

**NEW YORK STATE
DEPARTMENT OF HEALTH
AIDS INSTITUTE**

**UNINSURED CARE PROGRAMS
AIDS DRUG ASSISTANCE PROGRAM (ADAP)
PHARMACY PROVIDER MANUAL**

**Uninsured Care Programs
Empire Station
P.O. Box 2052
Albany, NY 12220-0052
1-800-832-5305**



**PHARMACY PROVIDER MANUAL
HIV UNINSURED CARE PROGRAMS
AIDS DRUG ASSISTANCE PROGRAM
ADAP**

PURPOSE

The AIDS Drug Assistance Program (ADAP) provides reimbursement for medications (specific formulary) for New York State residents who meet Program eligibility criteria. The Formulary may change as new drugs are approved by the FDA and available resources allow. Any Program change which decreases covered medications will be sent in writing to participants and providers. The most current ADAP Formulary can be viewed at the Department of Health Website: <http://www.health.state.ny.us/diseases/aids/resources/adap/index.htm>

BACKGROUND

The initiative is a partnership between New York State, and the HIV Planning Councils of the New York City, Long Island, Lower Hudson and Dutchess County Regions. The enrollment and claims processing functions of this initiative are integrated with that of ADAP Plus and Home Care for improved coordination and efficiency.

FUTURE DIRECTIONS

The Program's Clinical Advisory Workgroup is continually investigating current and new medications in an effort to provide access to medications useful to all participants, while using scarce fiscal resources to the fullest extent possible. Requests for formulary additions or changes should be addressed in writing to the Program at:

**ADAP
EMPIRE STATION
P.O.BOX 2052
ALBANY, NEW YORK 12220-0052**

POPULATION SERVED

ADAP serves HIV-infected New York State residents who are uninsured or under-insured and who meet established eligibility criteria. Applicants who have partial insurance or limitations on their insurance may be eligible. Applicants who are enrolled in Medicaid and approved with a Medicaid Spenddown or Surplus are also eligible when Medicaid is not active. Participants who are eligible to enroll in Medicare Part D and who do not have existing "creditable" prescription coverage will be required to enroll in Medicare Part D. Pharmacies providing service to participants will need to verify Medicare Part D plan enrollment and submit claims to the Medicare plan before submitting claims to ADAP. The Program will coordinate benefits with Medicare Prescription Drug Plans (PDP). Applicants who meet Program eligibility criteria receive a Program eligibility card. They present their ADAP card at a participating pharmacy along with a prescription to receive the approved medication(s).

PARTICIPANT ELIGIBILITY

- (1) Residency - New York State
- (2) Medical - HIV Infection (Chronic medical dependency due to HIV illness and physician's orders to be eligible for Home Care services)
- (3) Financial - Income for a household of one \$44,000 per year; \$59,200 for two; and \$74,400 for three or more
Liquid assets less than \$25,000

PARTICIPANT ENROLLMENT PROCESS

- Applicants apply to the Program, providing proof of residency, income, assets, and insurance, if applicable.
- A Medical Application completed by a physician is required, verifying HIV-infection and indicating medical/disease status.
- Upon determination of eligibility, an ADAP Identification Card is sent to the applicant that may be used to receive prescriptions from an enrolled pharmacy provider for covered medications dispensed following program approval. There is **NO co-payment** requirement for participants.

IDENTIFICATION OF PARTICIPANT ELIGIBILITY

ADAP assigns a unique identification number to every participant at the time of enrollment. Participants enrolled in ADAP must present their identification card whenever they have a prescription filled at an ADAP enrolled pharmacy. Pharmacies must submit all claims electronically, using NCPDP version 5.1. Utilization of the Point of Sale system will verify the participants' eligibility and specific drug coverage as well as process claims.

MEDICARE PART D

Effective January 1, 2006 ADAP participants who are eligible for Medicare Part D must enroll in a Medicare Part D Pharmacy Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD).

Participants with income or assets in excess of low-income assistance or "Extra Help" thresholds (income in excess of 135% of poverty or assets in excess of \$6,000) may encounter a monthly premium.

Monthly premiums may be paid by the ADAP Plus Insurance Continuation (APIC) program. Participants will need to select a plan and opt for self pay rather than direct deduction from their Social Security payment and complete an APIC application.

If a participant requires medication and presents an ADAP ID Card, you **must** also ask for a Medicare Prescription Drug Plan Card and first try to use their **Medicare Card**. **ADAP will be secondary payer to Medicare part D plans except in cases when the participant has a Medicaid Spenddown and is not Medicaid active (See below, Medicare Part D and Medicaid Spenddown).**

Pharmacy procedures and coordination of benefits between Medicare Part D and ADAP will be updated regularly. Please contact the Program at 1-800-542-2437 for updated information or look for mailings sent with processed claim remittance statements.

MEDICAID

Since Medicaid covers the cost of prescription drugs, individuals enrolled in Medicaid are not eligible for this Program. Individuals awaiting Medicaid eligibility determination, or who have Medicaid Spenddown requirements **are** eligible. ADAP assistance may be provided on a short-term basis to persons eligible for, or pending Medicaid approval. Once other assistance becomes available, the client will no longer receive ADAP coverage for prescription drugs. ADAP reserves the right to deny any claims for individuals who have active Medicaid eligibility covering prescription drugs. The Program will interface with Medicaid to prevent duplication of enrollment and billing. The Program will seek to identify individuals who are potentially eligible for Medicaid at eligibility determination and at periodic intervals; and encourage them to apply to Medicaid. Providers will also be required to identify and encourage potentially eligible participants to enroll in Medicaid.

MEDICAID SPENDDOWN ELIGIBILITY VERIFICATION

ADAP has received a directive from the New York State Department of Social Services that requires the Program to assist individuals who are in a Medicaid Spenddown situation, in meeting their spenddown amounts (91-ADM-11 NYS DSS). In order to respond to this directive and to expedite the process, the following procedures have been established.

ADAP participants who have an income Spenddown will receive an ADAP identification card that has an "**M**" as the last digit of the ADAP ID# and the words "**MEDICAID SPENDDOWN**" printed on the card.

If a participant requires medication and presents an ADAP ID Card identified as Medicaid Spenddown, you **must** first try to use their **Medicaid Card or Medicaid Identification #** to determine that they are in fact **not** eligible under Medicaid to receive the medication.

If they are not eligible for Medicaid, the ADAP ID Card can be used to provide the medication and seek reimbursement as usual from us. You **must** verify eligibility through the ADAP Point of Sale system. **IN THIS INSTANCE ONLY**, you will issue a standard receipt or statement of expenditures incurred to the participant in the amount of the ADAP billing. The participant is responsible for bringing the receipt to their local Medicaid office to have that amount applied to their Spenddown requirements.

The first time a Medicaid Spenddown ADAP participant uses this process they must provide you with a copy of the letter issued to them by this office describing their Spenddown amounts and the process for meeting them. If they cannot provide a copy of this letter, please contact ADAP eligibility staff for clarification and approval if necessary or appropriate.

Pharmacies will enter the information into the Point of Sale system; the system will subtract the cost of the medication from the individual's monthly Medicaid Spenddown amount and determine if the individual has met their Spenddown amount for that month. If the system denies the prescription, **and** the participants Medicaid is not active, call the Program at 1-800-542-2437.

Medicare Part D and Medicaid Spenddown

One of the goals of the Ryan White Care act is to provide access to comprehensive health care for people living with HIV and AIDS. In order to accomplish this goal for individuals who are Medicare active and have a Medicaid Spenddown; ADAP will institute a Medicaid Spenddown verification letter. The letter will be sent to participants who need to meet their Medicaid Spenddown. The letter will state the amount of the Medicaid Spenddown to be met. Billing ADAP as Primary Payor in these instances will allow ADAP to meet the participants Medicaid Spenddown to ensure comprehensive health care coverage.

ADAP will only pay for the medication or medications required to meet the amount of the Medicaid Spenddown. Claims submitted for medications exceeding the Medicaid Spenddown will be denied with the denial code 41 stating Bill Primary Payor.

Example – John Jones, an ADAP participant with Medicare Part D coverage and a Medicaid Spenddown arrives at the pharmacy with his Medicaid Spenddown verification letter stating his Spenddown is \$240. Mr. Jones needs to fill prescriptions for Kaletra and Truvada. Either prescription refill exceeds the \$240 dollar Spenddown, therefore after the first medication is submitted and approved for payment by ADAP, the second medication will need to be billed through the participants Medicare Part D plan.

PROVIDER ELIGIBILITY

All licensed New York State pharmacies are eligible to enroll as ADAP providers if actively enrolled in New York State Medicaid, the New York State Elderly Pharmaceutical Insurance Coverage (EPIC) Program, enrolled with one or more Medicare Prescription Drug Plans, and able to submit claims electronically through Point of Sale. ADAP will utilize the Pharmacies' EPIC enrollment status and NAPB (National Association of Board Pharmacies) identification number to verify pharmacy eligibility. Pharmacies must recertify with EPIC periodically to maintain payment eligibility. Pharmacy providers who do not maintain active EPIC, New York State Medicaid, and one or more Medicare prescription Drug plan enrollment will be terminated.

Pharmacies outside New York State **must** be enrolled with NYS Medicaid, maintain a valid Pharmacy license in their appropriate state, and be able to submit claims electronically, utilizing both current NCPDP standards and NAPB identification number. Pharmacies outside of New York State must request to participate as an enrolled provider with ADAP in writing; complete a pharmacy enrollment form; provide documentation of NYS Medicaid enrollment; Medicare Prescription Drug plan participation; and current pharmacy license.

CLAIM DENIALS

ADAP utilizes both prospective and retrospective Utilization Review. Prospective reviews may cause claim denials. Each time a claim is submitted, a series of systemic edits are performed:

- Verification of NDC to determine if the medication is covered;
- Determination of prescription refill period, refills will be denied unless a minimum of 75% of last days supply period has occurred;
- Quantity verification to insure monthly maximum is not exceeded;
- Number of days supply, Program standard limit is 30 days;
- Maximum Anti-Retroviral/Protease Inhibitor Combination;
- Client eligibility verification including Date of Birth;
- Some medications require prior approval, a claim will be denied if the claim is submitted without first receiving prior approval;
- Provider eligibility verification including EPIC enrollment; and
- Other Primary Drug Coverage.

When a claim is denied please verify the denial code to determine if a data entry error has occurred.

Retrospective Utilization reviews include, but are not limited to:

- Excessive submission of early refills
- Acquisition cost review for PHS entities - ADAP will conduct comparative retroactive analysis of prices billed to the Program. This analysis may result in audit of these pharmacies and recoveries will be made based on the price difference between billed amount and acquisition cost. These recoveries will either be in the form of direct payment to the Program or by withholding future payments to the pharmacy until such time as all over-payments are recovered.

PROBLEMS, COMPLAINTS, AND BILLING ISSUES

If you have a problem with payment or other administrative aspects of the Program, please contact the Director of Operations or Fiscal Services at **1-800-542-2437**, or write to the program at Empire Station P.O. Box 2052, Albany, N.Y. 12220.

CONFIDENTIALITY

ADAP requires that all pharmacy staff observe the highest standards of confidentiality in providing services. The Health Care Portability and Accountability Act (HIPAA) defines personal identifiers and requires a detailed notice of privacy practices be given to patients no later than April 14, 2003 and at least once every three years thereafter. HIPAA also holds the provider accountable for non-specifically authorized disclosures. State Education Law as it relates to professional licensing specifically prohibits revealing personally identifiable facts, data or other information obtained in a professional capacity without the prior consent of the patient or client, except as authorized by law.

It is essential that you, as a provider for ADAP, are sensitive to the need of ADAP participants to have their prescriptions filled with complete confidentiality.

UTILIZATION REVIEW, RECORD KEEPING, AUDIT AND CLAIM REVIEW

Record-Keeping Requirements

Federal Law and State Regulations require Providers to maintain financial and health records necessary to fully disclose the extent of medications and supplies provided to ADAP Participants. Pharmacy providers must furnish information regarding any payment claimed to authorize officials upon request of the State Department of Health.

For audit purposes, records on Participants must be maintained and be available to authorized ADAP officials for six years following the date of payment. Failure to conform to these requirements may affect payment and may jeopardize a Provider's eligibility to continue as an ADAP Plus Provider.

Unacceptable Practice

An unacceptable practice is conduct by a person which conflicts with any of the policies, standards or procedures of the State of New York or Federal statute or regulation which relates to the provision of medication and or the fiscal integrity of the Program. Examples of unacceptable practices include, but are not limited to the following:

- knowingly making a claim for an improper amount or for unfurnished, unnecessary medications or supplies;
- practicing a profession fraudulently beyond its authorized scope, including the provision of medications or supplies while one's license to practice is suspended or revoked;
- failing to maintain records necessary to fully disclose the extent of the medications or supplies furnished;
- soliciting, receiving, offering or agreeing to make any payment for the purpose of influencing an ADAP participant to either utilize or refrain from utilizing any particular source of medication or supplies; and
- knowingly demanding or collecting any compensation in addition to claims made under ADAP.

Audit and Claim Review

- (a) Providers shall be subject to audit by the Department of Health or its designee's. With respect to such audits, the provider may be required:
1. To reimburse the department for overpayments discovered by audits; and
 2. To pay restitution for any direct or indirect monetary damage to the Program resulting from their improperly or inappropriately furnishing covered services.

- (b) The Department of Health may conduct audits and claim reviews, and investigate potential fraud or abuse in a provider's conduct.

The Department of Health may pay or deny claims; or delay claims for audit review.

- (d) When audit findings indicate that a provider has provided covered services in a manner which may be inconsistent with regulations governing the Program, or with established standards for quality, or in an otherwise unauthorized manner, the Department of Health may summarily suspend a provider's participation in the Program and/or payment of all claims submitted and all future claims may be delayed or suspended. When claims are delayed or suspended, a notice of withholding payment or recoupment shall be sent to the provider by the department. This notice shall inform the provider that within 30 days he/she may request in writing an administrative review of the audit determination before a designee of the Department of Health. The review must occur and a decision rendered within a reasonable time after a request for recoupment is warranted, or if no request for review is made by the provider within the 30 days provided, the department shall continue to recoup or withhold funds pursuant to the audit determination.
- (e) Where investigation indicates evidence of abuse by a provider, the provider may be fined, suspended, restricted or terminated from the Program.

Audits and Recovery of Overpayments

- (a) Recovery of overpayments shall be made only upon a determination by the Department of Health that such overpayments have been made, and recovery shall be made of all money paid to the provider to which it has no lawful right or entitlement.
- (b) Recovery of overpayments pursuant to this subject shall not preclude the Department of Health or any other authorized governmental body or agency from taking any other action with respect to the provider, including auditing or reviewing other payments, or claims for payment for the same or similar periods, imposing program sanctions, or taking any other action authorized by law.
- (c) The Department of Health may utilize any lawful means to recover overpayments, including civil lawsuit, participation in a proceeding in bankruptcy, common law settlement, or such other actions or proceedings authorized or recognized by law.
- (d) All fiscal and statistical records and reports of providers and all covered services which are used for the purpose of establishing the provider's right to payment under the Program and any underlying books, records, documentation which formed the basis for such fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation including all covered services provided shall be kept and maintained by the provider for a period of not less than six years from the date of completion of such reports, or the date upon which the fiscal and statistical records were required to be filed, whichever is later, or the date the service was provided.
- (e) All claims made under the Program shall be subject to audit by the Department of Health, his agents or designees, for a period of six years from the date of service. Time frame limitation shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the performance of an audit pursuant to this Part.

Fraud

Examples of fraud include when a person knowingly:

- Makes a false statement or representation which enables any person to obtain medical services to which he/she is not entitled;
- Presents for payment any false claim for furnishing services or merchandise;
- Submits false information for the purpose of obtaining greater compensation than that to which he/she is legally entitled;
- Submits false information for the purpose of obtaining authorization for the provision of services or merchandise.

Termination - Disenrollment

Either ADAP or the pharmacy may terminate a pharmacy enrollment with 30 days written notice. ADAP reserves the right to terminate or suspend pharmacies with less than 30 days written notice for any of the following practices.

- Violation of participant confidentiality
- Unacceptable practices
- Fraud
- Failure to comply with audit requirements
- Failure to maintain EPIC and New York State Medicaid enrollment

ADAP DISPENSING AND BILLING PROCEDURES

REIMBURSEMENT

ADAP will adhere to the Medicaid reimbursement methodology for all medications covered by the Program. In the case of generics versus brand name medications where an Orange book rated equivalent is available; no dispense as written override is available. ADAP will also limit prescription refills to five.

If the drug dispensed is a multiple source prescription drug or a brand-name prescription drug for which no specific upper limit has been set by the Federal Health Care Financing Administration (HCFA), payment will be made based on the package size dispensed as reported by the prescription drug pricing service used by the Program, less 14.0%. The Program's prescription drug pricing service currently is "Medispan." Drug prices are updated weekly. ADAP will not make retroactive adjusting payments for drug price changes occurring during the week.

Pharmacies eligible to purchase drugs under the Public Health Service (PHS) Section 602 discount program are required to enter their acquisition cost in the ingredient cost field. Acquisition cost will be the reimbursable amount provided it is lower than either the HCFA upper limits price or AWP less 14.0% for brand name medications and AWP less 25.0% for generics. Pharmacies designated as a HIV specialty pharmacy by NYS Medicaid will be paid at AWP less 12.0% for brand name medications.

For pharmacies eligible for 340b Public Health Service pricing, ADAP will conduct comparative retroactive analysis of prices billed to the Program. This analysis may result in audit of these agencies and recoveries will be made based on the price difference between billed amount and acquisition cost. These recoveries will either be in the form of direct payment to the Program or by withholding future payments to the agency until such time as all over-payments are recovered.

If the drug dispensed is a multiple source prescription drug for which a specific upper limit of reimbursement has been established by HCFA, the Program will make payment in the amount of the specific upper limit set by HCFA.

Dispensing Fees

Generic - Multiple source	\$4.50
Brand products	\$3.50

Generally, reimbursement will be made to pharmacies within 21 days of electronic claim submission.

If you have questions regarding our Point of Sale system, please call Ray Martin. If you have questions regarding the pricing policy, please call Ann Burnett or Christine Rivera at 1-800-542-2437.

CLAIM SUBMISSION

Providers must be certified to submit claims electronically to the EPIC Program in order to receive ADAP certification. Please contact your claim submission software vendor when you first enroll in ADAP. The software vendor will require the following information:

ANSI BIN Number: 610490 / State: New York / ADAP Destination: Albany, N.Y.

Participating pharmacies are required to submit ADAP claims on-line using insurance industry standard point of sale procedures. ADAP will accept claims in NCPDP V5.1 format. Up to four claims may be submitted within a single transaction. The ADAP system is available seven days a week between the hours of 7:00 am and 10:00 pm. All point of sale transactions for ADAP are routed through both of the following commercial switching companies: National Data Corporation and Envoy.

Claims must be submitted within fourteen days of dispensing medication. Claims may be reversed up to the time that they are processed for payment. Late claims and reversals may be submitted manually on universal claim forms within 90 days of service. Late claims and reversals submitted manually must be accompanied by a detailed letter of explanation.

Prescriptions should be filled for a one month supply. Partial prescription claim submission, in the event the pharmacy does not have adequate supply on hand, are supported under NCPDP v5.1. Current Program limitations preclude prescriptions for longer than a 30 day period. In cases where serious hardships would result for the participant, please contact ADAP at **1-800-542-2437**.

MANUAL CLAIMS

On occasion, due to Medicaid Spenddown conflicts, ADAP will direct the pharmacy to submit a manual claim. No other manual claims will be accepted unless the date of service is greater than 14 days, but less than 90 days, and a letter explaining why the claim was not submitted through the Point of Sale system is provided to the Program. Manual claims submitted in excess of 90 days will be denied as claim too old. Bulk submissions of manual claims will not be processed.

In order to ensure timely reimbursement, submit claims promptly. All claims made under this Program shall be subject to audit by the Department of Health, its agents or designees, for a period of six years from the date of service. This limitation shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the performance of an audit pursuant to this Part.

All reimbursement is issued by Health Research, Incorporated (HRI), and accompanied by a remittance statement detailing all payments and denials. When inquiring about a claim submission or payment amount please have the **authorization number** or **batch number** and the detailed explanation of payment available for discussion.

Submit all claims to:

**ADAP
EMPIRE STATION
P.O.BOX 2052
ALBANY, NY 12220-0052**

Questions regarding claim submission or dispensing of ADAP medications may be referred to ADAP's toll-free Hotline at **1-800-542-2437**. If you are calling from out of New York State please call 1-518-459-1641.

UNIVERSAL CLAIM FORM SUBMISSION INSTRUCTIONS

Card Holder	and	Mandatory, claims must include the ADAP ID # and the participant's name.
Participant Date of Birth		Mandatory, claims must include the participants Date of Birth, which is a verified field; enter MM/DD/YYYY.
Pharmacy Information		Mandatory, fill out all fields. All claims must include your NABP# , or claims will be returned.
Patient Signature		Optional if signature is on file at the store.
Authorized Pharmacy Signature		Optional if signature is on file with ADAP.
Rx Number		Mandatory, enter the prescription number.
New/Refill		Mandatory, check "N" or "R"
Refill Number		Mandatory, ADAP will only pay for 5 refills per prescription.
Metric Quantity		Mandatory, for capsules or tablets, enter the number of units dispensed. For others, enter metric measure. In all cases the pharmacy must adhere to NCPDP standards for billing units.
Days Supply		Mandatory, enter the days supply based on the prescriber's directions and quantity dispensed.
National Drug Code and Drug Name		Mandatory, enter the drug code (eleven digits), exactly as it appears on the package, and the name of the drug being dispensed.
Prescriber Identification		Mandatory, physician DEA number.
Cost of Drug		Enter reimbursable amount for the drug.
Dispensing Fee		Enter appropriate dispensing fee.
Dispense as Written		Mandatory, enter as appropriate.

ADAP will not research and correct claims. Incomplete or illegible claims will be returned to the pharmacy for correction and resubmission.

ADAP Specifications for NCPDP 5.1 Transactions

GENERAL INFORMATION

Payer Name: NYS Uninsured Care Programs	Date: 09/17/2002
Plan Name/Group Name: New York State ADAP / Uninsured Care Programs	
Processor: ADAP	Switch: NDC, Envoy
Effective as of: 10/16/2002	Version/Release #: 5.1
Contact/Information Source: See notes	
Certification Testing Window: See notes	
Provider Relations Help Desk Info: See notes	
Other versions supported: 3.2, 3A (Until 4/1/2003)	

** OTHER TRANSACTIONS SUPPORTED **

Transaction Code	Transaction Name
E1	Eligibility Verification
B2	Reversal
B3	Rebill

BILLING TRANSACTION REQUEST:

SEGMENTS

Transaction Header Segment: Mandatory for All Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	61Ø49Ø	M	
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B1	M	
1Ø4-A4	Processor Control Number	ADAPØ1	M	
1Ø9-A9	Transaction Count	Ø1 = One occurrence Ø2 = Two occurrences Ø3 = Three occurrences Ø4 = Four occurrences	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7 = NCPDP Provider ID	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service		M	
11Ø-AK	Software Vendor/Certification ID	Blank fill	M	Not used

Insurance Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID		M	ADAP ID number from card – see notes

Claim Segment: Mandatory

Note: Partial fill transactions are supported, compound transactions are not supported.

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Ø1 = Rx billing	M	
4Ø2-D2	Prescription/Service Reference Number		M	Rx number
436-E1	Product/Service ID Qualifier	Ø3 = NDC	M	
4Ø7-D7	Product/Service ID		M	11-Digit NDC
403-D3	Fill Number		R	
405-D5	Days Supply		R	
408-D8	Dispense As Written		R	
414-DE	Date Prescription Written		R	
415-DF	Number Of Refills Authorized		R	
442-E7	Quantity Dispensed		R	
343-HD	Dispensing Status	P = Partial fill C = Completed partial fill	RW	Required for all partial fill transactions
456-EN	Associated Prescription/Service Reference #		RW	Required for partial fill completion
457-EP	Associated Prescription/Service Reference Date		RW	Required for partial fill completion
344-HF	Quantity Intended To Be Dispensed		RW	Required for all partial fill transactions
335-HG	Days Supply Intended To Be Dispensed		RW	Required for all partial fill transactions

Prescriber Segment: Required for ADAP

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø3	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	12 = DEA #	R	
411-DB	Prescriber ID		R	DEA #

Pricing Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	11	M	Pricing Segment
409-D9	Ingredient Cost Submitted		R	
426-DQ	Usual And Customary		R	

ELIGIBILITY VERIFICATION REQUEST:

****SEGMENTS****

Transaction Header Segment: Mandatory for All Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	61Ø49Ø	M	
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	E1	M	
1Ø4-A4	Processor Control Number	ADAPØ1	M	
1Ø9-A9	Transaction Count	Ø1	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7 = NCPDP Provider ID	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service		M	
11Ø-AK	Software Vendor/Certification ID	Blank fill	M	Not used

Insurance Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID		M	ADAP ID number from card – see notes

REVERSAL TRANSACTION REQUEST:

****SEGMENTS****

Transaction Header Segment: Mandatory for All Transactions

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	61Ø49Ø	M	
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B2	M	
1Ø4-A4	Processor Control Number	ADAPØ1	M	
1Ø9-A9	Transaction Count	Ø1 = One occurrence Ø2 = Two occurrences Ø3 = Three occurrences Ø4 = Four occurrences	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7 = NCPDP Provider ID	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service		M	
11Ø-AK	Software Vendor/Certification ID	Blank fill	M	Not used

Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Ø1 = Rx billing	M	
4Ø2-D2	Prescription/Service Reference Number		M	Rx number
436-E1	Product/Service ID Qualifier	Ø3 = NDC	M	
4Ø7-D7	Product/Service ID		M	11-Digit NDC

REBILL TRANSACTION REQUEST:

****SEGMENTS****

Note: Rebill Transaction Requests are identical to Claim Transaction Requests. The only difference is in field 1Ø3-A3 (Transaction Type).

ADAP RESPONSE SEGMENTS

Transmission Rejected Response

****SEGMENTS****

Transaction Header Segment: Mandatory

Field#	NCPDP Field Name	Value	M/R/RW	Comment
102-A2	Version/Release Number	Same value as in request billing	M	
103-A3	Transaction Code	Same value as in request billing	M	
109-A9	Transaction Count	Same value as in request billing	M	
501-F1	Header Response Status	R	M	
202-B2	Service Provider ID Qualifier	Same value as in request billing	M	
201-B1	Service Provider ID	Same value as in request billing	M	
401-D1	Date of Service	Same value as in request billing	M	

Response Status Segment: Mandatory

Field#	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	R	M	
501-FA	Reject Count		R	
511-FB	Reject Code		R	
526-HQ	Response Message		R	
549-7F	Help Desk # Qualifier	03 = Processor/PBM	R	ADAP help desk
550-8F	Help Desk Number		R	

Billing Accepted Response – Transaction PAID or Duplicate of Paid

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
102-A2	Version/Release Number	Same value as in request billing	M	
103-A3	Transaction Code	Same value as in request billing	M	
109-A9	Transaction Count	Same value as in request billing	M	
501-F1	Header Response Status	A	M	
202-B2	Service Provider ID Qualifier	Same value as in request billing	M	
201-B1	Service Provider ID	Same value as in request billing	M	
401-D1	Date of Service	Same value as in request billing	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	P = Paid D = Duplicate of Paid	M	
503-F3	Authorization Number		R	ADAP Transaction Tracking

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	01 = Rx Billing	M	
402-D2	Prescription/Service Reference Number		M	Rx Number

Response Pricing Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	23	M	Response Pricing Segment
505-F5	Patient Pay Amount		R	
506-F6	Ingredient Cost Paid		R	
507-F7	Dispensing Fee Paid		R	
509-F9	Total Amount Paid		R	
522-FM	Basis of Reimbursement Determination		R	
346-HH	Basis of Calculation – Dispensing Fee	Ø2 = Quantity Intended Ø4 = Waived Due to Partial	RW	Used for partial fill
347-HJ	Basis of Calculation – Co-pay	Ø2 = Quantity Intended Ø4 = Waived Due to Partial	RW	Used for partial fill

Billing Accepted Response – Transaction Rejected

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
102-A2	Version/Release Number	Same value as in request billing	M	
103-A3	Transaction Code	Same value as in request billing	M	
109-A9	Transaction Count	Same value as in request billing	M	
501-F1	Header Response Status	A	M	
202-B2	Service Provider ID Qualifier	Same value as in request billing	M	
201-B1	Service Provider ID	Same value as in request billing	M	
401-D1	Date of Service	Same value as in request billing	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	R = Reject	M	
503-F3	Authorization Number		R	ADAP Transaction Tracking #
501-FA	Reject Count		R	
511-FB	Reject Code		R	
526-HQ	Response Message		R	
549-7F	Help Desk # Qualifier	Ø3 = Processor/PBM	R	ADAP help desk
550-8F	Help Desk Number		R	

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Ø1 = Rx Billing	M	
402-D2	Prescription/Service Reference Number		M	Rx Number

Eligibility Verification Response – Accepted

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	E1	M	
1Ø9-A9	Transaction Count	1	M	
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7 = NCPDP Provider ID	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service	Same value as in request	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	A = Approved	M	
5Ø3-F3	Authorization Number		R	ADAP Transaction Tracking #

Eligibility Verification Response – Rejected

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	E1	M	
1Ø9-A9	Transaction Count	1	M	
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7= NCPDP Provider ID #	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service	Same value as in request	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	R = Reject	M	
5Ø3-F3	Authorization Number		R	ADAP Transaction Tracking #
5Ø1-FA	Reject Count		R	
511-FB	Reject Code		R	
526-HQ	Response Message		R	
549-7F	Help Desk # Qualifier	Ø3 = Processor/PBM	R	ADAP help desk
55Ø-8F	Help Desk Number		R	

Reversal Response Accepted - Transaction Approved or Duplicate of Approved

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B2	M	
1Ø9-A9	Transaction Count	Same value as in request	M	
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7 = NCPDP Provider ID	M	
2Ø1-B1	Service Provider ID		M	NABP #
4Ø1-D1	Date of Service	Same value as in request	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	A = Approved S = Duplicate of Approved	M	
503-F3	Authorization Number		R	

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Ø1 = Rx Billing	M	
402-D2	Prescription/Service Reference Number		M	Rx Number

Reversal Response Accepted - Transaction Rejected

****SEGMENTS****

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
102-A2	Version/Release Number	51	M	
103-A3	Transaction Code	B2	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A	M	
202-B2	Service Provider ID Qualifier	Ø7= NCPDP Provider ID	M	
201-B1	Service Provider ID		M	NABP #
401-D1	Date of Service	Same value as in request	M	

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	R = Reject	M	
503-F3	Authorization Number		R	
501-FA	Reject Count		R	
511-FB	Reject Code		R	
526-HQ	Response Message		R	
549-7F	Help Desk # Qualifier	Ø3 = Processor/PBM	R	ADAP help desk
550-8F	Help Desk Number		R	

Response Claim Segment: Mandatory

<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	M/R/RW	Comment
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Ø1 = Rx Billing	M	
402-D2	Prescription/Service Reference Number		M	Rx Number

REBILL TRANSACTION RESPONSE

****SEGMENTS****

Note: Rebill Transaction Responses are identical to Billing Transaction Responses. The only difference is in field 103-A3 (Transaction Type). Additionally, there is no duplicate status for rebill transactions.

Notes on ADAP 5.1 Implementation

ADAP will begin accepting NCPDP 5.1 transactions on 10/16/2002. ADAP will continue to support 3.2 and 3A claims until 4/1/2003. At that time, 5.1 will be required for all electronic transactions. ADAP will be supporting the following transaction types:

B1 – Billing

Compound prescription types are not supported
Partial fill transactions are supported

B2 – Reversal

E1 – Eligibility Verification

B3 - Rebill

ADAP accepts claims for processing between the hours of 7:00 AM and 10:00 PM seven days a week. Billing transactions must be submitted within 14 days of the date of service. Claims may be reversed up until the time that they are processed for payment. Claims are processed for payment on a weekly basis.

ADAP Cardholder ID: The cardholder ID (302-C2) is an 11-digit field. On the card, it has the format 999999999-9-A. When this field is sent, omit the dashes and use the format 999999999A.

Pharmacy providers must be registered with ADAP prior to submitting claims electronically. There is no formal testing process for 5.1, however, providers may call and request ADAP to monitor the initial transmission of 5.1 transactions.

Questions Should Be Directed to:

**ADAP
EMPIRE STATION
P.O.BOX 2052
ALBANY, NY 12220-0052**

From Within New York State: **(800) 542-2437**
From Outside New York State: **(518) 459-1641**

HIV Uninsured Care Programs Troubleshooting Guide to Online Claims Processing

Common Error Codes and Corrective Actions

Code: M2 Recipient Locked In

Explanation: The participant is restricted to a single pharmacy and the claim is not from that pharmacy.

Correction: Call ADAP to confirm restriction. Instruct the participant go to assigned pharmacy. In certain situations, ADAP may change or remove the restriction.

Code: M4 Prescription Number/Time Limit Exceeded

Explanation: ADAP will pay for a total of five concurrent antiretroviral medications with no more than two of these being protease inhibitors.

Correction: This error can occur when a participant is changing medications or when a physician has deemed that more than five antiretroviral are required. In either case, the prescribing physician must sign an Exception To ADAP Antiretroviral Combination Limit form. Once this form is received by ADAP, an entry will be made in the ADAP concurrent treatment system that will allow more than five antiretroviral drugs for a given period.

Code: 19 Missing/Invalid Days Supply

Explanation: This code is generated when the days supply field (NCPDP # 405) is blank or is greater than 40 days (100 days in the case of vitamins or supplements).

Correction: Adjust the days supply to fit within ADAP limits where applicable, otherwise, an extended supply approval is required. A 90 day extended supply can be approved without written justification. Requests for an extended supply beyond 90 days or for a subsequent extended supply require a written justification

Code: 25 Missing/Invalid Prescriber ID

Explanation: All claims require a valid DEA number in the prescriber ID field (NCPDP # 411). DEA numbers have a total of nine characters. The first two characters are alphanumeric and the remaining seven are numeric.

Correction: Enter a valid DEA number. If the prescribing physician's DEA number, is not available, the pharmacy DEA number can be used.

Code: 41 Submit Bill To Other Processor Or Primary Payer

Explanation: This code is generated when an individual has Medicaid spenddown. ADAP will pay claims for individuals on spenddown. After the spenddown amount has been met and a seven day grace period has passed, claims will be denied with code 41.

Correction: Bill Medicaid

Code: 65 Patient Is Not Covered

Explanation: Individual is not covered by ADAP on the date of service.

Correction: Call ADAP to verify eligibility.

Note: Many individuals are terminated from ADAP once they become eligible for Medicaid. Verify Medicaid eligibility and bill Medicaid if approved.

Code: 70 NDC Not Covered

Explanation: **This error code does not indicate that a drug is not covered by ADAP.** NDC codes are specific to a medication manufacturer, dosage, and package size. A code 70 is generated when an active price for a NDC is not located in the ADAP system. This code is often generated in conjunction with a code 54 (Non-Matched NDC Number).

Correction: Call ADAP to verify that the drug is not covered.

Code: 75 Prior Authorization Required

Explanation: A number of medications covered by ADAP require prior approval before dispensing. Medications requiring prior approval are:

Correction: Prescribing physician must sign a Prior Authorization Request form. When this form is received by ADAP, an entry will be made in the prior approval system that will approve the medication for a given time period.

Code: 76 Plan Limitations Exceeded

Explanation: The quantity of all medications and devices is limited to a maximum supply for a 30 day period. This limit is prorated based on the days supply field (NCPDP # 405). The quantity of the drug or device dispensed divided by the days supply cannot exceed the maximum daily limit.

Correction: The days supply field may be adjusted to fall within ADAP limits. However, a physician may deem that it is clinically necessary to exceed ADAP limits. In this case, the physician must sign a Medication Limit Override form. Once this form is received by ADAP, an entry will be made in the drug limit override system that will allow a new limit for a designated participant for a specified time period.

Code: 79 Early Refill

Explanation: A prescription cannot be refilled until 75% of the supply has been used.

Correction: A reasonable justification for an early refill is required. This may include a dispensing error, lost or damaged prescription, or a patient use error. An entry will be made in the ADAP early refill system that will allow a refill for a designated participant for the specified NDC on a given day.

Code: 88 DUR Reject Error

Explanation: Needles/syringes require a prior approved claim for an injectable medication within one day prior to the claim.

Correction: If dispensing an injectable medication and syringe at the same time, submit the medication first. If no injectable medication is being dispensed, a needle/drug proximity override is required. If a needle/drug proximity override is required, call ADAP.

Questions regarding claim rejections should be directed to:

From Within New York State: **(800) 542-2437**

From Outside New York State: **(518) 459-1641**