STATE OF NEW YORK
DEPARTMENT OF HEALTH

eMedNY
Prospective Drug Utilization Review/ Electronic Claims Capture and Adjudication
ProDUR/ECCA Provider Manual

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Computer Sciences Corporation
Healthcare Group

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1.0 INTRODUCTION (Rev. 11/02)

The New York State Department of Health (NYSDOH) has implemented a program that allows the pharmacy community to submit MEVS transactions in an on-line real-time environment that performs a Prospective Drug Utilization Review (Pro-DUR). This program was implemented on June 1, 1994 and is currently being administered by the eMedNY contractor. In order to receive payment for services rendered, all pharmacies must submit their transactions through the on-line ProDUR system. An optional feature of the ProDUR program is the Electronic Claim Capture and Adjudication (ECCA) of claims by the eMedNY contractor. The purpose of the Pro-DUR program is to be in compliance with OBRA 90 mandated Pro-DUR requirements. This program will check all prescriptions with prescription drugs the recipient has taken over the past 90 days and alert the pharmacists to possible medical problems associated with dispensing the new drug.

The telecommunication standards chosen for the Pro-DUR/ECCA system are the same as those recommended by the National Council for Prescription Drug Program, Inc. (NCPDP). Only the NCPDP variable format version 3.2 and the fixed RTDS-3A formats are supported. New York State format specifications were developed and approved by NCPDP using the February 11, 1992 Official Release of the NCPDP Version 3 Release 2 standard. The NCPDP Official Release is available to NCPDP members from the following address:

National Council for Prescription Drug Programs Inc.
4201 North 24th Street
Suite 365
Phoenix, AZ 85016-6268
(602) 957-9105

2.0 GENERAL INFORMATION (Rev. 11/02)

The mandatory Pro-DUR/ECCA program was implemented June 1, 1994 and is currently being administered by the eMedNY contractor. In order to receive payment for services rendered, all pharmacies must submit their transactions through the on-line Pro-DUR program using the NCPDP transaction format. Each pharmacy must choose an access method for these transactions. It is also each pharmacy's decision as to whether the transactions go directly to the eMedNY contractor or through a switch company, which in turn sends the transactions to the eMedNY contractor for processing.

Each on-line claim transaction is processed through the eligibility edits first, then through the Utilization Threshold (UT), Post and Clear (P&C), DUR, and Dispensing Validation System processing, if warranted. An accepted transaction gives you all the necessary UT, P&C and DUR authorizations in addition to recipient eligibility information. **There is no need to do an eligibility or UT service authorization inquiry on the TRANZ 330 POS VeriFone Terminal or via telephone.**

If you are already processing your transactions on-line, you should not be sending the same transaction through the POS terminal (transaction 1). This causes two service authorizations to be issued and increases the UT counts for the recipient. A recipient could reach his/her UT limit in error if double service authorizations were posted.

The Pro-DUR/ECCA on-line system is an adjudication system. The dollar amount returned in the on-line response is not the amount that you will be paid. It is the maximum reimbursable unit price amount.

The on-line system was designed to allow for capture and adjudication of the electronic submission. It is each pharmacy's option as to whether the claim data should be immediately captured by the eMedNY contractor for payment or if the actual claim will be sent by the provider using paper or magnetic media.

2.1 Access Methods (Rev. 11/02)

There are three potential access methods for submission of claims through the DUR system:

- PC to host - your Personal Computer will directly dial the MEVS host.
- CPU to CPU - your computer system has a dedicated leased line directly into the MEVS host processor.
- CPU to CPU through a switching company - your Personal Computer will access the MEVS host through a switching company. This access could be through dial up or leased line. The switching company will have a direct line into the MEVS host processor.

Providers must select one of the alternate access methods. If they choose not to use a switching company, they must become certified with the eMedNY contractor to verify their ability to access and process within the MEVS system. Submission via PC-Host or CPU-CPU access (switch or direct) allows up to a maximum of four claims per transaction.

Special Note: Switching companies or software vendors may restrict claims per transaction to less than four.

Pharmacies selecting the PC-to-Host access method must call **1-800-343-9000** to request a contract and certification package. If choosing to access through a switch, pharmacies must notify the switch and the switch company must notify the eMedNY contractor of the pharmacy's name and MMIS provider number.

Once a pharmacy has selected an alternate access method, they will receive communication protocol information from the eMedNY contractor or from their switching company. For more information on these access methods OR if you would like a copy of the Pro-DUR/ECCA Specifications please contact the **Provider Services Department at 1-800-343-9000.**

2.2 Card Swipe (Rev. 11/02)

The card swipe function will still be available on the TRANZ 330 terminal for pharmacy providers who are designated by NYSDOH Quality Assurance and Audit Office as card swipe providers. **Designated pharmacies must swipe the recipient's card on the TRANZ 330 POS Verifone Terminal using transaction type 5, prior to entering the on-line DUR transaction.** No DATA should be entered on the POS terminal. The eMedNY contractor will match the transactions to ensure that a swipe was performed. Only transaction type 5 will register and match the swipe to the online DUR transaction. **The swipe only has to be done once for each recipient per date of service, regardless of the number of prescriptions being filled that day for that particular recipient.**

2.3 Response Formats (Rev. 11/02)

Responses will be returned via the same alternate access method as the input transaction. The response for each claim will either be accepted or rejected. If the claim is rejected, reject codes will be provided to identify the nature of the problem.

If the claim has passed all edits and is acceptable, a **C** (captured) will be returned in the prescription (claim) response status code. Each prescription (claim) in the transaction will have a prescription response. If multiple claims are entered on one transaction via the variable format, it is possible some will be "C" and some will be "R" (Reject). **The presence of a "C" does not mean that the claim has been electronically captured for adjudication by the eMedNY contractor.** Refer to the ECCA section for further information.

Reject codes may appear in one or more of the following fields: **NCPDP Reject Codes** will be returned in the **Reject Code** field. **MEVS Accepted and Denial Codes** listed in Tables 1 and 2, **Rx Denial codes listed** in Table 7, **UT/PC** Codes listed in Table 8, DVS codes listed in Table 9, and the **Pend Reason** Codes listed in Table 10 will be returned in the **Claim Message** field. If a claim is rejected, an **NCPDP Reject Code** will always be returned in the **Reject Code** field and may have a corresponding **MEVS Code** placed in the **Claim Message** field to further clarify the error. Both fields should always be reviewed. The valid **NCPDP** and **MEVS Codes** can be found in the tables at the end of this manual.

DUR denials will be returned via the rejected response format and will be found in the **DUR Response Data** field. DUR warnings can be returned in both the approved and rejected response formats. Each submitted claim could have three (3) possible DUR responses. If a claim has three denial responses and also has warnings, only the denials will be returned. Additional information on DUR Response Data can be found in the Pro-DUR Processing section.

2.4 Electronic Claims Capture and Adjudication (ECCA) (Rev. 11/02)

The **Electronic Claim Capture and Adjudication** feature is optional. Providers may elect to have their on-line claims captured electronically by the eMedNY contractor for editing and final adjudication.

Captured claims will be fully edited for completeness and validity of the format of the entered data. There is a possibility that claims captured by the eMedNY contractor for final adjudication may be pended and subsequently denied. When a captured claim is pended, final adjudication results will appear on the remittance statement produced from the eMedNY contractor processing cycle in which the claim either approved for payment or denied. All claim processing edits are performed during the adjudication process. An advantage of ECCA is that it saves the pharmacy from having to file the claims separately.

Pharmacies that choose to use the ECCA option must select a **Personal Identification Number (PIN)** and forward that number to NYSDOH for processing. The PIN selection form can be found in the FORM section at the end of this manual. Additionally, the pharmacy must also have a **Transmission/Transmittal Supplier Number (TSN)** (a/k/a Magnetic Supplier Number) on file with the eMedNY contractor. To obtain a TSN, or for more information, call (518) 447-9256. Remittances for claims submitted for ECCA will be returned to you via the media you select for that TSN. If you use your service bureau's TSN, a paper remittance will automatically be returned to you. If you choose your own TSN, you can select paper or tape remittance. Once the eMedNY contractor has assigned you a TSN, you must complete a Certification Statement, have it notarized and returned to the eMedNY contractor. The Certification Statement can be found in the FORM section at the end of this manual.

If you wish your claim electronically captured, you must enter the required data in the **Processor Control Number** field. The required data is the **Read Certification Statement, Pharmacist's Initials, PIN,** and **TSN**. Further details of all input fields are explained in the input data section of this manual. If you are submitting via the variable 32 format, the **Pharmacist's Identification** field can also be used to enter the pharmacist's initials in lieu of entering them in the **Processor Control Number** Field. Some software vendors and switch companies have the pharmacy enter this information in fields other than the **Processor Control Number** field. This is OK as long as they forward it to the eMedNY contractor in the **Processor Control Number** field.

If the **Processor Control Number** field is completed properly and the claim is not rejected for an edit, an invoice number is assigned to the claim. This 9-digit number will be returned in the **Authorization Number** field of the response. Only one invoice number will be returned for a transaction, which could include up to four claims. The invoice number will appear on your remittance statement. If the **Processor Control Number** field is completed and an invoice number was not returned in the **Authorization Number** field, the system will return **NO CLAIM TO FA** indicating that the claim was captured for Service Authorization but not processed for adjudication by the eMedNY contractor.

If a claim has passed all eligibility, UT, P&C, claim history, DUR and DVS editing, a "C" is returned in the response. The NCPDP definition of "C" is Claim Captured. Some software packages may translate this code into words. **The only time a claim has been captured for adjudication is if you see an authorization (invoice) number in your**

response. Claims that have an **Authorization Number** assigned online do not have to be submitted on paper or magnetic media. Please note and retain the authorization number of the claim for your records, as the eMedNY contractor may require it for problem investigation. Only claims that do not have an **Authorization Number** assigned will have to be submitted by the provider directly to the eMedNY contractor, via paper or mag media.

The following types of claims cannot be submitted to the eMedNY contractor for ECCA.

1. An original claim with a date of service more than ninety days old. However, claims over ninety days old will be processed for eligibility, UT and P&C service authorizations, but they need to be sent to the eMedNY contractor on paper or magnetic media with appropriate over ninety day reason indicated. Rebills and reversals are allowed to be submitted ECCA with service dates up to two years old.

2. Compound Prescription Drugs. Although each ingredient can be billed on a per line item basis via ECCA, a transaction for any other compound billing method will be automatically converted to non-ECCA.

3. Durable Medical Equipment (DME) claims. DME includes any claim identified by Specialty Code 307 or Category of Service 0442. Please Note: DME does NOT include the product supply codes (1 alpha, 4 numeric) found in the **MMIS Pharmacy Provider Manual** pages 4-9 through 4-31. These codes can be submitted for ECCA using the variable **32** format where the alternate product type and alternate product code fields are available for submission.

4. Fixed Format (3A) Only: Because Other Payor Amount (Field 431) is not available, third party insurance claims will not be captured, but a service authorization will be created by the eMedNY contractor.

5. A Dispensing Validation System (DVS) transaction for an item that is only reimbursable under category of service 0442 (DME). Items reimbursable under category of service 0441 (Rx) will be processed for ECCA if the claim is billed without the 307 (DME) designated specialty code and the Processor Control Number is properly completed.

2.5 Third Party Claims (Rev. 11/02)

A recipient's other insurance information (if any) is returned to you in the on-line response via the **Additional Message** field. If the recipient's other insurance covers drugs, either H, K, M, O or the word ALL will be returned in the Insurance Coverage Code position of the **Additional Message** Field.

For a third party claim to be successfully captured for ECCA via the variable 32 format, the **Other Coverage Code** field (308) **and Other Payor Amount** field (431) must be entered. It is extremely important that you make sure that the value entered in the **Other Coverage Code** field corresponds to the entry in the **Other Payor Amount** field. The entry in each field must correlate to the other field and be logically correct for your claim to be accepted.

Please Note: The Other Payor Amount Field is an optional field and should not be submitted unless the recipient has other drug coverage and you have received reimbursement or been notified that the service is not covered by the other insurance company.

Third party drug claims can be processed on-line for the UT, P&C, and DUR service authorizations using the variable 32 or fixed 3A NCPDP formats. However, for ECCA, the claim must be submitted using the variable 32 format since the Other Payor Amount field is not available in the fixed format. If a claim is submitted via the fixed format and the recipient has third party drug coverage; the claim will be processed for all applicable service authorizations but not for ECCA. If ECCA is requested, a 'NO CLAIM TO FA' will be returned in the Authorization Number field and the claim must be forwarded to the eMedNY contractor on paper or magnetic media.

The values for field 308 (Other Coverage Code) are:

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

There are several edits in place to ensure that logical entries are made in both field 308 and 431. The charts, on the following page, describe what the status of the claim will be based on the field entries. The edits on Chart #1 will occur when the recipient has MEVS Insurance Coverage Codes H, K, M, O or ALL on file with the eMedNY contractor. Chart #2 will occur when no MEVS Insurance Coverage Codes indicating Pharmacy coverage for the recipient are on file.

Please Note: Since field 431 is not available in the fixed RTDS "A" format, third party claims can only be captured for ECCA using the variable format. However, all Service Authorizations can still be obtained for Third Party claims using the Fixed Format.

Chart 1 – Recipient with Coverage Codes H, K, M, O or ALL on file

Field 308 Value	Field 431 Value	NCPDP Format Version	Field 104 Value	Claim Status
0, 1, 2, 3, or 4	431 is Not sent (spaces)	32 (variable) or 3A (fixed)	Non-ECCA (Processor Control Number not sent) or ECCA (Processor Control Number sent)	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. (“C - capture” (field 501) and “NO CLAIM TO FA” (field 503) will be returned).
0, 1 or 4	Zeros or greater	32	ECCA or Non-ECCA	The transaction will be rejected. NCPDP Reject Code: 13 “M/I Other Coverage Code” and Response Code: 717 “Client Has Other Insurance” will be returned on-line.
2	Zeros	32	ECCA or Non-ECCA	The transaction will be rejected. NCPDP Reject Code 13 “M/I Other Coverage Code” and Response Code 715 ‘Other Payor Amount Must Be Greater Than 0’ will be returned.
2	Greater than Zero	32	ECCA	If all other edits are passed, the claim will be approved for payment. (“C - capture” (field 501) and an invoice number (field 503) will be returned). Other payor amount will be subtracted from the claim’s payment amount.
2	Greater than Zero	32	Non-ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. (“C - capture” (field 501) and “NO CLAIM TO FA” (field 503) will be returned).
3	Zeros	32	ECCA	If all other edits are passed, the claim will be approved for payment. (“C - capture” (field 501) and an invoice number (field 503) will be returned).
3	Zeros	32	Non-ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. (“C - capture” (field 501) and “NO CLAIM TO FA” (field 503) will be returned).
3	Greater than Zero	32	ECCA or Non-ECCA	The transaction will be rejected. NCPDP Reject Code “13 M/I Other Coverage Code” and Response Code “716 ‘ Other Payor Amount Must Be Equal to 0” will be returned.

Chart 2 - Recipient without Coverage Codes on file

Field 308 Value	Field 431 Value	NCPDP Format Version	Field 104 Value	Claim Status
0, 1, 2, or 3	Not sent	32 or 3A	Non-ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. (“C - capture” (field 501) and “NO CLAIM TO FA” (field 503) will be returned).
0 or 1	Not sent	32 or 3A	ECCA	If all other edits are passed, the claim will be approved for payment. (“C - capture” (field 501) and an invoice number (field 503) will be returned).
0, 1, or 3	Zeros	32	Non-ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. (“C - capture” (field 501) and “NO CLAIM TO FA” (field 503) will be returned).
0, 1, or 3	Zeros	32	ECCA	If all other edits are passed, the claim will be approved for payment. (“C - capture” (field 501) and an invoice number (field 503) will be returned).
0, 1, 3, or 4	Greater than Zero	32	Non-ECCA or ECCA	The transaction will be rejected. NCPDP Reject Code “DV - M/I Other Payor Amount” and Response Code “320 – Other Insurance Information Inconsistent” will be returned.
2 or 3	Not sent	32 or 3A	Non-ECCA or ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. (“C - capture” (field 501) and “NO CLAIM TO FA” (field 503) will be returned).
4	Not sent or zeros	32 or 3A	Non-ECCA or ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. (“C - capture” (field 501) and “NO CLAIM TO FA” (field 503) will be returned).
2	Greater than Zero	32	Non-ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. (“C - capture” (field 501) and “NO CLAIM TO FA” (field 503) will be returned).
2	Greater than Zero	32	ECCA	If all other edits are passed, the transaction will be accepted for payment. (“C - capture” (field 501) and an invoice number (field 503) will be returned).

Field 308 Value	Field 431 Value	NCPDP Format Version	Field 104 Value	Claim Status
2	Zeros	32	Non-ECCA or ECCA	The claim will reject. NCPDP Reject Code "13 M/I Other Coverage Code" and Response Code "715 Other Payor Amount Must Be Greater Than 0" will be returned.

2.6 Rebills/Adjustment Information (Rev. 11/02)

Rebills will be processed as adjustments to a previously submitted claim that was approved for payment. Rebills cannot be submitted for claims that are pending or were rejected.

NCPDP standards dictate that a rebill must be submitted with a Transaction ID (Field 103) value of 31 through 34. The number of claim lines contained within the transaction is indicated by the second digit. (If one claim line is contained in the transaction, the Transaction ID should be 31. If four claim lines are contained in the transaction, the Transaction ID should be 34).

Although you will need to submit all fields required for the original claim transaction, your claims will be matched to the original claim using: Medicaid Provider Identification Number, Prescription Number, and Date Filled. If by chance these fields do not define uniqueness, meaning that more than one active claim meeting the criteria resides on the eMedNY contractor's claims history file, the most recently submitted claim will be selected for adjustment. If you are trying to adjust the older submission, you will need to submit the rebill via paper or magnetic media where you can supply the Claim Reference Number of the specific claim you are trying to adjust.

Both the fixed and variable NCPDP formats can be used. Rebill transactions can be submitted for service dates up to two years old if the original transaction was submitted directly to the eMedNY contractor. This includes paper and magnetic media, as well as online claim submissions.

If the rebill is adjusting a paid claim, the rebill will appear on your remittance statement. If the rebill is adjusting a paid claim, you must complete the Processor Control Number field.

You can not adjust a non-ECCA claim to become an ECCA claim. The adjustment will apply any updated information, but the adjustment claim will remain a non-ECCA claim and the NO CLAIM TO FA response will be returned to you. If the rebill is adjusting a non-ECCA transaction, the rebill will not appear on your remittance statement.

Rebills will not affect previously established service authorization limits.

Rebills will not be allowed for original claims that generated a DVS prior approval. If a change is needed to a paid DVS claim, then you can submit the adjustment on paper or magnetic media. You may also reverse the original claim and then submit another original transaction with the corrected information.

2.7 Refills Information (Rev. 11/02)

New York State only allows a maximum of five (5) refills on a prescription. All of the refills must be dispensed within 180 days from the date the prescription was written. Claims for refills over 180 days from the date the prescription was written will be rejected.

The New York State DUR Board has established a standard that if a refill is dispensed too early, you will receive a **TD WARNING – EARLY REFILL MMDDYY** warning in your DUR response. **Please note** that the **TD WARNING – EARLY REFILL MMDDYY** response is only a warning, not a DUR denial (reject).

2.8 Alternate Product Codes (Rev. 04/03)

These codes are also referred to as Sickroom Supplies, "Z" codes, or DME item codes and consist of a 5 digit alpha-numeric code. The valid codes can be found on pages 4-9 through 4-31 of the MMIS Pharmacy Provider Manual. For DVS transactions, some of the item codes are only in the DME Provider Manual since they are only reimbursable under COS 0442 (DME).

The 5 digit alpha-numeric codes must be submitted in the **Alternate Product Code (APC)** field using the NCPDP variable 32 format. If the code is submitted in the **NDC** field, your claim will be rejected.

The NCPDP fixed RTDS 3A format does not contain an **APC** field. If you are using the fixed format, you will not be able to send an APC claim for ECCA processing. However, you can use the 3A format to obtain a UT/P&C service authorization for the APC codes by putting zeroes in the **NDC Code** field and a zero in the **Compound Code** field. The claim will not be captured for adjudication. The provider must submit the claim directly to the eMedNY contractor on paper or magnetic media.

If using the variable 32 format for submitting APC claims, make sure that the fields specified below are correctly completed as indicated:

FIELD	CONTENTS
Compound Code	Must contain a zero or one. Use zero for DVS transactions.
Alternate Product Type	Must contain a value of one.
Alternate Product Code	13 characters in length. The first six positions must contain zeroes followed by the 5-character alpha/numeric code. The last two positions must contain blanks or BO modifier.
NDC Code	Must contain zeroes.

A correct entry in the Alternate Product Code field would look as follows:

0000Z2500bbbb	(where bbbb equals four blanks or BO modifier and 2 blanks)
000000Z2500bb	(where bb equals two blanks or BO modifier)

2.9 APC Quantities (Rev. 11/02)

Be aware that the Quantity/Size listed in the MMIS Provider Manual for each APC code is **not** usually the quantity that should be entered in the **Metric Quantity** field. The quantities listed in the manual refer to ounces, milligrams, sizes, units or the number contained in each unit (box, package, bottles, etc). The entry in the **Metric Quantity** field should be the number of units dispensed.

The following examples are listed to help clarify the correct Metric Quantity entries.

APC		QUANTITY SIZE IN MANUAL	METRIC QUANTITY FIELD ENTRY	MAX QUANTITY
Z2001	Butterfly Clamps	100's (up to 1)	00001 (1 box dispensed)	1 box
Z2003	Plastic Strips	30's	00002 (2 boxes of 30 dispensed)	5 boxes
Z2012	Adhesive Tape	2" x 5 yd	00003 (3 rolls dispensed)	5 rolls
A4244	Alcohol or peroxide per pint	473 ml	00001 (1 pint bottle dispensed)	5 bottles
A4215	Needles	each (up to 100)	00056 (56 needles dispensed)	100 needles
A4635	Underarm pad crutch replacement	each (up to 2)	00001 (1 pad dispensed)	2 pads

Enteral Products

The metric quantity for enteral products should be entered as caloric units. For example: A prescription is for Regular Ensure 1-8 oz. can/day, 30 cans with five refills. There are 75 caloric units per 30 cans (one month supply). The correct entry for the current date of service is 00075. Do not include refills.

Please Note: The metric quantity entry examples shown contain 5 digits because the NCPDP field requires a five digit entry. New York State only accepts 4 digits at this time. Your software may only be requiring you to enter 4 digits which is OK as long as they add the leading zero when submitting the transaction in order to comply with NCPDP field length.

2.10 Dispensing Validation System (Rev. 04/03)

This function enables suppliers of predesignated enteral nutrition products, for prescriptions written prior to date of service 4/1/03, prescription footwear items, specified drugs, certain medical surgical supplies and durable medical equipment to receive a prior approval number (DVS number) through an automated electronic MEVS system. The DVS transaction can be submitted through the NCPDP variable 3.2 format. For fixed RTDS-3A format, DVS is allowed for NDC codes only since the alternate product code field is not available. The claims processing system will recognize an item/NDC code requiring a DVS number and will process the transaction through all required editing. If approved, and if the item/NDC code is reimbursable under category of service 0441, 0161 or 0288, the DVS number will be returned in response field 526 and the claim will be processed for adjudication (if ECCA is requested). Only items reimbursable under Category of Service 0441, 0161 or 0288 (Rx) will be processed through ECCA. Items, which are only reimbursable under Category of Service 0442 (DME), can be submitted through NCPDP, but must be billed on DME Claim Form C. Be sure to put the DVS number from Field 526 on the claim form.

Important Information Regarding DVS Transactions

- Transactions for both NDC's and APC's can be submitted using the variable 3.2 format. Only NDC can be submitted through the fixed RTDS-3A format.
- Although multiple claim line transactions (02, 03, or 04) can be submitted, only one DVS claim line item can be submitted per transaction and the DVS line must be the first line item within the transaction.
- Required claim fields for a DME Category of Service ***0442*** transaction are:

  404 - Metric Quantity
  406 - Compound Code, Value 0
  411 - Prescriber ID
  421 - Primary Prescriber
  436 - Alternate Product Type
  437 - Alternate Product Code

Note: There may be some items where you are specifically instructed by New York State to use the 11 digit National Drug Code. If this occurs, use field 407 (NDC) in lieu of field 436 and 437. Field 406 value should then be 1.

In addition to the other required header transaction fields, Field 201 must contain the Category of Service on your file that you will be billing under. Valid Categories of Service are:

  0161 - Clinic Pharmacy
  0288 - Hospital Based Pharmacy
  0441 - Pharmacy
  0442 - Pharmacy DME

- Item codes that require a DVS number will not be processed through the UT, P & C or DUR programs. Prescription Drugs that require a DVS number will be subject to UT, P & C and DUR processing.
- Only current dates of service will be accepted for DVS transactions.

2.11 Prior Authorization/MC Code and Number - Field 416 (Rev. 11/02)

This field is a twelve (12) position numeric field. There are two possible values for the first digit:

1 = Prior Authorization/Prior Approval. If this value is used, the next eight digits must contain the prior approval number.

4 = Exemption from co-pay. Use to indicate the recipient is exempt. If this value is used, the last three positions must contain a value to indicate the reason for the co-pay exemption. There are five possible values for the final three digits:

000 = No Co-pay Exemption
005 = Co-pay Exempt - Emergency
007 = Co-pay Exempt - Private Managed Care
008 = Co-pay Exempt - OMH Community Resident and/or Traumatic Brain Injury
009 = Co-pay Exempt - Pregnancy

If a claim requires prior approval and the recipient is also exempt from co-pay, use a value of one (1) in the first digit followed by the eight (8) digit PA number and the appropriate co-pay exempt value. If submitting a **DVS transaction** and the recipient is also exempt from co-pay, use a value of one (1) in the first digit followed by eight zeros and the appropriate co-pay exempt value.

2.12 Temporary Medicaid Authorizations (Rev. 11/02)

There have been increasing concerns regarding Medicaid provider acceptance of the Temporary Medicaid Authorization (DSS-2831A), especially from pharmacy providers. When an applicant is determined eligible and has an immediate medical need, the local district may issue a Temporary Medicaid Authorization pending the client receipt of a permanent Common Benefit Identification Card.

Please be aware that a mechanism is in place to reimburse providers for rendering services to a client with a Temporary Medicaid Authorization. Providers should first make a copy of all Temporary Medicaid Authorizations for their records. These claims **cannot** be submitted by pharmacies through the on-line Pro-DUR/ECCA program because eligibility is not yet on the files and may not have been determined yet. Pharmacy providers must put the letter "M" in the Service Authorization Exception field and submit the claim directly to the eMedNY contractor via paper or magnetic media. The claim will pay upon the local district verifying eligibility in WMS. If the claim pends for client ineligibility, wait for the final adjudication of the claim. This information will appear on your remittance statement. If the final adjudication of the claim results in a denial for client ineligibility, please contact NYS DOH, OMM Local District Support Unit. For Upstate recipients call (518) 474-8216; the number for New York City recipients is (212) 268-6855.

2.13 Excess Income/Spenddown Claims (Rev. 11/02)

Unlike the Temporary Medicaid Authorizations mentioned on the preceding page, these claims **can** be submitted through the on-line Pro-DUR/ECCA program. To properly submit a spenddown claim, the **Eligibility Clarification Code** field must contain a value of two (2) and the **Patient Paid Amount** field should contain the amount of the spenddown paid by the recipient, even if that amount is zero. These claims will not be processed through the eligibility edits. If the claim passes all other editing and you have elected the ECCA option, your claim will be captured and pended by the eMedNY contractor waiting for the WMS eligibility file update from the local district to indicate that the spenddown has been met. If the eligibility information does not appear in a timely manner on the eMedNY contractor file, the claim will be denied.

2.14 Duplicate Claim Transactions (Rev. 11/02)

When an online claim transaction is sent to the MEVS, it will be matched against previously captured (approved) claims. If the transaction is determined to be an exact duplicate of a previously approved claim, the MEVS will return a "C" in the Claim Response Field 501. The remaining response fields will contain the data that was returned in the original response. The following fields will be examined to determine if the original captured response will be issued:

- Pharmacy Number (201 positions 21-28)
- Cardholder ID Number (302)
- Date Filled (401)
- Prescription Number (402)
- New/Refill Code (403)
- P.A./M.C. Number (416 positions 2-9)
- and if not a compound, either the NDC Number (407)or Alternate Product Code (437).

If identical data exists only in certain subsets of the above fields, your claim will be rejected for NCPDP Reject Code 83 "Duplicate Paid/Captured Claim" unless prior approval was obtained for one of the two conflicting transactions (meaning field 416 Prior Authorization/Medical Certification Code/Number would need to contain a PA Number on one claim, and no PA Number for the other claim.)

For example, a NCPDP Reject Code of 83 "Duplicate Paid/Captured Claim" is returned when a claim is submitted and the Pharmacy Number, Cardholder ID, and Prior Approval Number fields match a previous paid claim and one of the following conditions also exists:

- Prescription Number matches, but NDC/APC is different.
- NDC/APC (if not a compound) matches, but Prescription Number is different.
- Prescription Number and New/Refill Code is the same, but the Date Filled is different.

If the original transaction was non-ECCA and the duplicate transaction is ECCA, the transaction response will be the original non-ECCA response. No adjudication process will occur.

3.0 Pro-DUR PROCESSING (Rev. 11/02)

A drug history profile is maintained for all recipients. This file contains a record for each accepted prescription or OTC item entered through the ProDUR system. Each prescription on the drug profile is assigned an expiration date. This date is calculated using the date filled plus the days supply.

All prescription and OTC transactions are compared to the recipient's drug profile. If the new prescription falls within the active date range (date filled plus days supply) and a conflict exists, a DUR response will be returned. ProDUR editing is not performed on compound drugs or sickroom supplies. DUR editing will also be performed for the majority of the denial codes on Tables 2,7,8, and 9.

The DUR edits are based on the clinical database compiled by First DataBank. This information is used to administer the New York State Medicaid Pro-DUR program under the direction of the DUR Board.

Up to three (3) DUR related conflicts can be identified and returned for each drug submitted. Information about these conflicts is returned in the response in order of importance. In cases where more than three conditions are identified, a DUR **Overflow** indicator is also returned.

Conflicts detected by the Pro-DUR editing may result in reject or warning conditions. At present, there are only two conditions that will cause a requested drug to be rejected: clinical significance (severity) one (1) condition from the Therapeutic Duplication edit and clinical significance one (1) condition from the Drug-Drug Interaction edit. Any other DUR response is a warning and will not cause the claim to be rejected. If a DUR reject is returned for a drug, no DUR, UT, P&C, or DVS authorizations will be retained for the claim. In order to get the necessary authorizations from the Pro-DUR system to dispense a drug that has been rejected by the DUR edits, an override request must be submitted. Overrides are discussed further in the Override Processing section.

The following series of edits are performed by the Pro-DUR system:

Therapeutic Duplication (TD)
The Therapeutic Duplication edit checks the therapeutic class of the new drug against the classes of the recipient's current, active drugs already dispensed.

Drug-Drug Interactions (DD)
The Drug-Drug Interaction edit matches the new drug against the recipient's current, active drugs to identify clinically relevant interactions.

Drug-Disease Contraindications (DC)
The Drug-Disease Contraindications edit determines whether the new drug is potentially harmful to the individual's disease condition. The active drugs on drug history determine the recipient’s disease condition(s).

Drug Pregnancy Alert (PG)
Drug Pregnancy Alert warnings are returned for females between the ages of 13 and 52 on new drugs that may be harmful to pregnant women.

Pediatric Precautions (PA)
Pediatric Precautions are returned for children under the age of eighteen (18) on new drugs that may be harmful to children.

Lactation Precautions (PG)
Lactation Precautions are returned for females between the ages of 13 and 52 on new drugs that may be harmful to nursing women or their babies.

Geriatric Precautions (PA)
Geriatric Precautions are returned for adults over the age of 60 on new drugs that may be harmful to older adults.

High Dose Alert (HD)
A High Dose Alert is returned if the dosage for the new drug exceeds the maximum dosage recommended for the recipient's age group.

Low Dose Alert (LD)
A Low Dose Alert is returned if the dosage for the new drug is below the minimum dosage recommended for the recipient's age group.

Call Provider Services (CH)
If this response is received, there may be a need for further explanation of the free text. If so, contact Provider Services at 1-800-343-9000.

3.1 DUR Response Fields (Rev. 11/02)

The following information is returned in the response from the Pro-DUR system for each identified DUR conflict:

Drug Conflict Code
Clinical Significance
Other Pharmacy Indicator
Previous Date of Fill
Quantity of Previous Fill
Database Indicator
Other Prescriber Indicator
Free Text

Drug Conflict Code

The Drug Conflict Code identifies the type of DUR conflict found when a new prescription is compared against the recipient's drug history file and demographics. Following are the values that may be returned as Drug Conflict Codes:

TD = Therapeutic Duplication
DD = Drug-Drug Interactions
DC = Inferred Drug Disease Precaution
PG = Drug Pregnancy Alert
PA = Drug Age Precaution
LD = Low Dose Alert
HD = High Dose Alert
CH = Call Provider Services (1-800-343-9000)

Clinical Significance

The Clinical Significance is a code that identifies the severity level and how critical the conflict. The following chart lists each drug conflict code and the clinical significance codes which may be returned for that code as well as whether they are DUR rejects or warnings.

Conflict Code	Reject/ Warning	Clinical Significance	Description of Clinical Significance
TD Therapeutic Duplication	R	**1**	An Original Prescription that duplicates a therapy the recipient is already taking.
	W	**2**	Prescription is a Refill and is being filled prior to 75% of the prior script's days supply.

Conflict Code	Reject/ Warning	Clinical Significance	Description of Clinical Significance
DD Drug-Drug	R	**1**	Most significant. Documentation substantiates interaction is at least likely to occur in some patients, even though more clinical data may be needed. Action to reduce risk of adverse interaction usually required.
	W	**2**	Significant. Documentation substantiates interaction is at least likely to occur in some patients, even though more clinical data may be needed. Assess risk to patient and take action as needed.
	W	**3**	Possibly significant. Little clinical data exists. Conservative measures are recommended because the potential for severe adverse consequences is great.
DC Drug Disease	W	**1**	Absolute Contraindication. Drug Therapy for the recipient should be changed.
	W	**2**	Precaution. The risk/benefit of therapy should be considered and the recipient's response closely monitored.
PG Pregnancy	W	**D**	**PREGNANCY** There is positive evidence of human fetal risk based on adverse reaction data from investigation or marketing experience or studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.
	W	**X**	**PREGNANCY** Studies in animals or humans have demonstrated fetal abnormalities and/or there is positive evidence of human fetal risk based on adverse reaction data from investigation or marketing experience, and the risks involved in use of the drug in pregnant women clearly outweigh potential benefits.
	W	**1**	**PREGNANCY** No FDA rating but is contraindicated or not recommended; may have animal and/or human studies or pre- or post-marketing information.
	W	**1**	**LACTATION** Absolute Contraindication. The Drug should not be dispensed.
	W	**2**	**LACTATION** Precaution. Use of the Drug should be evaluated carefully.

Conflict Code	Reject/ Warning	Clinical Significance	Description of Clinical Significance
PA Drug Age	W	**1**	Absolute Contraindication. Drug Therapy should be changed.
LD Low Dose	W	**1**	Prescribed dose is less than the minimum appropriate for the drug.
HD High Dose	W	**1**	Prescribed dose is greater than the maximum appropriate for the drug.
CH Call Provider Services	W	**1**	Further explanation may be required. Call 1-800-343-9000.

Other Pharmacy Indicator

The following values may be returned in the Other Pharmacy Indicator:

0 = Not Specified
1 = Your Pharmacy
3 = Other Pharmacy

Previous Date of Fill

The Previous Date of Fill provides the date the conflicting drug was dispensed.

Quantity of Previous Fill

The Quantity of Previous Fill provides the quantity of the conflicting drug.

Database Indicator

The Database Indicator will always be returned with a value of 1 to indicate that First DataBank is the DUR database provider.

Other Prescriber Indicator

The Other Prescriber Indicator compares the Prescriber of the current prescription to the Prescriber of the conflicting drug from the recipient's active drug profile, and returns one of the following codes:

0 = Not Specified
1 = Same Prescriber
2 = Other Prescriber

Conflict Code Free Text Descriptions

A Free Text message is returned for each conflict to provide additional information about the DUR condition. Following is a description of the Free Text:

CODE **FREE TEXT DESCRIPTION**

TD For Clinical Significance **1**, the name, strength, dose form and day's supply of the conflicting drug from the Drug Profile.

Example
TD 1 1 20020926 00030 1 PROPRANOLOL 10MG TABLET 030

For Clinical Significance **2** the words **WARNING - EARLY REFILL MMDDYY**

Example
TD 2 1 20020929 00030 1 WARNING – EARLY REFILL 10/22/02

Note: MMDDYY is the earliest date that the refill should be filled.

DD Will contain the Clinical Effect Code followed by the Drug Name from the Drug Profile of the drug interacting with the new prescription being filled. The latter drug will be the new prescription drug and the former drug will be the drug from the Drug Profile. The Clinical Effect Code will consist of one of the following values: Examples of each Clinical Effect code is included.

INF Increased effect of former drug

Example
DD 2 1 20021011 00030 1 INF DIGITALIS/KALURETICS

DEF Decreased effect of former drug

Example
DD 2 1 20021012 00030 1 DEF CORTICOSTEROIDS/BARBITURAT

INL Increased effect of latter drug

Example
DD 3 1 20021003 00030 1 INL VERAPAMIL/DIGOXIN

DEL Decreased effect of latter drug

Example
DD 2 1 20020920 00060 DEL NSAID/LOOP DIURETICS

CODE **FREE TEXT DESCRIPTION**

ARF Adverse reaction of former drug

Example
DD 2 1 20021018 00090 1 ARF THEOPHYLLINES/TICLOPIDINE

ARL Adverse reaction of latter drug

Example
DD 1 1 20021014 00050 1 ARL NSAID/TRIAMTERENE

MAR Adverse reaction of both drugs

Example
DD 2 1 20020920 00090 1 MAR ACE INHIBITORS/POTASS.SPAR

MXF Mixed effects of former drug

Example
DD 2 1 20021018 00015 1 MXF ANTICOAGULANTS,ORAL/ANTITH

MXL Mixed effects of latter drug

Example
DD 2 1 20020919 00060 1 MXL HYDANTOINS/DISOPYRAMIDE

DC The description of the drug/disease contraindication.

Example
DC 1 1 20020914 00090 1 HYPERTENSION

PG For pregnancy precautions the words **PREGNANCY PRECAUTION**

Example
PG 1 0 00000000 00000 0 PREGNANCY PRECAUTION

For lactation precautions the words **LACTATION PRECAUTION**

CODE **FREE TEXT DESCRIPTION**

Example
PG 2 0 00000000 00000 0 LACTATION PRECAUTION

PA For pediatric precautions the word **PEDIATRIC**

Example
PA 1 0 00000000 00000 0 PEDIATRIC

For geriatric precautions the word **GERIATRIC**

Example
PA 1 0 00000000 00000 0 GERIATRIC

LD For low dose precautions the recommended minimum and maximum dosage will be shown.

Example
LD 1 0 00000000 00000 0 3.000 12.000

HD For high dose precautions the recommended minimum and maximum dosage will be shown.

Example
HD 1 0 00000000 00000 0 1.000 8.00

CH* Call Provider Services if further explanation needed.

Example
(to be determined)

***** Code CH is not currently returned but may be returned in the response in the future if a condition arises to necessitate its return.

4.0 OVERRIDE PROCESSING (Rev. 11/02)

4.1 DUR Override (Rev. 11/02)

If your claim transaction was rejected due to a DUR conflict and you intend to dispense the drug, you will need to override the conflict (if appropriate). In order to process a DUR override, the same code that was returned as the denial code (Drug Conflict Code) must be placed in the **DUR Conflict Code** field. The **DUR Conflict Code** being sent as the override must match the DUR Conflict Code received in the response of the original transaction. A corresponding entry must also be entered in the **DUR Outcome Code** field. The only conflict codes that are DUR denials and reject the claim are TD (severity level 1) and DD (severity level 1). All of the other codes being returned are warnings and allow your claim to be accepted. Any attempt to override a warning will be rejected. However, we have learned that some software packages are requiring you to do internal overrides for the warnings.

At this time the only rejects that can be overridden are:

TD = Therapeutic Duplication
DD = Drug to Drug Interaction

One of the following values must be used in the **DUR Outcome Code** for DUR reject overrides:

1A = Filled as is, false positive
1B = Filled, Prescription as is
1C = Filled with Different Dose
1D = Filled with Different Directions
1E = Filled with Different Drug
1F = Filled with Different Quantity
1G = Filled with Prescriber Approval

DUR Override Documentation

If a pharmacist overrides a rejected DUR conflict, it is recommended that:

a) The pharmacist writes the date, reason for override and his/her signature or initials on the back of the prescription.
OR
b) If the software permits, comment and electronically store the reason for the override in the patient profile for the specific prescription filled.

4.2 Utilization Threshold (UT) Override (Rev. 11/02)

If you receive a reject because a recipient is at their Utilization Threshold service limit (see message text field, UT/P&C codes DA, DD, or DN from Table 8), and you intend to dispense the prescription, you will need to override the UT limit. To submit a UT override, the provider must resubmit the original transaction with an entry in the **Prescription Denial Clarification** field. This is the field that replaces the **Service Authorization (SA) Exception Code** field currently used for UT overrides when billing the eMedNY contractor on paper or magnetic media. If multiple claims are submitted in a single transaction, this field must contain the same value for each claim submitted. **Please Note: If a UT override is submitted and the recipient has not reached their UT limit, the transaction will be rejected.** The following are the only acceptable values to be used in the **Prescription Denial Clarification** field if requesting a UT override.

02 = Other Override - use to replace SA Exception code P (Pending an override). If 02 is indicated a "Request for increase in UT Service Limit" must be submitted by the physician or other qualified practitioner.

07 = Medically Necessary - use to replace SA Exception Code J (Immediate Urgent Care) and L (Emergency).

5.0 Pro-DUR/ECCA Input Information (Rev. 11/02)

This section describes the input fields required by the New York State Pro-DUR/ECCA system. The way you see this information as you provide input is largely a factor of your computer's software. In fact, some of these field values may be entered on your behalf by your software.

The **required transaction header information** shown in this section is needed for each transaction request that is sent to the MEVS Pro-DUR/ECCA system.

The NCPDP field numbers are shown in parenthesis at the end of the description for each field.

Following is a description of the fields that must be submitted to the Pro-DUR/ECCA system for each transaction.

FIELD	DESCRIPTION
Bin Number	All requests must send **004740**, which identifies the New York MEVS Pro-DUR/ECCA system. In most cases, this information is automatically provided by your computer software. (101)
Cardholder ID Number	The Cardholder ID Number is the eight position alpha numeric Medicaid Client Number (CIN) or the thirteen digit Access Number without the six digit ISO # prefix. Both of these values are provided on the recipient's benefit card. (302)
Category of Service	The 4 digit category of service assigned to your provider number that identifies DME or RX services is required if the item/NDC code requires a DVS number. Enter the COS in the last four positions of the pharmacy number field immediately after your MMIS provider ID. (201)
Date Filled	The Date Filled is the date the prescription was dispensed. The current date must be used for DVS transactions. (401)
Date of Birth	The Date of Birth is the date the recipient was born, including the century, which is provided on the recipient's benefit card. Format = CCYYMMDD (304)
Other Coverage Code	This field is used by the pharmacy to indicate whether or not the patient has other insurance coverage. (308) Valid entries are: **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
Person Code	The Person Code is the Sequence Number found on the recipient's benefit card in the last 2 positions of the access number. (303)

FIELD	DESCRIPTION
Pharmacist's Initials	The Pharmacist's Initials entered in the **Processor Control Number** provides the first and last initial of the person submitting the claim. (104)
Pharmacy Number	The Pharmacy Number is an eight digit Medicaid Provider Identification Number assigned to the pharmacy by the Department of Health. (201)
PIN	The four digit PIN entered in the **Processor Control Number** is the Personal Identification Number previously selected by the provider and submitted to the Department of Health. (104)
Processor Control Number	Information entered in the Processor Control Number is used to indicate that you are requesting **Electronic Claim Capture and Adjudication**. The following fields are required by Pro-DUR/ECCA if you are requesting your claim(s) to be captured for adjudication by the eMedNY contractor. **Read Certification Statement Indicator** **Pharmacist's Initials** **PIN** **TSN** (104)
Read Certification	A (Y) entered in the Read Certification Indicator contained in the **Processor Control Number** indicates that you have read and attest to the agreements in the Certification Statement (see Form Section). An "N" indicates that you have not read the Certification Statement or that you do not agree. (104)
Sex Code	The sex code indicates the recipient's gender as follows: **1** = Male **2** = Female (305)
Specialty Code	A Specialty Code is normally not required, except to identify the type of service being provided as below: **307** = Durable Medical Equipment (DME) (201)

FIELD	DESCRIPTION
Transaction Code	This field identifies the type of transaction request and the number of prescriptions being submitted. Acceptable codes are: **00** = Eligibility Verification with no claim submitted **01** = 1 Rx Billing **02** = 2 Rx Billings **03** = 3 Rx Billings **04** = 4 Rx Billings For Durable Medical Equipment (DME) authorizations use 01. **11** = 1 Rx Reversal Used to cancel a previous transaction. Please see section on Reversals. **31** = 1 Rx Rebill **32** = 2 Rx Rebill **33** = 3 Rx Rebill **34** = 4 Rx Rebill Note that 31-34 are used to adjust a previously paid claim(s). **81** = 1 Rx DUR only **82** = 2 Rx DUR only **83** = 3 Rx DUR only **84** = 4 Rx DUR only 81-84 are used to supply DUR information only for purposes of updating a recipient's drug history file when no claim submission or reimbursement is allowed or expected. (103)
TSN	The 3 character Transmission Supplier Number entered in the **Processor Control Number** is assigned to the provider by the EMedNY contractor. (104)
Version/Release Number	This identifies the NCPDP version used for your transaction and is commonly provided by your computer software. Some information fields are not available in the Fixed Format. These exceptions will be noted as the fields are described. (102) **32** = Variable Format **3A** = Fixed Format

5.1 Claim Information Fields (Rev. 11/02)

Following is a list of information that may be required to process a claim.

FIELD	DESCRIPTION
Alternate Product Code	The Alternate Product Code is used to enter the 5 digit alpha/numeric *product supply code*. The MMIS Provider Manual contains a list of the valid *product supply codes* (pg. 4-9 through 4-31). When entering an Alternate Product Code, the **Alternate Product Type** field entry must be a **1**. When entering an **Alternate Product Code**, the **NDC Code** field must be all zeroes. This field should also be used for DVS transactions. Note that this field is not available for use in the NCPDP Fixed RTDS 3A format. (437)
Alternate Product Type	The Alternate Product Type is used to identify the *Product Type* dispensed. This field must contain a "1" when the item dispensed is a product supply item (pg. 4-9 through 4-31 of the MMIS Provider Manual), or for item codes requiring a DVS number which were published in a list. **Please Note:** This field is not available when using the NCPDP Fixed RTDS 3A format. (436)
Compound Code	The Compound Code identifies the type of prescription as follows: **0** = Not specified. Use for DVS transactions. **1** = Not a compound - use when dispensing a prescription drug with an 11 digit NDC code. **2** = Compound - use when dispensing a compound drug. ECCA is not allowed for compounds. **Please Note: 0** or **1** may be used for sickroom supplies if you are using the NCPDP Variable format. If you are using the NCPDP Fixed format, you must use **0** for sickroom supplies. (406)
Date Prescription Written	The Date the Prescription was written is entered in this field. The Date Prescription Written must be no more than 60 days prior to the **Date Filled** for original scripts. For Refills, the Date Prescription Written cannot be over 180 days old from the **Date Filled.** (414)
Days Supply	The Days Supply is the estimated number of days that the prescription should last. New York State does not accept a days supply greater than 366. When the prescription's directions state "take as directed" (PRN), it is strongly advised that 180 be entered as the days supply. (405)

FIELD	DESCRIPTION
Dispense As Written (DAW)/Product Selection Code	Acceptable values for the Dispense As Written (DAW) code are as follows: **0** = No product selection **1** = Substitution not allowed by prescriber **4** = Substitution allowed - Generic Drug not in stock **5** = Substitution allowed - Brand Drug dispensed as a Generic **7** = Substitution not allowed - Brand Drug mandated by Law **8** = Substitution allowed - Generic Drug not available in the Marketplace (408)
DUR Conflict Code	The DUR Conflict Code is used to indicate an **override** for a DUR reject of a previously entered claim. Acceptable values are: **TD** = Therapeutic Duplication **DD** = Drug to Drug Interaction (439)
DUR Outcome Code	The DUR Outcome Code is used to indicate the action taken by the pharmacist, and is required for a DUR **override**. Acceptable values are: **1A** = Filled as is, false positive **1B** = Filled, Prescription as is **1C** = Filled with Different Dose **1D** = Filled with Different Directions **1E** = Filled with Different Drug **1F** = Filled with Different Quantity **1G** = Filled with Prescriber Approval (441)
Eligibility Clarification Code	The Eligibility Clarification Code is used to indicate an eligibility override for Excess Income/Spenddown recipients when the spenddown has been met but eligibility has not been updated on file. Recognized value is: **2** = Override **Note** that this is the only value used to override eligibility by NYSDOH and can only be used for spenddown claims. Any other NCPDP allowable values entered in this field will be ignored. Refer to Section 2.13 for additional information on this field. (309)
Metric Quantity	The Metric Quantity is the total number of Metric Units dispensed for the prescription. New York State cannot accept a quantity greater than 9,999. (404)

FIELD	DESCRIPTION
NDC Number	The NDC Number is the 11 digit National Drug Code identifying the dispensed drug. For compound drugs, use the following values: Legend: 99999999999 Schedule II: 99999999992 Schedule III: 99999999993 Schedule IV: 99999999994 Schedule V: 99999999995 Compounds: 99999999996 (407)
New/Refill Code	The New/Refill Code values are as follows: **00** = New Prescription **01** = First Refill **02** = Second Refill **03** = Third Refill **04** = Fourth Refill **05** = Fifth Refill The maximum number of refills allowed is 5. This value cannot be greater than the **Number of Refills Authorized** (403)
Number of Refills Authorized	The Number of Refills Authorized is entered in this field. New York State only allows a maximum of 5 refills. (415)
Other Payor Amount	This field is used by the pharmacy to enter the dollar amount received from a recipient's other third party insurance company. **Note:** If other third party coverage exists but the claim being submitted is not covered, enter zeroes in this field. Refer to the chart in Section 2.5 for information on the proper completion of this field. This field is not available for use in the NCPDP Fixed RTDS-3A format. (431)
Patient Paid Amount	This field is used by the pharmacy to enter the dollar amount collected as a spenddown from an excess income recipient. **Note:** If the spenddown was previously met but the eligibility file has not yet been updated, enter zeroes in this field. Refer to Section 2.13 for additional information on this field. (433)
Pharmacist's Identification	The Pharmacist's Identification may be entered on claims in place of the pharmacist's initials found in the **Processor Control Number** field. If used, the first two positions must contain the first and last initial of the pharmacist's name. (444)
Prescriber ID	The Prescriber ID is the Ordering Provider who wrote the prescription. Either the ordering provider's MMIS Provider ID number or license type and license number must be entered. Refer to MEVS Denial code 056 in Table 2 for further clarification. (411)

FIELD	DESCRIPTION
Prescription Denial Clarification	The Prescription Denial Clarification is used to indicate a Utilization Threshold override and replaces the use of the *SA Exception Code*. Following are the recognized values: **00** = Not Specified **01** = No Override **02** = Other Override - use to replace *SA Exception Code* **P** (pending an override) **07** = Medically Necessary - use to replace *SA Exception Code* **J** (Immediate Urgent Care) & **L** (Emergency). **Note** that these are the only values used for UT Override by NYSDOH when using the NCPDP format. Any other value entered in this field will be ignored. (420)
Prescription Number	The Prescription Number is assigned by the pharmacy. (402)
Primary Prescriber	The Primary Prescriber is used to enter the 8 digit MMIS Provider ID Number of the primary provider to which the recipient is restricted. This field must be completed for a restricted recipient unless you are the primary provider or the primary provider is indicated as the prescriber in field 411. (421)
Prior Authorization/ Medical Certification	The Prior Authorization/Medical Certification Code and Number is used to enter a prior approval number. The format for this field is: 1 followed by the 8 digit prior approval number and then three zeroes or co-pay exemptions. Refer to Section 2.11 for additional information on this field. (416)
Usual and Customary Charge	The Usual and Customary Charge is used to enter the amount charged for the prescription. (426)

6.0 PRO-DUR/ECCA RESPONSE MESSAGES (Rev. 04/03)

The information that is received from the New York State Department of Health Pro-DUR/ECCA system will vary depending upon whether the claim has been accepted or rejected. A separate response will be received for each claim submitted. For example, if three claims are submitted at a time, three responses will be returned from Pro-DUR/ECCA.

The NCPDP field numbers are shown in parenthesis at the end of the description for each field.

Following is a description of the information returned from Pro-DUR/ECCA for each request that is sent.

FIELD	DESCRIPTION
Response Status (Header)	An A (Accepted) will be returned if the information in the header is valid. An R (Rejected) will be returned if the information in the header is invalid. Further clarification of the reject will be indicated by NCPDP Reject codes and in the Message Area. **Please Note:** When an R is returned in the Header Response Status, all of the claims submitted on this request transaction will be rejected. (501)

Following is a description of the information that will be returned from Pro-DUR/ECCA for each claim sent. **Please Note: The following field descriptions are in alphabetical order and not necessarily the order in which they appear in the response.**

FIELD	DESCRIPTION
Additional Message	The Additional message area, in the NCPDP format, is used to return additional MEVS information about your request transaction. Your system may separate this information to clearly identify the contents of this additional message. However, some systems may display this message as it is returned in the NCPDP format. Please refer to Chart B for an example of the Additional Message. The following information is returned in the Additional Message: **Medicare Coverage** **HIC Number** **Insurance Carrier Codes** **Insurance Coverage Codes** **Indication of Additional Coverage** **Restriction Information - Exception Codes** **Dispensing Validation System Number** (526)
Amount of Copay/ Coinsurance	The amount of co-pay due for the entered NDC or APC (NY Product Supply Code) will be returned in the Amount of Copay/Coinsurance if the recipient has not met their co-pay or is exempt. (518)
Anniversary Month	The Anniversary Month found in the **Message Text is** the month of the recipient's Medicaid eligibility recertification. (504)
Authorization Number	The authorization number is the 9 digit invoice number returned if ECCA was requested and all edits were passed. This is the invoice number that will appear on your remittance statement from the eMedNY contractor. Please Note: NO CLAIM TO FA will be returned if the claim is captured but cannot be processed for adjudication. Below are a few examples of when this will occur: • Original claims over 90 days old. • Some third party claims • Processor Control Number blank or missing • Compound drug claims If a claim is captured but cannot be processed for adjudication, it must be billed via paper or magnetic media. (503)
Category of Assistance	Category of Assistance Code returned within the **Message Text**: S = SSI * = No valid category of assistance is available (504)

FIELD	DESCRIPTION
Claim Response Status	This is the status for each claim that was submitted. A "**C**" indicates that the claim is accepted and/or pending, and an "**R**" indicates that it is rejected. A separate Claim Response Status will be received for each claim submitted on your request (1 - 4). Refer to the **Reject Codes**, the **MEVS Denial Code**, the **Rx Denial Code**, the **Utilization Threshold/Post & Clear Code**, **and the Dispensing Validation Reason Code** to determine why an "**R**" is returned in the Claim Response Status. If a "**C**" is returned, the **Authorization Number** field must be checked to determine if the claim has been electronically captured for adjudication. The MEVS Pend Response Code Table should also be checked to see if the claim is pending. (501)
Clinical Significance	Clinical Significance returned within the **DUR Response Data** indicates how critical the conflict is. This value reflects the severity level assigned to a contraindication. See **DUR Processing** Section for a list of clinical significance codes and their meanings. (528)
Co-Payment Code	The Co-Payment Code returned within the **Message Text** provides the status of co-payment for this claim. (504)
Co-Payment Met Date	The Co-Payment Met Date returned within the **Message Text** identifies the date the recipient has met this year's co-payment requirement. (504)
County Code	The two-digit code for the county of fiscal responsibility for the recipient is provided within the **Message Text**. Refer to the list of county codes in the Codes section of the MEVS Provider Manual. (504)
Database Indicator	The Database Indicator returned within the **DUR Response Data** is always **1** to indicate that First DataBank is the source of the DUR database. (532)
Dispensing Validation System Number	The eight digit DVS Number (prior approval) will be returned in the **Additional Message Text** if the DVS transaction is accepted. The number will be automatically entered on your ECCA claim for adjudication processing. If you did not submit the claim for ECCA and are billing manually, this number must be put on your claim form. (526)
Dispensing Validation System Reason Code	The three-digit code indicating either the accepted or rejected status of the DVS request is returned within the **Message Text**. Refer to Table 9 for the codes and descriptions. (504)

FIELD	DESCRIPTION
Drug Conflict Code	The Drug Conflict Code returned within the **DUR Response Data** will be generated and sent back to the pharmacy when a DUR conflict is detected. See **DUR Processing** section for further clarification. The following values may be returned. **TD** = Therapeutic Duplication **DD** = Drug-Drug Interactions **DC** = Inferred Drug Disease Precaution **PG** = Drug Pregnancy Alert **PA** = Drug Age Precaution **LD** = Low Dose Alert **HD** = High Dose Alert **CH** = Call Provider Services 1-800-343-9000 (439)
DUR Overflow	DUR Overflow indicates whether there were more than three conflicts found, and all could not be reported in the space provided in the NCPDP response format. The DUR responses are reported in order of severity. The values are: **0** = Not specified **1** = No overflow **2** = Overflow (535)
DUR Response Data	Up to three DUR responses may be returned for each claim. Following is a list of the information returned in the DUR Response Data: (525) **Drug Conflict Code** **Clinical Significance** **Other Pharmacy Indicator** **Previous Date of Fill** **Quantity of Previous Fill** **Database Indicator** **Other Prescriber Indicator** **Free Text** For an example of the DUR Response Data please see Chart D.
Exception Codes	Up to four Exception Codes may be returned within the **Additional Message** area. These codes indicate special eligibility circumstances and can be found in the Codes section of the MEVS Provider Manual. (526)
Free Text	The Free Text returned within the **DUR Response Data** contains information to assist the pharmacist in further identifying the DUR conflict. Please refer to the **DUR Processing** section. (544)
HIC Number	The HIC Number returned within the **Additional Message** area is the Health Insurance Claim number for Medicare. (526)

FIELD	DESCRIPTION
Indication of Additional Coverage	A **ZZ** in the **Indication of Additional Coverage**, returned within **Additional Message** area, indicates that the recipient has more than two insurance carriers. You must call the Provider Services Department at 1-800-343-9000 to obtain complete information. (526)
Insurance Carrier Codes	Up to two Insurance Carrier Codes are returned within the **Additional Message** area to provide the codes for insurance carriers. (Also, see **Insurance Coverage Codes**). (526)
Insurance Coverage Codes	Up to two sets of Insurance Coverage Codes are returned within the **Additional Message** area. These correspond one for one to the **Insurance Carrier Codes** and indicate the scope of benefits. Refer to the Codes section of the MEVS Provider Manual for a description of the Insurance Coverage Codes. (526)
Maximum Per Unit Price	The Maximum Per Unit Price returned within the **Message Text** is the per unit amount on New York State's Drug File. The price is the maximum reimbursable unit price amount. The dollar amount returned to you in your response does not indicate the amount of payment you will receive. (504)
Medicaid Number	The Client's Identification Number (CIN) is provided within the **Message Text**. (504)

FIELD	DESCRIPTION
Medicare Coverage	The Medicare Coverage code is returned within the **Additional Message** area and indicates the type of Medicare coverage. **A** = Recipient has only Part A Medicare coverage (inpatient hospital). **B** = Recipient has only Part B Medicare coverage (outpatient). **AB** = Recipient has both Part A and Part B Medicare coverage. **ABQMB** = Recipient has Part A and Part B Medicare coverage and is a Qualified Medicare Beneficiary (QMB). **AQMB** = Recipient has Part A Medicare coverage and is a Qualified Medicare Beneficiary (QMB). **BQMB** = Recipient has Part B Medicare coverage and is a Qualified Medicare Beneficiary (QMB). **QMB** = Recipient is a Qualified Medicare Beneficiary (QMB) Only. If a recipient's eligibility code is 09 (Medicare Coinsurance/Deductible), Medicaid will only reimburse for the Medicare coinsurance/deductible if Medicare approves the drug or item being dispensed. Since the majority of drugs are not covered by Medicare, Medicaid would not be making payment in most cases. Therefore, the DUR system has been programmed to reject this type of claim (Table 2 code 105). In the rare case that Medicare does approve the drug, the claim can be manually submitted to the eMedNY contractor for payment. If the recipient has full Medicaid coverage (coverage code 01) and is QMB, the claim will not be rejected but will be captured and if ECCA was opted, processed for adjudication. (526)
MEVS Accepted Code	The MEVS Accepted Code returned within the **Message Text** indicates the type of Medicaid eligibility the recipient has. See Table 1 for a list of values and meanings. (504)
MEVS Denial Code	The MEVS Denial Code returned within the **Message Text** indicates the type of MEVS error for rejected transactions. See Table 2 for a list of values and meanings. (504)

FIELD	DESCRIPTION
Message Text	A Message Text area returned in the NCPDP format is used to provide MEVS information about your requested transaction. Your system may separate this information to clearly identify the contents of this message. However, some systems may display this message as it is returned in the NCPDP format. The following information is returned in the Message field for accepted claims (when **Claim Response = C**): **Medicaid Number** **County Code** **MEVS Accepted or Pending Code** **Utilization Threshold/Post & Clear Code** **Anniversary Month** **Sex Code** **Year of Birth** **Category of Assistance** **Re-certification Month** **Office Number** **Service Date** **Maximum Per Unit Price** **Co-Payment Code** **Co-Pay Met Date** **DVS Reason Code** Please refer to Chart A for an example of the Message. (504) The following information is returned in the Message field for rejected claims (when **Claim Response** = **R**): **MEVS Accepted, or Denial Code** **Rx Denial Code** **Utilization Threshold/Post & Clear Code** **DVS Reason Code** Please refer to Chart C for an example of the Message. (504)
Office Number	The Office Number returned within the **Message Text** represents the New York City office code. Refer to the Codes section of the MEVS Provider Manual for a list of valid office codes. (504)
Other Pharmacy Indicator	The Other Pharmacy Indicator returned within the **DUR Response Data** indicates the source of the previous prescription that forms the basis for the conflict with the present prescription. The following values may be returned. **0** = Not Specified **1** = Your Pharmacy **3** = Other Pharmacy (529)

FIELD	DESCRIPTION
Other Prescriber Indicator	The Other Prescriber Indicator returned within the **DUR Response Data** compares the Prescriber of the current prescription to the Prescriber of the previously filled conflicting prescription. The following values may be returned: **0** = Not Specified **1** = Same Prescriber **2** = Other Prescriber (533)
Pend Reason Code	The Pend Reason Code returned within the **Message Text** indicates that the claim has passed all other online adjudication edits but has been pended for one of the reasons listed in Table 10. See Section 15.0 for values and descriptions. The Table 10 reason code will be returned in the same field positions that a Table 1 Accepted Code is normally returned (Field 504, positions 34-36 in the variable format, and positions 45-47 in the fixed format.) Consequently, when the return of a Table 10 Pend Code is warranted, a Table 1 Accepted Code will not be returned. (504)
Previous Date of Fill	The Previous Date of Fill returned within the **DUR Response Data** is the date that the previous prescription was filled. (530)
Quantity of Previous Fill	The Quantity of Previous Fill returned within the **DUR Response Data** is the quantity of the previously filled prescription. (531)
Recertification Month	The Recertification Month returned within the **Message Text** is the month the recipient is due for recertification. (504)
Reject Codes	A maximum of 20 Reject Codes could be returned if the Claim Response Status is "R" (Reject). See NCPDP Reject Code list for values. (511)
Rx Denial Code	The Rx Denial Code returned within the **Message Text** provides prescription related reject reasons. See Table 7 for possible values. (504)
Service Date	The Service Date returned within the **Message Text** is the same as the Date Filled (or dispensed), entered on your transaction. (504)
Sex Code	Valid Sex Codes returned within the **Message Text** are: **F** - Female **M** - Male **U** - Unborn (504)
Utilization Threshold/ Post and Clear	The Utilization Threshold/Post & Clear codes indicate the status of the UT/P&C service authorization requests. See Table 8 for further clarification. (504)
Year of Birth	The Year of Birth returned within the **Message Text** shows the century and year of the recipient's birth. Example: 1980 will appear as 980. (504)

7.0 PRO-DUR/ECCA REVERSAL/CANCEL TRANSACTIONS (Rev. 11/02)

This section describes the use of reversal transactions in the New York State Pro-DUR/ECCA system. A reversal transaction is used to cancel or reverse a previously submitted claim that was approved by the Pro-DUR/ECCA system. A reversal can now be used to void out a paid claim submitted via paper or magnetic media. Reversal transactions can be submitted online up to two years from the service date.

Reversal transactions can only cancel one claim at a time. For example, if four claims were submitted and approved on a single transaction request, four separate reversal transactions would be needed to cancel the entire transaction.

The primary matching values used to determine which claim is being canceled are the **Provider Identification Number**, **Prescription Number, and Service Date,** which were submitted on the original claim. If the reversal is approved, code **021** is returned in the **MEVS Accepted Code**. If no match is found for the reversal, code **045** (No Authorization Found) is returned in the **MEVS Denial Code**.

The following fields are required for a reversal transaction. Please see the Pro-DUR/ECCA Input Information section for a description of these fields.

BIN Number
Version/Release Number
Transaction Code (11)
Pharmacy Number
Date Filled
Prescription Number
Processor Control Number (if a paid claim is being reversed)

The following information is returned if the cancel is accepted.

Response Status (A)
Authorization Number (The invoice number of the original claim will be returned in the response.)
MEVS Response Code (021)

The following information is returned if the cancel was denied.

MEVS Denial Code (R)
Rx Denial Code
Reject Codes (up to 10)

NCPDP Reversals can be submitted for service dates up to two years old as long as the previous transaction (either ECCA, non-ECCA, or claims submitted via paper or magnetic media) was submitted directly to the eMedNY contractor, or the transaction was submitted to eFunds no longer than 90 days prior to the eMedNY contractor takeover of the MEVS system.

By submitting a reversal via NCPDP format, you can either: reverse a previous NCPDP transaction, or use the NCPDP reversal to void a claim sent via paper or magnetic media. If a non-capture transaction (NO CLAIM TO FA) is being reversed, the action taken by the

claims processing system is contingent on if the subsequent paper or magnetic media claim was approved during the interim.

If a paper or magnetic media claim was approved for payment during the interim, the paper or magnetic media claim will be voided, and any units used by the claim will be restored to its applicable service authorization or prior approval. The service authorization and prior approval will remain available for future use until the record becomes inactive.

If a subsequent paper or magnetic media claim has **not** been approved for payment during the interim, the non-capture transaction will be reversed, and any applicable service authorization or DVS prior approval generated as a result of submitting the non-capture transaction will be cancelled. When cancelled, the authorizations and approvals previously generated are no longer useable.

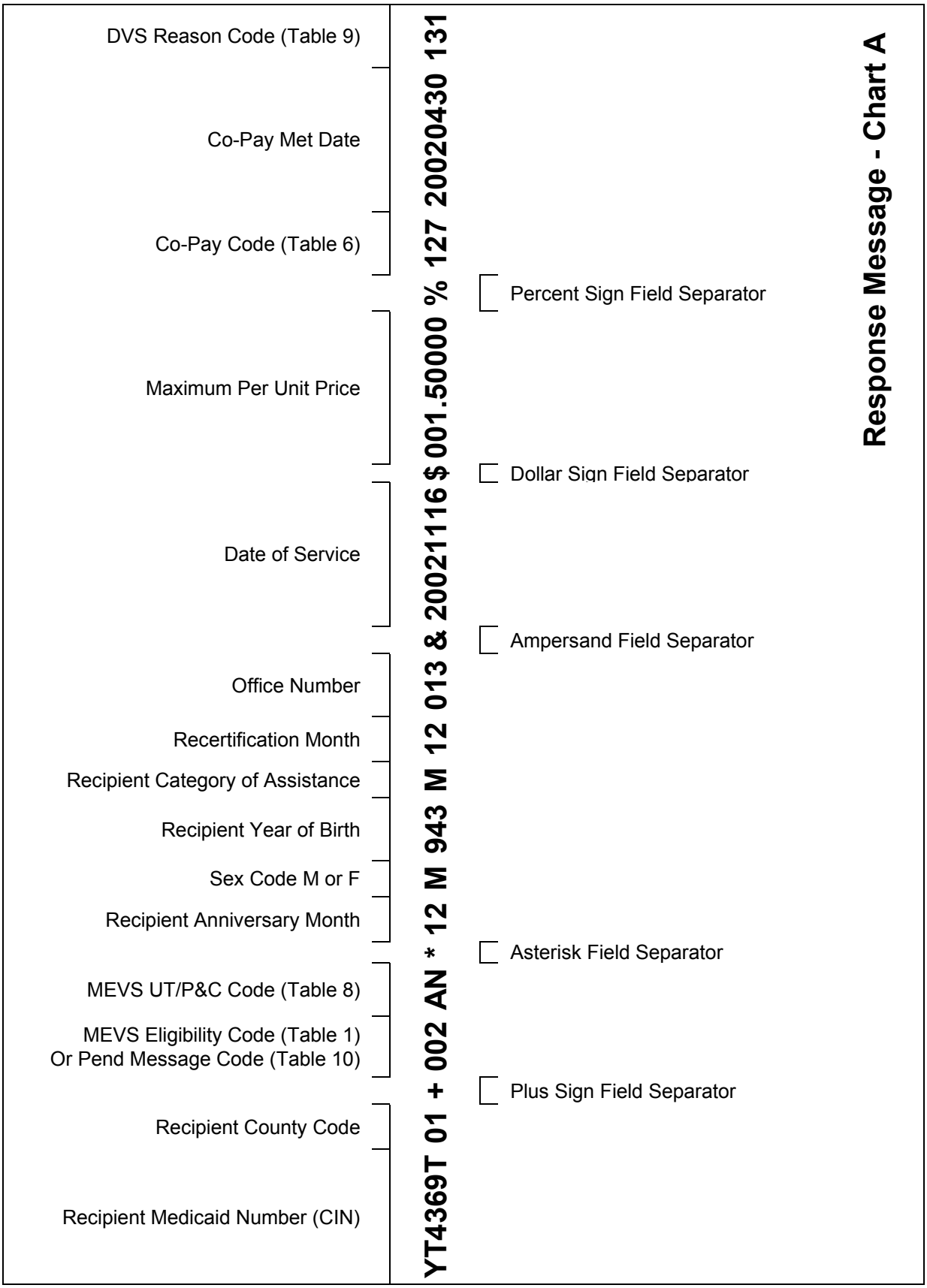
When reversing a previously submitted ECCA transaction that was captured for payment, if approved, the reversal will cancel any service authorization or DVS prior approval generated by the original transaction.

If you need to reverse a previously paid ECCA, paper, or magnetic media claim online, you must complete the processor control number field on the reversal transaction. If omitted, your reversal will be rejected for response code 323 (see Table 2 codes). If you need to reverse a non-ECCA claim, then you may choose to forego entering your processor control number.

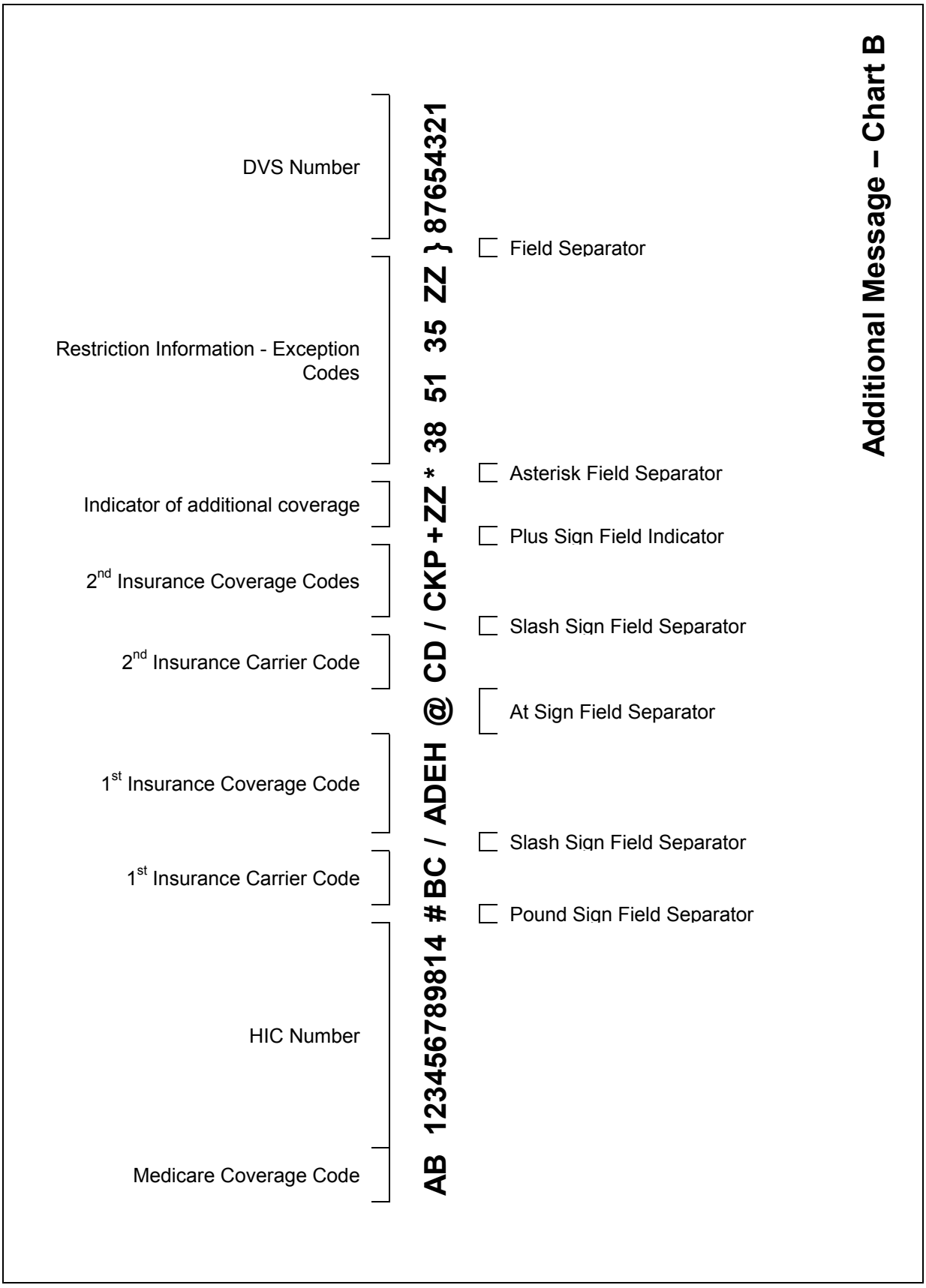
8.0 MESSAGE CHARTS (Rev. 11/02)

The following charts are used to illustrate various types of messages you can receive from your transactions. The charts are shown as to content of data. A single chart does not reflect the entire message you will receive in a single response.

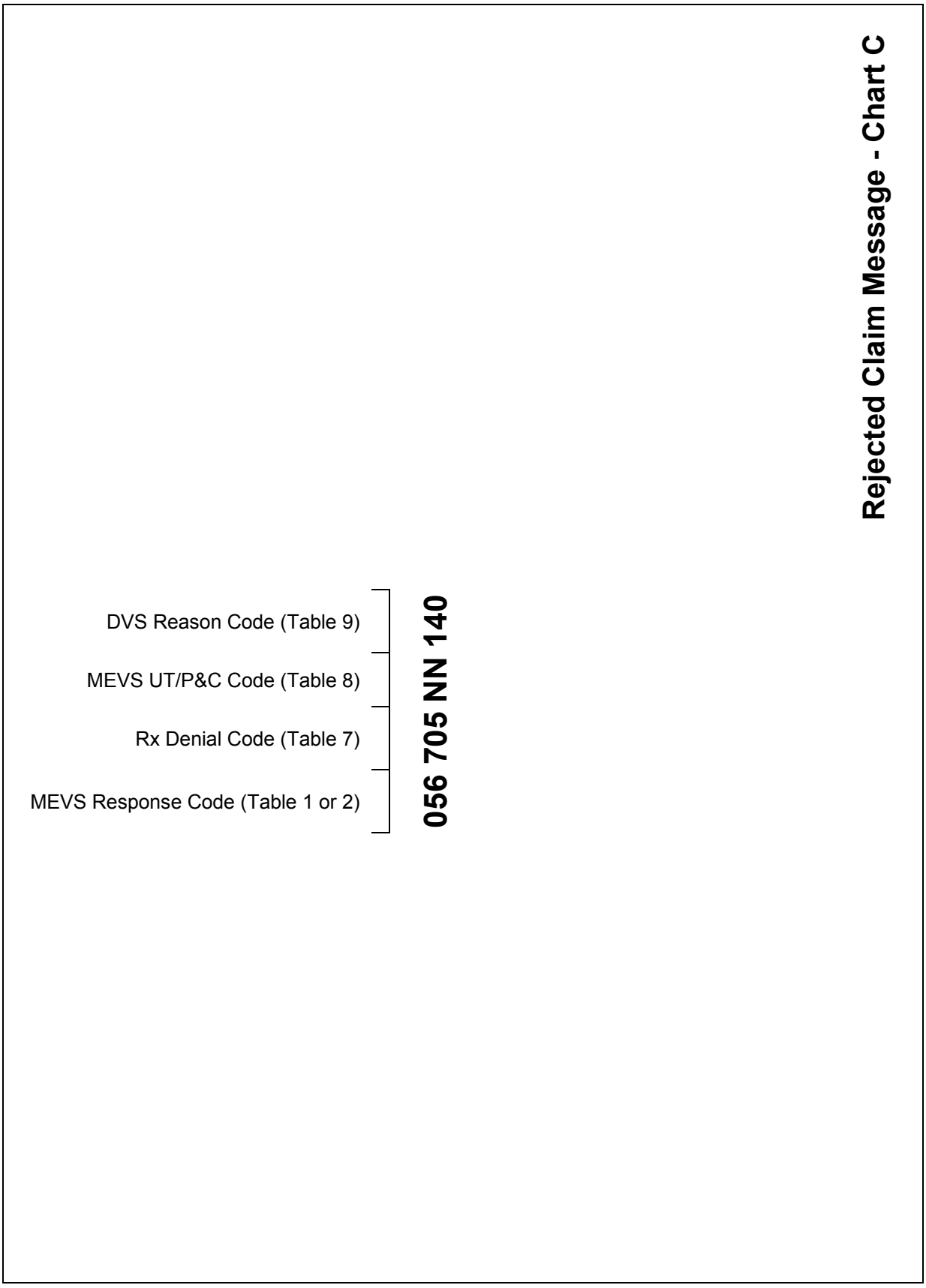
Response Message - Chart A



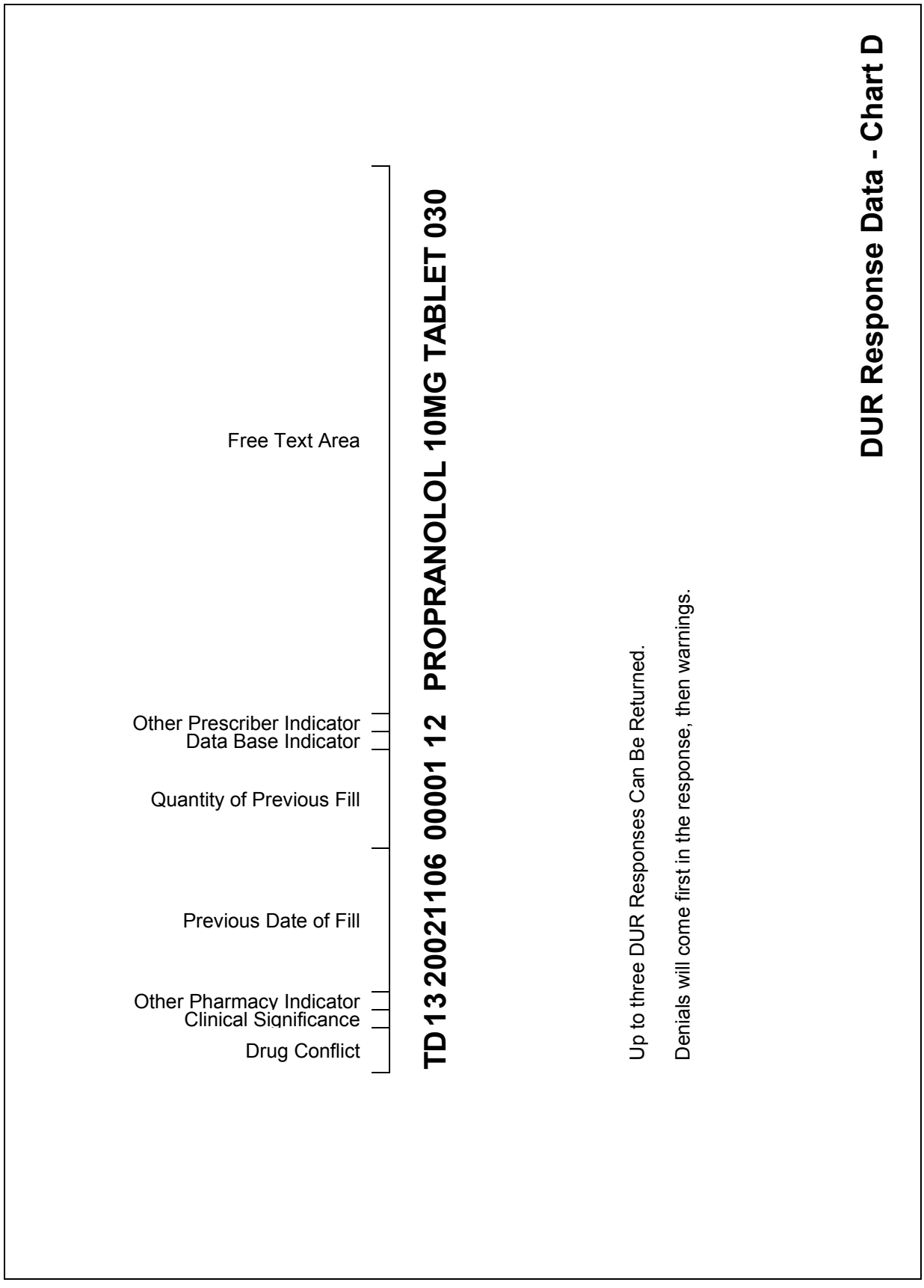
Additional Message - Chart B



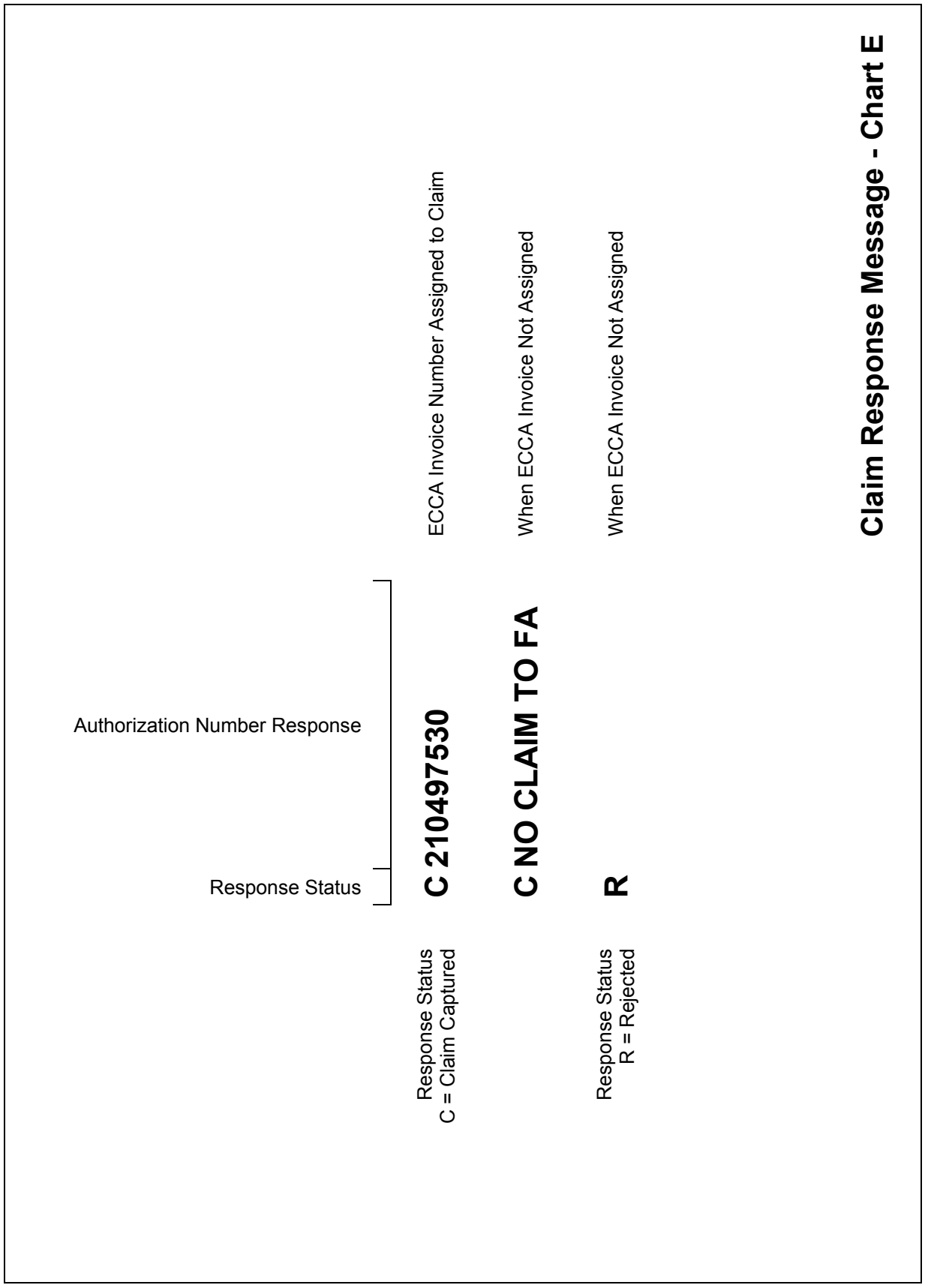
Rejected Claim Message - Chart C



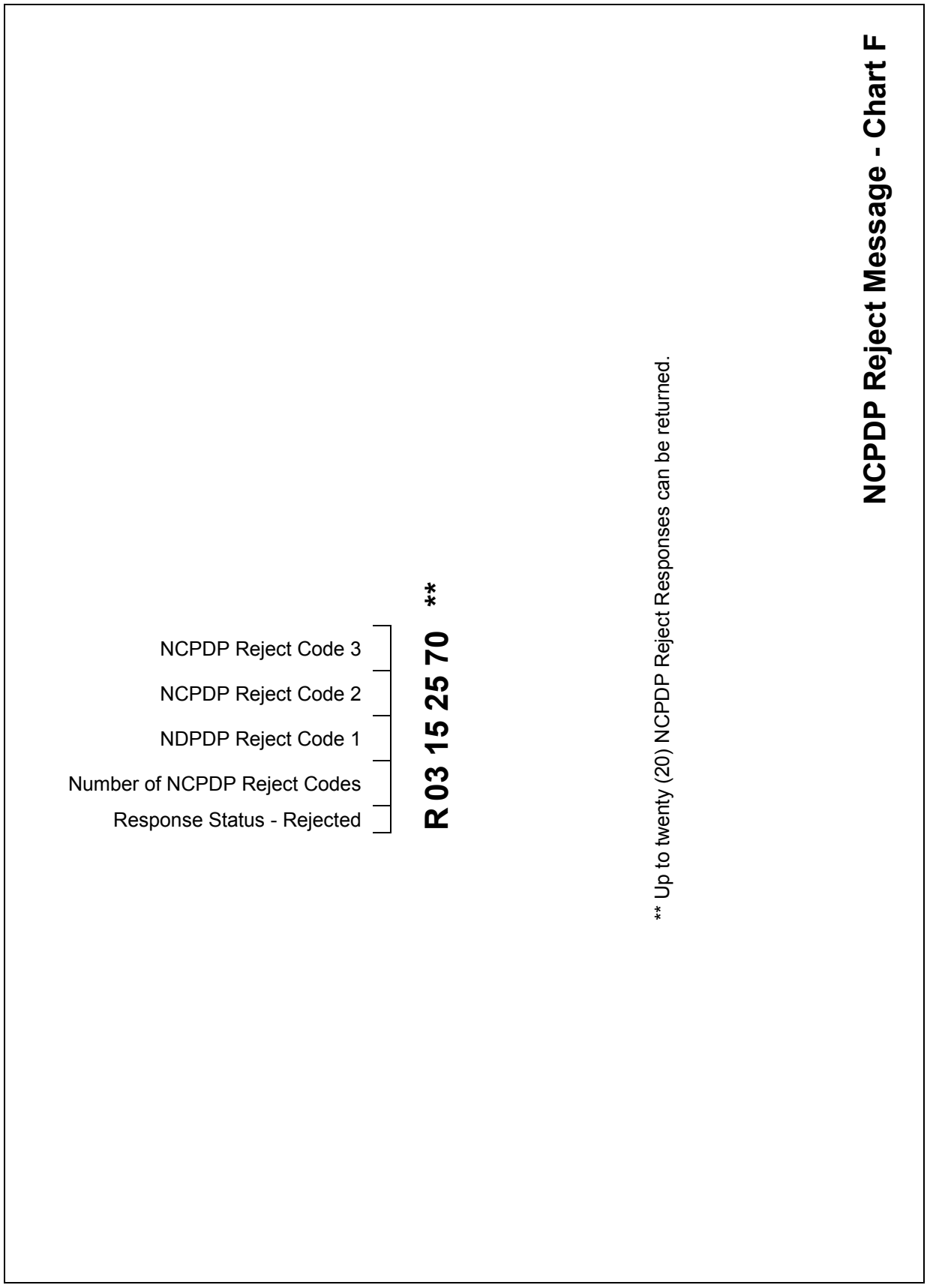
DUR Response Data - Chart D



Claim Response Message - Chart E



NCPDP Reject Message - Chart F



9.0 MEVS ACCEPTED CODES - TABLE 1 (Rev. 11/02)

All of the Table 1 codes (except 017 and 021) indicate the type of Medicaid eligibility for the recipient. If the recipient is Medicaid eligible, a Table 1 code will be returned on each claim transaction even if the transaction is rejected for other reasons. (i.e.: Utilization Threshold, DUR Denial, etc.). An exception to this is if the transaction is rejected for header field errors (Code 999 found in Table 2) and is not processed through the eligibility modules or an invalid Medicaid ID or sequence number is entered. Another exception is when a pend reason code from Table 10 is warranted in the response. Table 1 codes are eligibility codes. There are no existing comparable NCPDP codes that are returned with these codes.

Code 017 does not indicate Medicaid eligibility but denotes a recipient enrolled in the Family Health Plus Program.

Code 021 is not an eligibility status code. It is returned if your transaction to cancel a previously accepted claim has been accepted.

Code	Description
002	MA Eligible
003	Eligible Only Outpatient Care
005	Eligible Capitation Guarantee Only
006	Eligible PCP
007	Emergency Services Only
008	Presumptive Eligible Long-Term/Hospice
009	Medicare Coinsurance Deductible Only
010	Eligible Except Long-Term Care
013	Presumptive Eligibility Prenatal A
014	Presumptive Eligibility Prenatal B
015	Perinatal Family
016	MA Eligible-HR-Utilization Threshold
017	Family Health Plus Services Only
018	Family Planning Services Only
021	Record Canceled – Cancels a Previously Accepted Claim

10.0 MEVS DENIAL CODES - TABLE 2 (Rev. 11/02)

All of the following codes are MEVS Denial Codes. Their presence in your response area means the entire transaction has been rejected. If a MEVS Denial Code has a comparable NCPDP Reject Code, both codes will be returned. If there is no comparable code, then NCPDP code 85, "Claim Not Processed" is returned along with the MEVS Code. In those cases, the MEVS Denial Code will further qualify the reason for the claim being rejected. The following chart indicates the relationship between the MEVS Denial Code and any comparable NCPDP Reject Code, if one applies.

Code 999 will be returned if any invalid data is entered in the NCPDP required header fields. For example, an entry of 05 in the **Transaction Code** field will result in an MEVS Denial Code 999 being returned since it exceeds the number of claims authorized to be sent in a transaction. Also included is a description and relevant comments about the code.

MEVS CODE	DESCRIPTION	NCPDP CODE	DESCRIPTION
001	Not MA Eligible	65	Patient is Not Covered
030	Expired Card	07	M/I Cardholder ID Number
031	Invalid Card Status	07	M/I Cardholder ID Number
033	Non-Current Card	07	M/I Cardholder ID Number
045	No Authorization Found	87	Reversal Not Processed
050 *	Alternate Access Not Allowed	**	
051	Invalid Provider Number	05	M/I Pharmacy Number
052	Provider Not on File	50	Non-Matched Pharmacy Number
053	SSN Access Not Allowed	07	M/I Cardholder ID Number
054	Provider Cannot Access by Account Type	**	
055	Provider Not Eligible	**	
056 *	Re-enter Ordering Provider Number	25	M/I Prescriber ID
059 *	Invalid License Type	25	M/I Prescriber ID
061 *	Invalid Access Number	07	M/I Cardholder ID Number
062 *	Invalid Medicaid Number	07	M/I Cardholder ID Number
063 *	Invalid Sequence Number	08	M/I Person Code
065	Recipient Not on File	52	Non Matched Cardholder ID
066	Disqualified Ordering Provider	25	M/I Prescriber ID
067	Deceased Ordering Provider	25	M/I Prescriber ID
068	Invalid Ordering Provider	25	M/I Prescriber ID
071	Invalid Date	15	M/I Date Filled

MEVS CODE	DESCRIPTION	NCPDP CODE	DESCRIPTION
092	Invalid Specialty Code	05	M/I Pharmacy Number
100 *	Invalid Referring Provider Number	35	M/I Primary Prescriber
101 *	Restricted Recipient No Auth	35	M/I Primary Prescriber
103	No Coverage: Pending Family Health Plus	65	Patient Not Covered
104	No Coverage: Excess Income	65	Patient Not Covered
105	QMB Requires Medicare Approval	65	Patient Not Covered
118 *	MCCP Recipient No Auth	35	M/I Primary Prescriber
300	Service Date Prior to Birthdate	09	M/I Birthdate
302	Provider Ineligible Service on Date Performed	**	
303	Prior Approval Indicated Denied/Rejected by NYS	30	M/I PA/MC CODE
304	Recipient ID Unequal to Prior Approval File	30	M/I PA/MC CODE
305	Child Care Recipient – Bill Agency	**	
307	Prior Approval Units or Payment Amount Exceeded	**	
308	Service Date Not Within Prior Approval Range	**	
309	Claim Type Unequal to Prior Approval Record Class	**	
310	Pharmacy Service Included in In-state Facility Rate	**	
312	Pregnancy Indicated – Invalid for Recipient Sex or Age	**	
313	Provider Reimbursed for Medicare Only	**	
314	Recipient Not QMB, Services Not Reimbursable	**	
315	Recipient Not Medicare, Services Not Reimbursable	**	
316	Claim Previously Paid Using Another Provider Number	**	
318	Prescribing Provider License Not in Active Status	25	M/I Prescriber ID
320	Other Insurance Information Inconsistent	DV	
321	Pharmacy Service Included In Out-of-State Facility Rate	**	

MEVS CODE	DESCRIPTION	NCPDP CODE	DESCRIPTION
322	Online Adjustments/Rebills Not Allowed For DVS Items/Drugs	**	
323	Processor Control Number Needed for Rebill/Reversal of Paid Claim	**	
324	The system or file necessary to process the transaction is currently unavailable.	92	System Unavailable
700 *	Year of Birth Not Equal to File	09	M/I Birthdate
701	Sex Not Equal to File	10	M/I Sex Code
702*	ECCA Not Allowed	81 04	Claim too Old M/I Processor Control Number
703 *	Invalid PIN	04	M/I Processor Control Number
704 *	Invalid TSN	04	M/I Processor Control Number
999	Header Field Error	***	

* For further explanation and examples of error conditions refer to Table 2 Error Chart

** NCPDP equivalent reject code does not exist. Code 85 "Claim Not Processed" will be returned.

*** Several Different NCPDP Reject Codes could be returned with MEVS Code 999. These Reject Codes will indicate which header field is in error.

TABLE 2 ERROR CHART

Key: ~~b~~ = Blanks/Spaces
Left Justify = Begin in First Position on Left

MEVS CODE	NCPDP CODE	EXAMPLES OF CORRECT ENTRY	COMMON ERRORS BEING MADE / COMMENTS
050 Alternate Access not allowed	None	None - No entry made	1. In order to access the DUR/ECCA online system you must choose an alternate access method. 2. Code 050 will be returned if your provider number has not been updated with your selected access method on the eMedNY contractor's production file. 3. In order to be updated on the production file, you must have: A) Notified the eMedNY contractor of your alternate access method. B) Signed the contract and sent it to the eMedNY contractor. C) Signed the contract and submitted your check to your switch company if you chose to transmit through a switch. The switch must then send an approval to the eMedNY contractor before your number will be updated on production.
053 SSN Access Not Allowed	None	None – 9 digit entry not allowed	Card holder ID field (302) has only two acceptable formats: 1. Eight position alpha/numeric Medicaid Client Number (CIN) OR 2. Thirteen-digit Access Number without the six-digit ISO # prefix
054 Provider Cannot Access by Account Type	None	None – No entry made	If you submit a transaction via an access method other than the method assigned to your provider number on the production file, code 054 will be returned. For example, if your provider number is on the file as going through a switch company and a transaction is sent using a second switch company that is not on your file, your transaction will be rejected.

MEVS CODE	NCPDP CODE	EXAMPLES OF CORRECT ENTRY	COMMON ERRORS BEING MADE / COMMENTS
056 or 059 Reenter Ordering Provider Number or Invalid License Type	25 M/I Prescriber ID	0100567892 (NYS Physician) 290F654938 (Nurse Practitioner) 00240588 (8 digit MMIS Provider ID for enrolled prescriber) 11NJ456193 (Out of State Physician from New Jersey). 250U452749 (Optometrist)	1. The Prescriber ID field length is 10. The Prescriber's License type must be in the first two positions, followed by either two zeroes or two alpha (out of state) followed by the 6 digit license number. An 8 digit provider number must be left justified, space filled. **Note:** When entering a license number, the last six positions of the entry should be the actual numeric license number. If the license number does not contain six numbers, zero fill the appropriate positions preceding the actual license number. For example, an entry for an Optometrist whose license number is U867 would be 250U000867. 2. Some incorrect entries being received are: A) 567892: License number only B) 00567892: License number without License Type. C) 0156892: License Type, License Number without zeroes or 2 alpha in between. D) ~~bb~~00240588: Eight digit MMIS Provider Number NOT left justified. E) DEA Number: Some software packages are sending the physician's DEA numbers instead of the license number. 3. Nurse Practitioners: A nurse practitioner may have several different license numbers because the State Education Department issues them a license for each specialty for which they are certified. Not All Nurse Practitioners are licensed to prescribe drugs. A nurse practitioner who is licensed to prescribe will have the letter "F" preceding the 6 digit license number. This is the license number that must be used when submitting your transaction. The license type 29 followed by 0F and the 6 digit number is the only correct entry for nurse practitioners' license numbers. 4. Optometrists: An optometrist who is licensed to prescribe will have the letter 'U' or 'V' preceding the six -digit license number. The license type 25 followed by 'OU' or 'OV' and the six- digit number are the only correct entries for optometrists' license numbers.

MEVS CODE	NCPDP CODE	EXAMPLES OF CORRECT ENTRY	COMMON ERRORS BEING MADE / COMMENTS
061 Invalid Access Number 062 Invalid Medicaid Number.	07 M/I Cardholder ID Number	2631578424139 (13 digit access number found on recipient's Medicaid card) LZ00083W (CIN Number)	1. The entry in the Cardholder ID field must contain either the recipient's 13 digit access number or their 8 character alpha numeric CIN number. Both must be left justified, space filled. 2. The most common error being received that causes code 061 to be returned is an entry of 8 numeric digits in the Cardholder ID field. Check your software to make sure the alpha characters in the CIN number are not being converted to numeric values. 3. Rejections also occur when either number is not left justified. 4. Code 062 is returned when the number entered cannot be found on the file.
063 Invalid Sequence Number	08 M/I Person Code	03 (2 digit sequence number) 12 (2 digit sequence number)	1. The recipient's 2 digit sequence number is required on each transaction. The sequence number can be found on the recipient's Medicaid card. 2. Our format requires the 2 digit sequence number to be placed in the 3 digit Person Code field. The number must be left justified and space filled. We have learned that some software packages have the number placed in a different field, which is fine as long as it is sent to the eMedNY contractor in the Person Code field. 3. Some incorrect entries being received are: A) Person Code field is blank B) Sequence number is not left justified. C) Sequence number transmitted does not match the most current number on the eMedNY contractor's file. A new sequence number is issued each time a recipient receives a new card.

MEVS CODE	NCPDP CODE	EXAMPLES OF CORRECT ENTRY	COMMON ERRORS BEING MADE / COMMENTS
100 Invalid Referring Provider Number 101 Restricted Recipient No Auth 118 MCCP Recipient No Auth	35 M/I Primary Prescriber	00240588 (8 digit MMIS identification number of the provider to which a recipient is restricted).	1. If a recipient is restricted, the Primary Prescriber field must contain the 8 digit MMIS Number that the recipient is restricted to. The provider number is the only valid entry. An entry in this field is in addition to an entry in the Prescriber ID field. The entry must be left justified and space filled. 2. Some incorrect entries being received are: A) ~~bb~~00240588: Eight digit MMIS Provider number NOT left justified. B) 00240588bA: Eight digit MMIS Provider number left justified but followed by a space and an alpha character. C) Field is blank and recipient is restricted. D) Field contains the same provider number that is being sent in the Prescriber ID field and recipient is not restricted to that provider. E) Field contains a license number.
700 Year of Birth not equal to file.	09 M/I Birthdate	19490228 (Century, Year, Month, Day)	The Date of Birth field requires an 8 digit entry which includes the Century of the recipient's birth. The majority of your software packages only require you to enter the birth year and the software is automatically sending 19 as the Century. This has caused some rejections when the recipient was born in the 18th Century. When this occurs, you need to contact your software company.
702 ECCA Not Allowed	81 Claim Too Old 04 M/I Processor Control Number	20010601 (Century, Year, Month, Day) Y (Yes)	1. The date filled requires an eight-digit entry which includes the century of the date filled. The eMedNY contractor will only accept fill dates up to two years old via NCPDP for rebills and reversals. This reject will be returned for any rebill or reversal with a fill date over two years old. 2. The first position of the Processor Control Number must equal 'Y' to indicate the provider has read and attests to the data in the Certification Statement on page 19.0.3.

MEVS CODE	NCPDP CODE	EXAMPLES OF CORRECT ENTRY	COMMON ERRORS BEING MADE / COMMENTS
703 Invalid PIN 704 Invalid TSN	04 M/I Processor Control Number	YTG1234QBK (Certification, Initials, PIN, TSN) Y~~bb~~1234QBK (Certification, Two Blanks, PIN, TSN). If the initials are not sent in the Processor Control Number field, they must be sent in the Pharmacists Identification field.	1. If you wish your transaction to be electronically captured, the Processor Control Number field must be completed. Correct completion of this field alerts the on-line system to capture an accepted claim transaction for adjudication. 2. The reject denial code 703 will be returned if: A.) You have not submitted the PIN selection form to the Department of Health. B.) The PIN number has not been added to your provider file record at the eMedNY contractor. C.) The PIN number transmitted does not match the number selected, which was added to your provider file record. 3. The reject denial code 704 will be returned if: A.) You have not applied for and/or submitted your TSN number on a notarized certification statement to the eMedNY contractor. B.) The TSN transmitted does not match the TSN submitted on the certification statement, which was added to the TSN file. 4. Some software has hard coded the TSN of the billing service into this field. If that TSN was not on the certification statement, the transaction will reject.

11.0 CO-PAYMENT CODES - TABLE 6 (Rev. 11/02)

Code	Description
127	Co-payment Requirements Have Been Met
128	No Co-payment Required – Recipient Under 21 or Exempt

12.0 Rx DENIAL CODES - TABLE 7 (Rev. 11/02)

All of the Table 7 codes are denial codes. Their presence in your response means that the claim has been rejected. If none of the Table 7 codes apply to your claim, you will see 000 in your response instead.

MEVS CODE	DESCRIPTION	NCPDP CODE	DESCRIPTION
132	M/I Item / NDC Code	21	M/I NDC Number
133	Item Not Covered for Patient Gender	61	Drug Not Covered for Patient Gender
134	Patient Age Exceeds Maximum Age	66	Patient Age Exceeds Maximum Age
135	Patient Age Precedes Minimum Age	85	Claim Not Processed
136	Requested Item Exceeds Frequency Limitation	85	Claim Not Processed
137	Missing/Invalid Quantity Dispensed	18	M/I Metric Quantity
140	Category of service not valid for item / NDC code	05	M/I Pharmacy Number
142	Missing / Invalid category of service	05	M/I Pharmacy Number
705	NDC/APC Not Covered	70, 77	NDC Not Covered, Discontinued NDC Number
706	Refill Code Exceeds Number of Refills Authorized	17	M/I New Refill Code
707	Previously Filled Refill	17	M/I New Refill Code
708	Exceeds NY Allowed Refill Maximum	29	M/I Refills Authorized
709	Maximum Day's Supply Exceeded	19	M/I Day's Supply
710	Maximum Quantity Exceeded	76	Plan Limitations Exceeded
711	Date Filled Prior to Date Rx Written	28	M/I Date Prescription Written
712	Override Denied - UT not at limit	34	M/I Prescription Denial Override
713	Refill over 180 days from Date Rx Written	28	M/I Date Prescription Written
714	Date Filled More than 60 days from Date Rx Written	28	M/I Date Prescription Written
715	Other Insurance Amount must be greater than zero	13	M/I Other Coverage Code
716	Other Insurance Amount must be equal to zero	13	M/I Other Coverage Code
717	Recipient has Other Insurance	13	M/I Other Coverage Code
718	HR Recipient - No Rebate Agreement	77	Discontinued NDC Number
719	MA Only Covers Family Planning	65	Patient Is Not Covered
720	Days Supply is Less than the Minimum Required	19	M/I Days Supply
722	Family Health Plus Denial	65	Patient Not Covered

The chart starting on the following page lists the most frequently returned reject denial codes from Table 7 and describes the entry errors being received.

MEVS CODE	NCPDP CODE	EXAMPLES OF CORRECT ENTRY	COMMON ERRORS BEING MADE
705 NDC/APC Not Covered	70 NDC Not Covered 77 Discontinued NDC Number	00074738601 (11 digit NDC Code)	1. The NDC field entry must contain an 11 digit numeric NDC code. Alpha characters in this field will cause a rejection. 2. Some common errors being received are: A) NDC field is blank - software is not pulling code off of your drug file. B) NDC field is incomplete. Entry does not contain a full 11 numbers, but is a combination of blanks and numbers. C) A five digit alpha/numeric sickroom supply code is being transmitted in the NDC field. D) We have learned that some software packages are converting your 11 digit NDC code entry to a five digit alpha/numeric code for some over the counter items that used to be billed using the alpha/numeric code but have now been assigned an 11 digit NDC code. E) Conversely, other software packages are converting your 5 digit alpha/numeric code entry from the Alternate Product Supply code field to an 11 digit NDC code. These items used to be billed using an NDC code but have been changed to a five digit alpha/numeric code. **PLEASE NOTE:** If you receive a rejection code for your NDC entry, you should check with your software vendor to see what code is being transmitted. F) The Compound Code field must contain a value of 1 for each NDC entry. An entry of any other code in the compound code field when submitting an 11 digit NDC code will cause a rejected claim.

MEVS CODE	NCPDP CODE	EXAMPLES OF CORRECT ENTRY	COMMON ERRORS BEING MADE
710 Maximum Quantity Exceeded	76 Plan Limitations Exceeded	00100 (100 Tablets) 00001 (1 package of gauze pads) 00075 (75 Caloric Units)	1. The Metric Quantity field is a five digit numeric field. The first digit must always be a zero as New York State cannot accept a quantity greater than 09999. 2. The quantity that you enter in this field is checked against the maximum quantity on the Drug Plan File for each drug or supply item. If the amount entered exceeds the amount on the Drug Plan File, the claim will deny. 3. If you have received prior approval to dispense a quantity that exceeds the established maximum, you must enter the prior approval number on your transaction. This will allow your claim to override the edit. 4. Some incorrect entries being received are: A) 12652 - A five digit number cannot be entered. B) 12650 - Number is left justified instead of right justified. The zero must be in the first position. C) 00500 - The number of items in a box or package are being submitted rather than the number of boxes or packages. If there are 500 gauze pads in 1 box, the quantity should be submitted as 00001.
712 Override Denied UT Not at Limit	34 M/I Prescription Denial Override	00 (No Override required) 01 (No Override Required) 02 (UT Service Authorization Exception Code P - Override Pending) 07 (UT Service Authorization Exception Code J or L - Immediate Urgent Care or Emergency)	1. An entry must be placed in the Prescription Denial Clarification field. 2. If the recipient is not at their UT limit, 00 or 01 should be entered. 3. If the recipient is at their limit, value 02 or 07 should be entered to override the limit. 4. Code 712 is returned if a value of 02 or 07 is entered and the recipient has not reached their limit.

13.0 PHARMACY UT/P & C CODES - TABLE 8 (Rev. 11/02)

CODE	DESCRIPTION	APPROVAL OR DENIAL	PROCESSING RESULTS DESCRIPTION
AA	UT Approved, P&C Approved	A	UT&P&C S/A
AD	UT Approved, Services Not Ordered	D	No S/A
AN	UT Approved, P&C Not Invoked	A	UT S/A
DA	UT At Service Limits, P&C Approved	D	No S/A
DD	UT At Service Limits, Services Not Ordered	D	No S/A
DN	UT At Service Limits, P&C Not Invoked	D	No S/A
LA	UT Approved Near Limits, P&C Approved	A	UT&P&C S/A
LD	UT Approved Near Limits, Services Not Ordered	D	No S/A
LN	UT Approved Near Limits, P&C Not Invoked	A	UT S/A
NA	UT Not Invoked, P&C Approved	A	P&C S/A
ND	UT Not Invoked, Services Not Ordered	D	No S/A
NN	UT Not Invoked, P&C Not Invoked	A	Exempt - No S/A Necessary
PA	UT Override Denied, P&C Approved	D	No S/A
PD	UT Override Denied, Services Not Ordered	D	No S/A
PN	UT Override Denied, P&C Not Invoked	D	No S/A
XX	DUR Denial	D	No S/A

Table 8 codes were formulated to return a code which combines the Utilization Threshold (UT) and Post and Clear (P&C) programs. The first alpha character indicates the UT status; the second character indicates the P&C status. Both characters must indicate an approval in order for service authorizations to be generated. The key to recognizing an approval code:

The first character must be an "A", "L", or "N" and
The second character must be an "A" or "N".

The only Table 8 codes that indicate an approval for a UT and/or P&C service authorization are:

AA (UT and P&C service authorization)
AN (UT only, P&C exempt)
LA (UT and P&C service authorization)
LN (UT only - P&C exempt)
NA (UT exempt, P&C service authorization)
NN (UT exempt, P&C exempt)

PLEASE NOTE: Although these are approval codes, the approval is for the UT and P&C programs only. The claim must pass all other editing in order for the authorizations to be considered approved for payment. If the response status field contains a "C" (Claim Captured), any necessary service authorizations have been established. If the response status field contains an "R" (Rejected), no authorizations are generated. A Table 8 code is returned in every response even if the claim is rejected.

The third column in Table 8 lists the approval (A) or denial (D) status of each code.

The fourth column in Table 8 indicates whether service authorization requirements were satisfied.

Not invoked means that the claim did not have to be processed through that designated program. For example: UT Not Invoked means that the claim was not processed through the UT program for various reasons. (Recipient may be exempt from UT, etc).

If the claim is denied for DUR (Code XX), the UT and P&C status code will not be displayed because the UT, P&C approval has been negated by the DUR denial.

14.0 DISPENSING VALIDATION SYSTEM REASON CODES - TABLE 9 (Rev. 11/02)

CODE	DESCRIPTION
129	Duplicate/Redundant DVS request
130	DVS process was not invoked
131	Item approved / DVS number issued
132	Missing / Invalid item / NDC code
133	Item not covered for patient gender
134	Patient age exceeds maximum age
135	Patient age precedes minimum age
136	Requested item exceeds frequency limitation
137	Missing / Invalid quantity dispensed
139	DVS requires current date entry
140	Category of service not valid for item / NDC code
142	Missing / Invalid category of service
705	NDC/APC Not Covered
710	Maximum Order Quantity Exceeded

15.0 PEND REASON CODES – TABLE 10 (Rev. 11/02)

CODE	DESCRIPTION
301	Pending for Manual Pricing. (The NDC being billed requires manual review and pricing by DOH).
306	Item Requires Manual Review. (The NDC being billed requires manual review by DOH prior to payment).
311	PCP Plan Code Not on Contract File. (Recipient is enrolled in a managed care plan but the plan code has not yet been added to DOH's Managed Care Contract file). Call Provider Services 1-800-343-9000
317	Claim Pending: Excess Income/Spenddown. (Recipient has income in excess of the allowable Medicaid levels and will be considered eligible for Medicaid reimbursable services only at the point his/her excess income is reduced to the appropriate level. This response will be issued if you override the excess income denial [code 104] and the LDSS has not yet updated eligibility on the Client database).
319	Prior Approval Not on or Removed From File. (PA is not found on or no longer active on the eMedNY contractor's PA file).

Note: These codes may appear in the Table 2 response area for non-ECCA transactions since non-ECCA transactions will not be held in a pending status. They will be rejected if the conditions for these reason codes exist.

16.0 NCPDP REJECT CODES (Rev. 11/02)

CODE	DESCRIPTION - M/I = Missing/Invalid	MEVS CODE
01	M/I BIN	
04	M/I Processor Control Number	702,703, 704
05	M/I Pharmacy Number	051, 092, 140, 142
07	M/I Cardholder ID Number	030, 031, 033, 061, 062
08	M/I Person Code	063
09	M/I Birthdate	300, 700
10	M/I Sex Code	701
13	M/I Other Coverage Code	715, 716, 717
14	M/I Eligibility Override Code	
15	M/I Date Filled	071
16	M/I Prescription Number	
17	M/I New-Refill Code	706, 707
18	M/I Metric Quantity	137
19	M/I Days Supply	709, 720
20	M/I Compound Code	
21	M/I NDC Number	132
22	M/I Dispense as Written Code	
25	M/I Prescriber ID	056, 059, 066, 067, 068, 318
28	M/I Date Prescription Written	711, 713, 714
29	M/I Refills Authorized	708
30	M/I P.A./M.C. Code	303, 304, 319
34	M/I Prescription Denial Override	712
35	M/I Primary Prescriber	100, 101, 118
50	Non-Matched Pharmacy Number	052
52	Non-Matched Cardholder ID	065
61	Drug Not Covered For Patient Gender	133
65	Patient is Not Covered	001, 103, 104, 719, 722
66	Patient Age Exceeds Maximum Age	134
70	NDC Not Covered	705
75	Prior Authorization Required	
76	Plan Limitations Exceeded	710
77	Discontinued NDC Number	705, 718
81	Claim Too Old	702
82	Claim is Post Dated	
83	Duplicate Paid/Captured Claim	
84	Claim Has Not Been Paid/Captured	
85	Claim Not Processed	
87	Reversal Not Processed	045
88	DUR Reject Error	
92	System Unavailable	324
DQ	M/I Usual and Customary	

CODE	DESCRIPTION - M/I = Missing/Invalid	MEVS CODE
DV	M/I Other Payor Amount	320
DX	M/I Patient Paid Amount	
E1	Alternate Product Type	
E2	Alternate Product Code	
E4	DUR Conflict Code	
E6	DUR Outcome Code	
E9	Pharmacist's ID	
MZ	Error Overflow	

Up to twenty (20) NCPDP reject codes can appear in the rejected response. If a code has a comparable MEVS reject code that code will also be returned in the response. Most of the NCPDP reject codes are self-explanatory or have been further explained in other sections. Those needing further clarification are described below.

Code 22 - M/I Dispense As Written Code:

An entry is required. The acceptable values are:

0 - No Product Selection Indicated.
1 - Substitution not allowed by Prescriber.
4 - Substitution allowed - Generic Drug not in stock.
5 - Substitution allowed - Brand Drug Dispensed as a Generic.
7 - Substitution not allowed - Brand Drug mandated by law.
8 - Substitution allowed - Generic Drug not available in marketplace.

Code 30 - M/I P.A./M.C. Code:

If an NDC or APC requires a prior approval number, the prior approval field must contain the prior approval number assigned to you for the NDC or APC. The prior approval field is 12 digits in length. The entire field must be completed. The first digit should always be a 1 followed by the 8 digit prior approval number with three zeroes or co-pay exemptions following. Example 156734268000. Additionally, if you are submitting claims using the NCPDP RTDS "3A" fixed format, the field needs to be zero filled if a prior authorization is not required for the NDC code. Refer to Section 2.11 for field values.

Code 83 - Duplicate Paid/Captured Claim:

This code is returned when a claim is submitted and the Pharmacy Number, Cardholder ID, Date Filled, and Prior Approval Number fields match a previously paid claim and one of the following three conditions also exist:

- Prescription Number, NDC/APC (if not a compound), and Generic Code match, but the New/Refill Code is different.
- Prescription Number and Generic Code match, but NDC/APC is different
- NDC/APC (if not a compound) match, but Prescription Number is different.

Refer to section 2.14 for additional information.

Code 84 - Claim Has Not Been Paid/Captured:

This code is returned when a transaction is submitted (transactions codes 81-84) with the intent of supplying DUR information only for purposes of updating the recipient's drug history file when no claim submission or reimbursement is allowed or expected. If Code 84 is the only code returned, the drug history file has been updated.

DQ - M/I Usual and Customary:

An entry is required in the Usual and Customary Charge field. If the claim is being sent for ECCA processing, the amount in this field must be greater than zeroes. If ECCA is not being requested, the field must be zero filled.

17.0 GLOSSARY OF ABBREVIATIONS AND TERMS (Rev. 11/02)

Several abbreviations are used when referring to the Drug Utilization Program. These abbreviations are listed below with a brief description.

APC	Alternate Product Code a/k/a/ Product Supply Code. The five digit alpha/numeric code assigned by New York State to over the counter sickroom supplies. These codes are found on pages 4-9 through 4-31 of the MMIS Pharmacy Provider Manual. The five digit alpha/numeric DME item codes are also entered as APC codes for DVS Transactions.
CPU	Central Processing Unit. This is also known as the mainframe computer.
CPU-CPU Link	A direct telecommunication connection to the eMedNY contractor's mainframe computer using a central processing unit to access the MEVS/Pro-DUR systems.
DME	Durable Medical Equipment. These items and their codes are listed in the DME MMIS Provider Manual and are further identified by use of specialty code 307 or category of service 0442 when billing and must be submitted on a DME claim form. Some DME item codes require a DVS number.
DVS	Dispensing Validation System. This feature allows you to obtain the required prior approval number (DVS number) for pre-designated DME item codes and certain prescription drugs in the same transaction as your DUR/ECCA claim. Items, which are only reimbursable under COS 0442, can also be submitted through the NCPDP format but not for DUR/ECCA.
ECCA	Electronic Claims Capture and Adjudication. This is an optional feature of the Pro-DUR program, which allows you to have your DUR claim captured and adjudicated for payment by the eMedNY contractor.
MEVS	Medicaid Eligibility Verification System. The system which processes providers' eligibility inquiries and service authorization requests for New York State Medicaid recipients.

LICENSE TYPE	Two digit code indicating the type of provider that wrote the prescription. The valid license types are: 01 NYS Physician 02 NYS Dentist 09 NYS Physician Assistant 25 NYS Optometrist 26 NYS Podiatrist 27 NYS Audiologist 29 NYS Nurse Practitioner/Midwife 11 Out-of-State Physician 12 Out-of-State Dentist 19 Out-of-State Physician Assistant 35 Out of State Optometrist 36 Out-of-State Podiatrist 37 Out-of-State Audiologist 39 Out-of-State Nurse Practitioner/Midwife
MAGNETIC MEDIA	Tape, Cartridge, or Diskette used to submit claims for processing.
NCPDP	National Council for Prescription Drug Program. A nonprofit membership organization working toward the standardization and efficiency of third party prescription drug program processing. New York State is using NCPDP's Version 3.2 variable and fixed RTDS-A formats to administer the DUR program.
NDC	National Drug Code. The eleven digit number assigned to each drug or OTC item.
NYSDOH	New York State Department of Health
OTC	Over the Counter drug or supply which does not require a prescription.
P & C	Post and Clear. The program in effect which requires certain prescribers to post their prescriptions on the MEVS system. The posted prescriptions must then be "cleared" by the dispensing provider. P & C service authorizations are required for payment to be made.
PC	Personal Computer.
PC-Host Link	A dial up into the MEVS network using a personal computer to access the MEVS/Pro-DUR systems.

PIN	Personal Identification Number. A four digit number selected by each pharmacy and submitted to the New York State Department of Health for input to the pharmacy's provider file. Pharmacies must enter the number on each Pro-DUR transaction in order to have their claim electronically captured and submitted for adjudication.
Pro-DUR	Prospective Drug Utilization Review. This is a mandatory program, which alerts pharmacists to possible contraindications when dispensing drugs to a recipient.
RTDS-3A	Recommended Transaction Data Set established by NCPDP for electronic transmission of pharmacy claims in a fixed format.
Switch (Switching)	A company that passes the Pro-DUR/ECCA transaction from the provider to the MEVS network, via a dedicated telecommunications link, and returns the response from the MEVS network to the provider.
TSN	Transmission Supplier Number. A three-character code assigned by the eMedNY contractor to a provider who wishes to send their claims electronically or via magnetic media. The Transmission Supplier Number has also been referred to as a Magnetic Supplier Number. Each pharmacy must submit their TSN with a notarized certification statement to the eMedNY contractor. The TSN must be entered on each Pro-DUR transaction in order to have the claim electronically captured.
UT	Utilization Threshold. The mandatory program in effect, which limits Medicaid recipients to a designated number of services, prescriptions, etc. per year. Providers must receive a UT service authorization in order for payment to be made.

18.0 QUESTIONS AND ANSWERS (Rev. 11/02)

Q: How does my software work?
A: If you have any questions regarding your software, refer them to your software vendor. The New York State Department of Health and the eMedNY contractor do not have any control over software written to interface with the Pro-DUR/ECCA system.

Q: What phone number do I dial to access the production Pro-DUR/ECCA system?
A: For PC-Host going direct to the eMedNY contractor, you will receive the production phone numbers once you have completed certification and testing.
For providers going through a switch, you should contact your switch for access procedures and information.

Q: What is my PIN?
A: The Provider Services Department staff can verify if the PIN you are using is correct. They are not authorized to give out your PIN number for security reasons. If you do not know your PIN number, you must complete a new "PIN Selection Form" and return it to New York State Department of Health.

Q: What is my TSN?
A: Contact Provider Services at 1-800-343-9000 for the TSN that is authorized for electronic processing.

Q: Will my claim be paid?
A: If your claim is electronically captured and approved for payment, your claim will be paid. One exception to this rule is for excess income/spenddown. Once you have overridden the 104 denial response, your claim will pend waiting for an eligibility update from the WMS. If the update is not timely, your claim will release from its pending status and deny. These “captured, then denied” claims will appear on your remittance statement as being denied. Refer to the Electronic Claims Capture and Adjudication section of the manual for additional information.

Q: Why am I getting "NO CLAIM TO FA"?
A: You receive this message any time the system has determined the claim can not be captured for adjudication. There are many reasons for this, including if the Processor Control Number is not submitted. Refer to the Electronic Claims Capture and Adjudication section of the manual for additional information.

Q: Will this claim be paid on-line?
A: Your claim will be fully adjudicated. Claims approved for payment will appear as paid within the remittance statement issued for that payment cycle.

Q: What is Person Code?
A: The Person Code is the NCPDP field used to input the Recipient's Sequence Number. The sequence number can be found on the recipient's card.

Q: I received a DUR warning for *high dosage* and *refills too early* and my claim was denied? Why?

A: In the on-line Pro-DUR/ECCA system, the eMedNY contractor sends back warning information about certain drug interactions. These are only warnings and are NOT rejects in the on-line system. Some software companies will treat these warnings as REJECTS when interpreting the DUR response. You need to talk to your software provider to determine how to deal with this condition.

Q: What is the valid NDC code for a particular drug?

A: You should look at the microfiche you receive from New York Medicaid. All reimbursable drugs are listed. If you cannot find it, you can call New York State Department of Health at 1-518-486-3209.

Q: What is the proper procedure for entering sickroom supplies (alternate product codes) or Z-coded items?

A: Refer to Section 2.8 on Alternate Product Codes in the manual for clarification.

Q: Was a UT service authorization produced by the eMedNY contractor?

A: Refer to Table 8 UT, P&C codes in this manual for clarification.

Q: Why am I getting M/I PA/MC Code? This doesn't need a PA!

A: If the item you are entering does not need Prior Approval/Authorization and you're using the variable format, only enter spaces in the field. For the variable format, 32, the field should not be transmitted (your software system should take care of this). For the fixed format, 3A, or variable format if the field is being sent, the field should contain zeroes.

Q: How should the PA/MC Code be put in the field?

A: This is a 12 position field where:

Position 1 = one (1).

Positions 2 thru 9 = prior approval number.

Positions 10 thru 12 = zeroes (000) or co-pay exempt values.

Refer to Section 2.11 for field description.

Q: Why was I rejected?

A: Refer to Tables 2, 7, 8, 9 and the NCPDP Reject Codes list for clarification.

Q: What were my DUR reject codes, I cleared my screen already?

A: You should first check with your software vendor to see if there is a method of recovering or re-displaying the response for a transaction. If there is not, you can resubmit the transaction and get the same errors.

Q: I received DUR Reject Code 85 in my response, what does it mean?

A: You should look for the accompanying error codes that are part of the response in the **Message** field. The first is the MEVS Accepted or Denial code. This code is in the first three positions. The other code is the Rx Denial Code. It follows the MEVS code and a space. Additionally, the claim could be rejected because of UT/P&C denials or DVS denials. Refer to Tables 2, 7, 8, and 9 in this manual.

Q: Why does it say M/I NDC or NDC Not Covered, when the NDC is in fact covered?

A: Refer to Table 7 error chart for further explanation.

Q: What is Maximum Quantity, or Plan Limitations exceeded?

A: The maximum quantity or plan limitations reject is when the amount in the Metric Quantity field is greater than the allowed or approved New York State Medicaid quantity. For assistance call Provider Services at 1-800-343-9000.

Q: I am getting a reject code of 100 or 101, what do I do?

A: Refer to Table 2 error chart for further explanation.

Q: What is E4 DUR Conflict Code or E6?

A: These are both NCPDP Reject Codes. The E4 code indicates there is a problem with the **DUR Conflict Code** input with the claim. It could be because the data is not one of the DUR reject conflict codes, a DUR override was not required, or the field was the wrong size. The E6 code indicates there is a problem with the **DUR Outcome Code**. The common problems are a DUR override is not needed or the wrong value was input. Another common problem is only one of the fields is entered. Both fields should be reviewed and the transaction resubmitted. Refer to the Override Processing section for further clarification.

Q: How do I process an override?

A: There are three types of overrides for transactions. The first is the MEVS UT or Utilization Threshold override. It is entered in NCPDP field 420, **Prescription Denial Clarification**. The UT override is needed when you receive a UT Denial or a **D** in the first position of the codes for UT/PC in field 504, **Message**. The second override is for DUR. This is entered in field 439, **DUR Conflict Code**. The DUR override is required when you receive a DUR Reject, error code **88**. Both can be entered in the same transaction. Beware; if the override is not required, the transaction will be rejected. Refer to the Override Processing section for further clarification. The third override is the excess income/spenddown override. This override can be entered in field 309 to override response code 104. Once overridden, your claim will be captured if the processor control number field is completed properly. Once captured, your claims will pend, waiting for a WMS eligibility update to occur. If the update is not timely, your claim will appear as denied on your remittance statement.

19.0 FORMS (Rev. 11/02)

The following forms are included in the manual:

Personal Identification Number Request
Certification Statement

PERSONAL IDENTIFICATION NUMBER REQUEST

Provider Number _____

Provider Name _____

Provider Address _____

_____

_____

_____

Pin Number ____ ____ ____ ____
(Any four (4) digits)

Name _____
(Print of Type)

Signature _____ Date _____

Telephone Number ( ) _____

Return To:

New York State Department of Health
Suite 608
99 Washington Avenue
Albany, NY 12210
Attn: Diane Sumell

TSN (1) BILLING SERVICE NAME (IF APPLICABLE (2)
MEDICAID MANAGEMENT INFORMATION SYSTEM

CERTIFICATION STATEMENT FOR PROVIDER UTILIZING ELECTRONIC BILLING

As of (date) (3) and for one year after this date all claims electronically submitted to the State's Medicaid fiscal agent, for services or supplies furnished by (provider name) (4) (provider number) (5) will be subject to the following certification.

I am (or the business entity named in this form of which I am a partner, officer or director is) a qualified provider enrolled with and authorized to participate in the New York State Medicaid Assistance Program and in the profession or specialties, if any, required in connection with this claim; the persons providing services, care and supplies have the necessary licensing, certification, training and experience to perform the claimed service; I have reviewed these claims; I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized and done so in accordance with applicable federal and state laws and regulations; I have read the Medicaid Management Information Systems Provider Manual and all revisions thereto; all claims are made in full compliance with the pertinent provisions of the manual and revisions; all claims for care, services and supplies provided at the order of another professional have to the best of my knowledge been ordered by that professional in bona fide compliance with the procedures set forth in the manual and revisions. All care, services and supplies for which claim is made are medically necessary for the treatment of the named recipients, the amounts listed are due and except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than the Medical Assistance Program, payment of fees made in accordance with established schedules is accepted as payment in full other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid; ALL STATEMENTS, DATA AND INFORMATION TRANSMITTED ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED; I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT: taxes from which the state is exempt are excluded; all records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding these claims and payments therefore shall be promptly furnished upon request to the local or State Departments of Health, the State Medicaid Fraud Control Unit or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion: I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to claims submitted under this agreement to enable its automated processing, subject to reversal by provider, and (2) accept the claim submitted under this agreement as original evidence of care, services and supplies furnished.

In submitting claims under this agreement I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Health as set forth in title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including Medicaid Management Information System Provider Manuals and other official bulletins of the Department. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, present or future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

I UNDERSTAND THAT MY SIGNATURE HEREON GUARANTEES THE ABOVE CERTIFICATION WILL APPLY TO ALL ELECTRONIC CLAIMS SUBMITTED, USING MY (OR THE ENTITY'S) MEDICAID PROVIDER IDENTIFICATION NUMBER.

(Signature) (6) (Date) (7)

(Typed Name and Title) (8)

STATE OF NEW YORK
COUNTY OF NEW YORK (9)

On this day of , 19 ,before me personally came , to me known and known to me to be the individual described in and who executed the foregoing instrument, and (s)he acknowledged to me that (s)he executed the same.
(SEAL)

NOTARY PUBLIC

Electronic Billing Certification Statement Instructions

Field (1): TSN (Magnetic Supplier Number)

Please indicate the TSN under which the claims are being transmitted.

Field (2): BILLING SERVICE NAME

If applicable, enter the name of the billing service that the provider is enrolled with. If not using a billing service, leave this field blank.

Field (3): DATE

Enter the date the Certification Statement is signed and notarized (same date as Field 7).

Field (4): PROVIDER NAME

Enter the name of the provider whose signature is being notarized.

Field (5): PROVIDER NUMBER

Enter the 8-digit Medicaid provider ID number which was assigned by the Department of Health at the time of the provider's enrollment. This must be the individual provider number, not a group number or license number.

Field (6): SIGNATURE

Enter the signature of the individual indicated in Field 4. The signature must be original.

Field (7): DATE

Enter the date the Certification Statement is signed and notarized.

Field (8): NAME AND TITLE

Print the name and the title of the individual whose signature appears in Field 6.

Field (9): NOTARY PUBLIC

To be completed and signed by the Notary Public. Certification Statements that are not notarized cannot be accepted by the fiscal agent.

PLEASE NOTE:

Electronic Billing Certification must be renewed annually. Renewal documents will be provided prior to certification expiration.