Pharmacy Billing Instructions

Oregon Health Authority

HEALTH SYSTEMS DIVISION

Billing instructions for Provider Web Portal and UCF 5.1 pharmacy claim formats for Oregon Medicaid providers

June 2017

Oregon HEALTH PLAN

Contents

Introduction

The *Pharmacy Claim Instructions* handbook is designed to help those who bill the Oregon Health Authority (OHA) for Medicaid services submit their claims correctly the first time. This will give you step-by-step instructions so that OHA can pay you, the provider, more quickly.

Use this handbook with the Oregon Health Plan (OHP) General Rules and your provider guidelines (administrative rules and supplemental information), which contain information on policy and covered services specific to your provider type.

- You can find all OHP provider guidelines at www.oregon.gov/OHA/HSD/OHP/pages/policies.aspx.
- As noted in *Oregon Administrative Rule 410-121-0100 – Drug Use Review*, also follow Oregon Board of Pharmacy rules defining specific requirements relating to patient counseling, record keeping and screening.

This handbook lists the requirements for completion prior to sending your claim to OHA for payment processing, as well as helpful hints on how to avoid common billing errors. It is designed to assist the following providers[1]:

- Pharmacy providers
- Durable Medical Equipment providers billing for diabetic supplies

The pharmacy claim is also known as the NCPDP claim. Throughout this billing guide you will see the claim type being referred to as a pharmacy claim.

[1] If in doubt of which claim format to use, contact Provider Services at 800-336-6016, or refer to your provider guidelines.

Claims processing

The federal government requires OHA to process Medicaid claims through an automated claim processing system known as MMIS - the Medicaid Management Information System. This system is a combination of people and computers working together to process claims.

Paper claims submitted by mail go first to the DHS/OHA Office of Imaging and Records Management Services.

- The document is scanned through an Optical Character Recognition (OCR) machine and the claim is given an Internal Control Number (ICN).
- The scanned documents are then identified and sorted by form type and indexed by identifiers such as client name, prime identification number, the date of service, and provider number.
- Finally, the data is entered in the MMIS and images of the documents are stored on an Electronic Document Management System (EDMS).

The ICN is a unique identifier.

- The first two digits indicate the type of format of the claim (*e.g.*, '22'Web claim, '10' paper claim, '20' electronic).
- The next two are the year; '11' (2011).
- The next three are the Julian date; "031" (January 31).
- The remaining digits are details of the claims regarding how they are 'batched' within the MMIS.

Data from web claims directly enter the MMIS if all information is entered correctly. Electronic data interchange (EDI, or electronic batch submission) claims are reviewed for compliance and translated from the HIPAA standard formats for MMIS processing.

Once the data enters the MMIS, staff can immediately access submitted claim information by checking certain MMIS screens.

The system performs daily edits for presence and validity of data as each claim is processed. Once a week, the system audits all claims to ensure that they conform to medical policy. Every weekend, a payment cycle runs, and the system produces checks for claims that successfully pass all edits and audits.

If MMIS cannot make a payment decision based on the information submitted or if policy determines manual review is needed, the claim is routed to OHA staff for specific manual, medical or administrative review. This type of claim is a *suspense (suspended) claim*.

OHA does not return denied claims to providers in this process. Instead, OHA sends a listing of all claims paid and/or denied to the provider (with payment if appropriate). The listing is called a Remittance Advice (RA).

- The RA comes in paper and electronic formats. The paper format will list suspended claims while the electronic does not.
- If you aren't already receiving the electronic RA, contact EDI Support at DHS.EDISupport@state.or.us. for more information.

Before you bill OHA:

1. Verify that the client is eligible on the date of service for the services rendered. Claims for services to clients enrolled with an OHP managed care organization (MCO) or coordinated care organization (CCO) must be billed to the appropriate MCO/CCO.
2. Medicaid is always the payer of last resort. If the client has Medicare or third-party insurance, bill them first before billing Medicaid.
3. Verify that the drug you are billing is rebateable (*i.e.*, part of the federal Medicaid Drug Rebate Program). To verify that an NDC is rebateable, search for it in the CMS rebate drug product data file on the CMS Medicaid Drug Rebate Program Data page. If the NDC is on file, it is rebateable.

Pharmacy web claim instructions

When to submit a web claim

In order to use the web portal to submit claims, you must have received your Personal Identification Number (PIN) from OHA. If you do not know your PIN, contact Provider Services at 800-336-6016 for assistance.

Do not submit a web claim when:

- **You need to submit hard copy attachments (*e.g.*, written documentation).** If you submit a web claim for a service that requires attached documentation, the claim will suspend, then deny for missing documentation. Always bill on paper for claims that require attachments.
- **You need to bill for services more than a year after the date of service.** Claims past timely filing limits must be sent on paper.

Before you submit a web claim

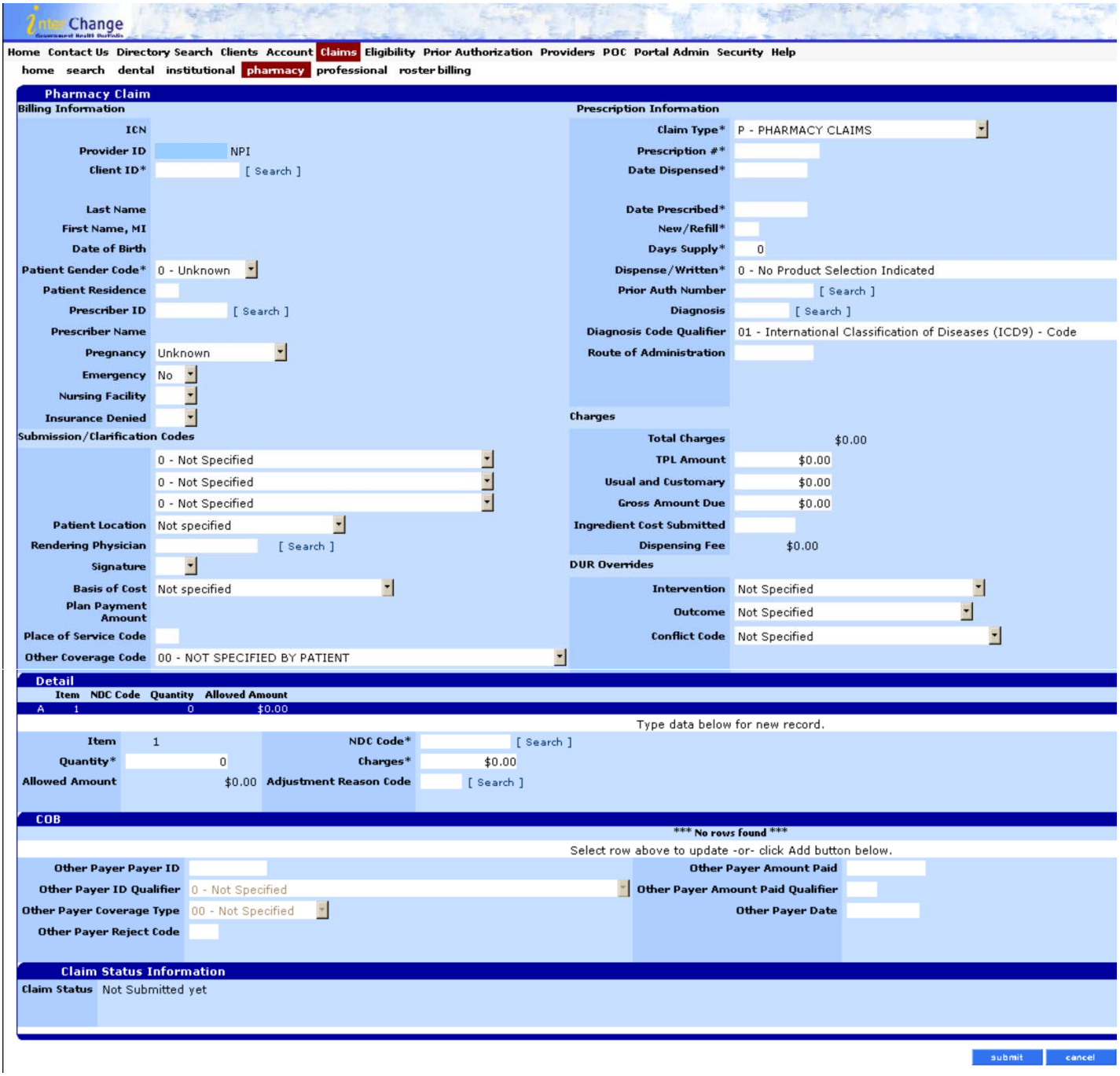
The following list will help you to better understand what needs to be done prior to submitting a web claim.

1. Verify that you are signed on and are acting on behalf of the correct provider. It is crucial to make sure you are logged on under the correct provider number because this is the provider OHA will pay.
2. You must complete and submit the claim in its entirety in order to save the data entered. Partially completed claims data cannot be saved.
3. The session will end after 20 minutes of inactivity. Any work or changes that have not been submitted will be lost.
4. The pharmacy claim has three screens (see box at right). In some screens you simply move from field to field while in others you must indicate you wish to "Add" information by selecting the "Add" button. Make sure you review all screens and enter all required and/or applicable data in each screen.

1. Pharmacy Claim Header
2. Detail
3. Claims Status Information

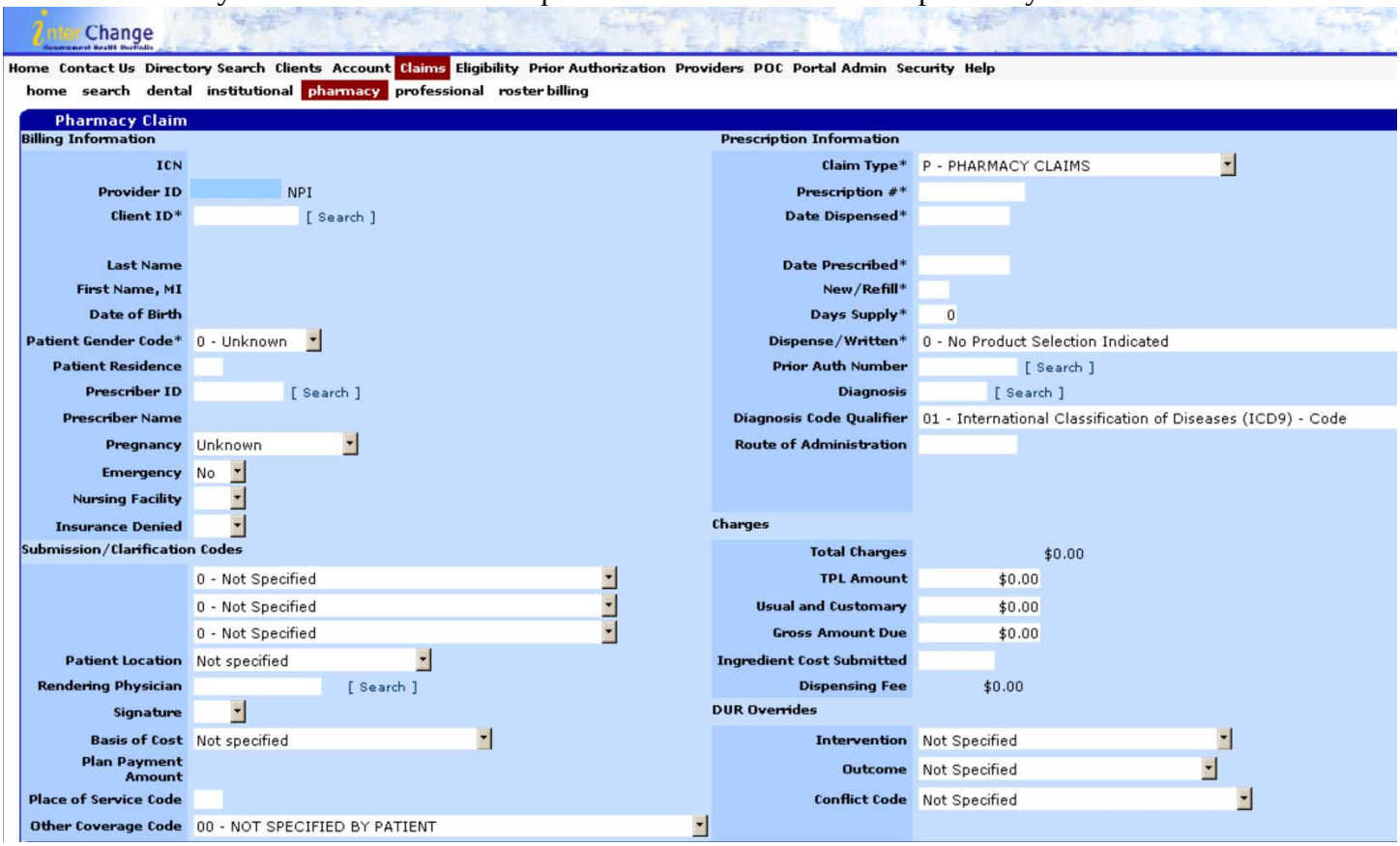
How to submit a pharmacy web claim

Click on “Claims,” then “Pharmacy.” The following screen will appear:



Step 1: Enter header information

From this screen you can enter all of the required information to submit a pharmacy claim.



Field descriptions

Shaded boxes are always mandatory. Non-shaded boxes are mandatory if applicable.

Field	Description
ICN	Claim's internal control number (ICN). (Read-only)
Provider ID	National Provider Identifier (NPI) or Oregon Medicaid Provider ID associated with this Provider Web Portal login (Read-only).
Billing Provider ID*	The NPI or Medicaid Provider ID that should receive payment from OHA.
Client ID*	Client identification number.
Last Name	Last name of the client. Client name auto-populates based on a valid client ID. (Read-only)
First Name, MI	First name and middle initial of the client. Client name auto-populates based on a valid client ID. (Read-only)
Date of Birth	The client's date of birth. Client DOB auto-populates based on a valid client ID. (Read-only)
Patient Gender Code*	Valid options are 0 = Unknown, 1 = Male, 2 = Female.
Patient Residence	

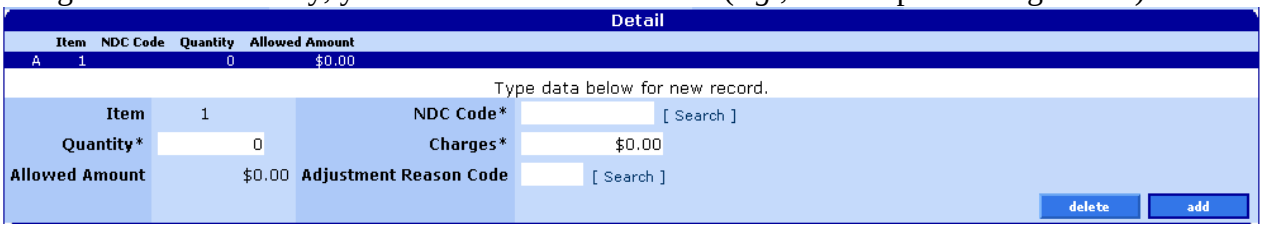
Field	Description
Prescriber ID	NPI of the provider who is prescribing the drugs. If you do not have the prescriber's NPI, click the "Search" link to search for the prescriber's NPI by name or Medicaid Provider ID. ■ Only NPIs for enrolled OHA providers who have registered their NPI with OHA will be available using this search. ■ The prescriber must be enrolled with OHA to comply with Affordable Care Act requirements. ■ When the prescriber is a resident at a teaching hospital, enter the supervising physician's information. ■ If you are unable to locate the prescriber ID via search, look up the NPI at https://npiregistry.cms.hhs.gov/ or contact the prescriber's office to obtain a valid NPI.
Prescriber Name	This is the name of the prescriber. Prescriber name auto-populates based on a valid prescriber ID. (Read-only)
Pregnancy	This field indicates if the patient is pregnant or not-pregnant. Valid options are: Unknown, Not pregnant, or Pregnant.
Emergency	This field indicates if the claim is an emergency situation. Valid options are YES/NO.
Nursing Facility	This field indicates if the drug was prescribed in a nursing facility. It is an optional field. Valid options are YES/NO.
Insurance Denied	This field indicates if other insurance (third party liability, or TPL, including Medicare) was denied. Valid options are YES/NO. ■ If TPL was billed, you also need to enter the appropriate HIPAA Adjustment Reason Code (ARC) in the Adjustment Reason Code field on the detail line.
Submission/ Clarification Code	This field indicates that the pharmacist is clarifying the submission. Use the drop-down boxes to view valid options.
Patient Location	The location of the patient when receiving pharmacy services.
Rendering Physician (Optional)	NPI or Medicaid Provider ID of the provider who would provide services. ■ Click the "Search" link next to this field to locate a rendering physician. ■ If you are unable to locate the rendering provider ID, you can leave this field blank.
Signature	This field indicates whether the claim was signed by the prescribing physician. Valid options are YES/NO.
Basis of Cost	Indicates whether this is a 340B claim.
Place of Service Code	Use CMS Place of Service codes.
Other Coverage Code	Use this field to show how other coverage paid. Use the drop-down boxes to view valid options.
Claim Type*	Code that specifies the type of claim. Valid options are: P-Pharmacy Claims or Q-Compound Pharmacy Claims.
Prescription# *	RX number which uniquely identifies a drug dispensed to a client.
Date Dispensed*	Date the prescription was filled.
Date Prescribed*	Date the physician prescribed the drug to the client.

Field	Description
New/Refill*	Code that indicates whether the prescription is new or refill. Valid options are: ■ 0-New refill ■ 1-1st refill ■ 2- 2nd refill ■ 3-3rd refill, and so on.
Days Supply*	Number of days a prescribed drug should last a client.
Dispense/Written*	Dispense as written indicator. Use the drop-down list to view and select the most appropriate option. ■ This field is required for P-Pharmacy Drug claim type but is not required for Q-Compound Drug claim type.
Prior Auth Number	The Prior Authorization number for the drug.
Diagnosis (Optional)	The ICD-9 or ICD-10 diagnosis code associated with the claim. ■ Use ICD-9 codes for dates of service on or before 9/30/2015. ■ Use ICD-10 codes for dates of service on or after 10/1/2015.
Diagnosis Code Qualifier	Use the drop-down list to view and select the most appropriate option.
Route of Administration	See NCPDP Data Dictionary for accepted values.
Total Charges	Total dollar amount charged for the claim. Total charges are the sum of all charges and are derived from the detail line item. This field will not populate with total charges until the detailed line is completed. (Read-only)
TPL Amount	Dollar amount paid by TPL (including Medicare). ■ If TPL was billed, you also need to enter the appropriate HIPAA ARC in the Adjustment Reason Code field on the detail line.
Usual and Customary	The billed amount.
Gross Amount Due	The sum of all charges on the claim.
Ingredient Cost Submitted	Enter costs for compound drugs only.
Dispensing Fee	Amount of dispensing fee, if paid. (Read-only)
DUR Override fields: These fields are required only if the ProDUR denies the claim with an ER, HD, or PG alert. Refer to the Pharmaceutical Services Supplemental Information for more information.	
Intervention	Intervention Code indicating the pharmacist's interaction: ■ 00: No intervention ■ M0: Prescriber consulted ■ P0: Patient consulted ■ R0: Pharmacist consulted - Other source
Outcome	Result of Service/Outcome Code indicating the action taken by the pharmacist: ■ 1A: Filled As is, False Positive ■ 1B: Filled Prescription As Is ■ 1C: Filled, With Different Dose ■ 1D: Filled, Different Direction ■ 1E: Filled, With Different Drug ■ 1F: Filled, Different Quantity ■ 1G: Filled, Prescriber Approval ■ 2A: Prescription Not Filled – For HD alerts only ■ 2B: Not filled-Direction Clarified – For HD alerts only

Field	Description
Conflict Code	Conflict Reason Code: ■ ER: Early Refill/Overutilization ■ HD: High Dose ■ PG: Drug-Pregnancy

Step 2: Enter claim detail lines

This section displays fields for entering the first detail line. Enter the NDC, quantity, and charges for the drug being billed. If necessary, you can add more detail lines (*e.g.*, for compound drug claims).



Field descriptions

Shaded boxes are always mandatory. Non-shaded boxes are mandatory if applicable.

Field	Description
Item	The number of the detail line. (Read-only)
Quantity*	Number of units of a drug dispensed to a client.
Allowed Amount	Maximum amount allowed for services provided to a client. (Read-only)
National Drug Code (NDC)*	11-digit NDC used to uniquely identify a drug. Use the NDC listed on the drug being dispensed. Enter in 5-4-2 format. ■ You can also use the "Search" link next to this field to search for NDC by description (drug name). ■ Search results will display the NDC in the "Drug" column.
Charges*	Dollar amount charged to Medicaid for the drug.
Adjustment Reason Code	If you billed TPL (including Medicare), enter an ARC code to describe how TPL processed the claim (e.g., denied or paid partial).

To add a detail line item

Use this process only when you need to add more than one detail line.

Step	Action	Response
1	Click the Add button.	Detail screen activates fields for data entry.
2	Enter data in the required fields on the detail screen (quantity, NDC code, and charges).	
3	Enter an Adjustment Reason Code if TPL denied or made a partial payment on the claim.	

To delete a detail line item

Use this process to delete a specific line item. It does not delete the claim.

Step	Action	Response
1	Choose the line item to be deleted.	Data populates fields in the Detail screen.
2	Click the Delete button.	Dialog displays to confirm deletion.
3	Click OK.	

To update a detail line item

Use this process to make changes to an existing line item on the claim.

Step	Action	Response
1	Choose the line item to be updated.	Data populates detail fields in the detail screen.
2	Enter updated data in the quantity, NDC code, charges, and Adjustment Reason Code fields as needed.	

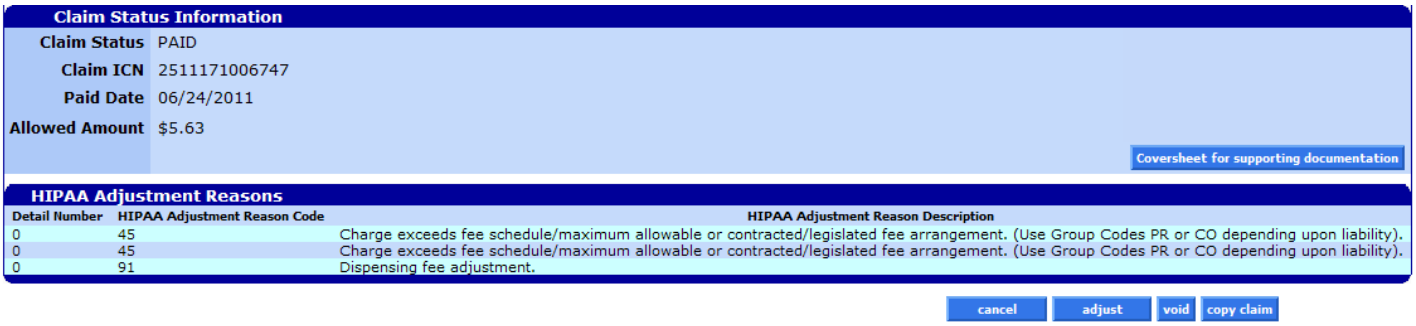
Step 3: Submit claim and review claim status information

Click the "Submit" button to submit the claim. Claim status information will only display after the claim has been completed and submitted. Claim status will indicate if a claim has been paid or denied.

Before you click "Submit,"- no data displays:

After you click "Submit," the claim adjudicates in real-time so that you can immediately view the status of the claim.

- Claim status may show that the claim has been paid, denied, or suspended.
- This screen also displays HIPAA ARCs, if applicable.



The "Cover Sheet for Supporting Documentation" button **does not apply to pharmacy claims.**

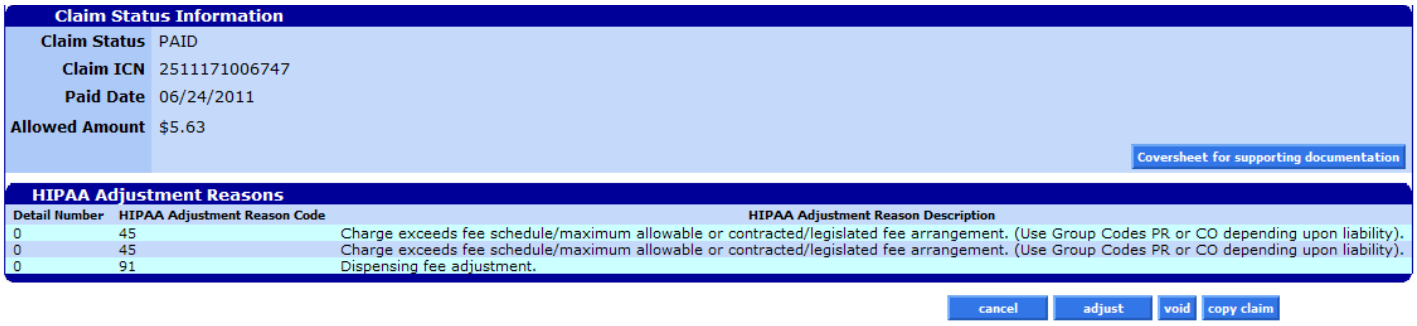
Field descriptions

Field	Description
Claim Status	The detailed description of the status of the claim.
Claim ICN	Internal control number that uniquely identifies the claim.
Paid Date	The date that the claim was paid.
Allowed Amount	The dollar amount allowed for the claim.
Coversheet for supporting documentation	Link to the coversheet used when submitting claim attachments. Does not apply to pharmacy claims.
Detail Number	The claim detail on which the EOB posted.
HIPAA Adjustment Reason Code	The code for the ARC.
HIPAA Adjustment Reason Description	The description of the ARC.

Paid claim

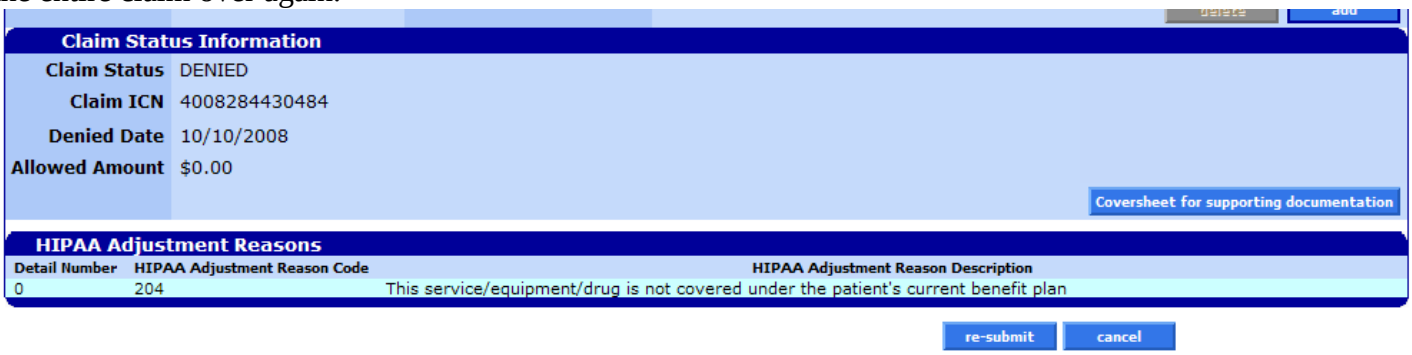
Paid claims will have a claim status of "PAID." The Claim ICN, paid date, allowed amount, and EOB information is displayed on all paid claims.

- On paid claims, the adjust, void and copy claim buttons at the bottom of the claim will activate. See the *Claim Adjustment Handbook* for more information about how to adjust paid claims.
- Web claims are processed in real-time, which means you will receive an immediate claim status response; however, payments are still made on a weekly basis.



Denied claim

A denied claim will have a claim status of "DENIED." The resubmit button at the bottom of the claim will activate. It allows you to correct the claim and resubmit it as an original, new claim, without having to complete the entire claim over again.



How to copy a paid claim

The **copy claim** button allows you make an exact duplicate of an existing paid claim to a new screen. Once copied, you can update the claims data and submit the copied claim as a new claim. This feature saves time because you do not have to enter all new data but you must make sure to update all relevant data. Once the claim is submitted, a new ICN will be generated.

Step	Action	Response
1	Select the **copy claim** button.	Duplicate claim displays with a status of "Not submitted yet." Data fields are activated.
2	Update all required and/or applicable fields. ■ Pharmacy Claim Header ■ Detail	
3	Click the submit button.	The new claim ICN, status, and/or error code is returned.

How to resubmit a claim

On denied claims, two (2) buttons will be displayed at the bottom of the screen: 1) Re-submit and 2) Cancel.

To resubmit a claim

Step	Action	Response
1	Correct data in all required and/or applicable fields. ■ Pharmacy Claim Header ■ Detail	
2	If ProDUR denies the claim with an ER, HD or PG alert, enter appropriate codes in the DUR Override fields in the claim header. ■ Intervention ■ Outcome ■ Conflict Reason	
3	Click the re-submit button.	New claim status information displays with new ICN, status, and ARC Information.

Drug search

Click on “Providers,” then “Drug Search.” The following screen will appear:

Field descriptions

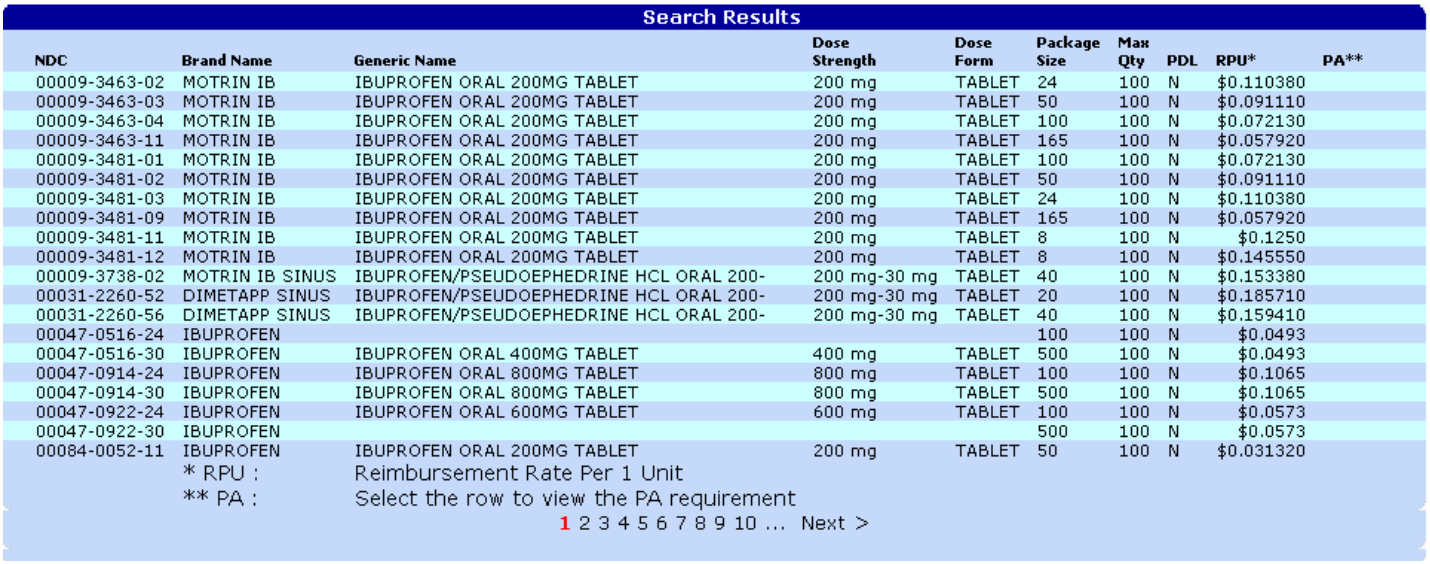
Field	Description
DOS	Date of Service. (Defaults to today’s date.)
Drug Name	Name of the drug or 11-digit NDC is required.
NDC	11-digit NDC or name of drug is required.
Records	Determine number of records to view per page in search results.
Clear	Clears all the selection criteria fields
Search	Initiates the search
Sounds-Like	Checking this box will enable you to use the sounds-like feature to search for drug names.

To complete a Drug Search

Enter the 11-digit NDC or drug name, then click “Search.” You can also enter the first few letters of the drug name (*e.g.*, “ibu” for ibuprofen) and use the “sounds-like” feature.

Drug Search results

The results will display underneath the search criteria you entered.



Search Results

NDC	Brand Name	Generic Name	Dose Strength	Dose Form	Package Size	Max Qty	PDL	RPU*	PA**
00009-3463-02	MOTRIN IB	IBUPROFEN ORAL 200MG TABLET	200 mg	TABLET	24	100	N	$0.110380	
00009-3463-03	MOTRIN IB	IBUPROFEN ORAL 200MG TABLET	200 mg	TABLET	50	100	N	$0.091110	
00009-3463-04	MOTRIN IB	IBUPROFEN ORAL 200MG TABLET	200 mg	TABLET	100	100	N	$0.072130	
00009-3463-11	MOTRIN IB	IBUPROFEN ORAL 200MG TABLET	200 mg	TABLET	165	100	N	$0.057920	
00009-3481-01	MOTRIN IB	IBUPROFEN ORAL 200MG TABLET	200 mg	TABLET	100	100	N	$0.072130	
00009-3481-02	MOTRIN IB	IBUPROFEN ORAL 200MG TABLET	200 mg	TABLET	50	100	N	$0.091110	
00009-3481-03	MOTRIN IB	IBUPROFEN ORAL 200MG TABLET	200 mg	TABLET	24	100	N	$0.110380	
00009-3481-09	MOTRIN IB	IBUPROFEN ORAL 200MG TABLET	200 mg	TABLET	165	100	N	$0.057920	
00009-3481-11	MOTRIN IB	IBUPROFEN ORAL 200MG TABLET	200 mg	TABLET	8	100	N	$0.1250	
00009-3481-12	MOTRIN IB	IBUPROFEN ORAL 200MG TABLET	200 mg	TABLET	8	100	N	$0.145550	
00009-3738-02	MOTRIN IB SINUS	IBUPROFEN/PSEUDOEPHEDRINE HCL ORAL 200-	200 mg-30 mg	TABLET	40	100	N	$0.153380	
00031-2260-52	DIMETAPP SINUS	IBUPROFEN/PSEUDOEPHEDRINE HCL ORAL 200-	200 mg-30 mg	TABLET	20	100	N	$0.185710	
00031-2260-56	DIMETAPP SINUS	IBUPROFEN/PSEUDOEPHEDRINE HCL ORAL 200-	200 mg-30 mg	TABLET	40	100	N	$0.159410	
00047-0516-24	IBUPROFEN				100	100	N	$0.0493	
00047-0516-30	IBUPROFEN	IBUPROFEN ORAL 400MG TABLET	400 mg	TABLET	500	100	N	$0.0493	
00047-0914-24	IBUPROFEN	IBUPROFEN ORAL 800MG TABLET	800 mg	TABLET	100	100	N	$0.1065	
00047-0914-30	IBUPROFEN	IBUPROFEN ORAL 800MG TABLET	800 mg	TABLET	500	100	N	$0.1065	
00047-0922-24	IBUPROFEN	IBUPROFEN ORAL 600MG TABLET	600 mg	TABLET	100	100	N	$0.0573	
00047-0922-30	IBUPROFEN				500	100	N	$0.0573	
00084-0052-11	IBUPROFEN	IBUPROFEN ORAL 200MG TABLET	200 mg	TABLET	50	100	N	$0.031320	

* RPU : Reimbursement Rate Per 1 Unit

** PA : Select the row to view the PA requirement

1 2 3 4 5 6 7 8 9 10 ... Next >

Field descriptions

Field	Description
NDC	The 11-digit National Drug Code for the product.
Brand Name	The name of the product according to the NDC.
Generic Name	The generic name of the product according to the NDC.
Dose Strength	The dosage strength of the product.
Dose Form	The delivery method of the product.
Package Size	The manufacture's package size for the product according to the NDC.
Max Qty	The maximum quantity allowed by Medicaid without an override.
PDL	Indicates if the drug is preferred (Y) or non-preferred (N).
RPU	Reimbursement Rate Per 1 Unit.
PA	A value which indicates if a Prior Authorization is required (Y= yes) or not (N=no).

Appendix

Provider Web Portal resources

Go to the Provider Web Portal page at www.oregon.gov/OHA/HSD/OHP/pages/webportal.aspx.

Quick reference: How to submit a web pharmacy claim

Step	Action	Response
1	Click the Claims menu.	The Claims menu options display.
2	Click Pharmacy.	The Pharmacy claim displays.
3	Enter data in all required and/or applicable fields. ■ Pharmacy Claim Header ■ Detail	
4	Click the submit button.	The claim ICN, status, and/or error code is returned.

If the claim denies due to a ProDUR alert, enter the appropriate override codes in the claim header, then click the “Re-submit” button.

Paper billing instructions

You only need to bill on paper when you need to submit hardcopy attachments, bill for claims over a year old, or as instructed by OHA for special handling.

Accepted forms

The 5.1 Universal Claim Form is available through CommuniForm, LLC, through agreement with the National Council for Prescription Drug Programs (NCPDP). You can place UCF orders on the Web at www.communiform.com/ncpdp or by calling 800-869-6508.

Where to mail claims

Death with Dignity claims

OHP Clinical Review
PO Box 992
Salem, OR 97308-0992

Claims less than a year old

OHP Provider Services
PO Box 14955
Salem, OR 97309

Claims more than a year old

Provider Services Unit
500 Summer St NE, E44
Salem, OR 97301-1079

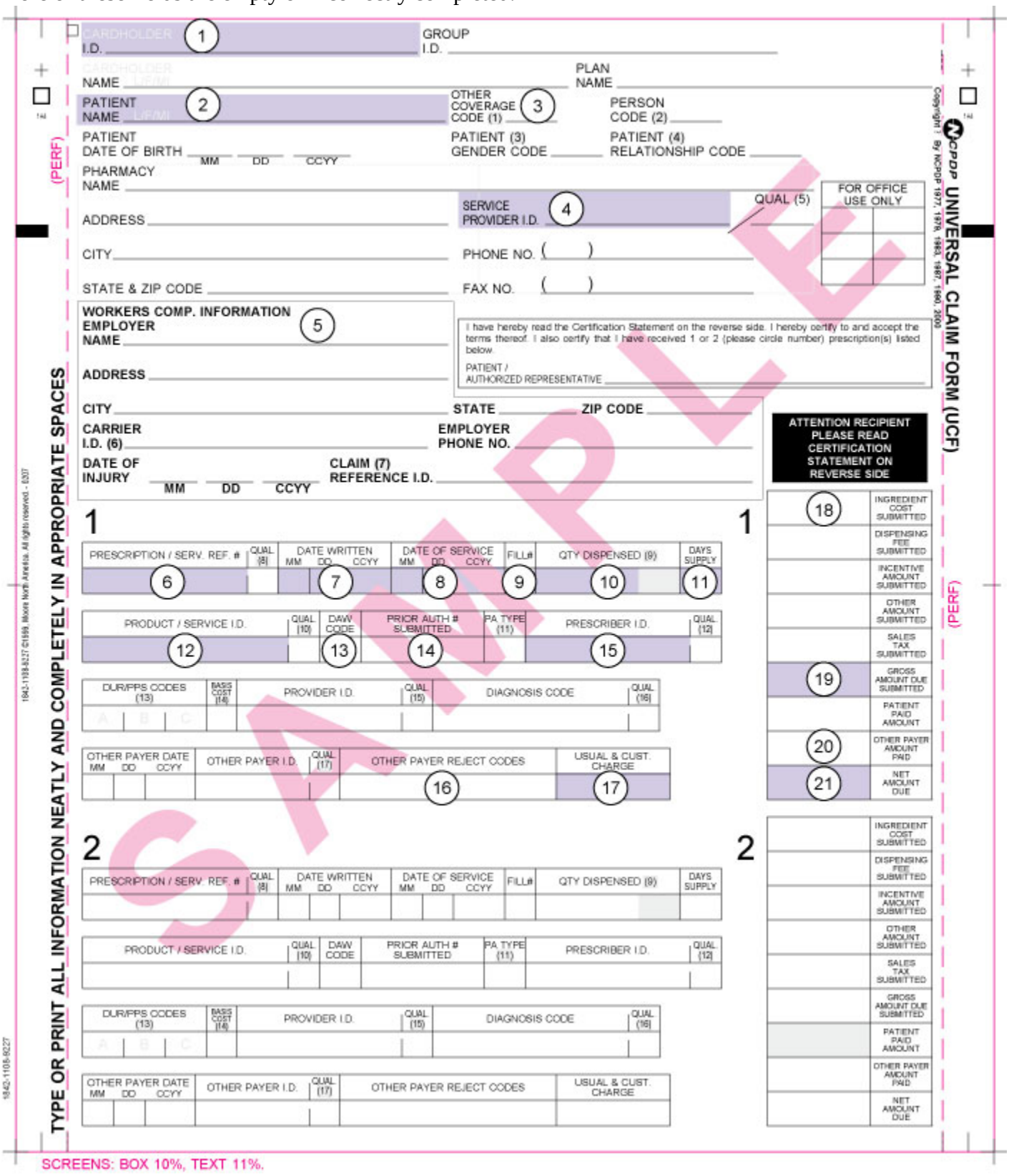
Important notes about paper claim processing

OHA processes all hardcopy claims using Optical Character Recognition (OCR) scanning. To avoid processing delays, use only commercially available forms (not black and white copies).

- If your forms are not to scale, or if the fields on your form are not correctly aligned, OHA will manually enter your claim, which may delay processing of the claim.
- If any claim information is handwritten, write clearly and in the appropriate box. Client identification numbers are alpha numeric so it can be difficult to distinguish between the number zero (“0”) and the letter “O”, the number one (“1”) and the letter “I”, or the number five (“5”) and the letter “S”. These errors can cause a claim to deny.

NCPDP 5.1 Universal Claim Form

Shaded boxes indicate the fields OHA uses to process your claim; your claim may suspend or deny if one or more of these fields are empty or incorrectly completed.



Required NCPDP UCF 5.1 fields

Shaded fields are always mandatory. Unshaded fields are optional or required only in certain circumstances.

Box	Field/Description
1.	**Cardholder ID:** Enter the 8-digit Client ID number found on the Oregon Health ID (formerly the Medical Care ID).
2.	**Patient Name:** Enter the client's name as printed on the Oregon Health ID.
3.	**Other Coverage Code:** Enter a code from the "Other Coverage Code" list on page 21 to indicate response received from other resources. ■ If the client has other health insurance coverage, and no payment was received from that resource, this space must be used to explain why no payment was made.
4.	**Service Provider ID:** Enter the 10-digit National Provider Identifier (NPI).
5.	**Workers Comp Information:** Only complete this section when the claim is for a workers compensation injury.
6.	**Prescription ID:** Enter the unique 7-digit number assigned by the pharmacy to the prescription. Compound prescriptions must have a unique prescription number for each compound. ■ For compounded prescriptions, bill each component separately. Each component must have a unique 7-digit prescription number. OHA allows a dispensing fee for each component billed in this manner.
7.	**Date Written:** Enter the date written on the prescription (MMDDYYYY).
8.	**Date of Service:** Enter the date you dispensed the drug (MMDDYYYY).
9.	**Fill #:** Enter "0" for a new prescription, "1" for the 1st refill, "2" for the second refill, and so on.
10.	**Quantity Dispensed:** Enter the quantity dispensed as a whole number. If you need to bill decimal quantities, bill electronically (point of sale or Provider Web Portal). ■ Do not include descriptive designations such as "ml," "gm," or "each." ■ For additional information, refer to OAR 410-121-0280 Billing Quantities, Metric Quantities and Package Sizes.
11.	**Days Supply:** Estimate in days the duration of this prescription supply.
12.	**Product/Service ID:** Enter the 11-digit National Drug Code (NDC) code for the drug being billed. Use 5-4-2 format. ■ If you cannot find an NDC number for an item that is prescribed and eligible for payment under this program, contact the Oregon Pharmacy Call Center.
13.	**Prior Authorization:** For diabetic supply billing, enter the 10-digit prior authorization number received from OHA.
14.	**DAW Code:** Enter "1" to indicate substitution not allowed by prescriber when the drug is a brand-name product and the proper documentation is on file with the pharmacy. PA is required. ■ To be "Dispensed as Written (DAW)," the prescription must have "Medically necessary," "Brand medically necessary," or "Brand necessary" written on it by the prescriber. ■ Initials or checked boxes are not acceptable.
15.	**Prescriber ID:** Enter the 10-digit NPI for the provider who prescribed the drug. ■ The prescribing provider must be enrolled with OHA to comply with Affordable Care Act requirements. ■ If the prescribing provider is a resident at a teaching hospital, enter the supervising physician's NPI. You can search for the provider's NPI at https://nppes.cms.hhs.gov.

Box	Field/Description
16.	**Diagnosis Code:** Enter the ICD-9- or ICD-10-CM diagnosis code obtained from the treating practitioner. The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records. • Use ICD-9 codes for dates of service on or before 9/30/2015. • Use ICD-10 codes for dates of service on or after 10/1/2015.
17.	**Other Payer Reject Codes:** Enter the 2-digit NCPDP reject codes returned by other payers.
18.	**Usual and Customary Charge**
19.	**Ingredient Cost Submitted:** Enter costs for compound drugs only.
20.	**Gross Amount Due Submitted:** Enter the sum of all charges for the prescription.
21.	**Other Payer Amount Paid:** Enter the total amount paid by any other resource. Do not include OHA copayments in this field. If the client has other insurance and this amount is zero, you must enter a code in the "Other Coverage" field.
22.	**Net Amount Due:** Subtract the Other Payer Amount Paid from the Gross Amount Due Submitted to get the total for this field.

Helpful tips

Additional information is available on the OHP website at www.oregon.gov/OHA/HSD/OHP. Click on "Tools for Providers," then "Billing tips."

READ your provider guidelines! Pay special attention to the billing instructions. Be sure you have the most current rulebook and supplemental information that are in effect for the date of service you are billing for.

- Provider guidelines are available at www.oregon.gov/OHA/HSD/OHP/pages/policies.aspx.
- If you do not have internet access, you may contact OHA at 800-527-5772 and ask to have provider guidelines mailed to you.

VERIFY client eligibility on the date the service is being provided. Use one of the services listed on OHP's Eligibility Verification Web page at www.oregon.gov/OHA/HSD/OHP/Pages/Eligibility-Verification.aspx.

- Provider Web Portal: Go to https://www.or-medicaid.gov;
- Automated Voice Response (AVR): Call 866-692-3864;
- 270/271 EDI transaction: Available to approved Electronic Data Interchange (EDI) providers. Go to www.oregon.gov/OHA/HSD/OHP/Pages/edi.aspx for more EDI information.

The client name and number on the claim needs to match the name and number on the Oregon Health ID. A Client ID number is always eight characters and is listed on the front of the Oregon Health ID. The General Rules supplemental information book shows an example of an Oregon Health ID.

BEFORE billing OHA…

- **MAKE SURE** that you billed prior resources and reported the correct dollar amount.
- **DO NOT** attach prior resource EOBs unless specifically requested.
- **ALWAYS USE** the correct Other Coverage Code when the client has TPR.

USE only one prior authorization number.

ALWAYS ENTER the OHA 6- or 9-digit provider number you want OHA to send payment to in the Billing Provider (Service Provider ID) field. It is crucial that you list this information. An invalid or missing provider number could delay your payment, make payment to a wrong provider or deny your payment.

CHECK your claim form for legibility so that we can clearly read it. Avoid tiny print, print that overlaps onto a line, entering more than 6 lines per claim, and poorly hand written claim forms. Complete only the required boxes.

READ the explanation of benefit (EOB) codes on your Remittance Advice. They will tell you what the error is, and if you should re-bill or submit an adjustment request.

CONTACT the Oregon Pharmacy Call Center at 888-202-2126 for assistance in completing your NCPDP UCF. 5.1 claim form, pharmacy Web claim, or if you have other questions regarding pharmacy claims.

UCF 5.1 code definition/values

Use the following codes as indicated on the back of the NCPDP Universal Claim Form 5.1.

Other Coverage Code

0 = Not specified
1 = No other coverage identified
2 = Other coverage exists payment collected
3 = Other coverage exists this claim not covered
4 = Other coverage exists payment not collected
7 = Other coverage exists not in effect at time of service

Patient Gender Code

0 = Not specified
1 = Male
2 = Female

Patient Relationship Code

0 = Not specified
1 = Cardholder
2 = Spouse
3 = Child
4 = Other

Provider ID Qualifier

Blank = Not specified
01 = National Provider Identifier (NPI)
02 = Blue Cross
03 = Blue Shield
04 = Medicare
05 = Medicaid
06 = UPIN
07 = NCPDP Provider ID
08 = State license
09 = Champus
10 = Health Industry number (HIN)
11 = Federal Tax ID
12 = Drug Enforcement Administration (DEA)
13 = State Issued
14 = Plan Specific
99 = Other

Prescription Service Reference # Qualifier

Blank = Not specified
1 = Rx billing
2 = Service billing

Product Service ID Qualifier

Blank = Not specified
00 = Not specified
01 = Universal Product Code (UPC)
02 = Health Related Item (HRI)
03 = National Drug Code (NDC)
04 = Universal Product Number (UPN)
05 = Department of Defense (DOD)
06 = Drug Use Review Professional Pharm. Services (DUR/PPS)
07 = Common Procedure Terminology (CPT4)
08 = Common Procedure Terminology (CPT5)
09 = CMS Common Procedural Coding System (HCPCS)
10 = Pharmacy Practice Activity Classification (PPAC)
11 = National Pharmaceutical Product Interface Code (NAPPI)
12 = International Article Numbering System (EAN)
13 = Drug Identification Number (DIN)
99 = Other

Prior authorization type code

0 = Not specified
1 = Prior Authorization
2 = Medical Certification
3 = Early Periodic Screening Diagnosis Treatment
4 = Exemption from copay
5 = Exemption from Rx limits
6 = Family Planning Indicator
7 = Aid to Families with dependent Children
8 = Payer defined exemption

DUR/Professional Service Codes

For values, refer to current NCPDP data dictionary.
A = Reason for service
B = Professional Service code
C = Result of Service

Basis of Cost Determination

Blank = Not specified
00 = Not specified
01 = AWP (average wholesale price)
02 = Local Wholesale
03 = Direct
04 = EAC (Estimated Acquisition Cost)
05 = Acquistion
06 = MAC (Maximum Allowable Cost)
07 = Usual and Customary
09 = Other

Provider ID Qualifier

Blank = Not specified
01 = Drug Enforcement Administration (DEA)
02 = State License
03 = Social Security Number (SSN)
04 = Name
05 = National Provider Identifier (NPI)
06 = Health Industry Number (HIN)
07 = State issued
99 = Other

Diagnosis Code Qualifier

Blank = Not specified
00 = Not specified
01 = International Classification of Diseases (ICD9)
02 = International Classification of Diseases (ICD10)
03 = National Criteria Care Institute (NDCC)
04 = Systemized Nomenclature of Human and Veterinary Medicine
05 = Common Dental Term (CDT)
Diagnosis Code Qualifier (continued)
06 = Medi-Span Diagnosis Code
07 = American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM/V)
99 = Other

Other Payer ID Qualifier

Blank = Not specified
01 = National Payer ID
02 = Health Industry Number (HIN)
03 = Bank Information Number (BIN)
04 = National Association of Insurance Commissioners (NAIC)
09 = Coupon
99 = Other