Provider Reference Manual

SelectHealth Pharmacy Plans

selecthealth

Table of Contents

Continued on page 3....

Table of Contents, Continued

1.0 General Overview

This pharmacy provider manual has been developed by SelectHealth to assist network pharmacies in all aspects of providing pharmacy services to SelectHealth covered members. Periodically, this manual will be updated with new or modified information. To ensure accuracy and usability of this manual, please incorporate the revised information as instructed. This manual has been assembled to provide administrative information only and is not meant to supersede any local or federal regulations.

SelectHealth administers a variety of plans including Commercial, Small Employer, Individual, Medicaid, Medicare and other Government sponsored plans. The SelectHealth pharmacy network is comprised of nationally contracted chain and independent pharmacies located in all 50 states. Covered members with SelectHealth prescription drug coverage must have their prescriptions filled at a participating pharmacy to obtain the maximum benefit. Covered members traveling outside their local service area must also use a participating pharmacy to obtain the maximum benefit. Pharmacies participating in the SelectHealth pharmacy network are eligible to fill prescriptions for all SelectHealth-covered members except when restricted by the plan. For some plans, the prescriber writing the prescription must be participating in the plan.

1.1 Confidentiality Statement

The information included in this provider manual is considered confidential and proprietary to SelectHealth and provided for business purposes only. Provider is not authorized to copy, reproduce, distribute or otherwise share the information contained in the manual except as authorized by the pharmacy network agreement.

1.2 Pharmacy Requirements

SelectHealth has established service, credentialing, and operational standards for participating pharmacies to ensure delivery of quality service to all covered members.

Patient service standards include that pharmacies/pharmacists will:

> Maintain patient profiles for prescription medication dispensed.

> Not destroy any patient record produced, unless prior written consent is obtained from SelectHealth for a period of at least five (5) years.

> React appropriately to online edits, which may affect the patient's medical status or coverage.

> Provide instruction to the patient on the use of medication, including information based on the online drug messages, before dispensing of each prescription, according to state and federal law.

> Provide all drug products covered by the benefit plans, including products normally stocked and those that require special order, if possible.

> Have established formal prescription quality assurance and error prevention measures.

> A formal process for handling prescription errors.

Provider credentialing standards include that the pharmacy will:

> Carry a valid pharmacy operating license.

> Maintain valid professional liability and general liability insurance for the pharmacy in the amounts of $1,000,000 per occurrence and $3,000,000 aggregate coverage.

> Maintain a valid DEA registration.

> Cooperate with SelectHealth pharmacy auditors and recovery of any overages identified as a result of an audit.

> Maintain a current/valid State Board of Pharmacy License that contains no restrictions. (established procedures for verification of pharmacist licensure will be in place).

2.0 Contact Information

2.1 SelectHealth Pharmacy Help Desk

**24 hours a day,
7 days a week**

Contact the Pharmacy Help Desk for items, such as the following:

> Claims Processing

> Prior Authorization Requests

> Assistance with Reject Messages

> Contract Issues/Questions

> Network Issues/Questions

> Claims Investigation

> Provider Remittance Statements

> Payment Issues/Questions

> General Questions

For SelectHealth Commercial and PBM Products and SelectHealth Community Care® (Utah State Medicaid):

> Phone: **801-442-4912**

> Toll Free: **800-442-3129**

> Fax: **801-442-3006**

For SelectHealth Advantage® (Medicare Part D):

> Phone: **801-442-9988**

> Toll Free: **855-442-9988**

> Fax: **801-442-0413**

2.2 SelectHealth Member Services

**Monday through Friday,
7:00 a.m.–8:00 p.m. (MST)**

**Saturday,
9:00 a.m.–2:00 p.m. (MST)**

Closed Sunday

Contact the relevant Member Services line listed below for eligibility verification or member-specific questions about benefit coverage:

> **SelectHealth Commercial Products**

- Phone: **801-442-5038**
- Toll Free: **800-538-5038**
- Fax: **801-442-3006**

> **SelectHealth PBM Products**

- Phone: **801-442-4910**
- Toll Free: **800-442-3127**
- Fax: **801-442-3006**

> **SelectHealth Advantage (Medicare Part D)**

- Phone: **801-442-9900** (Utah), **208-429-9900** (Idaho)
- Toll Free: **855-442-9900**
- Fax: **801-442-0413**

> **SelectHealth Community Care (Utah State Medicaid)**

- Phone: **801-442-3234**
- Toll Free: **855-442-3234**
- Fax: **801-442-3006**

2.2 SelectHealth Addresses

Physical Address: 5381 Green Street, Murray, UT 84123

Claims Mailing Addresses:

> **Commercial, PBM, and SelectHealth Community Care**

- PO Box 30192
- Salt Lake City, UT 84130

> **SelectHealth Advantage (Medicare Part D)**

- PO Box 30196
- Salt Lake City, UT 84130

3.0 General Claims Processing Information

3.1 Online Processing Information

See Payer Sheet in Appendix A for additional processing instructions and requirements.

> SelectHealth Commercial and PBM Products

- BIN – 800008
- PCN – **not required**
- Group – **not required**

> SelectHealth Advantage (Medicare Part D)

- BIN – 015938
- PCN – 7463
- Group – UT/ID = U1000009; NV Intermountain = U1000011

> SelectHealth Community Care (Utah State Medicaid)

- BIN – 800008
- PCN – 606
- Group – **not required**

The pharmacy must submit all prescription claims online to SelectHealth using the most current version of the NCPDP telecommunications standard. Tape billing will not be accepted or paid. The pharmacy must submit prescription claims within 90 days of the fill date. The pharmacy is required to bill the most cost-effective package size.

Each individual claim will be processed as received by SelectHealth. Extensive edit checks are made to ensure proper claims adjudication. Claims submitted containing one or more errors will be rejected.

The pharmacy shall not submit claims for payment for prescriptions filled, but not dispensed to a covered member. Non-compliance with this contractual provision will be grounds for termination of the Prescription Drug and Pharmacy Services Agreement and/or adjustment of payment on these claims.

3.2 SelectHealth ID Cards

SelectHealth maintains a guide with sample ID cards on their website in the Resource Center. The primary cardholder of SelectHealth will receive an ID card that will provide the cardholder's identification number and copayment information.

3.3 Member Identification Number

The identification number will appear as follows: 800000000 (example).

3.3.1 SelectHealth Community Care Identification Numbers

Individuals enrolled in SelectHealth Community Care will be issued a SelectHealth identification number upon enrollment. The Utah Department of Health will continue to issue Medicaid identification cards. Pharmacies should request both the SelectHealth and Medicaid cards when dispensing medication.

SelectHealth Community Care claims can be submitted for processing using either the SelectHealth or Medicaid identification number.

3.4 Dependent Coverage

Dependent coverage may include a spouse and or children. Covered family members are identified by the following relationship codes:

0 – Not Specified	5 – Student
1 – Cardholder	6 – Disabled Dependent
2 – Spouse	7 – Adult Dependent
3 – Child	8 – Significant Other
4 – Other	

NOTE: Use of the correct relationship code is important. Prescription claims must be submitted to SelectHealth only for the eligible member for whom the prescription is written by the prescriber. This requirement has added significance in that DUR reviews are based on claims submitted for the correct eligible member.

3.5 Eligibility Verification

The pharmacy agrees to use an online point-of-sale (POS) authorization terminal or host-to-host online link with the SelectHealth system for verifying eligibility of covered members. The cardholder's identification number for POS entry should be obtained from their ID card. These cards are used for identification purpose only and are not a guarantee of coverage.

If eligibility cannot be verified using the above method, the pharmacy should call the SelectHealth Pharmacy Help Desk for verification of eligibility using the telephone number listed on the identification card. SelectHealth will advise the pharmacy if the patient is eligible.

SelectHealth Community Care members must use a participating pharmacy of Utah Medicaid and SelectHealth Community Care to obtain benefits. All other members not using a participating pharmacy must pay in full for their prescription(s) and seek reimbursement from SelectHealth.

Members will be reimbursed the discounted amount that the plan would have had to pay to a participating pharmacy for the prescription(s), less the copayment. For Medicare, SelectHealth Advantage will only cover up to a 30-day supply at an out-of-network pharmacy. The member will be reimbursed for Part D medications covered on the plan's Drug List (formulary) that were not paid for with assistance from a discount or coupon card.

3.6 Coordination of Benefits (COB)

Most SelectHealth plans allow for coordination of benefits (COB) with a member's primary carrier. If a member has an additional prescription benefit plan, the pharmacy should submit the claim to the appropriate payer in accordance with any coordination of benefits requirements. The pharmacy should submit the primary claim to the member's primary payer for adjudication. In some instances, the secondary claim can be electronically submitted to SelectHealth for adjudication. The member may seek reimbursement from SelectHealth for any secondary claims not processed electronically.

3.6.1 Secondary Claim Submission (SelectHealth Community Care)

Pharmacies must explore payment from all other liable parties such as insurance coverage, including a health plan, before seeking Medicaid payment. Before submitting a secondary claim to SelectHealth Community Care, collect only the applicable Medicaid co-payment usually charged at the time of service. Refer to Utah Medicaid Provider Manual, Section 1, Chapter 11.4 for additional instruction regarding coordination with other liable parties.

3.7 Prescription Costs and Reimbursement

3.7.1 Member Financial Responsibility

When a person presents a SelectHealth ID card to the pharmacy, the ID card may advise of the copayment amount to be collected. Since the pharmacy is submitting the claim via the point-of-sale system, the electronic response to the pharmacy will include a detailed description of the member's financial responsibility.

If the member is questioning the calculated copay or coinsurance amounts returned on the transaction, remind the member that the copay is determined by many factors. The following is a non-inclusive list of items that may affect the copayment or coinsurance being returned:

> Brand vs. Generic Drug

> Quantity Dispensed

> Day Supply Dispensed

> Member Deductible

If a review of the above items still leaves questions for the member regarding their calculated copay, direct the member to contact the SelectHealth Member Services line for assistance.

3.7.2 Prohibition on Billing Patients (SelectHealth Community Care)

Participating pharmacies of Utah Medicaid and SelectHealth Community Care are only allowed to collect payment from Medicaid enrollees for non-covered services when certain circumstances are met. The specific policy is described in the Utah Medicaid provider manual. See the Utah Medicaid Provider Manual, Section 4.

3.7.3 Reimbursement Rate Questions

If the pharmacy has questions regarding the reimbursement rate for a particular medication, they are welcome to contact the SelectHealth Pharmacy Help Desk for assistance. Additionally, the pharmacy can review

the following items that can directly affect the reimbursement rate to ensure the transaction was submitted correctly:

> **Quantity Submitted:** Confirm that the metric quantity of the prescription was submitted correctly.

> **Day Supply:** Confirm that the day supply of the prescription was submitted correctly.

> **DAW Code:** Confirm that the submitted DAW code accurately reflects the situation.

After evaluating the above fields, if all appears to be accurate, call the SelectHealth Pharmacy Help Desk for further assistance.

3.8 Signature Log

The pharmacy will maintain an approved daily signature log which contains a disclaimer verifying the member has received the prescription and authorizes the release of all prescriptions and related information to SelectHealth. The pharmacy will also require the member or the representative who receives the service to sign for all prescriptions dispensed.

3.9 E-prescribing

Electronic prescribing (e-prescribing) is the transmission, using electronic media, of prescription or prescription-related information between a prescriber, dispensing pharmacy, pharmacy benefit manager, or health plan, either directly or through an intermediary. E-prescribing should improve quality, safety, efficiency, and consumer convenience.

Pharmacies need to submit the Origin Code on the transaction to indicate how the prescription was obtained by the pharmacy.

4.0 Dispensing Edits

This section contains information on some of the more common edits applied to the SelectHealth plans.

4.1 Quantity and Day Supply Limits

SelectHealth Commercial and PBM Products and SelectHealth Community Care (Utah State Medicaid)

The following quantity limits will be applied to all transactions processed to SelectHealth:

> Maximum thirty-four (34)-day supply of tablets, capsules, and liquids to be taken orally.

> Maximum one (1) vial containing no more than fifteen (15) milliliters of any otic or ophthalmic product; if only manufactured in package sizes greater than fifteen (15) milliliters, the smallest package size available from the manufacturer is mandated. One copay will be charged per vial.

> Some products may be limited to an approved quantity per each acute treatment period.

Unless otherwise specified, one copayment will apply for each item dispensed within the limit. There are instances in which exceptions can be made.

Except for SelectHealth Community Care (Medicaid), most SelectHealth plans offer a ninety (90)-day supply benefit for maintenance medications, if the member and medication meet specific qualifications. The necessary qualifications include that the medication must be approved on the formulary, and the member must have filled the prescription, at the same strength, at least once within the past 180 days. If the pharmacy has questions regarding eligibility or if a rejection is received when the claim is processed, please contact the Pharmacy Help Desk for assistance.

SelectHealth Advantage (Medicare Part D)

For certain drugs, the Medicare plan may limit the amount of a prescription a member can receive (maximum number of tablets or capsules, etc. per prescription). Asking for an exception may allow for greater quantity dispensed when a medication exceeds the plan limits.

4.2 Refills

The following refill edits will be applied to all transactions processed to SelectHealth:

> Prescriptions cannot be refilled beyond **twelve (12) months** from the date on which the prescription was written. After the 12 months have lapsed, a new prescription with a new prescription number must be assigned.

> Prescriptions should not be refilled more times than the number specified by the prescriber.

> Additional refills authorized by the prescriber must be documented on the hard copy of the prescription or a new prescription number must be assigned with the refills indicated.

> Changes in dosage or an increase in quantity assigned by the prescriber must be documented on the hard copy prescription or a new prescription number must be assigned with these changes documented.

Pharmacies that do not comply with the above dispensing limitations may be subject to review by the SelectHealth Pharmacy auditors or designated vendor.

4.3 DAW Codes

The pharmacy is required to bill the correct Dispense as Written (DAW) code corresponding to the prescription. Valid DAW codes are as follows:

DAW Code	Code Description
0	No product selection indicated
1	Substitution not allowed by prescriber
2	Substitution allowed – patient requested product dispensed
3	Substitution allowed – pharmacist selected product dispensed
4	Substitution allowed – generic drug not in stock
5	Substitution allowed – brand drug dispensed as generic
6	Override
7	Substitution not allowed – brand drug mandated by law
8	Substitution allowed – generic drug not available in marketplace
9	Other – not a valid code for SelectHealth

4.4 Compound Prescriptions

Compounded prescriptions must be prepared following good compounding practices as defined by the United States Pharmacopoeia (USP DI-Volume III: Approved Drug Products and Legal Requirements). The pharmacy will follow USP good compounding practices concerning the following:

> Facility space and equipment

> Source ingredient selection and calculations

> Stability, sterility and beyond-use dating

> Formulation and checklist for acceptable strength, quality and purity

> Compounding log and quality control

Formulation records, compounding logs and quality control records may be subject to review by the SelectHealth Pharmacy Auditors. Claim dollars for compounded prescriptions found not following good compounding practices will be subject to adjustment.

All active ingredients in a compounded prescription must be FDA-approved for human use and must be covered under the member's plan. The SelectHealth Pharmacy Help Desk is available to assist in determining a member's coverage. Dispensing quantity limitations apply to all covered compounded prescriptions. (see "Quantity Dispensed" section)

In accordance with NCPDP version D.0 as mandated by HIPAA 5010, SelectHealth processes multi-ingredient compounds. Each NDC should be included in the compound segment of the transaction. Refer to the SelectHealth payer sheet in appendix A for additional requirements. Compounded prescriptions where the reimbursement due to the pharmacy exceeds $75.00 will require a review from the SelectHealth Pharmacy Help Desk and an official prior authorization request may be required.

4.4.1 Non-covered Ingredients

The cost of non-covered ingredients may not be billed or collected from an enrollee of a SelectHealth plan when there are covered ingredients of the compound.

5.0 Appeals and Grievances

SelectHealth Commercial and PBM Products and SelectHealth Community Care (Utah State Medicaid)

Please direct all appeals or grievances concerning claim submission, status, processing, and reimbursement, by phone through the SelectHealth Pharmacy Help Desk or Member Services line, or in writing, to:

SelectHealth

Attn: Pharmacy Department

5381 Green Street

Murray, UT 84123

Fax: **801-442-3006**

SelectHealth Advantage (Medicare Part D)

A grievance is an escalated complaint from a Medicare member regarding a specific issue as it relates to the service they received. For example, an official grievance is not filed over specific formulary rules or plan costs, but rather would be related to the timeliness of filling a prescription or if the member received other poor service. Members are welcome to contact SelectHealth through the Medicare Member Services line, fax line, or through U.S. mail.

6.0 Audit Information

SelectHealth regularly monitors and audits pharmacy claims. Part of this process is accomplished by the pharmacy providing access at reasonable times upon request by either SelectHealth or their designee or any governmental regulatory agency to inspect the facilities, equipment, books and records of the pharmacy. This includes, but is not limited to, member records and all prescription dispensing records. A notice will be sent to the pharmacy location that has filled the prescription(s) in question. A description of the issue under review will be included, along with specific claim related information.

The pharmacy is given sixty (60) days from the date of the letter to respond, depending on the scope of the audit. If a response is not received within this period, this will be interpreted as non-compliance and the pharmacy is subject to adjustment of the paid dollars on those claims.

Additionally, when billing discrepancies are identified by SelectHealth and are disclosed to the pharmacy, the pharmacy is given fourteen (14) days to review/dispute the findings. If a response is not received within this time, this will be interpreted as consent to the finding and the adjustments will be reflected on the pharmacy's next remittance cycle.

When necessary, extensions will be granted if the pharmacy contacts SelectHealth within the specified time.

7.0 Formulary Information

7.1 SelectHealth Commercial and PBM Products

Covered Medications and Services

Covered prescription drugs and pharmacy services include most medications which require a prescription by state or federal law when prescribed by a physician and listed on the SelectHealth drug formulary. Among other medications, this includes the following:

> Injectable insulin and insulin syringes when written on a prescription

> Compounded medications that are prepared following good compounding practices as defined by the United States Pharmacopoeia (USP DI-Volume III: Approved Drug Products and Legal Requirements). (see "Compound Prescriptions" section)

> Oral contraceptives (plan specific)

> Blood glucose test strips

> Flu vaccine

Covered Injectable and Specialty Medications

Most SelectHealth plans have specialty benefits incorporated in the benefit structure. This allows pharmacies to bill covered injectable drugs and specialty medications through the pharmacy benefit. Some injectable drugs may be covered under other tiers of the pharmacy benefit when not classified as a specialty injectable medication according to SelectHealth formularies.

For questions on coverage of specific injectable and specialty medications, the pharmacy may contact the SelectHealth Pharmacy Help Desk for assistance.

Generally Excluded Medications and Services

Most prescription drugs for covered medical conditions are covered by the prescription drug benefits. However, unless noted otherwise in plan documents or preauthorized as an exception by the plan, the following drugs are not covered under the prescription drug benefit but may be covered elsewhere under the medical benefit.

> All non-prescription contraceptive jellies, ointments, foams and/or devices, such as IUDs

> Appetite suppressants and weight loss medications

> Certain off-label drug usage, unless the use has been approved by a SelectHealth Medical Director or clinical pharmacist

> Compound drugs when alternative products are available commercially

> Cosmetic agents, health or beauty aids or prescriptions used for cosmetic purposes, including minoxidil for hair growth

> DMSO (dimethyl sulfoxide)

> Drugs or medicines delivered or administered to the member by the prescriber or the prescriber's staff

> Drugs or medicines purchased and received prior to the member's effective date of coverage or after the member's termination of coverage

> Food supplements, food substitutes, medical foods and formulas (covered only when preauthorized for members with amino acid disorders)

> Human growth hormone (unless preauthorized as medically necessary)

> Immunizing agents, injectables, biological sera, blood or blood plasma, or medications prescribed for parenteral use or administration

> Infertility medications

> Medication not requiring a prescription, even if ordered by a participating provider by means of a prescription, medications prescribed by a physician or referral specialist who is not a participating provider with SelectHealth, drugs which are not medically necessary or which are used inappropriately

> Medication which may be properly received without charge under local, state or federal programs or which are reimbursable under other insurance including Worker's Compensation

> Medications not meeting the minimum levels of evidence based upon Food and Drug Administration (FDA) approval OR SelectHealth accepted drug compendia, such as Drugdex (category 1-2b) and National Comprehensive Cancer Network (NCCN) (category 1-2A), if applicable

> Medications to be taken or administered to the eligible member while he or she is a patient in a hospital, rest home, nursing home, sanitarium or other institution

> Minerals, fluoride, vitamins (other than prenatal for use during pregnancy or nursing)

> Nonprescription vitamins

> Over-the-counter (OTC) medications, except when all of the following conditions are met:

- The OTC medication is listed on the SelectHealth formulary as a covered medication
- The SelectHealth Pharmacy & Therapeutics Committee has approved the OTC medication as a medically appropriate substitution of a prescription drug or medication
- The member has obtained a prescription for the OTC medication from a licensed provider and filled the prescription at a participating pharmacy

> Prescriptions written by a licensed dentist, unless for the prevention of infection or pain in conjunction with a dental procedure

> Progesterone suppositories and progesterone powder (micronized progesterone), except when prior authorized during pregnancy or other FDA-approved use

> Therapeutic devices or appliances including hypodermic needles, syringes, support garments and other non-medicinal substances (except insulin syringes, glucose test strips, inhaler extensions)

7.2 SelectHealth Advantage (Medicare Part D)

Covered Medications and Services

The SelectHealth formulary for the Medicare Advantage plan has five tiers with coverage of most Part D generic drugs and most Part D brand drugs.

Any injectable medication considered part of the Medicare Part D benefit will be eligible for processing under the member's pharmacy benefit, even if the service is submitted under the medical benefit.

Generally Excluded Part D Medications

Non-Part D drugs, including prescription drugs covered by Part A or part B and other drugs excluded from coverage by Medicare.

Diabetic Supplies

Lancets and Test Strips, through part of the Medicare Part B benefit, will be allowed to process at the pharmacy through the POS.

Step Therapy

SelectHealth Advantage requires Step Therapy for certain drugs. This means that certain drugs are covered by the Medicare plan only after the member has tried the alternative therapy without success.

Exceptions and Coverage Determinations

At any time, a member may request a coverage determination or an exception to a prior authorization requirement or other edit imposed by the Medicare Part D plan. The individual member, member's representative or the prescribing physician or other prescriber may initiate the exception request. Common reasons coverage determination or an exception is requested are as follows:

> Request for coverage of a drug that requires prior authorization

> Request for coverage of a drug that is not covered on the plan's formulary

> Request to bypass step therapy or quantity limit restrictions

> Request to cover a drug at a lower tier

If an exception is approved, it will generally be honored for the remainder of the plan year with no requirement to initiate another coverage determination each time the medication is being filled.

There is no guarantee that a request for exception will be granted. Each request will be evaluated individually based on the situation at hand.

Part B and Part D Benefit Overlap

Drugs that are eligible under a member's Medicare Part B benefit are not eligible for coverage under the Part D benefit. The determination for under which benefit a drug will be covered is not just determined by the drug itself, but also its indication and administration. Medicare Part B covers a limited list of specific drugs including injectable and infusible drugs that are not usually self-administered. Edits will be applied in the SelectHealth system to manage these rules at adjudication.

Exceptions to Plan Coverage

Exceptions to SelectHealth Medicare Plan coverage include any pharmacy claims processed from a foreign pharmacy. Claims processed at pharmacies outside the United States will not be paid through the SelectHealth Medicare Advantage program.

7.3 SelectHealth Community Care (Medicaid)

The SelectHealth Community Care plan generally covers all medications included on the Prescription Drug Formulary for Traditional and Non-Traditional enrollees.

There are some drugs that will continue to be covered by the State Medicaid agency. Coverage and applicable costs are not decided by SelectHealth Community Care. Therapeutic classes carved out include:

> Attention deficit hyperactivity disorder (ADHD)

> Antidepressant

> Antianxiety

> Anticonvulsant

> Antipsychotic

> Hemophilia factor

> Immunosuppressive

> Substance abuse (opioid or alcohol)

Medical necessity is evaluated for services typically not covered for children and pregnant women.

General exclusions include the following services.

> Duplicate prescription for lost, stolen, destroyed, spilled, or otherwise non-usable medication with some exceptions

> Compounded prescriptions

> Lozenges, suckers, rapid dissolve, lollipop, pellets, patches, or other unique formulation delivery methodologies developed to garner

"uniqueness," except where the specific medication is unavailable in any other form

> Specific excluded drug classes:

- Cosmetic preparations
- Minerals
- Patches
- Weight gain or loss
- Vitamins, except when provided for:
  - Pregnant women: prenatal vitamins with folic acid (prenatal vitamins are not covered post-delivery)
  - Children through age five: children's vitamin drops with or without fluoride
  - Adults and children of all ages: fluoride supplement

> Covered outpatient drugs that the manufacturer seeks to require as a condition of sale for which associated tests and monitoring services are purchased exclusively from the manufacturer or its designee.

> Agents used for the treatment of sexual or erectile dysfunction.

8.0 Common Reject Messages

09: M/I Birthdate	SelectHealth requires a valid date of birth for the cardholder ID to be submitted in order to verify eligibility and process claims. If the member's date of birth is submitted incorrectly, the pharmacy will receive the M/I Birthdate rejection. When received, the pharmacy should contact the SelectHealth Help Desk to verify the correct information and for assistance in processing.
13: M/I Other Coverage Code	The M/I Other Coverage Code error message may appear when a claim is being submitted to SelectHealth as the secondary payer and SelectHealth does not have record of other health insurance for the member. When received, the pharmacy should contact the SelectHealth Help Desk to verify the correct order of benefits information and for assistance in processing.
40: Pharmacy Not Contracted with Plan on Date of Service	SelectHealth requires an active contract for pharmacies to submit claims for payment at point of sale. When the Pharmacy Not Contracted with Plan on Date of Service error is received, the pharmacy should contact the SelectHealth Help Desk to verify their contract status.
41: Submit Bill to Other Processor or Primary Payor	The Submit Bill to Other Processor or Primary Payor error message may appear when a claim is being submitted to SelectHealth as the primary payer and SelectHealth records has other health insurance on file as the primary payor for the member. When received, the pharmacy should contact the SelectHealth Help Desk to verify the correct order of benefits information and for assistance in processing.
52: Non-Matched Cardholder ID	SelectHealth requires a valid cardholder ID to be submitted in order to verify eligibility and process claims. The ID number is the 9-digit subscriber ID number that can be found on the member's ID card. If the member's ID number or the member's date of birth is submitted incorrectly, the pharmacy will receive the Non-Matched Cardholder ID rejection. When received, the pharmacy should contact the SelectHealth Help Desk to verify the correct information and for assistance in processing.
70: Product/Service Not Covered and MR: Product Not on Formulary	This error messages may appear for a member with a formulary requirement. If this is the case, the online system will not return financial information and the prescription will not be reimbursed by SelectHealth. SelectHealth members have the following options should this rejection be received: > Consult with the prescribing physician to discuss formulary alternatives prior to having the prescription filled > Pay in full for the non-covered medication and discuss formulary alternatives for future fills (this is not reimbursable) > Pay in full for the non-covered medication

Contact the Select Health Member Services line for assistance in determining prescription benefit coverage. Pharmacists may also contact the member's prescribing physician to discuss formulary alternatives and/or formulary exception requests, which can be initiated by the prescribing physician.

Please note that if the member pays in full for the non-covered medication, SelectHealth does not guarantee that reimbursement will be made, either retroactively or for future fills.

71: Prescriber is Not Covered

There are several situations that could cause a Prescriber is Not Covered error. Below are the most common examples:

> SelectHealth requires a valid NPI number for prescriber identification. SelectHealth relies on the pharmacy for submission of accurate information.

> Some plans require that the prescribing physician participate in the SelectHealth physician network for a medication to be covered.

> The prescriber may be sanctioned by the Office of Inspector General (OIG).

75: Prior Authorization Required

There are certain medications that SelectHealth requires prior authorization before the medication can be dispensed to the member. When this rejection is received, the pharmacy may contact the SelectHealth Help Desk to begin the prior authorization process. The SelectHealth Prescription Drug List (PDL) notates the medications that require prior authorization with a "(PA)" in the "Spec. Requirements" column. For the most up-to-date drug information, access the PDL through the SelectHealth website.

76: Plan Limitations Exceeded

The Plan Limitations Exceeded rejection could occur for a variety of reasons, including the following most common:

> Over Quantity Limits:

- This could be caused by a dose optimization issue which would require the prescribing physician's office to change to a different strength of the same medication.
- Alternatively, the prescribing physician can send into SelectHealth a Letter of Medical Necessity (LMN) for review as originally prescribed.
- As a final option, the pharmacy can resubmit the prescription for the amount SelectHealth will allow.

> Cost Exceeds Maximum:

- SelectHealth applies a max cost per prescription of $1,000; in most instances when this reject is received for exceeding the max cost edit, the pharmacy can call the SelectHealth Help Desk for an override.
- Compound medications have a different cost edit of $75 per prescription; in many cases, a compound medication will require a LMN from the prescribing physician to obtain the necessary cost override.

> **Over Day Supply Limits:** SelectHealth applies a max day supply that can vary by plan and by drug. If the pharmacy has questions if this rejection is received, please contact the Pharmacy Help Desk for assistance.

> **Patient Age Exceeds Maximum Age Allowed for Drug:** SelectHealth applies age limitations to applicable medications depending on safety, efficacy, or specialized dosage form.

> **Over Maximum Daily Dose:** SelectHealth may apply a maximum daily dose based on the U.S. Food and Drug Administration (FDA) approved labeling and other accepted drug compendia guidelines meeting minimum levels of evidence.

79: Refill Too Soon

SelectHealth applies an edit for refilled medications that require the medication be 75% gone before a refill can be allowed, for most plans. For controlled substances the edit requires that the medication be 80% gone before a refill can be allowed. Contact the SelectHealth Pharmacy Help Desk for additional information or assistance processing.

88: DUR Reject Error

There are several situations that could cause a DUR Reject Error. Below are the most common examples:

> **Opioid Care Coordination**: SelectHealth will give a soft rejection when prescriptions are written for more than 90 morphine milligram equivalents (MME) daily. For a Medicare or commercial member, the pharmacist must verify dosing and plan with the prescriber. After verification has taken place, the pharmacy can override the edit using a Submission Clarification Code of 07: Medically Necessary. For a Medicaid member the maximum restriction is 90 morphine milligram equivalents (MME) daily and cannot be overridden on the pharmacy side.

> **Opioid High-Dosage Limits**: SelectHealth will reject claims when filling for a high dose opioid, greater than 200 MME for most plans. For Medicaid members, SelectHealth will reject claims when filling for a high dose opioid, greater than 90 MME. The patient or prescriber is required to send a prior authorization request to SelectHealth if they believe an exception should be granted for this restriction.

> **Seven-Day Max Fill For Opioid Naïve Patients**: SelectHealth will only allow a maximum 7-day fill for any patient that is opioid naïve for their first fill. (For a Medicaid member, opioids prescribed by a dentist are limited to a maximum 3-day fill.)

> **Concurrent Benzodiazepine and Opioid Therapy**: SelectHealth will give a soft rejection when a patient has overlapping days supplies of benzodiazepine and opioid medications. The pharmacist must verify dosing and plan with the prescriber. After verification has taken place, the pharmacy can override the edit using a submission clarification code of **07: Medically Necessary**.

> **Multiple Long-Acting Opioid Prescriptions**: SelectHealth will give a soft rejection when a patient attempts to fill more than one long-acting opioid medication with overlapping days supplies. The pharmacist must verify dosing and plan with the prescriber. After verification has taken place, the pharmacy can override the edit using a submission clarification code of 07: Medically Necessary.

569: Provide Notice: Medicare Prescription Drug Coverage and Your Rights

When a claim for a Medicare Part D drug is submitted to the SelectHealth Medicare plan and is not covered on the formulary or exceeds formulary limitations and is outside the Medicare Part D transition fill coverage period, the Provide Notice: Medicare Prescription Drug Coverage and Your Rights rejection will be sent. When this rejection is received and the member must leave the pharmacy without their prescription, the pharmacy is required to provide the member with the Member's Rights document.

608: Step Therapy, Alternate Drug Therapy Required Prior To Use of Submitted Product Service ID

SelectHealth applies Step Therapy edits to certain medications, which will require qualifying medication(s) before SelectHealth will cover the one that is rejecting. If those step therapy rules have not been met, the pharmacy will receive this rejection.

9.0 Payment and Reconciliation Information

9.1 Payment Schedule

SelectHealth Commercial, PBM Products and SelectHealth Community Care (Utah State Medicaid)

For reimbursement to the pharmacies, payment cycles are run every **two (2) weeks**. Checks will be disbursed within **fifteen (15) working days** of the end of the cycle and will be mailed to the pharmacy.

SelectHealth Advantage (Medicare Part D)

For reimbursement to the pharmacies for Medicare claims, SelectHealth will issue, mail, or otherwise transmit payment for all clean claims, submitted by network pharmacies (other than mail-order and long-term care pharmacies) within **(14) days** after the date the claim is received for an electronic claim or **(30) days** after the date the claim is received for any other claim.

9.2 Remittance Report

Each payment to the pharmacy will be accompanied by one copy of the Pharmacy Claims Reconciliation Report. This report will provide a detailed list of all claims submitted during the current cycle for each pharmacy and will provide totals for the reconciliation or the payment amount. This report will include all paid, rejected, and reversed claims for the current processing cycle. As an alternative format, the report can also be made available in 835 format, delivered via sFTP in place of the paper remittance report.

Additional copies of the Claims Reconciliation Summary Report may be obtained by request from the SelectHealth Pharmacy Help Desk. There will be a charge per additional copy requested. Questions regarding the payment cycle and remittance files should be directed to the SelectHealth Pharmacy Networks Team at SHPharmacyContracting@selecthealth.org.

9.3 Electronic Funds Transfer (EFT)

Pharmacies wishing to receive payments via Electronic Funds Transfer (EFT) may submit a request to the SelectHealth Pharmacy Networks Team by emailing SHPharmacyContracting@selecthealth.org._

Please note that pharmacies must receive their Remittance Report via 835 file format. No paper Remittance Report would be supplied to the pharmacy.

9.3.1 340b Claims:
Federal requirements dictate that a rebate or discount is required for all covered outpatient drugs for Medicaid plans. SelectHealth will collect all forfeited rebate amounts resulting from 340B Claims.

10.0 SelectHealth Advantage (Medicare Part D)-Specific Information

10.1 Plan Summary

SelectHealth's Medicare plan is an MA-PD plan that covers parts of Utah, Idaho and Nevada. The plan is committed to following CMS guidelines and ensuring access to necessary medications while working closely with the pharmacies to provide the best customer experience possible.

10.2 Fraud, Waste, and Abuse

It is expected that the provider agrees to adhere to the CMS Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse, and Part D Sponsors' policies and procedures, training and corrective action plans related to the program. Cooperation with the Part D Plan Sponsor includes providing copies of prescriptions, signature logs, and other related documentation to assist in any investigations.

10.3 Training

To be considered a pharmacy in compliance with Medicare Part D rules and regulations, pharmacies must agree under CMS guidelines to provide ongoing Medicare Part D training and documentation to its staff.

As part of the audit process with SelectHealth, copies of this training and record of the staff receiving the training may be required to be produced, as needed.

10.4 Pharmacy Certification for Part D

To process Medicare part D claims for SelectHealth, pharmacies are required to sign a specific Medicare contract addendum. If not signed, any Medicare claims processed to SelectHealth will be rejected at POS.

10.5 Federal Health Care Programs Participation Exclusion

Veterans' Administration benefits are separate and distinct from benefits provided under Medicare Part D, per federal regulations. By law, VA cannot bill Medicare. A beneficiary may not use both VA prescription drug benefits and Part D benefits for a single prescription.

10.6 General Procedures for Acknowledg-ment Letters

To be in compliance with CMS requirements, if a member should present a Part D acknowledgement letter in place of an ID card, the pharmacy should honor that letter as sufficient eligibility to process a claim to SelectHealth for their Medicare Part D benefit. If the presented letter does not contain sufficient information to process a claim to SelectHealth, please contact the SelectHealth Medicare Part D Help Desk for assistance in processing.

10.7 Formulary Transition Fill Plan

In accordance to the transition plan requirements from CMS, SelectHealth will offer short-term coverage for Part D benefits to members that are new to the plan. During this transition period, a member can receive an initial fill of an ongoing medication even if it is not covered under the new Medicare Part D plan (including if it requires prior authorization or step therapy). It is assumed that during this transition period, the member will be working with their physician to identify alternative equivalent medications that are covered under the plan.

10.8 Long-term Care Facilities (LTCs)

For long-term care facilities to process Medicare Part D claims to SelectHealth, the pharmacy is required to sign a specific LTC Medicare contract addendum. If not signed, any Medicare claims processed to SelectHealth will be rejected at POS.

10.9 Home Infusion Therapy

For a home infusion pharmacy to process Medicare Part D claims to SelectHealth, the pharmacy must sign a specific home infusion Medicare contract addendum. If not signed, any Medicare claims processed to SelectHealth will be rejected at POS.

10.10 Medicare Service Area

The SelectHealth Medicare Advantage program covers the following service areas::

> **Utah Counties**: Box Elder, Cache, Davis, Franklin (ID), Garfield, Iron, Juab, Millard, Morgan, Piute, Rich, Salt Lake, Sanpete, Sevier, Summit, Tooele, Utah, Washington, Wayne, Weber

> **Idaho Counties**: Ada, Adams, Boise, Canyon, Cassia, Elmore, Gem, Gooding, Jerome, Minidoka, Owyhee, Payette, Valley, Twin Falls, Washington

> **Nevada Counties**: Clark, Nye

11.0 SelectHealth Community Care (Medicaid)-Specific Information

Pharmacies that contract to provide services to SelectHealth Community Care members must also be a participating provider with Utah Medicaid. See the **Utah State Medicaid Provider Manual** for more information.

11.1 Tamper-Resistant Prescription Pad Requirements

All written prescriptions for drugs under the Medicaid program must be on tamper-resistant prescription pads.

Compliance with all federal and state laws regarding the types of documentation and how prescriptions are filled must be maintained.

To be considered "tamper resistant," Medicaid written prescriptions must contain one or more industry-recognized features designed to **prevent**:

1. Unauthorized copying of a completed or blank prescription form;
2. The erasure or modification of information written on the prescription by the prescriber; and
3. The use of counterfeit prescription forms.

11.2 Generic Preparations

Medicaid requires use of generic drugs, unless the physician obtains a prior approval for the brand name drug. However, Medicaid does not pay for generic house-brand or store brand products unless the manufacturer has entered into a rebate agreement for each specific NDC number. Manufacturers that have not entered the federal rebate program will not have their products covered. This includes almost all 'house brand' and 'store brand' products.

11.3 Medications Provided in a Medical Emergency

Some medications that require PA may be provided in a medical emergency before authorization is obtained from SelectHealth. When a medical emergency occurs, and a medication requiring a prior authorization is required, pharmacy providers may provide up to a 72-hour supply of the medication. When contacted, Medicaid will issue an authorization for the 72-hour supply of the medication on the next business day. All subsequent quantities must meet all plan requirements for the medication. It is the responsibility of the medication prescriber to provide the necessary documentation.

11.4 Restriction Program

SelectHealth Community Care enrollees who inappropriately utilize health care services may be enrolled in the Restriction Program. Enrollees are identified for enrollment through:

> Periodic review of patient profiles to identify inappropriate over-utilization of medical providers, urgent care centers, specialists, medications, and/or pharmacies.

> Verbal and written reports of inappropriate use of services generated by one or more health care providers regarding the member. These reports are verified through a review of the patient's claim history by Medicaid staff and medical consultants.

> Referral from Medicaid staff.

Enrollees in the Restriction Program are informed of the reasons for enrollment, counseled in the appropriate use of health care services, and assigned a Primary Care Provider and a pharmacy. In addition to the SelectHealth Community Care card, enrollees will receive a Utah Medicaid card, which identifies the enrollee as "RESTRICTED" below the eligibility information and above the members name. These clients must receive all healthcare services through either the assigned primary care provider or receive a referral from this primary care to see any other provider. All pharmacy services must be received from the assigned pharmacy. SelectHealth will only pay claims for services rendered by providers:

> Listed on the card; and

> From whom members were appropriately referred.

Emergency services are not restricted to assigned providers.

Appendix: Payer Sheet

General Information

Payer Name: SelectHealth, Inc.	Date: 1/1/2022		
Plan Name/Group Name:	**BIN:**	**PCN:**	**GROUP:**
SelectHealth Commercial	8ØØØØ8	Not required	Not required
Scripius (PBM)	8ØØØØ8	Not required	Not required
SelectHealth Community Care (Medicaid)	8ØØØØ8	6Ø6	Not required
SelectHealth Advantage (Medicare)	Ø15938	7463	Printed on card
SelectHealth Worker's Compensation	Ø183Ø8	WCØØ1	Not required
Intermountain Rx Charity Program	Ø24Ø61	PA123	Not required
Effective as of: 9/21/2020	NCPDP Telecommunication Standard Version/Release: DØ ECL version: July 2Ø14		
Certification Testing Window: N/A			
Certification Contact Information: Rx_BA@imail.org			
Provider Relations Contact Information: SHPharmacyContracting@selecthealth.org			
Other Contact Information: SelectHealth Pharmacy Services 8ØØ-442-3129 M-F 7:ØØ AM – 8:ØØ PM (MT) Sat 9:ØØ AM – 3:ØØ PM (MT) SelectHealth Advantage (Medicare) Pharmacy Services 855-442-9988 Medicare Assistance Available 24 hours a day / 7 days a week			
Maximum Number of Transactions Supported Per Transmission	1 – Medicare 4 – Commercial/Medicaid		
Submission and Reversal Window (days from date filled/dispensed to date submitted)	Commercial	9Ø Days	
	Medicaid	9Ø Days	
	Medicare	9Ø Days	
	If an exception is needed, please contact the SelectHealth Pharmacy Services		

Supported Transactions

Transaction Code	**Transaction Type**
B1, B3	Billing
B2	Reversal
E1	Eligibility Inquiry

Appendix: Payer Sheet, continued

Table Legend

Payer Usage	Value	Explanation	Payer Situation
Mandatory	M	Mandatory for the segment in the designated transaction in accordance with NCPDP Telecommunication Implementation Guide, Version DØ.	No
Required	R	Required as defined by the processor.	No
Qualified Requirement	RW	Required as defined by the situation.	Yes

Segment and Field Requirements

The following lists the segments and fields in a Billing transaction based on the NCPDP Telecommunication Standard Implementation Guide Version DØ.

Fields that are not used in the Claim Billing/Claim Rebill transaction, and those that do not have qualified requirements (e.g. not used) for this payer, are excluded.

Claim Billing/Claim Rebill Transaction

Transaction Header Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
1Ø1-A1	BIN Number	M	8ØØØØ8 = Commercial/Medicaid/PBM Ø15938 = Medicare Ø183Ø8 = Workers' Compensation Ø24Ø61 = Intermountain Rx Charity Program
1Ø2-A2	Version/Release Number	M	DØ
1Ø3-A3	Transaction Code	M	B1, B3
1Ø4-A4	Processor Control Number	M	6Ø6 = Medicaid 7463 = Medicare PA123=Intermountain Rx Charity Program
1Ø9-A9	Transaction Count	M	Ø1 = 1 occurrence (Required for Medicare) Ø2 = 2 occurrences Ø3 = 3 occurrences Ø4 = 4 occurrences
2Ø2-B2	Service Provider ID Qualifier	M	Ø1 – NPI
2Ø1-B1	Service Provider ID	M	1Ø digit NPI number

Appendix: Payer Sheet, continued

4Ø1-D1	Date of Service	M	CCYYMMDD
11Ø-AK	Software Vender/Certification ID	M	Use value for Switch's requirements or send spaces

Insurance Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø4 – Insurance Segment
3Ø2-C2	Cardholder ID	M	9 character ID beginning with 8Ø
312-CC	Cardholder First Name	R	
313-CD	Cardholder Last Name	R	
3Ø3-C3	Person Code	R	Submit only if instructed by Pharmacy Services
3Ø6-C6	Patient Relationship Code	R	
36Ø-2B	Medicaid Indicator	RW	Submit when patient has Medicaid coverage
115-N5	Medicaid ID Number	RW	Required if known, when patient has Medicaid coverage
3Ø1-C1	Group ID	RW	Required for all Medicare Part D claims: U1ØØØØØ9 U1ØØØØ1Ø U1ØØØØ11 Required only if printed on card or otherwise communicated by SelectHealth for Workers' Compensation claims.

Patient Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø1 – Patient Segment
331-CX	Patient ID Qualifier	M	Ø4 – Health Plan Assigned
332-CY	Patient ID	M	
3Ø4-C4	Date of Birth	R	
3Ø5-C5	Patient Gender Code	R	1 = Male 2 = Female
31Ø-CA	Patient First Name	R	
311-CB	Patient Last Name	R	
384-4X	Patient Residence	RW	Required for all Medicare Part D claims: Ø – Not Specified 1 – Home

Appendix: Payer Sheet, continued

			2 – Skilled Nursing Facility (Part B only with prior authorization) 3 – Nursing Facility (required for Part D Short-Cycle Dispensing claims) 4 – Assisted Living Facility 5 – Custodial Care Facility (Part B only with prior authorization) 6 – Group Home 9 – Intermediate Care Facility/Mentally Retarded 11 – Hospice
3Ø7-C7	Place of Service	RW	Required for all Medicare Part D claims

Claim Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
This payer does not support partial fills		X	Pharmacies should reverse and reprocess initial claim when they have satisfied the requirements as written on the prescription
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø7 – Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	M	1 = Rx Billing
4Ø2-D2	Prescription/Service Reference Number	M	
436-E1	Product/Service ID Qualifier	M	Ø3 – National Drug Code (NDC)
4Ø7-D7	Product/Service ID	M	NDC
442-E7	Quantity Dispensed	R	
4Ø3-D3	Fill Number	R	Ø = Original Dispensing 1-99 = Refill Number
4Ø5-D5	Days Supply	R	
4Ø6-D6	Compound Code	R	1 – Not a Compound 2 – Compound
4Ø8-D8	Dispense As Written (DAW)/Product Selection Code	R	
414-DE	Date Prescription Written	R	CCYYMMDD
415-DF	Number of Refills Authorized	R	
419-DJ	Prescription Origin Code	R	1 – Written 2 – Telephone 3 – Electronic (excludes fax, e-mail, internal clinic messaging system or a physician printing to a

Appendix: Payer Sheet, continued

			printer at the pharmacy) 4 – Facsimile (fax) 5 – Pharmacy
42Ø-DK	Submission Clarification Code	RW	Required for Medicaid 34ØB claims: 2Ø – 34ØB Required for Medicare Part D claims when Patient Residence = 3: 16 – LTC Emergency Box (Kit) or Automated Dispensing Machine 22 – LTC Dispensing: 7 days 23 – LTC Dispensing: 4 days 24 – LTC Dispensing: 3 days 25 – LTC Dispensing: 2 days 26 – LTC Dispensing: 1 day 27 – LTC Dispensing: 4-3 days 28 – LTC Dispensing: 2-2-3 days 29 – LTC Dispensing: Daily and 3-day weekend 3Ø – LTC Dispensing: Per shift dispensing 31 – LTC Dispensing: Per med pass dispensing 32 – LTC Dispensing: PRN on demand 33 – LTC Dispensing: 7 day or less cycle not otherwise represented 34 – LTC Dispensing: 14 days 35 – LTC Dispensing: 8-14 day dispensing method not listed above
3Ø8-C8	Other Coverage Code	RW	1 – No Other Coverage 2 – Other Coverage Exists – Payment Collected 3 – Other Coverage Billed – Claim Not Covered 4 – Other Coverage Exists – Payment Not Collected
453-EJ	Originally Prescribed Product/Service ID Qualifier	RW	Required when medication was changed from the original script
445-EA	Originally Prescribed Product/Service Code	RW	Required if submitting a claim that replaces an originally prescribed product/service
446-EB	Originally Prescribed Quantity	RW	Required if submitting a claim that replaces an originally prescribed product/service
147-U7	Pharmacy Service Type	RW	Required for all Medicare Part D claims
429-DT	Special Packaging Indicator	RW	Required for Medicare Part D claims when Patient Residence Code = 3
46Ø-ET	Quantity Prescribed	RW	Required for all Schedule II drugs

Appendix: Payer Sheet, continued

Pricing Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	11 – Pricing Segment
4Ø9-D9	Ingredient Cost Submitted	R	
412-DC	Dispensing Fee Submitted	R	
481-HA	Flat Sales Tax Amount Submitted	RW	Required when provider is claiming sales tax and its value has an effect on the Gross Amount Due (43Ø-DU) calculation
482-GE	Percentage Sales Tax Amount Submitted	RW	Required when provider is claiming sales tax and its value has an effect on the Gross Amount Due (43Ø-DU) calculation
483-HE	Percentage Sales Tax Rate Submitted	RW	Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX)
484-JE	Percentage Sales Tax Basis Submitted	RW	Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX)
426-DQ	Usual and Customary Charge	M	
43Ø-DU	Gross Amount Due	R	
423-DN	Basis of Cost Determination	R	Ø1 – AWP Ø7 – U&C 1Ø – ASP 12 – WAC

Pharmacy Provider Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø2 – Pharmacy Provider Segment
465-EY	Provider ID Qualifier	R	
444-E9	Provider ID	R	

Prescriber Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø3 – Prescriber Segment
466-EZ	Prescriber ID Qualifier	R	Ø1 – NPI (Required for Medicare) 12 – DEA
411-DB	Prescriber ID	R	
427-DR	Prescriber Last Name	R	

Appendix: Payer Sheet, continued

Coordination of Benefits/Other Payments Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is situational		X	Required only for secondary, tertiary, etc. claims
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø5 – Coordination of Benefits/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count	M	Maximum count of 9
338-5C	Other Payer Coverage Type	M	Ø1 – Primary Ø2 – Secondary Ø3 – Tertiary
339-6C	Other Payer ID Qualifier	R	Ø3 – BIN
34Ø-7C	Other Payer ID	R	BIN
443-E8	Other Payer Date	R	
341-HB	Other Payer Amount Paid Count	RW	Required when Other Payer Amount Paid (431-DV) is specified Maximum count of 9 Value should be greater than zero when OCC = 2 or 4; blank/null when OCC = 3
342-HC	Other Payer Amount Paid Qualifier	RW	Required when Other Payer Amount Paid (431-DV) is specified
431-DV	Other Payer Amount Paid	RW	Required when Other Payer Amount Paid Count (341-HB) is specified Value of the sum of all payers should be greater than zero when OCC = 2; zero when OCC = 4; blank/null when OCC = 3
471-5E	Other Payer Reject Count	RW	Required when claim has been rejected by previous payer(s) and the Other Payer Reject Code (472-6E) is specified Maximum count of 5 Value should be blank/null when OCC = 2 or 4; greater than zero when OCC = 3
472-6E	Other Payer Reject Code	RW	Required when Other Payer Reject Count (471-5E) is specified and Other Coverage Code (3Ø8-C8) = 3 Value should be other payer NCPDP Reject Code
353-NR	Other Payer-Patient Responsibility Amount Count	RW	Required when Other Payer-Patient Responsibility Amount (352-NQ) is specified

Appendix: Payer Sheet, continued

			Maximum count of 25 Allowed if OCC = 2 or 4; not allowed if OCC = 3
351-NP	Other Payer-Patient Responsibility Amount Qualifier	RW	Required when Other Payer-Patient Responsibility Amount (352-NQ) is specified Components of Patient Pay are required for values Ø1 – Ø5 and Ø7 – 13 Usage of Ø6 "Patient Pay as Reported by Previous Payer" accepted as an exception and subject to audit
352-NQ	Other Payer-Patient Responsibility Amount	RW	Required when Other Payer-Patient Responsibility Amount Count (353-NR) is specified and when necessary for state/federal/regulatory agency programs Must be submitted for accurate pricing calculations on OCC 2 and 4, for all SelectHealth Commercial

The COB segment and all required fields must be sent if the Other Coverage Code (3Ø8-C8) = 2, 3, or 4.

Note: When Other Coverage Code (3Ø8-C8) = 2 (Other Coverage Exists – payment collected), fields 341-HB, 342-HC and 431-DV are required.

Compound Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is situational		X	Only required for submission of a compound claim (Field 4Ø6-D6 = 2)
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	1Ø – Compound Segment
45Ø-EF	Compound Dosage Form Description Code	M	Ø1 – Capsule Ø2 – Ointment Ø3 – Cream Ø4 – Suppository Ø5 – Powder Ø6 – Emulsion Ø7 – Liquid 1Ø – Tablet 11 – Solution 12 – Suspension 13 – Lotion 14 – Shampoo 15 – Elixir 16 – Syrup 17 – Lozenge 18 – Enema
451-EG	Compound Dispensing Unit Form Indicator	M	1 – Each 2 – Grams 3 – Milliliters
447-EC	Compound Ingredient Component Count	M	Count must match the submitted number of repetitions Maximum 25 ingredients

Appendix: Payer Sheet, continued

488-RE	Compound Product ID Qualifier	M	Ø3 - NDC
489-TE	Compound Product ID	M	Component NDC(s) of compound
448-ED	Compound Ingredient Quantity	M	Amount expressed in metric decimal units
449-EE	Compound Ingredient Drug Cost	R	
49Ø-UE	Compound Ingredient Basis Of Cost Determination	R	
362-2G	Compound Ingredient Modifier Code Count	R	Maximum count of 1Ø
363-2H	Compound Ingredient Modifier Code	R	

Note: The sum of all Compound Ingredient Drug Costs (449-EE) must equal Ingredient Cost Submitted (4Ø9-D9).

Clinical Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is situational		X	Only required for a few select groups and only on select drug classes
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	13 - Clinical Segment
491-VE	Diagnosis Code Count	R	Maximum count of 5
492-WE	Diagnosis Code Qualifier	R	
424-DO	Diagnosis Code	R	

DUR/PPS Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is situational		X	Required to receive a service fee on certain vaccines
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
438-E3	Service Fee	R	
441-E6	Result of Service Code	R	1A 1D 1G 1J 1B 1E 1H 1K 1C 1F 1I 3N
439-E4	Reason for Service Code	R	A valid Reason for Service Code must be submitted
44Ø-E5	Professional Service Code	R	A valid Professional Service Code must be submitted

Appendix: Payer Sheet, continued

Worker's Compensation Segment		Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is situational		X	Only required for submission of a compound claim (Field 4Ø6-D6 = 2)
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	06 – Woker's Compensation Segment
434-DY	Date of Injury	M	CCYYMMDD
315-CF	Employer Name	RW	
316-CG	Employer Street Address	RW	
317-CH	Employer City Address	RW	
318-CI	Employer State	RW	
319-CJ	Employer Zip/Postal Code	RW	
320-CK	Employer Phone	RW	
321-CR	Carrier ID	RW	
435-DZ	Claim/Reference ID	RW	

Claim Reversal Transaction

Transaction Header Segment		Check	Claim Reversal If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
1Ø1-A1	BIN Number	M	Same value as Claim Billing transaction
1Ø2-A2	Version/Release Number	M	DØ
1Ø3-A3	Transaction Code	M	B2
1Ø4-A4	Processor Control Number		Same value as Claim Billing transaction
1Ø9-A9	Transaction Count	M	Maximum of 4 transactions
2Ø2-B2	Service Provider ID Qualifier	M	Same value as Claim Billing transaction
2Ø1-B1	Service Provider ID	M	Same value as Claim Billing transaction
4Ø1-D1	Date of Service	M	Same value as Claim Billing transaction
11Ø-AK	Software Vendor/Certification ID	M	Use value for Switch's requirements or send spaces
Insurance Segment		**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø4 – Insurance Segment
3Ø2-C2	Cardholder Id	M	Same value as Claim Billing transaction

Appendix: Payer Sheet, continued

Claim Segment		**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø7 – Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	M	1 – Rx Billing
4Ø2-D2	Prescription/Service Reference Number	M	Same value as Claim Billing transaction
436-E1	Product/Service ID Qualifier	M	Same value as Claim Billing transaction
4Ø7-D7	Product/Service ID	M	Same value as Claim Billing transaction
4Ø3-D3	Fill Number	RW	Required when multiple fills of the same Prescription/Service Reference Number (4Ø2-D2) occur on the same day
3Ø8-C8	Other Coverage Code	RW	Same value as Claim Billing transaction

Pricing Segment		**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	11 – Pricing Segment
43Ø-DU	Gross Amount Due	R	Same value as Claim Billing transaction

Coordination of Benefits/Other Payments Segment		**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is situational		X	Required only for secondary, tertiary, etc. claims
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø5 – Coordination of Benefits/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count	M	Maximum count of 9
338-5C	Other Payer Coverage Type	M	Same value as Claim Billing transaction

Testing Information

Test BIN	8ØØØØ8
Test PCN	DØTEST
SelectHealth is the primary insurer for this test patient	
Cardholder ID	8ØØØØØØØØ
Person Code	ØØØ
Patient Name	Fred Select
Patient Date of Birth	11/15/1958
Relationship	1 – Cardholder
Gender	1 – Male
SelectHealth is the secondary insurer for this test patient	
Cardholder ID	8ØØØØØØØØ
Person Code	ØØ1
Patient Name	Sally Select
Patient Date of Birth	Ø3/Ø8/196Ø
Relationship	2 – Spouse
Gender	2 – Female