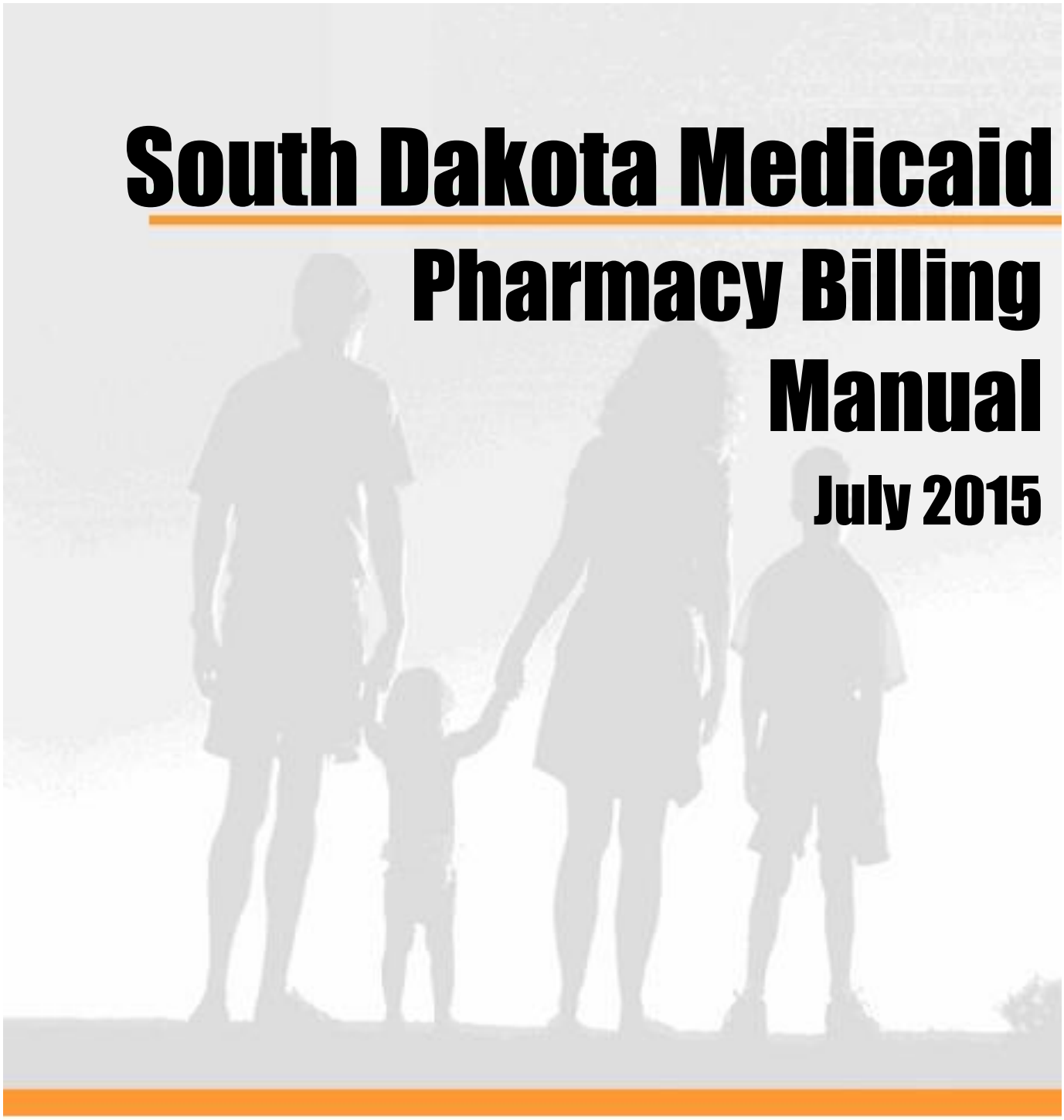
South Dakota Medicaid Pharmacy Billing Manual

July 2015



DSS

Strong Families - South Dakota's Foundation and Our Future

Important Contact Information

<table>
<tr><td colspan="2">Telephone Service Unit for Claim Inquiries
In State Providers: 1-800-452-7691
Out of State Providers: (605) 945-5006</td></tr>
<tr><td colspan="2">Provider Response for Enrollment and Update Information
1-866-718-0084
Provider Enrollment Fax: (605) 773-8520
Email: SDMEDXGeneral@state.sd.us</td></tr>
<tr><td colspan="2">Prior Authorizations
Pharmacy Prior Authorizations: 1-866-705-5391
Medical and Psychiatric Prior Authorizations: (605) 773-3495</td></tr>
<tr><td>Dental Claim and Eligibility Inquiries
1-800-627-3961</td><td>Recipient Premium Assistance
1-888-828-0059</td></tr>
<tr><td>Managed Care and Health Home Updates
(605) 773-3495</td><td>SD Medicaid for Recipients
1-800-597-1603</td></tr>
<tr><td colspan="2">Medicare
1-800-633-4227</td></tr>
<tr><td colspan="2">Division of Medical Services
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
Division of Medical Services Fax: (605) 773-5246</td></tr>
<tr><td colspan="2">Medicaid Fraud</td></tr>
<tr><td>Welfare Fraud Hotline: 1-800-765-7867

File a Complaint Online:
http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx</td><td>OFFICE OF ATTORNEY GENERAL
MEDICAID FRAUD CONTROL UNIT
Assistant Attorney General Paul Cremer
1302 E Hwy 14, Suite 4
Pierre, South Dakota 57501-8504
PHONE: 605-773-4102 FAX: 605-773-6279
EMAIL:
ATGMedicaidFraudHelp@state.sd.us</td></tr>
<tr><td colspan="2">Join South Dakota Medicaid’s listserv to receive important updates and guidance from the Division of Medical Services:
http://www.dss.sd.gov/medicaid/contact/ListServ.aspx</td></tr>
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INTRODUCTION

This manual is one of a series published for use by medical services providers enrolled in South Dakota Medicaid. It is designed to be readily updated by replacement or addition of individual pages as necessary. It is designed to be used as a guide in preparing claims, and is not intended to address all South Dakota Medicaid rules and regulations. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing South Dakota Medicaid in Article § 67:16.

Problems or questions regarding South Dakota Medicaid rules and policies as well as claims, covered services, and eligibility verification should be directed to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

Problems or questions concerning recipient eligibility requirements can be addressed by the local field Division of the Department of Social Services in your area or can be directed to:

Department of Social Services
Division of Economic Assistance
700 Governors Drive
Pierre, SD 57501-2291
PHONE: (605) 773-4678

Medicare is a separately administered federal program and questions concerning Medicare cannot be answered by South Dakota Medicaid Program personnel.

CHAPTER I:
GENERAL INFORMATION

The purpose of the Medicaid Program (Title XIX) is to assure the availability of quality medical care to low-income individuals and families through payments for a specified range of services. The Medicaid program was implemented in South Dakota in 1967.

Funding and control of Medicaid are shared by federal and state governments under Title XIX of the Social Security Act; regulations are written to comply with the actions of Congress and the State Legislature.

A brief description of general information about the Medicaid program is provided in this manual. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing Medicaid in Article § 67:16.

PROVIDER RESPONSIBILITY

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a ten (10) digit National Provider Identification (NPI) number. This number should be included on all correspondence with the Department of Social Services.

ENROLLMENT

Providers, who render one or more services covered under the Medicaid Program, and who wish to participate in the Medicaid Program, must become an enrolled provider. The provider must complete an online enrollment application, comply with the terms of participation, as identified in the agreement and requirements, stated in Administrative Rules of South Dakota ARSD § 67:16 which govern the Medicaid Program, and sign a Provider Agreement. Failure to comply with these requirements may result in monetary recovery, or civil or criminal action.

An individual (i.e. consultant, staff, etc.) who does not have a provider agreement, but who furnishes a covered service to a recipient under your provider agreement and receives payment or benefits indirectly from the Department of Social Services, is also subject to the rules, regulations and requirements of the South Dakota Medicaid Program.

Participating providers agree to accept Medicaid payment as payment in full for covered services. The provider must NOT bill any of the remaining balance to the recipient, their family, friends or political subdivisions.

ENROLLMENT RECORD MAINTENANCE

It is the provider's responsibility to maintain their enrollment record to accurately reflect their business practices and status as a health care provider. This includes, but is not limited to, addresses, licensure (entity & practitioner level), payment details, ownership and controlling

interests, billing agent/clearinghouse relationships, exclusionary status, and individual participation (if individual leaves practice, must end date on enrollment record).

LICENSING CHANGE

A participating provider must update their SD MEDX enrollment record to show the provider's licensing or certification status within ten days after the provider receives notification of a change in status. This includes updates to license expiration. If a provider's licensure ends due to choice, death, disciplinary action, or any other reason, there must also be an email notification to SDMEDXGeneral@state.sd.us outlining the reason for the provider's closure.

TERMINATION OF AGREEMENT

When a provider agreement has been terminated, the Department of Social Services will not pay for services provided after the termination date. Pursuant to ARSD § 67:16:33:04, a provider agreement may be terminated for any of the following reasons:

- The agreement expires
- The provider fails to comply with conditions of the signed provider agreement or conditions of participation
- The ownership, assets, or control of the provider's entity are sold or transferred
- Thirty days elapse since the department requested the provider to sign a new provider agreement
- The provider requests termination of the agreement
- Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement
- The provider is convicted of a criminal offense that involves fraud in any state or federal medical assistance program
- The provider is suspended or terminated from participating in Medicare
- The provider's license or certification is suspended or revoked
- The provider fails to comply with the requirements and limits of this article
- Inactivity

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity, or who plans to obtain a new FEIN, must provide DSS Medical Services Provider Enrollment notice of the pending sale or transfer at least 30 days before the effective date. This can be done via email to SDMEDXGeneral@state.sd.us. In a change of ownership, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. This responsibility may be transferred to the buyer through a sales contract or written agreement. The South Dakota Medicaid Provider Agreement is NOT transferable to the new owner. The new owner must apply to become a South Dakota Medicaid provider and sign a new provider agreement before claims can be submitted.

RECORDS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least six (6) years after the last date a claim was paid or denied. Records must not be destroyed when an audit or investigation is pending.

Providers must grant access to these records to agencies involved in Medicaid review or investigations.

THIRD PARTY LIABILITY

SOURCES

Third-party liability is the payment source or obligation, other than Medicaid, for either partial or full payment of the medical cost of injury, disease, or disability. Payment sources include Medicare, private health insurance, worker's compensation, disability insurance, and automobile insurance.

PROVIDER PURSUIT

Because South Dakota Medicaid is the payer of last resort, the provider must pursue the availability of third-party payment sources.

CLAIM SUBMISSION TO THIRD-PARTY SOURCE

The provider must submit the claim to a third-party liability source before submitting it to Medicaid except in the following situations:

- Prenatal care for a pregnant woman
- HCBS waiver services
- Services for early and periodic screening, diagnosis, and treatment provided under ARSD § 67:16:11, except for psychiatric inpatient services, nutritional therapy, nutritional supplements, and electrolyte replacements
- A service provided to an individual if the third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department
- The probable existence of third-party liability cannot be established at the time the claim is filed
- The claim is for nursing facility services reimbursed under the provisions of ARSD § 67:16:04
- The claim is for services provided by a school district under the provisions of ARSD § 67:16:37

A claim submitted to Medicaid must have the third-party explanation of benefits (EOB) attached, when applicable.

PAYMENTS

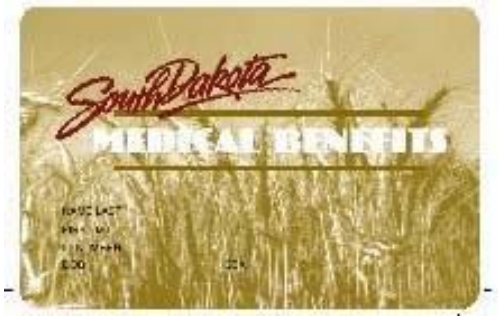
When third-party liability has been established and the amount of the third-party payment equals or exceeds the amount allowed under Medicaid, the provider must not seek payment from the recipient, relative, or any legal representative.

The provider is eligible to receive the recipient's third party allowable amount or the amount allowed under the department's payment schedule less the third-party payment, whichever is less.

When third-party liability source(s) and Medicaid have paid for the same service the provider must reimburse Medicaid. Reimbursement must be either the amount paid by the third party source(s) or the amount paid by Medicaid, whichever is less.

RECIPIENT ELIGIBILITY

The South Dakota Medicaid Identification Card is issued by the Department of Social Services on behalf of eligible South Dakota Medicaid recipients. The magnetic stripe card has the same background as the Supplemental Nutrition Assistance Program (SNAP) EBT card. The information on the face of the card includes the recipient's complete name (first, middle initial and last), the nine digit recipient identification number (RID#) plus a three digit generation number, and the recipient's date of birth and sex.



NOTE: The three digit generation number is automatically added in the system to indicate the number of cards sent to an individual. This number is not part of the recipient's ID number and should not be entered on a claim.

Each card has only the name of an individual on it. There are no family cards.

Recipients must present a South Dakota Medicaid identification card to a South Dakota Medicaid provider each time before obtaining a South Dakota Medicaid covered service. Failure to present their South Dakota Medicaid identification card is cause for payment denial. Payment for non-covered services is the responsibility of the recipient, as stated in ARSD §67:16:01:07.

South Dakota Medicaid emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID card each time a recipient obtains services. It is to the provider's advantage to see the ID card to verify that the recipient is South Dakota Medicaid eligible at the time of service, as well as to identify any other program limitations and the correct listing of the recipient name on the South Dakota Medicaid file.

The Medicaid Eligibility Verification System (MEVS) offers three ways for a provider to access the state's recipient eligibility file:

- **Point of Sale Device:** Through the magnetic strip, the provider can swipe the card and have an accurate return of eligibility information in approximately 10 seconds.
- **PC Software:** The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.
- **Secure Web Based Site.**

All three options provide prompt response times and printable receipts, and can verify eligibility status for prior dates of service. There is a nominal fee for each verification obtained through Emdeon.

The alternative to electronic verification is to use the SD Medical Assistance telephone audio response unit (ARU) by calling 1-800-452-7691. Each call takes approximately one minute to complete. This system is limited to current eligibility verification only.

For more information about the MEVS system, contact Emdeon at 1-866-369-8805 for new customers and 1-877-469-3263 for existing customers or visit Emdeon's website at www.emdeon.com.

MEVS ELIGIBILITY INFORMATION

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket, immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket' sent to the provider.

Please note that certain South Dakota Medicaid recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

**********SD MEDICAID**********
Eligibility 10/19/2004 08:47:25
**********PAYER INFORMATION**********
Payer: SOUTH DAKOTA MEDICAL SERVICES
Payer ID: SD48MED
**********PROVIDER INFORMATION**********
Provider: Dr. Physician
Service Provider #: 9999999
**********SUBSCRIBER INFORMATION**********
Current Trace Number: 200406219999999
Assigning Entity: 9000000000
Insured or subscriber: Doe, Jane P.
Member ID: 999999999
Address: Pierre Living Center
2900 N HWY 290
PIERRE, SD 575011019
Date of Birth: 01/01/1911
Gender: Female
**********ELIGIBILITY AND BENEFIT INFORMATION**********
**********HEALTH BENEFIT PLAN COVERAGE**********
ACTIVE COVERAGE
Insurance Type: Medicaid 13
Eligibility Begin Date: 10/19/2004
ACTIVE COVERAGE
Insurance Type: Medicare Primary 13
Eligibility Date Range: 10/19/2004 – 10/19/2004

**********HEALTH BENEFIT PLAN COVERAGE**********
**********OTHER OR ADDITIONAL PAYER**********
Insurance Type: Other
Benefit Coord. Date Range: 10/19/2004-10/19/2004
Payer: BLUE CROSS/BLUE SHIELD
Address: 1601 MADISON
PO BOX 5023
SIOUX FALLS, SD 571115023
Information Contact: Telephone: (800)774-1255
TRANS REF #: 999999999

Over 150 payers now support eligibility requests. For a full list, contact fax-on-demand at 800-7602804, #536. To add new payers, call 800-215-4730.

CLAIM STIPULATIONS

PAPER CLAIMS

Claims that, by policy, require attachments and reconsideration claims will be processed for payment on paper. Providers are required to use the original National Standard Form (CMS 1500) printed in red OCR ink to submit claims to South Dakota Medicaid.

ELECTRONIC CLAIM FILING

Electronic claims must be submitted using the 837P, HIPAA-compliant X12 format.

SUBMISSION

The provider must verify an individual's eligibility before submitting a claim, either through the ID card or, in the case of long-term care, a letter from the caseworker. The provider must record the recipient identification information as required for the claim.

A provider may only submit claims for those items and services that the provider knows or should have known are covered under South Dakota Medicaid. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for medically necessary covered services actually provided to South Dakota Medicaid recipients eligible on the date the service is provided.

TIME LIMITS

The department must receive a provider's completed claim form within 6 months following the month the services were provided, as stated in ARSD § 67:16:35:04. This time limit may be waived or extended only when one or more of the following situations exist:

- The claim is an adjustment or void of a previously paid claim and is received within 3 months after the previously paid claim;
- The claim is received within 6 months after a retroactive initial eligibility determination was made as a result of an appeal;
- The claim is received within 3 months after a previously denied claim;
- The claim is received within 6 months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
- To correct an error made by the department.

PROCESSING

The Division of Medical Services processes claims submitted by providers for their services as follows:

- Claims and attachments are received by the Division of Medical Services and sorted by claim type and scanned.
- Each claim is assigned a unique fourteen (14) digit Reference Number. This number is used to enter, control and process the claim. An example of a reference number is

2004005-0011480. The first four digits represent the year. The next 3-digits represent the day of the year the claim was received. The next 7-digits are the sequential number order of the claims received on that day. Each line is separately adjudicated, reviewed and processed using the 14-digit reference number. However, claims with multiple lines will be assigned a single claim reference number; and

- Each claim is individually entered into the computer system and is completely detailed on the Remittance Advice.

To determine the status of a claim, providers must reconcile the information on the Remittance Advice with their files.

UTILIZATION REVIEW

The Federal Government requires states to verify receipt of services. Each month a sample of South Dakota Medicaid recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under 42 C.F.R. part 456, South Dakota Medicaid is mandated to establish and maintain a Surveillance and Utilization Review System (SURS). The SURS unit safeguards against unnecessary or inappropriate use of South Dakota Medicaid services or excess payments, assesses the quality of those services and conducts a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers under § 42 CFR 456.23.

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid.

FRAUD AND ABUSE

The SURS Unit is responsible for the identification of possible fraud and/or abuse. The South Dakota Medicaid Fraud Control Unit (MFCU), under the Office of the Attorney General, is certified by the Federal Government with the primary purpose to detect, investigate, and prosecute any fraudulent practices or abuse against the Medicaid Program. Civil or criminal action or suspension from participation in the Medicaid program is authorized under South Dakota Codified Law (SDCL) 22-45 entitled, Unlawfully Obtaining Benefits or Payments from the Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of SDCL 22-45 and ARSD § 67:16.

DISCRIMINATION PROHIBITED

South Dakota Medicaid, participating medical providers, and contractors may not discriminate against South Dakota Medicaid recipients on the basis of race, color, creed, religion, sex, ancestry, handicap, political belief, marital or economic status, or national origin. All enrolled South Dakota Medicaid providers must comply with this non-discrimination policy. A statement of compliance with the Civil Rights Act of 1964 shall be submitted to the Department upon request.

MEDICALLY NECESSARY

South Dakota Medicaid covered services are to be payable under the Medicaid Program when the service is determined medically necessary by the provider. To be medically necessary, the covered service must meet all of the following conditions under ARSD §67:16:01:06.02:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition
- It is not furnished primarily for the convenience of the recipient or the provider
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

CHAPTER II:
PHARMACY SERVICES

DEFINITIONS

Terms used in this manual are defined according to Administrative Rule of South Dakota (ARSD) 67:16:14:01.

1. Bioavailability— the degree to which a drug or other substance becomes available to the target tissue after administration.

2. Brand name— an arbitrarily adopted name that is given by a manufacturer to a drug to distinguish it as produced or sold by the manufacturer and which may be used and protected as a trademark.

3. Compounded medication— a therapeutic product prescribed by a licensed practitioner requiring the mixing together of two or more substances by the pharmacist or prescriber.

4. Consolidated price— a replacement for average wholesale price calculated according to the guidelines provided in the South Dakota Medicaid State Plan.

5. Contractor— a vendor that has a contract with the department to provide a list of drugs that are widely and consistently available to South Dakota pharmacies at a price that is less than the consolidated price.

6. Cost— for all drugs and supplies, the actual amount paid by the dispensing provider to the supplier after all discounts are deducted.

7. Estimated acquisition cost— for all drugs not subject to the federal upper limit pricing covered under the provisions of subdivision 67:16:14:06(3) or the state maximum allowable cost covered under the provisions of subdivision 67:16:14:06(4), the consolidated cost of the drug less 13 percent.

8. Generic drugs— drugs of similar chemical composition available from multiple sources and not protected by trademark registration.

9. Legend drugs— drugs which may be dispensed by prescription only.

10. Maintenance drugs— a medication that has been dispensed three times in the same strength, regardless of dosage schedule, in any combination of brand name or generic form, and used in the treatment of a chronic health condition.

11. Multiple-source drug— a drug that is sold in therapeutically equivalent forms under one or more brand names, available from two or more generic distributors, and available from one or more drug wholesale firms located in South Dakota.

12. Non-legend drugs— drugs and supplies available without a prescription.

13. Over-the-counter or OTC— drugs available without a prescription which have been recommended by the P and T committee for coverage under South Dakota Medicaid.

14. Pharmacist— a person licensed to practice pharmacy under SDCL chapter 36-11 or by the state in which the pharmacist is located;

15. Pharmacy— a facility defined as a pharmacy under SDCL chapter 36-11 or by the state in which it is located.

16. PHS provider— an entity which participates as a public health service provider under the provisions of 42 U.S.C. § 256b(a)(4), except § 256b(a)(4)(C), as in effect on October 1, 1995, and provides covered drugs on an outpatient basis to an individual who is a patient of the PHS provider. Entities operated by state or local government are not considered PHS providers.

17. State maximum allowable cost (MAC) list— the maximum allowable cost established by the department, in consultation with the contractor, for drugs listed on the state MAC list and covered under the provisions of this chapter.

18. Therapeutically equivalent— drug products that contain the same active ingredients and are identical in strength or concentration, dosage form, and route of administration with comparable bioavailability.

19. Trademark— a device or word which points distinctly to the origin or ownership of the drug to which it is applied and whose exclusive use is legally reserved to the owner.

COVERED SERVICES

A prescription is required for all of the items and services and non-legend drugs and supplies covered under this section. The following prescription drugs, biologicals, and related items and services are covered under chapter § 67:16:14:04:

1. Legend eye preparations, vaginal therapeutics, otic pharmaceutical preparations, or inhalations for asthmatic conditions;
2. Antibiotic products which are known, either by sensitivity test or product information, to be the single item of choice for the diagnosis;
3. All other legend prescription drugs and biologicals, except for the items listed in § 67:16:14:05;
4. Insulin;
5. Concentrated cryoprecipitate used in the home treatment of hemophilia;
6. Legend vitamins prescribed for the prenatal care of pregnant women;
7. Calcitriol if used for renal impairment and determined medically necessary by the prescriber;

8. Spacers, such as Aerochamber and InspirEase, and solutions that are medically necessary for the administration of legend drugs used for the delivery of respiratory or inhalation therapy;
9. Syringes and needles for the administration of medication covered under this chapter;
10. Urine and blood testing items for a diabetic, except for glucometers which are covered under the provisions of § 67:16:29; and
11. The OTC items recommended for coverage by the P and T committee and approved for coverage by the department.

Under chapter §67:16:14:06.10, growth hormones are covered when the use of the drug has received prior authorization from the department.

RENAL DRUG PROGRAM

A limited number of persons are entitled to assistance under this program. These persons will not have an identification card, but will have a letter of authorization to program benefits. Their medical identification number begins with an “8”. Payment for drugs will be restricted to the following prescription drugs necessary for dialysis or transplants not covered by any other sources:

1. Digoxin;
2. Diuretics (Lasix-dyazide, etc.)
3. Prescription vitamin and mineral supplements;
4. Immunosuppressives;
5. Corticosteroids;
6. Angiotensin Converting Enzyme (ACE) inhibitors and Angiotensin Receptor Blockers (ARB);
7. Hematinics.

Any items billed by the provider that are not included in this list will be denied as a non-covered service under the renal program.

FOSTER CHILDREN

Foster children may be identified by an individual medical identification number beginning with a “5” or “6”, such as 531, 571, 621, etc.

Payment will be allowed for all drug or health care items provided for foster children when the item is prescribed specifically for the child and not an item normally used by other members of the household.

PRIOR AUTHORIZATION

South Dakota Medicaid requires prior approval of certain prescription drugs. The provider must obtain approval from South Dakota Medicaid before supplying drugs subject to prior authorization.

If South Dakota Medicaid informs a pharmacist that a requested drug requires prior authorization and the recipient indicates to the pharmacist that the recipient wishes to proceed, the pharmacist must contact the medical professional who wrote the prescription and request permission to substitute a therapeutically-equivalent drug.

If the request to substitute is not successful, the pharmacist must inform the medical professional that South Dakota Medicaid will not cover the cost unless the medical professional can justify the use of the drug and ultimately receives approval from the department to dispense the drug as written.

BASIS FOR PAYMENT

Payment to pharmacy providers for covered items shall be made at the lowest of the following:

1. The provider's usual and customary charge;
2. The estimated acquisition cost (as established by the department) of the drug dispensed, plus a dispensing fee of $4.30;
3. The payment limit established by the United States Department of Health and Human Services under the provisions of 42 C.F.R. § 447.332 (i.e. the FUL list) for multiple-source drugs, plus a dispensing fee of $4.30;
4. The payment limit established by the department, in consultation with the contractor, for drugs contained on the state MAC list, plus a dispensing fee of $4.30. The list can be viewed online at: https://sd.providerportal.sxc.com/providerportal/faces/PreLogin.jsp

TAMPER RESISTANT PRESCRIPTIONS

For written prescriptions, the cost of the prescribed drug or over-the-counter item is not covered unless the prescription was written on a tamper-resistant prescription drug pad. To be considered tamper resistant, a prescription pad must contain the following three characteristics:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form, such as a high security watermark;
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber, such as tamper-resistant background ink that shows erasures or attempts to change written information; or
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms, such as sequentially numbered blanks and duplicate or triplicate blanks.

Prescriptions transmitted electronically to the pharmacy, prescriptions transmitted to the pharmacy by facsimile, and prescriptions communicated to the pharmacy by telephone are considered tamper resistant.

CERTIFICATION OF BRAND NAME DRUGS

The reimbursement of a brand name drug is not limited to the MAC price if a physician certifies through the prior authorization process that in his/her medical judgment a brand name product is medically necessary.

A check off box on a prescription form is not acceptable certification. For a telephone prescription requesting brand name necessary by the prescriber, the pharmacist shall indicate on the face of the prescription that a brand name was requested by the prescriber. The pharmacist must also indicate the time of day the telephone order was taken on the face of the prescription.

Ingredient cost will not be limited to FUL or MAC if a claim is submitted electronically with a DAW code of “1” or “1” is inserted in the DAW block on the universal pharmacy claim form. This declares that the prescribing physician has stated that the brand product is medically necessary and a prior authorization has been obtained.

UNIT DOSE

Payment for items provided using a unit dose system will be made using the following guidelines:

Payment for drugs dispensed under a unit dose system includes a container cost in addition to the amount determined under ARSD § 67:16:14:06. The container cost is limited to one fee for each prescription each month.

Manufacturers' prepackaged strip items, liquid preparations, or items dispensed in original containers do not qualify for additional container costs.

Payment for drugs dispensed under a unit dose system is limited to a recipient who is a participant under home- and community-based services or resides in a nursing facility, an intermediate care facility for the mentally retarded, an assisted living center, or an adjustment training center.

Note: It is the provider’s responsibility to include the appropriate unit dose indicator on the claim. The Division of Medical Services does not automatically add this to the claim.

MAINTENANCE DRUGS

As defined in ARSD § 67:16:14:01, a maintenance drug is a medication that has been dispensed three times in the same strength, regardless of dosage schedule, in any combination of brand name or generic form, and used in the treatment of a chronic health condition.

Dispensing fee payments for maintenance drugs or items are limited to one each month for each drug or item except for the following:

1. Schedule II, III, and IV controlled substances;
2. Clozapine;

3. Antipsychotic drugs for recipients who are not institutionalized if the physician indicates on the prescription that a month's supply of the drug is not in the patient's best interests and that the quantities may not be increased;
4. Liquid products, ointments, or biologicals dispensed in their original containers if the product is not available from the manufacturer in a container which is adequate for a one-month's supply; and
5. Drugs that must be dispensed in smaller quantities to ensure the stability and effectiveness of the drug.

FAMILY PLANNING

An initial prescription for a family planning item may be dispensed in less than a three-month supply until maintenance is established. Once maintenance is established, the item may be dispensed in at least a three-month supply and, if prescribed by the physician, may be dispensed in a 12-month supply.

USUAL AND CUSTOMARY CHARGE

A provider's usual and customary charge is that charge made by the provider to third-party payers for a specific item on the day the item is supplied.

COST SHARING

A $3.30 deduction for recipient cost sharing will be made from the agency's calculated payment amount for each brand name prescription provided to persons over 21 years of age. A $1.00 deduction for recipient cost sharing will be made from the agency's calculated payment amount for each generic prescription provided to persons over 21 years of age.

The cost sharing deduction will not be made for recipients who are federally exempt from cost sharing.

RENAL COST SHARING

A five percent deduction for a renal recipient cost share will be made from the agency's calculated payment amount for each renal prescription provided to persons over 21 years of age.

NON COVERED SERVICES

The following items and services are not covered:

1. Non-legend prescription drugs and over-the-counter items and medical supplies except for those items covered under ARSD §67:16:14:04;
2. Medical supplies or delivery charges;
3. Legend oral vitamins except for legend vitamins prescribed for the prenatal care of pregnant women covered under ARSD §67:16:14:04;
4. Nicotine patches and other nicotine replacement products;

5. Agents to promote fertility or treat impotence;
6. Agents used for cosmetic purposes;
7. Hair growth products;
8. Items or drugs manufactured by a firm that has not signed a rebate agreement with the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services;
9. Items which exceed a 34-day supply, except for family planning items and prenatal vitamins;
10. Services, procedures, or drugs which are considered experimental;
11. Drugs and biologicals which the federal government has determined to be less than effective according to Pub. L. No. 97-35, § 2103 (August 13, 1981), 95 Stat. 787; and
12. Drugs that did not receive prior authorization from the department under the provisions of this chapter.
13. Agents used for anorexia, weight loss or weight gain.
14. Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
15. Agents when used for the treatment of sexual or erectile dysfunction.

CHAPTER III:
BILLING INSTRUCTIONS

HOW TO COMPLETE THE UNIVERSAL PHARMACY CLAIM FORM

(UNIVERSAL PHARMACY CLAIM FORM, VERSION DAH1-01)

THE FOLLOWING IS AN EXPLANATION OF HOW TO COMPLETE THE PRESCRIPTION DRUG CLAIM FORM

NOTE: Please leave the upper right hand corner of the claim form blank. It is used by South Dakota Medicaid for control numbering.

Proper entries must be entered in the fields listed below.

I.D.: Enter the South Dakota Medicaid Recipient Identification Number.

PATIENT NAME: Enter the recipient name as it appears on the South Dakota Medicaid Identification Card.

PHARMACY NAME: Enter the name of the pharmacy as it is listed with South Dakota Medicaid.

ADDRESS, CITY, STATE & ZIP CODE: Enter the address of the pharmacy as it is listed with South Dakota Medicaid.

SERVICE PROVIDER I.D.: Enter the NPI of the pharmacy.

PRESCRIPTION/SERV. REF. #: Enter the provider designated number assigned to the claim to help identify individual claims.

DATE OF SERVICE: Enter the date on which the product was dispensed to the recipient. The date should be listed as the following example indicates: 01-01-2005

QTY DISPENSED: The unit quantity of the product dispensed.

DAYS SUPPLY: Enter the number of days (may be an estimate for some products) the dispensed product should last the patient based on administration directions.

PRODUCT/SERVICE I.D.: Enter the NDC Code for the product dispensed. See Chapter II for a complete listing of products, which may be dispensed by Pharmacy Providers.

PRESCRIBER I.D.: Enter the prescribing physicians DEA number.

USUAL AND CUST. CHARGE: Enter the amount that is usually charged for the product being dispensed.

OTHER PAYER AMOUNT PAID: This field is only used when the patient has primary insurance coverage. If this situation occurs the claim must be billed to the primary insurance before being billed to South Dakota Medicaid. Enter the amount paid by the primary insurance in this field. South Dakota Medicaid will pay the difference of what the primary paid and the calculated Medicaid reimbursement.

CHAPTER IV:
POINT-OF-SALE (POS)

INTRODUCTION

The South Dakota Department of Social Services uses a Point-of-Sale (POS) and Prospective Drug Utilization Review (ProDUR) system for pharmacy claims.

It is important that pharmacies meet the technical requirements needed to submit claims via POS. Claims submitted via POS are processed in real time and may be paid, denied, reversed or captured. POS billing confirms the recipient's eligibility on the date the prescription is dispensed.

The POS system is available 24 hours a day, seven days a week, except for maintenance.

PROBLEMS OR QUESTIONS

Network Processing Difficulties
The POS system is accessed via a pharmacy switch network. At times an individual commercial switch network system may be out of service or unable to exchange information with the Medicaid system. If the condition persists, please contact your contracted switch network help desk for assistance.

State Processing Difficulties
If the state network files are out of service, specific messages you may receive are as follows:

- POS Suspense File is out of service
- Recipient Master Files are out of service
- Drug Pricing File is out of service
- Provider Master File is out of service
- Other Master Files are out of service
- Data field problem is Drug File
- SDPOS Not Responding (T33)

If one of these conditions persists more than 20 minutes, record the message you have received and contact the South Dakota State Help Desk at 1-605-773-HELP. Before calling the Help Desk, print your screen, or write down the exact message on your screen.

The State Help Desk is for technical problems and cannot answer billing or coverage questions. Please refer to the phone numbers listed in the front of this manual for billing, coverage and eligibility questions.

SOUTH DAKOTA POINT-OF-SALE GENERAL INFORMATION

BIN NUMBER

South Dakota Medicaid processor BIN number is 601574.
The BIN number must be included in all NCPDP transactions routed to the South Dakota Medicaid POS system.

PAPER CLAIMS

South Dakota Medicaid accepts paper claims via the Universal Pharmacy Claim Form, but prefers claims sent electronically via the POS.

FORMAT FOR CLAIMS

Claims submitted via point-of-sale must follow National Council for Prescription Drug Programs (NCPDP) guidelines. Please direct questions to your software company.

NAME VERIFICATION

Names submitted on claims must match the name on the recipient's South Dakota Medicaid Recipient Identification Card. Claims with names that do not match will be denied. Please check your claim and data base to ensure an exact match.

Example: Nicknames that do not match the identification cardholders name will cause a claim to be denied.

POS FORMAT

Pharmacy software vendors and programmers should assure that:

1. All the information required for submitting transactions are transmitted in the NCPDP format.
2. All information in each South Dakota Medicaid return transaction is made available to the pharmacist at the time the prescription is dispensed.

Other important considerations:

1. Pharmacists must be able to see the contents of the message fields returned with the various transactions by South Dakota Medicaid. The message fields will be used to pass information about:
   - Recipient eligibility;
   - Recipient liability;
   - Drug coverage;
   - Coordination of benefits with primary insurance-third party liability (TPL);
   - Prior Authorization; and
   - Drug utilization review and early refill alerts.

PROSPECTIVE DUR DENIALS AND OVERRIDE PROCEDURES

The Prospective Drug Utilization Review process follows NCPDP ProDUR standard formats for conflict, intervention, and outcome. The department has the capability to control which of the conflicts will result in a denial of a claim. In order for the early refill alert to function properly the correct days supply must be entered on the claim.

POS OVERRIDE

Should South Dakota Medicaid deny (reject) claims because of a prospective drug utilization review alert, the POS/ProDUR system will allow the pharmacist utilizing professional judgement to override the denial using entry of 3 codes: Conflict code, Intervention code, and Outcome code. One code from each column is required to override a denied claim which results from a ProDUR alert. **Please review the process with your software vendor to ensure a proper procedure for your software system.**

DUR OVERRIDE CODES

(One for each column is needed to override an alert)

CONFLICT CODES		INTERVENTION CODES		OUTCOME CODES	
ER	Early refill	M0*	Prescriber consulted		
DD	Drug Drug intervention	P0*	Patient consulted	IB	Filled Rx as is
ID	Duplicate therapy same	R0*	Pharmacist consulted	IC	Filled with different dose
TD	Therapeutic duplication			ID	Filled with different dose
M C	Medical disease (diagnosed) contraindicated				
DC	Drug disease contraindicated			IF	Filled with different quantity
HD	Adult geriatric, or pediatric high dose			IG	Filled with prescriber approval
LD	Adult, geriatric or pediatric low dose				
AT	Additive toxicity				
IC	Iatrogenic Side Effect (Inferred)				

* These are not the alpha letter “o”, they are the number zero “0”.

EARLY REFILL OVERRIDES AND DAYS SUPPLY

Overrides of the early refill denial must be medically necessary and consistent with the recipient’s symptoms, diagnosis, condition, or injury. **The override process is not to be used for the convenience of the recipient or the provider.** Accurate day supply information is required for the early refill alert.

POINT-OF-SALE (POS) REVERSALS

Pharmacist may retract any claim that has been paid or captured by submitting a NCPDP reversal transaction. Reversals may be used in many circumstances.

Examples:

1. A prescription is not picked up by the recipient
2. An error was made when submitting the initial claim. A corrected claim may be submitted and processed at any time after the reversal.

DENIED POS CLAIM

If a claim has been denied for any reason, you may resubmit via the POS system after making any necessary claim corrections.

Example:
If the claim is denied because the South Dakota Medicaid Recipient ID number is invalid, correct the ID number and resubmit.

OVERPAYMENTS

It is important to watch for overpayments. In the event that you receive a payment from South Dakota Medicaid in error, or in excess of the amount properly due under the applicable rules and procedures, you must promptly notify the Department of Medical Services and arrange for the return of any excess money received. You may, however, reverse and resubmit a claim if errors are found in the original claim.

DRUG UTILIZATION REVIEW (DUR) REQUIREMENTS

The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires that all State Medicaid programs include a retrospective and prospective drug utilization review (DUR) program for all covered outpatient pharmaceuticals as well as patient counseling. The primary goal of drug utilization review is to enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal drug use. The DUR program must ensure that prescribed medications are appropriate, medically necessary, and are not likely to result in adverse medical outcomes. The Medicaid DUR program includes: retrospective DUR and prospective DUR.

RETROSPECTIVE DUR

The retrospective DUR program involves reviews of recipient drug history profiles generated from Medicaid paid claims data by a panel of active practicing physicians and pharmacists. The reviews are based upon predetermined standards consistent with the following:

1. American Medical Association Drug Evaluations;
2. United States Pharmacopoeia-Drug Information;
3. American Hospital Formulary Service Drug Information; and
4. Peer-reviewed medical literature.

The retrospective review of the recipient drug history profiles by the panel of reviewers includes evaluation for:

1. Therapeutic appropriateness;
2. Over and under utilization;
3. Appropriate use of generic products;
4. Therapeutic duplication;
5. Drug-disease contraindications;
6. Drug-drug interactions;
7. Incorrect dosage or duration of therapy; and
8. Clinical abuse/misuse.

PROSPECTIVE DRUG UTILIZATION REVIEW (ProDUR)

ProDUR information provided to pharmacists is based on the patient's medical diagnosis and prescription history.

The ProDUR program enables the pharmacy provider to screen for drug therapy problems at point-of-sale or distribution. In compliance with OBRA 1990 DUR requirements, pharmacy providers must screen each prescription for certain therapeutic problems using standards consistent with OBRA 1990 requirements. OBRA requires:

1. A pharmacist using his/her professional judgment shall review the patient record and each prescription drug order presented for dispensing for purposes of promoting therapeutic appropriateness by identifying the following, when possible:
   - Over or under utilization;
   - Therapeutic duplication;
   - Drug-disease contraindications, where diagnosis is provided by the prescriber;
   - Drug-drug contra-indications;
   - Incorrect drug dosage or duration of drug treatment;
   - Drug allergies; and
   - Clinical abuse/misuse.
2. Upon recognizing any of the above, the pharmacist shall take appropriate steps to avoid or resolve the problem which shall, if necessary, include consultation with the prescriber.

Point-of-Sale (POS) providers may receive additional ProDUR information provided by the South Dakota Medicaid POS system. These audits are supplemental to those required by law to be performed by the pharmacy provider and not in lieu of those audits. South Dakota Medicaid ProDUR audits are based on information from the current claim, from claim history for same and different pharmacies, and from the recipient's diagnostic history on medical claims. The medical, clinical, and pharmaceutical information used in POS ProDUR audits is supplied by First Data Bank.

Pharmacists billing via POS can evaluate the ProDUR information and intervene appropriately. ProDUR information is a tool to assist the pharmacist in providing the highest quality of care possible.

POINT-OF-SALE FORMAT TABLE REQUIREMENTS

Please provide this information to your software vendors.

NCPDP VERSION D.0 Claim Billing/Claim Rebill

Request Claim Billing/Claim Rebill Payer Sheet

**** Start of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet ****

GENERAL INFORMATION

Payer Name: State of South Dakota	Date: 10/17/2011	
Plan Name/Group Name: Medicaid	BIN: 601574	PCN:
Plan Name/Group Name:	BIN:	PCN:
Plan Name/Group Name:	BIN:	PCN:
Plan Name/Group Name:	BIN:	PCN:
Processor: Sate of South Dakota		
Effective as of: 1/1/2012	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: June 2010	NCPDP External Code List Version Date: June 2010	
Contact/Information Source: Mike Jockheck		
Certification Testing Window: n/a		
Certification Contact Information: n/a		
Provider Relations Help Desk Info: In-state 800-452-7691, Out-of-State 605-945-5006		
Other versions supported:		

OTHER TRANSACTIONS SUPPORTED

Payer: *Please list each transaction supported with the segments, fields, and pertinent information on each transaction.*

Transaction Code	Transaction Name

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	**RW**	“Required when”. The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

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.

CLAIM BILLING/CLAIM REBILL TRANSACTION

The following lists the segments and fields in a Claim Billing or Claim Rebill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used		

	Transaction Header Segment			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	601574	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	Max # 4	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Blanks, 01	M	
2Ø1-B1	SERVICE PROVIDER ID		M	Must be enrolled with Medicaid
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		M	

Insurance Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	

	Insurance Segment Segment Identification (111-AM) = "Ø4"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	Medicaid ID
312-CC	CARDHOLDER FIRST NAME		RW	*Imp Guide:* Required if necessary for state/federal/regulatory agency programs when the cardholder has a first name.

	Insurance Segment Segment Identification (111-AM) = "Ø4"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				*Payer Requirement: When Patient First Name (Field 310-CA) not submitted and m*ust Match First Name listed on Medicaid ID Card
313-CD	CARDHOLDER LAST NAME		RW	*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. *Payer Requirement: When Patient Last Name (Field 311-CB) not submitted and m*ust Match Last Name listed on Medicaid ID Card
115-N5	MEDICAID ID NUMBER		M	*Imp Guide:* Required, if known, when patient has Medicaid coverage. *Payer Requirement:*

Patient Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	Y	
This Segment is situational		

	Patient Segment Segment Identification (111-AM) = "Ø1"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
331-CX	PATIENT ID QUALIFIER			*Imp Guide:* Required if Patient ID (332-CY) is used. *Payer Requirement:*
332-CY	PATIENT ID		RW	*Imp Guide:* Required if necessary for state/federal/regulatory agency programs to validate dual eligibility. *Payer Requirement: When Medicaid ID Number (Field 115-N5) not submitted and must be Medicaid ID Number as listed on Medicaid ID card.*
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE		R	
31Ø-CA	PATIENT FIRST NAME		R	*Imp Guide:* Required when the patient has a first name.

	Patient Segment Segment Identification (111-AM) = "Ø1"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				*Payer Requirement: M*ust Match First Name listed on Medicaid ID Card
311-CB	PATIENT LAST NAME		R	*Payer Requirement: M*ust Match Last Name listed on Medicaid ID Card

Claim Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	
This payer supports partial fills	Y	
This payer does not support partial fills		

	Claim Segment Segment Identification (111-AM) = "Ø7"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	Ø1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER		RW	*Imp Guide:* Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. *Payer Requirement:* Must other than zeros
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE		RW	*Imp Guide:* Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if Associated Prescription/Service Reference Number (456-EN) is used. Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there

	Claim Segment Segment Identification (111-AM) = "Ø7"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				are multiple occurrences of partial fills for this prescription. *Payer Requirement:* Must be a date in the past and can not be the same date as the Date Of Service (401-D1) for this billing
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE		R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
308-C8	OTHER COVERAGE CODE		RW	Payer Requirement: When patient has Other Coverage then appropriate code must be submitted.
429-DT	SPECIAL PACKAGING INDICATOR			*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:*
6ØØ-28	UNIT OF MEASURE			*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:*
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement: When NDC requires prior authorization, then must be Prior Authorization number issued by Medicaid.*
343-HD	DISPENSING STATUS		RW	*Imp Guide:* Required for the partial fill or the completion fill of a prescription. *Payer Requirement:*
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	*Imp Guide:* Required for the partial fill or the completion fill of a prescription. *Payer Requirement:* Must be greater than zeros
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	*Imp Guide:* Required for the partial fill or the completion fill of a prescription. *Payer Requirement:* Must be greater then zeros

Pricing Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
433-DX	PATIENT PAID AMOUNT SUBMITTED		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:*
426-DQ	USUAL AND CUSTOMARY CHARGE		R	*Imp Guide:* Required if needed per trading partner agreement. *Payer Requirement:*
43Ø-DU	GROSS AMOUNT DUE		R	

Prescriber Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	Y	
This Segment is situational		

	Prescriber Segment **Segment Identification (111-AM) = "Ø3"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	'05', '12'	R	*Imp Guide:* Required if Prescriber ID (411-DB) is used. *Payer Requirement:* Must bill with code '05' - Medicaid or '12' - Drug Enforcement Administration Number
411-DB	PRESCRIBER ID		R	*Imp Guide:* Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* Must bill Medicaid Provider Number or Drug Enforcement Administration Number
427-DR	PRESCRIBER LAST NAME		RW	*Imp Guide:* Required when the Prescriber ID (411-DB) is not known.

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Required if needed for Prescriber ID (411-DB) validation/clarification. *Payer Requirement:*
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	'05'	RW	Payer Requirement: When patient is on Lockin then must bill with code '05' Medicaid Provider Number
421-DL	PRIMARY CARE PROVIDER ID		RW	Payer Requirement: When patient is on Lockin then must bill with Medicaid Provider Number

Coordination of Benefits/Other Payments Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 1 - Other Payer Amount Paid Repetitions Only		
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	X	

If the Payer supports the Coordination of Benefits/Other Payments Segment, only one scenario method shown above may be supported per template. The template shows the Coordination of Benefits/Other Payments Segment that must be used for each scenario method. The Payer must choose the appropriate scenario method with the segment chart, and delete the other scenario methods with their segment charts. See section *Coordination of Benefits (COB) Processing* for more information.

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing/Claim Rebill** Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
443-E8	OTHER PAYER DATE		R	*Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. *Payer Requirement:*
341-HB	OTHER PAYER AMOUNT PAID	Maximum count of 9.	RW	*Imp Guide:* Required if Other Payer

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing/Claim Rebill** Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
	COUNT			Amount Paid Qualifier (342-HC) is used. *Payer Requirement:*
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER		RW	*Imp Guide:* Required if Other Payer Amount Paid (431-DV) is used. *Payer Requirement:*
431-DV	OTHER PAYER AMOUNT PAID		RW	*Imp Guide:* Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. *Payer Requirement:*
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	*Imp Guide:* Required if Other Payer Reject Code (472-6E) is used. *Payer Requirement:*
472-6E	OTHER PAYER REJECT CODE		RW	*Imp Guide:* Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered). *Payer Requirement:*
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. *Payer Requirement:*
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		RW	*Imp Guide:* Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. *Payer Requirement:*
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	*Imp Guide:* Required if necessary for patient financial responsibility only billing. Required if necessary for state/federal/regulatory agency programs.

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing/Claim Rebill** Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted. *Payer Requirement:*

DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when DUR/PPS is found by Dispensing Provider or when Dispensing Provider is overriding a DUR/PPS denial from Medicaid

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	M	*Imp Guide:* Required if DUR/PPS Segment is used. *Payer Requirement:*
439-E4	REASON FOR SERVICE CODE		M	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:*
44Ø-E5	PROFESSIONAL SERVICE CODE		M	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:*
441-E6	RESULT OF SERVICE CODE		M	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:*

Coupon Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required for Manufactor Coupon

	Coupon Segment Segment Identification (111-AM) = "Ø9"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
485-KE	COUPON TYPE		M	
486-ME	COUPON NUMBER		M	
487-NE	COUPON VALUE AMOUNT			*Imp Guide:* Required if needed for receiver claim/encounter determination when a coupon value is known. Required if this field could result in different pricing and/or patient financial responsibility. *Payer Requirement:*

Compound Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required if billing is for Compounded Drug

	Compound Segment Segment Identification (111-AM) = "1Ø"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER		M	
489-TE	COMPOUND PRODUCT ID		M	

	Compound Segment Segment Identification (111-AM) = "1Ø"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		M	*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement:*

**** End of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet ****

Response Claim Billing/Claim Rebill Payer Sheet

Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) Response

**** Start of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet ****

GENERAL INFORMATION

Payer Name: State of South Dakota	Date: 10/17/2011	
Plan Name/Group Name: Medicaid	BIN: 601574	PCN:
Plan Name/Group Name:	BIN:	PCN:
Plan Name/Group Name:	BIN:	PCN:

CLAIM BILLING/CLAIM REBILL PAID (OR DUPLICATE OF PAID) RESPONSE

The following lists the segments and fields in a Claim Billing or Claim Rebill response (Paid or Duplicate of Paid) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	

	Response Transaction Header Segment			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
5Ø3-F3	AUTHORIZATION NUMBER		M	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement:*
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:*
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:*
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail. *Payer Requirement:*
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:*
549-7F	HELP DESK PHONE NUMBER QUALIFIER		M	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement:*

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
55Ø-8F	HELP DESK PHONE NUMBER		M	*Imp Guide:* Required if needed to provide a support telephone number to the receiver. *Payer Requirement:*

Response Claim Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response Pricing Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø5-F5	PATIENT PAY AMOUNT		R	
5Ø6-F6	INGREDIENT COST PAID		R	
5Ø7-F7	DISPENSING FEE PAID			*Imp Guide:* Required if this value is used to arrive at the final reimbursement. *Payer Requirement:*
5Ø9-F9	TOTAL AMOUNT PAID		R	
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	*Payer Requirement: When Other Payer Amount Paid (Field 431-DV) is reported*

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		R	*Imp Guide:* Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing. *Payer Requirement:*
518-FI	AMOUNT OF COPAY		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes copay as patient financial responsibility. *Payer Requirement:*
346-HH	BASIS OF CALCULATION—DISPENSING FEE		R	*Imp Guide:* Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). *Payer Requirement:*
347-HJ	BASIS OF CALCULATION—COPAY		RW	*Imp Guide:* Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). *Payer Requirement:*

Response DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when DUR/PPS conditions found by Medicaid

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	M	*Imp Guide:* Required if Reason For Service Code (439-E4) is used. *Payer Requirement:*
439-E4	REASON FOR SERVICE CODE		M	*Imp Guide:* Required if utilization conflict is detected. *Payer Requirement:*
529-FT	OTHER PHARMACY INDICATOR		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
53Ø-FU	PREVIOUS DATE OF FILL		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. *Payer Requirement:*
531-FV	QUANTITY OF PREVIOUS FILL		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used. *Payer Requirement:*
532-FW	DATABASE INDICATOR		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*
533-FX	OTHER PRESCRIBER INDICATOR		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*
544-FY	DUR FREE TEXT MESSAGE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*

Claim Billing/Claim Rebill Accepted/Rejected Response

CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	

	Response Transaction Header Segment			Claim Billing/Claim Rebill Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		M	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement:*
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence. *Payer Requirement:*
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:*
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:*
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail. *Payer Requirement:*
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:*

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
549-7F	HELP DESK PHONE NUMBER QUALIFIER		M	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement:*
55Ø-8F	HELP DESK PHONE NUMBER		M	*Imp Guide:* Required if needed to provide a support telephone number to the receiver. *Payer Requirement:*

Response Claim Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when DUR/PPS conditions found by Medicaid

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	M	*Imp Guide:* Required if Reason For Service Code (439-E4) is used. *Payer Requirement:*
439-E4	REASON FOR SERVICE CODE		M	*Imp Guide:* Required if utilization conflict is detected. *Payer Requirement:*
529-FT	OTHER PHARMACY INDICATOR		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill Accepted/Rejected
53Ø-FU	PREVIOUS DATE OF FILL		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. *Payer Requirement:*
531-FV	QUANTITY OF PREVIOUS FILL		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used. *Payer Requirement:*
532-FW	DATABASE INDICATOR		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*
533-FX	OTHER PRESCRIBER INDICATOR		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*
544-FY	DUR FREE TEXT MESSAGE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*

Claim Billing/Claim Rebill Rejected/Rejected Response

CLAIM BILLING/CLAIM REBILL REJECTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Billing/Claim Rebill Rejected/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Rejected/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence. *Payer Requirement:*
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:*
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:*
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail. *Payer Requirement:*
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:*
549-7F	HELP DESK PHONE NUMBER QUALIFIER		M	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement:*
55Ø-8F	HELP DESK PHONE NUMBER		M	*Imp Guide:* Required if needed to provide a support telephone number to the receiver. *Payer Requirement:*

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing/Claim Rebill Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Claim Billing/Claim Rebill Accepted/Captured Response

CLAIM BILLING/CLAIM REBILL ACCEPTED/CAPTURED RESPONSE

Response Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Captured** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			**Claim Billing/Claim Rebill Accepted/Captured**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Captured** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill Accepted/Captured**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	C = Captured, Q = Duplicate of Capture	M	
5Ø3-F3	AUTHORIZATION NUMBER		M	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement:*
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill Accepted/Captured**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence. *Payer Requirement:*
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:*
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement:*
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail. *Payer Requirement:*
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement:*
549-7F	HELP DESK PHONE NUMBER QUALIFIER		M	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement:*
55Ø-8F	HELP DESK PHONE NUMBER		M	*Imp Guide:* Required if needed to provide a support telephone number to the receiver. *Payer Requirement:*

Response Claim Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Captured** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing/Claim Rebill Accepted/Captured**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing/Claim Rebill Accepted/Captured**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Captured** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when DUR/PPS conditions found by Medicaid

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing/Claim Rebill Accepted/Captured**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	M	*Imp Guide:* Required if Reason For Service Code (439-E4) is used. *Payer Requirement:*
439-E4	REASON FOR SERVICE CODE		M	*Imp Guide:* Required if utilization conflict is detected. *Payer Requirement:*
529-FT	OTHER PHARMACY INDICATOR		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*
53Ø-FU	PREVIOUS DATE OF FILL		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. *Payer Requirement:*
531-FV	QUANTITY OF PREVIOUS FILL		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used. *Payer Requirement:*
532-FW	DATABASE INDICATOR		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill Accepted/Captured
533-FX	OTHER PRESCRIBER INDICATOR		M	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*
544-FY	DUR FREE TEXT MESSAGE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement:*

**** End of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet ****

1. NCPDP Version D Claim Reversal

1.1 Request Claim Reversal Payer Sheet

**** Start of Request Claim Reversal (B2) Payer Sheet ****

GENERAL INFORMATION

Payer Name: State of South Dakota	Date: 1/1/2012	
Plan Name/Group Name: Medicaid	BIN: 601574	PCN:
Plan Name/Group Name:	BIN:	PCN:
Plan Name/Group Name:	BIN:	PCN:

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

NOT USED	**NA**	The Field is not used for the Segment in the designated Transaction. Not used are shaded for clarity for the Payer when creating the Template. For the actual Payer Template, not used fields must be deleted from the transaction (the row in the table removed).	No

Question	**Answer**
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	6 months

CLAIM REVERSAL TRANSACTION

The following lists the segments and fields in a Claim Reversal Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Transaction Header Segment Questions	**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used		

	Transaction Header Segment			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	601574	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		M	
1Ø9-A9	TRANSACTION COUNT	Max # 4	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Blank, 01	M	
2Ø1-B1	SERVICE PROVIDER ID		M	Must be Enrolled with Medicaid
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank	M	

Claim Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*
This Segment is always sent	X	

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Reversal
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER		M	*Imp Guide:* For Transaction Code of "B2", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

**** End of Request Claim Reversal (B2) Payer Sheet ****

1.2 Response Claim Reversal Payer Sheet

1.2.1 Claim Reversal Accepted/Approved Response

**** Start of Claim Reversal Response (B2) Payer Sheet ****

GENERAL INFORMATION

Payer Name: State of South Dakota	Date:	
Plan Name/Group Name: Medicaid	BIN: 601574	PCN:
Plan Name/Group Name:	BIN:	PCN:

CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

The following lists the segments and fields in a Claim Reversal response (Approved) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Response Transaction Header Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Reversal – Accepted/Approved
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	

2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	**Check**	**Claim Reversal – Accepted/Approved** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Reversal – Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	A = Approved, S = Duplicate of Approved	M	
549-7F	HELP DESK PHONE NUMBER QUALIFIER		R	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER		R	*Imp Guide:* Required if needed to provide a support telephone number to the receiver.

Response Claim Segment Questions	**Check**	**Claim Reversal – Accepted/Approved** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Reversal – Accepted/Approved**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

1.2.2 Claim Reversal Accepted/Rejected Response

CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Reversal - Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Reversal – Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	Check	Claim Reversal - Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail.

131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		R	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER		R	*Imp Guide:* Required if needed to provide a support telephone number to the receiver.

Response Claim Segment Questions	**Check**	**Claim Reversal - Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Reversal – Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

1.2.3 Claim Reversal Rejected/Rejected Response

CLAIM REVERSAL REJECTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	**Check**	**Claim Reversal - Rejected/Rejected** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			**Claim Reversal – Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	Check	Claim Reversal - Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Rejected/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		R	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER		R	*Imp Guide:* Required if needed to provide a support telephone number to the receiver.

Response Claim Segment Questions	Check	Claim Reversal - Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Reversal – Rejected/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).

4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

**** End of Claim Reversal (B2) Response Payer Sheet ****