State of Illinois
Department of Healthcare and Family Services

Handbook for
Pharmacy
Electronic Processing

Chapter 300
General Policy and Procedures

Version -1.0
Last Revision Date: May 2011

Chapter 304 – Pharmacy Claims

Table of Contents

304.1 General Information

Chapter 304 contains information on electronic pharmacy transactions processing based on the National Council for Prescription Drugs Programs (NCPDP) Telecommunication Standard, Version D, Release 0 (Real Time processing). This chapter contains specialized information that is needed by pharmacies, health plans, clearinghouses, billing services, and others, to conduct their business with the Illinois Medical Assistance Program administered by the Illinois Department of Healthcare and Family Services, hereafter referred to as either "The department," or "HFS".

Any questions regarding this chapter should be directed to HFS Webmaster. For correct routing please enter "Pharmacy ECP" in the subject line.

304.2 Transmission Types

B1 – Billing
This transmission is used for a request for payment for a pharmacy service. Services submitted in this transmission must be identified using an NDC (National Drug Code). HCPCS (Health Care Financing Administration Common Procedure Coding System) codes and UPC (Universal Product Code) codes are not allowed. Please consult the appropriate Chapter 300 subchapter regarding the use of the HIPAA 837P (Professional) transaction to bill for non-drug items.

B2 – Billing Reversal
This transmission is used to reverse a payable or paid claim. It may not be used for a rejected claim. If the reversal is processed on the same day of the request for payment, no record of the original claim will be retained on the department's system. If the reversal is submitted subsequent to the day of claim processing, the pharmacy will see the original claim and the offsetting adjustment on a Remittance Advice. If the reversal is submitted after the claim has been reported on a Remittance Advice (HIPAA 835 transaction or HFS paper version), only the reversal adjustment will appear on a Remittance Advice.

B3 – Billing Rebill
This transmission is used to reverse and rebill a payable or paid claim. This transmission is equivalent to a B2 transmission followed by a B1 transmission. When a Billing Rebill transmission (B3) is used, the Provider Number, Patient Number, Date of Service, Prescription Number and NDC code must duplicate the original B1 transmission. If any of these fields must be changed, then the original service must be reversed using the B2 transmission, and the prescription billed as a separate B1 transmission

D1 – Predetermination of Benefits
This transmission is used to:

- Determine if the patient is eligible for prescription coverage,

- Determine if the submitted product has coverage limitations, and/or
- Identify the patient's financial responsibility.

E1 – Eligibility Verification
This transmission is used to determine an individual's HFS Medical Assistance Programs Eligibility status. This same eligibility verification is performed on each submitted claim.

P2 – Prior Approval Reversal
This transmission is used to withdraw a request for Prior Approval. This transmission may be used only until HFS has begun review of the request for Prior Approval. Once review has begun, HFS will not accept the P2 transmission.

P3 – Prior Approval Inquiry
This transmission is used to check the status of a request for Prior Approval. If the Prior Approval has been received, but not been acted upon by HFS, the response returned will indicate "Captured." If the HFS staff have begun an evaluation of the Prior Approval, but have not reached a final decision, it will be marked as "Deferred." If the Prior Approval is marked as "Approved," then the claim can be submitted. If the Prior Approval is marked as "Denied," then HFS will indicate the reason for the denial.

P4 – Prior Approval Request Only
This transmission is used to submit a request for Prior Approval for a given NDC. This request is used whether the NDC is billed individually, or as part of a Compound.

S1 – Service Billing
This transmission is only to be used to request a service fee for the administration of vaccines, subsequent to the successful billing of the associated drug.

S2- Service Reversal
This transmission is used to reverse a payable, or paid, service billing. It may not be used for a rejected service billing. If the reversal is processed on the same day of the request for payment, no record of the original service billing will be retained on the department's system. If the reversal is submitted subsequent to the day of service billing processing, the pharmacy will see the original service billing, the offsetting adjustment on a Remittance Advice. If the reversal is submitted after the service billing has been reported on a Remittance Advice (HIPAA 835 transaction or HFS paper version), only the reversal adjustment will appear on a Remittance Advice.

S3- Service Rebill
This transmission is used to reverse, and rebill, a payable, or paid, service billing. This transmission is equivalent to a S2 transmission, followed by a S1 transmission.

HFS does not support the following transmissions:

C1 – Controlled Substance Reporting
C2 – Controlled Substance Reversal

C3 – Controlled Substance Rebill
N1 – Information Reporting
N2 – Information Reporting Reversal
N3 – Information Reporting Rebill
P1 – Prior Approval Request and Billing

304.3 Business Rules

304.3.1 General Billing

Pharmacies submitting claims electronically must conform to the standards of the NCPDP Version D.0 Implementation Guide; the instructions set forth by HFS in this Electronic Handbook; HFS's Handbook for Pharmacy, and any applicable notices, rules and laws.

NDCs will only be accepted in the 5-4-2 format.

Codes which are for Equipment and Supplies must be billed on the HIPAA 837P (Professional) transaction.

The following fields must match a paid claim in order for it to be reversed on the department's claims processing system:

Provider Number
Patient Number
Prescription Number
Date of Service
National Drug Code

A claim reversed on the day it is submitted for processing will not appear on the Remittance Advice, either electronic or paper. A claim reversed on a date subsequent to its submittal date will appear on a Remittance Advice as paid. There will be an adjustment on either the same or a later Remittance Advice detailing the claim void.

304.3.2 Payor Sheets

HFS has developed Payor Sheets for the use of programmers in creating software to generate pharmacy claims and other transactions for the Illinois Medical Assistance Program. These Payor Sheets define the required fields and allowable values that may be used within each field. The Payor Sheets may be found on the HFS Web site, Provider Payor Sheets for NCPDP Version D.0 ECP Input Transactions.

304.3.3 Partial Fills

HFS will accept only one partial fill transaction per prescription. Additional partial transactions will be rejected.

Dispensing fees will only be paid on completed prescriptions.

When a partial fill prescription is submitted, it must have a completed prescription submitted, prior to the next refill.

When a partial fill prescription is dispensed, but the patient does not receive the remainder of the prescription, the pharmacy must void the partial fill prescription, and bill the prescription as a completed prescription, to receive the dispensing fee.

The same prescription number must be assigned to both the partial fill and completed prescriptions.

304.3.4 Prior Approvals

The Department will accept P2, P3 and P4 Prior Approval transmissions, and will not support the P1 transmission. Prior Approval requests will be processed in accordance with HFS policy.

It is the pharmacy's responsibility to check the department's system, using the P3 transmission, to determine whether a final decision has been made on their request.

When a Prior Approval is entered into the HFS system, it will have a Prior Approval Reference Number (PARN) assigned. The pharmacy will need to use the PARN to inquire on the status of the Prior Approval. The PARN will be returned to the pharmacy in the Prior Authorization Number – Assigned (498-PY) field.

The Prior Authorization Supporting Documentation field (498 PP) of the Prior Approval segment is a 500 byte free text field to be used to supply supporting documentation for the prior approval request. The following information is required:

- Pharmacy contact person, phone number with extension and fax number.
- Diagnosis description if no diagnosis code is submitted on the clinical segment.
- If you are requesting an override of specific limitations please indicate:
  Age, Sex, Daily Dose, Brand Name Only, Maximum/Minimum Quantity, Three Brand Limit, Emergency 72 hour supply.
- Directions for use.
- All medications previously tried and description of failure.
- Additional information or reason for requesting drug (please provide specific justification for using this drug instead of one that does not require prior approval).

To request a Refill Too Soon Prior Approval, enter the following information in the Prior Authorization Supporting Documentation field (498 PP):

- RTS or Refill Too Soon.
- Pharmacy contact person, phone number with extension and fax number.
- Reason for request including directions for use of NDC requested.
- Last Rx date, quantity, directions for use and pharmacy if known.
- Be sure to specify date of service you wish to bill because a Refill Too Soon Override is only good for ONE DAY.

A selected few drugs require a drug specific Prior Approval form to be completed. Prior approval requests for these drugs should not be submitted using the P4 transaction. See Prior Authorization Guidelines and Forms for the drug specific forms.

Please note that once the department has made a decision on a Prior Approval, the pharmacy may not reverse the Prior Approval. The pharmacy must contact the department to have the Prior Approval reversed from the system.

304.3.5 Compound Drugs

The Illinois Medical Assistance Program defines a compound as the combination of two or more drugs into a single entity. For the purposes of billing a compound a maximum of 25 ingredients may be included. If a compound is submitted to the department with over the maximum of 25 components, the transaction will be rejected.

Any ingredient requiring Prior Approval, if billed as a standalone NDC, will require a Prior Approval as an ingredient in the compound. Only ingredients identified as rebateable NDCs will be paid.

The department will edit each ingredient within the compound individually and will price each ingredient based on the quantity of the ingredient used in the compound. If any ingredient is not payable, the compound will be rejected in total.

The pharmacy will then be able to correct any error causing the rejection or include a Submission Clarification Code of 8 (Process Compound for Approved ingredients). The use of this code bypasses the reimbursement for non-covered drugs. In this way, the department will be able to process and price all valid NDC values instead of rejecting the transmission.

The following edits will be bypassed when the Submission Clarification Code of 8 is used:

HFS Error Code	HFS Edit Message
A91	OTC Drug Not Covered for All Kids Recip
B94	Part D Service – Bill Medicare

B54	Not an ILCares Rx Basic Covered Service
B26	Compound NDC Determined Obsolete
B24	NDC is Not on File
B29	Manufacturer Not Eligible for Quarter
B63	Compound PA Not on File
B65	Compound Item for Group Care Only
B66	Compound Item Group Care Restricted
B74	Compound Item Not Covered on Fill Date
B75	Compound DESI Drug Not Allowed
B76	Compound MFGR Not on File for Rebate
B77	Compound MFGR Not on File for Rebate/DOS
B83	Compound Item is Not Preferred Drug.

304.4 Transmission Responses

304.4.1 Transmission Reject Response

A transmission rejected response will be returned for all transmission types if the data fails the basic format edits as defined in the NCPDP Version D.0 specifications.

304.4.2 Billing Transmission Responses (B1)

In some situations the NCPDP reject code does not indicate specifically why the claim was rejected. Please refer to the Additional Message areas (field 526-FQ) for detail information.

Programmers should make provisions so that users can access the Additional Message field as needed.

304.4.2.1 Payable or Duplicate Response

If the transmission passes all HFS defined edits, a payable response is returned. If the transmission is a duplicate of a payable transmission previously submitted, a duplicate response is returned. Duplicate responses are identical to payable responses with the exception of a “D” in the Transmission Response Status.

304.4.2.2 Rejected Response

If the transmission fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Areas (field 526-FQ), for the first 5 errors.

304.4.3 Reversal Transmission Responses (B2)

304.4.3.1 Approved Response

If the transmission passes all HFS defined edits, an approved response is returned. Check the Additional Message Areas for a message that describes how the reversal was handled by HFS.

304.4.3.2 Rejected Response

If the transmission fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Areas (field 526-FQ), for the first five errors.

304.4.4 Rebill Transmission Responses (B3)

304.4.4.1 Payable Response

If the transmission passes all HFS defined edits, a payable response is returned. Check the Additional Message Areas (field 526-FQ) for a message that describes how the reversal part of the rebill was handled by HFS.

304.4.4.2 Rejected Response

If the transmission fails one or more HFS defined edits for the reversal part of the rebill, a rejected response is returned indicating that the reversal and the rebilled claim were not processed. If the reversal is successful, but the claim fails one or more HFS defined edits, a rejected response is returned for the claim only. In addition to the NCPDP reject codes, a descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Areas (field 526-FQ), for the first five errors.

304.4.5 Predetermination of Benefits Transmission Responses (D1)

In some situations the NCPDP reject code does not indicate specifically why the transmission was rejected. Please refer to the Additional Message areas (field 526-FQ) for detail information.

Programmers should make provisions so that users can access the Additional Message field (field 526-FQ) as needed.

304.4.5.1 Benefit Response

If the transmission passes all HFS defined edits, a benefit response is returned.

304.4.5.2 Rejected Response

If the transmission fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Areas (field 526-FQ), for the first five errors.

304.4.6 Eligibility Verification Transmission Responses (E1)

304.4.6.1 Approved Response

If the transmission passes all HFS defined edits, an approved response is returned. Check the Additional Message Areas (field 526-FQ) for HFS eligibility information.

304.4.6.2 Rejected Response

If the transmission fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a descriptive message defined by HFS for the reject error will be returned in the Additional Message Areas (field 526-FQ) for the first five errors.

304.4.7 Prior Approval Reversal Responses (P2)

304.4.7.1 Approved Response

If the transmission passes all HFS defined edits, an approved response is returned. Check the Additional Message Areas (field 526-FQ) for a message that describes how the reversal was handled by HFS.

304.4.7.2 Rejected Response

If the transmission fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes a descriptive message, defined by HFS for the reject error will be returned in the Additional Message Areas (field 526-FQ) for the first five errors.

304.4.8 Prior Approval Inquiry Responses (P3)

304.4.8.1 Captured or Deferred Response

If the transmission passes all HFS defined edits, and no action has been taken on the approval request, a captured response is returned. If the action taken indicates that there will be a delay in approval, a prior approval deferred response will be returned. Check the Additional Message Areas (field 526-FQ) for additional information.

304.4.8.2 Approved Response

If the transmission passes all HFS defined edits, and the action taken was to approve the request, an approved response is returned. Check the Additional Message Areas (field 526-FQ) for information related to the approval.

304.4.8.3 Denied Response

If the transmission passes all HFS defined edits, and the action taken was to deny the request, a rejected response is returned with a reject code of 3Y (Prior Authorization Denied).

304.4.8.4 Rejected Response

If the transmission fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a descriptive message, defined by HFS for the reject error will be returned in the Additional Message Areas (field 526-FQ) for the first five errors.

304.4.9 Prior Approval Request Responses (P4)

304.4.9.1 Deferred Response

If the transmission passes all HFS defined edits, a deferred response is returned. Check the Additional Message Areas (field 526-FQ) for additional information. If the transaction is a duplicate of an approved transaction previously submitted, a rejected response is returned.

304.4.9.2 Rejected Response

If the transmission fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Areas (field 526-FQ) for the first five errors.

304.4.10 Service Billing Transmission Responses (S1)

In some situations the NCPDP reject code does not indicate specifically why the service claim was rejected. Please refer to the Additional Message Areas (field 526-FQ) for detail information.

Programmers should make provisions so that users can access the Additional Message field as needed.

304.4.10.1 Payable or Duplicate Response

If the transmission passes all HFS defined edits, a payable response is returned. If the transmission is a duplicate of a payable transmission previously submitted, a duplicate response is returned. Duplicate responses are identical to payable responses with the exception of a “D” in the Transmission Response Status.

304.4.10.2 Rejected Response

If the transmission fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Areas (field 526-FQ), for the first five errors.

304.4.11 Service Reversal Transmission Responses (S2)

304.4.11.1 Approved Response

If the transmission passes all HFS defined edits, an approved response is returned. Check the Additional Message Areas (field 526-FQ) for a message that describes how the reversal was handled by HFS.

304.4.11.2 Rejected Response

If the transmission fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Areas (field 526-FQ), for the first five errors.

304.4.12 Service Rebill Transmission Responses (S3)

304.4.12.1 Payable Response

If the transmission passes all HFS defined edits, a payable response is returned. Check the Additional Message Areas (field 526-FQ) for a message that describes how the reversal part of the rebill was handled by HFS.

304.4.12.2 Rejected Response

If the transmission fails one or more HFS defined edits for the reversal part of the rebill, a rejected response is returned indicating that the reversal and the rebilled claim were not processed. If the reversal is successful, but the claim fails one or more HFS defined edits, a rejected response is returned for the claim only. In addition to the NCPDP reject codes, a descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Areas (field 526-FQ), for the first five errors.

304. 5 Third Party Liability

The pharmacy must show the disposition of each request to an Other Payer when submitting the claim to HFS. If the payer made a payment to the pharmacy, then both the Other Payer Amount Paid Qualifier (342-HC) and the Other Payer Amount Paid (431-DV) must be shown. If a payer rejected the request for payment, then each separate value in the Other Payer Reject Code (field 472-6E) must be shown.

If the Other Payer ID qualifier is = 99 (Other), then the Other Payer ID must be a valid Third Party Liability code as assigned by HFS. Complete the Other Payer ID (field 340-7C) by referring to Chapter 100 (General Policy and Procedures), Appendix 9 (Third Party Liability Resource Code Directory) on HFS' Web site.

In some situations HFS will deduct a co-payment amount for the patient from the amount of reimbursement to the pharmacy. In the event that the pharmacy had identified one or more TPL sources when submitting the transaction, HFS will report back the TPL amounts and the co-payment amount separately.

Patient Pay Amount (505-F5): The total amount to be collected from the customer at the time the prescription is filled.

Other Payer Amount Recognized (566-Z5): The amount known by the pharmacy from other sources.

304.6 Medicare Part B Drug Coverage

HFS has developed edits to reject claims for Part B covered drugs if there is no indication that Medicare has adjudicated the claim. It is the responsibility of the pharmacy to submit the claim to Medicare for processing. After Medicare has processed the claim, it may be submitted to HFS electronically with the Third Party fields completed. HFS will then process the claim and pay the lesser of the HFS's allowable amount or the difference between the Pharmacy charge and Medicare's payment.