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

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

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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

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. 05/11)

The card swipe function will still be available on the VeriFone POS Terminal for pharmacy providers who are designated by the NYS Office of Medicaid Inspector General (OMIG) as card swipe providers. Designated pharmacies must swipe the member's card through the VeriFone POS Terminal using transaction type 5. No data should be entered into the terminal. OMIG will match the transactions to ensure a swipe was performed. A provider has 14 days from the date of fill (including the date of fill) to swipe the member's card in order for a favorable swipe transaction to occur. The swipe only has to be done once per each member, per date of fill, regardless of the number of prescriptions being filled that day, for that particular member.

The card swipe will result in a full eligibility response.

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. 05/11)

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, 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.

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 Pro-DUR/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. 05/11)

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.

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. 11/11)

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
TD Therapeutic Duplication	R	**1**	An Original Prescription that duplicates a therapy the member is already taking.
ER Drug Overuse	R	**1**	Prescription is a Refill and is being filled prior to 75% of the previously dispensed amount having been used.

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

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

Other Pharmacy Indicator (529-FT)

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

0 = Not Specified
1 = Your Pharmacy
3 = 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:

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

Conflict Code Free Text Descriptions

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

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.

Example
TD 1 1 20020926 0000030000 1 1 **PROPRANOLOL 10MG TABLET 030**

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

ER

Example
ER 1 1 20080727 0000030000 1 1 **REJECT – DRUG OVERUSE 081808**

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

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

INF Increased effect of former drug

Example
DD 2 1 20021011 0000030000 1 1 **INF DIGITALIS/KALURETICS**

DEF Decreased effect of former drug

Example
DD 2 1 20021012 0000030000 1 1 **DEF CORTICOSTEROIDS/BARBITURAT**

INL Increased effect of latter drug

Example
DD 3 1 20021003 0000030000 1 1 **INL VERAPAMIL/DIGOXIN**

DEL Decreased effect of latter drug

Example
DD 2 1 20020920 0000060000 1 1 **DEL NSAID/LOOP DIURETICS**

CODE **FREE TEXT DESCRIPTION**

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**

Example							
PG	2	0	00000000	0000000000	1	0	**LACTATION PRECAUTION**

CODE	FREE TEXT DESCRIPTION

PA For pediatric precautions the word **PEDIATRIC**

Example							
PA	1	0	00000000	0000000000	1	0	**PEDIATRIC**

For geriatric precautions the word **GERIATRIC**

Example							
PA	1	0	00000000	0000000000	1	0	**GERIATRIC**

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

Example								
LD	1	0	00000000	0000000000	1	0	**3.000**	**12.000**

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

Example								
HD	1	0	00000000	0000000000	1	0	**1.000**	**8.00**

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. 05/11)

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
Bin Number	All requests must send **004740**. In most cases, this information is automatically provided by your computer software. (101-A1)
Cardholder ID Number	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)
Date of Birth	The Date of Birth is the date the member was born, which is provided on the member's benefit card. Format = CCYYMMDD (304-C4)
Date of Service	The Date of Service is the date the prescription was filled. The current date must be used for DVS transactions. (401-D1)
ETIN	The 3 or 4 character Electronic Transmitter Identification Number entered in the **Processor Control Number** assigned to the provider. (104-A4)
Patient First Name	Required when a patient has a first name. (310-CA)
Patient Gender Code	The patient gender code indicates the member's gender as follows: **1** = Male **2** = Female (305-C5)
Patient Last Name	Enter patient's last name. (311-CB)

FIELD	DESCRIPTION
Pharmacist's Initials	The Pharmacist's Initials entered in the **Processor Control Number** provides the first and last initial of the person submitting the claim. (104-A4)
PIN	The four digit PIN entered in the **Processor Control Number** is the Personal Identification Number previously selected by the provider and submitted to the Department of Health. (104-A4)
Place of Service	Code identifying the place where a drug or service is dispensed or administered. Refer to external code list at https://www.cms.gov/ Search for Place of Service Codes. (307-C7)
Pregnancy Indicator	This code will specify whether the patient is pregnant. Valid values are: Blank = Not Specified **1** = Not pregnant **2** = Pregnant (335-2C)
Processor Control Number	Information entered in the Processor Control Number is used to indicate that you are requesting **Electronic Claim Capture and Adjudication**. The following fields are required by Pro-DUR/ECCA if you are requesting your claim(s) to be captured for adjudication by the eMedNY contractor. If you have been issued a four digit ETIN, you may omit the "Y" (Read Certification Statement) Indicator in the first byte. **Read Certification Statement Indicator (omit when ETIN length is 4)** **Pharmacist's Initials** **PIN** **ETIN** (104-A4)
Service Provider ID (aka Pharmacy Number)	This field must contain the ten digit NPI number. (201-B1)
Service Provider ID Qualifier	Enter **01** = National Provider Identification (NPI) (202-B2)
Software Vendor/Certification ID	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
Transaction Code	This field identifies the type of transaction request being submitted. Acceptable codes are: B1 = Rx Billing B2 = Rx Reversal Note: B2 is used to cancel a previous transaction. Please refer to section on Reversals 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 S1 = Service Billing S2 = Service Reversal S3 = Service Rebill (103-A3)
Transaction Count	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. **E1 =** Eligibility **(1 only)** **B1 =** Billing submit from **1 to 4** **B2 =** Reversal submit **1** per transaction for NYS. If reversing a four (4) line transaction submit each line on a separate B2 transaction. **B3 =** Rebill submit from **1 to 4**. **P1 =** Billing with P.A. Request submit only **1** **P2 =** P.A. Reversal submit only **1**. **P4 =** P.A. Request Only submit only **1**. **N1 =** DUR Info Report submit from **1 to 4**. **N2 =** DUR Reversal submit **1** per transaction. **N3 =** DUR Rebill submit from **1 to 4**. **S1** = Service Billing submit from **1 to 4**. **S2** = Service Reversal submit only **1.** **S3** = Service Rebill submit from **1 to 4**. (109-A9)

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

5.2 Claim Information Fields (Rev. 11/11)

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

FIELD	DESCRIPTION
Basis of Cost Determination	The Basis of Cost Determination Code indicates the method by which (Ingredient Cost Submitted) was calculated. Use value **05 (Acquisition) when billing claims for Clotting Factor Products to indicate that the actual acquisition cost has been reported on the claim.** Use value **09 (Other)** when submitting claims for which a drug rebate has been received as a participant of a 340B Drug Purchasing Program. (423-DN)
Compound Code	The Compound Code identifies the type of prescription as follows: **1 =** Not a compound **2** = Compound - use when dispensing a compound drug. (406-D6)
Compound Dispensing Unit Form Indicator	This field is used to enter the NCPDP Standard Product billing code. (451-EG)
Compound Dosage Form Description Code	This field is used to enter the Dosage form of the complete Compound mixture. (450-EF)
Compound Ingredient Component Count	This field is used to enter the number of ingredients reported for the Compound claim. A maximum of 25 ingredients is allowed. (447-EC)
Compound Product ID	This field is used to specify the Product Identification of an ingredient used in a Compound. Enter the NDC code of the drug. (489-TE)
Compound Product ID Qualifier	Enter a code qualifying the type of product dispensed. Enter: • 03= NDC (488-RE)
Compound Ingredient Quantity	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

FIELD	DESCRIPTION
	Dispensed). (448-ED)
Compound Ingredient Drug Cost	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)
Compound Ingredient Basis of Cost Determination	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)
Compound Type	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)
Date Prescription Written	The Date the Prescription was written is entered in this field. The Date Prescription Written must be no more than 60 days prior to the **Date Filled** for original scripts. For Refills, the Date Prescription Written cannot be over 180 days old from the **Date Filled.** (414-DE)
Days Supply	The Days Supply is the estimated number of days that the prescription should last. New York State does not accept a days supply greater than 366. When the prescription's directions state "take as directed" (PRN), it is strongly advised that 180 be entered as the days supply. (405-D5)
Delay Reason Code	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)
Diagnosis Code	Code Identifying the diagnosis of the patient. When submitting the decimal point is always implied. (424-DO)
Diagnosis Code Count	Count of diagnosis occurrences. 1 to 5 Diagnosis Codes may be sent. (491-VE)
Diagnosis Code Qualifier	Code qualifying the 'Diagnosis Code' being sent. '**01**' = International Classification of Diseases (ICD9). (492-WE)

FIELD	DESCRIPTION
Dispense As Written (DAW)/Product Selection Code	Acceptable values for the Dispense As Written (DAW) code are as follows: **0** = No product selection **1** = Substitution not allowed by prescriber **2** = Substitution allowed – Patient Request Product Dispensed **3** = Substitution allowed – Pharmacist Select Product Dispensed **4** = Substitution allowed - Generic Drug not in stock **5** = Substitution allowed - Brand Drug dispensed as a Generic **6** = Override **7** = Substitution not allowed - Brand Drug mandated by Law **8** = Substitution allowed - Generic Drug not available in the Marketplace **9** = Substitution allowed by Prescriber – Plan Request Brand (408-D8)
Eligibility Clarification Code	The Eligibility Clarification Code is used to indicate: • An eligibility override for Excess Income/Spenddown when the member's spend down has been met but eligibility has not been updated on file. • 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: **2** = Override (309-C9)
Fill Number	The maximum number of refills allowed is 5. This value cannot be greater than the **Number of Refills Authorized**. (403-D3)
Number of Refills Authorized	The Number of Refills Authorized is entered in this field. New York State only allows a maximum of 5 refills. (415-DF)

FIELD	DESCRIPTION
Other Coverage Code	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: **0** = Not Specified – **1** = No Other Coverage Identified **2** = Other Coverage Exists, Payment Collected – Use for Medicare Part B **3** = Other Coverage Exists, This Claim Not Covered. **4** = Other Coverage Exists, Payment Not Collected (308-C8)
Other Payer Amount Paid	The amount qualified by the Other Payer Amount Paid Qualifier. (431-DV)
Other Payer Amount Paid Qualifier	Codes qualifying the Other Payer Amount Paid in field 431-DV. (342-HC)
Other Payer ID	ID assigned to the payer when submitting electronically. For Medicare Part B use: Medicare Managed Care = **13** Medicare Part B = Carrier Number Commercial Payers (TPL) = **99** (340-7C)
Other Payer Date	Payment or denial Date of the claim being submitted for coordination of benefits. (443-E8)
Other Payer Amount Paid Count	Other payer amount paid count which is the count of other payer amount occurrences. (341-HB)
Other Payer ID Qualifier	Code qualifying the 'Other Payer ID'. (340-7C) NYSDOH will process using the following codes. **05 =** Medicare Carrier No. **99** = Medicare Managed Care or Commercial Insurance (TPL) (339-6C)

FIELD	DESCRIPTION
Other Payer Coverage Type	Code identifying the sequence of payment responsibility for the Other Payer ID. (340-7C) (338-5C)
Other Payer Patient Responsibility Amount	Enter the Patient Responsibility as determined by the previous payer. Example: If field 351-NP = (01-Deductible), then enter Deductible Amount. (352-NQ)
Other Payer Patient Responsibility Amount Count	Enter the count of the Payer-Patient Responsibility Amount occurrences (351-NP / 352-NQ) – (Max 25). (353-NR)
Other Payer Patient Responsibility Amount Qualifier	This code qualifies the Patient Responsibility amount entered in 352-NQ. The amounts used by Medicaid are as follows: • Blank = Not Specified • 01= Deductible Amount • 05= Co-Payment Amount • 07= Coinsurance Amount (351-NP)
Other Payer Reject Count	Number of third party denial codes. (471-5E)
Other Payer Reject Code	Enter the rejection code that was received from the primary payer. (472-6E)
Patient First Name	Required when the patient has a first name. (310-CA)
Patient Last Name	Enter the Patient's last name. (311-CB)
Patient Paid Amount Submitted	This field is used by the pharmacy to enter the dollar amount collected toward satisfying the member's spend down requirement. **Note:** If the spend down was previously met but the eligibility file has not yet been updated, enter zeroes in this field. Refer to Section 2.10 on page 2.10.1 for additional information on this field. (433-DX)
Place of Service	Code identifying the Place where a drug or service is dispensed or administered. Enter Place of Service. Note: Refer to https://www.cms.gov/ Search for Place of Service Codes.

FIELD	DESCRIPTION
	(307-C7)
Primary Care Provider ID	Enter the NPI of the primary care provider the member is restricted to. (421-DL)
Primary Care Provider ID Qualifier	Enter 01 (NPI) (468-2E)
Prior Authorization Number Submitted	Enter the 11 digit Prior Authorization Number when applicable . (462-EV)
Prior Authorization Type Code	This code will specify co-pay exemption or clarify a Prior Authorization request or submission. Valid values are: **00** = Not specified **01** = Prior Authorization **04** = Exemption from co-pay (461-EU)
Prescriber ID	Enter the NPI of the Prescriber. (411-DB)
Prescriber ID Qualifier	Enter 01 (NPI) (466-EZ)
Prescription Origin Code	Code indicating the origin of the prescription. (419-DJ)
Prescription/Service Reference Number	The Prescription Number assigned by the pharmacy. (402-D2)
Prescription/Service Reference Number Qualifier	Indicates the type of billing submitted. Valid Values are: **1 = Rx Billing for B1, B2, B3** **2 = Service Billing for S1, S2, S3** (455-EM)
Procedure Code Modifier	The Procedure code modifier is reported in this field. Up to four occurrences are allowed. (459-ER)
Procedure Modifier Code Count	Enter the number of Procedure Modifiers reported. (458-SE)

FIELD	DESCRIPTION
Product/Service ID Number	The NDC Number or the HCPCS code being billed. For compounds, enter 0. (407-D7)
Product/Service ID Qualifier	Enter the appropriate Product/Service ID Qualifier. When billing for a compound, enter '00' 00 = Not Specified **03** = NDC **09** = HCPCS (436-E1)
Provider ID (Pharmacy)	Enter the NPI of the dispensing pharmacist. (444-E9)
Provider ID Qualifier (Pharmacy)	**Enter 05**= National Provider Identifier (NPI). (465-EY)
Reason for Service Code	When a claim is denied due to one or more of the following DUR Conflict Codes, each must have an appropriate DUR reject **override** for the claim to pay. **TD** = Therapeutic Duplication **ER** = Drug Overuse **DD** = Drug to Drug Interaction **NP** = New Patient Processing **AD** = Additional Drug Needed **PN =** Prescriber Consultation (439-E4)
Result of Service Code	The DUR Outcome Code is used to indicate the action taken by the pharmacist, and is required for a DUR **override**. (441-E6)
Route of Administration	This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture. Refer to the NCPDP D.0 External Code List for valid values. (995-E2)

FIELD	DESCRIPTION
Scheduled Prescription ID Number	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: • Prescriptions on Hospital and their affiliated Clinics Prescription Pads, use: HHHHHHHH • Prescriptions written by Out of State prescribers, use: ZZZZZZZZ • Prescriptions submitted via fax or electronically, use: EEEEEEEE • Oral Prescriptions, use: 99999999 • Prescriptions for carve-out drugs for nursing home patients, use: NNNNNNNN (454-EK)

FIELD	DESCRIPTION
Submission Clarification Code	The Submission Clarification Code is used for UT and specific DUR **overrides**. **02** = Other Override – Required when: • a "Threshold Override Application (TOA)" form has been submitted by the physician or other qualified practitioner. • the Reason for Service **NP** (New Patient Processing) and the Result of Service Code to bypass early fills due to new admissions to nursing home / child (foster) care facilities. **05** = Therapy Change – Required when: or **06** = Starter Dose - Required When: or **07** = Medically Necessary – Required When: • to override Polypharmacy Conflicts with prior service and Reason for Service **PN** (Prescriber Consultation) DUR Reject , following prescriber consultation; submit Reason for Service **PN** with Submission Clarification Code. **07** = Medically Necessary - use to indicate the service is provided as a result of Immediate Urgent Care or Emergency. Required when: • the Reason for Service **AD** (Medically Necessary) and the Result of Service Code to bypass early fill due to Brand medication needed in place of Generic (or vice versa). . (420-DK)
Submission Clarification Code Count	This field is used for reporting the Number of occurrences (up to 3) of the Submission Clarification Code field (420-DK). (354-NX)
Quantity Dispensed	The Quantity Dispensed is the total number of Metric Units dispensed for the prescription. (442-E7)
Usual and Customary Charge	The Usual and Customary Charge is used to enter the amount charged for the prescription. (426-DQ)

6.0 PRO-DUR/ECCA RESPONSE MESSAGES (Rev. 11/11)

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
Header Response Status	An **A** (Accepted) will be returned if the information in the transmission is valid. An **R** (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. **Note:** When an R is returned in the Header Response Status, all of the claims submitted on this request transaction will be rejected. (501-F1)

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
Additional Message Info	The Additional message area, in the NCPDP format, is used to return additional MEVS information about your request transaction. The following information is returned for accepted or pended transactions: • **MEVS Response Code (See Table 1)** • **Utilization Threshold Code (See Table 8)** • **Maximum Per Unit Price** • **Co-Payment Code (See Table 6)** • **Co-Payment Met Date** • **DVS Reason Code (See Table 9)** • **Medicare Coverage Code** • **HIC Number** • **First Insurance Carrier Code** • **First Insurance Coverage Codes (See Table 11)** • **Second Insurance Carrier Code** • **Second Insurance Coverage Codes (See Table 11)** • **Indication of Additional Coverage** • **Exception Codes (See Table 12)** • **DVS Number** (526-FQ) Please refer to Chart B for an example of the Additional Message. The following information is returned for rejected claims: • **MEVS Response Code (See Table 2)** • **Rx Denial Code (See Table 7)** • **Utilization Threshold Code (See Table 8)** • **DVS Reason Code (See Table 9)** Please refer to Chart C for an example of the Message. (526-FQ)
Amount of Copay	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)
Anniversary Month	The Anniversary Month found in the **Message Field** (504-F4) is the beginning month of the benefit year under the Utilization Threshold program.

FIELD	DESCRIPTION
Authorization Number	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. If a claim is captured but cannot be processed for adjudication, it must be billed via paper. (503-F3)
Category of Assistance	Category of Assistance Code returned within the **Message Field** (504-F4): S = SSI * = No valid category of assistance is available
Clinical Significance	Clinical Significance returned within the **DUR Response** area indicates how critical the conflict is. This value reflects the severity level assigned to a contraindication. Refer to **DUR Processing** Section for a list of clinical significance codes and their meanings. (528-FS)
Co-Payment Code	The Co-Payment Code returned within the **Additional Message Info** (526-FQ) provides the status of co-payment for this claim.
Co-Payment Met Date	The Co-Payment Met Date returned within the **Additional Message Info** (526-FQ) identifies the date the member has met this year's co-payment requirement.
County Code	The two-digit code for the county of fiscal responsibility for the member is provided within the **Message Field** (504-F4). **(See Table 13)**
Database Indicator	The Database Indicator returned within the **DUR Response** area is always **1** to indicate that First DataBank is the source of the DUR database. (532-FW)
Dispensing Fee Paid	The Dispensing Fee paid will be returned on the Response. (507-F7)
Dispensing Validation System Number	The eleven digit DVS Number (prior approval) will be returned in the **Additional Message Info** (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.
Dispensing Validation System Reason Code	The three-digit code indicating either the accepted or rejected status of the DVS request is returned within the **Additional Message Info** (526-FQ).
Exception Codes	Up to four Exception Codes may be returned within the **Additional Message Info** (526-FQ). **(See Table 12)**
Free Text	The Free Text returned within the **DUR Response** area contains information to assist the pharmacist in further identifying the DUR conflict. Please refer to the **DUR Processing** section. (544-FY)

FIELD	DESCRIPTION
HIC Number	The HIC Number returned within the **Additional Message Info** (526-FQ) is the Health Insurance Claim number for Medicare.
Indication of Additional Coverage	A **ZZ** returned within **Additional Message Info** (526-FQ) indicates that the member has more than two insurance carriers. Call 1-800-343-9000 to obtain complete information.
First Insurance Carrier Codes	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 **Additional Message Info** (526-FQ).
First Insurance Coverage Codes	The First Insurance Coverage Codes are returned within the **Additional Message Info** (526-FQ). These indicate the scope of benefits. **(See Table 11)**
Second Insurance Carrier Codes	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 **Additional Message Info** (526-FQ).
Second Insurance Coverage Codes	The Second Insurance Coverage Codes are returned within the **Additional Message Info** (526-FQ). These indicate the scope of benefits. **(See Table 11)**
Maximum Per Unit Price	The Maximum Per Unit Price returned within the **Additional Message Info** (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.
Medicaid Number	The Member's Identification Number is provided within the **Message Field** (504-F4).
Medicare Coverage	The Medicare Coverage code is returned within the **Additional Message Info** (526-FQ) and indicates the type of Medicare coverage. **A** = Member has only Part A Medicare coverage. **B** = Member has only Part B Medicare coverage. **C** = Member has both Part A and Part B Medicare coverage. **Q** = Member has Part A and Part B Medicare coverage and is a Qualified Medicare Beneficiary (QMB). **T** = Member is a QMB only. **D** = Member has only Part D Medicare coverage. **E** = Member has both Part A and Part D Medicare coverage.

FIELD	DESCRIPTION
Medicare Coverage (cont)	**F** = Member has both Part B and Part D Medicare coverage. **G** = Member has Part A and Part B and Part D Medicare coverage. **H =** Member has Part A and Part B and Part D Medicare coverage and is a QMB.
Message field	A Message field is used to provide eligibility information. The following information is returned for accepted claims (when **Claim Response = C**): • **Medicaid Number** • **County Code (See Table 13)** • **Anniversary Month** • **Patient Gender Code** • **Year of Birth** • **Category of Assistance** • **Re-certification Month** • **Office Number (See Table 14)** • **Service Date** Please refer to Chart A for an example of the Message. (504-F4)
MEVS Response Code	The MEVS Code for a member eligible transaction is returned within the **Additional Message Info** (526-FQ). Refer to Table 1 for a list of values and meanings.
MEVS Denial Code	The MEVS Denial Code for a member ineligible transaction is returned within the **Additional Message Info** (526-FQ) and indicates the MEVS error for rejected transactions. Refer to Table 2 for a list of values and meanings.
Office Number	The Office Number returned within the **Message field** (504-F4) represents the New York City office code. Table 14
Other Pharmacy Indicator	The Other Pharmacy Indicator returned within the **DUR Response** 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. **0** = Not Specified **1** = Your Pharmacy **3** = Other Pharmacy (529-FT)
Other Prescriber Indicator	The Other Prescriber Indicator returned within the **DUR Response** area compares the Prescriber of the current prescription to the Prescriber of the previously filled conflicting prescription. The following values may be returned: **0** = Not Specified **1** = Same Prescriber **2** = Other Prescriber (533-FX)

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

FIELD	DESCRIPTION
Transaction Response Status	This is the status for each claim that was submitted. A "**C**" indicates that the claim is accepted and/or pending, and an "**R**" indicates that it is rejected. A separate Claim Response Status will be received for each claim submitted on your request (1 - 4). If a "**C**" is returned, the **Authorization Number** field must be checked to determine if the claim has been electronically captured for adjudication. The MEVS Pend Response Code Table should also be checked to see if the claim is pending. Refer to Table 10. (112-AN)
Utilization Threshold Code	The Utilization Threshold codes indicate whether the member's UT availability is sufficient. Refer to Table 8. (526-FQ)
Year of Birth	The Year of Birth returned within the **Message Field** is a 3 digit field formatted as follows: 1980 will appear as 980. (504-F4)

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.

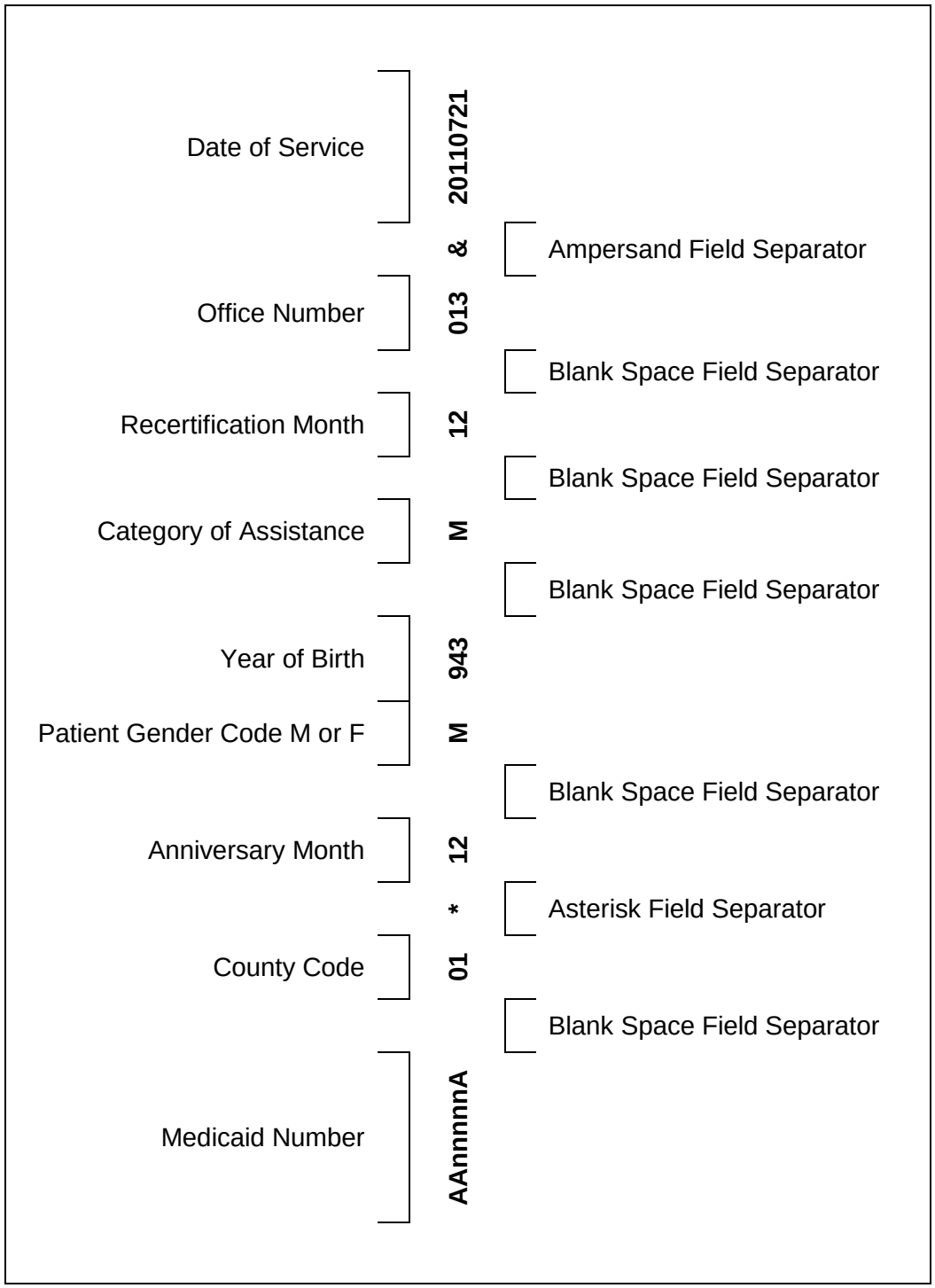
MEVS Denial Code (R)
Rx Denial Code
Reject Codes (up to 5)

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.

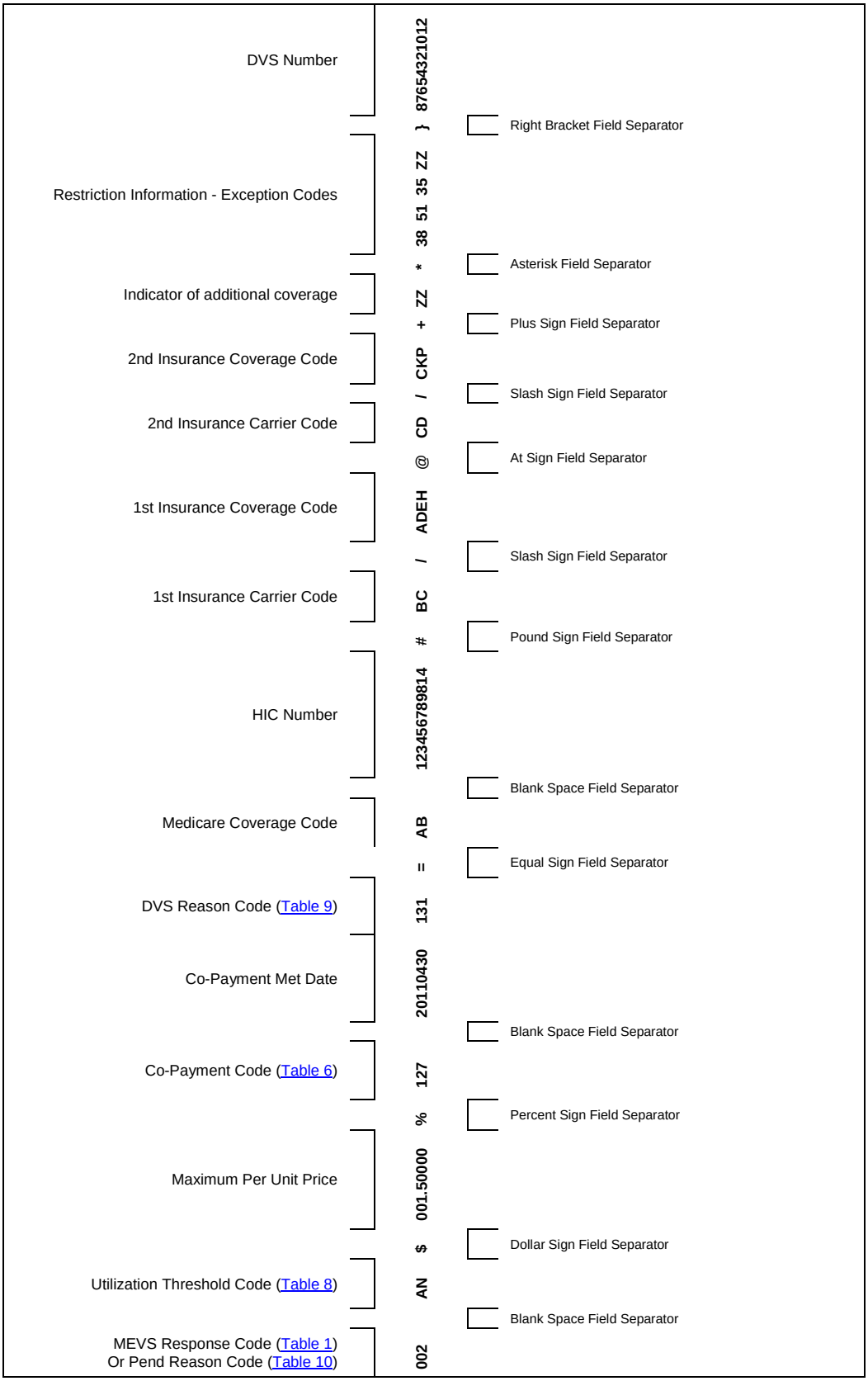
8.0 MESSAGE CHARTS (Rev. 05/11)

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

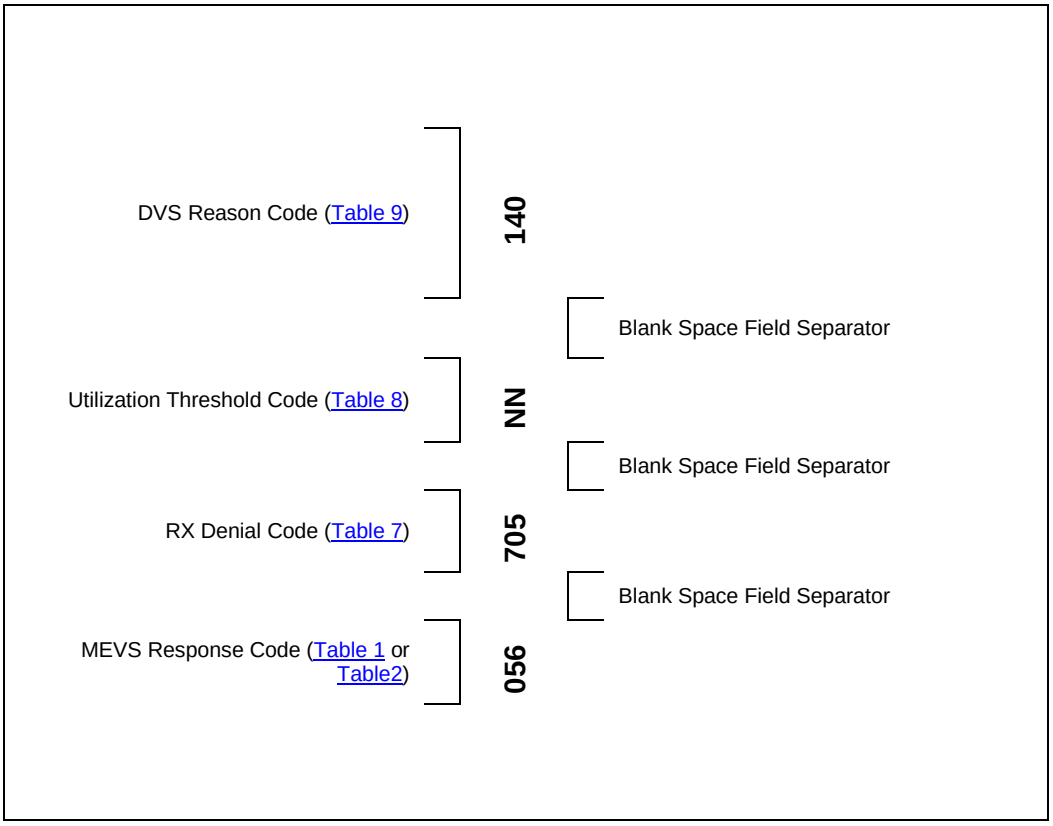
Response Message – Chart A



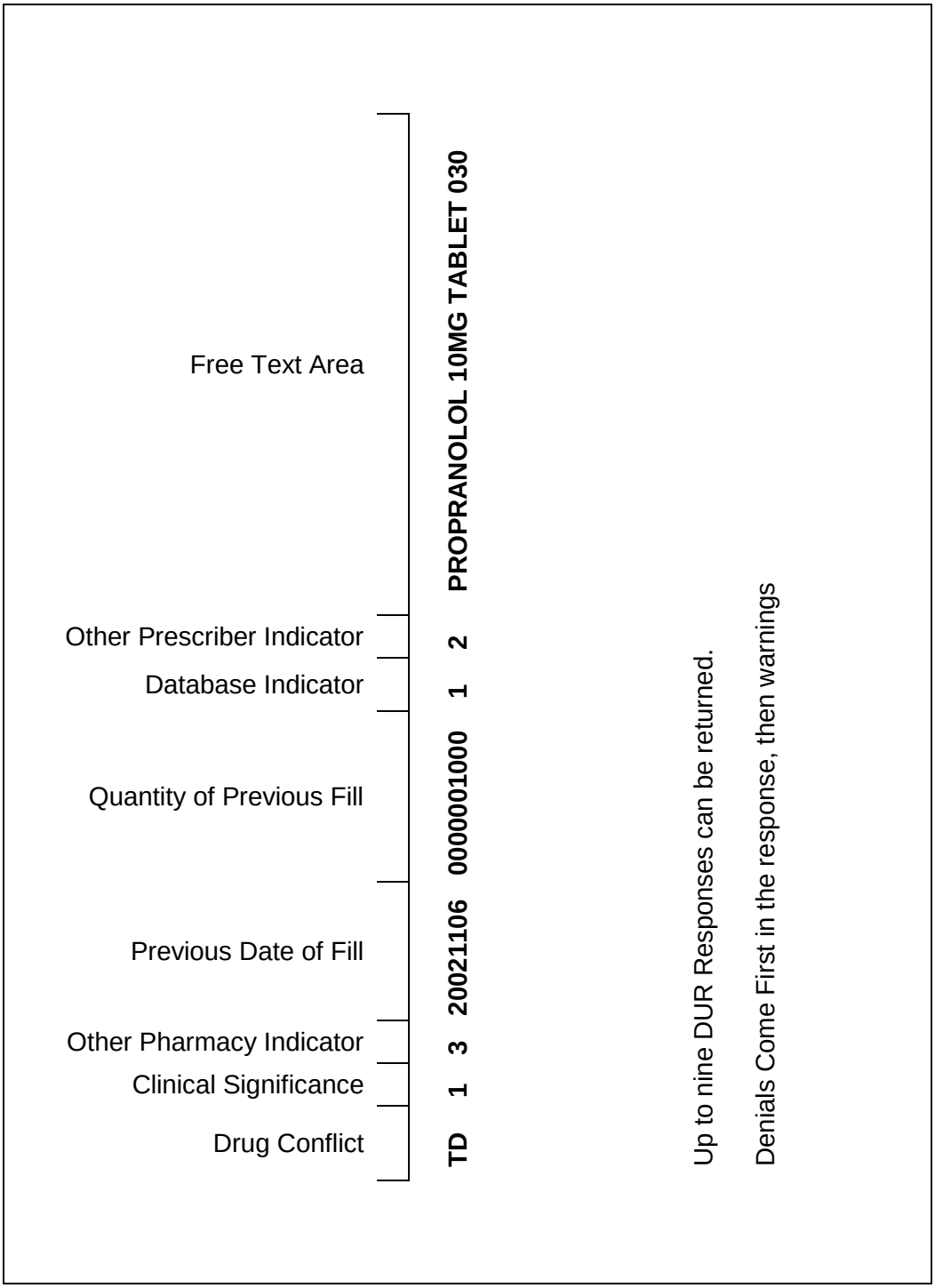
Additional Message – Chart B



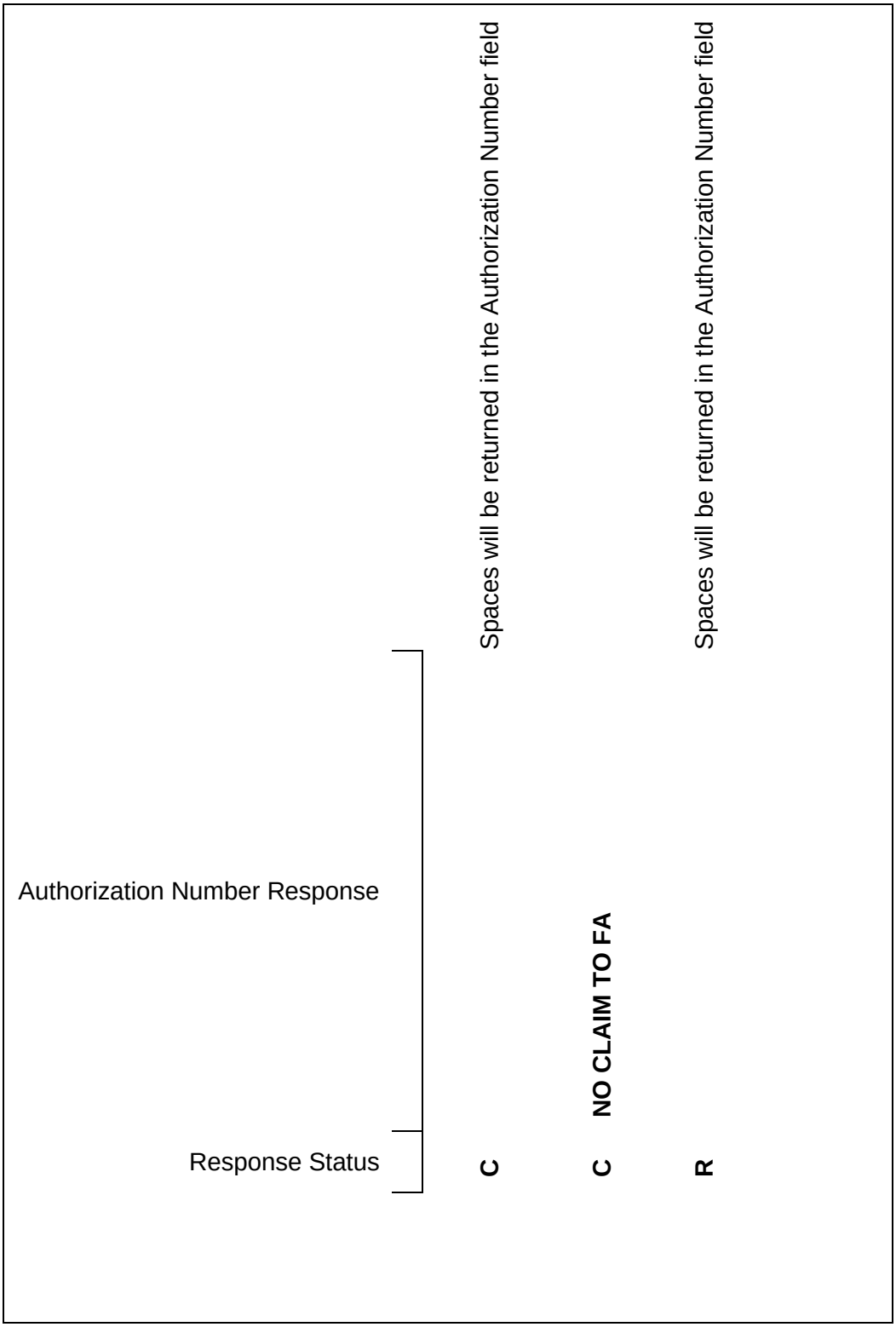
Rejected Claim Message – Chart C



DUR Response – Chart D



Claim Response Message – Chart E



9.0 MEVS ACCEPTED CODES - TABLE 1 (Rev. 02/12)

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 10.0.1) 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
003	Eligible Only Outpatient Care
005	Eligible Capitation Guarantee Only
006	Eligible PCP
007	Emergency Services Only
008	Presumptive Eligible Long-Term/Hospice
009	Medicare Coinsurance Deductible Only
010	Eligible Except Nursing Facility Services
013	Presumptive Eligibility Prenatal A
014	Presumptive Eligibility Prenatal B
015	Perinatal Family
016	MA Eligible-HR-Utilization Threshold
017	Family Health Plus Services Only
018	Family Planning Services Only
021	Record Canceled – Cancels a Previously Accepted Claim
034	Community Coverage with Community Based Long Term Care
035	Community Coverage without Long Term Care
036	Outpatient Coverage with Community Based Long Term Care
037	Outpatient Coverage without Long Term Care
038	Outpatient Coverage with No Nursing Facility Services
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
224	Family Health Plus with Pharmacy Carve-out

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

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

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

MEVS CODE (526-FQ)	DESCRIPTION	NCPDP CODE (F11 – FB)	DESCRIPTION
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
103	No Coverage: Pending Family Health Plus	65	Patient Not Covered

MEVS CODE (526-FQ)	DESCRIPTION	NCPDP CODE (F11 – FB)	DESCRIPTION
104	No Coverage: Excess Income	65	Patient Not Covered
105	QMB Requires Medicare Approval	65	Patient Not Covered
118	MCCP Recipient – No Auth	35	M/I Primary Care Provider ID
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	**	
324	The system or file necessary to process the transaction is currently unavailable.	92	System Unavailable

MEVS CODE (526-FQ)	DESCRIPTION	NCPDP CODE (F11 – FB)	DESCRIPTION
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		1. The entry in the Cardholder ID field must contain the member's 8 character alpha numeric Member ID. 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. 3. Rejections also occur when the ID is not left justified. 4. Code 062 is returned when the number entered cannot be found on the file.
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)	**T**he Primary Care Provider field must contain the 10 digit NPI number that the member is restricted to. This field is in addition to an entry in the Prescriber ID 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
703 Invalid PIN 704 Invalid ETIN	04 M/I Processor Control Number	YTG1234QBK (Certification, Initials, PIN, ETIN)	1. The reject denial code 703 will be returned if: A.) You have not submitted the PIN selection form to the Department of Health. B.) The PIN number has not been added to your provider file record at the eMedNY contractor. C.) The PIN number transmitted does not match the number selected, which was added to your provider file record. 2. The reject denial code 704 will be returned if: A.) You have not applied for and/or submitted your ETIN number on a notarized certification statement to the eMedNY contractor. B.) The ETIN transmitted does not match the ETIN submitted on the certification statement, which was added to the ETIN file. 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.
712 Override Denied UT Not at Limit	34 M/I Prescription Denial Override	01 (No Override) 02 (Other Override) 07 (Medically Necessary)	1. An entry must be placed in the Submission Clarification Code field. 2. If the member is not at their UT limit, 01 should be entered. 3. If the member is at their limit, value 02 or 07 should be entered to override the limit. 4. Code 712 is returned if a value of 02 or 07 is entered and the member has not reached their limit.
999 Header Field Error	None	None – Please resubmit using NCPDP Version D.0	Used for various Header errors, also used to indicate non-HIPAA compliance.

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. 11/11)

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.

MEVS CODE	DESCRIPTION	NCPDP CODE	DESCRIPTION
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
722	Family Health Plus Denial	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

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.

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

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. 08/11)

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	
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	
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	

CODE (511-FB)	DESCRIPTION – M/I = Missing/Invalid	MEVS CODE
76	Plan Limitations Exceeded	
77	Discontinued Product/Service ID Number	718
78	Cost Exceeds Maximum	421
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	
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	
6Z	Provider Not Eligible to Perform Service/ Dispense Product	
7C	M/I Other Payer ID	
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.

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.

COVERAGE CODES	DESCRIPTION	EXPLANATION
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 **COVERED** 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.

COVERAGE CODES	DESCRIPTION	EXPLANATION
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. 05/11)

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

Code 23	This code identifies a member who is enrolled in the OMH Home and Community Based Services (HCBS) Waiver for Seriously Emotionally Disturbed (SED) children. This member is exempt from Utilization Threshold and Co-pay requirements.
Code 24	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. This member is not exempt from Utilization Threshold and co-payment requirements.
Code 30	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. This member is not exempt from Utilization Threshold and co-payment requirements.
Code 35	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. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 38	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. This member is exempt from Utilization Threshold and Co-payment requirements and may be eligible for some fee-for-service Medicaid coverage.
Code 39	This code identifies a member in the Aid Continuing program. This member is subject to Utilization Threshold and exempt from Co-payment requirements.
Code 44	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. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 45	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. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 46	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. 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 *supervised* 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 *supportive* Community Residence (CR) or a *supportive* 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 *supervised* 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 **not** 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.
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.
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.
Code 65	This code identifies a member in the Care At Home IV program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.

Code 66	This code identifies a member in the Care At Home V program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 67	This code identifies a member in the Care At Home VI program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 68	This code identifies a member in the Care At Home VII program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 69	This code identifies a member in the Care At Home VIII program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 70	This code identifies a member in the Care At Home IX program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 71	This code identifies a member in the Care At Home X program. This member is exempt from completion of HARRI (the Long Term Home Health Care Assessment Tool), Co-payment and Utilization Threshold requirements.
Code 72	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. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 73	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. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 74	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. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 75	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. This member is not exempt from to Utilization Threshold and Co-payment

	requirements.
Code 76	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. This member is not exempt from to Utilization Threshold and Co-payment requirements.
Code 77	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. This member is not exempt from Utilization Threshold and Co-payment requirements.
Code 81	This code identifies a member in a Home and Community Based Services (HCBS) Waiver Program for Traumatic Brain Injury (TBI). This member is exempt from Utilization Threshold and Co-payment requirements.
Code 83	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. 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.
Code 84	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. Other base and clinical PROS programs, OMH clinic, CDT, IPRT, PMHP, and ACT intensive claims will be denied payment. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 85	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. Other base PROS programs, OMH CDT, IPRT, and ACT intensive claims will be denied payment. This member is exempt from Utilization Threshold and Co-payment requirements.
Code 86	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). Other PROS providers will be denied payment for these services. OMH IPRT claims will be denied payment. This member is exempt from Utilization Threshold and Co-payment requirements.

Code 95	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: 1435 - MR/DD/TBI APG Base Rate 1436 - MR/DD/TBI Existing Payment for Blend 1437 - Capital and R&R Add-on This member is not exempt from the Utilization Threshold or Co-payment requirements.
Code AL	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: 1. Adult day health care provided in a program approved by the Department of Health; 2. Home health aide services; 3. Medical supplies and equipment NOT requiring prior approval (underlined procedure codes in the DME and Pharmacy provider manuals are prior approved); 4. Nursing services; 5. Personal care services; 6. Personal emergency response services; and 7. Physical therapy, speech therapy, and occupational therapy.
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.

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

20.0 NEW YORK CITY OFFICE CODES – TABLE 14 (Rev. 05/11)

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 34th 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.