Pharmacy Provider Manual

Select Health Pharmacy Plans

January 2025

Select Health

Scripius

Table of Contents

Continued on page 3....

Table of Contents, Continued

1.0 General Overview

For any questions or issues not resolved in this provider manual, please email SHPharmacyContracting@selecthealth.org.

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

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

1.1 CONFIDENTIALITY STATEMENT

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

1.2 PHARMACY REQUIREMENTS

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

Patient service standards include that pharmacies/pharmacists will:

- Maintain patient profiles for prescription medication dispensed.
- Not destroy any patient record produced, unless prior written consent is obtained from Select Health, for a period of at least five (5) years.
- React appropriately to online edits, which may affect the patient's medical status or coverage.
- Provide instruction to the patient on the use of medication, including information based on the online drug messages, before dispensing of each prescription, according to state and federal law.
- Provide all drug products covered by the benefit plans, including products normally stocked and those that require special order, if possible.
- Have established formal prescription quality assurance and error prevention measures.
- Have a formal process for handling prescription errors.

Provider credentialing standards include that the pharmacy will:

- Carry a valid pharmacy operating license.
- Maintain valid professional liability and general liability insurance for the pharmacy in the amounts of $1,000,000 per occurrence and $3,000,000 aggregate coverage.
- Maintain a valid DEA registration.
- Cooperate with Select Health pharmacy auditors and recovery of any overages identified as a result of an audit.
- Maintain a current/valid State Board of Pharmacy License that contains no restrictions (established procedures for verification of pharmacist licensure will be in place).

Pharmacies who wish to join the Select Health Pharmacy Provider Network may email SHPharmacyContracting@selecthealth.org to initiate a contract request.

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

- Claims Processing
- Prior Authorization Requests

2.0 Contact Information

2.1 SELECT HEALTH PHARMACY HELP DESK

24 hours a day, 7 days a week

- Assistance with Reject Messages (see **Section 8.0**)

Contact the Help Desk for:

- Network and Contract Issues/Questions
- Claims Investigation
- Provider Remittance Statements
- Payment Issues/Questions
- General Questions

Help Desk Phone Numbers:

Select Health Commercial\ Scripius PBM Products

- Toll Free: **800-442-3127**
- Fax: **801-650-3279**

Select Health Medicare® (Medicare Part D):

- Toll Free: **855-442-9988**
- Fax: **801-650-3170**

Select Health Community Care® (Utah State Medicaid)

- Toll Free: **855-442-9988**
- Fax: **866-811-4997**

2.2 PRIOR AUTHORIZATION REQUESTS

Electronic preauthorization requests can be submitted using most electronic medical record platforms, or via **https://selecthealth.org/pa**.
For Avera group members ONLY, submit requests via **https://avera.promptpa.com.**

2.3 SELECT HEALTH MEMBER SERVICES

Monday through Friday, 7:00 a.m.–9:00 p.m. (MST)

Saturday, 9:00 a.m.–3:00 p.m. (MST)

Closed Sunday

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

- Select Health Commercial Products
  - Toll Free: **800-538-5038**
  - Fax: **801-650-3279**
- Select Health/Scripius PBM Products
  - Toll Free: **800-442-3127**
  - Fax: **801-650-3279**
- Select Health/Scripius Avera Products
  - Toll Free: **833-464-7663**
  - Fax: **801-650-3279**
- Select Health Medicare (Medicare Part D)
  - Toll Free: **855-442-9900**
  - Fax: **801-650-3170**
- Select Health Community Care (Medicaid)
  - Toll Free: **855-442-9900**
  - Fax: **866-811-4997**

2.4 SELECT HEALTH ADDRESSES

Physical Address: 5381 Green Street, Murray, UT 84123

Claims Mailing Addresses:

- Commercial, Scripius PBM, and Select Health Community Care (Medicaid)
  - PO Box 30192
  - Salt Lake City, UT 84130
- Select Health Medicare (Medicare Part D)
  - PO Box 30196
  - Salt Lake City, UT 84130

3.0 General Claims Processing Information

3.1 ONLINE PROCESSING INFORMATION

See Appendix: Payer Sheet beginning on page 31 for additional processing instructions and requirements.

- Select Health Commercial and Scripius PBM Products
  - BIN – 800008 PCN – **not required**
  - Group – **not required**
- Avera Health Plans Rx
  - BIN – 026952 PCN – Avera
  - Group – **not required**
- Select Health Medicare (Medicare Part D)
  - BIN – 015938 PCN – 7463
  - Group – UT/ID/CO = U1000009; NV Intermountain = U1000011
- Select Health Medicare Prescription Payment Plan
  - BIN – 027357 PCN – MPPP
  - Group – **not required**
- Select Health Community Care (Utah State Medicaid)
  - BIN – 800008 PCN – 606
  - Group – **not required**

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

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

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

3.2 SELECT HEALTH ID CARDS

Select Health maintains a guide with **sample ID cards** on their website. The primary cardholder of Select Health will receive an ID card that will provide the card holder's identification number and co-payment information.

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

3.3 MEMBER IDENTIFICATION NUMBER

Select Health Community Care Identification Numbers

Individuals enrolled in Select Health Community Care will be issued identification cards by the Utah Department of Health. Pharmacies should request Medicaid identification cards when dispensing medication. Select Health Community Care claims can be submitted for processing using the Medicaid identification number.

3.4 DEPENDENT COVERAGE

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

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

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

3.5 ELIGIBILITY VERIFICATION

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

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

Select Health Community Care members must use a participating pharmacy of Utah Medicaid and Select Health Community Care to obtain benefits.

Members not using a participating pharmacy must pay in full for their prescription(s) and seek reimbursement from Select Health.

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

3.6 COORDINATION OF BENEFITS (COB)

Most Select Health plans allow for coordination of benefits (COB) with a member's primary carrier. If a member has an additional prescription benefit plan, the pharmacy should submit the claim to the appropriate payer in accordance with any coordination of benefits requirements. The pharmacy should submit the primary claim to the member's primary payer for adjudication. In some instances, the secondary claim can be electronically submitted to Select Health for adjudication. The member may

seek reimbursement from Select Health for any secondary claims not processed electronically.

Secondary Claim Submission (Select Health Community Care)

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

3.7 PRESCRIPTION COSTS AND REIMBURSEMENT

Member Financial Responsibility

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

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

- Brand vs. Generic Drug
- Quantity Dispensed
- Day Supply Dispensed
- Member Deductible

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

Prohibition on Billing Patients

Participating pharmacies of Select Health/Scripius are prohibited from collecting payment from members, for covered services, that exceeds any designated cost-sharing amount returned via the point-of-sale system. This includes, but is not limited to, any amount less than the pharmacy's acquisition cost, any additional cost incurred when a specific brand or manufacturer is requested by the member, additional fees for services included in the dispensing of the drug (i.e. additional compounding fees), etc.

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

Reimbursement Rate Questions

If the pharmacy has questions regarding the reimbursement rate for a particular medication, they are welcome to contact the Select Health Pharmacy Help Desk for assistance. Additionally, the pharmacy can review the following items that can directly affect the reimbursement rate to ensure the transaction was submitted correctly:

- Quantity Submitted: Confirm that the metric quantity of the prescription was submitted correctly.
- Day Supply: Confirm that the day supply of the prescription was submitted correctly.
- DAW Code: Confirm that the submitted DAW code accurately reflects the situation.

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

3.8 SIGNATURE LOG

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

3.9 E-PRESCRIBING

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

Pharmacies must submit the Origin Code on the transaction, in accordance with the Payer Sheet included in this Provider Manual, to indicate how the prescription was obtained by the pharmacy.

To qualify as an electronic prescription, the electronic prescription must be noted prior to dispensing, and must clearly record, in a manner that cannot be altered, the system-assigned user and date and time stamp to take the place of hard copy documentation. For auditing purposes, the following data elements should be present on an electronic prescription as authentication of electronic signatures:

- Electronic Transaction Identifier
- Prescriber Identifier(s)
- Written Date/Time
- Designated Agent (if applicable)

Pharmacies may only dispense federally Controlled Substances based on a written or electronic prescription that complies with all applicable laws and regulations for prescribing and dispensing Controlled Substances.

4.0 Dispensing Edits

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

4.1 QUANTITY AND DAY SUPPLY LIMITS

Select Health Commercial, Scripius PBM Products, and Select Health Community Care (Utah State Medicaid)

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

- Maximum thirty-four (34)-day supply of tablets, capsules, and liquids to be taken orally.
- Maximum one (1) vial containing no more than fifteen (15) millliliters of any otic or ophthalmic product; if only manufactured in package sizes greater than fifteen (15) millliliters, the smallest package size available from the manufacturer is mandated. One copay will be charged per vial.
- Some products may be limited to an approved quantity per each acute treatment period.

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

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

Select Health Medicare (Medicare Part D)

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

4.2 REFILLS

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

- Prescriptions cannot be refilled beyond twelve (12) months from the date on which the prescription was written. After the 12 months have lapsed, a new prescription with a new prescription number must be assigned.
- Prescriptions should not be refilled more times than the number specified by the prescriber.
- Additional refills authorized by the prescriber must be documented on the hard copy of the prescription or a new prescription number must be assigned with the refills indicated.

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

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

4.3 DAW CODES

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

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

4.4 COMPOUND PRESCRIPTIONS

NOTE: Compounds are not covered for all plans or lines of business.

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

- Facility space and equipment
- Source ingredient selection and calculations
- Stability, sterility, and beyond-use dating
- Formulation and checklist for acceptable strength, quality, and purity
- Compounding log and quality control

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

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

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

Non-Covered Ingredients

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

5.0 Appeals and Grievances

5.1 MEMBER APPEALS AND GRIEVANCES

Select Health Commercial, Select Health/Scripius PBM Products, and Select Health Community Care (Utah State Medicaid)

Please direct all appeals or grievances on behalf of a member, to the Select Health Member Appeals department, by phone or in writing to:

Select Health
Attn: Member Appeals Department
P.O. Box 30192
Salt Lake City, UT 84130
Phone: **844-208-9012**
Fax: **801-442-0762**
Email: **appeals@imail.org**

Select Health Medicare (Medicare Part D)

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

5.2 AVERA APPEALS

Please direct all appeals on behalf of a member to the Avera Appeals department, by phone or in writing to:

— Toll Free: **888-322-2115**
— Email: **ComplaintAppeals@AveraHealthPlans.com**
— Mailing Address: **5300 S Broadband Ln. Sioux Falls, SD 57108**."

5.3 MAC LIST REQUESTS

Pharmacies can email **SHPharmacyContracting@selecthealth.org** to obtain a copy of the MAC list. Pharmacies will not be charged a fee for the request. The list will be supplied as an Excel file to the pharmacy within one (1) business day.

Pharmacies may request additional MAC lists for historical pricing records. Pharmacy must specify the dates needed for MAC pricing within their request so that the correct information can be supplied to the pharmacy.

5.4 MAC PRICING RESEARCH REQUESTS

Select Health and its designated vendor(s):

- Use multiple sources, including but not limited to Medi-Span data, to review AWP, WAC, NADAC, AAC, and FUL pricing, along with other marketplace data to determine the costs on MAC pricing lists.
- Monitor these sources for updates at least every seven (7) calendar days to help manage market fluctuations.
- Review MAC pricing lists at least every seven (7) calendar days and update accordingly.

Pharmacies who disagree with MAC pricing on a claim may submit a MAC Pricing Research Request (appeal) through Select Health's online tool available at **selecthealth.org/pharmacy/resources**. Pharmacies will not be charged a fee or assessed any costs associated with submitting a MAC Pricing Research Request (appeal).

Requests must be received within twenty-one (21) days of initial adjudication. Additionally, an invoice dated within thirty (30) days of the claim date of service, showing the pharmacy's acquisition cost, must be provided. Requests outside of these parameters or sent via email will not be accepted.

Requests are investigated and resolved within fourteen (14) days after a request is received. Responses to the pharmacy include the rationale for the determination. When the request is approved, the price will be adjusted prior to notifying the pharmacy of the determination of the request to allow for immediate reprocessing.

All review determinations on any individual claim from a pharmacy are final and will not be reviewed again.

Requests where the basis of reimbursement is other than MAC pricing cannot be reviewed via the MAC Pricing Research Request process, including but not limited to non-covered compound ingredients and rejected claims.

If any state-specific law, rule, or regulations differs or contradicts the MAC process set forth herein, Select Health follows the state-specific law, rule, or regulation.

5.5 TENNESSEE REIMBURSEMENT APPEALS

FOR TENNESSEE PHARMACIES ONLY

The initial appeal process is available for all prescription drugs or devices covered under the pharmacy benefit in Tennessee for which a pharmacy alleges it did not receive its actual cost. The appeal must be filed within seven (7) business days of the initial claim adjudication.

Select Health accepts the Tennessee reimbursement appeal form found on the Tennessee website (Tennessee Insurance: Pharmacy Benefits Managers). Appeals should be submitted via email to **SHPharmacyContracting@selecthealth.org**. The appeal must include a complete appeal form and supporting documentation, including the name and contact information of the wholesaler or manufacturer from which the pharmacy purchased the drug, device, or medical product.

Select Health adheres to all timelines for the initial appeal process as outlined in T.C.A 56-7-3206(c)(2)(B)(ii) and TN Rule 0780-01-95-.05, including:

- Confirming receipt of a complete or incomplete appeal within five (5) business days of receipt. If an incomplete appeal is received, Select Health will notify the pharmacy of the information needed to review and complete the appeal.

- Allowing the pharmacy five (5) business days to respond and provide additional information.
- Reviewing and providing a final determination for the appeal within seven (7) business days, once Select Health has received all required information from the pharmacy.

Select Health may choose to deny the appeal if a pharmacy fails to comply with applicable timing requirements. If Select Health does not comply with applicable timing and notice requirements, the request will be resolved in favor of the pharmacy.

Questions regarding the appeal process can be sent to **SHPharmacyContracting@selecthealth.org**.

5.6 PHARMACY APPEALS

For any escalated questions or issues not resolved in this provider manual, pharmacies may email concerns to **SHPharmacyContracting@selecthealth.org**.

6.0 Audit Information

Select Health has an obligation to members and clients to ensure all contracted services are provided in accordance with the Pharmacy Provider Services Agreement. Select Health and its designated vendor regularly monitor and audit pharmacy claims to ensure program integrity and to help protect against Fraud, Waste, and Abuse (FWA). All claims submitted to Select Health are subject to audit.

The pharmacy will provide access at reasonable times upon request by either Select Health or their designee or any governmental regulatory agency to inspect the facilities, equipment, books, signature logs, files, and records of the pharmacy. This includes, but is not limited to, member records and all prescription dispensing records. A notice will be sent to the pharmacy location that has filled the prescription(s) in question. A description of the issue under review will be included, along with specific claim-related information.

Advanced notice of an audit is not required when the audit is performed for suspected fraud, waste or abuse (FWA).

Audits may take the form of a phone call, desktop audit, on-site visit, internal claims review, compliance reviews, or investigative (FWA) audits. Audits are conducted in accordance with applicable laws and state regulatory guidelines.

Failure to comply with an audit or investigation may result in recoveries and/or termination from the network. Pharmacies will receive written preliminary and final results following an audit.

6.1 AUDIT APPEALS - PRELIMINARY RESULTS

The pharmacy is given thirty (30) days from the date of the Preliminary Results letter to review the claim(s) in question and contest the results by supplying supporting documentation, depending on the scope of the audit. Instructions to reply to the audit are included in the Preliminary Results letter and must be submitted in writing. The auditor will review the appeal and supporting documentation. The pharmacy will be notified of the final audit results after the appeal window is closed.

Lack of response to the Preliminary Results letter will be interpreted as non-compliance and the pharmacy is subject to adjustment of the paid dollars on those claims. Appeals will not be accepted after the thirty (30) day appeal period has passed, and the audit will be considered final.

Additionally, when billing discrepancies are identified by Select Health and are disclosed to the pharmacy, the pharmacy is given thirty (30) days to review/dispute the findings. If a response is not received within this time, this will be interpreted as consent to the finding and the adjustment will be reflected on the pharmacy's next remittance cycle.

When necessary, extensions will be granted if the pharmacy contacts Select Health or its designated vendor within the specified time for the appeal. Appeals are reviewed in accordance with applicable laws and state regulatory guidelines.

6.2 AUDIT APPEALS - FINAL RESULTS

The pharmacy is given thirty (30) days from the date of the Final Results letter to review the claim(s) in question and contest the results by supplying supporting documentation, depending on the scope of the audit. Instructions to appeal are included in the Final Results letter and must be submitted in writing. Select Health will review the appeal and supporting documentation. The pharmacy will be notified of the final audit results after the appeal window is closed.

Lack of response to the Final Results letter will be interpreted as consent with the audit findings and the pharmacy is subject to adjustment of the paid dollars on those claims. Appeals will not be accepted after the thirty (30) day appeal period has passed, and the audit will be considered final.

Appeals are reviewed in accordance with applicable laws and state regulatory guidelines.

6.3 AUDIT RECOVERIES

Claim adjustments (recoveries) will not be completed until the appeal windows have closed and the pharmacy has been given sufficient opportunity to contest the audit findings. Audit recoveries are handled by offsetting the audit finding amounts against future payments on the pharmacy's next remittance.

6.4 PRESCRIPTION VALIDATION REVIEWS

Select Health regularly conducts prescription validation reviews for quality assurance purposes, which are distinct from and are not considered audits. Reviews are used to verify the validity and accuracy of submitted prescription claims.

The pharmacy will be contacted via email, fax, or phone and asked to provide photocopies of specific documents and records related to the claim(s) in question. The pharmacy will be given seven (7) business days, unless otherwise indicated in the request, to provide the applicable and necessary documentation to satisfy the review.

The pharmacy is required to answer reasonable fax, email, and phone inquiries to validate a member being billed, prescriber information, quantities being dispensed, prescription directions, compounded drug ingredients, etc.

7.0 Formulary Information

7.1 SELECT HEALTH COMMERCIAL AND SCRIPIUS PBM PRODUCTS

NOTE: Compounds are not covered for all plans or lines of business.

Covered Medications and Services

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

- Injectable insulin and insulin syringes when written on a prescription
- Compounded medications that are prepared following good compounding practices as defined by the United States Pharmacopoeia (USP DI-Volume III: Approved Drug Products and Legal Requirements). (see “Compound Prescriptions” section)
- Oral contraceptives (plan specific)
- Blood glucose test strips
- Flu vaccine

Covered Injectable and Specialty Medications

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

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

Generally Excluded Medications and Services

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

- Certain drugs with a therapeutic over-the-counter (OTC) equivalent
- Drugs purchased from Out-of-Network Providers over the Internet
- Flu symptom drugs, except when approved by an expert panel of Physicians and Select Health
- Non-Sedating Antihistamines
- Prescription drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion
- Replacement of lost, stolen, or damaged drugs
- Sexual dysfunction drugs

- Travel-related medications, including preventive medication for the purpose of travel to other countries
- All non-prescription contraceptive jellies, ointments, foams, and/or devices, such as IUDs
- Appetite suppressants and weight loss medications
- Certain off-label drug usage, unless the use has been approved by a Select Health Medical Director or clinical pharmacist
- Compound drugs when alternative products are available commercially
- Cosmetic agents, health or beauty aids, or prescriptions used for cosmetic purposes, including minoxidil for hair growth
- DMSO (dimethyl sulfoxide)
- Drugs not meeting the minimum levels of evidence based upon Food and Drug Administration (FDA) approval, the drug has no active ingredient and/or clinically relevant studies as determined by Select Health
- Drugs or medicines purchased and received prior to the member's effective date of coverage or after the member's termination of coverage
- Food supplements, food substitutes, medical foods, and formulas
- Human growth hormone
- Infertility medications or drugs used for infertility purposes
- Medication not requiring a prescription, even if ordered by a participating provider by means of a prescription, and drugs that are not medically necessary or that are used inappropriately
- Medication which may be properly received without charge under local, state, or federal programs or which are reimbursable under other insurance, including Worker's Compensation
- Pharmacy & Therapeutics Committee, nationally recognized compendium sources currently utilized by Select Health, National Comprehensive Cancer Network (NCCN), or as defined within Select Health's Preauthorization criteria or medical policy
- Minerals, fluoride, and vitamins other than prenatal or when determined to be Medically Necessary to treat a specifically diagnosed disease
- Non-prescription vitamins
- Over-the-counter (OTC) medications, except when **all of the following** conditions are met:
  - The OTC medication is listed on the Select Health formulary as a covered medication.
  - The Select Health Pharmacy & Therapeutics Committee has approved the OTC medication as a medically appropriate substitution of a prescription drug or medication.
  - The member has obtained a prescription for the OTC medication from a licensed provider and filled the prescription at a participating pharmacy.

- Prescriptions written by a licensed dentist, unless for the prevention of infection or pain in conjunction with a dental procedure.
- Progesterone powder (micronized progesterone), except when prior authorized during pregnancy or other FDA-approved use.
- Therapeutic devices or appliances including hypodermic needles, syringes, support garments, and other non-medicinal substances (except insulin syringes, glucose test strips, and inhaler extensions).

7.2 SELECT HEALTH MEDICARE (MEDICARE PART D)

Covered Medications and Services

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

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

Generally Excluded Part D Medications

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

Diabetic Supplies

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

Step Therapy

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

Exceptions and Coverage Determinations

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

- For coverage of a drug that requires prior authorization
- For coverage of a drug that is not covered on the plan's formulary
- To bypass step therapy or quantity limit restrictions
- To cover a drug at a lower tier

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

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

Part B and Part D Benefit Overlap

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

Exceptions to Plan Coverage

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

7.3 SELECT HEALTH COMMUNITY CARE (MEDICAID)

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

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

- Attention deficit hyperactivity disorder (ADHD)
- Antidepressant
- Anti-anxiety
- Anticonvulsant
- Antipsychotic
- Hemophilia factor
- Immunosuppressive
- Substance abuse (opioid or alcohol)

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

General exclusions include these services:

- Duplicate prescription for lost, stolen, destroyed, spilled, or otherwise non-usable medication with some exceptions
- Compounded prescriptions
- Lozenges, suckers, rapid dissolve, lollipop, pellets, patches, or other unique formulation delivery methodologies developed to garner "uniqueness," except where the specific medication is unavailable in any other form
- Specific excluded drug classes:
  - Cosmetic preparations
  - Minerals
  - Patches
  - Weight gain or loss
  - Vitamins, except when provided for:
    - **Pregnant women**: prenatal vitamins with folic acid (prenatal vitamins are not covered post-delivery)
    - **Children through age five**: children's vitamin drops with or without fluoride
    - **Adults and children of all ages**: fluoride supplement
- Covered outpatient drugs that the manufacturer seeks to require as a condition of sale for which associated tests and monitoring services are purchased exclusively from the manufacturer or its designee
- Agents used for the treatment of sexual or erectile dysfunction

8.0 Payment and Reconciliation Information

8.1 PAYMENT SCHEDULE

Select Health Commercial, Scripius PBM Products, and Select Health Community Care (Utah State Medicaid)

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

Select Health Medicare (Medicare Part D)

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

8.2 REMITTANCE REPORT

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

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

8.3 ELECTRONIC FUNDS TRANSFER (EFT)

Pharmacies wishing to receive payments via Electronic Funds Transfer (EFT) may submit a request to the Select Health Pharmacy Networks Team by emailing **SHPharmacyContracting@Selecthealth.org**.

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

8.4 340B CLAIMS

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

9.0 Select Health Medicare (Medicare Part D): Specific Information

9.1 PLAN SUMMARY

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

9.2 FRAUD, WASTE, AND ABUSE

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

9.3 TRAINING

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

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

9.4 PHARMACY CERTIFICATION FOR PART D

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

9.5 FEDERAL HEALTH CARE PROGRAMS PARTICIPATION EXCLUSION

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

9.6 MEDICARE PRESCRIPTION PAYMENT PLAN

Beginning **January 1, 2025**, Medicare beneficiaries may opt into the Medicare Prescription Payment Plan (M3P). The M3P is an option for all Medicare beneficiaries where they can spread the costs of their regular pharmacy copays over time rather than pay the full copay at the pharmacy counter. Once a Medicare beneficiary has opted into the M3P they will no longer pay their regular copays at point of sale. Instead, they will pay nothing at the pharmacy counter and Select Health will bill them directly for the cost of their copay.

Select Health will cover the cost of the copay to the pharmacy and the pharmacy will not be required to collect the copay. To make this possible, pharmacies will be required to bill Select Health for both the regular Part D covered medication as well as the copay electronically. Pharmacies will need to follow the steps below to bill correctly:

1. Pharmacy bills Select Health using Medicare BIN/PCN (015938/7463) as usual

2. Upon receipt of the paid claim, pharmacy will receive messaging from Select Health that the Medicare beneficiary has opted into the M3P and should not pay their normal copay.

3. Pharmacy bills any secondary, tertiary, etc. insurance the Medicare beneficiary has on file.

4. Pharmacy bills the resultant copay back to Select Health using the M3P BIN/PCN of 027357/MPPP .

5. Pharmacy will receive confirmation of paid copay amount from Select Health.

Pharmacies will be required to provide information about the M3P to Medicare beneficiaries that are likely to benefit from this new program. When a Medicare beneficiary that is not participating in the M3P program has a copay of $600 or greater, Select Health will provide a code to instruct the pharmacy to provide the M3P informational sheet to the beneficiary to help them understand the benefits to them of participating in the M3P program. This process is similar to the procedure for providing appeals rights to Medicare beneficiaries when they receive a rejected claim. This information sheet will give the beneficiary the information to opt into the program if desired.

For additional assistance on this program, contact the Select Health Medicare Help Desk at **855-442-9988**.

9.7 GENERAL PROCEDURES FOR ACKNOWLEDGMENT LETTERS

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

9.8 FORMULARY TRANSITION FILL PLAN

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

9.9 LONG-TERM CARE (LTC) FACILITIES

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

9.10 HOME INFUSION THERAPY

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

9.11 MEDICARE SERVICE AREA

The Select Health Medicare Advantage program covers the following service areas:

- **Utah Counties**: Box Elder, Cache, Davis, Franklin (ID), Garfield, Iron, Juab, Millard, Morgan, Piute, Rich, Salt Lake, Sanpete, Sevier, Summit, Tooele, Utah, Washington, Wayne, Weber
- **Idaho Counties**: Ada, Adams, Boise, Canyon, Cassia, Elmore, Gem, Gooding, Jerome, Minidoka, Owyhee, Payette, Valley, Twin Falls, Washington
- **Nevada Counties**: Clark, Nye
- **Colorado Counties**: Adams, Arapahoe, Broomfield, Boulder, Clear Creek, Delta, Denver, Douglas, Elbert, El Paso, Gilpin, Jefferson, Mesa, Park, Pueblo, Teller

10.0 Select Health Community Care (Medicaid): Specific Information

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

10.1 TAMPER-RESISTANT PRESCRIPTION PAD REQUIREMENTS

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

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

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

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

10.2 GENERIC PREPARATIONS

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

10.3 MEDICATIONS PROVIDED IN A MEDICAL EMERGENCY

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

10.4 RESTRICTION PROGRAM

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

- Periodic review of patient profiles to identify inappropriate over-utilization of medical providers, urgent care centers, specialists, medications, and/or pharmacies.
- Verbal and written reports of inappropriate use of services generated by one or more health care providers regarding the member. These reports are verified through a review of the patient's claim history by Medicaid staff and medical consultants.
- Referral from Medicaid staff.

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

- Listed on the card; and
- From whom members were appropriately referred.

Emergency services are not restricted to assigned providers.

Appendix A: State-Specific Pharmacy Regulatory Resources

Several states require provider and pharmacy benefit managers (PBMs) to comply with certain statutes and regulations when providing pharmacy services to members. The information below includes various resources to determine the state-specific regulations, requirements, and laws that may apply to the Pharmacy Services Agreement between Select Health and its participating Pharmacy Providers. Providers and PBMs are required to comply with all applicable requirements. In the event there is a conflict between a provision in the agreement or provider manual and the applicable state-specific provision, the state-specific provision will be followed.

This appendix may be amended from time to time to reflect changes to the applicable law(s).

Colorado

- Audit Laws/Regulations - https://leg.colorado.gov/bills/hb21-1297
- Board of Pharmacy - https://dpo.colorado.gov/Pharmacy
- Pharmacy Laws/Regulations - https://dpo.colorado.gov/Pharmacy/Laws

Idaho

- Audit Laws/Regulations - https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2018/legislation/S1336.pdf
- Board of Pharmacy - https://bop.idaho.gov/
- Pharmacy Laws/Regulations - https://bop.idaho.gov/pharmacy-code-administrative-rules/

Iowa

- Audit Laws/Regulations - https://www.legis.iowa.gov/docs/ACO/chapter/191.59.pdf
- Board of Pharmacy - https://pharmacy.iowa.gov/
- Pharmacy Laws/Regulations - https://pharmacy.iowa.gov/ruleslaws

Minnesota

- Audit Laws/Regulations - https://www.revisor.mn.gov/
- Board of Pharmacy - https://mn.gov/boards/pharmacy/
- Pharmacy Laws/Regulations - https://mn.gov/boards/pharmacy/statutes/

Nebraska

- Audit Laws/Regulations - https://nebraskalegislature.gov/laws/statutes.php?statute=44-4607
- Board of Pharmacy - https://dhhs.ne.gov/licensure/Pages/Pharmacy-Professions.aspx
- Pharmacy Laws/Regulations - https://dhhs.ne.gov/licensure/Documents/Pharmacy.pdf

Nevada

- Board of Pharmacy - https://bop.nv.gov/
- Pharmacy Laws/Regulations - https://bop.nv.gov/board/ALL/Regulations/

North Dakota

- Audit Laws/Regulations - https://www.nodakpharmacy.com/pdfs/2012lawbook.pdf
- Board of Pharmacy - https://www.nodakpharmacy.com/
- Pharmacy Laws/Regulations - https://www.nodakpharmacy.com/laws-rules.asp

Oregon

- Audit Laws/Regulations - https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013orLaw0570.pdf
- Board of Pharmacy - https://www.oregon.gov/pharmacy/Pages/index.aspx
- Pharmacy Laws/Regulations - https://www.oregon.gov/pharmacy/Pages/Laws-Rules.aspx

South Dakota

- Audit Laws/Regulations - https://sdlegislature.gov/Statutes/Codified_Laws/2076360
- Board of Pharmacy - https://doh.sd.gov/boards/pharmacy/
- Pharmacy Laws/Regulations - https://sdlegislature.gov/Statutes/Codified_Laws/2060038

Tennessee

- Audit Laws/Regulations - https://casetext.com/statute/tennessee-code/title-56-insurance/chapter-7-policies-and-policyholders-33373/part-31-pharmacy-benefits-managers
- Board of Pharmacy - https://www.tn.gov/health/health-program-areas/health-professional-boards/pharmacy-board.html
- Pharmacy Laws/Regulations - https://publications.tnsosfiles.com/rules/1140/1140.htm
- Reimbursement Appeals - https://publications.tnsosfiles.com/rules/0780/0780-01/0780-01.htm

Utah

- Audit Laws/Regulations - https://le.utah.gov/xcode/Title58/Chapter17B/C58-17b-S622_1800010118000101.pdf
- Board of Pharmacy - https://dopl.utah.gov/pharm/index.html
- Pharmacy Laws/Regulations - https://dopl.utah.gov/pharmacy/laws-and-rules/

Appendix B: Payer Sheet

General Information

Payer Name: SelectHealth, Inc.	Date: 8/21/2Ø24		
Plan Name/Group Name:	**BIN:**	**PCN:**	**GROUP:**
Select Health Commercial	8ØØØØ8	Not required	Not required
Scripius (PBM)	8ØØØØ8	Not required	Not required
Select Health Medicaid	8ØØØØ8	6Ø6	Not required
Select Health Medicare	Ø15938	7463	Printed on card
Select Health Worker's Compensation	Ø183Ø8	WCØØ1	Not required
Intermountain Rx Charity Program	Ø24Ø61	PA123	Not required
Avera Health Plans Rx	Ø26952	AVERA	Not required
Select Health Medicare Prescription Payment Plan	Ø27357	MPPP	Not required
Effective as of: 1/1/2Ø25	NCPDP Telecommunication Standard Version/Release: DØ ECL version: July 2Ø14		
Certification Testing Window: N/A			
Certification Contact Information: Rx_BA@imail.org			
Provider Relations Contact Information: SHPharmacyContracting@selecthealth.org			
Other Contact Information: Select Health Pharmacy Services 8ØØ-442-3129 M-F 7:ØØ AM – 9:ØØ PM (MST) Sat 9:ØØ AM – 3:ØØ PM (MST) Select Health Medicare Pharmacy Services 855-442-9988 Medicare Assistance Available 24 hours a day / 7 days a week			
Maximum Number of Transactions Supported Per Transmission	1 – Medicare 4 – Commercial/Medicaid		
Submission and Reversal Window (days from date filled/dispensed to date submitted)	Commercial	9Ø Days	
	Medicaid	9Ø Days	
	Medicare	9Ø Days	
	If an exception is needed, please contact SelectHealth Pharmacy Services		

Supported Transactions

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

Table Legend

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

Segment and Field Requirements

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

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

Claim Billing/Claim Rebill Transaction

Transaction Header Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
1Ø1-A1	BIN Number	M	8ØØØØØ8 – Commercial/Medicaid/PBM Ø15938 – Medicare Ø183Ø8 – Workers' Compensation Ø24Ø61 – Intermountain Rx Charity Program Ø26952 – Avera Health Ø27357 - Select Health Medicare Prescription Payment Plan
1Ø2-A2	Version/Release Number	M	DØ

1Ø3-A3	Transaction Code	M	B1, B3
1Ø4-A4	Processor Control Number	M	6Ø6 – Medicaid 7463 – Medicare PA123 – Intermountain Rx Charity Program AVERA- Avera Health MPPP - Select Health Medicare Prescription Payment Plan
1Ø9-A9	Transaction Count	M	Ø1 – 1 occurrence (Required for Medicare) Ø2 – 2 occurrences Ø3 – 3 occurrences Ø4 – 4 occurrences
2Ø2-B2	Service Provider ID Qualifier	M	Ø1 – NPI
2Ø1-B1	Service Provider ID	M	1Ø digit NPI number
4Ø1-D1	Date of Service	M	CCYYMMDD
11Ø-AK	Software Vender/Certification ID	M	Use value for Switch's requirements or send spaces

Insurance Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø4 – Insurance Segment
3Ø2-C2	Cardholder ID	M	9-character ID beginning with 8Ø. Use Select Health Medicare Cardholder ID for Select Health Medicare Payment Plan.
312-CC	Cardholder First Name	R	
313-CD	Cardholder Last Name	R	
3Ø3-C3	Person Code	R	Not required unless patient is a twin, triplet, etc., covered under the same policy or if otherwise instructed by Pharmacy Services
3Ø6-C6	Patient Relationship Code	R	
36Ø-2B	Medicaid Indicator	RW	Submit when patient has Medicaid coverage
115-N5	Medicaid ID Number	RW	Required if known, when patient has Medicaid coverage
3Ø1-C1	Group ID	RW	Required for all Medicare Part D and Medicare Prescription Payment Plan claims: U1ØØØØØ9 U1ØØØØ11

			Required only if printed on card or otherwise communicated by SelectHealth for Workers' Compensation claims.

Patient Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø1 – Patient Segment
331-CX	Patient ID Qualifier	M	Ø4 – Health Plan Assigned
332-CY	Patient ID	M	
3Ø4-C4	Date of Birth	R	
3Ø5-C5	Patient Gender Code	R	1 – Male 2 – Female
31Ø-CA	Patient First Name	R	
311-CB	Patient Last Name	R	
384-4X	Patient Residence	RW	Required for all Medicare Part D claims: Ø – Not Specified 1 – Home 2 – Skilled Nursing Facility (Part B only with prior authorization) 3 – Nursing Facility (required for Part D Short-Cycle Dispensing claims) 4 – Assisted Living Facility 5 – Custodial Care Facility (Part B only with prior authorization) 6 – Group Home 9 – Intermediate Care Facility/Mentally Retarded 11 – Hospice
3Ø7-C7	Place of Service	RW	Required for all Medicare Part D claims

Claim Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
This payer does not support partial fills		X	Pharmacies should reverse and reprocess initial claim when they have satisfied the requirements as written on the prescription
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø7 – Claim Segment

455-EM	Prescription/Service Reference Number Qualifier	M	1 – Rx Billing
4Ø2-D2	Prescription/Service Reference Number	M	
436-E1	Product/Service ID Qualifier	M	Ø3 – National Drug Code (NDC)
4Ø7-D7	Product/Service ID	M	NDC
442-E7	Quantity Dispensed	R	
4Ø3-D3	Fill Number	R	Ø – Original Dispensing 1-99 – Refill Number
4Ø5-D5	Days Supply	R	
4Ø6-D6	Compound Code	R	1 – Not a Compound 2 – Compound
4Ø8-D8	Dispense As Written (DAW)/Product Selection Code	R	
414-DE	Date Prescription Written	R	CCYYMMDD
415-DF	Number of Refills Authorized	R	
419-DJ	Prescription Origin Code	R	1 – Written 2 – Telephone 3 – Electronic (excludes fax, e-mail, internal clinic messaging system or a physician printing to a printer at the pharmacy) 4 – Facsimile (fax) 5 – Pharmacy
42Ø-DK	Submission Clarification Code	RW	Required for Medicaid 34ØB claims: 2Ø – 34ØB Required for Medicare Part D claims when Patient Residence = 3: 16 – LTC Emergency Box (Kit) or Automated Dispensing Machine 22 – LTC Dispensing: 7 days 23 – LTC Dispensing: 4 days 24 – LTC Dispensing: 3 days 25 – LTC Dispensing: 2 days 26 – LTC Dispensing: 1 day 27 – LTC Dispensing: 4-3 days 28 – LTC Dispensing: 2-2-3 days 29 – LTC Dispensing: Daily and 3-day weekend 3Ø – LTC Dispensing: Per shift dispensing 31 – LTC Dispensing: Per med pass dispensing 32 – LTC Dispensing: PRN on demand 33 – LTC Dispensing: 7 day or less cycle not otherwise represented

			34 – LTC Dispensing: 14 days 35 – LTC Dispensing: 8-14 day dispensing method not listed above
3Ø8-C8	Other Coverage Code	RW	1 – No Other Coverage 2 – Other Coverage Exists – Payment Collected 3 – Other Coverage Billed – Claim Not Covered 4 – Other Coverage Exists – Payment Not Collected Required for Medicare Prescription Payment Plan: 8 – Claim is billing for patient financial responsibility only
453-EJ	Originally Prescribed Product/Service ID Qualifier	RW	Required when medication was changed from the original script
445-EA	Originally Prescribed Product/Service Code	RW	Required if submitting a claim that replaces an originally prescribed product/service
446-EB	Originally Prescribed Quantity	RW	Required if submitting a claim that replaces an originally prescribed product/service
147-U7	Pharmacy Service Type	RW	Required for all Medicare Part D claims
429-DT	Special Packaging Indicator	RW	Required for Medicare Part D claims when Patient Residence Code = 3
46Ø-ET	Quantity Prescribed	RW	Required for all Schedule II drugs

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

423-DN	Basis of Cost Determination	R	Ø1 – AWP Ø7 – U&C 1Ø – ASP 12 – WAC

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

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

Coordination of Benefits/Other Payments Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is situational		X	Required for secondary, tertiary, etc. claims Required for Medicare Prescription Payment Plan claims
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø5 – Coordination of Benefits/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count	M	Maximum count of 9
338-5C	Other Payer Coverage Type	M	Ø1 – Primary Ø2 – Secondary Ø3 – Tertiary
339-6C	Other Payer ID Qualifier	R	Ø3 – BIN
34Ø-7C	Other Payer ID	R	BIN
443-E8	Other Payer Date	R	

341-HB	Other Payer Amount Paid Count	RW	Required when Other Payer Amount Paid (431-DV) is specified Maximum count of 9 Value should be greater than zero when OCC = 2 or 4; blank/null when OCC = 3
342-HC	Other Payer Amount Paid Qualifier	RW	Required when Other Payer Amount Paid (431-DV) is specified
431-DV	Other Payer Amount Paid	RW	Required when Other Payer Amount Paid Count (341-HB) is specified Value of the sum of all payers should be greater than zero when OCC = 2; zero when OCC = 4; blank/null when OCC = 3
471-5E	Other Payer Reject Count	RW	Required when claim has been rejected by previous payer(s) and the Other Payer Reject Code (472-6E) is specified Maximum count of 5 Value should be blank/null when OCC = 2 or 4; greater than zero when OCC = 3
472-6E	Other Payer Reject Code	RW	Required when Other Payer Reject Count (471-5E) is specified and Other Coverage Code (3Ø8-C8) = 3 Value should be other payer NCPDP Reject Code
353-NR	Other Payer-Patient Responsibility Amount Count	RW	Required when Other Payer-Patient Responsibility Amount (352-NQ) is specified Maximum count of 25 Allowed if OCC = 2 or 4; not allowed if OCC = 3 Required for Medicare Prescription Payment Plan claims
351-NP	Other Payer-Patient Responsibility Amount Qualifier	RW	Required when Other Payer-Patient Responsibility Amount (352-NQ) is specified Components of Patient Pay are required for values Ø1 – Ø5 and Ø7 – 13 Usage of Ø6 "Patient Pay as Reported by Previous Payer" accepted as an exception and subject to audit

			Required for Medicare Prescription Payment Plan claims
352-NQ	Other Payer-Patient Responsibility Amount	RW	Required when Other Payer-Patient Responsibility Amount Count (353-NR) is specified and when necessary for state/federal/regulatory agency programs Must be submitted for accurate pricing calculations on OCC 2 and 4, for all SelectHealth Commercial Required for Medicare Prescription Payment Plan claims

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

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

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

49Ø-UE	Compound Ingredient Basis Of Cost Determination	R	
362-2G	Compound Ingredient Modifier Code Count	R	Maximum count of 1Ø
363-2H	Compound Ingredient Modifier Code	R	

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

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

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

Worker's Compensation Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is situational		X	Only required for submission of a compound claim (Field 4Ø6-D6 = 2)
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**

111-AM	Segment Identification	M	06 – Woker's Compensation Segment
434-DY	Date of Injury	M	CCYYMMDD
315-CF	Employer Name	RW	
316-CG	Employer Street Address	RW	
317-CH	Employer City Address	RW	
318-CI	Employer State	RW	
319-CJ	Employer Zip/Postal Code	RW	
320-CK	Employer Phone	RW	
321-CR	Carrier ID	RW	
435-DZ	Claim/Reference ID	RW	

Claim Reversal Transaction

Transaction Header Segment		**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
1Ø1-A1	BIN Number	M	Same value as Claim Billing transaction
1Ø2-A2	Version/Release Number	M	DØ
1Ø3-A3	Transaction Code	M	B2
1Ø4-A4	Processor Control Number		Same value as Claim Billing transaction
1Ø9-A9	Transaction Count	M	Maximum of 4 transactions
2Ø2-B2	Service Provider ID Qualifier	M	Same value as Claim Billing transaction
2Ø1-B1	Service Provider ID	M	Same value as Claim Billing transaction
4Ø1-D1	Date of Service	M	Same value as Claim Billing transaction
11Ø-AK	Software Vendor/Certification ID	M	Use value for Switch's requirements or send spaces
Insurance Segment		**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø4 – Insurance Segment
3Ø2-C2	Cardholder Id	M	Same value as Claim Billing transaction
Claim Segment		**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø7 – Claim Segment

455-EM	Prescription/Service Reference Number Qualifier	M	1 – Rx Billing
4Ø2-D2	Prescription/Service Reference Number	M	Same value as Claim Billing transaction
436-E1	Product/Service ID Qualifier	M	Same value as Claim Billing transaction
4Ø7-D7	Product/Service ID	M	Same value as Claim Billing transaction
4Ø3-D3	Fill Number	RW	Required when multiple fills of the same Prescription/Service Reference Number (4Ø2-D2) occur on the same day
3Ø8-C8	Other Coverage Code	RW	Same value as Claim Billing transaction

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

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

Testing Information

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

Appendix C: Medicare Prescription Payment Plan Payer Sheet

General Information

Payer Name: Select Health/Scripius	Date: 11/1/2024		
Plan Name/Group Name:	**BIN:**	**PCN:**	**GROUP:**
Select Health Medicare Prescription Payment Plan	Ø27357	MPPP	Use Group printed on Select Health Medicare card
Effective as of: 1/1/2Ø25	NCPDP Telecommunication Standard Version/Release: DØ ECL version: July 2Ø24		
Certification Testing Window: N/A			
Certification Contact Information: MedicareBA@imail.org			
Provider Relations Contact Information: SHPharmacyContracting@selecthealth.org			
Other Contact Information: Select Health Medicare Pharmacy Services 855-442-9988 Medicare Assistance Available 24 hours a day / 7 days a week			
Maximum Number of Transactions Supported Per Transmission	1		
Submission and Reversal Window (days from date filled/dispensed to date submitted)	9Ø Days		
	If an exception is needed, please contact Select Health Medicare Pharmacy Services		

Supported Transactions

Transaction Code	Transaction Type
B1, B3	Billing
B2	Reversal

Table Legend

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

Segment and Field Requirements

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

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

Claim Billing/Claim Rebill Transaction

Transaction Header Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
1Ø1-A1	BIN Number	M	Ø27357 Refer to BIN returned within the last occurrence of the Response COB Other Payer Segment from the Medicare Part D Claim Response.
1Ø2-A2	Version/Release Number	M	DØ
1Ø3-A3	Transaction Code	M	B1, B3

1Ø4-A4	Processor Control Number	M	MPPP Refer to PCN returned within the last occurrence of the Response COB Other Payer Segment from the Medicare Part D Claim Response.
1Ø9-A9	Transaction Count	M	Ø1 – 1 occurrence
2Ø2-B2	Service Provider ID Qualifier	M	Ø1 – NPI
2Ø1-B1	Service Provider ID	M	1Ø digit NPI number
4Ø1-D1	Date of Service	M	CCYYMMDD
11Ø-AK	Software Vender/Certification ID	M	Use value for Switch's requirements or send spaces

Insurance Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø4 – Insurance Segment
3Ø2-C2	Cardholder ID	M	9-character ID beginning with 8Ø Use Select Health Medicare Cardholder ID Refer to Cardholder ID returned within the last occurrence of the Response COB Other Payer Segment from the Medicare Part D Claim Response.
312-CC	Cardholder First Name	R	
313-CD	Cardholder Last Name	R	
3Ø3-C3	Person Code	R	
3Ø6-C6	Patient Relationship Code	R	
36Ø-2B	Medicaid Indicator	RW	Submit when patient has Medicaid coverage
115-N5	Medicaid ID Number	RW	Required if known, when patient has Medicaid coverage
3Ø1-C1	Group ID	R	U1ØØØØØ9 U1ØØØØ11 Use Select Health Medicare Group ID Refer to Group ID returned within the last occurrence of the Response COB Other Payer Segment from the Medicare Part D Claim Response.

Patient Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø1 – Patient Segment
331-CX	Patient ID Qualifier	M	Ø4 – Health Plan Assigned
332-CY	Patient ID	M	
3Ø4-C4	Date of Birth	R	
3Ø5-C5	Patient Gender Code	R	1 – Male 2 – Female
31Ø-CA	Patient First Name	R	
311-CB	Patient Last Name	R	
384-4X	Patient Residence	R	Ø – Not Specified 1 – Home 2 – Skilled Nursing Facility (Part B only with prior authorization) 3 – Nursing Facility (required for Part D Short-Cycle Dispensing claims) 4 – Assisted Living Facility 5 – Custodial Care Facility (Part B only with prior authorization) 6 – Group Home 9 – Intermediate Care Facility/Mentally Retarded 11 – Hospice
3Ø7-C7	Place of Service	R	

Claim Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø7 – Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	M	1 – Rx Billing
4Ø2-D2	Prescription/Service Reference Number	M	
436-E1	Product/Service ID Qualifier	M	Ø3 – National Drug Code (NDC)
4Ø7-D7	Product/Service ID	M	NDC
442-E7	Quantity Dispensed	R	
4Ø3-D3	Fill Number	R	Ø – Original Dispensing 1-99 – Refill Number
4Ø5-D5	Days Supply	R	
4Ø6-D6	Compound Code	R	1 – Not a Compound 2 – Compound

4Ø8-D8	Dispense As Written (DAW)/Product Selection Code	R	
414-DE	Date Prescription Written	R	CCYYMMDD
415-DF	Number of Refills Authorized	R	
419-DJ	Prescription Origin Code	R	1 – Written 2 – Telephone 3 – Electronic (excludes fax, e-mail, internal clinic messaging system or a physician printing to a printer at the pharmacy) 4 – Facsimile (fax) 5 – Pharmacy
42Ø-DK	Submission Clarification Code	RW	Required for Medicare Part D claims when Patient Residence = 3: 16 – LTC Emergency Box (Kit) or Automated Dispensing Machine 22 – LTC Dispensing: 7 days 23 – LTC Dispensing: 4 days 24 – LTC Dispensing: 3 days 25 – LTC Dispensing: 2 days 26 – LTC Dispensing: 1 day 27 – LTC Dispensing: 4-3 days 28 – LTC Dispensing: 2-2-3 days 29 – LTC Dispensing: Daily and 3-day weekend 3Ø – LTC Dispensing: Per shift dispensing 31 – LTC Dispensing: Per med pass dispensing 32 – LTC Dispensing: PRN on demand 33 – LTC Dispensing: 7 day or less cycle not otherwise represented 34 – LTC Dispensing: 14 days 35 – LTC Dispensing: 8-14 day dispensing method not listed above
3Ø8-C8	Other Coverage Code	R	8 – Claim is billing for patient financial responsibility only
453-EJ	Originally Prescribed Product/Service ID Qualifier	RW	Required when medication was changed from the original script
445-EA	Originally Prescribed Product/Service Code	RW	Required if submitting a claim that replaces an originally prescribed product/service
446-EB	Originally Prescribed Quantity	RW	Required if submitting a claim that replaces an originally prescribed product/service
147-U7	Pharmacy Service Type	R	
429-DT	Special Packaging Indicator	RW	Required for Medicare Part D claims when Patient Residence Code = 3
46Ø-ET	Quantity Prescribed	RW	Required for all Schedule II drugs

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

Pharmacy Provider Segment		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø2 – Pharmacy Provider Segment
465-EY	Provider ID Qualifier	R	Ø1 – NPI
444-E9	Provider ID	R	

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

Coordination of Benefits/Other Payments Segment		Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø5 – Coordination of Benefits/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count	M	Maximum count of 9
338-5C	Other Payer Coverage Type	M	Ø1 – Primary Ø2 – Secondary Ø3 – Tertiary
339-6C	Other Payer ID Qualifier	R	Ø3 – BIN
34Ø-7C	Other Payer ID	R	BIN
443-E8	Other Payer Date	R	
353-NR	Other Payer-Patient Responsibility Amount Count	R	Maximum count of 25 Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used
351-NP	Other Payer-Patient Responsibility Amount Qualifier	R	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used
352-NQ	Other Payer-Patient Responsibility Amount	R	Required if necessary for patient financial responsibility only billing
392-MU	Benefit Stage Count	RW	Maximum count of 4 Required if Benefit Stage Amount (394-MW) is used
393-MV	Benefit Stage Qualifier	RW	Required if Benefit Stage Amount (394-MW) is used
394-MW	Benefit Stage Amount	RW	Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts.

Compound Segment		Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is situational		X	Only required for submission of a compound claim (Field 4Ø6-D6 = 2)
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	1Ø – Compound Segment

45Ø-EF	Compound Dosage Form Description Code	M	Ø1 – Capsule Ø2 – Ointment Ø3 – Cream Ø4 – Suppository Ø5 – Powder Ø6 – Emulsion Ø7 – Liquid 1Ø – Tablet 11 – Solution 12 – Suspension 13 – Lotion 14 – Shampoo 15 – Elixir 16 – Syrup 17 – Lozenge 18 – Enema
451-EG	Compound Dispensing Unit Form Indicator	M	1 – Each 2 – Grams 3 – Milliliters
447-EC	Compound Ingredient Component Count	M	Count must match the submitted number of repetitions Maximum 25 ingredients
488-RE	Compound Product ID Qualifier	M	Ø3 - NDC
489-TE	Compound Product ID	M	Component NDC(s) of compound
448-ED	Compound Ingredient Quantity	M	Amount expressed in metric decimal units
449-EE	Compound Ingredient Drug Cost	R	
49Ø-UE	Compound Ingredient Basis of Cost Determination	R	
362-2G	Compound Ingredient Modifier Code Count	R	Maximum count of 1Ø
363-2H	Compound Ingredient Modifier Code	R	

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

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

Claim Reversal Transaction

Transaction Header Segment		**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
1Ø1-A1	BIN Number	M	Same value as Claim Billing transaction
1Ø2-A2	Version/Release Number	M	DØ
1Ø3-A3	Transaction Code	M	B2
1Ø4-A4	Processor Control Number		Same value as Claim Billing transaction
1Ø9-A9	Transaction Count	M	Maximum of 1 transaction
2Ø2-B2	Service Provider ID Qualifier	M	Same value as Claim Billing transaction
2Ø1-B1	Service Provider ID	M	Same value as Claim Billing transaction
4Ø1-D1	Date of Service	M	Same value as Claim Billing transaction
11Ø-AK	Software Vendor/Certification ID	M	Use value for Switch's requirements or send spaces
Insurance Segment		**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø4 – Insurance Segment
3Ø2-C2	Cardholder Id	M	Same value as Claim Billing transaction
Claim Segment		**Check**	**Claim Reversal** If Situational, *Payer Situation*
This Segment is always sent		X	
Field	**NCPDP Field Name**	**Payer Usage**	**Value/Comments**
111-AM	Segment Identification	M	Ø7 – Claim Segment
55-EM	Prescription/Service Reference Number Qualifier	M	1 – Rx Billing
4Ø2-D2	Prescription/Service Reference Number	M	Same value as Claim Billing transaction
436-E1	Product/Service ID Qualifier	M	Same value as Claim Billing transaction
4Ø7-D7	Product/Service ID	M	Same value as Claim Billing transaction
4Ø3-D3	Fill Number	RW	Required when multiple fills of the same Prescription/Service Reference Number (4Ø2-D2) occur on the same day
3Ø8-C8	Other Coverage Code	RW	Same value as Claim Billing transaction

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

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

Appendix D: Common Reject Messages

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

Message	Explanation
71: Prescriber is Not Covered	There are several situations that could cause a Prescriber is Not Covered error. Below are the most common examples: • Select Health requires a valid NPI number for prescriber identification. Select Health relies on the pharmacy for submission of accurate information. • Some plans require that the prescribing physician participate in the Select Health physician network for a medication to be covered. • The prescriber may be sanctioned by the Office of Inspector General (OIG).
75: Prior Authorization Required	There are certain medications that Select Health requires prior authorization before the medication can be dispensed to the member. When this rejection is received, the pharmacy may contact the Select Health Help Desk to begin the prior authorization process. The Select Health Prescription Drug List (PDL) notates the medications that require prior authorization with a "(PA)" in the "Spec. Requirements" column. For the most up-to-date drug information, access the PDL through the Select Health website.
76: Plan Limitations Exceeded	The Plan Limitations Exceeded rejection could occur for a variety of reasons, including the most common: • Over Quantity Limits: — This could be caused by a dose optimization issue which would require the prescribing physician's office to change to a different strength of the same medication. — Alternatively, the prescribing physician can send into Select Health a Letter of Medical Necessity (LMN) for review as originally prescribed. — As a final option, the pharmacy can resubmit the prescription for the amount Select Health will allow. • Cost Exceeds Maximum: — Select Health applies a max cost per prescription of $1,000; in most instances when this reject is received for exceeding the max cost edit, the pharmacy can call the Select Health Help Desk for an override. — Compound medications have a different cost edit of $75 per prescription; in many cases, a compound medication will require a LMN from the prescribing physician to obtain the necessary cost override. — **Over Day Supply Limits**: Select Health applies a max day supply that can vary by plan and by drug. If the pharmacy has questions if this rejection is received, please contact the Pharmacy Help Desk for assistance. — **Patient Age Exceeds Maximum Age Allowed for Drug**: Select Health applies age limitations to applicable medications depending on safety, efficacy, or specialized dosage form. — **Over Maximum Daily Dose**: Select Health may apply a maximum daily dose based on the U.S. Food and Drug Administration (FDA) approved labeling and other accepted drug compendia guidelines meeting minimum levels of evidence.
79: Refill Too Soon	Select Health applies an edit for refilled medications that require the medication be 75% gone before a refill can be allowed, for most plans. For controlled substances the edit requires that the medication be 80% gone before a refill can be allowed. Contact the Select Health Pharmacy Help Desk for additional information or assistance processing.

Message	Explanation
88: DUR Reject Error	There are several situations that could cause a DUR Reject Error. The most common examples are: • **Opioid Care Coordination**: Select Health will give a soft rejection when prescriptions are written for more than 90 morphine milligram equivalents (MME) daily. For a Medicare or commercial member, the pharmacist must verify dosing and plan with the prescriber. After verification has taken place, the pharmacy can override the edit using a Submission Clarification Code of 07: Medically Necessary. For a Medicaid member the maximum restriction is 90 morphine milligram equivalents (MME) daily and cannot be overridden on the pharmacy side. • **Opioid High-Dosage Limits**: Select Health will reject claims when filling for a high-dose opioid, greater than 200 MME for most plans. For Medicaid members, Select Health will reject claims when filling for a high-dose opioid, greater than 90 MME. The patient or prescriber is required to send a prior authorization request to Select Health if they believe an exception should be granted for this restriction. • **Seven-Day Max Fill For Opioid Naïve Patients**: Select Health will only allow a maximum 7-day fill for any patient that is opioid naïve for their first fill. (For a Medicaid member, opioids prescribed by a dentist are limited to a maximum 3-day fill.) • **Concurrent Benzodiazepine and Opioid Therapy**: Select Health will give a soft rejection when a patient has overlapping days supplies of benzodiazepine and opioid medications. The pharmacist must verify dosing and plan with the prescriber. After verification has taken place, the pharmacy can override the edit using a submission clarification code of 07: Medically Necessary. • **Multiple Long-Acting Opioid Prescriptions**: Select Health will give a soft rejection when a patient attempts to fill more than one long-acting opioid medication with overlapping days supplies. The pharmacist must verify dosing and plan with the prescriber. After verification has taken place, the pharmacy can override the edit using a submission clarification code of 07: Medically Necessary.
569: Provide Notice: Medicare Prescription Drug Coverage and Your Rights	When a claim for a Medicare Part D drug is submitted to the Select Health Medicare plan and is not covered on the formulary or exceeds formulary limitations and is outside the Medicare Part D transition fill coverage period, the Provide Notice: Medicare Prescription Drug Coverage and Your Rights rejection will be sent. When this rejection is received and the member must leave the pharmacy without their prescription, the pharmacy is required to provide the member with the Member's Rights document.
608: Step Therapy, Alternate Drug Therapy Required Prior To Use of Submitted Product Service ID	Select Health applies Step Therapy edits to certain medications, which will require qualifying medication(s) before Select Health will cover the one that is rejecting. If those step therapy rules have not been met, the pharmacy will receive this rejection.