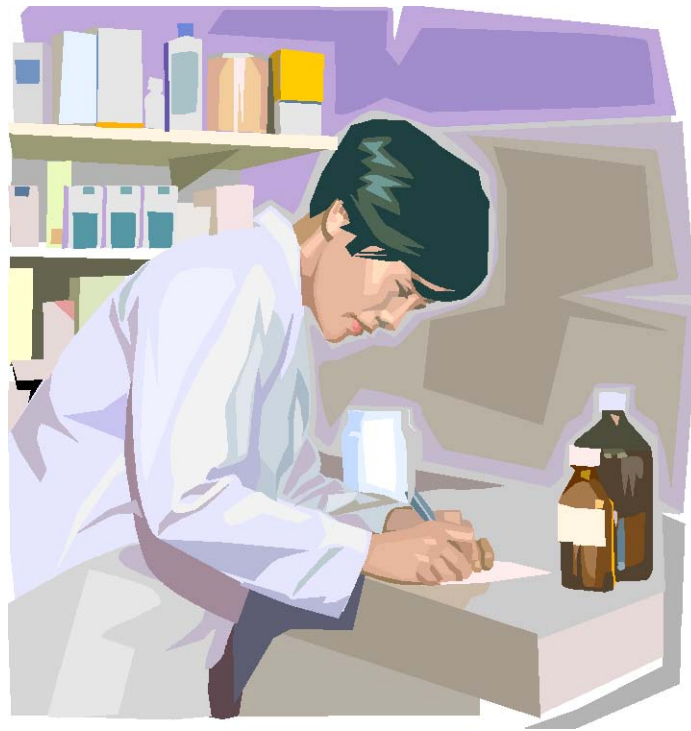


SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM



PHARMACY MANUAL

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INTRODUCTION

This manual is one of a series published for the use of medical services providers enrolled in the South Dakota Medical Assistance Program. It is designed to be readily updated by replacement or addition of individual pages as necessary. When such changes occur, providers will be notified by Remittance Advice. **It is important that the provider read the Remittance Advice messages each week for updates.** It is designed to be used as a guide in preparing claims, and is not intended to address all Medical Assistance Program rules and regulations.

Problems or questions regarding Medical Assistance Program 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, South Dakota 57501-2291
E-Mail: Medical@dss.state.sd.us
PHONE: (605) 773-3495**

If you are not currently submitting claims electronically and are interested in doing so, please contact our office for further information.

PROVIDER TOLL FREE NUMBER 1-800-452-7691 *Toll free telephone number is NOT to be given to recipients. This number is only to be used by the provider.

The telephone service unit will not give out recipient ID numbers. The Medical Assistance Program 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 (other than true emergency services.) It is to the provider's advantage to see the ID card to verify that the recipient is Medical Assistance Program eligible at the time of service, as well as to identify any other program limitations and the listing of the recipient name on the Medical Assistance Program file.

Problems or questions concerning **recipient eligibility requirements** can be addressed by the local field office 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, South Dakota 57501-2291
PHONE: (605) 773-4678**

Medicare is a separately administered federal program and questions concerning Medicare cannot be answered by Medical Assistance Program personnel.

CHAPTER I

GENERAL INFORMATION

The purpose of the Medical Assistance 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 Medical Assistance Program was implemented in South Dakota in 1967.

Federal and state governments under Title XIX of the Social Security Act share funding and control of the Medical Assistance Program. Regulations are written to comply with the actions of Congress and the State Legislature.

The following sections provide a description of general information about the program. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing the Medical Assistance Program in ARSD 67:16.

PROVIDER RESPONSIBILITY

ENROLLMENT AGREEMENT

A provider who renders a covered service to an eligible South Dakota Medical Assistance Program recipient, and wishes to participate in the Medical Assistance Program must apply to become an enrolled provider. The provider must sign a Provider Agreement with the Department of Social Services. Providers must comply with the terms of participation in the agreement and requirements stated in Administrated Rules of South Dakota (ASRD 67:16) which govern the Medical Assistance Program. Failure to comply with these requirements may result in monetary recovery, and/or civil or criminal action.

Participating providers agree to accept the Medical Assistance Program payment as payment in full for covered services.

An individual (i.e. employee, contractual employee, consultant 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 Medical Assistance Program.

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a seven (7) digit identification number, assigned by the South Dakota Department of Social Services and/or a ten (10) National Provider Identification (N.P.I.) number.

TERMINATION – AGREEMENT

When a provider agreement has been terminated the Department of Social Services will not pay for services provided after the termination date. A provider agreement may be terminated for any one of the following reasons:

1. The agreement expires;
2. The provider fails to comply with conditions of participation of the signed provider agreement;
3. The ownership, assets, or control of the provider's entity are sold or transferred;
4. Thirty days have elapsed since the department requested the provider to sign a new provider agreement;
5. The provider has requested termination of the agreement;
6. Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement;
7. The provider has been convicted of a criminal offense that involves fraud in any state or federal medical assistance program;
8. The provider is suspended or terminated from participating in Medicare;
9. The provider's license or certification is suspended or revoked; or
10. Due to inactivity.

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity must give the Department of Social Services written notice of the pending sale or transfer at least 30 days before the effective date. 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 Medical Assistance Program provider number is NOT transferable to the new owner. The new owner must apply and sign a new provider agreement and a new number must be issued before claims can be submitted.

RECORDS

Providers must keep legible medical and financial records that fully justify and disclose the medical necessity and extent of services provided and billed to the Medical Assistance Program. These records must be retained for at least six years after the last remittance date a claim was paid or denied. Records must not be destroyed when an audit or investigation is being conducted.

Agencies involved in the Medical Assistance Program review or investigation must be granted access to these records.

CLAIM SUBMISSION

The provider must submit the claim to a third-party liability source before submitting it to the Medical Assistance Program with the exception of the following:

1. Prenatal care;
2. EPSDT screening services;
3. Nursing home care; or
4. HCBS Elderly Waiver Service

The claim submitted to the Medical Assistance Program must have the notice of third-party payment or rejection attached to the claim. Failure to attach the notice to each claim will be cause for denial of the claim.

PAYMENTS

Once the provider has identified a third-party source, and, prior to requesting payment from the department, a completed claim for services must be submitted for payment to the third-party source. When the claim is subsequently submitted to the department for payment, evidence of third-party payment or rejection must accompany the claim. The provider is eligible to receive the amount allowed under the department's payment schedule less the third-party liability payment amount.

When the third-party payment equals or exceeds the amount allowed under the Medical Assistance Program, the provider must not seek payment from the recipient, relative, or any legal representative.

MEDICAL ASSISTANCE PROGRAM RECIPIENT ELIGIBILITY AND POLICIES

The South Dakota Medical Assistance Identification Card is issued by the Department of Social Services on behalf of eligible Medical Assistance Program recipients. The magnetic stripe card has the same background as the Food Stamp 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 ID (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 the claim.

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

Recipients must present their Medical Assistance Program identification card to a Medical Assistance Program provider each time, before obtaining a Medical Assistance Program covered service. Failure to present their Medical Assistance Program identification card is cause for payment denial. Payment for denied services becomes the responsibility of the recipient.



Medicaid eligibility verification system (MEVS) offers three ways for a provider to access the state's recipient eligibility file.

- Point of Service terminal: (swipe device similar to credit care verification) which maybe purchased or leased.

- 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, printable receipts and can verify eligibility status for prior dates of service. There is a nominal fee for each verification obtained through WebMD Envoy.

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 Medical Assistance Program 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: MID-DAKOTA HOSP
Service Provider #: 9999999
*****SUBSCRIBER INFORMATION*****
Current Trace Number: 200406219999999
Assigning Entity: 9000000000
Insured or subscriber: Mertz, Ethel R.
Member ID: 999999999
Address: Pierre Living Center
          2900 N HWY 290
          PIERRE, SD 575011019
Date of Birth: 06/21/1908
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

FORMS

Providers are required to use the National Standard Form (CMS 1500) to submit claims to the South Dakota Medical Assistance Program.

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 the South Dakota Medical Assistance Program. 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 Medical Assistance Program recipients eligible on the date the service is provided.

TIME LIMITS

The Division of Medical Services must receive a completed claim form within 12 months following the month the service was provided. This time limit may be waived or extended only if one or more of the following situations exist:

1. The claim is a replacement or void of a previously paid claim, and is received within six months after the previously paid claim;
2. The claim is received within six months after a retroactive initial eligibility determination was made as a result of an appeal;
3. The claim is received within six months after a previously denied claim;
4. The claim is received within six 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
5. To correct an error made by the department.

PROCESSING

The Division of Medical Services processes paper claims submitted by providers in the following manner:

1. Claims and attachments are received by the Division of Medical Services and sorted by claim type and microfilmed;
2. Each claim is given a unique 14-digit Reference Number. This number is used to enter, control, and process the claim. An example of a reference number is 20040050011480. 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.
3. All claims are separately entered into the computer system and will be completely detailed on the Remittance Advice.

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

UTILIZATION REVIEW

The Federal Government requires states to verify receipt of services. Each month a sample of Medical Assistance Program recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in nontechnical 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 42CFR 456.3, the Medical Assistance Program is mandated to establish and maintain a SURS surveillance and utilization review system (SURS). The SURS unit safeguards against unnecessary or inappropriate use of Medical Assistance Program services or excess payments, and assesses the quality of those services. 42CFR 456.23 authorizes a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers.

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by the Medical Assistance Program.

FRAUD AND ABUSE

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

DISCRIMINATION PROHIBITED

South Dakota Medical Assistance Program, participating medical providers, and contractors may not discriminate against Medical Assistance Program recipients on the basis of race, color, national origin, religion, age, sex or disability. All enrolled Medical Assistance Program providers must comply with this non-discrimination policy.

MEDICALLY NECESSARY

Medical Assistance Program covered services are to be payable under the Medical Assistance 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:

1. It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
2. It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
3. 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;
4. It is not furnished primarily for the convenience of the recipient or the provider; and
5. 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

COVERED SERVICES

A prescription is required for all items and services covered under this section including non-legend drugs and supplies. Payment, unless otherwise authorized for special groups will be limited to the following:

1. Legend dosage forms of medication used for asthmatic conditions;
2. Legend antihistamines;
3. Legend decongestants;
4. Legend antihistamine – decongestant combinations;
5. Legend cough and cold remedies;
6. Legend eye preparations;
7. Legend optic preparations;
8. Legend arthritic drugs;
9. Legend vaginal preparations;
10. Legend rectal suppositories, creams, foams, and ointments;
11. Legend antibiotics;
12. Legend drugs for the treatment of hemophilia;
13. Legend drugs used for the treatment of anxiety;
14. Legend antidepressants;
15. Legend topical creams, lotions, ointments and shampoos;
16. Legend antacids;
17. Legend **Injectable** vitamins;
18. Legend hematinics;
19. Items used for family planning;
20. Legend **oral vitamins when prescribed for pre-natal care**;
21. Calcitriol for treatment of renal impairment;
22. The following non-legend (over the counter items) when a prescription is presented:
 - Insulin;
 - Syringes and needles for the administration of legend drugs used for the delivery of respiratory or inhalation therapy;
 - Urine and blood glucose test items for diabetes (glucometers are not covered under the drug program);
 - Solutions (i.e. normal saline) that are necessary for the administration of legend drugs used for the delivery of respiratory or inhalation therapy;
 - Omeprazole;
 - Loratadine.

For the most current updates to the covered OTC drug list please refer to the internet at:
<http://dss.sd.gov/medicalservices/providerinfo/pharmacy/overthecounter.asp>

23. Spacers, such as Aerochamber and InspirEase necessary for the administration or delivery of a covered drug;

24. All other legend drugs and biologicals except for those items which are listed in non-covered services;
25. Drugs prescribed for patients who have tested positive to human immuno deficiency (HIV) when the physician has determined the treatment with these products is medically necessary;
26. Growth hormones covered when the use of the drug has received prior authorization from the department. Either the prescribing physician or the pharmacist must complete the prior authorization form which is available from the department. Authorization for payment is based on diagnosis and medical necessity. The department will respond to the request for prior authorization within one business day after receiving the completed form.

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. Vitamin and Mineral Supplements;
4. Immunosuppressives;
5. Corticosteroids;
6. Angiotensin Converting Enzyme (ACE) inhibitors and Angiotensin;
7. Receptor blockers (ARB)
8. 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. Special cough remedies, vitamins and lotions will be covered.

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 \$4.75;
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 \$4.75;

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 \$4.75. The list can be viewed on the internet at: <http://www.primetherapeutics.com/mac/macsearch.asp>
5. Payment for drugs dispensed by a physician will be limited to not more than the cost of the drug, unless a pharmacy is not available in the community.

CERTIFICATION OF BRAND NAME DRUGS

1. The cost of a brand name drug is not limited to the MAX if a physician certifies in his own handwriting that in his medical judgment a specific brand is medically necessary for a particular recipient.
2. A check off box on a prescription form is not acceptable certification. However, a handwritten notation (i.e., "brand name necessary") on the face of the prescription is allowable. 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 medically necessary by an oral order. The pharmacist must also indicate the time of day the telephone order was taken on the face of the prescription.
3. Payment for MAC drugs. Ingredient cost will not be limited to FUL or MAX if a claim is submitted electronically with a DAW code of "1" or "1" is inserted in the DAW block on the pharmacy claim form. This declares that the prescribing physician has stated that the brand product is medically necessary.

CO-PAYMENT

A \$2.00 co-payment deduction for recipient co-payment will be made from the agency's calculated payment amount for each prescription provided to persons over 18 years of age. The co-payment deduction will not be made for "family planning" items or for items provided to persons under 18 years of age, or those recipients residing in a long term care facility.

RENAL CO-PAYMENT

A five percent co-payment deduction for a renal recipient co-payment will be made from the agency's calculated payment amount for each renal prescription provided to persons over 18 years of age.

UNIT DOSE

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

1. The basis of payment will be the lower of estimated acquisition cost of the ingredient, plus fee, or the provider's usual and customary charge to the unit dose recipient;
2. MAC prices apply to stock items repackaged into unit dose dispensing unit;
3. A unit dose packaging payment will be paid for items repackaged into unit dose dispensing units from stock containers. Request for such payment is made by inserting a "3" in the unit dose indicator field for electronic claims, and by inserting "9" in the block labeled "PA Type" on the paper claim form. The packaging fee will be paid as an adjustment to the fee amount.
4. Manufacturer prepackaged strip items, liquid preparations, or items dispensed in original containers do not qualify for the additional packaging payment;

5. Fee payment will be limited to one fee per drug per month with the exception of refills of liquid products, ointments, biologicals or other products that are not available from the manufacturer in a container which is adequate for a one month supply;
6. Manufactures' prepackaged, 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 unit dose fee to the usual and customary charge. This is not added on automatically by the Division of Medical Services.

MAINTENANCE DRUGS

(Definition) "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.

1. Dispensing fee payments are limited to one per month per drug for maintenance items, except for the following:
 - Controlled substances;
 - Anti-psychotic drugs for non-institutionalized recipients when the physician indicates on the prescription that a month's supply of the drug is not in the patient's best interest and that the quantities may not be increased;
 - Payment for refills of liquid products, ointments biologicals, or other products when not available from the manufacturer in a container which is adequate for a one month supply.
2. Maximum Allowable Quantities. Quantity dispensed may not exceed a 34 day supply with the exception of family planning items and prenatal vitamins.

BIRTH CONTROL PILLS

Payment for maintenance prescriptions for birth control pills must be dispensed in no less than a 3 month supply and may be dispensed for a 12 month supply if prescribed by the physician. However, new prescriptions for birth control pills may be dispensed in less than a 3 month supply until maintenance has been established.

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. For example, if a pharmacy charges \$100 to the Medical Assistance Program for a prescription it is appropriate for the provider to accept a greater payment from the Medical Assistance Program, but the charge to both payers should be the same.

NON COVERED SERVICES

The following are not reimbursable under the Department of Social Services Pharmacy Program**:

1. Non legend drugs (except those items that are listed under covered services);
2. Medical supplies, food or nutritional supplements, delivery charges;

3. Oral vitamins except for legend vitamins prescribed for prenatal care or Rocaltrol (see covered services);
4. Items prescribed for weight control or appetite suppressants;
5. Nicotine replacement drugs;
6. Agents used for cosmetic purposes;
7. Hair growth products;
8. Agents to promote fertility or agents used to treat impotence *** (i.e. Clomid) **will not be covered regardless of age**;
9. Services, procedures, or drugs which are considered experimental;
10. Less than effective drugs**** (DESI drugs);
11. Drugs manufactured by a firm that has not signed a rebate agreement with the United States Department of Health and Human Services (agreement currently does not apply to syringes and needles or other covered devices).

In the event a legend non covered prescription item that is not classified a DESI drug, or an experimental drug is written for an eligible recipient under the age of 21, it will be reimbursable (**with the exception of agents to promote fertility**).

****The DESI drug rule does not apply to foster children.

CHAPTER III

BILLING INSTRUCTIONS

HOW TO COMPLETE THE PHARMACY CLAIM FORM

(NCPDP 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 patient's Medicaid Identification Number is listed here. The Department uses the last nine digits of the I.D. number to process claims.

PATIENT NAME: Enter the patient's name as it appears on the patient's Medicaid Identification Card.

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

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

SERVICE PROVIDER I.D.: Enter the seven digit identification number assigned by the Medicaid Program.

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 patient. Should be listed as the following example indicates: 01-01-2005

QTY DISPENSED: The unit quantity of the product dispensed. See Chapter II, page one for the units listed for the Family Planning Products.

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; page one for a complete listing of products, which can be dispensed by Family Planning Providers.

PRESCRIBER I.D.: Enter the South Dakota Medicaid assigned Prescriber Identification Number for the physician ordering the family planning item. If the prescribing physician does not have a Medicaid prescriber number, enter the physician's last name in this field.

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, with the assistance of a private contractor, has developed 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

Print your screen, or write down the exact message on your screen before calling about any problem.

Network Processing Difficulties – The POS system is accessed via one of the pharmacy claims networks contracting with South Dakota Medical Assistance Program. At times the switch network system may be out of service or unable to exchange information with the state's computer. If the condition persists, please contact the network's help desk directly for assistance. The switch companies and their telephone numbers are:

- NDC Help Desk 1-800-388-2316 24hrs/7days
- Web MD 1-800-333-3672 24hrs/7days
- Web MD Envoy 1-800-333-6869 24hrs/7days
- NDC Network Control 1-404-728-2570 24hrs/7days
- QS/1 Data Systems 1-864-503-9455 24hrs/7days

State Processing Difficulties – If the network returns information that state files are out of service, specific messages you may see 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've received and contact 1-605-773-4357 or 1-605-773-HELP .

Pharmacies are reminded to call their switch company if there are network difficulties. The State Help Desk is for technical problems such as when a line is down, or a file is down.

The help desk at the State is a computer technical support team and checks incoming transmission lines and main frame files and cannot answer billing and coverage questions. Please rely on the Division of Medical Services' staff for billing and coverage questions.

- Questions regarding adjudication, claims submission, replacements, voids and remittance advice; and format specifications contact:
Meredith Heermann at 1-605-773-5188
- Questions regarding pharmacy coverage and policies contact:
Mike Jockheck at 1-605-773-3498
- Questions on Medical Assistance Program Claims, covered services or eligibility verification can be directed to the Medical Assistance Program Provider Support Unit at 1-800-452-7691.

***The toll free number is NOT to be given to recipients. This number is only to be used by the provider.**

NDC Numbers

If you are unable to locate a NDC number, please check your Red Book, Blue Book or other nationally recognized publication. If you notice coverage discrepancies in NDC numbers, you may fax a list to (605)-773-5246 or call the Medical Assistance Program Provider Support Unit at 1-800-452-7691.

SOUTH DAKOTA POINT-OF-SALE GENERAL INFORMATION

Pharmacy software vendors and computer programmers may need to make changes to their systems and/or submission procedures. In order to assure a smooth transition and uninterrupted cash flow for the pharmacy, please ensure that your system meets the following requirements.

BIN NUMBER

South Dakota Medical Assistance Program processor BIN number is 601574.

This number has been assigned to the South Dakota Medical Assistance Program by the American National Standards Institute (ANSI). The BIN number must be included in all NCPDP transactions routed to the South Dakota Medicaid (SDMCD) POS system.

PAPER CLAIMS

The South Dakota Medical Assistance Program will continue to accept paper claims, but prefers that claims are sent via the POS.

FORMAT FOR CLAIMS

Claims that are submitted via point-of-sale must follow NCPDP guidelines. Please visit with your software companies if you have questions.

FORMAT FOR RECIPIENT CARDHOLDER IDENTIFICATION NUMBER

Pharmacies may continue to send recipient cardholder identification numbers in the same format as in the past. Please notify your software developer that no change in recipient identification

number format is required. Whatever format you are currently using for recipient identification numbers can be continued via point-of-sale.

NAME VERIFICATION

Names submitted on claims must match with the name on the recipient cardholder identification number. Claims with names that do not match with the recipient cardholder identification number 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 also cause a denied claim.

SWITCH CONNECTIONS

Direct switch connections are established with Web MD, QS/1 and NDC.

Web MD Envoy	QS/1 Data Systems	National Data Corporation (NDC)
26 Century Blvd. Suite #601	PO Box 6052	National Data Plaza
Nashville, TN 37214	Spartanburg, SC 29304-9975	Atlanta, GA 30329-2010
(800)933-6869	(864)503-9455	(404)728-2000
		FAX: (404) 728-2551
		Help Desk: (800)388-2316

POS FORMAT

POS/ProDUR system is compatible with most pharmacy computer systems, but some may need software changes. (Please pay special attention to the override process.)

The SDMCD POS/ProDUR system will accept either of the following formats:

1. NCPDP Version 3.2 variable length format containing the “required” fixed format sections of the header and claim data as specified in Recommended Transaction Data Set “C” (RTDS “C” Medicaid Claim Format); or
2. NCPDP Version 3C fixed length format (Medicaid Claim Format).

For each of the SDMCD supported POS claim transactions, the tables list:

1. The NCPDP elements needed from the pharmacy’s system in order to process a SDMCD claim.
2. The SDMCD required/conditional/optional data elements that are returned to the pharmacy via the NCPDP format (conditional means that the data element is required if certain conditions are true.)

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 SDMCD return transaction is made available to the pharmacist at the time the prescription is dispensed.

Other important implementation considerations:

1. Pharmacists must be able to see the contents of the message fields returned with the various transactions by SDMCD. 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);
- Primary Care Provider (PCP) information;
- Prior Authorization; and
- Drug utilization review and early refill alerts.

2. All dates must be submitted and received in CCYYMMDD format (century dates).

PROSPECTIVE DUR DENIALS AND OVERRIDE PROCEDURES

The Prospective Drug Utilization Review process follows the National Council for Prescription Drug Pricing (NCPDP) ProDUR standard formats for conflict, intervention, and outcome. These formats are found in the SDMCD Technical Specifications, Table 9 and 10 (see pages 11 and 12). The department has the capability to control which of the conflicts in Table 9 will result in a denial of a claim. The “Early Refill” or ‘ER’ code will be the first conflict in place with other conflicts added to production over a period of several months. In order for the early refill alert to function properly the correct days supply must be entered on the claim.

EARLY REFILL OVERRIDE

Note that the override process is not the same as with some of the private insurers/processors. They use the 420-DK field and position, while SDMCD will use only those codes found in the ProDUR tables.

An example of how to override a denial for an early refill is to enter 3 codes. To override a denied claim because of a ProDUR edit required the entry of three codes in the appropriate locations:

1. The Conflict Code (from table 9 as returned by SDMCD on a denied claim)
2. The Intervention Code* (from table 10)
3. The Outcome Code (from table 10)

*The Intervention codes (table 10) are alpha-numeric.

Examples:

M0 (zero), Po (zero), and R0 (zero). However, the intervention code 00 is zero, zero (numeric, numeric).

POS OVERRIDE

In summary: Should SDMCD choose to deny (reject) claims because of a prospective drug utilization review alert, the POS/ProDUR system will allow the pharmacist to override the rejection using entry of 3 codes: Conflict code, Intervention code, and Outcome code. These codes are located in Tables 9 and 10. One code from each column is required to override a denied claim which results from ProDUR alert. **Please review the process with your software vendor to ensure a smooth implementation.**

DUR OVERRIDE CODES

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

CONFLICT CODES		INTERVENTION CODES		OUTCOME CODES	
(SEE TABLE 9)		(SEE TABLE 10)		(SEE TABLE 10)	
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. Use of the override process is not 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 an NCPDP reversal transaction. Reversals may be used in many circumstances.

Examples:

1. A prescription is not picked up by the patient;
2. The quantity dispensed is changed or not utilized;
3. Prospective Drug Utilization Review (ProDUR) information provided by the system as a claim was paid results in a prescription not being dispensed or being modified. If modified, the new claim may be submitted at any time after the reversal, and
4. An error was made when submitting the claim. A corrected claim may be submitted and processed at any time after the reversal. Generally, a reversal and resubmission can be used in place of the hard copy adjustment form.

DENIED POS CLAIM

If a claim has been denied for any reason, you may rebill via the POS system if you think the claim should be payable, making any needed claim corrections.

Example:

If the claim is denied because the Medical Assistance Program ID number is invalid, correct the ID number and resubmit.

Compound Prescriptions

Do not bill via the POS system for compounded prescriptions. Continue to use the same procedure using the hard copy claim form with the NDC number 09999200000.

Replacements and Voids

The point-of-sale system allows the pharmacy to reverse any claim that has been paid or captured by submitting an NCPDP reversal transactions and rebilling with correct information. Your software vendor can assist you in the correct process for your type of software.

OVERPAYMENTS

It is important to watch for overpayments. In the event that you receive a payment from the Medical Assistance Program in error, or in excess of the amount properly due under the applicable rules and procedures, you must promptly notify 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.

POINT-OF-SALE FORMAT TABLE REQUIREMENTS

Please provide this information to your software vendors.

Table 1: SDMCD Incoming NCPDP Medicaid Claim Format		
Data Element	Format	Required/Conditional/Optional
Required transaction header section		
BIN #	NCPDP	Required '601574'
Version #	NCPDP	Required
Transaction code	NCPDP	Required
Processor control #	NCPDP	Optional
Pharmacy ID	7N	Required SDMCD Provider ID#
*Cardholder ID#	9A/N	Required SDMCD Provider Medical Assistance ID#

Table 2: SDMCD Claim Payable Response Format		
	NCPDP claim payable response output format	NCDP field number
From current claim		
Constant value '32' or '3C'	VERSION NUMBER	102
The NCPDP trans code submitted for the claim being processed	TRANS CODE	103
Constant value 'A'	HEADER STATUS	501
Constant value spaces	PLAN IDENTIFICATION	524
Constant value 'P'	RESPONSE STATUS	501
SDMCD amount to be paid by recipient (co pay)	PATIENT PAY AMOUNT	505
Drug MAC price or Drug EAC price	INGREDIENT COST PAID	506
Professional/dispensing fee	CONTRACT FEE PAID	507

Constant value zero	PAID SALES TAX	508
SDMCD reimbursement amount	TOTAL PAID AMOUNT Note: The amount paid may be reconciled as: The sum of: Ingredient Cost Paid (506) Contract Fee Paid (Dispensing Fee) (507) Sales Tax Paid \$0 (508) Less: Other payor amount (from incoming record) Equals the sum of: Patient Pay Amount (505) Total Amount Paid (509)	509
SDMCD Reference Number for paid claim	PAID AUTHORIZATION NUMBER	503
Constant value 'PAID'	PAID MESSAGE	504
DUR messages pertaining to the claim	PAID DUR RESPONSE	525

Table 3: SDMCD Claim Captured Format		
FROM CURRENT CLAIM	NCPDP CLAIM ACCEPTED REVERSAL OUTPUT	NCPDP FIELD NUMBER
Constant value '32' or '3C'	VERSION NUMBER	102
The NCPDP TRANS CODE submitted for the claim being captured.	TRANS CODE	103
Constant value 'A'	HEADER STATUS	501
Constant value zero	PLAN IDENTIFICATION	524
Constant value 'C'	RESPONSE STATUS	501
SDMCD Reference Number for the captured claim	AUTHORIZATION NUMBER	503
A SD<CD specific message, if assigned to the condition, or a constant value 'CLAIM NOT PROCESSED'	MESSAGE	504
Constant value '/CAPTURED FOR REVIEW'	MESSAGE	504
Constant value zero	AMT OF COPAY	518
DUR messages pertaining to the claim (see Table 9)	DUR RESPONSE DATA	525
Constant value spaces	ADDITIONAL MESSAGE INFO	526

Table 4: SDMCD Claim Rejected Response Format		
FROM CURRENT CLAIM	NCPDP CLAIM REJECTED RESPONSE OUTPUT	NCPDP FIELD NUMBER
Constant value '32' or '3C'	VERSION NUMBER	102
The NCPDP TRANS CODE submitted for the claim being rejected	TRANS CODE	103
Constant value 'A'	HEADER STATUS	501
Constant value SPACES	PLAN ID	524
Constant value 'R'	RESPONSE STATUS	501
Up to 20 NCPDP reject codes can be returned for a single claim	REJECT CODE 01 THROUGH REJECT CODE 20	511

DUR messages pertaining to the claim (See Table 9)	DUR RESPONSE	525
SDMCD Reference Number for the rejected claim	REJECTED REFERENCE NUMBER	504
'NOT PAID' or a single specific SDMCD reject message that does not convert to a NCPDP reject code	REJECT MESSAGE	504

Table 5: SDMCD Duplicate Claim Response Format	
FROM CURRENT CLAIM	NCPDP DUPLICATE REJECT
Constant value 'D'	NCPDP DUPLICATE REJECT
Constant value zero	DEDUCTIBEL, FIELD 505 INGR-COST-PD, FIELD 506 DISPENSING FEE, FIELD 507 SALES TAX, FIELD 504
Constant value 'ORIGINAL CLAIM PAID', SDMCD Reference Number and date paid from the previously paid claim	MESSAGE FIELD, 504
SDMCD Reference Number for the current rejected claim	AUTHORIZATION NUMBER, FIELD 503
Reimbursement amount from previously paid claim	TOTAL AMOUNT PAID, FIELD 509
SDMCD amount to be paid by recipient (co-payment) from the previously paid claim	MESSAGE FIELD, 504

Table 6: SDMCD Incoming NCPDP Reversal Transaction Format	
NCPDP Reversal Input Claim Format	NCPDP Field Number
BIN Number, the card issuer ID or bank ID number used for network routing	101
Version Number '32' or '3C'	102
TRANS CODE '11'	103
Pharmacy Number, Medicaid Provider #	201
Date Filled. The date on which the prescription was filled.	401
Prescription Number. The prescription number assigned by the provider.	402

Table 7: SDMCD Reversal Response – Accepted – Format		
The following data elements are moved from the current claim to the NCPDP accepted reversal response format for return to the pharmacist through POS when a claim is reversed.		
From Current Claim	NCPDP Claim Accepted Reversal Output	NCPDP Field Number
Constant value '32' or '3C'	VERSION NUMBER	102
The NCPDP TRANS CPDE submitted for the claim being reversed	TRANS CODE	103
Constant value 'A'	HEADER STATUS	501
SDMCD Reference Number of the reversed claim	AUTHORIZATION NUMBER	503
Constant value 'CLAIM REVERSED'	MESSAGE	504

Table 8: SDMCD Reversal Response – Rejected – Format		
The following data elements are moved from the current claim to the NCPDP rejected reversal response format for return to the pharmacist through POS when a reversal is rejected.		
From Current Claim	NCPDP Claim Rejected Reversal Output	NCPDP Field Number
Constant value '32' or '3C'	VERSION NUMBER	102

The NCPDP TRANS CODE submitted for the claim being reversed	TRANS CODE	103
Constant value 'R'	HEADER STATUS	501
Constant value 'REVERSAL NOT PROCESSED'	MESSAGE	504
Constant value 'CLAIM NOT FOUND' or 'ALREADY REVERSED OR ADJUSTED'	MESSAGE	504
Constant NCPDP reject value 87	REJECT CODE (1)	511
Constant value 01 or 02	REJECT COUNT	510
If the reject count is equal to 02 move constant NCPDP reject value 86	REJECT CODE (2)	511

Table 9: SDMCD Prospective Drug Utilization Review (ProDUR) Modules Note: The NCPDP format supports passing up to 3 DUR conflict codes to the pharmacy per claim. The SDMCD system may post additional codes. All DUR codes that are posted by SDMCD are prioritized in the following order and up to 3 are reported as follows:

Priority	Reported	DUR Conflict	Code
1	1	Early Refill (Same drug, same pharmacy)	ER
2	Up to 3	Drug Interactions	DD
3	Up to 3	Duplicate Therapy Same Drug	ID
		Therapeutic Duplication	TD
	Up to 3	Medical Disease Diagnosed Contraindicated	MC
		Drug Disease Contraindicated	DC
5	1	Adult High Dose	HD
		Geriatric High Dose	HD
		Pediatric High Dose	HD
6	1	Adult Low Dose	LD
		Geriatric Low Dose	LD
		Pediatric Low Dose	LD
7	Up to 3	Additive Toxicity	AT
8	Up to 3	Latrogenic Side Effect (Inferred)	IC

Table 10: Pharmacist ProDUR Override Codes

Should SDMCD ever choose to deny (reject) claims because of a prospective drug utilization review alert, the POS/ProDUR system will allow the pharmacist to override the rejection using an NCPDP Outcome Code. Following are the allowable NCPDP Intervention Codes. Outcome Codes and related descriptions Pharmacists must be able to submit these codes along with the conflict codes in Table 9 in the incoming NCPDP Medicaid Claim:

Intervention Code	Description	Outcome Code	Description
'M0' (zero)	Prescriber consulted	1A	Filled, False Positive
'P0' (zero)	Patient consulted	1B	Filled Prescription as is
'R0' (zero)	Pharmacist consulted other source	1C	Filled with different dose
'00' (zero – zero)	No intervention	1D	Filled with different directions
Blank	Not specified	1E	Filled with different drug
		1F	Filled with different quantity
		1G	Filled with prescriber approval
		2A	Prescription not filled
		2 B	Prescription not filled – directions clarified

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, prospective DUR, and the State DUR Board, as well as patient counseling.

RETROSPECTIVE DUR

The retrospective DUR program involves reviews of patient 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 patient 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 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 patient'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.