



Pharmacy Provider Manual

1.0	General Overview	
1.1	Confidentiality Statement	4
1.2	Pharmacy Requirements	4
2.0	Contact Information	4
2.1	SelectHealth Pharmacy Help Desk	5
2.2	SelectHealth Member Services	5
2.3	SelectHealth Addresses	6
3.0	General Claims Processing Information	6
3.1	Online Processing Information	7
3.2	Sample ID Cards	7
3.3	Member Identification Number	7
3.4	Dependent Coverage	9
3.5	Eligibility Verification	9
3.6	Coordination of Benefits	9
3.7	Prescription Costs and Reimbursement	10
3.7.1	Member Financial Responsibility	10
3.7.2	Reimbursement Rate Questions	10
3.8	Signature Log	
3.9	E-prescribing	11
4.0	Dispensing Edits	11
4.1	Quantity and Day Supply Limits	11
4.2	Refills	11
4.3	DAW Codes	12
4.4	Compound Prescriptions	12
4.5	Restriction Program	13
5.0	Appeals and Grievances	14
6.0	Audit Information	14
7.0	Formulary Information	15
7.1	SelectHealth Commercial and PBM Products and SelectHealth Community Care (Utah State Medicaid)	15
7.2	SelectHealth Advantage (Medicare Part D)	17
8.0	Common Reject Messages	18
9.0	Payment and Reconciliation Information	20
9.1	Payment Schedule	20
9.2	Remittance Report	20
10.0	SelectHealth Advantage (Medicare Part D) Specific Information	21
10.1	Plan Summary	21
10.2	Fraud, Waste and Abuse	21
10.3	Training	21
10.4	Pharmacy Certification for Part D	21

10.5	Federal Health Care Programs	21
	Participation Exclusion	22
10.6	General Procedures for	
	Acknowledgement Letters	22
10.7	Formulary Transition Fill Plan	22
10.8	Long-term Care Facilities	22
10.9	Home Infusion Therapy	22
10.10	Medicare Service Area	
Appendices		22
	Appendix A- Payer Sheet	

1.0 General Overview

This pharmacy provider manual has been developed by SelectHealth to assist network pharmacies in all aspects of providing pharmacy services to SelectHealth covered members. Periodically, this manual will be updated with new or modified information. To ensure accuracy and usability of this manual, please incorporate the revised information as instructed. This manual has been assembled to provide administrative information only and is not meant to supersede any local or federal regulations.

SelectHealth administers a variety of plans including Commercial, Small Employer, Individual, Medicaid, Medicare and other Government sponsored plans. The SelectHealth pharmacy network is comprised of nationally contracted chain and independent pharmacies located in all 50 states. Covered members with SelectHealth prescription drug coverage must have their prescriptions filled at a participating pharmacy to obtain the maximum benefit. Covered members traveling outside their local service area must also use a participating pharmacy to obtain the maximum benefit. Pharmacies participating in the SelectHealth pharmacy network are eligible to fill prescriptions for all SelectHealth covered members except when restricted by the plan. For some plans, the prescriber writing the prescription must be participating in the plan.

1.1 Confidentiality Statement

The information included in this provider manual is considered confidential and proprietary to SelectHealth and provided for business purposes only. Provider is not authorized to copy, reproduce, distribute or otherwise share the information contained in the manual except as authorized by the pharmacy network agreement.

1.2 Pharmacy Requirements

SelectHealth has established service, credentialing and operational standards for participating pharmacies to ensure delivery of quality service to all covered members.

Patient service standards include:

- Patient profiles will be maintained for prescription medication dispensed.
- For a period of at least five (5) years, no pharmacy shall destroy any patient record produced, unless prior written consent is obtained from SelectHealth.
- Pharmacists will react appropriately to online edits, which may affect the patient's medical status or coverage.
- Pharmacists will provide instruction to the patient on the use of medication, including information based on the online drug messages, before dispensing of each prescription, according to state and federal law.
- Pharmacies should have the ability to provide all drug products covered by the benefit plans, including products normally stocked and those that require special order.
- Pharmacies will have established formal prescription quality assurance and error prevention measures.
- Pharmacies will have established a formal process for handling prescription errors.

Provider Credentialing Standards include:

- Pharmacy will carry a valid pharmacy operating license.
- Pharmacy will maintain valid professional liability and general liability insurance for the pharmacy in the amounts of \$1,000,000 per occurrence and \$3,000,000 aggregate coverage.
- Pharmacy will maintain a valid DEA registration.
- Pharmacy will cooperate with the SelectHealth Pharmacy Auditors and recovery of any overages identified as a result of an audit.
- Pharmacy will maintain a current/valid State Board of Pharmacy License that contains no restrictions.
- Established procedures for verification of pharmacist licensure will be in place.

2.0 Contact Information

2.1 SelectHealth Pharmacy Help Desk

Contact the Pharmacy Help Desk for items such as the following:

- Claims Processing
- Prior Authorization Requests
- Assistance with Reject Messages
- Contract Issues/Questions
- Network Issues/Questions
- Claims Investigation
- Provider Remittance Statements
- Payment Issues/Questions
- General Questions

SelectHealth Commercial and PBM Products and SelectHealth Community Care (Utah State Medicaid)

Phone: 801-442-4912

Toll Free: 800-442-3129

Fax: 801-442-3006

Hours of Operation: 24 hours a day, 7 days per week

SelectHealth Advantage (Medicare Part D)

Phone: 801-442-9988

Toll Free: 855-442-9988

Fax: 801-442-3006

Hours of Operation: 24 hours a day, 7 days a week

2.2 SelectHealth Member Services

Contact the Member Services Line for items such as the following:

- Eligibility Verification
- Member-specific questions about benefit coverage

SelectHealth Commercial Products and SelectHealth Community Care (Utah State Medicaid)

Phone: 801-442-5038

Toll Free: 800-538-5038

Fax: 801-442-3006

Hours of Operation: Monday through Friday 7:00 AM, MT – 8:00 PM, MT, Saturday 9:00 AM, MT – 2:00 PM, MT, closed Sunday

SelectHealth PBM Products

Phone: 801-442-4910

Toll Free: 800-442-3127

Fax: 801-442-3006

Hours of Operation: Monday through Friday 7:00 AM, MT – 8:00 PM, MT, Saturday 9:00 AM, MT – 2:00 PM, MT, closed Sunday

SelectHealth Advantage (Medicare Part D)

Phone: 801-442-9900 (Utah), 208-429-9900 (Idaho)

Toll Free: 855-442-9900

Fax: 801-442-3006

Hours of Operation: 24 hours per day, seven days per week.

2.3 SelectHealth Addresses

Physical Address

5381 Green Street

Murray, UT 84123

Claims Mailing Addresses

Commercial, PBM, and SelectHealth Community Care

PO Box 30192

Salt Lake City, UT 84130

SelectHealth Advantage (Medicare Part D)

Attn: Pharmacy Services

PO Box 30196

Salt Lake City, UT 84130

3.0 General Claims Processing Information

3.1 Online Processing Information

SelectHealth Commercial and PBM Products

BIN – 800008

PCN – *not required*

Group – *not required*

SelectHealth Advantage (Medicare Part D)

BIN – 015938

PCN – 7463

Group – U1000009

SelectHealth Community Care (Utah State Medicaid)

BIN – 800008

PCN – 606

Group – *not required*

See Payer Sheet in Appendix A for additional processing instructions and requirements.

The pharmacy must submit all prescription claims online to SelectHealth using the most current version of the NCPDP telecommunications standard. Tape billing will not be accepted or paid. The pharmacy must submit prescription claims within 45 days of the fill date (Commercial, PBM and SelectHealth Community Care) or within 90 days of the fill date (SelectHealth Advantage). The pharmacy is required to bill the most cost-effective package size.

Each individual claim will be processed as received by SelectHealth. Extensive edit checks are made to ensure proper claims adjudication. Claims submitted containing one or more errors will be rejected.

The pharmacy shall not submit claims for payment for prescriptions filled, but not dispensed to a covered member. Non-compliance with this contractual provision will be grounds for termination of the Prescription Drug and Pharmacy Services Agreement and/or adjustment of payment on these claims.

3.2 Sample ID Cards

Below are images of sample SelectHealth ID cards.

select:care+

JOHN DOE ID: **800000000**

Participating Benefits

Office PCP/SCP: \$15/\$25	InstaCare: \$25
Mental Health:* 50%	Medical Ded: \$250
Rx: \$10/\$25/\$45	Rx Ded: None
ER Participating:* \$100	ER Nonparticipating:* \$250
Supplemental Accident: Yes	Maternity: Yes

*After medical deductible

selecthealth. selecthealth.org

Questions? Call Member Services: **801-442-5038 (SLC), 800-538-5038**
Hours: Mon. - Fri. 7:00 a.m. to 8:00 p.m. and Sat. 9:00 a.m. to 2:00 p.m.

Need a healthcare provider? Call SelectHealth Member Advocates:
801-442-4993 (SLC), 800-515-2220

Behavioral Health Advocates: **801-442-1989 (SLC), 800-876-1989**

Outside of Utah? Use MultiPlan or PHCS providers. Call **888-342-7427**

PHCS **MultiPlan**

Life-threatening Emergencies? Covered anywhere. Call Member Services within 48 hours if you use nonparticipating providers or facilities.

THIS CARD DOES NOT GUARANTEE COVERAGE.
P.O. Box 30192, Salt Lake City, UT 84130-0192 BIN: 800008

selecthealth.
PRESCRIPTIONS selecthealthprescriptions.org

JOHN A DOE ID: **800000000**

Pharmacy Benefits

Retail Tier 1: \$5	Maintenance Tier 1: \$5
Retail Tier 2: \$10	Maintenance Tier 2: \$10
Retail Tier 3: \$15	Maintenance Tier 3: \$15

Individual Deductible: None

BIN: 800008

selecthealth.
PRESCRIPTIONS selecthealthprescriptions.org

Questions? Call us at 801-442-4910 (Salt Lake area) or 800-442-3127 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

Participating Pharmacies To get the most from your pharmacy benefits, use a participating pharmacy and present your ID Card when filling a prescription.

Online Tools Log in to our website to locate a participating pharmacy, view copay and benefit information, and find lower cost alternatives to your medications.

THIS CARD DOES NOT GUARANTEE COVERAGE.
P.O. Box 30192, Salt Lake City, UT 84130-0192 BIN: 800008

selecthealth.
ADVANTAGE H1994 002

Member: **JOHN DOE**
Member ID: **800000000**

IN-NETWORK BENEFITS

Medical Ded: None	Urgent Care: \$40
Office PCP/SCP: \$5/\$40	Emergency Room: \$65
Preventive PCP/SCP: \$0/\$0	

Rx BIN: 015938 Rx PCN: 7463
Rx GRP ID: GXXXXXXX

selecthealthadvantage.org

Questions? Call Member Services: **801-442-9900 (SLC), 855-442-9900 (toll-free) TTY: 711**

Need help finding a doctor? Call SelectHealth Member Advocates®: **801-442-4993 (SLC), 800-515-2220**

SelectHealth Pharmacy Services (for pharmacies only):
801-442-9988 (SLC), 855-442-9988 (toll-free)

Send claims to:
P.O. Box 30196, Salt Lake City, UT 84130-0196

SelectHealth Advantage Utah

selecthealth.
ADVANTAGE H1994 002

Member: **JOHN DOE**
Member ID: **800000000**

IN-NETWORK BENEFITS

Medical Ded: None	Urgent Care: \$40
Office PCP/SCP: \$5/\$40	Emergency Room: \$65
Preventive PCP/SCP: \$0/\$0	

Rx BIN: 015938 Rx PCN: 7463
Rx GRP ID: GXXXXXXX

selecthealthadvantage.org

Questions? Call Member Services: **208-429-9900 (Boise), 855-442-9900 (toll-free) TTY: 711**

Need help finding a doctor? Call SelectHealth Member Advocates®: **801-442-4993 (SLC), 800-515-2220**

SelectHealth Pharmacy Services (for pharmacies only):
801-442-9988 (SLC), 855-442-9988 (toll-free)

Send claims to:
P.O. Box 30196, Salt Lake City, UT 84130-0196

3.3 Member Identification Number

The primary cardholder of SelectHealth will receive an ID card which will provide the cardholder's identification number and copayment information. The identification number will appear as follows: 800000000 (example).

- 3.3.1 Individuals enrolled in SelectHealth Community Care will be issued a SelectHealth membership identification card upon enrollment. Cards are reissued when there is a change in benefits or when there is a change in the primary care provider. The Utah Department of Health will continue to issue monthly Medicaid identification cards. Pharmacies should request both the SelectHealth and Medicaid cards when dispensing medication.
- 3.3.2 SelectHealth Community Care claims can be submitted for processing using either the SelectHealth or Medicaid identification number.

3.4 Dependent Coverage

Dependent coverage may include a spouse and/or children. Covered family members are identified by the following Relationship Codes:

- 0 – Not Specified
- 1 – Cardholder
- 2 – Spouse
- 3 – Child
- 4 – Other
- 5 – Student
- 6 – Disabled Dependent
- 7 – Adult Dependent
- 8 – Significant Other

Important note – Use of the correct relationship code is important. Prescription claims must be submitted to SelectHealth only for the eligible member for whom the prescription is written by the prescriber. This requirement has added significance in that DUR reviews are based on claims submitted for the correct eligible member.

3.5 Eligibility Verification

The pharmacy agrees to use an online point-of-sale authorization terminal or host-to-host online link with SelectHealth's system to verify eligibility of covered members. The cardholder's identification number for point-of-sale entry should be obtained from their ID card. These cards are used for identification purpose only and are not a guarantee of coverage.

In the event that eligibility cannot be verified using the above method, the following methods may be used:

- The pharmacy should call the SelectHealth Pharmacy Help Desk for verification of eligibility using the telephone number listed on the identification card. SelectHealth will advise the pharmacy if the patient is eligible.

Members not using a participating pharmacy must pay in full for their prescription(s) and seek reimbursement from SelectHealth.

Members will be reimbursed the discounted amount that the plan would have had to pay to a participating pharmacy for the prescription(s), less the copayment. For Medicare, SelectHealth Advantage will only cover up to a 30-day supply at an out-of-network pharmacy. The member will be reimbursed for covered Part D medications that are covered on the plan's Drug List (formulary) up to the full amount the member paid for the prescription(s), less the copayment.

3.6 Coordination of Benefits

Most SelectHealth plans allow for coordination of benefits (COB) with a member's primary carrier. If a member has an additional prescription benefit plan, the provider should submit the claim to the appropriate payer in accordance with any coordination of benefits requirements. The provider should submit the primary claim to the member's primary payer for adjudication. In some instances, the secondary claim can be electronically submitted to SelectHealth for adjudication. The member may seek reimbursement from SelectHealth for any secondary claims not processed electronically.

3.7 Prescription Costs and Reimbursement

3.7.1 Member Financial Responsibility

When a person presents a SelectHealth ID card to the pharmacy, the ID card may advise of the copayment amount to be collected. Since the pharmacy is submitting the claim via the point-of-sale system, the electronic response to the pharmacy will include a detailed description of the member's financial responsibility.

If the member is questioning the calculated copay or coinsurance amounts returned on the transaction, remind the member that the copay is determined by many factors. The following is a non-inclusive list of items that may affect the copayment or coinsurance being returned:

- Brand vs. Generic Drug
- Quantity Dispensed
- Day Supply Dispensed
- Member Deductible

If a review of the above items still leaves questions for the member regarding their calculated copay, direct the member to contact the SelectHealth Member Services line for assistance.

3.7.2 Reimbursement Rate Questions

If the pharmacy has questions regarding the reimbursement rate of a particular medication, they are welcome to contact the SelectHealth Pharmacy Help Desk for assistance. Additionally, the pharmacy can review the following items that can directly affect the reimbursement rate to ensure the transaction was submitted correctly:

- Quantity Submitted – confirm that the metric quantity of the prescription was submitted correctly

- Day Supply – confirm that the day supply of the prescription was submitted correctly
- DAW Code – confirm that the submitted DAW code accurately reflects the situation

After evaluating the above fields, if all appears to be accurate, call the SelectHealth Pharmacy Help Desk for further assistance.

3.8 Signature Log

The pharmacy will maintain an approved daily signature log which contains a disclaimer verifying the member has received the prescription and authorizes the release of all prescriptions and related information to SelectHealth. The pharmacy will also require the member or the representative who receives the service to sign for all prescriptions dispensed.

3.9 E-prescribing

Electronic prescribing (e-prescribing) is the transmission, using electronic media, of prescription or prescription-related information between a prescriber, dispensing pharmacy, pharmacy benefit manager or health plan, either directly or through an intermediary. E-prescribing should improve quality, safety, efficiency and consumer convenience. As the pharmacy, it is required to submit on the transaction, the Origin Code, to indicate how the prescription was obtained by the pharmacy.

4.0 Dispensing Edits

This section contains information on some of the more common edits applied to the SelectHealth plans.

4.1 Quantity and Day Supply Limits

SelectHealth Commercial and PBM Products and SelectHealth Community Care (Utah State Medicaid)

The following quantity limits will be applied to all transactions processed to SelectHealth:

- Maximum thirty-four (34) day supply of tablets, capsules and liquids to be taken orally.
- Maximum one (1) vial containing no more than fifteen (15) milliliters of any otic or ophthalmic product; if only manufactured in package sizes greater than fifteen (15) milliliters, the smallest package size available from the manufacturer is mandated. One copay will be charged per vial.
- Some products may be limited to an approved quantity per each acute treatment period.

Unless otherwise specified, one copayment will apply for each item dispensed within the limit. There are instances in which exceptions can be made.

Most SelectHealth plans offer a ninety (90) day supply benefit for maintenance medications, if the member and medication meet specific qualifications. The necessary qualifications include that the medication must be approved on the formulary, and the member must have filled the prescription, at the same strength, at least once within the past 180 days. If the pharmacy has questions regarding

eligibility or if a rejection is received when the claim is processed, please contact the Pharmacy Help Desk for assistance.

SelectHealth Advantage (Medicare Part D)

For certain drugs, the Medicare plan may limit the amount of a prescription a member can receive (maximum number of tablets or capsules, etc. per prescription). Asking for an exception may allow for greater quantity dispensed when a medication exceeds the plan limits.

4.2 Refills

The following refill edits will be applied to all transactions processed to SelectHealth:

- Prescriptions cannot be refilled beyond twelve (12) months from the date on which the prescription was written. After the 12 months have lapsed, a new prescription with a new prescription number must be assigned.
- Prescriptions should not be refilled more times than the number specified by the prescriber.
- Additional refills authorized by the prescriber must be documented on the hard copy of the prescription or a new prescription number must be assigned with the refills indicated.
- Changes in dosage or an increase in quantity assigned by the prescriber must be documented on the hard copy prescription or a new prescription number must be assigned with these changes documented.

Pharmacies that do not comply with the above dispensing limitations may be subject to review by the SelectHealth Pharmacy Auditors.

4.3 DAW Codes

The pharmacy is required to bill the correct Dispense as Written (DAW) code corresponding to the prescription. Valid DAW codes are as follows:

DAW Code	Code Description
0	No product selection indicated
1	Substitution not allowed by prescriber
2	Substitution allowed – patient requested product dispensed
3	Substitution allowed – pharmacist selected product dispensed
4	Substitution allowed – generic drug not in stock
5	Substitution allowed – brand drug dispensed as generic
6	Override
7	Substitution not allowed – brand drug mandated by law
8	Substitution allowed – generic drug not available in marketplace
9	Other – not a valid code for SelectHealth

4.4 Compound Prescriptions

Compounded prescriptions must be prepared following good compounding practices as defined by the United States Pharmacopoeia (USP DI-Volume III: Approved Drug Products and Legal

Requirements). The pharmacy will follow USP good compounding practices concerning the following:

- Facility space and equipment
- Source ingredient selection and calculations
- Stability, sterility and beyond-use dating
- Formulation and checklist for acceptable strength, quality and purity
- Compounding log and quality control

Formulation records, compounding logs and quality control records may be subject to review by the SelectHealth Pharmacy Auditors. Claim dollars for compounded prescriptions found not following good compounding practices will be subject to adjustment.

All active ingredients in a compounded prescription must be FDA-approved for human use and must be covered under the member's plan. The SelectHealth Pharmacy Help Desk is available to assist in determining a member's coverage. Dispensing quantity limitations apply to all covered compounded prescriptions. (see *Quantity Dispensed* section)

In accordance with NCPDP version D.0 as mandated by HIPAA 5010, SelectHealth processes multi-ingredient compounds. Each NDC should be included in the compound segment of the transaction. Refer to the SelectHealth payer sheet in appendix A for additional requirements. Compounded prescriptions where the reimbursement due to the pharmacy exceeds \$75.00 will require a review from the SelectHealth Pharmacy Help Desk and an official prior authorization request may be required.

4.5 Restriction Program

SelectHealth Community Care enrollees who inappropriately utilize health care services may be enrolled in the Restriction Program. Enrollees are identified for enrollment through:

- A. Periodic review of patient profiles to identify inappropriate over-utilization of medical providers, urgent care centers, specialists, medications, and/or pharmacies.
- B. Verbal and written reports of inappropriate use of services generated by one or more health care providers regarding the member. These reports are verified through a review of the patient's claim history by Medicaid staff and medical consultants.
- C. Referral from Medicaid staff.

Enrollees in the Restriction Program are informed of the reasons for enrollment, counseled in the appropriate use of health care services, and assigned a Primary Care Provider and a pharmacy. In addition to the SelectHealth Community Care card, enrollees will receive a Utah Medicaid card, which identifies the enrollee as "RESTRICTED" below the eligibility information and above the member's name. These clients must receive all health care services through either the assigned primary care provider, or receive a referral from this primary care to see any other provider. All pharmacy services must be received from the assigned pharmacy. SelectHealth will only pay claims

for services rendered by the providers listed on the card, and by providers from whom the member was appropriately referred. Emergency services are not restricted to assigned providers.

5.0 Appeals and Grievances

SelectHealth Commercial and PBM Products and SelectHealth Community Care (Utah State Medicaid)

Please direct all appeals or grievances concerning claim submission, status, processing and reimbursement, by phone through the SelectHealth Pharmacy Help Desk or Member Services line, or in writing, to:

SelectHealth
Attn: Pharmacy Department
5381 Green Street
Murray, UT 84123
Fax: 801-442-3006

SelectHealth Advantage (Medicare Part D)

A grievance is an escalated complaint from a Medicare member regarding a specific issue as it relates to the service they received. For example, an official grievance is not filed over specific formulary rules or plan costs, but rather would be related to the timeliness of filling a prescription or if the member received other poor service. Members are welcome to contact SelectHealth through the Medicare Member Services line, fax line or through mail.

An appeal is a request a member may make for reconsideration of our determination on a service, supply or drug a member has received or requested. A member may file an appeal whenever they believe that the services or supplies should be covered or that those services or supplies should be covered differently than SelectHealth Advantage approved or paid them.

6.0 Audit Information

SelectHealth regularly monitors and audits pharmacy claims. Part of this process is accomplished by the pharmacy providing access at reasonable times upon request by either SelectHealth or their designee or any governmental regulatory agency to inspect the facilities, equipment, books and records of the pharmacy. This includes, but is not limited to, member records and all prescription dispensing records. A notice will be sent to the pharmacy location that has filled the prescription(s) in question. A description of the issue under review will be included, along with specific claim related information.

The pharmacy is given between fourteen (14) and thirty (30) days from the date of the letter to respond, depending on the scope of the audit. If a response is not received within this period, this will be interpreted as non-compliance and the pharmacy is subject to adjustment of the paid dollars on those claims.

Additionally, when billing discrepancies are identified by SelectHealth and are disclosed to the pharmacy, the pharmacy is given fourteen (14) days to review/dispute the findings. If a response is not received within this time period, this will be interpreted as consent to the finding and the adjustments will be reflected on the pharmacy's next remittance cycle.

When necessary, extensions will be granted if the pharmacy contacts SelectHealth within the specified time period.

7.0 Formulary Information

7.1 SelectHealth Commercial, PBM Products and SelectHealth Community Care (Utah State Medicaid)

Covered Medications and Services

Covered prescription drugs and pharmacy services include most medications which require a prescription by state or federal law when prescribed by a physician and listed on the SelectHealth drug formulary. Among other medications, this includes the following items:

- Injectable insulin and insulin syringes when written on a prescription
- Compounded medications that are prepared following good compounding practices as defined by the United States Pharmacopoeia (USP DI-Volume III: Approved Drug Products and Legal Requirements). (see *Compound Prescriptions* section)
- Oral contraceptives (plan specific)
- Blood glucose test strips
- Flu Vaccine

Covered Injectable Medications

The following injectable medications are covered under the SelectHealth pharmacy benefit and can be processed and dispensed from retail pharmacies. This list may change with the introduction of new drugs, new therapies or other factors.

- Blood Modifiers
 - Heparin
 - Low Molecular Weight Heparin (Lovenox)
- Hormones
 - Glucagon
 - Insulin
- Miscellaneous
 - Epinephrine (Epipen)
 - Sumatriptan (Imitrex)

Depending on the pharmacy and the individual member's benefits, certain Tier 4 Specialty benefits may allow for additional injectable medications to be dispensed and processed under the member's pharmacy benefit. For specific questions regarding this eligibility, please contact the SelectHealth Pharmacy Help Desk for assistance.

Generally Excluded Medications and Services

Most prescription drugs for covered medical conditions are covered by the prescription drug benefits. However, unless noted otherwise in plan documents or preauthorized as an exception by the plan, the following drugs are not covered under the prescription drug benefit, but may be covered elsewhere under the medical benefit.

- All non-prescription contraceptive jellies, ointments, foams and/or devices, such as IUDs
- Appetite suppressants and weight loss medications
- Certain off-label drug usage, unless the use has been approved by a SelectHealth Medical Director or clinical pharmacist
- Compound drugs when alternative products are available commercially
- Cosmetic agents, health or beauty aids or prescriptions used for cosmetic purposes, including minoxidil for hair growth
- DMSO (dimethyl sulfoxide)
- Drugs or medicines delivered or administered to the member by the prescriber or the prescriber's staff
- Drugs or medicines purchased and received prior to the member's effective date of coverage or subsequent to the member's termination of coverage
- Food supplements, food substitutes, medical foods and formulas (covered only when preauthorized for members with amino acid disorders)
- Human growth hormone (unless preauthorized as medically necessary)
- Immunizing agents, injectables, biological sera, blood or blood plasma, or medications prescribed for parenteral use or administration
- Infertility medications
- Medication not requiring a prescription, even if ordered by a participating provider by means of a prescription, medications prescribed by a physician or referral specialist who is not a participating provider with SelectHealth, drugs which are not medically necessary or which are used inappropriately
- Medication which may be properly received without charge under local, state or federal programs or which are reimbursable under other insurance including Worker's Compensation
- Medications not meeting the minimum levels of evidence based upon Food and Drug Administration (FDA) approval and/or DrugDex level 2A strength of recommendation and National Comprehensive Cancer Network (NCCN) category 2A, if applicable
- Medications to be taken or administered to the eligible member while he or she is a patient in a hospital, rest home, nursing home, sanitarium or other institution
- Minerals, fluoride, vitamins (other than prenatal for use during pregnancy or nursing)
- Nicotine and smoking cessation medications, except in conjunction with a SelectHealth-sponsored smoking cessation program
- Nonprescription vitamins
- Over-the-counter (OTC) medications, except when *all* of the following conditions are met:
 - The OTC medication is listed on the SelectHealth formulary as a covered medication
 - The SelectHealth Pharmacy & Therapeutics Committee has approved the OTC medication as a medically appropriate substitution of a prescription drug or medication

- The member has obtained a prescription for the OTC medication from a licensed provider and filled the prescription at a participating pharmacy
- Prescriptions written by a licensed dentist, unless for the prevention of infection or pain in conjunction with a dental procedure
- Progesterone suppositories and progesterone powder (micronized progesterone), except when prior authorized during pregnancy or other FDA-approved use
- Therapeutic devices or appliances including hypodermic needles, syringes, support garments and other non-medicinal substances (except insulin syringes, glucose test strips, inhaler extensions)

7.2 SelectHealth Advantage (Medicare Part D)

Covered Medications and Services

The SelectHealth formulary for the Medicare Advantage plan has four tiers with coverage of most Part D generic drugs and most Part D brand drugs.

Any injectable medication considered part of the Medicare Part D benefit, will be eligible for processing under the member's pharmacy benefit.

Generally Excluded Part D Medications

Non-Part D drugs, including prescription drugs covered by Part A or part B and other drugs excluded from coverage by Medicare.

Diabetic Supplies

Lancets and Test Strips, through part of the Medicare Part B benefit, will be allowed to process at the pharmacy through the POS.

Step Therapy

SelectHealth Advantage requires Step Therapy for certain drugs. This means that certain drugs are covered by the plan only after the member has tried the alternative therapy without success.

Exceptions and Coverage Determinations

At any time, a member may request a coverage determination or an exception to a prior authorization requirement or other edit imposed by the Medicare Part D plan. The individual member, member's representative, the prescribing physician or other prescriber may initiate the exception request. Common reasons a prior authorization or exception is requested are as follows:

- Request for coverage of a drug that requires prior authorization
- Request for coverage of a drug that is not covered on the plan's formulary
- Request to bypass step therapy or quantity limit restrictions
- Request to cover a drug at a lower tier

If an exception is approved, our approval usually is valid until the end of the plan year. This is true as long as the doctor continues to prescribe the drug for the member and that drug continues to be safe and effective for treating the member's condition.

There is no guarantee that a request for exception will be granted. Each request will be evaluated individually based on the situation at hand.

Part B and Part D Coverage Overlap

Drugs that are eligible under a member's Medicare Part B coverage are not eligible for coverage under the Part D plan. The determination for under which plan a drug will be covered is not just determined by the drug itself, but also its indication and administration. Medicare Part B covers a limited list of specific drugs including injectable and infusible drugs that are not usually self-administered. Edits will be applied in the SelectHealth system to manage these rules at adjudication.

Exceptions to Plan Coverage

Exceptions to SelectHealth Advantage Plan coverage include any pharmacy claims processed from a foreign pharmacy. Claims processed at pharmacies outside the United States will not be paid through the SelectHealth Medicare Advantage program.

8.0 Common Reject Messages

52: Non Matched Cardholder ID

SelectHealth requires a valid cardholder ID to be submitted in order to verify eligibility and process claims. The ID number is the 9-digit subscriber ID number which can be found on the member's ID card. If the member's ID number or the member's date of birth is submitted incorrectly, the pharmacy will receive the Non Matched Cardholder ID rejection. When received, the pharmacy should contact the SelectHealth Help Desk to verify the correct information and for assistance in processing.

56: Non Matched Prescriber ID

SelectHealth requires a valid NPI number for prescriber identification. SelectHealth relies on the pharmacy for submission of accurate information. Some plans require that the prescribing physician participate in the SelectHealth physician network in order for a medication to be covered.

70: Product/Service Not Covered

The Product/Service Not Covered error message may appear for a member with a formulary requirement. If this is the case, the online system will not return financial information and the prescription will not be reimbursed by SelectHealth. SelectHealth members have the following options should this rejection be received:

- Consult with the prescribing physician to discuss formulary alternatives prior to having the prescription filled
- Pay in full for the non-covered medication and discuss formulary alternatives for future fills (this is not reimbursable)

- Pay in full for the non-covered medication
- Contact the Select Health Member Services line for assistance in determining prescription benefit coverage

The Product/Service Not Covered reject message may appear as an advisory message for covered members with an increased copay amount for non-formulary items. If this is the case, the online system will return an increased copay which should be collected from the member.

Pharmacists may also contact the member's prescribing physician to discuss formulary alternatives and/or formulary exception requests, which can be initiated by the prescribing physician.

Please note that if the member pays in full for the non-covered medication, SelectHealth does not guarantee that reimbursement will be made, either retroactively or for future fills.

75: Prior Authorization Required

There are certain medications that SelectHealth requires prior authorization before the medication can be dispensed to the member. When this rejection is received, the pharmacy should contact the SelectHealth Help Desk to begin the prior authorization process started. The SelectHealth Prescription Drug List (PDL) notates the medications that require prior authorization with a "(PA)" in the "Spec. Requirements" column. For the most up-to-date drug information, access the PDL through the SelectHealth website.

76: Plan Limitations Exceeded

The Plan Limitations Exceeded rejection could occur for a variety of reasons including the following most common:

- Over Quantity Limits
 - This could be caused by a dose optimization issue which would require the prescribing physician's office to change to a different strength of the same medication
 - Alternatively, the prescribing physician can send into SelectHealth a Letter of Medical Necessity (LMN) for review as originally prescribed
 - As a final option, the pharmacy can resubmit the prescription for the amount SelectHealth will allow
- Cost Exceeds Maximum
 - SelectHealth applies a max cost per prescription of \$750; in most instances when this reject is received for exceeding the max cot edit, the pharmacy can call the SelectHealth Help Desk for an override
 - Compound medications have a different cost edit of \$75 per prescription; in many cases, a compound medication will require a LMN from the prescribing physician in order to obtain the necessary cost override

79: Refill Too Soon

SelectHealth applies an edit for refilled medications that require that the medication be 75% gone before a refill can be allowed, for most plans. For controlled substances the edit requires that the medication be 80% gone before a refill can be allowed.

The table below outlines the common reasons a rejection of Refill Too Soon may be received. Contact the SelectHealth Pharmacy Help Desk for additional information or assistance if any of the following situations occur:

Reason for Refill	Authorization Required?
Prescriber has changed the directions	Yes
Incorrect day supply was submitted initially	Yes
Mail order supply has not yet arrived	Yes, if certain criteria are met
Supply needed for vacation	Yes, if certain criteria are met
Patient has lost the prescription	No, patient must pay for the replacement supply
Medication was stolen or destroyed	No, patient must pay for the replacement supply
Patient is attempting to refill early	No, patient must pay for the replacement supply or wait until appropriate time has passed

88: DUR Reject Error

There are several situations that could cause a DUR Reject Error. Below are the most common examples:

- Step Therapy
 - SelectHealth applies Step Therapy edits to certain medications, which will require qualifying medication(s) before SelectHealth will cover the one that is rejecting. If those step therapy rules have not been met, the pharmacy will receive this rejection.
- Multiple Long Acting ADHD Agents
 - Certain ADHD medications required a LMN from the prescribing physician along with prior authorization before the medication will be allowed to process.

9.0 Payment and Reconciliation Information

9.1 Payment Schedule

SelectHealth Commercial and PBM Products and SelectHealth Community Care (Utah State Medicaid)

For reimbursement to the pharmacies, payment cycles are run every two (2) weeks. Checks will be disbursed within fifteen (15) working days of the end of the cycle and will be mailed to the pharmacy.

9.2 Remittance Report

Each payment to the pharmacy will be accompanied by one copy of the Pharmacy Claims Reconciliation Report. This report will provide a detailed list of all claims submitted during the current cycle for each pharmacy and will provide totals for the reconciliation or the payment amount. This report will include all paid and reversed claims for the current processing cycle. As an alternative format, the report can also be made available in 835 format on a CD that can be mailed to the pharmacy in place of the paper remittance report.

Additional copies of the Claims Reconciliation Summary Report may be obtained by request from the SelectHealth Pharmacy Help Desk. There will be a charge per additional copy requested. Questions regarding the payment cycle and remittance files should be directed to the Pharmacy Help Desk.

10.0 SelectHealth Advantage (Medicare Part D) Specific Information

10.1 Plan Summary

SelectHealth's Medicare plan is an MA-PD plan that covers parts of Utah and Idaho. The plan is committed to following CMS guidelines and ensuring access to necessary medications while working closely with the pharmacies to provide the best customer experience possible.

10.2 Fraud, Waste and Abuse

It is expected that the provider agrees to adhere to the CMS Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse, and Part D Sponsors' policies and procedures, training and corrective action plans related to the program. Cooperation with the Part D Plan Sponsor includes providing copies of prescriptions, signature logs and other related documentation to assist in any investigations.

10.3 Training

In order to be considered a pharmacy in compliance with Medicare Part D rules and regulations, pharmacies must agree under CMS guidelines to provide ongoing Medicare Part D training and documentation to its staff. As part of the audit process with SelectHealth, copies of this training and record of the staff receiving the training may be required to be produced, as needed.

10.4 Pharmacy Certification for Part D

In order to process Medicare part D claims for SelectHealth, pharmacies are required to sign a specific Medicare contract addendum. If not signed, any Medicare claims processed to SelectHealth will be rejected at POS.

10.5 Federal Health Care Programs Participation Exclusion

Veterans' Administration benefits are separate and distinct from benefits provided under Part D. A beneficiary may not use both VA prescription drug benefits and Part D benefits for a single prescription.

10.6 General Procedures for Acknowledgement Letters

In order to be in compliance with CMS requirements, if a member should present a Part D acknowledgement letter in place of an ID card, the pharmacy should honor that letter as sufficient eligibility to process a claim to SelectHealth for their Medicare Part D benefit. If the presented letter does not contain sufficient information to process a claim to SelectHealth, please contact the SelectHealth Medicare Part D Help Desk for assistance in processing.

10.7 Formulary Transition Fill Plan

In accordance to the transition plan requirement from CMS, SelectHealth will offer short-term coverage for Part D benefits to members that are new to the plan. During this transition period a member is able to receive an initial fill of an ongoing medication even if it is not covered under the new Medicare Part D plan (including if it requires prior authorization or step therapy). It is assumed that during this transition period, the member will be working with their physician to identify alternative equivalent medications that are covered under the plan.

10.8 Long-term Care Facilities

For Long-term Care facilities to process Medicare Part D claims to SelectHealth, the pharmacy is required to sign a specific LTC Medicare contract addendum. If not signed, any Medicare claims processed to SelectHealth will be rejected at POS.

10.9 Home Infusion Therapy

For Home Infusion pharmacies to process Medicare Part D claims to SelectHealth, the pharmacy is required to sign a specific Home Infusion Medicare contract addendum. If not signed, any Medicare claims processed to SelectHealth will be rejected at POS.

10.10 Medicare Service Area

The SelectHealth Medicare Advantage program covers the following service areas:
The following counties in Utah – Davis, Iron, Morgan, Salt Lake, Utah, Washington, Weber
The following counties in Idaho – Ada, Boise, Canyon, Cassia, Jerome, Minidoka, Twin Falls

Appendices

Appendix A – Payer Sheet

General Information

Payer Name: SelectHealth, Inc.	Date: 10/01/2011	
Plan Name/Group Name:	BIN:	PCN:

SelectHealth Commercial	800008	Not required
SelectHealth Medicare**	015938	7463
SelectHealth Medicaid	800008	606
Effective as of: 1/1/2012	NCPDP Telecommunication Standard Version/Release #: D.0 ECL version: June 2010	
Certification Testing Window: 10/01/2011 – 12/31/2011		
Certification Contact Information: Levi Richins (801) 442-7966 or RX_BA@selecthealth.org		
Provider Relations Help Desk Info: Nathan Maples (801) 442-7815		
Other Contact Information: SelectHealth Help Desk (801) 442-4912 or (800) 442-3129 or SelectHealth Medicare Help Desk (801) 442-9988 or (855)-442-9988. Hours of Operation: 24 hours a day, 7 days a week		
Maximum Number of Transactions Supported per Transmission	4	
Submission and Reversal Window (days from date filled/dispensed to date submitted)	45 Days If an exception is needed please contact the SelectHealth Help Desk at the numbers listed above	

Other Supported Versions And Transactions

NCPDP version 5.1 will continue to be supported as described to the right.	Claim Type	Last Submission Date Allowed
	B1 (billing), B3 (rebilling)	12/31/2011
	B2 (reversal)*	12/31/2012
	*Rx Number padding was used in the submission of NCPDP version 5.1 claims. For example, if Rx Number 1234 was submitted, it was padded to become 0001234 (a seven-character field). D.0 claims will not be padded. Please be advised of this when submitting and reversing claims.	
Transaction Code	Transaction Name	
E1	Eligibility Inquiry	
B2	Reversals	

The following table lists the segments available in a Billing Transaction. The table also lists values as defined under NCPDP Version D.0 for your reference. Other fields are required as noted:

Payer Usage Column	Value	Explanation	Payer Situation Column
Mandatory	M	The Field is mandatory for the Segment in the designated Transaction. This is in accordance with NCPDP Telecommunication Implementation Guide, Version D.0.	No
Required	R	Required as defined by the Processor	No
Qualified requirement	RW	Required When as defined by the situation	Yes

Segment and Field Requirements

The following lists the segments and fields in a Billing Transaction for the NCPDP Telecommunication Standard Implementation Guide Version D.0.

Fields that are not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the template.

Please note the payer requirement is considered to be the same as stated the Imp Guide statement of the Payer Situation unless otherwise noted.

Transaction Header Segment Questions		Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is not used		X	
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Payer Usage</i>	<i>Value/Comments</i>
1Ø1-A1	BIN Number	M	800008
1Ø2-A2	Version/Release Number	M	DØ
1Ø3-A3	Transaction Code	M	B1, B3
1Ø9-A9	Transaction Count	M	01= 1 occurrence 02= 2 occurrences 03= 3 occurrences 04= 4 occurrences
2Ø2-B2	Service Provider ID Qualifier	M	01 NPI
2Ø1-B1	Service Provider ID	M	10 digit NPI number
4Ø1-D1	Date of Service	M	CCYYMMDD
11Ø-AK	Software Vender/Certification ID	M	Use value for Switch's requirements or send spaces

Insurance Segment Questions		Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		X	
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Payer Usage</i>	<i>Value/Comments</i>
111-AM	Segment Identification	M	04- Insurance Segment
3Ø2-C2	Cardholder Id	M	The SelectHealth cardholder ID is a 9 character ID that begins with 800
312-CC	Cardholder First Name	R	
313-CD	Cardholder Last Name	R	
3Ø3-C3	Person Code	R	Submit only if instructed by Help Desk.
3Ø6-C6	Patient Relationship Code	R	
36Ø-2B	Medicaid Indicator	RW	Required if known, when patient has Medicaid coverage.
115-N5	Medicaid Id Number	RW	Required if known, when patient has Medicaid coverage.

Patient Segment Questions		Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		X	
Field #	NCPDP Field Name	Payer Usage	Value/Comments
111-AM	Segment Identification	M	01- Patient Segment
331-CX	Patient Id Qualifier	M	04- Health Plan Assigned
332-CY	Patient Id	M	
3Ø4-C4	Date Of Birth	R	
3Ø5-C5	Patient Gender Code	R	1=Male 2=Female
31Ø-CA	Patient First Name	R	
311-CB	Patient Last Name	R	

Claim Segment Questions		Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		X	
This payer does not support partial fills		X	Pharmacies should reverse and reprocess initial claim when they have satisfied the requirements as written on the prescription.
Field #	NCPDP Field Name	Payer Usage	Value/Comments
111-AM	Segment Identification	M	07- Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	M	1 = Rx Billing
4Ø2-D2	Prescription/Service Reference Number	M	
436-E1	Product/Service Id Qualifier	M	03- National Drug Code (NDC)
4Ø7-D7	Product/Service Id	M	NDC Number
442-E7	Quantity Dispensed	R	
4Ø3-D3	Fill Number	R	0 = Original Dispensing 1-99= Refill Number
4Ø5-D5	Days Supply	R	
4Ø6-D6	Compound Code	R	1- Not a Compound 2- Compound

408-D8	Dispense As Written (Daw)/Product Selection Code	R	
414-DE	Date Prescription Written	R	CCYYMMDD
415-DF	Number Of Refills Authorized	R	
419-DJ	Prescription Origin Code	R	<p>1- Written- Prescription obtained via paper from the provider.</p> <p>2- Telephone- Prescription obtained via oral instructions or interactive voice response (IVR) using a telephone.</p> <p>3- Electronic- Prescription obtained via secure messaging protocols sent over the internet (SCRIPT or HL7 Standard transactions). Excludes fax, e-mail, inner-clinic messaging system, or a physician printing to a printer at the pharmacy.</p> <p>4- Facsimile (fax)- Prescription obtained via transmission using a fax machine.</p> <p>5- Pharmacy- This value is used to cover any situation where a new prescription needs to be created from an existing valid prescription such as traditions transfers, intra-chain transfers, file buys, software upgrades/migrations, and any reason necessary to “give it a new number”.</p>
308-C8	Other Coverage Code	RW	Required only for select groups that allow on-line COB claim processing.
453-EJ	Originally Prescribed Product/Service Id Qualifier	RW	Required when medication was changed from the original script
445-EA	Originally Prescribed Product/Service Code	RW	Required if submitting a claim that replaces an originally prescribed product/service
446-EB	Originally Prescribed Quantity	RW	Required if submitting a claim that replaces an originally prescribed product/service

Pricing Segment Questions		Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		X	
Field #	NCPDP Field Name	Payer Usage	Value/Comments
111-AM	Segment Identification	M	11- Pricing Segment

409-D9	Ingredient Cost Submitted	R	
412-DC	Dispensing Fee Submitted	R	
481-HA	Flat Sales Tax Amount Submitted	RW	Required when provider is claiming sales tax and if it's value has an effect on the Gross Amount Due (430-DU) calculation
482-GE	Percentage Sales Tax Amount Submitted	RW	Required when provider is claiming sales tax and if it's value has an effect on the Gross Amount Due (430-DU) calculation
483-HE	Percentage Sales Tax Rate Submitted	RW	Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).
484-JE	Percentage Sales Tax Basis Submitted	RW	Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).
426-DQ	Usual and Customary Charge	M	
430-DU	Gross Amount Due	R	
423-DN	Basis of Cost Determination	R	01- AWP 07- U&C 10- ASP 12- WAC

Pharmacy Provider Segment Questions		Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		X	
Field #	NCPDP Field Name	Payer Usage	Value/Comments
111-AM	Segment Identification	M	02- Pharmacy Provider Segment
465-EY	Provider Id Qualifier	R	
444-E9	Provider Id	R	

Prescriber Segment Questions		Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		X	
Field #	NCPDP Field Name	Payer Usage	Value/Comments
111-AM	Segment Identification	M	03- Prescriber Segment
466-EZ	Prescriber Id Qualifier	R	01- NPI (Preferred) 12- DEA
411-DB	Prescriber Id	R	

427-DR	Prescriber Last Name	R	
--------	----------------------	---	--

Coordination of Benefits/Other Payments Segment Questions		Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is situational		X	Required only for secondary, tertiary, etc claims. On-line COB is only supported by selected groups. SelectHealth intends to roll this out on a larger scale in 2012.
Field #	NCPDP Field Name	Payer Usage	Value/Comments
111-AM	Segment Identification	M	05- Coordination of Benefits/Other Payments Segment
337-4C	Coordination Of Benefits/Other Payments Count	M	Maximum count of 9.
338-5C	Other Payer Coverage Type	M	01- Primary 02- Secondary 03- Tertiary
339-6C	Other Payer Id Qualifier	R	03- BIN
340-7C	Other Payer Id	R	BIN
443-E8	Other Payer Date	R	
341-HB	Other Payer Amount Paid Count	RW	Maximum count of 9. Value (greater than zero) required when OCC = 2 or 4. Value must be blank/null when OCC=3. Value allowed but not required when OCC = 8 Required when Other Payer Amount Paid (431-DV) is specified.
342-HC	Other Payer Amount Paid Qualifier	RW	Required when Other Payer Amount Paid (431-DV) is specified.

431-DV	Other Payer Amount Paid	RW	<p>Required when Other Payer Amount Paid Count (341-HB) is specified.</p> <p>Value of the sum of all payers should be greater than zero when OCC=2; zero when OCC= 4; greater than or equal to zero when OCC= 8; blank/null when OCC=3.</p>
471-5E	Other Payer Reject Count	RW	<p>Maximum count of 5. Required when claim has been rejected by previous payer(s) and the Other Payer Reject Code (472-6E) is specified.</p> <p>Value should be blank/null when OCC=2, 4, or 8; greater than zero when OCC=3.</p>
472-6E	Other Payer Reject Code	RW	<p>NCPDP Reject Code required when the other payer has denied the payment for the billing (471-5E), designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered).</p>
353-NR	Other Payer-Patient Responsibility Amount Count	RW	<p>Maximum count of 25.</p> <p>Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.</p> <p>Required if Other Payer-Patient Responsibility Amount (352-NQ) is specified.</p> <p>Allowed if OCC=2; not allowed if OCC=3; required if OCC=4 or 8.</p>
351-NP	Other Payer-Patient Responsibility Amount Qualifier	RW	<p>Ø1 –Ø5 Ø7 -13</p> <p>Components of Patient Pay are required. Usage of Ø6 “Patient Pay as Reported by Previous Payer” accepted as an exception and subject to audit.</p> <p>Required if Other Payer-Patient Responsibility Amount (352-NQ) is specified.</p>

352-NQ	Other Payer-Patient Responsibility Amount	RW	<p>Required if necessary for patient financial responsibility only billing.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p>Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted.</p> <p>Required if Other Payer-Patient Responsibility Amount Count (353-NR) is specified.</p>
--------	---	----	---

The COB segment and all required fields must be sent if the Other Coverage Code (3Ø8-C8) = 2, 3, 4, or 8.

Note: When Other Coverage Code (3Ø8-C8) = 2 (Other Coverage Exists – payment collected), fields 341-HB, 342-HC and 431-DV are required.

When Other Coverage Code (3Ø8-C8) = 8 (Claim is billing for patient financial responsibility only), fields 353-NR, 351-NP and 352-NQ are required.

Compound Segment Questions		Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>																
This Segment is situational		X	Only required for submission of a compound claims (Field 406-D6 = 2)																
Field #	NCPDP Field Name	Payer Usage	Value/Comments																
111-AM	Segment Identification	M	10- Compound Segment																
45Ø-EF	Compound Dosage Form Description Code	M	<table> <tr> <td>01- Capsule</td> <td>11- Solution</td> </tr> <tr> <td>02- Ointment</td> <td>12- Suspension</td> </tr> <tr> <td>03- Cream</td> <td>13- Lotion</td> </tr> <tr> <td>04- Suppository</td> <td>14- Shampoo</td> </tr> <tr> <td>05- Powder</td> <td>15- Elixir</td> </tr> <tr> <td>06- Emulsion</td> <td>16- Syrup</td> </tr> <tr> <td>07- Liquid</td> <td>17- Lozenge</td> </tr> <tr> <td>10- Tablet</td> <td>18- Enema</td> </tr> </table>	01- Capsule	11- Solution	02- Ointment	12- Suspension	03- Cream	13- Lotion	04- Suppository	14- Shampoo	05- Powder	15- Elixir	06- Emulsion	16- Syrup	07- Liquid	17- Lozenge	10- Tablet	18- Enema
01- Capsule	11- Solution																		
02- Ointment	12- Suspension																		
03- Cream	13- Lotion																		
04- Suppository	14- Shampoo																		
05- Powder	15- Elixir																		
06- Emulsion	16- Syrup																		
07- Liquid	17- Lozenge																		
10- Tablet	18- Enema																		
451-EG	Compound Dispensing Unit Form Indicator	M	1- Each 2- Grams 3- Milliliters																
447-EC	Compound Ingredient Component Count	M	Maximum 25 ingredients. This count must match the submitted number of repetitions.																
488-RE	Compound Product Id Qualifier	M	03 - NDC																

489-TE	Compound Product Id	M	Component NDC(s) of compound mixture
448-ED	Compound Ingredient Quantity	M	Amount expressed in metric decimal units
449-EE	Compound Ingredient Drug Cost	R	
490-UE	Compound Ingredient Basis Of Cost Determination	R	
362-2G	Compound Ingredient Modifier Code Count	R	Maximum count of 10.
363-2H	Compound Ingredient Modifier Code	R	

Clinical Segment Questions		Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is situational		X	Only required for a few select groups and only on select drug classes
Field #	NCPDP Field Name	Payer Usage	Value/Comments
111-AM	Segment Identification	M	13- Clinical Segment
491-VE	Diagnosis Code Count	R	Maximum count of 5.
492-WE	Diagnosis Code Qualifier	R	
424-DO	Diagnosis Code	R	

**Medicare specific information will be available in 3rd quarter 2012.