

- For Prerequisite Drug Therapy denials, providers should contact the Magellan Clinical Support Center (1-866-257-1181) to request a prior authorization.

4.2 Days' Supply

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 positive ProDUR messages or claim denial for that particular claim or for drug claims that are submitted in the future.

4.3 Pharmacy Support Center

Magellan's Pharmacy Support Center is available 24 hours per day, 7 days per week. The telephone number is 1-866-254-1669. Alert message information is available from the support center after the message appears. If you need assistance with any alert or denial messages, it is important to contact the support center about Magellan ProDUR messages at the time of dispensing. The support center can provide claims information on all error messages that are sent by the ProDUR system. This information includes NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days' supply.

The Pharmacy Support Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. Magellan 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 patients.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, Magellan staff pharmacists are available for consultation.

4.4 ProDUR Alert/Error Messages

All ProDUR alert messages appear at the end of the claims adjudication transmission. Alerts will appear in the following format:

Format	Field Definitions
Reason for Service	Up to three characters. Code transmitted to pharmacy when a conflict is detected. (e.g., ER, HD, TD, DD).
Severity Index Code	One character. Code indicates how critical a given conflict is.
Other Pharmacy Indicator	One character. Indicates if the dispensing provider also dispensed the first drug in question. ▪ 1 = Your pharmacy ▪ 3 = Other pharmacy
Previous Date of Fill	Eight characters. Indicates previous fill date of conflicting drug in YYYYMMDD format.
Quantity of Previous Fill	Five characters. Indicates quantity of conflicting drug previously dispensed.
Database Indicator	One character. Indicates source of ProDUR message. ▪ 1 = First DataBank ▪ 4 = Processor Developed
Other Prescriber	One character. Indicates the prescriber of conflicting prescription. ▪ 0 = No Value ▪ 1 = Same Prescriber ▪ 2 = Other Prescriber

5.0 Edits

5.1 Online Claims Processing Messages

Following an online claim submission by a pharmacy, the system will return a message to indicate the outcome of processing. If the claim passes all edits, a "Paid" message will be returned with South Carolina Medicaid's allowed amount for the paid claim. A claim that fails an edit and is rejected (denied) will also return a message. Following is a list of the program's error codes with their corresponding NCPDP rejection codes.

As shown below, an NCPDP error code is returned with an NCPDP message. Where applicable, the NCPDP field that should be checked is referenced. Check the Solutions box if you are experiencing difficulties. For further assistance, contact Magellan at

Pharmacy Support Center
1-866-254-1669 (nationwide toll-free number)

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
ØØ	M/I means Missing/Invalid		
Ø1	M/I BIN	1Ø1	Use ØØ9745
Ø2	M/I Version Number	1Ø2	Use D.0
Ø3	M/I Transaction Code	1Ø3	Transactions allowed = B1, B2, B3.
Ø4	M/I Processor Control Number	1Ø4	Use PØØ62 ØØ9745.
Ø5	M/I Pharmacy Number	2Ø1	Use NPI (refer to *Section 2.6 – Required Data Elements* for requirements); do not send South Carolina Medicaid ID. Must be actively enrolled with South Carolina Medicaid on DOS. Check with software vendor to ensure appropriate number has been set up in your system.
Ø6	M/I Group Number	3Ø1	Use SC MEDICAID only.

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
Ø7	M/I Cardholder ID Number	3Ø2	Use South Carolina Medicaid 10-digit beneficiary ID number. Providers should always examine a beneficiary's Medicaid ID card before services are rendered. It is the provider's responsibility to establish the identity of the individual and to verify the effective date of coverage for the card presented.
Ø8	M/I Person Code	3Ø3	
Ø9	M/I Birth Date	3Ø4	Format = CCYYMMDD
1C	M/I Smoker/Non-Smoker Code	334	
1E	M/I Prescriber Location Code	467	
1Ø	M/I Patient Gender Code	3Ø5	Values = 0/not specified, 1/male, and 2/female
11	M/I Patient Relationship Code	3Ø6	Allowed value = 1/cardholder
12			
13	M/I Other Coverage Code	3Ø8	Refer to *Section 3.7 – Coordination of Benefits (COB)/Third-Party Liability (TPL).*
14	M/I Eligibility Clarification Code	3Ø9	
15	M/I Date of Service	4Ø1	
16	M/I Prescription/Service Reference Number	4Ø2	Ensure all appropriate codes on refill are same as original fill.
17	M/I Fill Number	4Ø3	
19	M/I Days Supply	4Ø5	
2C	M/I Pregnancy Indicator	335	
2E	M/I Primary Care Provider ID Qualifier	468	
2Ø	M/I Compound Code	4Ø6	
21	M/I Product/Service ID	4Ø7	
22	M/I Dispense As Written (DAW)/Product Selection Code	4Ø8	

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
23	M/I Ingredient Cost Submitted	4Ø9	
25	M/I Prescriber ID	411	
26	M/I Unit of Measure	6ØØ	
28	M/I Date Prescription Written	414	
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		

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
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	Do not enter any names in this field.
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		
41	Submit Bill to Other Processor or Primary Payer		Refer to additional messaging in Additional Message field for Other Payer ID, name, and policy # (if available).
5C	M/I Other Payer Coverage Type	338	
5E	M/I Other Payer Reject Count	471	Must equal the number of Other Payer Reject Codes if submitted.
5Ø	Non-Matched Pharmacy Number	2Ø1	
51	Non-Matched Group ID	3Ø1	
52	Non-Matched Cardholder ID	3Ø2	Validate patient's first and last names.
53	Non-Matched Person Code	3Ø3	
54	Non-Matched Product/Service ID Number	4Ø7	
55	Non-Matched Product Package Size	4Ø7	

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
56	Non-Matched Prescriber ID	411	
58	Non-Matched Primary Prescriber	421	
6C	M/I Other Payer ID Qualifier	422	Enter 99/other.
6E	M/I Other Payer Reject Code	472	Ensure validly formatted codes are sent.
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	Validate patient's first and last names.
63	Institutionalized Patient Product/Service ID Not Covered		
64	Claim Submitted Does Not Match Prior Authorization	2Ø1, 4Ø1, 4Ø4, 4Ø7, 416	
65	Patient Is Not Covered	3Ø3, 3Ø6	
66	Patient Age Exceeds Maximum Age	3Ø3, 3Ø4, 3Ø6	
67	Filled Before Coverage Effective	4Ø1	
68	Filled After Coverage Expired	4Ø1	
69	Filled After Coverage Terminated	4Ø1	
7C	M/I Other Payer ID	34Ø	Must be appropriate South Carolina Other Payer ID.
7E	M/I DUR/PPS Code Counter	473	
7Ø	Product/Service Not Covered	4Ø7	
71	Prescriber Is Not Covered	411	
72	Primary Prescriber Is Not Covered	421	
73	Refills Are Not Covered	4Ø2, 4Ø3	
74	Other Carrier Payment Meets or Exceeds Payable	4Ø9, 41Ø, 442	
75	Prior Authorization Required	462	

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
76	Plan Limitations Exceeded	4Ø5, 442	
77	Discontinued Product/Service ID Number	4Ø7	
78	Cost Exceeds Maximum	4Ø7, 4Ø9, 41Ø, 442	
79	Refill Too Soon	4Ø1, 4Ø3, 4Ø5	
8C	M/I Facility ID	336	
8E	M/I DUR/PPS Level of Effort	474	
8Ø	Drug-Diagnosis Mismatch	4Ø7, 424	
81	Claim Too Old	4Ø1	Claim exceeds filing limit; validate DOS.
82	Claim Is Post-Dated	4Ø1	DOS is greater than submittal date.
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 Processed	None	Reversals must match on Provider #, Rx #, DOS, and NDC.
88	DUR Reject Error		
89	Rejected Claim Fees Paid		Response not in appropriate format to be displayed.
9Ø	Host Hung Up		Processing host did not accept transaction/did not respond within time out period.
91	Host Response Error		
92	System Unavailable/Host Unavailable		
*95	Time Out		
*96	Scheduled Downtime		
*97	Payer Unavailable		

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
*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	
CB	M/I Patient Last Name	311	
CC	M/I Cardholder First Name	312	
CD	M/I Cardholder Last Name	313	
CE	M/I Home Plan	314	
CF	M/I Employer Name	315	

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
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	
DX	M/I Patient Paid Amount Submitted	433	
DY	M/I Date of Injury	434	
DZ	M/I Claim/Reference ID	435	

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
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	

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
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 appropriate DUR problem type (e.g., ER = Early Refill) for override consideration.
E5	M/I Professional Service Code	44Ø	Enter appropriate DUR intervention type (e.g., M0 = prescriber consulted) for override consideration.
E6	M/I Result of Service Code	441	Enter appropriate DUR outcome type (e.g., 1A = filled as is, false positive) for override consideration.
E7	M/I Quantity Dispensed	442	Enter appropriate metric decimal quantity.
E8	M/I Other Payer Date	443	Used for COB. Enter valid date Other Payer paid or denied the primary claim. Date must be =/< DOS of claim to Medicaid.
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	

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
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		

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
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 Segment	111	
PN	M/I Prescriber Segment	111	
PP	M/I Pricing Segment	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 ID	333	
PX	Non-Matched Other Payer ID	34Ø	

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
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 Expired	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	Mismatched 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		

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
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	

Point-of-Sale Reject Codes and Messages All edits may not apply to this program. All submitted data elements will be edited for valid format and valid values.			
Reject Code	**Explanation**	**Field Number Possibly In Error**	**Possible Solutions**
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	

5.2 Host System Problems

Occasionally, providers may receive a message that indicates their network is having technical problems communicating with Magellan.

NCPDP	Message
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.
93	Planned Unavailable Transmission occurred during scheduled downtime. Scheduled downtime for file maintenance is Saturday 11:00 p.m.–6:00 a.m. (ET).
99	Host Processing Error Do not retransmit claims.

5.3 DUR Fields

Following are the ProDUR edits that will deny for South Carolina Medicaid:

- Drug/Drug Interactions – (Severity level 1) – provider override allowed
- Early Refill – Contact the Magellan Pharmacy Support Center to request an override
- Therapeutic Duplication – (selected therapeutic classes) – provider override allowed
- Prerequisite Drug Therapy (COX-2 PA Edit) – Contact the Magellan Clinical Support Center to request prior authorization

NCPDP	Message
88	DUR Reject Error

Also note that the following ProDUR edits will return a warning message only (i.e., an override is not necessary):

- Drug/Drug Interactions – (Severity levels 2, 3)
- Late Refill
- Duplicate Ingredient
- Drug to Pregnancy Precaution – (Severity level 1)
- Minimum/Maximum Daily Dosing
- Drug-to-Pediatric Precautions – (Severity level 1)
- Drug-to-Geriatric Precautions – (Severity level 1)
- Drug-to-Known Disease – (Severity level 1)
- Drug-to-Inferred Disease – (Severity level 1)
- Therapeutic Duplication – (selected therapeutic classes)

Note: Provider overrides are processed on a per-claim (date of service only) basis. For quality of care purposes, pharmacists are required to retain documentation relative to these overrides.

DUR Reason for Service (Conflict) Code

The DUR Conflict Code is used to define the type of utilization conflict that was detected (NCPDP Field # 439).

Valid DUR Reason for Service (Conflict) Codes for the South Carolina Medicaid Program are

- DD Drug/Drug Interactions;
- ER Early Refill;
- TD Therapeutic Duplication;
- LR Late Refill;
- ID Duplicate Ingredient;
- PG Drug-to-Pregnancy Precaution;
- LD/HD Minimum/Maximum Daily Dosing;
- PA Drug-to-Pediatric Precautions;
- PA Drug-to-Generic Precautions;
- MC Drug-to-Known Disease;
- DC Drug-to-Inferred Disease; and
- SR Prerequisite Drug Therapy: Cox-2 PA Edit.

NCPDP	Message
E4	M/I DUR conflict/reason for service code

DUR Professional Service (Intervention) Code

The DUR Reason for Service (Intervention) Code is used to define the type of interaction or intervention that was performed by the pharmacist (NCPDP Field # 44Ø).

Valid DUR Professional Service (Intervention) Codes for the South Carolina Medicaid Program are

- 00 No intervention;
- CC Coordination of care;
- M0 Prescriber consulted;
- PE Patient education/instruction;
- PH Patient medication history;
- P0 Patient consulted; and
- R0 Pharmacist consulted other source.

NCPDP	Message
E5	M/I DUR intervention/professional service code

DUR Result of Service (Outcome) Code

The DUR Result of Service (Outcome) Code is used to define the action taken by the pharmacist in response to a ProDUR Conflict code or the result of a pharmacist's professional service (NCPDP Field # 441).

Valid DUR Result of Service (Outcome) Codes for the South Carolina Medicaid Program are

- 1A filled as is, false positive;
- 1B filled prescription as is;
- 1C filled with different dose;
- 1D filled with different directions;
- 1F filled with different quantity;
- 1G filled with prescriber approval;
- 2A prescription not filled;
- 3B recommendation not accepted; and
- 3C discontinued drug.

NCPDP	Message
E6	M/I DUR outcome/result of service code