

**STATE OF NEW YORK (NYS)  
DEPARTMENT OF HEALTH (DOH)**

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

**February 11, 2019  
Version 2.40**

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## 1.0 INTRODUCTION (Rev. 05/11)

The New York State Department of Health (DOH) has implemented a program that allows the pharmacy community to submit transactions in an online real-time environment that performs a Prospective Drug Utilization Review (Pro-DUR). In order to receive payment for services rendered, all pharmacies must submit their transactions through the online ProDUR system. An optional feature of the ProDUR program is the Electronic Claim Capture and Adjudication (ECCA) of claims. This program will check all prescription drugs paid by Medicaid for the member over the past 90 days and alert the pharmacists to possible medical problems associated with dispensing the new drug.

The telecommunication standards for the Pro-DUR/ECCA system are those named under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The NCPDP 5.1 and D.0 Telecommunications standard and the 1.1 and 1.2 Batch formats are supported until 01/01/2012. The NCPDP Official Release is available to NCPDP members from the following address:

National Council for Prescription Drug Programs Inc.  
9240 East Raintree Drive  
Scottsdale, AZ 85260  
(480) 477-1000

## 2.0 GENERAL INFORMATION (Rev. 05/11)

In order to receive payment for services rendered, all pharmacies must submit their transactions through the online Pro-DUR program using the NCPDP transaction format. Each pharmacy must choose an access method for these transactions.

Access methods are further outlined in the Trading Partner Information Companion Guide [www.eMedNY.org](http://www.eMedNY.org)

An accepted transaction gives you all the necessary Utilization Threshold (UT), DUR, and member eligibility information. **There is no need to do an eligibility inquiry.**

The online system is 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 online by the eMedNY contractor for payment or if the actual claim will be sent by the provider using paper or electronic batch.

## **2.1 Card Swipe (Rev. 02/19)**

Effective February 1, 2019 - eMedNY no longer supports the Verifone Vx570 Point of Sale (POS) terminal or any other devices, as they are no longer in compliance with the data privacy and security requirements and cannot be remediated.

## 2.2 Response Formats (Rev. 05/11)

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.

Reject codes may appear in one or more of the following fields: **NCPDP Reject Codes** will be returned in the **Reject Code** (511-FB) field. **MEVS Accepted and Denial Codes** listed in [Table 1](#) (page 9.0.1) and [Table 2](#) (page 10.0.1), **Rx Denial codes** listed in [Table 7](#) (page 12.0.1), **DVS** codes listed in [Table 9](#) (page 14.0.1), and **Pend Reason** Codes listed in [Table 10](#) (page 15.0.1) will be returned in the **Additional Message Info** (526-FQ) field. If a claim is rejected, an **NCPDP Reject Code** will always be returned in the **Reject Code** (511-FB) field and may have a corresponding **MEVS Code** placed in the **Additional Message Info** (526-FQ) 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.

### 2.3 Electronic Claims Capture and Adjudication (ECCA) (Rev. 05/11)

Captured claims will be fully edited for completeness and validity. There is a possibility that claims captured for final adjudication may be pended and subsequently denied. When a captured claim is pended, final adjudication results will appear on the remittance statement.

To submit ECCA transactions, a **Personal Identification Number (PIN)** is required. Additionally, the pharmacy must have an **Electronic Transmitter Identification Number (ETIN)** on file with eMedNY. Both of these forms may be accessed from the eMedNY website:

<http://www.emedny.org/info/ProviderEnrollment/allforms.html>

If the claim is not rejected for an edit, a "C" is returned in the response. When spaces are returned in the **Authorization Number** (503-F3) field, the claim was captured and processed for adjudication. If the **Processor Control Number** (104-A4) field is completed and a "C" is returned in the response with the message **NO CLAIM TO FA** in the **Authorization Number** (503-F3) field, the claim was captured, but was not processed for adjudication.

The following types of claims cannot be submitted for ECCA:

A Rebill (Transaction Code B3) for an original ECCA transaction with a date of service more than ninety (90) days old, which contains a PA (Prior Approval) with a PA status date of over ninety (90) days old, will become a non-ECCA claim. You may submit the adjustment on paper or electronic batch.

Durable Medical Equipment (DME) claims

Please Note: DME does NOT include the product supply codes (1 alpha, 4 numeric) found in the MMIS Pharmacy Provider Manual in sections 4.2 and 4.3. Pharmacy DME Claims must be submitted using 837 Professional ASC X12N.



## 2.4 Medicare and Third Party Claims (Rev. 05/14)

### Third Party and Medicare Managed Care Organizations (MCO)

A member's other insurance information (if any) is returned to you in the online response via the **Additional Message** field. If the member's other insurance covers drugs, either 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 or Medicare Managed Care Organization (MCO) claim to be successfully captured, the **Other Coverage Code** field and **Other Payer Amount Paid** field must be entered. Refer to the Standard Companion Guide Transaction Information for exact formatting of the COB segment. It is extremely important that the value entered in the **Other Coverage Code** field corresponds to the entry in the **Other Payer Amount Paid** field. The entry in each field must correlate to the other field and be logically correct for your claim to be accepted.

To report Patient Responsibility Amounts for Deductible, Coinsurance and Co-Pay and valid Other Patient Responsibility Amounts, refer to the COB Segment in the Standard Companion Guide, fields 351-NP (Other Payer Patient Responsibility Amount Qualifier) and field 352-NQ (Other Payer Patient Responsibility Amount). Example:

- 351-NP- Enter "01" Qualifies Deductible reported in field 352-NQ.
- 352-NQ- Enter Deductible Amount.
- 351-NP- Enter "05" Qualifies Co-Payment Amount reported in field 352-NQ.
- 352-NQ- Enter Co-Payment Amount.
- 351-NP- Enter "07" Qualifies Coinsurance Amount reported in field 352-NQ.
- 352-NQ- Enter Coinsurance Amount.

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

When submitting claims with value "3" in the (Other Coverage Code) field 308-C8, the NCPDP reject code or code(s) from the Other Payer(s) must also be entered in field 472-6E (Other Payer Reject Code).

The values for 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

### **Medicare Part B**

A member's Medicare information (if known) is returned to you in the online response via the Additional Message field. If Medicare Part B covers the NDC/HCPCS code being dispensed, a claim must be submitted to Medicare first.

For a Medicare Part B primary claim to be successfully captured, the appropriate Medicare fields must be entered. Refer to the D.0 Standard Companion Guide for the formatting of the COB Segment.

Note: The Medicare fields must be submitted if Medicare has adjudicated the claim.

### **Medicare Part D**

Prescription drugs for Medicare/Medicaid dual eligible's who have Part D coverage must be submitted to the member's Part D Prescription Drug Plan. When submitting claims for Drugs/OTCs that are excluded from Part D coverage but are covered by NYS, do not send the COB Segment.

## **2.5 Rebills/Adjustment Information (Rev. 05/11)**

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.

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, Cardholder ID, Prescription Number, and Date Filled. If more than one active claim meets the criteria, the most recently submitted claim will be selected for adjustment. To adjust an older submission, submit the rebill via paper and supply the Claim Reference Number of the specific claim to adjust.

Rebill transactions can be submitted for service dates up to two years old. While a non-ECCA claim can be adjusted, it cannot be converted to an ECCA claim.

Rebills are not allowed for original claims that generated a DVS prior approval. If a change is needed to a paid DVS claim, then the adjustment must be submitted on paper or electronic batch. To reverse the original claim, submit another original transaction with the corrected information.

## **2.6 Refills Information (Rev. 05/11)**

Prescriptions are limited to a maximum of five refills. All refills must be dispensed within 180 days from the date of the prescription. Claims for refills over 180 days from the date of the prescription will be rejected.

## 2.7 Dispensing Validation System (DVS) (Rev. 05/11)

DVS enables suppliers of prescription footwear items, specified drugs, certain medical surgical supplies and durable medical equipment to receive a prior approval number (DVS number). The DVS number will be returned in the Additional Message (526-FQ) field and the claim will be processed for adjudication (if ECCA is requested).

### **Important Information Regarding DVS Transactions**

- Transactions for both NDC's and HCPCS can be submitted if reimbursable under COS 0441, 0161 or 0288.
- Although multiple claim lines per transaction 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.
- The Date of Service for DVS transactions must be today's date.

## 2.8 Prior Auth Type Code and Prior Auth Number Submitted (Rev. 05/11)

The Prior Auth Type Code (461-EU) field is a two (2) position numeric field. There are two values expected by NYSDOH for this field.

- 01** = Prior Authorization. If this value is used, then Prior Auth Number Submitted (462-EV) field must contain the eleven-digit Prior Approval number.
  
- 04** = Exemption from co-pay. Use to indicate the member is exempt. If this value is used, 462-EV is not submitted unless a previously obtained Prior Approval is also being reported on the claim.

## 2.9 Temporary Medicaid Authorizations (Rev. 05/11)

Providers must make a copy of all Temporary Medicaid Authorizations (DSS-2831A) for their records. These claims **cannot** be submitted by pharmacies through the online ProDUR/ECCA program because eligibility is not yet on file. Pharmacy providers must put the Number 4 in the Service Authorization Exception field and submit the claim directly to the eMedNY contractor via paper. If the final adjudication of the claim results in a denial for member ineligibility, please contact the Local District Support Unit. For Upstate members call 518-474-8887; the number for New York City members is 212-417-4500.

## 2.10 Excess Income/Spenddown Claims (Rev. 05/11)

To properly submit a spend down claim, the **Eligibility Clarification Code** (309-C9) field must contain a value of two (2) and the **Patient Paid Amount** (433-DX) field must contain the amount paid by the member, even if that amount is zero. If the claim passes all other editing and you have elected the ECCA option, your claim will be captured and pended waiting for the eligibility file update from the local district to indicate that the spend down has been met. If the eligibility information is not updated, the claim will be denied.



## 2.11 Duplicate Claim Transactions (Rev. 05/11)

When an online claim transaction is sent to eMedNY, it will be matched against previously captured (approved) claims. If the transaction is determined to be an exact duplicate of a previously approved claim, eMedNY will return a “C” in the **Transaction Response Status** (112-AN) field. The remaining response fields will contain the data that was returned in the response from the original claim.

If identical data exists only in certain 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 Prior Auth Number Submitted (462-EV) field would need to contain a PA Number on one claim, and no PA Number for the other claim.)

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. 01/15)

A drug history profile is maintained for all members. 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 member'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.

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 nine 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.

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 member's current, active drugs already dispensed.

**Drug Overuse Alert (ER)**The Drug Overuse edit determines at the time of refill that less than 75% of the previously dispensed amount, based on the previously dispensed supply, has been used. Or the remaining days supply of the drug dispensed for the member's history claims, based on the past 90 days, has accumulated to an additional 10 days or more.

#### **Drug-Drug Interactions (DD)**

The Drug-Drug Interaction edit matches the new drug against the member'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 member'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 member'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 member's age group.

### 3.1 DUR Response Fields (Rev. 01/15)

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

**Drug Conflict Code (439-E4)**  
**Clinical Significance (528-FS)**  
**Other Pharmacy Indicator (529-FT)**  
**Previous Date of Fill (530-FU)**  
**Quantity of Previous Fill (531-FV)**  
**Database Indicator (532-FW)**  
**Other Prescriber Indicator (533-FX)**  
**Free Text (544-FY)**

#### Reason For Service (Conflict Code)

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

**TD** = Therapeutic Duplication  
**ER** = Drug Overuse Alert  
**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  
**NP** = New Patient Processing  
**AD** = Additional Drug Needed  
**PN** = Prescriber Consultation

#### 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
<b>TD</b> Therapeutic Duplication	R	<b>1</b>	An Original Prescription that duplicates a therapy the member is already taking.
<b>ER</b> Drug Overuse	R	<b>1</b>	Prescription is a Refill and is being filled prior to 75% of the previously dispensed amount having been used.
	R	<b>1</b>	The remaining Days Supply of the drug dispensed for the member's history claims over the past 90 days, has accumulated to an additional 10 days or more.

Conflict Code	Reject/ Warning	Clinical Significance	Description of Clinical Significance
<b>DD</b> Drug-Drug	R	<b>1</b>	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	<b>2</b>	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	<b>3</b>	Possibly significant. Little clinical data exists. Conservative measures are recommended because the potential for severe adverse consequences is great.
<b>DC</b> Drug Disease	W	<b>1</b>	Absolute Contraindication. Drug Therapy for the member should be changed.
	W	<b>2</b>	Precaution. The risk/benefit of therapy should be considered and the member's response closely monitored.
<b>PG</b> Pregnancy	W	<b>D</b>	<b>PREGNANCY</b> 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	<b>X</b>	<b>PREGNANCY</b> 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	<b>1</b>	<b>PREGNANCY</b> No FDA rating but is contraindicated or not recommended; may have animal and/or human studies or pre- or post-marketing information.
	W	<b>1</b>	<b>LACTATION</b> Absolute Contraindication. The Drug should not be dispensed.
	W	<b>2</b>	<b>LACTATION</b> Precaution. Use of the Drug should be evaluated carefully.

Conflict Code	Reject/Warning	Clinical Significance	Description of Clinical Significance
<b>PA</b> Drug Age	W	<b>1</b>	Absolute Contraindication. Drug Therapy should be changed.
<b>LD</b> Low Dose	W	<b>1</b>	Prescribed dose is less than the minimum appropriate for the drug.
<b>HD</b> High Dose	W	<b>1</b>	Prescribed dose is greater than the maximum appropriate for the drug.

### Other Pharmacy Indicator (529-FT)

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

<b>0</b>	=	Not Specified
<b>1</b>	=	Your Pharmacy
<b>3</b>	=	Other Pharmacy

Note: When the conflict is caused by an “Other Pharmacy”, eMedNY is not able to provide the identity of that pharmacy.

### Previous Date of Fill (530-FU)

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

### Quantity of Previous Fill (531-FV)

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

### Database Indicator (532-FW)

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 (533-FX)

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

<b>0</b>	=	Not Specified
<b>1</b>	=	Same Prescriber
<b>2</b>	=	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:

**Note:** Bold Text in the examples below represents 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.

<i>Example</i>									
TD	1	1	20020926	0000030000	1	1	<b>PROPRANOLOL 10MG TABLET 030</b>		

For Clinical Significance **1** the words **REJECT– DRUG OVERUSE MMDDYY**

<i>Example</i>									
ER	1	1	20080727	0000030000	1	1	<b>REJECT – DRUG OVERUSE 081808</b>		

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

<i>Example</i>									
ER	1	1	20150122	0000030000	1	1	<b>REJECT – DRUG OVERUSE (DYS) 020315</b>		

**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

<i>Example</i>									
DD	2	1	20021011	0000030000	1	1	<b>INF DIGITALIS/KALURETICS</b>		

**DEF**    Decreased effect of former drug

<i>Example</i>									
DD	2	1	20021012	0000030000	1	1	<b>DEF CORTICOSTEROIDS/BARBITURAT</b>		

**INL**    Increased effect of latter drug

<i>Example</i>									
DD	3	1	20021003	0000030000	1	1	<b>INL VERAPAMIL/DIGOXIN</b>		

**DEL**    Decreased effect of latter drug

**CODE    FREE TEXT DESCRIPTION*****Example***

DD	2	1	20020920	0000060000	1	1	DEL NSAID/LOOP DIURETICS
----	---	---	----------	------------	---	---	--------------------------

**ARF**      Adverse reaction of former drug***Example***

DD	2	1	20021018	0000090000	1	1	ARF THEOPHYLLINES/TICLOPIDINE
----	---	---	----------	------------	---	---	-------------------------------

**ARL**      Adverse reaction of latter drug***Example***

DD	1	1	20021014	0000050000	1	1	ARL NSAID/TRIAMTERENE
----	---	---	----------	------------	---	---	-----------------------

**MAR**      Adverse reaction of both drugs***Example***

DD	2	1	20020920	0000090000	1	1	MAR ACE INHIBITORS/POTASS.SPAR
----	---	---	----------	------------	---	---	--------------------------------

**MXF**      Mixed effects of former drug***Example***

DD	2	1	20021018	0000015000	1	1	MXF ANTICOAGULANTS,ORAL/ANTITH
----	---	---	----------	------------	---	---	--------------------------------

**MXL**      Mixed effects of latter drug***Example***

DD	2	1	20020919	0000060000	1	1	MXL HYDANTOINS/DISOPYRAMIDE
----	---	---	----------	------------	---	---	-----------------------------

**DC**      The description of the drug/disease contraindication.***Example***

DC	1	1	20020914	0000090000	1	1	HYPERTENSION
----	---	---	----------	------------	---	---	--------------

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

PG	1	0	00000000	0000000000	1	0	PREGNANCY PRECAUTION
----	---	---	----------	------------	---	---	----------------------

For lactation precautions the words **LACTATION PRECAUTION**



**CODE    FREE TEXT DESCRIPTION**

<i>Example</i>							
PG	2	0	00000000	0000000000	1	0	LACTATION PRECAUTION

**PA** For pediatric precautions the word **PEDIATRIC**

<i>Example</i>							
PA	1	0	00000000	0000000000	1	0	PEDIATRIC

For geriatric precautions the word **GERIATRIC**

<i>Example</i>							
PA	1	0	00000000	0000000000	1	0	GERIATRIC

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

<i>Example</i>							
LD	1	0	00000000	0000000000	1	0	<b>3.000      12.000</b>

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

<i>Example</i>							
HD	1	0	00000000	0000000000	1	0	<b>1.000      8.00</b>

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## 4.0 OVERRIDE PROCESSING (Rev. 05/11)

### 4.1 DUR Override (Rev. 05/11)

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 **Reason for Service Code** (439-E4) 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 **Result of Service Code** (441-E6) field. The only conflict codes that are DUR denials and reject the claim are TD (severity level 1), DD (severity level 1) and ER (severity level 1). All of the other codes being returned are warnings and allow your claim to be accepted.

**Result of Service Code** (441-E6) 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
- 1H = Brand-to-Generic Change
- 1J = Rx-to-OTC Change
- 1K = Filled with Different Dosage Form
- 2A = Prescription Not Filled
- 2B = Not Filled, Directions Clarified
- 3A = Recommendation Accepted
- 3B = Recommendation Not Accepted
- 3C = Discontinued Drug
- 3D = Regimen Changed
- 3E = Therapy Changed
- 3F = Therapy Changed – cost increased acknowledged
- 3G = Drug Therapy Unchanged
- 3H = Follow-Up/Report
- 3J = Patient Referral
- 3K = Instructions Understood
- 3M = Compliance Aid Provided
- 3N = Medication Administered
- 4A = Prescribed with acknowledgements

NOTE: The DUR Conflict Code **ER** (Drug Overuse) requires other specific Drug Conflict Codes and Submission Clarification Codes be submitted to override specific **ER** reject situations that occur.

When an early fill is needed for new admissions to Nursing Home/Child (foster) Care facilities, submit the Submission Clarification Code (420-DK) of **02** (Other Override) with a non-matching '**NP**' (New Patient Processing) in Reason for Service Code (439-E4) along with a Result of Service Code (441-E6) from the above list to override the **ER** conflict code.

When a Brand medication is needed in place of Generic (or vice versa), submit the Submission Clarification Code (420-DK) of **07** (Medically Necessary) with a non-matching '**AD**' (Additional Drug Needed) in Reason for Service Code (439-E4) along with a Result of Service Code (411-E6) from the above list to override the **ER** conflict code.

**DUR Override Documentation**

Pharmacies must document the reason for the override. Recommended forms of documentation are:

- a) The pharmacist writes the date, reason for override and his/her signature or initials on the back of the prescription.
- 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. 05/11)

If you receive a reject because a member is at their Utilization Threshold service limit (refer to message text field, UT codes DN, from [Table 8](#) on page 13.0.1), 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 **Submission Clarification Code** (420-DK) field. If multiple claims are submitted in a single transaction, this field must contain the same value for each claim submitted.

**Note:** If a UT override is submitted and the member has not reached their UT limit, the transaction will be rejected. The following are the only acceptable values to be used in the **Submission Clarification Code** field if requesting a UT override.

- 02** = Other Override - If 02 is indicated a "Threshold Override Application (TOA)" form has been submitted by the physician or other qualified practitioner.
- 07** = Medically Necessary - use to indicate the service is provided as a result of Immediate Urgent Care or Emergency.

## 5.0 Pro-DUR/ECCA Input Information (Rev. 12/17)

This section describes the input fields required by the Pro-DUR/ECCA system.

### 5.1 Header Information Fields (Rev. 05/11)

The **required header information** shown in this section is needed for each transaction request that is sent to the 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
<b>Bin Number</b>	All requests must send <b>004740</b> . In most cases, this information is automatically provided by your computer software. (101-A1)
<b>Cardholder ID Number</b>	The Cardholder ID Number is the eight position alpha numeric Medicaid Number or the thirteen digit Access Number without the six digit ISO # prefix. Both of these values are provided on the member's benefit card. (302-C2)
<b>Date of Birth</b>	The Date of Birth is the date the member was born, which is provided on the member's benefit card. Format = CCYYMMDD (304-C4)
<b>Date of Service</b>	The Date of Service is the date the prescription was filled. The current date must be used for DVS transactions. (401-D1)
<b>ETIN</b>	The 3 or 4 character Electronic Transmitter Identification Number entered in the <b>Processor Control Number</b> assigned to the provider. (104-A4)
<b>Patient First Name</b>	Required when a patient has a first name. (310-CA)
<b>Patient Gender Code</b>	The patient gender code indicates the member's gender as follows: 1 = Male 2 = Female (305-C5)
<b>Patient Last Name</b>	Enter patient's last name. (311-CB)

FIELD	DESCRIPTION
<b>Pharmacist's Initials</b>	The Pharmacist's Initials entered in the <b>Processor Control Number</b> provides the first and last initial of the person submitting the claim. (104-A4)
<b>PIN</b>	The four digit PIN entered in the <b>Processor Control Number</b> is the Personal Identification Number previously selected by the provider and submitted to the Department of Health. (104-A4)
<b>Place of Service</b>	Code identifying the place where a drug or service is dispensed or administered. Refer to external code list at <a href="https://www.cms.gov/">https://www.cms.gov/</a> Search for Place of Service Codes. (307-C7)
<b>Pregnancy Indicator</b>	This code will specify whether the patient is pregnant. Valid values are: Blank = Not Specified 1 = Not pregnant 2 = Pregnant (335-2C)
<b>Processor Control Number</b>	Information entered in the Processor Control Number is used to indicate that you are requesting <b>Electronic Claim Capture and Adjudication</b> . 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. If you have been issued a four digit ETIN, you may omit the "Y" (Read Certification Statement) Indicator in the first byte. <b>Read Certification Statement Indicator (omit when ETIN length is 4)</b> <b>Pharmacist's Initials</b> <b>PIN</b> <b>ETIN</b> (104-A4)
<b>Service Provider ID (aka Pharmacy Number)</b>	This field must contain the ten digit NPI number. (201-B1)
<b>Service Provider ID Qualifier</b>	Enter <b>01</b> = National Provider Identification (NPI) (202-B2)
<b>Software Vendor/Certification ID</b>	Mandatory field used to identify the software source by switches and/or processors. If not available or not used between trading partners, then submit 10 spaces. (110-AK)

FIELD	DESCRIPTION
<b>Transaction Code</b>	<p>This field identifies the type of transaction request being submitted. Acceptable codes are:</p> <p>B1 = Rx Billing  B2 = Rx Reversal  Note: B2 is used to cancel a previous transaction. Please refer to section on <a href="#">Reversals</a> on page 7.0.1  B3 = Rx Rebill  Note: B3 is used to adjust a previously paid claim(s).  E1 = Eligibility Verification with no claim submitted  N1 = Rx DUR only  Note: N1 is used to supply DUR information only for purposes of updating a member's drug history file when no claim submission or reimbursement is allowed or expected.  N2 = Rx DUR Reversal  N3 = Rx DUR Rebill  P1 = P.A. Request and Billing  P2 = PA Reversal  P4 = Prior Authorization Request Only</p> <p>S1 = Service Billing  S2 = Service Reversal  S3 = Service Rebill</p> <p>(103-A3)</p>
<b>Transaction Count</b>	<p>This field identifies the number of prescriptions being submitted for a specific transaction. A number from 1 to a maximum of 4 is allowed dependent on the type of transaction.</p> <p><b>E1 = Eligibility (1 only)</b>  <b>B1 = Billing submit from 1 to 4</b>  <b>B2 = Reversal submit 1 per transaction for NYS.</b>  If reversing a four (4) line transaction submit each line on a separate B2 transaction.  <b>B3 = Rebill submit from 1 to 4.</b>  <b>P1 = Billing with P.A. Request submit only 1</b>  <b>P2 = P.A. Reversal submit only 1.</b>  <b>P4 = P.A. Request Only submit only 1.</b>  <b>N1 = DUR Info Report submit from 1 to 4.</b>  <b>N2 = DUR Reversal submit 1 per transaction.</b>  <b>N3 = DUR Rebill submit from 1 to 4.</b>  <b>S1 = Service Billing submit from 1 to 4.</b>  <b>S2 = Service Reversal submit only 1.</b>  <b>S3 = Service Rebill submit from 1 to 4.</b></p> <p>(109-A9)</p>

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FIELD	DESCRIPTION
<b>Version/Release Number</b>	This identifies the NCPDP version used for your transaction and is commonly provided by your computer software. <b>D0</b> = Telecommunication Format  (102-A2)



## 5.2 Claim Information Fields (Rev. 12/18)

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

FIELD	DESCRIPTION
<b>Basis of Cost Determination</b>	<p>The Basis of Cost Determination Code indicates the method by which (Ingredient Cost Submitted) was calculated.</p> <p>Use value <b>05 (Acquisition)</b> when billing claims for <b>Clotting Factor Products</b> to indicate that the actual acquisition cost has been reported on the claim.</p> <p>Use value 08 (340B) when submitting claims for which a drug rebate has been received as a participant of a 340B Drug Purchasing Program. Also required:</p> <ul style="list-style-type: none"> <li>The Submission Clarification Code Value <b>20- (340B Drugs)</b>- Indicates that the drug being billed has been purchased through the 340B program.</li> </ul> <p>(423-DN)</p>
<b>Compound Code</b>	<p>The Compound Code identifies the type of prescription as follows:</p> <ul style="list-style-type: none"> <li><b>1</b> = Not a compound</li> <li><b>2</b> = Compound - use when dispensing a compound drug.</li> </ul> <p>(406-D6)</p>
<b>Compound Dispensing Unit Form Indicator</b>	<p>This field is used to enter the NCPDP Standard Product billing code.</p> <p>(451-EG)</p>
<b>Compound Dosage Form Description Code</b>	<p>This field is used to enter the Dosage form of the complete Compound mixture.</p> <p>(450-EF)</p>
<b>Compound Ingredient Component Count</b>	<p>This field is used to enter the number of ingredients reported for the Compound claim. A maximum of 25 ingredients is allowed.</p> <p>(447-EC)</p>
<b>Compound Product ID</b>	<p>This field is used to specify the Product Identification of an ingredient used in a Compound. Enter the NDC code of the drug.</p> <p>(489-TE)</p>
<b>Compound Product ID Qualifier</b>	<p>Enter a code qualifying the type of product dispensed. Enter:</p> <ul style="list-style-type: none"> <li>03= NDC</li> </ul> <p>(488-RE)</p>

FIELD	DESCRIPTION
<b>Compound Ingredient Quantity</b>	Enter the amount expressed in metric decimal units of the product included in the compound mixture. Enter the quantity for the specific ingredient reported in field 489-TE in this field. The total quantity of all ingredients for the entire Compound must also be entered in field 442-E7 (Quantity Dispensed).  (448-ED)
<b>Compound Ingredient Drug Cost</b>	Enter the Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in "Compound Ingredient Quantity" field 448-ED. The total dollar amount for all ingredients for the entire compound claim must be entered in field 426-DQ (Usual and Customary Charged Amount).  (449-EE)
<b>Compound Ingredient Basis of Cost Determination</b>	Enter the code indicating the method by which the drug cost of an ingredient used in a compound was calculated. Refer to the NCPDP D.0 External Code List for valid values.  (490-UE)
<b>Compound Type</b>	This field clarifies the Type of compound. The code submitted on the claim will be checked for validity during up-front editing. Refer to the NCPDP D.0 External Code List for valid values.  (996-G1)
<b>Date Prescription Written</b>	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 <b>Date Filled</b> for original scripts. For Refills, the Date Prescription Written cannot be over 180 days old from the <b>Date Filled</b> .  (414-DE)
<b>Days Supply</b>	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-D5)
<b>Delay Reason Code</b>	This field is used to submit an Over 90 Day Reason Code on the claim. Claims which are over 90 days old from the Date of Service without a valid over 90 day reason will be denied.  (357-NV)
<b>Diagnosis Code</b>	Code Identifying the diagnosis of the patient. When submitting the decimal point is always implied.  (424-DO)
<b>Diagnosis Code Count</b>	Count of diagnosis occurrences. 1 to 5 Diagnosis Codes may be sent.  (491-VE)

FIELD	DESCRIPTION
<p><b>Diagnosis Code Qualifier</b></p>	<p>Code qualifying the 'Diagnosis Code' being sent.  '<b>01</b>' = International Classification of Diseases (ICD-9).   After ICD-10 implementation, use:  '<b>02</b>' = International Classification of Diseases (ICD-10).   (492-WE)</p>
<p><b>Dispense As Written (DAW)/Product Selection Code</b></p>	<p>Acceptable values for the Dispense As Written (DAW) code are as follows:  <b>0</b> = No product selection  <b>1</b> = Substitution not allowed by prescriber  <b>2</b> = Substitution allowed – Patient Request Product Dispensed  <b>3</b> = Substitution allowed – Pharmacist Select Product Dispensed  <b>4</b> = Substitution allowed - Generic Drug not in stock  <b>5</b> = Substitution allowed - Brand Drug dispensed as a Generic  <b>6</b> = Override  <b>7</b> = Substitution not allowed - Brand Drug mandated by Law  <b>8</b> = Substitution allowed - Generic Drug not available in the Marketplace  <b>9</b> = Substitution allowed by Prescriber – Plan Request Brand   (408-D8)</p>
<p><b>Eligibility Clarification Code</b></p>	<p>The Eligibility Clarification Code is used to indicate:</p> <ul style="list-style-type: none"> <li>• An eligibility override for Excess Income/Spenddown when the member's spend down has been met but eligibility has not been updated on file.</li> <li>• To resubmit a previously denied claim when a Member is a Resident of an In-State Skilled Nursing Facility or Health Related Facility this includes coverage for pharmacy services. When the Member has been discharged and the records still reflect residency within the Facility, the claim may be incorrectly denied. An override may be submitted which will result in a pend status, giving the local district time to update the Member's file. Recognized value is:  <b>2</b> = Override</li> </ul> <p>(309-C9)</p>
<p><b>Fill Number</b></p>	<p>The maximum number of refills allowed is 5. This value cannot be greater than the <b>Number of Refills Authorized</b>.  (403-D3)</p>

FIELD	DESCRIPTION
<b>Ingredient Cost Submitted</b>	Enter ingredient cost. 340B providers billing Medicaid primary claims: <ul style="list-style-type: none"> <li>• Enter 340B Acquisition Cost</li> </ul> 340B providers billing Medicaid secondary claim (Medicare, Commercial Insurance): <ul style="list-style-type: none"> <li>• Leave this field blank.</li> </ul> 409-D9
<b>Number of Refills Authorized</b>	The Number of Refills Authorized is entered in this field. New York State only allows a maximum of 5 refills. (415-DF)
<b>Other Coverage Code</b>	This field is used by the pharmacy to indicate whether or not the patient has other insurance coverage or is enrolled in a Medicare Managed Care Organization (MCO). (308-C8) Valid entries NYSDOH are: <ul style="list-style-type: none"> <li><b>0</b> = Not Specified –</li> <li><b>1</b> = No Other Coverage Identified</li> <li><b>2</b> = Other Coverage Exists, Payment Collected – Use for Medicare Part B</li> <li><b>3</b> = Other Coverage Exists, This Claim Not Covered.</li> <li><b>4</b> = Other Coverage Exists, Payment Not Collected</li> </ul> (308-C8)
<b>Other Payer Amount Paid</b>	The amount qualified by the Other Payer Amount Paid Qualifier. (431-DV)
<b>Other Payer Amount Paid Qualifier</b>	Codes qualifying the Other Payer Amount Paid in field 431-DV. (342-HC)
<b>Other Payer ID</b>	ID assigned to the payer when submitting electronically. For Medicare Part B use: <ul style="list-style-type: none"> <li>Medicare Managed Care = <b>13</b></li> <li>Medicare Part B = Carrier Number</li> <li>Commercial Payers (TPL) = <b>99</b></li> </ul> (340-7C)
<b>Other Payer Date</b>	Payment or denial Date of the claim being submitted for coordination of benefits. (443-E8)

FIELD	DESCRIPTION
<b>Other Payer Amount Paid Count</b>	Other payer amount paid count which is the count of other payer amount occurrences. (341-HB)
<b>Other Payer ID Qualifier</b>	Code qualifying the 'Other Payer ID'. (340-7C) NYSDOH will process using the following codes. <b>05</b> = Medicare Carrier No. <b>99</b> = Medicare Managed Care or Commercial Insurance (TPL) (339-6C)
<b>Other Payer Coverage Type</b>	Code identifying the sequence of payment responsibility for the Other Payer ID. (340-7C)  (338-5C)
<b>Other Payer Patient Responsibility Amount</b>	Enter the Patient Responsibility as determined by the previous payer.  Example: If field 351-NP = (01-Deductible), then enter Deductible Amount.  (352-NQ)
<b>Other Payer Patient Responsibility Amount Count</b>	Enter the count of the Payer-Patient Responsibility Amount occurrences (351-NP / 352-NQ) – (Max 25).  (353-NR)
<b>Other Payer Patient Responsibility Amount Qualifier</b>	This code qualifies the Patient Responsibility amount entered in 352-NQ.  The amounts used by Medicaid are as follows: <ul style="list-style-type: none"> <li>• 01 = Deductible Amount</li> <li>• 04 = Amount reported from previous payer as Exceeding Periodic Benefit Maximum.</li> <li>• 05 = Copay Amount</li> <li>• 06 = Patient Pay Amount</li> <li>• 07 = Coinsurance Amount.</li> <li>• 09 = Health Plan Assistance Amount</li> <li>• 12 = Coverage Gap Amount</li> </ul> (351-NP)
<b>Other Payer Reject Count</b>	Number of third party denial codes. (471-5E)
<b>Other Payer Reject Code</b>	Enter the rejection code that was received from the primary payer. (472-6E)
<b>Patient First Name</b>	Required when the patient has a first name.  (310-CA)
<b>Patient Last Name</b>	Enter the Patient's last name.

FIELD	DESCRIPTION
	(311-CB)
<b>Patient Paid Amount Submitted</b>	This field is used by the pharmacy to enter the dollar amount collected toward satisfying the member's spend down requirement. <b>Note:</b> If the spend down was previously met but the eligibility file has not yet been updated, enter zeroes in this field. Refer to <a href="#">Section 2.10</a> on page 2.10.1 for additional information on this field. (433-DX)
<b>Place of Service</b>	Code identifying the Place where a drug or service is dispensed or administered. Enter Place of Service.  Note: Refer to <a href="https://www.cms.gov/">https://www.cms.gov/</a> Search for Place of Service Codes. (307-C7)
<b>Primary Care Provider ID</b>	Enter the NPI of the primary care provider the member is restricted to. (421-DL)
<b>Primary Care Provider ID Qualifier</b>	Enter 01 (NPI) (468-2E)
<b>Prior Authorization Number Submitted</b>	Enter the 11 digit Prior Authorization Number when applicable . (462-EV)
<b>Prior Authorization Type Code</b>	This code will specify co-pay exemption or clarify a Prior Authorization request or submission. Valid values are:  <b>00</b> = Not specified <b>01</b> = Prior Authorization <b>04</b> = Exemption from co-pay (461-EU)
<b>Prescriber ID</b>	Enter the NPI of the Prescriber. (411-DB)
<b>Prescriber ID Qualifier</b>	Enter 01 (NPI) (466-EZ)
<b>Prescription Origin Code</b>	Code indicating the origin of the prescription. (419-DJ)
<b>Prescription/Service Reference Number</b>	The Prescription Number assigned by the pharmacy. (402-D2)

FIELD	DESCRIPTION
<b>Prescription/Service Reference Number Qualifier</b>	Indicates the type of billing submitted. Valid Values are: <b>1 = Rx Billing for B1, B2, B3</b> <b>2 = Service Billing for S1, S2, S3</b>  (455-EM)
<b>Procedure Code Modifier</b>	The Procedure code modifier is reported in this field. Up to four occurrences are allowed.  (459-ER)
<b>Procedure Modifier Code Count</b>	Enter the number of Procedure Modifiers reported.  (458-SE)
<b>Product/Service ID Number</b>	The NDC Number or the HCPCS code being billed. For compounds, enter 0.  (407-D7)
<b>Product/Service ID Qualifier</b>	Enter the appropriate Product/Service ID Qualifier.  When billing for a compound, enter '00' <b>00 = Not Specified</b> <b>03 = NDC</b> <b>09 = HCPCS</b>  (436-E1)
<b>Provider ID (Pharmacy)</b>	Enter the NPI of the dispensing pharmacist. (444-E9)
<b>Provider ID Qualifier (Pharmacy)</b>	<b>Enter 05= National Provider Identifier (NPI).</b>  (465-EY)
<b>Reason for Service Code</b>	When a claim is denied due to one or more of the following DUR Conflict Codes, each must have an appropriate DUR reject <b>override</b> for the claim to pay. <b>TD = Therapeutic Duplication</b> <b>ER = Drug Overuse</b> <b>DD = Drug to Drug Interaction</b> <b>NP = New Patient Processing</b> <b>AD = Additional Drug Needed</b> <b>PN = Prescriber Consultation</b>  (439-E4)
<b>Result of Service Code</b>	The DUR Outcome Code is used to indicate the action taken by the pharmacist, and is required for a DUR <b>override</b> .  (441-E6)
<b>Route of Administration</b>	This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of

FIELD	DESCRIPTION
	<p>the complete compound mixture. Refer to the NCPDP D.0 External Code List for valid values.</p> <p>(995-E2)</p>
<p><b>Scheduled Prescription ID Number</b></p>	<p>NYSDOH requires the Prescription Pad Serial Number of the Official New York State Prescription blank / form in order to process a claim. Some valid Prescriptions can be dispensed when not written on Official Prescription Forms. For these specific situations, in lieu of the Prescription Serial Number, use the following values:</p> <ul style="list-style-type: none"> <li>• Prescriptions on Hospital and their affiliated Clinics Prescription Pads, use: HHHHHHHH</li> <li>• Prescriptions written by Out of State prescribers, use: ZZZZZZZZ</li> <li>• Prescriptions submitted via fax or electronically, use: EEEEEEEE</li> <li>• Oral Prescriptions, use: 99999999</li> <li>• Prescriptions for carve-out drugs for nursing home patients, use: NNNNNNNN</li> <li>• Prescriptions for Medical-Surgical supplies, use: SSSSSSSS</li> <li>• Prescription transfers, use: TTTTTTTT</li> </ul> <p>(454-EK)</p>



FIELD	DESCRIPTION
<p><b>Submission Clarification Code</b></p>	<p>The Submission Clarification Code is used for UT, specific DUR <b>overrides</b>, and for other clarifications.</p> <p><b>02</b> = Other Override – Required when:</p> <ul style="list-style-type: none"> <li>• a "Threshold Override Application (TOA)" form has been submitted by the physician or other qualified practitioner.</li> <li>• the Reason for Service <b>NP</b> (New Patient Processing) and the Result of Service Code to bypass early fills due to new admissions to nursing home / child (foster) care facilities.</li> </ul> <p><b>05</b> = Therapy Change – Required when: or</p> <p><b>06</b> = Starter Dose - Required When: or</p> <p><b>07</b> = Medically Necessary – Required When:</p> <ul style="list-style-type: none"> <li>• to override Polypharmacy Conflicts with prior service and Reason for Service <b>PN</b> (Prescriber Consultation) DUR Reject, following prescriber consultation; submit Reason for Service <b>PN</b> with Submission Clarification Code.</li> </ul>
<p><b>Submission Clarification Code (cont)</b></p>	<p><b>07</b> = Medically Necessary - use to indicate the service is provided as a result of Immediate Urgent Care or Emergency. Required when:</p> <ul style="list-style-type: none"> <li>• the Reason for Service <b>AD</b> (Medically Necessary) and the Result of Service Code to bypass early fill due to Brand medication needed in place of Generic (or vice versa).</li> </ul> <p><b>10</b> = Meets Plan Limitations – The pharmacy certifies that the transaction is in compliance with the program’s policies and rules that are specific to the particular product being billed. Required when:</p> <ul style="list-style-type: none"> <li>• instructed by the NYSDOH</li> </ul> <p><b>20</b> = (340B Drugs) – Indicates that the drug being billed has been purchased through the 340B program. Required when:</p> <ul style="list-style-type: none"> <li>• the Basis of Cost Determination <b>08</b> (340B) is being submitted on a claim for which a drug rebate has been received as a participant of a 340B drug purchasing program.</li> </ul> <p>The following codes are used by Long Term Care (LTC) pharmacies to indicate when a claim is being dispensed with a short days supply of medication – Required When:</p> <ul style="list-style-type: none"> <li>• 21 = 14 Days or Less</li> <li>• 22 = 7 Day Supply</li> <li>• 23 = 4 Day Supply</li> <li>• 24 = 3 Day Supply</li> <li>• 25 = 2 Day Supply</li> <li>• 26 = 1 Day Supply</li> <li>• 27 = 4 Then 3 Day Supply</li> <li>• 28 = 2 Then 2 Then 3 Day Supply</li> </ul>

FIELD	DESCRIPTION
	<ul style="list-style-type: none"> <li>• 29 = Daily and 3 Day Weekend</li> <li>• 30 = Per Shift Dispensing</li> <li>• 31 = Per Med Pass Dispensing</li> <li>• 32 = PRN On Demand</li> <li>• 33 = 7 Days or Less</li> <li>• 34 = 14 Day Dispensing</li> <li>• 35 = 8 – 14 Days Dispensing</li> <li>• 36 = Outside Short Cycle</li> </ul> <p>(420-DK)</p>
<b>Submission Clarification Code Count</b>	<p>This field is used for reporting the Number of occurrences (up to 3) of the Submission Clarification Code field (420-DK).</p> <p>(354-NX)</p>
<b>Quantity Dispensed</b>	<p>The Quantity Dispensed is the total number of Metric Units dispensed for the prescription.</p> <p>(442-E7)</p>
<b>Usual and Customary Charge</b>	<p>The Usual and Customary Charge is used to enter the amount charged for the prescription.</p> <p>(426-DQ)</p>

## 6.0 PRO-DUR/ECCA RESPONSE MESSAGES (Rev. 09/18)

The information that is received from the NYS DOH 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
<b>Header Response Status</b>	<p>An <b>A</b> (Accepted) will be returned if the information in the transmission is valid. An <b>R</b> (Rejected) will be returned if the information in the transmission is invalid. Further clarification of the reject will be indicated by NCPDP Reject codes and in the Message Area.</p> <p><b>Note:</b> When an R is returned in the Header Response Status, all of the claims submitted on this request transaction will be rejected.</p> <p>(501-F1)</p>

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

**Note:** The following field descriptions are in alphabetical order and not necessarily the order in which they appear in the response.

FIELD	DESCRIPTION
<b>Additional Message Info</b>	<p>The Additional message area, in the NCPDP format, is used to return additional MEVS information about your request transaction.</p> <p>The following information is returned for accepted or pended transactions:</p> <ul style="list-style-type: none"> <li>• <b>MEVS Response Code (See <a href="#">Table 1</a>)</b></li> <li>• <b>Utilization Threshold Code (See <a href="#">Table 8</a>)</b></li> <li>• <b>Maximum Per Unit Price</b></li> <li>• <b>Co-Payment Code (See <a href="#">Table 6</a>)</b></li> <li>• <b>Co-Payment Met Date</b></li> <li>• <b>DVS Reason Code (See <a href="#">Table 9</a>)</b></li> <li>• <b>Medicare Coverage Code</b></li> <li>• <b>Medicare Identifier</b></li> <li>• <b>First Insurance Carrier Code</b></li> <li>• <b>First Insurance Coverage Codes (See <a href="#">Table 11</a>)</b></li> <li>• <b>Second Insurance Carrier Code</b></li> <li>• <b>Second Insurance Coverage Codes (See <a href="#">Table 11</a>)</b></li> <li>• <b>Indication of Additional Coverage</b></li> <li>• <b>Exception Codes (See <a href="#">Table 12</a>)</b></li> <li>• <b>DVS Number</b> (526-FQ)</li> </ul> <p>Please refer to <a href="#">Chart B</a> for an example of the Additional Message.</p> <p>The following information is returned for rejected claims:</p> <ul style="list-style-type: none"> <li>• <b>MEVS Response Code (See <a href="#">Table 2</a>)</b></li> <li>• <b>Rx Denial Code (See <a href="#">Table 7</a>)</b></li> <li>• <b>Utilization Threshold Code (See <a href="#">Table 8</a>)</b></li> <li>• <b>DVS Reason Code (See <a href="#">Table 9</a>)</b></li> </ul> <p>Please refer to <a href="#">Chart C</a> for an example of the Message. (526-FQ)</p>
<b>Amount of Copay</b>	<p>The amount of co-pay due for the entered NDC or HCPCS (NY Product Supply Code) will be returned if the member has not met their co-pay and is not exempt. (518-FI)</p>
<b>Anniversary Month</b>	<p>The Anniversary Month found in the <b>Message Field (504-F4)</b> is the beginning month of the benefit year under the Utilization Threshold program.</p>
<b>Authorization Number</b>	<p>If ECCA was requested and all edits were passed, spaces will be returned in the Authorization Number field. Please Note: NO CLAIM TO FA will be returned if the claim is captured but cannot be processed for adjudication.</p> <p>If a claim is captured but cannot be processed for adjudication, it must be billed via paper. (503-F3)</p>

FIELD	DESCRIPTION
<b>Category of Assistance</b>	Category of Assistance Code returned within the <b>Message Field</b> (504-F4): S = SSI * = No valid category of assistance is available
<b>Clinical Significance</b>	Clinical Significance returned within the <b>DUR Response</b> area indicates how critical the conflict is. This value reflects the severity level assigned to a contraindication. Refer to <b>DUR Processing</b> Section for a list of clinical significance codes and their meanings. (528-FS)
<b>Co-Payment Code</b>	The Co-Payment Code returned within the <b>Additional Message Info</b> (526-FQ) provides the status of co-payment for this claim.
<b>Co-Payment Met Date</b>	The Co-Payment Met Date returned within the <b>Additional Message Info</b> (526-FQ) identifies the date the member has met this year's co-payment requirement.
<b>County Code</b>	The two-digit code for the county of fiscal responsibility for the member is provided within the <b>Message Field</b> (504-F4). (See <a href="#">Table 13</a> )
<b>Database Indicator</b>	The Database Indicator returned within the <b>DUR Response</b> area is always 1 to indicate that First DataBank is the source of the DUR database. (532-FW)
<b>Dispensing Fee Paid</b>	The Dispensing Fee paid will be returned on the Response. (507-F7)
<b>Dispensing Validation System Number</b>	The eleven digit DVS Number (prior approval) will be returned in the <b>Additional Message Info</b> (526-FQ) if the DVS transaction is accepted. If you did not submit the claim for ECCA and are billing manually, this number must be put on your claim form.
<b>Dispensing Validation System Reason Code</b>	The three-digit code indicating either the accepted or rejected status of the DVS request is returned within the <b>Additional Message Info</b> (526-FQ).
<b>Exception Codes</b>	Up to four Exception Codes may be returned within the <b>Additional Message Info</b> (526-FQ). (See <a href="#">Table 12</a> )
<b>Free Text</b>	The Free Text returned within the <b>DUR Response</b> area contains information to assist the pharmacist in further identifying the DUR conflict. Please refer to the <b>DUR Processing</b> section. (544-FY)
<b>Medicare Identifier</b>	The Medicare Identifier will be returned within the <b>Additional Message Info</b> (526- FQ).
<b>Indication of Additional Coverage</b>	A ZZ returned within <b>Additional Message Info</b> (526-FQ) indicates that the member has more than two insurance carriers. Call 1-800-343-9000 to obtain complete information.

FIELD	DESCRIPTION
<b>First Insurance Carrier Codes</b>	The First Insurance Carrier Code is the first code found in the Medicaid files and should not be interpreted as primary. This is returned within the <b>Additional Message Info</b> (526-FQ).
<b>First Insurance Coverage Codes</b>	The First Insurance Coverage Codes are returned within the <b>Additional Message Info</b> (526-FQ). These indicate the scope of benefits. (See <a href="#">Table 11</a> )
<b>Second Insurance Carrier Codes</b>	The Second Insurance Carrier Code is the second code found in the Medicaid files and should not be interpreted as secondary. This is returned within the <b>Additional Message Info</b> (526-FQ).
<b>Second Insurance Coverage Codes</b>	The Second Insurance Coverage Codes are returned within the <b>Additional Message Info</b> (526-FQ). These indicate the scope of benefits. (See <a href="#">Table 11</a> )
<b>Maximum Per Unit Price</b>	The Maximum Per Unit Price returned within the <b>Additional Message Info</b> (526-FQ) is the per unit amount on the Drug File. The price is the maximum reimbursable unit price. The dollar amount returned to you in your response does not indicate the amount of payment you will receive.
<b>Medicaid Number</b>	The Member's Identification Number is provided within the <b>Message Field</b> (504-F4).
<b>Medicare Coverage</b>	<p>The Medicare Coverage code is returned within the <b>Additional Message Info</b> (526-FQ) and indicates the type of Medicare coverage.</p> <p><b>A</b> = Member has only Part A Medicare coverage.</p> <p><b>B</b> = Member has only Part B Medicare coverage.</p> <p><b>C</b> = Member has both Part A and Part B Medicare coverage.</p> <p><b>Q</b> = Member has Part A and Part B Medicare coverage and is a Qualified Medicare Beneficiary (QMB).</p> <p><b>T</b> = Member is a QMB only.</p> <p><b>D</b> = Member has only Part D Medicare coverage.</p> <p><b>E</b> = Member has both Part A and Part D Medicare coverage.</p>
<b>Medicare Coverage (cont)</b>	<p><b>F</b> = Member has both Part B and Part D Medicare coverage.</p> <p><b>G</b> = Member has Part A and Part B and Part D Medicare coverage.</p> <p><b>H</b> = Member has Part A and Part B and Part D Medicare coverage and is a QMB.</p>

FIELD	DESCRIPTION
<b>Message field</b>	<p>A Message field is used to provide eligibility information. The following information is returned for accepted claims (when <b>Claim Response = C</b>):</p> <ul style="list-style-type: none"> <li>• <b>Medicaid Number</b></li> <li>• <b>County Code (See <a href="#">Table 13</a>)</b></li> <li>• <b>Anniversary Month</b></li> <li>• <b>Patient Gender Code</b></li> <li>• <b>Year of Birth</b></li> <li>• <b>Category of Assistance</b></li> <li>• <b>Re-certification Month</b></li> <li>• <b>Office Number (See <a href="#">Table 14</a>)</b></li> <li>• <b>Service Date</b></li> </ul> <p>Please refer to <a href="#">Chart A</a> for an example of the Message. (504-F4)</p>
<b>MEVS Response Code</b>	<p>The MEVS Code for a member eligible transaction is returned within the <b>Additional Message Info</b> (526-FQ). Refer to <a href="#">Table 1</a> for a list of values and meanings.</p>
<b>MEVS Denial Code</b>	<p>The MEVS Denial Code for a member ineligible transaction is returned within the <b>Additional Message Info</b> (526-FQ) and indicates the MEVS error for rejected transactions. Refer to <a href="#">Table 2</a> for a list of values and meanings.</p>
<b>Office Number</b>	<p>The Office Number returned within the <b>Message field</b> (504-F4) represents the New York City office code. <a href="#">Table 14</a></p> <p>The Office Code 'H78' is returned for members who have coverage through the NY Health Benefit Exchange. The phone number for inquiries pertaining to eligibility issues for members enrolled through the NY Health Benefit Exchange is 855-355-5777.</p>
<b>Other Pharmacy Indicator</b>	<p>The Other Pharmacy Indicator returned within the <b>DUR Response</b> area indicates the source of the previous prescription that forms the basis for the conflict with the present prescription. The following values may be returned.</p> <ul style="list-style-type: none"> <li><b>0</b> = Not Specified</li> <li><b>1</b> = Your Pharmacy</li> <li><b>3</b> = Other Pharmacy</li> </ul> <p>(529-FT)</p>
<b>Other Prescriber Indicator</b>	<p>The Other Prescriber Indicator returned within the <b>DUR Response</b> area compares the Prescriber of the current prescription to the Prescriber of the previously filled conflicting prescription. The following values may be returned:</p> <ul style="list-style-type: none"> <li><b>0</b> = Not Specified</li> <li><b>1</b> = Same Prescriber</li> <li><b>2</b> = Other Prescriber</li> </ul> <p>(533-FX)</p>

FIELD	DESCRIPTION
<b>Patient Gender Code</b>	Valid patient gender Codes returned within the <b>Message Field</b> (504-F4) are: <b>F</b> = Female <b>M</b> = Male <b>U</b> = Unborn
<b>Pend Reason Code</b>	The Pend Reason Code returned within the <b>Additional Message Info</b> (526-FQ) indicates that the claim has passed all other online adjudication edits but has been pended for one of the reasons listed in <a href="#">Table 10</a> .
<b>Previous Date of Fill</b>	The Previous Date of Fill returned within the <b>DUR Response</b> . (530-FU)
<b>Quantity of Previous Fill</b>	The Quantity of Previous Fill is returned within the <b>DUR Response</b> area. (531-FV)
<b>Reason for Service Code</b>	The Reason for Service Code returned within the <b>DUR Response</b> area will be generated and sent back to the pharmacy when a DUR conflict is detected. Refer to <b>DUR Processing</b> section for further clarification. The following values may be returned. <b>TD</b> = Therapeutic Duplication <b>ER</b> = Drug Overuse <b>DD</b> = Drug-Drug Interactions <b>DC</b> = Inferred Drug Disease Precaution <b>PG</b> = Drug Pregnancy Alert <b>PA</b> = Drug Age Precaution <b>LD</b> = Low Dose Alert <b>HD</b> = High Dose Alert <b>NP</b> = New Patient Processing <b>PN</b> = Prescriber Consultation  (439-E4)
<b>Recertification Month</b>	The Recertification Month returned within the <b>Message Field</b> (504-F4) is the month the member is due for recertification.
<b>Reject Codes</b>	A maximum of 5 Reject Codes could be returned if the Claim Response Status is "R" (Reject). Refer to <a href="#">NCPDP Reject Code</a> list for values. (511-FB)
<b>Rx Denial Code</b>	The Rx Denial Code returned within the <b>Additional Message Info</b> (526-FQ) provides prescription related reject reasons. Refer to <a href="#">Table 7</a> .
<b>Service Date</b>	The Service Date returned within the <b>Message Field</b> (504-F4) is the same as the Date Filled (or dispensed), entered on your transaction.
<b>Total Amount Paid</b>	The Total Amount paid for the claim will be returned on the Response. (509-F9)



FIELD	DESCRIPTION
<b>Transaction Response Status</b>	<p>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). If a "C" is returned, the <b>Authorization Number</b> field must be checked to determine if the claim has been electronically captured for adjudication.</p> <p>The MEVS Pend Response Code Table should also be checked to see if the claim is pending. Refer to <a href="#">Table 10</a>. (112-AN)</p>
<b>Utilization Threshold Code</b>	<p>The Utilization Threshold codes indicate whether the member's UT availability is sufficient.</p> <p>Refer to <a href="#">Table 8</a>. (526-FQ)</p>
<b>Year of Birth</b>	<p>The Year of Birth returned within the <b>Message Field</b> is a 3 digit field formatted as follows:</p> <p>1980 will appear as 980. (504-F4)</p>

## 7.0 PRO-DUR/ECCA REVERSAL/CANCEL TRANSACTIONS (Rev. 05/11)

This section describes the use of reversal transactions in the 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. 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.

When a reversal transaction is performed on an ECCA transaction that generated a DVS authorization, the DVS authorization is cancelled as well.

The primary matching values used to determine which claim is being canceled are the **Service Provider ID** (201-B1), **Prescription/Service Reference #** (402-D2), and **Date of Service** (401-D1), 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** (B2)  
**Service Provider ID**  
**Service Provider ID Qualifier**  
**Date of Service**  
**Prescription/Service Reference #**  
**Prescription/Service Reference # Qualifier**  
**Processor Control Number** (if a paid claim is being reversed)

The following information is returned if the cancel is accepted.

**Transaction Response Status** (A)  
**MEVS Response Code** (021)

The following information is returned if the cancel was denied.

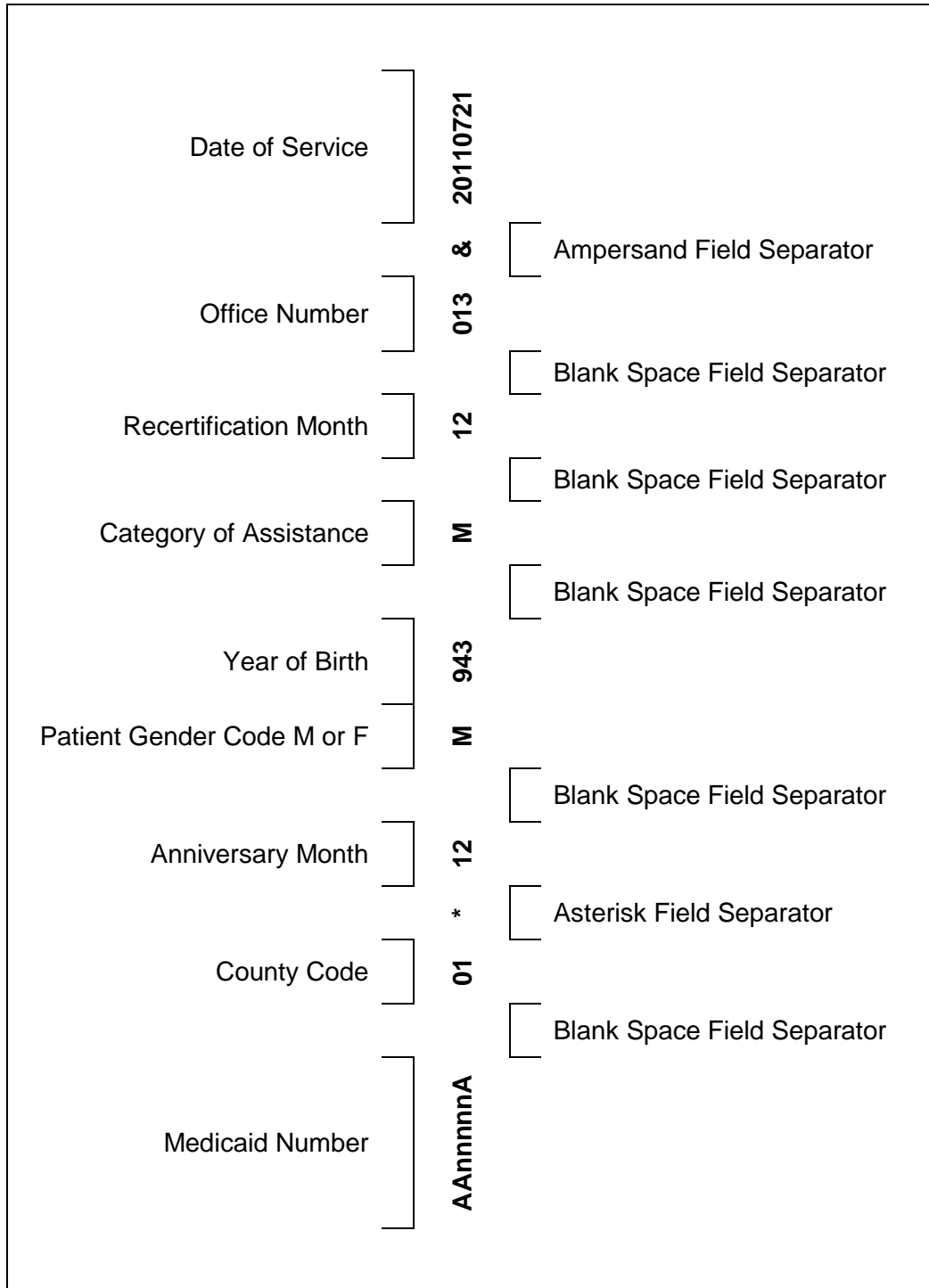
**MEVS Denial Code** (R)  
**Rx Denial Code**  
**Reject Codes** (up to 5)

If you need to reverse a previously paid ECCA, paper or electronic batch claim online, you must complete the processor control number field on the reversal transaction. If not completed, the reversal will be rejected with response code 323 (refer to [Table 2](#) codes on page 10.0.1). 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. 09/18)

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



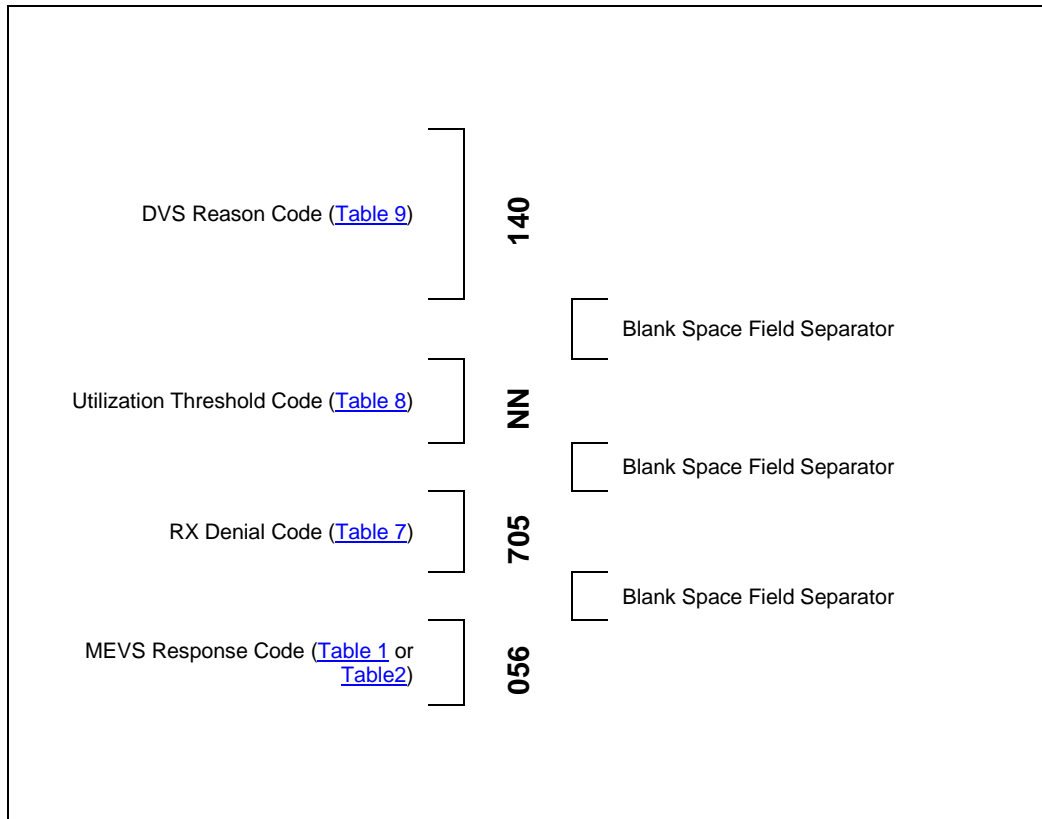
Response Message Segment – Chart A

**Additional Message – Chart B**

DVS Number	87654321012	
Restriction Information - Exception Codes	} 38 51 35 ZZ	<input type="checkbox"/> Right Bracket Field Separator
Indicator of additional coverage	* ZZ	<input type="checkbox"/> Asterisk Field Separator
2nd Insurance Coverage Code	+ CKP	<input type="checkbox"/> Plus Sign Field Separator
2nd Insurance Carrier Code	/ CD	<input type="checkbox"/> Slash Sign Field Separator
1st Insurance Coverage Code	@ ADEH	<input type="checkbox"/> At Sign Field Separator
1st Insurance Carrier Code	/ BC	<input type="checkbox"/> Slash Sign Field Separator
Medicare Identifier	# XXXXXXXXXXXXX	<input type="checkbox"/> Pound Sign Field Separator
Medicare Coverage Code	= AB	<input type="checkbox"/> Blank Space Field Separator
DVS Reason Code ( <a href="#">Table 9</a> )	131	<input type="checkbox"/> Equal Sign Field Separator
Co-Payment Met Date	20110430	
Co-Payment Code ( <a href="#">Table 6</a> )	127	<input type="checkbox"/> Blank Space Field Separator
Maximum Per Unit Price	% 001.50000	<input type="checkbox"/> Percent Sign Field Separator
Utilization Threshold Code ( <a href="#">Table 8</a> )	\$ AN	<input type="checkbox"/> Dollar Sign Field Separator
MEVS Response Code ( <a href="#">Table 1</a> ) Or Pend Reason Code ( <a href="#">Table 10</a> )	002	<input type="checkbox"/> Blank Space Field Separator

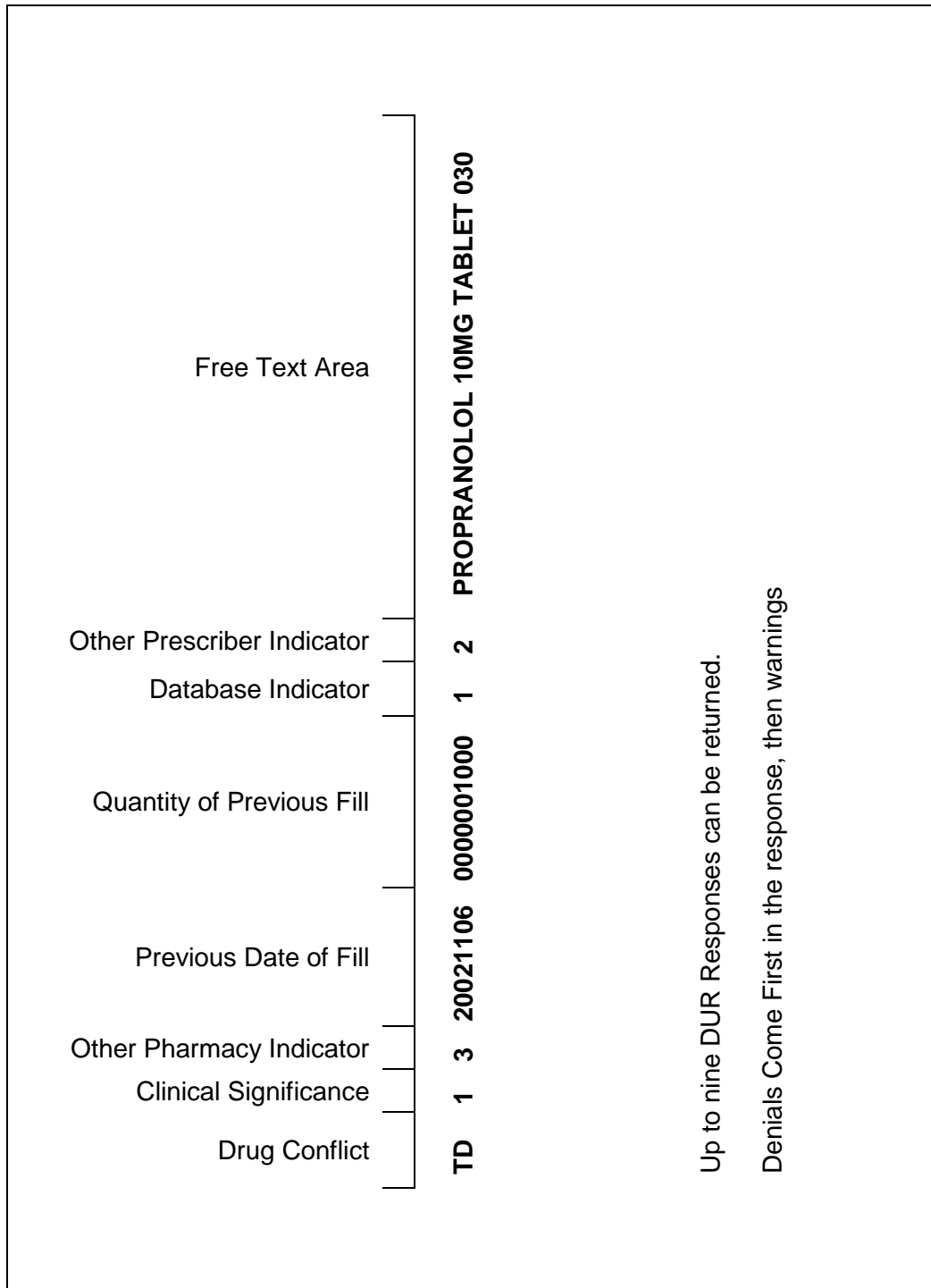
Additional Message Segment – Chart B

Rejected Claim Message – Chart C



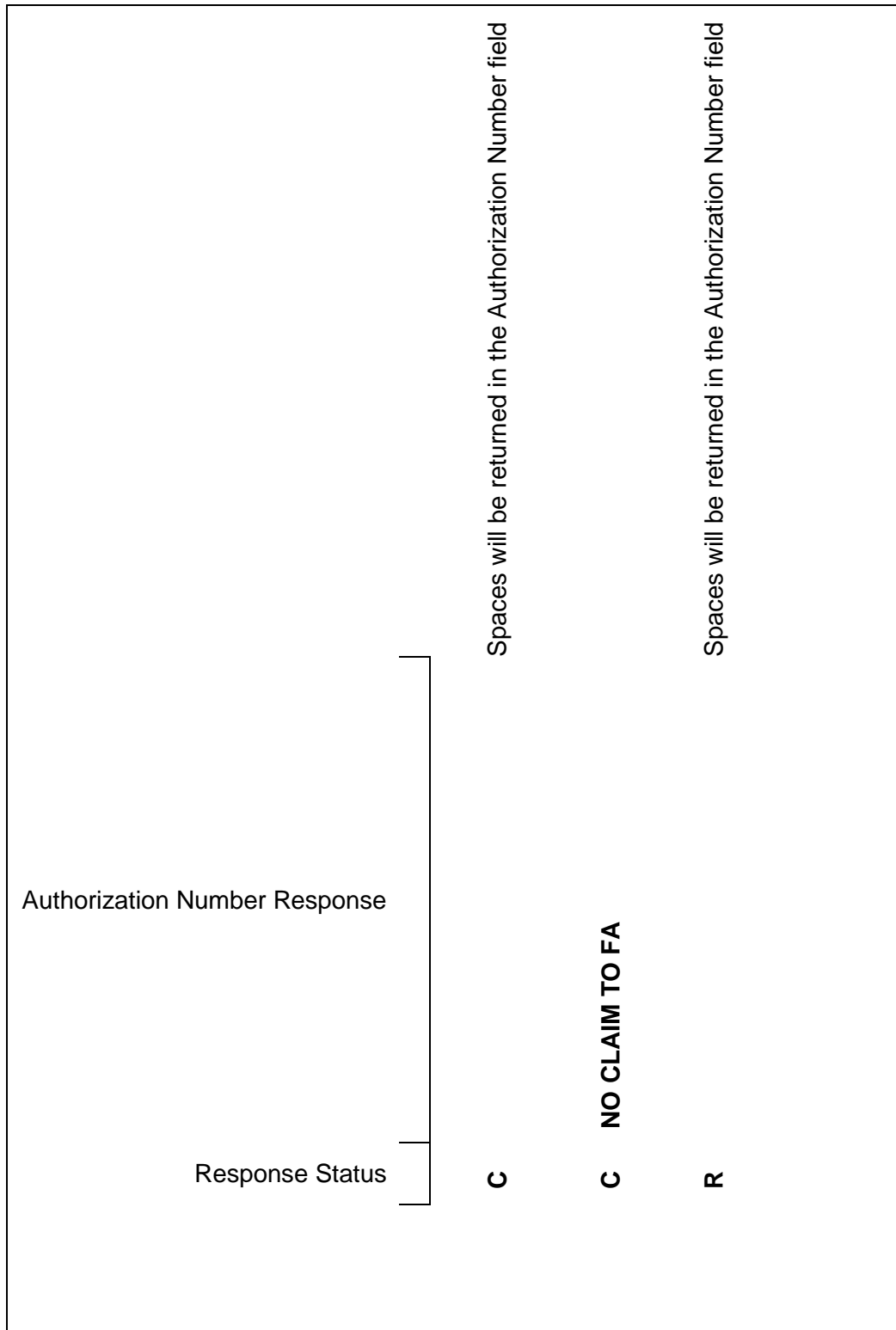
Rejected Claim Message Segment – Chart C

DUR Response – Chart D



DUR Response Segment – Chart D

Claim Response Message – Chart E





## 9.0 MEVS ACCEPTED CODES - TABLE 1 (Rev. 05/16)

All of the Table 1 codes (except 021) indicate the type of Medicaid eligibility for the member. If the member 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](#) on page 10.1) and is not processed through the eligibility modules or an invalid Medicaid ID 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 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
006	Eligible PCP
007	Emergency Services Only
008	Presumptive Eligible Long-Term/Hospice
009	Medicare Coinsurance Deductible Only
010	Eligible Except Nursing Facility Services
013	Presumptive Eligibility Prenatal A
014	Presumptive Eligibility Prenatal B
015	Perinatal Family
016	MA Eligible-HR-Utilization Threshold
018	Family Planning Services Only
019	Family Planning Benefit and Medicare Coinsurance and Deductible Only
021	Record Canceled – Cancels a Previously Accepted Claim
034	Community Coverage with Community Based Long Term Care
035	Community Coverage without Long Term Care
221	Eligible PCP with Pharmacy Carve-out
222	Eligible PCP with Mental Health Carve-out
223	Eligible PCP with Mental Health and Pharmacy Carve-out
225	Eligible Family Planning Services No Transportation
231	Eligible Only Outpatient Care
232	Outpatient Coverage with Community Based Long Term Care
233	Outpatient Coverage without Long Term Care
234	Outpatient Coverage with No Nursing Facility Services

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235	Eligible PCP with Family Planning Carve Out (Only)
236	Eligible PCP with Mental Health and Family Planning Carve Out
237	Eligible PCP with Mental Health, Family Planning and Pharmacy Carve Out
238	Eligible PCP with Family Planning and Pharmacy Carve-Out
245	EP – Family Planning and Non- Emergency Transportation Only

**10.0 MEVS DENIAL CODES - TABLE 2 (Rev. 05/16)**

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.

<b>MEVS CODE (526-FQ)</b>	<b>DESCRIPTION</b>	<b>NCPDP CODE (511 – FB)</b>	<b>DESCRIPTION</b>
001	Not MA Eligible	65	Patient is Not Covered
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 Prescriber Provider Number	25	M/I Prescriber ID
062 *	Invalid Medicaid Number	07	M/I Cardholder ID Number
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 of Service
100 *	Invalid Referring Provider Number	35	M/I Primary Care Provider ID
101	Restricted Recipient – No Auth	35	M/I Primary Care Provider ID
104	No Coverage: Excess Income	65	Patient Not Covered

<b>MEVS CODE (526-FQ)</b>	<b>DESCRIPTION</b>	<b>NCPDP CODE (511 – FB)</b>	<b>DESCRIPTION</b>
105	QMB Requires Medicare Approval	65	Patient Not Covered
118	MCCP Recipient – No Auth	35	M/I Primary Care Provider ID
	Other Payer- Patient Responsibility Value Not Supported	536	Other Payer - Patient Responsibility Amount Qualifier Value Not Supported
	Missing / Invalid Other Payer Reject Code	6E	M/I Other Payer Reject Code
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	EV	M/I Prior Authorization Number Submitted
304	Recipient ID Unequal to Prior Approval File	EV	M/I Prior Authorization Number Submitted
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	**	
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	**	
321	Pharmacy Service Included In Out-of-State Facility Rate	**	
322	Online Adjustments/Rebills Not Allowed For DVS Items/Drugs	**	
323	Processor Control Number Needed for Rebill/Reversal of Paid Claim	**	

MEVS CODE (526-FQ)	DESCRIPTION	NCPDP CODE (511 – FB)	DESCRIPTION
324	The system or file necessary to process the transaction is currently unavailable.	92	System Unavailable
325	Pharmacy Service included in – In-State Facility Rate	**	
326	Pend For State Review – OHIP/OIMG	**	
700 *	Year of Birth Not Equal to File	09	M/I Birthdate
701	Sex Not Equal to File	10	M/I Patient Gender 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 ETIN	04	M/I Processor Control Number
729	Denied for Polypharmacy Conflicts	88	DUR Reject Error
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.

**10.1 TABLE 2 ERROR CHART (Rev. 05/11)**

The following chart identifies the most common edit failures from the chart above. To assist in troubleshooting, possible reasons are provided for each of these common failures.

MEVS CODE	NCPDP CODE	EXAMPLES OF CORRECT ENTRY	COMMON ERRORS BEING MADE / COMMENTS
053 SSN Access Not Allowed	None	None – 9 digit entry not allowed	The provider does not have rights to perform transactions using the social security number as an identifier.
056 Reenter Ordering Provider Number	25 M/I Prescriber ID		1. The NPI is the only identifier accepted. Do not enter an MMIS ID or License/Profession Code.
062 Invalid Medicaid Number.	07 M/I Cardholder ID Number		<ol style="list-style-type: none"> <li>1. The entry in the Cardholder ID field must contain the member's 8 character alpha numeric Member ID.</li> <li>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 Member ID are not being converted to numeric values.</li> <li>3. Rejections also occur when the ID is not left justified.</li> <li>4. Code 062 is returned when the number entered cannot be found on the file.</li> </ol>
100 Invalid Referring Provider Number	35 M/I Primary Care Provider ID	1234567890 (10 digit National Provider Identification number of the provider to which a member is restricted)	The <u>Primary Care Provider</u> field must contain the 10 digit NPI number that the member is restricted to. This field is <u>in addition</u> to an entry in the <u>Prescriber ID</u> field. The entry must be left justified. The Primary Care Provider ID Qualifier must have a value of 01 when this field is entered.

MEVS CODE	NCPDP CODE	EXAMPLES OF CORRECT ENTRY	COMMON ERRORS BEING MADE / COMMENTS
<p>703 Invalid PIN 704 Invalid ETIN</p>	<p>04 M/I Processor Control Number</p>	<p>YTG1234QBK (Certification, Initials, PIN, ETIN)</p>	<ol style="list-style-type: none"> <li>1. The reject denial code 703 will be returned if:               <ol style="list-style-type: none"> <li>A.) You have not submitted the PIN selection form to the Department of Health.</li> <li>B.) The PIN number has not been added to your provider file record at the eMedNY contractor.</li> <li>C.) The PIN number transmitted does not match the number selected, which was added to your provider file record.</li> </ol> </li> <li>2. The reject denial code 704 will be returned if:               <ol style="list-style-type: none"> <li>A.) You have not applied for and/or submitted your ETIN number on a notarized certification statement to the eMedNY contractor.</li> <li>B.) The ETIN transmitted does not match the ETIN submitted on the certification statement, which was added to the ETIN file.</li> </ol> </li> <li>3. Some software has hard coded the ETIN of the billing service into this field. If that ETIN was not on the certification statement, the transaction will reject.</li> </ol>
<p>712 Override Denied UT Not at Limit</p>	<p>34 M/I Prescription Denial Override</p>	<p>01 (No Override) 02 (Other Override) 07 (Medically Necessary)</p>	<ol style="list-style-type: none"> <li>1. An entry must be placed in the Submission Clarification Code field.</li> <li>2. If the member is not at their UT limit, 01 should be entered.</li> <li>3. If the member is at their limit, value 02 or 07 should be entered to override the limit.</li> <li>4. Code 712 is returned if a value of 02 or 07 is entered and the member has not reached their limit.</li> </ol>
<p>999 Header Field Error</p>	<p>None</p>	<p>None – Please resubmit using NCPDP Version D.0</p>	<p>Used for various Header errors, also used to indicate non-HIPAA compliance.</p>

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**11.0 CO-PAYMENT CODES - TABLE 6 (Rev. 05/11)**

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. 12/17)**

All of the Table 7 codes are denial codes. Their presence in your response means that the claim has been denied and will appear on a subsequent remittance advice. If none of the Table 7 codes apply to your claim, you will see 000 in your response instead.

<b>MEVS CODE</b>	<b>DESCRIPTION</b>	<b>NCPDP CODE</b>	<b>DESCRIPTION</b>
142	Missing / Invalid category of service	05	M/I Pharmacy Number
421	Dispense Brand Drug Instead of Generic Equivalent	78	Cost Exceeds Maximum
709	Maximum Day's Supply Exceeded	19	M/I Days Supply
712	Override Denied - UT not at limit	34	M/I Submission Clarification Code
718	HR Recipient - No Rebate Agreement	77	Discontinued Product/Service ID Number
719	MA Only Covers Family Planning	65	Patient is Not Covered
728	UR Deny – Conflict With Previous Service	76	Plan Limitations Exceeded
729	Denied for Polypharmacy Conflicts	88	DUR Reject Error
731	UR Deny – Supporting Prior Service Not Found For Claim	85	Claim Not Processed
733	Controlled Substance Oral Prescription Exceeds the Emergency 5 Day Supply Limit	7X	Days Supply Exceeds Plan Limitation
734	Invalid Combination of Values for 340B Drug	85	Claim Not Processed

### 13.0 PHARMACY UT CODES - TABLE 8 (Rev. 05/11)

The following table defines the UT Code values provided in the Additional Message Info segment (526-FQ).

CODE	DESCRIPTION	APPROVAL OR DENIAL	PROCESSING RESULTS DESCRIPTION
AN	UT Approved	A	UT Counted
DN	UT At Service Limits	D	UT Not Counted
LN	UT Approved Near Limits	A	UT Counted
NN	UT Not Invoked	A	UT Exempt
PN	UT Override Denied	D	UT Not Counted
XX	DUR Denial	D	UT Not Counted

Table 8 codes were formulated to return a code relevant to the Utilization Threshold (UT) program. A code value with a processing result of UT Counted or UT Exempt indicates there are sufficient UT units available for the transaction submitted.

**Note:** 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 the UT program.

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

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**14.0 DISPENSING VALIDATION SYSTEM REASON CODES - TABLE 9 (Rev. 05/11)**

CODE	DESCRIPTION
129	Duplicate/Redundant DVS request
130	DVS process was not invoked
131	Item approved / DVS number issued
139	DVS requires current date entry
723	Client Medicare Part D Denial

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

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). Or the Medicare Paid Amount reported is less than reasonable.
310	Pharmacy Service Included in In-state Facility Rate
311	PCP Plan Code Not on Contract File. (Member 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. (Member 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 PA file).
321	Pharmacy Service Included in Out-of State Facility Rate
326	Pend For State Review – OHIP/OMIG
420	UR Pend – Conflict With Previous Service
422	Pended for Polypharmacy Conflicts
732	UR Pend – Supporting Prior Service Not Found For Claim

**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. 11/18)

CODE (511-FB)	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, 142
07	M/I Cardholder ID Number	030, 031, 033, 062
08	M/I Person Code	063
09	M/I Birthdate	300, 700
10	M/I Patient Gender Code	701
13	M/I Other Coverage Code	
14	M/I Eligibility Clarification Code	
15	M/I Date of Service	071
16	M/I Prescription/Service Reference Number	
17	M/I Fill Number Code	707
18	M/I Metric Quantity	
19	M/I Days Supply	
20	M/I Compound Code	
21	M/I Product/Service ID	
22	M/I Dispense as Written Code (DAW) Product Selection Code	
23	M/I Ingredient Cost Submitted (409-D9)	
25	M/I Prescriber ID	059, 066, 067
28	M/I Date Prescription Written	
29	M/I Number Refills Authorized	
33	M/I Prescription Origin Code	
34	M/I Submission Clarification Code	712
35	M/I Primary Care Provider ID	100
39	M/I Diagnosis Code	
41	Submit Bill To Other Processor Or Primary Payer	723
50	Non-Matched Pharmacy Number	052
52	Non-Matched Cardholder ID	065
53	Non-Matched Person Code	
56	Non-Matched Prescriber ID	
58	Non-Matched Primary Prescriber	
60	Product/Service Not Covered for Patient Age	
61	Product/Service Not Covered For Patient Gender	
64	Claim Submitted Does Not Match Prior Authorization	
65	Patient is Not Covered	722
66	Patient Age Exceeds Maximum Age	
70	Product/Service Not Covered	
75	Prior Authorization Required	
76	Plan Limitations Exceeded	
77	Discontinued Product/Service ID Number	718
78	Cost Exceeds Maximum	421

<b>CODE (511-FB)</b>	<b>DESCRIPTION (M/I = Missing/Invalid)</b>	<b>MEVS CODE</b>
79	Refill Too Soon	
80	Drug Diagnosis Code Mismatch	
81	Claim Too Old	
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
AA	Patient Spenddown Not Met	
AF	Patient Enrolled Under Managed Care	
A5	Not Covered Under Part D Law	
DN	M/I Basis of Cost Determination	
DQ	M/I Usual and Customary	
DV	M/I Other Payer Amount Paid	
DX	M/I Patient Paid Amount Submitted	
EK	M/I Scheduled Prescription ID Number	
EV	M/I Prior Authorization Number Submitted	303, 304, 319
E1	M/I Product/Service ID Qualifier	
E2	M/I Route of Administration	
E4	M/I Reason for Service Code	
E6	M/I Result for Service Code	
E7	M/I Quantity Dispensed	
H3	M/I Measurement Unit	
MZ	Error Overflow	
NQ	M/I Other Payer Patient Responsibility Amount	
NV	M/I Delay Reason Code	
PE	M/I COB/Other Payments Segment	
P6	Date of Service Prior to Date of Birth	
TO	Dosage Exceeds Product Labeling Limit	
4W	Must Fill Through Specialty Pharmacy	
6E	M/I Other Payer Reject Code	
6Z	Provider Not Eligible to Perform Service/ Dispense Product	
7C	M/I Other Payer ID	
7X	Days Supply Exceeds Plan Limitation	733
9M	Minimum of Two Ingredients Required	

Up to twenty (5 per line) 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.

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**17.0 INSURANCE COVERAGE CODES – TABLE 11 (Rev. 5/11)**

The message will only return coverage codes for Medicaid Managed Care Plans. These codes identify which services are covered by the member's managed care plan.

<u>COVERAGE CODES</u>	<u>DESCRIPTION</u>	<u>EXPLANATION</u>
A	Inpatient Hospital	All inpatient services are covered except psychiatric care.
B	Physician In-Office	Services provided in the physician's office are generally covered.
C	Emergency Room	Self-Explanatory.
D	Clinic	Both hospital based and freestanding clinic services are covered.
E	Psychiatric Inpatient	Self-Explanatory.
F	Psychiatric Outpatient	Self-Explanatory.
G	Physician In-Hospital	Physician services provided in a hospital or nursing home are covered.
H	Drugs No Card	Drug coverage is available but a drug card is not needed.
I	Lab/X-Ray	Laboratory and x-ray services are covered.
J	Dental	Self Explanatory.  Note: Orthodontia is a carved out service, so all <b>COVERED</b> orthodontic care is paid on a fee-for-service basis, even for members enrolled in a plan that otherwise covers dental services.
L	Nursing Home	Some nursing home coverage is available. You must bill until benefits are exhausted.
M	Drugs Major Medical	Drug coverage is provided as part of a major medical policy.
N	All Physician Services	Physician services, without regard to where they were provided, are covered.

<b><u>COVERAGE CODES</u></b>	<b><u>DESCRIPTION</u></b>	<b><u>EXPLANATION</u></b>
O	Drugs	Self-Explanatory.
P	Home Health	Some home health benefits are provided. Continue to bill until benefits are exhausted.
Q	Psychiatric Services	All psychiatric services, inpatient and outpatient, are covered.
R	ER and Clinic	Self-Explanatory.
S	Major Medical	The following services are covered: physician, clinic, emergency room, inpatient, laboratory, referred ambulatory, transportation and durable medical equipment.
T	Transportation	Medically necessary transportation is covered.
U	Coverage to Complement Medicare	All services paid by Medicare which require a coinsurance or deductible payment should be billed to the insurance carrier prior to billing Medicaid.
V	Substance Abuse Svcs.	All substance abuse services, regardless of where they are provided are covered.
W	Substance Abuse Outpatient	Self-Explanatory.
X	Substance Abuse Inpatient	Self-Explanatory.
Y	Durable Medical Equipment	Self-Explanatory.
Z	Optical	Self-Explanatory.
All	All of the above	All services listed in coverage codes A-Z are covered by the member's insurance carrier.



**18.0 EXCEPTION CODES – TABLE 12 (Rev. 08/18)**

Exception Codes are two-digit codes that identify a member's program exceptions or restrictions.

Code 23	<p>This code identifies a member who is enrolled in the OMH Home and Community Based Services (HCBS) Waiver for Seriously Emotionally Disturbed (SED) children.</p> <p>This member is exempt from Utilization Threshold and Co-pay requirements.</p> <p><i>This code will be inactivated to prevent use after January 1, 2019.</i></p>
Code 24	<p>This code identifies a member who is enrolled in a Chronic Illness Demonstration Project (CIDP) program. The member's participation in a CIDP does not affect eligibility for other Medicaid services.</p> <p>This member is not exempt from Utilization Threshold and co-payment requirements.</p>
Code 30	<p>This code identifies a Medicaid member who is enrolled in the Long Term Home Health Care Program Waiver also known as the Lombardi Program/nursing home without walls. The member is authorized to receive LTHHCP services from an enrolled LTHHCP provider.</p> <p>This member is not exempt from Utilization Threshold and co-payment requirements.</p>
Code 35	<p>This member is enrolled in a Comprehensive Medicaid Case Management (CMCM) program. The member's participation in CMCM does not affect eligibility for other Medicaid services.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p>
Code 38	<p>The member is resident in an ICF-DD facility. You should contact the ICF-DD to find out if the service is included in their per diem rate. If it is not, the claim can be submitted to the NYS Medicaid Program.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements and may be eligible for some fee-for-service Medicaid coverage.</p>
Code 39	<p>This code identifies a member in the Aid Continuing program.</p> <p>This member is subject to Utilization Threshold and exempt from Co-payment requirements.</p>
Code 44	<p>This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Services (HCBS) Waiver and is authorized to receive Non-Intensive At Home Residential Habilitation services.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p>
Code 45	<p>This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Services (HCBS) Waiver and is authorized to receive Intensive At Home Residential Habilitation services.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p>
Code 46	<p>This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Services (HCBS) Waiver and is authorized to receive services.</p>

	This member is exempt from Utilization Threshold and Co-payment requirements.
Code 47	This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Service (HCBS) Waiver and resides in a <i>supervised</i> Community Residence.  This member is exempt from Utilization Threshold and Co-payment requirements.
Code 48	This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Service (HCBS) Waiver and resides in a <i>supportive</i> Community Residence (CR) or a <i>supportive</i> Individual Residential Alternative (IRA).  This member is exempt from Utilization Threshold and Co-payment requirements.
Code 49	This code identifies a Medicaid member who is enrolled in OPWDD's Home and Community Based Services (HCBS) Waiver, resides in a <i>supervised</i> Individual Residential Alternative (IRA) and is authorized to receive IRA residential habilitation services.  This member is exempt from Utilization Threshold and Co-payment requirements.
Code 50	This member has Connect services, plus is eligible for the service package available to all members with Perinatal Family. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 51	This member has Connect services, plus is eligible for the services described in the Eligibility Response associated with the member. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 54	This code designates a member whose outpatient Medicaid coverage is limited to Home Health and Personal Care Services benefits.  This member is <b>not</b> exempt from Utilization Threshold and Co-payment requirements.
Code 60	This code identifies a member who is receiving Home and Community Based Services (HCBS) as part of the Nursing Home Transition and Diversion Waiver program.  This member is exempt from Utilization Threshold and Co-payment requirements.
Code 62	This code identifies a member in the Care At Home I program.  This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.  <i>This code will be inactivated to prevent use after January 1, 2019.</i>
Code 63	This code identifies a member in the Care At Home II program.  This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.  <i>This code will be inactivated to prevent use after January 1, 2019.</i>
Code 64	This code identifies a member in the Care At Home III program.  This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.

	<i>This code will be inactivated to prevent use after January 1, 2019.</i>
Code 65	<p>This code identifies a member in the Care At Home IV program.</p> <p>This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.</p> <p><i>This code will be inactivated to prevent use after January 1, 2019.</i></p>
Code 66	<p>This code identifies a member in the Care At Home V program.</p> <p>This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.</p>
Code 67	<p>This code identifies a member in the Care At Home VI program.</p> <p>This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.</p>
Code 68	<p>This code identifies a member in the Care At Home VII program.</p> <p>This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.</p>
Code 69	<p>This code identifies a member in the Care At Home VIII program.</p> <p>This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.</p>
Code 70	<p>This code identifies a member in the Care At Home IX program.</p> <p>This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.</p>
Code 71	<p>This code identifies a member in the Care At Home X program.</p> <p>This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.</p>
Code 72	<p>This Restriction/Exception code identifies Medicaid Members under the age of 21 who are participants in the Bridges to Health Waiver for the Seriously Emotionally Disturbed (B2H/SED). This waiver is for children who are initially in foster care and who can remain in the waiver once discharged, if otherwise eligible.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p> <p><i>This code will be inactivated to prevent use after January 1, 2019.</i></p>
Code 73	<p>This Restriction/Exception code identifies Medicaid Members under the age of 21 who are participants in the Bridges to Health Waiver for Developmentally Disabled (B2H). This waiver is for children who are initially in foster care and who can remain in the waiver once discharged, if otherwise eligible.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p> <p><i>This code will be inactivated to prevent use after January 1, 2019.</i></p>
Code 74	<p>This Restriction/Exception code identifies Medicaid Members under the age of 21 who are participants in the Bridges to Health Waiver for the Medically Fragile (B2H/MedF). This waiver is for children who are initially in foster care but who can remain in the waiver after discharge, if otherwise eligible.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p>

	<i>This code will be inactivated to prevent use after January 1, 2019.</i>
Code 75	<p>This code identifies a participant of the Partnership program who has Dollar for Dollar Asset Protection. The member may have long term care insurance benefits available for certain long term care services. You should contact the insurance to find out if the service is covered. If it is not, the claim can be submitted to the NYS Medicaid Program. Participation in the Partnership does not affect eligibility for other Medicaid services.</p> <p>This member is not exempt from Utilization Threshold and Co-payment requirements.</p>
Code 76	<p>This code identifies a participant of the Partnership program who has Total Asset Protection. The member may have long term care insurance benefits available for certain long term care services. You should contact the insurance to find out if the service is covered. If it is not, the claim can be submitted to the NYS Medicaid Program. Participation in the Partnership does not affect eligibility for other Medicaid services.</p> <p>This member is not exempt from Utilization Threshold and Co-payment requirements.</p>
Code 77	<p>This code identifies a member that may have long term care insurance benefits available for certain long term care services. You should contact the insurance to find out if the service is covered. If it is not, the claim can be submitted to the NYS Medicaid Program.</p> <p>This member is not exempt from Utilization Threshold and Co-payment requirements.</p>
Code 81	<p>This code identifies a member in a Home and Community Based Services (HCBS) Waiver Program for Traumatic Brain Injury (TBI).</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p>
Code 82	<p>This code identifies a member in the Recipient Restriction Program who is enrolled in a managed care plan. <b>The member is restricted to a plan network provider who is not a FFS MMIS provider.</b> Inquiries concerning service to recipients with Code 82 should be directed to the managed care plan. This member is not exempt from Utilization Threshold and Co-payment requirements.</p>
Code 83	<p>This code identifies a member who has been mandated by the local social services district to receive certain alcohol and substance abuse services as a condition of eligibility for public assistance or Medicaid as a result of welfare reform requirements.</p> <p>For managed care enrollees, the presence of this code allows certain substance abuse services to be paid on a fee for service basis. The code may be used to trigger prior approval requirements.</p>
Code 84	<p>This code identifies a Medicaid member who is enrolled in the OMH's Personalized Recovery Oriented Services (PROS) program and is authorized to receive Community Rehabilitation and Support (CRS) With Clinic Treatment.</p> <p>Other base and clinical PROS programs, OMH clinic, CDT, IPRT, PMHP, and ACT intensive claims will be denied payment.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p>

Code 85	<p>This code identifies a Medicaid member who is enrolled in the OMH's Personalized Recovery Oriented Services (PROS) program and is authorized to receive Community Rehabilitation and Support (CRS) Without Clinic Treatment.</p> <p>Other base PROS programs, OMH CDT, IPRT, and ACT intensive claims will be denied payment.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p>
Code 86	<p>This code identifies a Medicaid member who is enrolled in the OMH's Personalized Recovery Oriented Services (PROS) program and is authorized to receive Intensive Rehabilitation (IR) or Ongoing Rehabilitation and Support (ORS).</p> <p>Other PROS providers will be denied payment for these services. OMH IPRT claims will be denied payment.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p>
Code 89	<p>This code identifies a Medicaid member who is enrolled in the Money Follows The Person (MFP) Rebalancing Demonstration program. The member's participation in MFP does not affect eligibility for other Medicaid services.</p>
Code 95	<p>This code identifies members with a mental retardation or developmental disability diagnosis who are eligible to be billed under an enhanced APG (Ambulatory Patient Groups) base rate for clinical services. It will allow for payment of the following rates codes:</p> <p>1425- MR/DD/TBI APG Base Rate (Episode)</p> <p>1435- MR/DD/TBI APG Base Rate (Visit)</p> <p>1489- MR/DD/TBI APG Base Rate (Episode)</p> <p>1501- MR/DD/TBI APG Base Rate (Visit)</p> <p>This member is <b>not</b> exempt from the Utilization Threshold or Co-payment requirements. This member is exempt for annual visit caps for OT, PT, and SLP services delivered by clinics and independent practitioners. This member is eligible for the OPWDD Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD) enhanced reimbursement.</p>
Code A1	<p>Client assigned, in outreach or enrolled with a Care Management Agency, eMedNY will provide Provider NPI and Name.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p>
Code A2	<p>Client assigned, in outreach or enrolled with Health Home Program, eMedNY will provide Provider NPI and Name.</p> <p>This member is exempt from Utilization Threshold and Co-payment requirements.</p>
Code AL	<p>This code identifies a member who resides in an Assisted Living Program residence. The following services are included in the ALP's Medicaid per diem rate and cannot be billed to the Medicaid Program:</p> <ol style="list-style-type: none"> <li>1. Adult day health care provided in a program approved by the Department of Health;</li> </ol>

	<ol style="list-style-type: none"> <li>2. Home health aide services;</li> <li>3. Medical supplies and equipment NOT requiring prior approval (<u>underlined procedure codes in the DME and Pharmacy provider manuals are prior approved</u>);</li> <li>4. Nursing services;</li> <li>5. Personal care services;</li> <li>6. Personal emergency response services; and</li> <li>7. Physical therapy, speech therapy, and occupational therapy.</li> </ol>
Code B7	Non-EP Aliessa Immigrant
Code C1	Copay Exempt (Hospice) - Exempt individuals receiving Hospice Care from copay by recognizing Hospice Rate Codes.
Code CF	Clients who qualify for Community First Choice Options services who are not enrolled in OPWDD. This code identifies the person who has met the eligibility requirements for receiving these services
Code CH	This code identifies a Medicaid member who is enrolled in the Care Restructuring Enhancement Program (CREP), HCBS – Home and Community Based Services. This member is not exempt from Utilization Threshold and Co-payment requirements.
Code CM	This code identifies a Medicaid member who is enrolled in the Care Restructuring Enhancement Program (CREP), MLTC- Managed Long Term Care. This member is not exempt from Utilization Threshold and Co-payment requirements.
Code CO	Clients who qualify for Community First Choice Options services who are enrolled in OPWDD. This code identifies the person who has met the eligibility requirements for receiving these services.
Code G1	(Transgender Individual Male to Female) Individual has or is in the process of transitioning from a Male to a Female.
Code G2	(Transgender Individual Female to Male) Individual has or is in the process of transitioning from a Female to a Male.
Code H1	HARP enrolled without HCBS eligibility- This code identifies the person as enrolled in a HARP (Health and Recovery Plan). It also indicates that the person is NOT eligible for the special HARP wrap-around Home and Community Based Services (HCBS).
Code H2	HARP enrolled with Tier 1 HCBS eligibility- This code identifies the person as enrolled in a HARP. It also indicates that the person has been assessed and determined to be eligible for Tier 1 HCBS services (peer supports, employment supports, education supports).
Code H3	HARP enrolled with Tier 2 HCBS eligibility- This code identifies the person as enrolled in a HARP. It also indicates that the person has been assessed and determined to be eligible for Tier 2 HCBS services (which includes all Tier 1 services listed under H2, plus psychosocial rehab, community psychiatric supports and treatment, etc.).

Code H4	HIV SNP HARP – eligible without HCBS eligibility- This code identifies the person as HARP eligible, but with enrollment in an HIV SNP. They have NOT been determined to be eligible for the special HCBS benefit package associated with some HARP eligibles.
Code H5	HIV SNP HARP – eligible with Tier 1 HCBS eligibility- This code identifies the person as HARP eligible, but with enrollment in an HIV SNP. It also indicates they have been assessed and determined to be eligible for the Tier 1 HCBS services, which will be administered by their HIV SNP.
Code H6	HIV SNP HARP – eligible with Tier 2 HCBS eligibility- This code identifies the person as HARP eligible, but with enrollment in an HIV SNP. It also indicates they have been assessed and determined to be eligible for the Tier 2 HCBS services, which will be administered by their HIV SNP.
Code H7	Opted Out of HARP- This indicates a person was HARP- eligible but who, when given the option to enroll, declined enrollment.
Code H8	HARP ELIG COMMUNITY REFERRAL - This code indicates the person has been identified by OMH, OASIS, DOH, or another designated entity as potentially HARP eligible. An assessment will need to be done on the person and if the results of the assessment show the person to be HARP eligible they will be given the choice of joining a HARP (and given code H1, with the potential for H2 or H3 based on the results of a detailed assessment). If this person is already in an HIV SNP they can remain in the HIV SNP. They will receive code H4 and, based on the results of a more in depth assessment, possibly qualify for HCBS services under codes H5 or H6.
Code H9	HARP ELIG STATE IDENTIFIED - This person has been determined to be “categorically eligible” for a HARP. They will be given the option of moving to a HARP (where they will be given code H1, with the potential for H2 or H3 based on the results of a detailed assessment). If this person were already in an HIV SNP they would not have been given code H9, but rather code H4. They can choose to remain in the HIV SNP or move to a HARP. If they remain in the HIV SNP they could potentially, based on the results of a more in depth assessment, qualify for HCBS services under codes H5 or H6.
Code I1	This code identifies a Medicaid member who is enrolled in OPWDD MC CLASS 1. This member is not exempt from Utilization Threshold and co-payment requirements.
Code I2	This code identifies a Medicaid member who is enrolled in OPWDD MC CLASS 2. This member is not exempt from Utilization Threshold and co-payment requirements.
Code I3	This code identifies a Medicaid member who is enrolled in OPWDD MC CLASS 3. This member is not exempt from Utilization Threshold and co-payment requirements
Code I4	This code identifies a Medicaid member who is enrolled in OPWDD MC WILLOWBROOK. The member is not exempt from Utilization Threshold and co-payment requirements.

Code I5	This code identifies a Medicaid member who is enrolled in an OPWDD Care Coordination Organization/Health Home (CCO/HH) at level one acuity. The member is exempt from Utilization Threshold and Co-pay requirements.
Code I6	This code identifies a Medicaid member who is enrolled in an OPWDD Care Coordination Organization/Health Home (CCO/HH) at level two acuity. The member is exempt from Utilization Threshold and Co-pay requirements.
Code I7	This code identifies a Medicaid member who is enrolled in an OPWDD Care Coordination Organization/Health Home (CCO/HH) at level three acuity. The member is exempt from Utilization Threshold and Co-pay requirements.
Code I8	This code identifies a Medicaid member who is enrolled in an OPWDD Care Coordination Organization/Health Home (CCO/HH) at level four acuity. The member is exempt from Utilization Threshold and Co-pay requirements.
Code I9	This code identifies a Medicaid member who is eligible for OPWDD CCO/HH services, but has instead opted for basic plan support in lieu of full health home services. Although not a health home service itself, this option is also delivered by CCO/HH provider agencies. The member is exempt from Utilization Threshold and Co-pay requirements.
Code K1	This code identifies a consumer who is under 21 and meets a Level of Care HCBS Eligibility Determination. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K2	This code identifies a consumer who is under 21 and meets a Level of Need HCBS Eligibility Determination. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K3	This code identifies a consumer who is under age 21 and has a serious emotional disturbance as defined by the CANS-NY. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K4	This code identifies a consumer who is under age 21 and is medically fragile as defined by the CANS-NY. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K5	This code identifies a consumer who is under age 21 and a child in foster care with developmental disability as defined by the OPWDD. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K6	This code identifies a consumer who is under age 21 and has co-occurring developmental disability and medical fragility as defined by the CANS-NY. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K7	This code identifies a consumer who is under age 21 and has experienced physical, emotional, or sexual abuse or neglect, or maltreatment defined by the CANS-NY.



	Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K8	This code identifies a consumer who is under age 21 and has foster care placement through a voluntary foster care agency. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code K9	This code identifies a consumer who is under age 21 and has any foster care placement, either through a voluntary foster care agency or the local district of social services. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code KK	This code identifies a consumer who is under age 18 and is Medicaid-eligible using Family of One budgeting. Consumer is exempt from Utilization Threshold and Co-payment requirements.
Code M1	This code identifies a Medicaid member who is eligible in a MAGI (Modified Adjusted Gross Income) category and is receiving services only available through LDSS. This member is excluded from transition to NYSOH (NY State of Health).
Code N1	This code identifies a regular Nursing Home bed type of a Medicaid managed care enrollee to the managed care health plan. Entry of this code will allow Medicaid managed care plans to receive an adjusted premium due to long term Nursing Home placement.
Code N2	This code identifies an AIDS Nursing Home bed type of a Medicaid managed care enrollee to the managed care health plan. Entry of this code will allow Medicaid managed care plans to receive an adjusted premium due to long term Nursing Home placement.
Code N3	This code identifies a Neuro-Behavioral Nursing Home bed type of a Medicaid managed care enrollee to the managed care health plan. Entry of this code will allow Medicaid managed care plans to receive an adjusted premium due to Nursing Home placement.
Code N4	This code identifies a Traumatic Brain Injury (TBI) Nursing Home bed type of a Medicaid managed care enrollee to the managed care health plan. Entry of this code will allow Medicaid managed care plans to receive an adjusted premium due to long term Nursing Home placement.
Code N5	This code identifies a Ventilator Dependent Nursing Home bed type of a Medicaid managed care enrollee to the managed care health plan. Entry of this code will allow Medicaid managed care plans to receive an adjusted premium due to long term Nursing Home placement.
Code N6	This code identifies a MLTC partial cap/MAP enrollee who has been permanently placed in a nursing facility.
Code N7	This code identifies a fee for service consumer who has been determined eligible for nursing facility services and is required to enroll in a managed care health plan. Consumer will need to enroll in a managed care health plan within 60 days or will be auto assigned. This code triggers Enrollment Broker outreach/enrollment activities.

Code N8	This code is for local districts to enter a transfer penalty period for consumers who have been permanently placed in a nursing facility but are not eligible for Medicaid payment nursing facility services due to a transfer penalty
Code N9	This code identifies fee-for-service consumers and managed care plan enrollees who are pending nursing home eligibility determination. This member is not exempt from Utilization Threshold and Co-payment requirements.
Code NH	This code identifies a member in a Nursing Home facility. The majority of the member's care is provided by the Nursing Home and is included in their Medicaid per diem rate. If you provide a service to a NH member, you must contact the Nursing Home to find out if the service is included in their rate. If it is not, the claim can be submitted to the NYS Medicaid Program.
Code PL	(Upstate) Pre-release from NYS Department of Corrections and Community Supervision (NYS DOCCS) facility, Managed Care Ineligible.
Code PR	(Downstate) Pre-release from NYS Department of Corrections and Community Supervision (NYS DOCCS) facility, Managed Care Ineligible.
Code S1	Surplus Client not Eligible for Medicaid Managed Care or Medicaid Advantage Enrollment.

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**19.0 COUNTY/DISTRICT CODES – TABLE 13 (Rev. 05/11)**

The County/District, two-digit codes are used to identify the member's county of fiscal responsibility.

01 Albany	31 Onondaga
02 Allegany	32 Ontario
03 Broome	33 Orange
04 Cattaraugus	34 Orleans
05 Cayuga	35 Oswego
06 Chautauqua	36 Otsego
07 Chemung	37 Putnam
08 Chenango	38 Rensselaer
09 Clinton	39 Rockland
10 Columbia	40 St. Lawrence
11 Cortland	41 Saratoga
12 Delaware	42 Schenectady
13 Dutchess	43 Schoharie
14 Erie	44 Schuyler
15 Essex	45 Seneca
16 Franklin	46 Steuben
17 Fulton	47 Suffolk
18 Genesee	48 Sullivan
19 Greene	49 Tioga
20 Hamilton	50 Tompkins
21 Herkimer	51 Ulster
22 Jefferson	52 Warren
23 Lewis	53 Washington
24 Livingston	54 Wayne
25 Madison	55 Westchester
26 Monroe	56 Wyoming
27 Montgomery	57 Yates
28 Nassau	66 New York City
29 Niagara	97 OMH Administered
30 Oneida	98 OMR/DD Administered
	99 Oxford Home

**20.0 NEW YORK CITY OFFICE CODES – TABLE 14 (Rev. 01/15)**

For members who have coverage through the NY Health Benefit Exchange, the three-digit Office Code 'H78' will be returned. The phone number for inquiries pertaining to eligibility issues for members enrolled through the NY Health Benefit Exchange is 855-355-5777.

The office codes and descriptions listed below are only returned for **County Code 66** members.

**Public Assistance****Manhattan**

013 Waverly  
019 Yorkville  
023 East End  
024 Amsterdam  
026 St. Nicolas  
028 Hamilton  
032 East Harlem  
035 Dyckman  
037 Roosevelt

**Bronx**

038 Rider  
039 Boulevard  
040 Melrose  
041 Tremont  
043 Kingsbridge  
044 Fordham  
045 Concourse  
046 Crotona  
047 Soundview  
048 Bergen  
049 Willis

**Queens**

051 Queensboro  
052 Office of Treatment Monitoring  
053 Queens  
054 Jamaica  
079 Rockaway

**Brooklyn**

061 Fulton  
062 Clinton  
063 Wyckoff  
064 Dekalb  
066 Bushwick  
067 Linden  
068 Prospect  
070 Bay Ridge  
071 Nevins  
072 Livingston  
073 Brownsville  
078 Euclid  
080 Fort Greene  
084 Williamsburg

**Staten Island**

099 Richmond

**Medical Assistance**

500-593 34<sup>th</sup> Street Manhattan

**Special Services for Children (SSC)**

DOP Division of Placement  
OPA Office of Placement and Accountability

**Field Offices**

071 Bronx  
072 Brooklyn  
073 Manhattan  
074 Queens  
075 Staten Island

**Office of Direct Child Care Services**

801 Brooklyn  
802 Jamaica  
806 Manhattan  
810 Division of Group Homes  
823 Division of Group Residence  
826 Diagnostic Reception Centers

**PCP Plan Codes**

Click here to view the [Prepaid Capitation Plan Codes](#).