State of Illinois
Department of Healthcare and Family Services

Handbook for Pharmacy Electronic Processing

Chapter 304 – Pharmacy Claims

Version 2.0
Last Revision Date: September 2018

Table of Contents

304.1 General Information

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

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

304.2 Transmission Types

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

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

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

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

HFS does not support the following transmissions:

C1 – Controlled Substance Reporting
C2 – Controlled Substance Reversal
C3 – Controlled Substance Rebill
D1 – Predetermination of Benefits
N1 – Information Reporting
N2 – Information Reporting Reversal
N3 – Information Reporting Rebill
P1 – Prior Approval Request and Billing
P2 – Prior Approval Reversal
P3 – Prior Approval Inquiry
P4 – Prior Approval Request Only
S1 – Service Billing
S2 – Service Reversal
S3 – Service Rebill

304.3 Business Rules

304.3.1 General Billing

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

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

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

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

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

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

304.3.2 Payor Sheets

HFS has developed Payor Sheets for the use of programmers in creating software to generate pharmacy claims and other transactions for the Illinois Medical Assistance

Program. These Payor Sheets define the required fields and allowable values that may be used within each field. The Payor Sheets may be found on the HFS website, Provider Payor Sheets for NCPDP Version D.0 ECP Input Transactions.

304.3.3 Partial Fills

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

Dispensing fees will only be paid on completed prescriptions.

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

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

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

304.3.5 Compound Drugs

The Illinois Medical Assistance Program defines a compound drug as a pharmaceutical product that results from the combining, mixing, or altering of two or more ingredients, excluding flavorings, to create a customized medication for an individual patient in response to a licensed practitioner's prescription. For the purposes of billing a compound a maximum of 25 ingredients may be included. If a compound is submitted to the Department with over the maximum of 25 components, the transaction will be rejected.

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

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

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

When a submission clarification code of 8 is used, as long as one medication is accepted for payment, the system will bypass all additional rejections for other ingredients.

304.4 Transmission Responses

304.4.1 Transmission Reject Response

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

304.4.2 Billing Transmission Responses (B1)

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

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

304.4.2.1 Payable or Duplicate Response

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

304.4.2.2 Rejected Response

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

304.4.3 Reversal Transmission Responses (B2)

304.4.3.1 Approved Response

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

304.4.3.2 Rejected Response

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

304.4.4 Rebill Transmission Responses (B3)

304.4.4.1 Payable Response

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

304.4.4.2 Rejected Response

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

304.4.6 Eligibility Verification Transmission Responses (E1)

304.4.6.1 Approved Response

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

304.4.6.2 Rejected Response

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

304. 5 Third Party Liability

The pharmacy must show the disposition of each request to an Other Payer when submitting the claim to HFS. If the payer made a payment to the pharmacy, then both the Other Payer Amount Paid (431-DV) and the Other Payer Patient Responsibility Amount (352-NQ) along with applicable qualifiers must be shown. If a payer rejected the request for payment, then each separate value in the Other Payer Reject Code (field 472-6E) must be shown.

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

In some situations HFS will deduct a co-payment amount for the patient from the amount of reimbursement to the pharmacy.

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

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

304.6 Medicare Part B Drug Coverage

HFS has developed edits to reject claims for Part B covered drugs if there is no indication that Medicare has adjudicated the claim. It is the responsibility of the pharmacy to submit the claim to Medicare for processing. After Medicare has processed the claim, if the claim is not automatically crossed over from Medicare to HFS, it may be submitted to HFS electronically with the Third Party fields completed. HFS will then process the claim and pay the lesser of the HFS's allowable amount or the difference between the Pharmacy charge and Medicare's payment.