Arkansas Medicaid Rx Web Claims Submission User Guide

Version 1.0

March 2024

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1.0 Introduction

The Web Claims Submission (WCS) tool allows pharmacy staff members to enter, reverse, and search for claims via the Arkansas Medicaid Rx Web Portal.

To gain access to the WCS tool, a designated staff member has to complete registration via the User Administration Console (UAC) application (refer to the *User Administration Console (UAC) Quick Start Guide* for information on UAC registration). After the designated user has successfully registered, they can then set up the remaining staff members and grant them access to the tool.

This *Arkansas Medicaid Rx Web Claims Submission User Guide* will provide the steps and information necessary to successfully submit, reverse, or search for member pharmacy claims utilizing the WCS tool.

1.1 Payer Specification Document

The *NCPDP Payer Specification Sheet* outlines the NCPDP data fields, field names, the Arkansas Medicaid Rx accepted NCPDP values, and situational usages of those fields. The *NCPDP Payer Specification Sheet* is to be used in conjunction with the WCS tool to ensure that all required fields are completed and that all accepted and pertinent values are utilized for successful claim submission and adjudication. The *NCPDP Payer Specification Sheet* can be found in the Provider Documents section under the Resources tab of the Arkansas Medicaid Rx Web Portal.

2.0 Logging In/Out

2.1 Logging In

Use the following steps to access the WCS tool.

1. On the Arkansas Medicaid Rx Web Portal home page, click the **Login** button at the top right. See *Figure 2.1-1*.

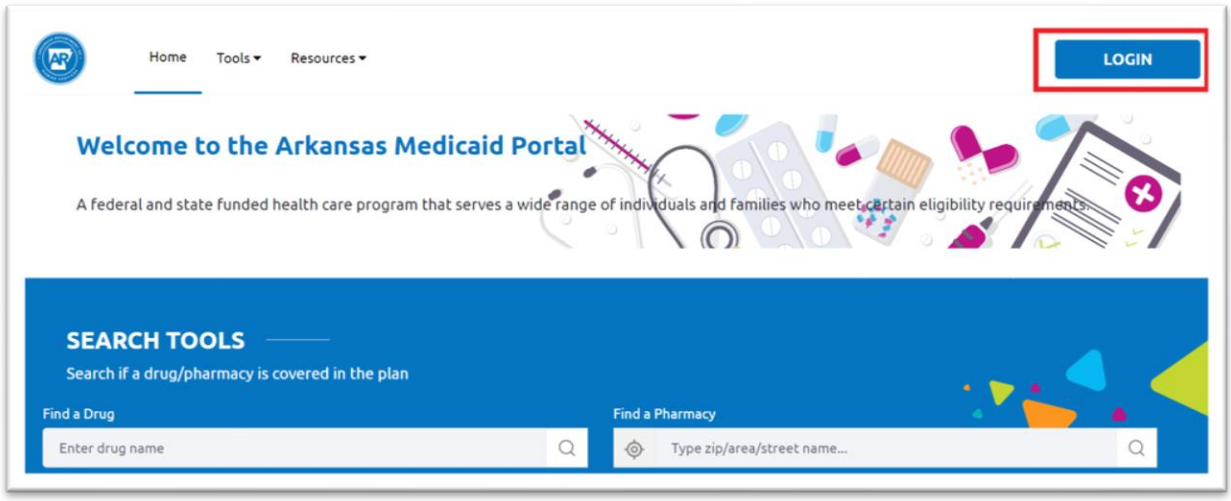


Figure 2.1-1: Accessing the Arkansas Medicaid Rx Web Portal

2. On the Login screen, click on the Provider header and enter the applicable credentials, then click **Login**. See *Figure 2.1-2.*

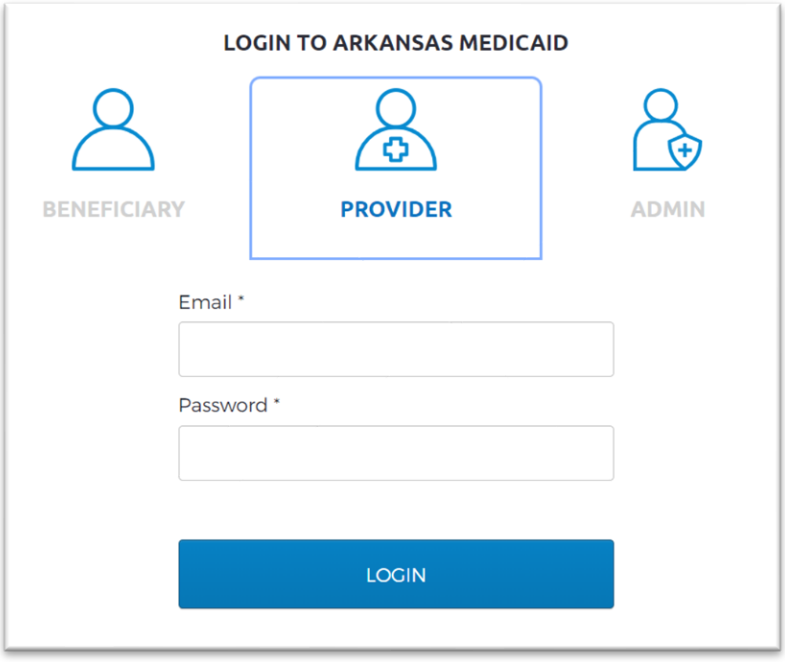


Figure 2.1-2: Log In

3. Select your Provider ID from the dropdown list and click the **Submit** button. See *Figure 2.1-3*.

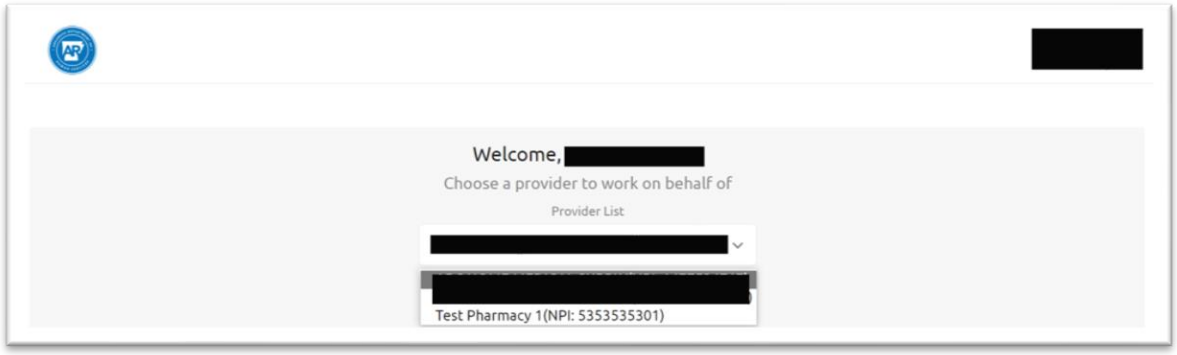


Figure 2.1-3: Provider ID Selection

The Provider IDs available in the Service Provider List are assigned to you by your Delegated Administrator or Local Administrator and are added using the UAC application. Provider IDs cannot be entered manually upon logging in to the Provider Portal or WCS tool.

4. From the Provider Dashboard, click on **Web Claims Submission**. See *Figure 2.1-4.*

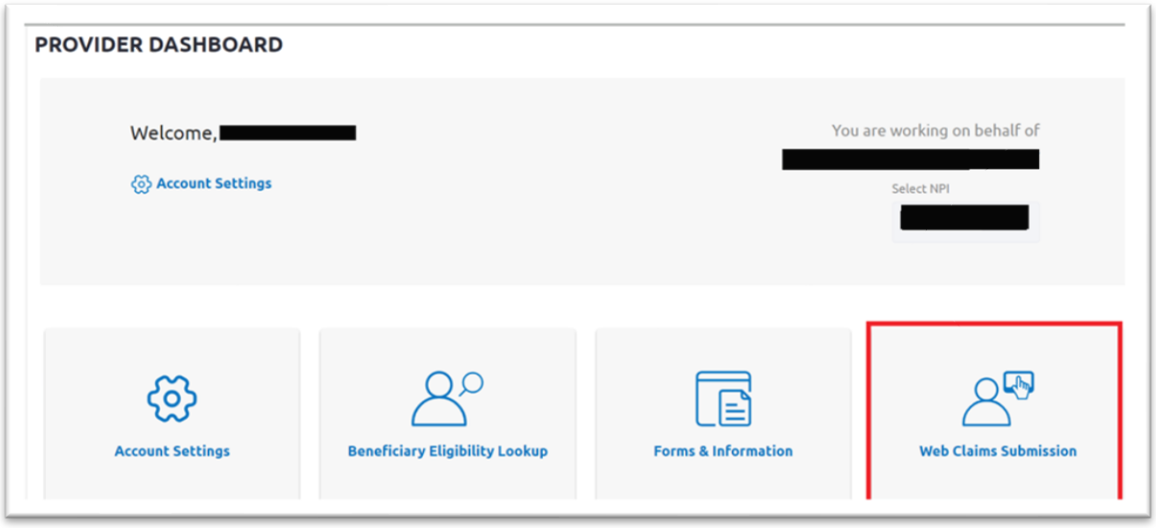


Figure 2.1-4: Web Claims Submission Link

5. After completing the above steps, the user is ready to use the WCS tool for claim submission, reversal, or claim search. Refer to *Section 3.0* and subsequent sections for additional information on these functionalities.

2.2 Logging Out of the WCS Tool

To log out of the WCS tool, select the **Padlock** icon at the bottom of the Claim Submission window. Refer to *Figure 2.2-1*.

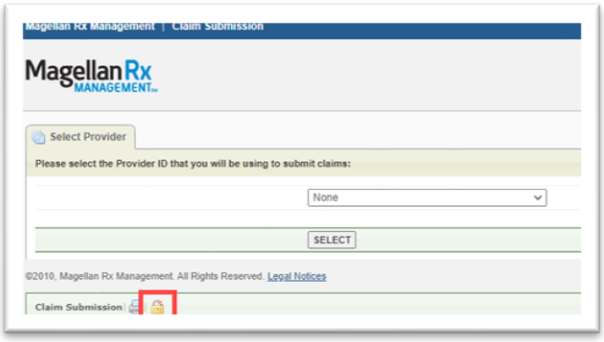


Figure 2.2-1: Logging Out of WCS – Padlock Icon

3.0 Submitting a Claim

After successfully logging in to the WCS tool, complete the following steps to submit a claim:

1. On the **Select Provider** tab, choose the appropriate Provider ID from the drop-down list and then choose **SELECT**. See *Figure 3.0-1*.

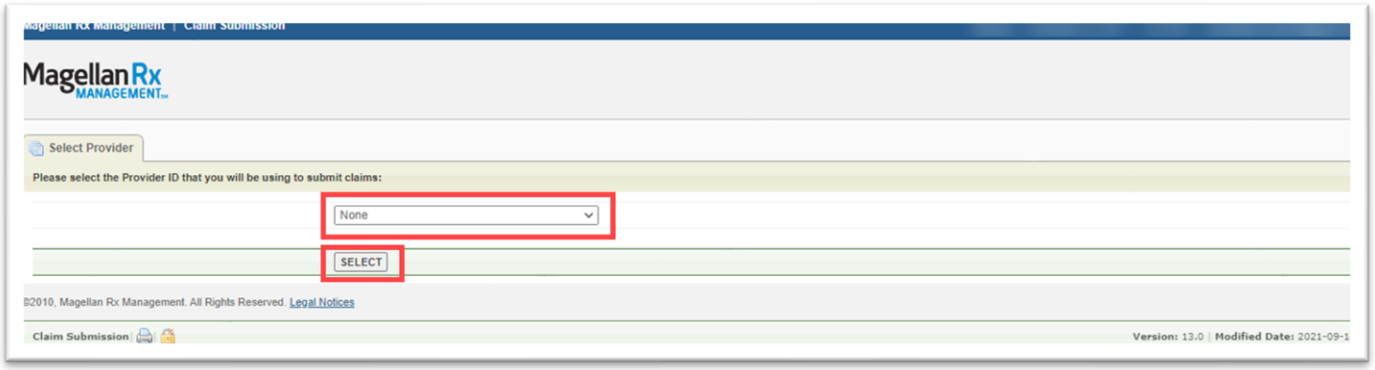


Figure 3.0-1: WCS – Select Provider

2. The Selection window will appear and give the option to either perform a Claim Search (see *Section 5.1*) or select an applicable Claim Template to submit a claim. See *Figure 3.0-2.*

3. You must first choose the appropriate template before you can submit a claim.

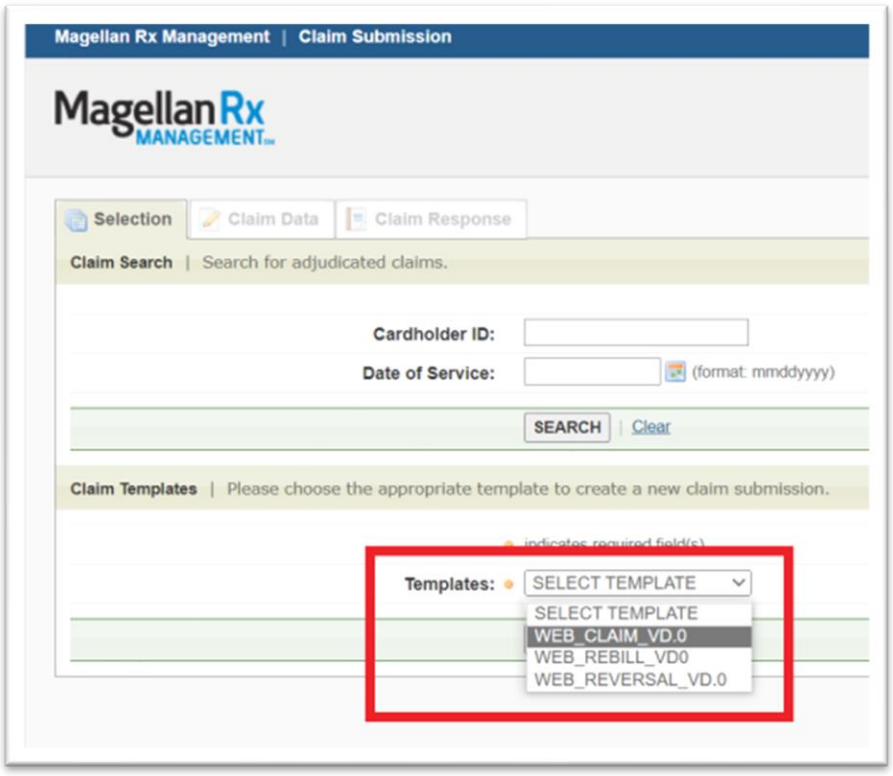


Figure 3.0-2: Selection Window – Claim Templates

4. The available claim template options are **WEB_CLAIM_VD.0_TEMPLATE, WEB_REBILL_VD0_TEMPLATE, or WEB_REVERSAL_VD.0_TEMPLATE**. Select the applicable template from the drop-down list (refer to *Figure 3.0-2)* and select **Continue**. The Claim Data Entry window will appear. See *Figure 3.0-3*.

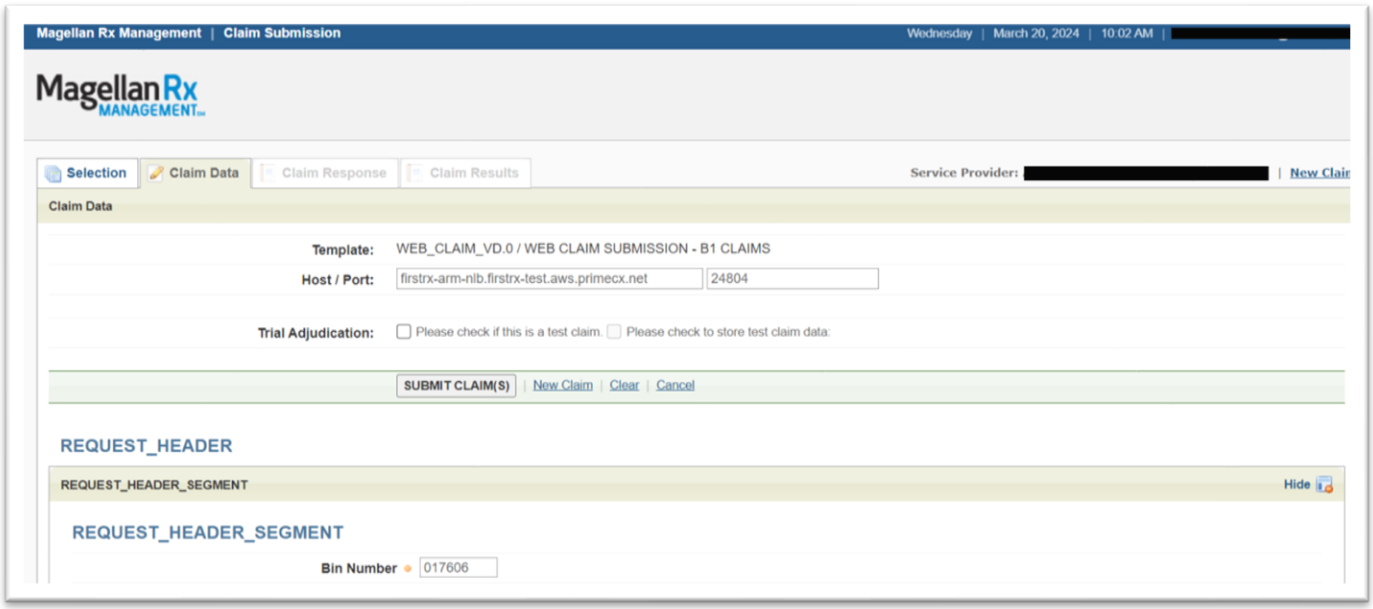
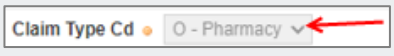


Figure 3.0-3: Claim Data Entry Window

The Claim Entry Template times out after 15 minutes of inactivity.
The Claim Entry Template has both optional and required fields.
Required fields are indicated with an orange dot in the WCS tool template. Noneditable fields are grayed out and cannot be manually populated.



Select the Clear hyperlink at the top of the Claim Data Entry window to clear all entered data and start over.
Select the Cancel hyperlink at the top of the Claim Data Entry window to return to the Selection window.
If you select Back to return to the Claim Submission main window, the system does not apply the changes you made on the window.
If the Search button appears directly following a field, you can use it to search and select information to populate field values.
If the Calendar button appears next to a date field, you can use the calendar to populate dates.
After selecting the Calendar button, select the Month list to choose the month, select the Year list to choose the year, and then select the appropriate day.

5. Refer to the next sections and subsections for guidance on completing the required fields for successful claim submission utilizing the WCS tool.

6. After **all** required and relevant fields have been completed, select the **Submit Claim(s)** button (at the top or bottom of the template screen) to submit the claim(s) for adjudication.

3.1 Claim Data Entry

To submit a claim, all required and pertinent fields must be completed. The following section and corresponding subsections provide additional information on the fields, values, and completion instructions for successful claim submission. Red asterisks (*) denote this is a required field.

Field	Description	Completion Instructions
Claim Data Segment		
* **Template**	Name of claim submission data entry template. Valid values are: • **WEB_CLAIM_VD.0_TEMPLATE** (B1) • **WEB_REVERSAL_VD.0_TEMPLATE** (B2) • **WEB_REBILL_VD0_TEMPLATE** (B3)	Select the applicable template based upon the type of claim the provider is submitting.
Host/Port	Website form that is submitted to the Arkansas Medicaid Rx vendor and the computer connection.	This field is automatically populated and cannot be manually updated.

3.2 Request Header Segment

The fields included in the Request Header Segment (see *Figure 3.2-1)* align with the NCPDP Designations.

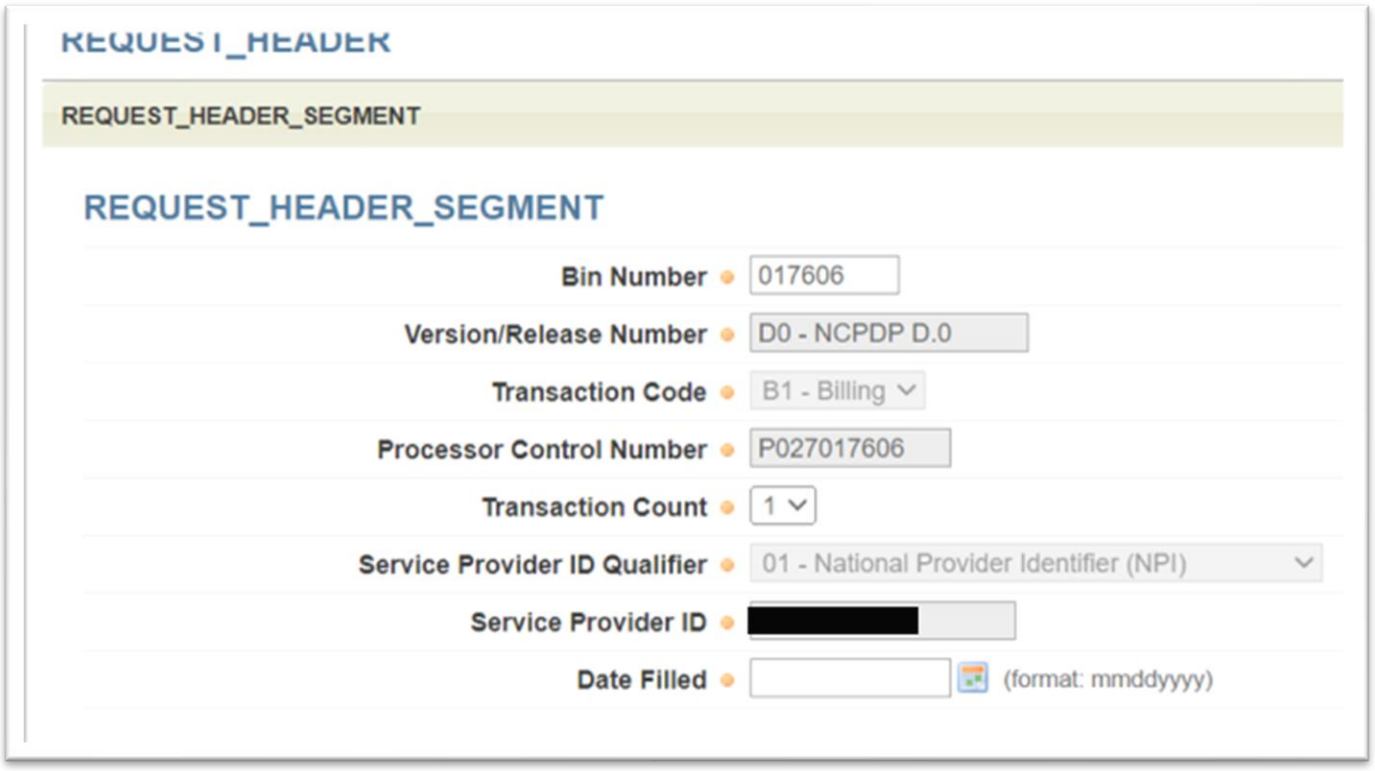


Figure 3.2-1: Request Header Segment

The following table provides field names, descriptions, and completion instructions for the Request Header Segment of the WCS tool. Red asterisks (*) denote this is a required field.

Field	Description	Completion Instructions
Request Header Segment		
* **BIN**	This is the card issuer or Bank ID used for network routing. • Arkansas Medicaid Rx BIN: **017606**	This field is pre-populated.
* **Version Number**	NCPDP D.0 Standard	This field is pre-populated.
* **Transaction Code**	This field denotes the type of transaction being submitted (for example, B1 – Billing, B2 – Reversal).	This field is pre-populated based on the template selected and cannot be manually updated.

Field	Description	Completion Instructions
Request Header Segment		
* **Processor Control Number**	The number assigned by the processor. • Arkansas Medicaid Rx PCN: **P027017606**	This field is pre-populated.
* **Transaction Count**	The number of transactions in the transmission. Valid values are: • One transaction for compound claim. • Up to four transactions allowed for B1 or B2.	Select the applicable transaction count from the drop-down list.
* **Service Provider ID Qualifier**	This field is defaulted based on the Service Provider selected upon securely logging in to WCS.	This field is pre-populated and cannot be manually updated.
* **Service Provider ID**	This field is defaulted based on the Service Provider selected upon securely logging in to WCS.	This field is pre-populated and cannot be manually updated.
* **Date Filled**	This field denotes the date of service (DOS) for the claim being submitted. • Format: MMDDYYYY	Enter the date *or* use the calendar icon to select the applicable date.

3.3 Request Transmission Segment

The fields included in the Request Transmission Segment (see *Figure 3.3-1*) align with the NCPDP Designations.

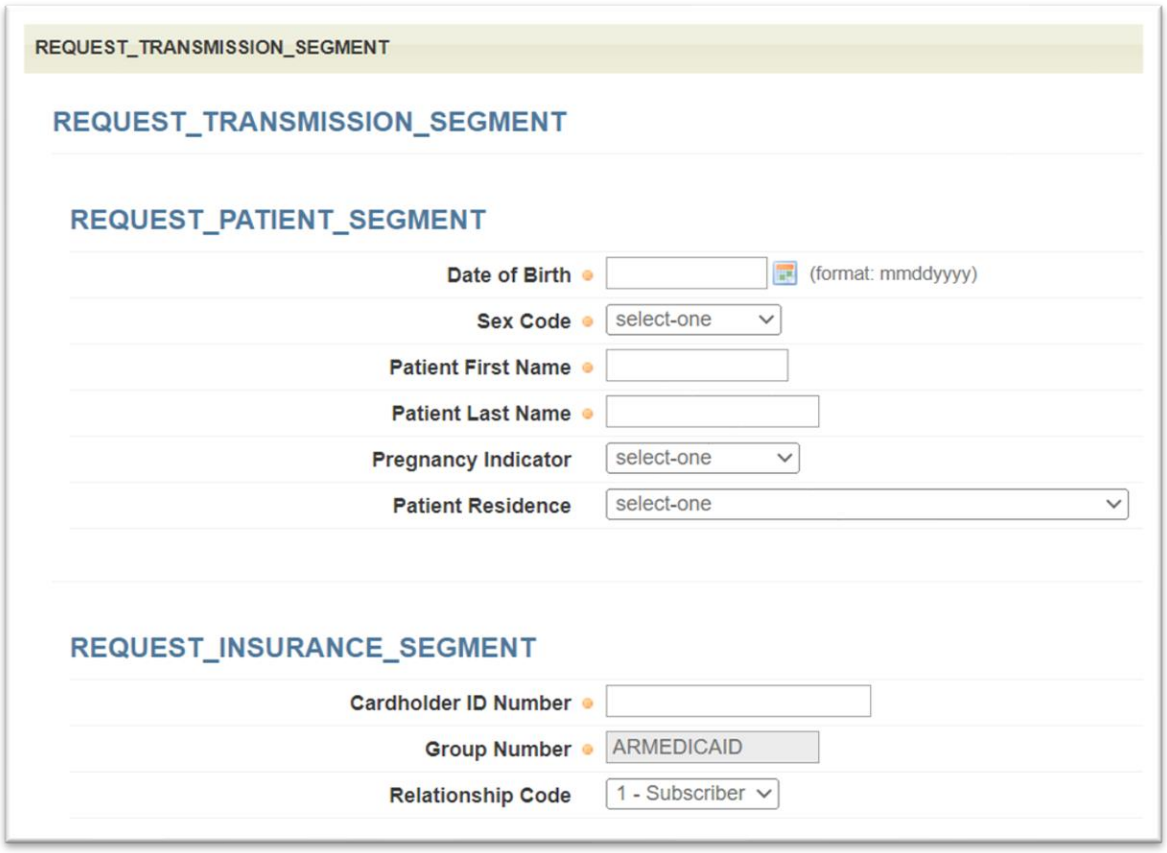


Figure 3.3-1: Request Transmission Segment

The following table provides field names, descriptions, and completion instructions for the Request Transmission Segment of the WCS tool. Red asterisks (*) denote this is a required field.

Field	Description	Completion Instructions
Request Patient Segment		
* **Date of Birth**	Identifies the member's date of birth (DOB). • Format: MMDDYYYY	Enter or select the member's DOB using the Calendar button.
* **Sex Code**	Identifies the member's gender.	Select the applicable gender from the drop-down list.
* **Patient First Name**	Identifies the member's first name.	Enter the member's first name.
* **Patient Last Name**	Identifies the member's last name.	Enter the member's last name.
Pregnancy Indicator	Identifies the member's pregnancy status.	Select the applicable Pregnancy Indicator from the drop-down list.
Patient Residence	Accepted values are: • **0 – Not Specified** • **1 – Home** • **3 – Skilled Nursing Facility** • **4 – Assisted Living Facility** • **6 – Group Home** • **7 – Inpatient Psychiatric Facility** • **8 – Psychiatric Facility – Partial Hospitalization** • **9 – Intermediate Care Facility/ Individuals with Intellectual Disabilities** • **10 – Residential Substance Abuse Treatment Facility** • **11 – Hospice**	Select the applicable Patient Residence from the drop-down list.

Field	Description	Completion Instructions
	• **12 – Psychiatric Residential Treatment Facility** • **13 – Comprehensive Inpatient Rehabilitation Facility** • **14 – Homeless Shelter** • **15 – Correctional Institution**	
Request Insurance Segment		
* **Cardholder ID Number**	Cardholder ID number	Enter the applicable Cardholder ID number.
* **Group Number**	ARMEDICAID	This field is pre-populated.
Request Insurance Segment		
Relationship Code	This field identifies the relationship to the Cardholder. This field is defaulted to **1 – Subscriber**.	This field is pre-populated and cannot be manually updated.

3.4 Request Claim Segment

The fields included in the Request Claim Segment (see *Figure 3.4-1)* align with the NCPDP Designations.

> Any time a “Repeating Segment Navigation” is mentioned in the template, there will be an arrow(s) present to move to the next or previous segment.
> For example, if more than one Submission Clarification Code (SCC) is needed on a given claim, use the arrow icon(s) ⇦ ⇨ to move to the next or previous SCC segment(s).

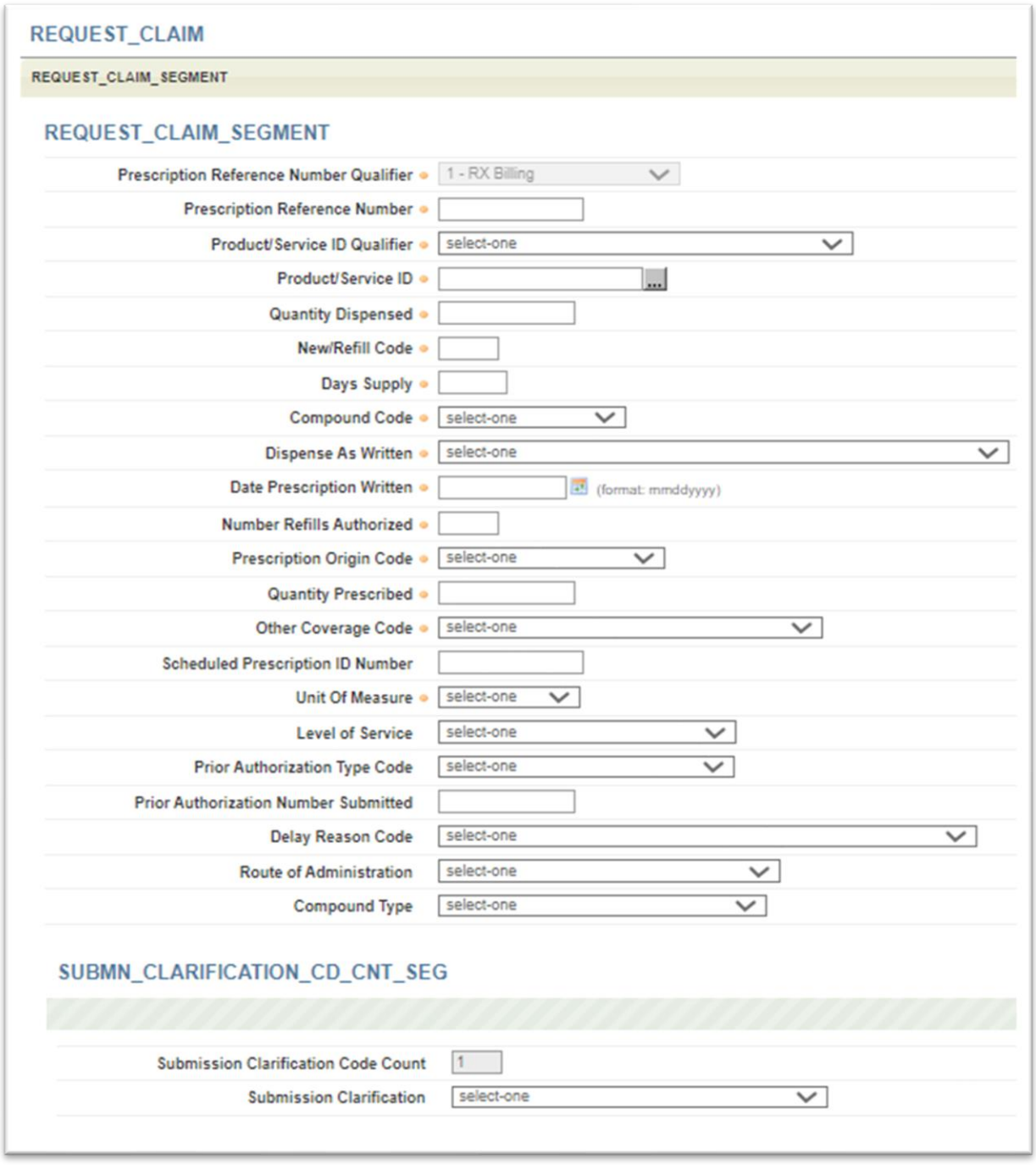


Figure 3.4-1: Request Claim Segment

The following table provides field names, descriptions, and completion instructions for the Request Claim Segment of the WCS tool. Red asterisks (*) denote this is a required field.

Field	Description	Completion Instructions
Request Claim Segment		
* **Prescription Reference Number Qualifier**	The code qualifying the Product/Service ID.	This field is pre-populated and cannot be manually updated.
* **Prescription Reference Number**	Prescription (Rx) Number assigned by the Service Provider.	Enter the assigned prescription number.
* **Product/Service ID Qualifier**	The code qualifying the Product/Service ID. Accepted values are: • **00 – Not specified** – **Must** select this value for compound claims. • **03 – National Drug Code** – This value is used for non-compound claims, medical supplies, and enteral nutrition products.	Select the applicable Product/ Service ID Qualifier from the drop-down list.
* **Product/Service ID**	ID of the product dispensed. • Must be an NDC for non-compound claims. • For compound claims, enter **0** in this field.	Enter the applicable NDC for the drug/product being dispensed.
Note: If the NDC is unknown, a search may be performed using the **Search** button  next to the **Product/Service ID** field. A **Product/Service ID Qualifier** is required before using this function.		
* **Quantity Dispensed**	Quantity dispensed, expressed in metric decimal units.	Enter the quantity of the drug/product dispensed.

Field	Description	Completion Instructions
* **New/Refill Code**	Code indicating whether prescription dispensed was a new (original) prescription or a refill. Accepted values are: • **0 – Original/New Fill** • **1-5 – Refill**	Enter the applicable fill number.
* **Days' Supply**	Number of days the prescription will last.	Enter the applicable days' supply for the drug/product dispensed.
* **Compound Code**	Code indicating whether the prescription is a compound. Accepted values are: • **1 – Not a Compound** • **2 – Compound**	Select the applicable Compound Code from the drop-down list.
* **Dispense as Written**	Code indicating whether the prescriber's instructions regarding generic substitution were followed. **Note:** Any value accepted.	Select the applicable Dispense as Written (DAW)/Product Selection Code from the drop-down list. **Note:** Any DAW code may be submitted on a claim, but the use of a DAW code will **not** override any claim edits (such as prior authorization [PA] request requirements).
* **Date Prescription Written**	Date the prescription was written by the prescriber. • Format: MMDDYYYY	Enter or select the date (using the Calendar button) the prescription was written by the prescriber.
* **Number Refills Authorized**	Number of refills authorized by the prescriber.	Enter the number of refills authorized by the prescriber on the prescription.

Field	Description	Completion Instructions
* **Prescription Origin Code**	Code indicating the origin of the prescription. Accepted values are: • **1 – Written Prescription** • **2 – Telephone Prescription** • **3 – Electronic** • **4 – Facsimile** • **5 – Pharmacy**	Select the applicable origin of the prescription from the drop-down list.
* **Quantity Prescribed**	Quantity of medication to be dispensed as indicated on the prescription by the prescriber.	Enter the total number of units prescribed on the prescription for the claim being submitted.
* **Other Coverage Code**	Code indicating whether the member has other insurance coverage. Accepted values are: • **0 – Not Specified** • **1 – No Other Coverage Identified** • **2 – Other Coverage, Payment Collected** • **3 – Other Coverage, Claim Not Covered** • **4 – Other Coverage, Payment Not Collected**	Select the applicable other coverage code (OCC) from the drop-down list. **Note:** Required for Coordination of Benefits. OCC-8 is not allowed.
Scheduled Prescription ID Number	Scheduled Prescription ID Number.	Enter the Scheduled Prescription ID Number, if known.
* **Unit of Measure**	Standard product billing codes. Accepted values are: • **EA – Each** • **GM – Grams** • **ML – Milliliters**	Select the applicable unit of measure for the drug/product submitted on the claim from the drop-down list. **Note:** While any value is accepted, the unit of measure submitted must align with the drug/product submitted.

Field	Description	Completion Instructions
Level of Service	Code indicating the type of service the provider rendered. Accepted values are: • **0 – Not Specified** • **3 – Emergency**	Select the relevant level of service (if applicable) from the drop-down list. **Note:** Required for Emergency Supply; "3" only allowed value. Must be submitted with a maximum 5 day supply.
Prior Authorization Type Code	Code clarifying the PA Type.	Select the relevant PA Type Code (if applicable) from the drop-down list.
Prior Authorization Number Submitted	PA Number Submitted.	Submit as needed.
Delay Reason Code	Code to specify reason why submission of the transaction was delayed	
Route of Administration	Code for the route of administration.	Select the relevant Route of Administration Systematized Nomenclature of Medicine (SNOMED) value (if applicable) from the drop-down list. **Note:** This field is required when submitting a compound claim.
Compound Type	Code to clarify the type of compound. Accepted values are: • **1 – Anti-infective** • **2 – Ionotropic** • **3 – Chemotherapy** • **4 – Pain Management** • **5 – TPN/PPN** • **6 – Hydration** • **7 – Opthalmic** • **99 – Other**	Select the relevant Compound Type (if applicable) from the drop-down list.

Field	Description	Completion Instructions
Submission Clarification Code Count Segment		
Submission Clarification Code Count	Number of submission clarification code(s) (SCCs) submitted. **Note:** Up to three SCCs allowed.	When submitting a claim via WCS, this field is pre-populated. If more than one SCC is needed, use the arrow icon(s) to move to the next/previous segment(s).
Submission Clarification	Code indicating that the pharmacist is clarifying the submission. Accepted Values: • **8 – Process Compound for Approved Ingredients**	Select the relevant SCC (if applicable) from the drop-down list.

3.5 Request Prescriber Segment

The fields included in the Request Prescriber Segment (see *Figure 3.5-1*) align with the NCPDP Designations.

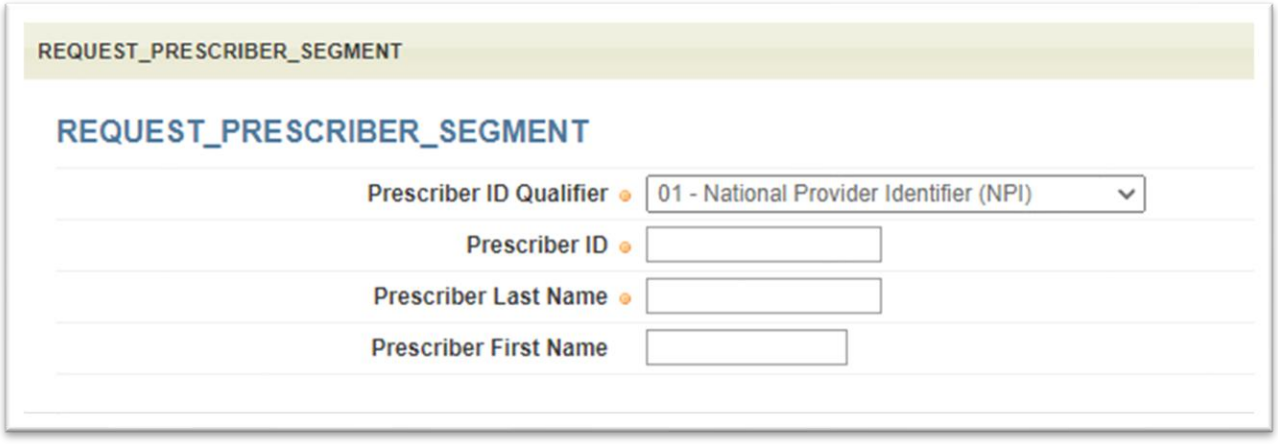


Figure 3.5-1: Request Prescriber Segment

The following table provides field names, descriptions, and completion instructions for the Request Prescriber Segment of the WCS tool. Red asterisks (*) denote this is a required field.

Field	Description	Completion Instructions
Request Prescriber Segment		
* **Prescriber ID Qualifier**	Code qualifying the Prescriber ID. Accepted Values: • **01 = NPI**	This field is pre-populated and cannot be manually updated.
* **Prescriber ID**	ID assigned to the prescriber.	Enter the Prescriber's 10-digit NPI number.
* **Prescriber Last Name**	Prescriber's last name.	Enter the Prescriber's last name.
Prescriber First Name	Prescriber's first name.	Enter the Prescriber's first name.

3.6 Request Coordination of Benefits (COB) Segment

The fields included in the Request COB Segment (see *Figure 3.6-1*) align with the NCPDP Designations.

> The Request COB and Other Payer Segments should only be populated if other coverage exists and is being billed for the member.
> Any time a "Repeating Segment Navigation" is mentioned in the template, there will be an arrow(s) present to move to the next or previous segment.
> For example, if more than one COB/Other Payments Count is needed on a given claim, use the arrow icon(s)  to move to the next or previous COB/Other Payments Count segment(s).

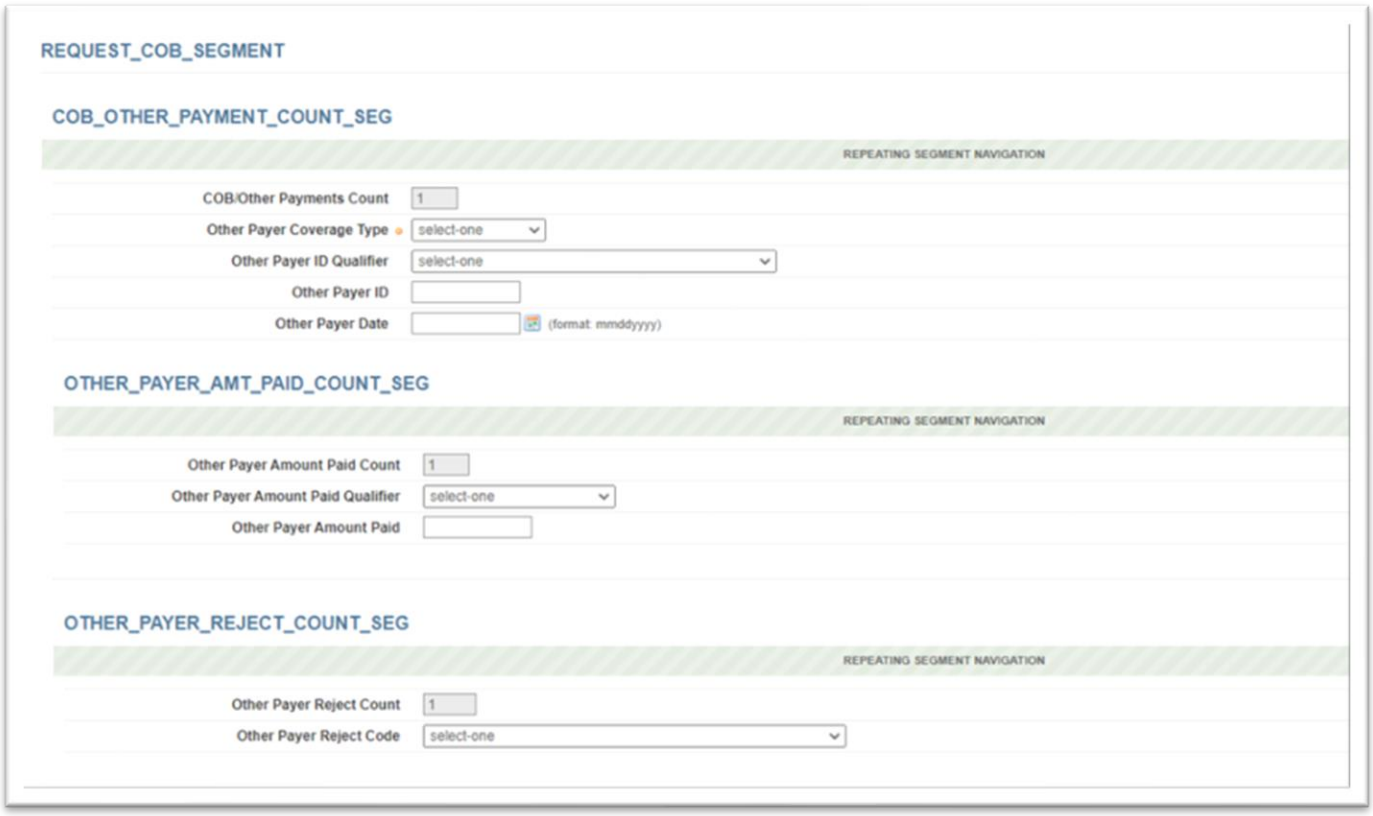


Figure 3.6-1: Request COB Segment

The following table provides field names, descriptions, and completion instructions for the Request Prescriber Segment of the WCS tool.

Field	Description	Completion Instructions
COB Other Payment Count Segment		
COB/Other Payments Count	Number of third-party payers; maximum of 9.	When submitting a claim via WCS, this field is pre-populated and cannot be manually updated. If there is more than one third-party payer, use the arrow icon(s) to move to the next/previous segment(s). **Note:** Maximum COB segments allowed is 9.
Other Payer Coverage Type	Code identifying the type of Other Payer ID. **Note:** Any value is accepted.	Select the applicable Other Payer Coverage Type from the drop-down list. If there is more than one third-party payer, use the arrow icon(s) to move to the next/previous segment(s). **Note:** This field is required if COB is being submitted on the claim.
Other Payer ID Qualifier	Accepted values are: • **03 – BIN** • **99 – Other**	Select the applicable Other Payer ID Qualifier from the drop-down list. If there is more than one third-party payer, use the arrow icon(s) to move to the next/previous segment(s). **Note:** This field is required if the **Other Payer ID** field is used.
Other Payer ID	ID assigned to the other payer.	Enter the applicable Other Payer ID. If there is more than one third-party payer, use the arrow icon(s) to move to the next/previous segment(s). **Note:** This field is required if COB is being submitted on the claim.

Field	Description	Completion Instructions
Other Payer Date	The payment or denial date of the claim submitted to the other payer. • Format: MMDDYYYY	Enter or select (using the Calendar button) the payment/denial date of the claim submitted to the other payer. If there is more than one third-party payer, use the arrow icon(s) to move to the next/previous segment(s). **Note:** This field is required if COB is being submitted on the claim.
Other Payer Amount Paid Count Segment		
Other Payer Amount Paid Count	The count of the Other Payer Amount Paid occurrences.	When submitting a claim via WCS, this field is pre-populated. If there is more than one third-party payer, use the arrow icon(s) to move to the next/previous Other Payer Amount Paid Count segment(s). **Note:** • Maximum segments allowed is 9. • This field is required if the **Other Payer Amount Paid Qualifier** field is used. • This field is required on all COB claims submitted with OCC = 2 or OCC = 4.
Other Payer Amount Paid Qualifier	Code qualifying the Other Payer Amount Paid. Accepted values are: • **07 – Drug Benefit**	Select the applicable Other Payer Amount Paid Qualifier from the drop-down list. **Note:** This field is required if the **Other Payer Amount Paid** field is used. This field is required on all COB claims submitted with OCC = 2

Field	Description	Completion Instructions
Other Payer Amount Paid	The amount of third-party payment known by the pharmacy.	Enter the applicable amount of the third-party payment per individual segment. **Note:** • This field is required if the other payer has approved payment for some or all of the billing, or accepted the billing but paid $0. • This field is required on all COB claims submitted with OCC = 2 or OCC = 4.
Other Payer Reject Count Segment		
Other Payer Reject Count	The count of the Other Payer Reject Code occurrences.	When submitting a claim via WCS, this field is pre-populated. If there is more than one Other Payer Reject code, use the arrow icon(s) to move to the next/previous Other Payer Reject Count segment(s). **Note:** • Maximum segments allowed is 5. • This field is required if the **Other Payer Reject Code** field is used.
Other Payer Reject Code	The NCPDP error received by the other payer.	Enter the applicable other payer reject code received. **Note:** This field is required when the other payer has denied the payment for the billing, designated with OCC = 3 – Other Coverage Billed – Claim Not Covered.

3.7 Request Drug Utilization Review (DUR) Segment

The fields included in the Request DUR Segment (see *Figure 3.7-1*) align with the NCPDP Designations.

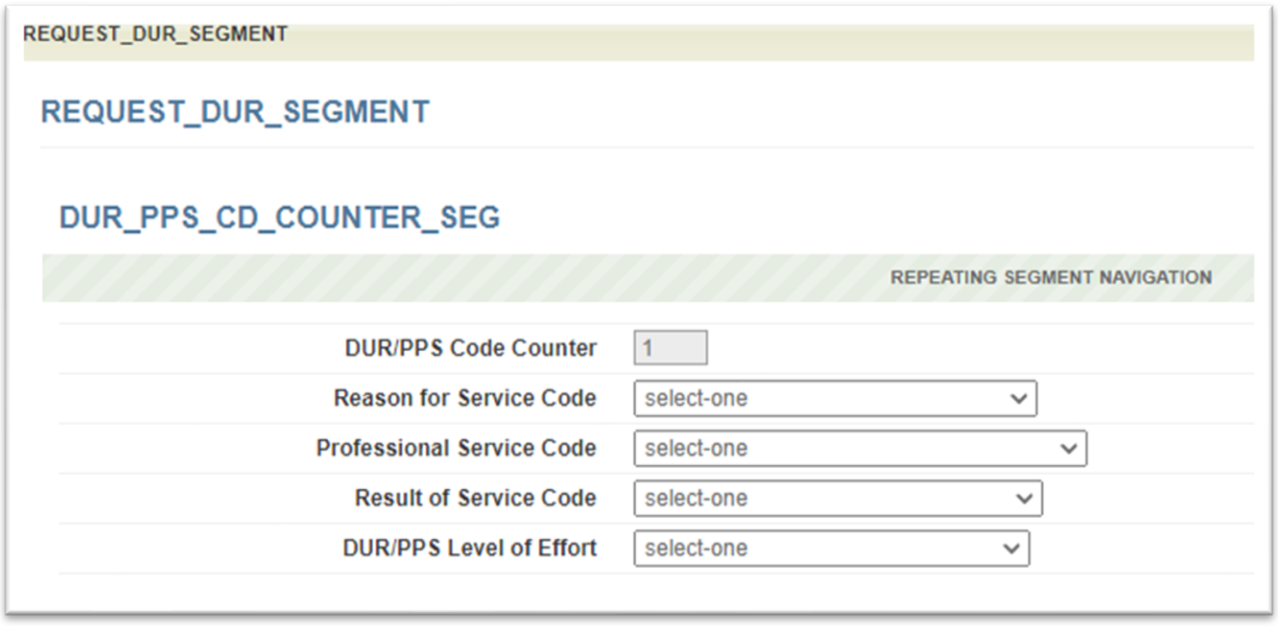


Figure 3.7-1: Request DUR Segment

The Request DUR Segment should only be populated if there is a DUR Encounter with the claim being submitted.
The service codes must be selected by the dispensing pharmacists.
Any time a “Repeating Segment Navigation” is mentioned in the template, there will be an arrow(s) present to move to the next or previous segment.
For example, if more than one DUR/professional pharmacy service (PPS) Code Counter is present, use the arrow icon(s) ⇦ ⇨ to move to the next or previous DUR/PPS Code Counter segment(s).

The following table provides field names, descriptions, and completion instructions for the Request DUR Segment of the WCS tool.

Field	Description	Completion Instructions
DUR PPS CD Counter Segment		
DUR/PPS Code Counter	Counter number for each DUR/PPS occurrence.	When submitting a claim via WCS, this field is pre-populated. If there is more than one DUR/PPS Code, use the arrow icon(s) to move to the next/previous DUR/PPS Code Counter segment(s). **Note:** • Maximum segments allowed is 9.
Reason for Service Code	Code identifying the type of utilization conflict detected or the reason of the pharmacist's professional service. Accepted values are: • **DD – Drug-Drug Interaction** • **ER – Early Refill** • **HD – Early High Dose** • **TD – Therapeutic Duplication**	Select the applicable Reason for Service Code from the drop-down list for each individual segment.
Professional Service Code	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered. Accepted values are: • **MØ – Prescriber Consulted** • **PØ – Patient Consulted** • **RØ – Pharmacist Consulted Other Source**	Select the applicable Professional Service Code from the drop-down list for each individual segment.

Field	Description	Completion Instructions
Result of Service Code	Action taken by pharmacist in response to a conflict or the result of a pharmacist's professional service. Accepted values are: • **1A – Filled As Is, False Positive** • **1B – Filled Prescription As Is** • **1C – Filled, With Different Dose** • **1D – Filled, With Different Directions** • **1E – Filled, with Different Drug** • **1F – Filled, With Different Quantity** • **1G – Filled, With Prescriber Approval** • **2A – Prescription Not Filled** • **2B – Not Filled, Directions Clarified**	Select the applicable Result of Service Code from the drop-down list for each individual segment.
DUR/PPS Level of Effort	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service. Accepted values are: • **0 – Not Specified** • **11 – Level 1 (Lowest)** • **12 – Level 2** • **13 – Level 3 (Highest)**	Select the applicable DUR/PPS Level of Effort from the drop-down list for each individual segment.

3.8 Request Pricing Segment

The fields included in the Request Pricing Segment (see *Figure 3.8-1*) align with the NCPDP Designations.

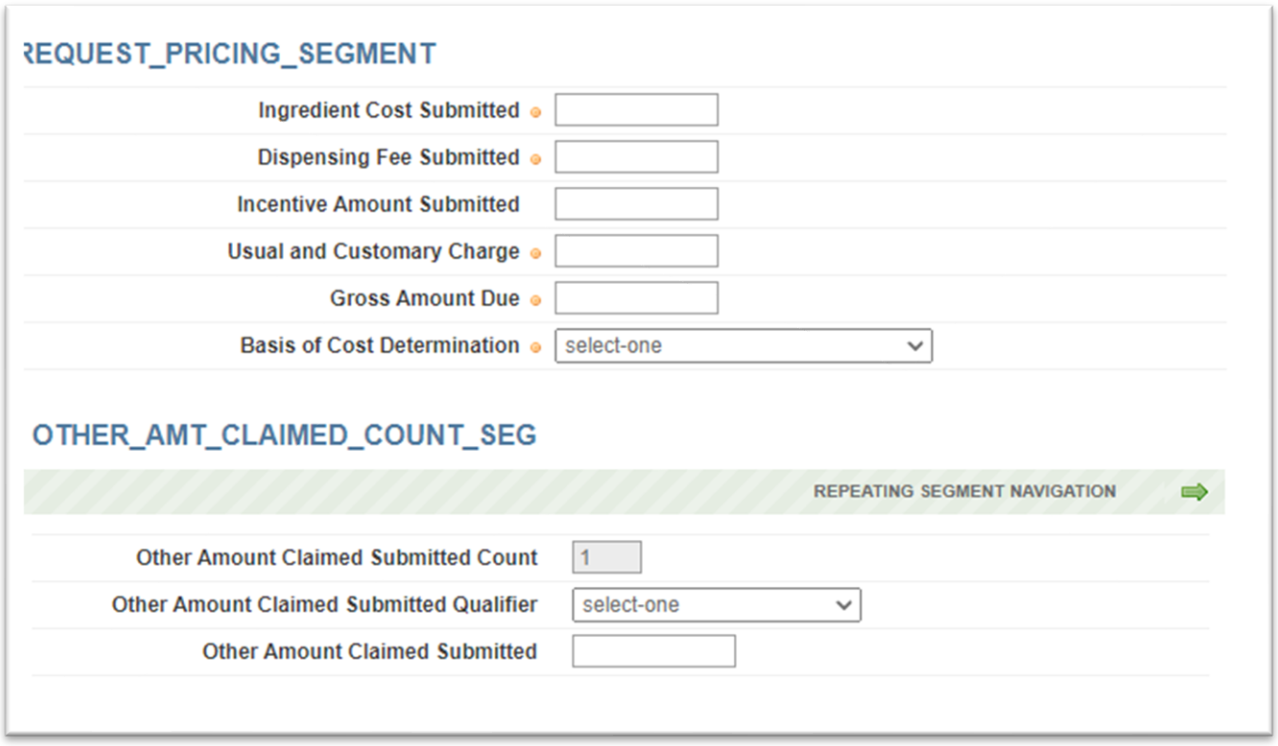


Figure 3.8-1: Request Pricing Segment

> Any time a “Repeating Segment Navigation” is mentioned in the template, there will be an arrow(s) present to move to the next or previous segment.
> For example, if more than one Other Amount Claimed Submitted Count is needed, use the arrow icon(s) ⇦ ⇨ to move to the next or previous segment(s).

The following table provides field names, descriptions, and completion instructions for the Request Pricing Segment of the WCS tool. Red asterisks (*) denote this is a required field.

Field	Description	Completion Instructions
Request Pricing Segment		
* **Ingredient Cost Submitted**	Submitted product component cost of the dispensed prescription. Included in the Gross Amount Due.	Enter the Ingredient Cost for the product dispensed.
* **Dispensing Fee Submitted**	Dispensing fee submitted by the pharmacy. Included in the Gross Amount Due.	Enter the Dispensing Fee for the product dispensed.
Incentive Amount Submitted	Amount represents the contractually agreed upon incentive fee paid for specific services rendered. Included in the Gross Amount Due.	Enter the Incentive Amount for the product dispensed.
* **Usual and Customary Charge**	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.	Enter the Usual and Customary (U&C) Charge for the product dispensed. **Note:** 340b pharmacies must submit actual acquisition cost in this field
* **Gross Amount Due**	Total price claimed from all sources.	Enter the Gross Amount Due for the product dispensed.

Field	Description	Completion Instructions
* **Basis of Cost Determination**	Code indicating the method by which Ingredient Cost Submitted was calculated. Accepted values are: • **00 – Not Specified** • **07 – Usual & Customary** • **08 – 340B/ Disproportionate Share Pricing/Public Health Service** • **13 – Special Patient Pricing – The cost calculated by the pharmacy for the drug for this special patient**	Select the applicable Basis of Cost Determination from the drop-down list. **Note:** Claims for products purchased through the 340b Program must be submitted with one of the following values: **07, 08, 13**
Other Amount Claimed Count Segment		
Other Amount Claimed Submitted Count	Count of Other Amount Claimed Submitted occurrences.	When submitting a claim via WCS, this field is pre-populated. If there is more than one Other Amount Claimed Submitted Count, use the arrow icon(s) to move to the next/previous Other Amount Claim Submitted Count segment(s).
Other Amount Claim Submitted Qualifier	Code identifying the additional incurred cost claimed in **Other Amount Claimed Submitted** field.	Select the applicable Other Amount Claim Submitted Qualifier from the drop-down list.
Other Amount Claimed Submitted	Amount representing the additional incurred costs for a dispensed prescription. Included in Gross Amount Due.	Enter the Other Amount Claimed submitted for the prescription dispensed.

3.9 Request Compound and Compound Ingredient Component Count Segments

The fields included in the Request Compound and Compound Ingredient Component Count Segment(s) (see *Figure 3.9-1*) align with the NCPDP Designations.

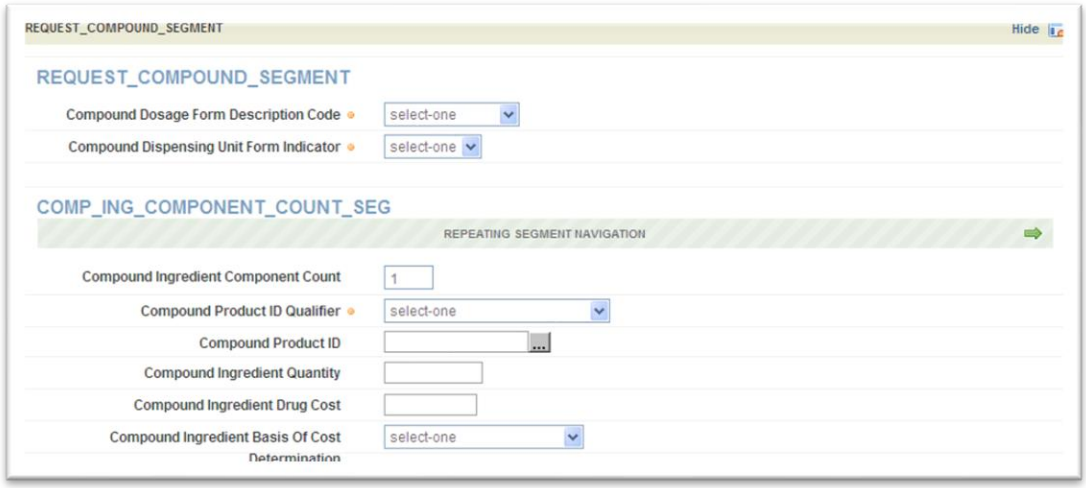


Figure 3.9-1: Request Compound Count Segment

When submitting a compound claim:

Be sure to select Compound Code of 2 – Compound, a Product Service ID Qualifier of 00 – Not Specified, a Product Service ID of 0, and, if necessary, select the applicable Compound Type (see *Section 3.4* for additional information).

Be sure to enter the total quantity dispensed for the entire product/compound dispensed in the Quantity Dispensed field of the Request Claim Segment (see *Section 3.4* for additional information).

A Route of Administration is required (see *Section 3.4* for additional information).

Submitting a SCC of 8 – Process Compound for Approved Ingredients will allow the claim to continue processing if at least one ingredient is covered.

Be sure to enter the total gross amount due for the entire product/compound dispensed (see *Section 3.8* for additional information).

Any time a “Repeating Segment Navigation” is mentioned in the template, there will be an arrow(s) present to move to the next or previous segment. For example, to move to the next or previous Compound Dosage Form Description Code segment(s), use the arrow icon(s) ⇦ ⇨ .

The following table provides field names, descriptions, and completion instructions for the Request Compound Segment of the WCS tool.

Field	Description	Completion Instructions
Request Component Segment		
Compound Dosage Form Description Code	Dosage form of the completed compound. Accepted values are: • **Blank – Not Specified** • **01 – Capsule** • **02 – Ointment** • **03 – Cream** • **04 – Suppository** • **05 – Powder** • **06 – Emulsion** • **07 – Liquid** • **10 – Tablet** • **11 – Solution** • **12 – Suspension** • **13 – Lotion** • **14 – Shampoo** • **15 – Elixir** • **16 – Syrup** • **17 – Lozenge** • **18 – Enema**	Select the applicable Compound Dosage Form Description Code from the drop-down list. **Note:** This field is required when submitting a compound claim.
Compound Dispensing Unit Form Indicator	NCPDP standard product billing codes. Accepted values are: • **EA – Each** • **GM – Grams** • **ML – Milliliters**	Select the applicable Compound Dispensing Unit Form Indicator from the drop-down list.

Field	Description	Completion Instructions
Compound Ingredient Component Count Segment		
Compound Ingredient Component Count	Count of compound product IDs in the compound mixture.	When submitting a claim via WCS, this field is pre-populated. Use the arrow icon(s) to move to the next/previous Compound Ingredient Component Count segment(s). **Note:** Maximum of 25 ingredients allowed.
Compound Product ID Qualifier	Code qualifying the type of product dispensed. Accepted value is: • **03 – NDC**	Select the applicable Compound Product ID Qualifier from the drop-down list.
Compound Product ID	Product NDC of the ingredient(s) used in the compound.	When submitting a claim via WCS, this field is pre-populated. Use the arrow icon(s) to move to the next/previous Compound Product ID segment(s). **Note:** Maximum of 25 allowed.
Compound Ingredient Quantity	Amount (expressed in metric decimal units) of the compound included in the compound mixture.	When submitting a claim via WCS, this field is pre-populated. Use the arrow icon(s) to move to the next/previous Compound Ingredient Quantity segment(s).
Compound Ingredient Drug Cost	Ingredient cost of the metric decimal quantity of the product included in the compound mixture indicated in the **Compound Ingredient Quantity** field.	When submitting a claim via WCS, this field is pre-populated. Use the arrow icon(s) to move to the next/previous Compound Ingredient Drug Cost segment(s).

Field	Description	Completion Instructions
Note: The **Compound Product ID Qualifier**, **Compound Product ID**, **Compound Ingredient Quantity**, and **Compound Ingredient Drug Cost** are all relative to individual ingredients and allocated by each segment specified, not the entire product.		
Compound Ingredient Basis of Cost Determination	Code indicating the method by which the cost of an ingredient used in a compound was calculated. Accepted values are: • **00 – Default** • **01 – AWP** • **02 – Local Wholesaler** • **03 – Direct** • **04 – EAC (Estimated Acquisition Cost)** • **05 – Acquisition** • **06 – MAC (Maximum Allowable Cost)** • **07 – Usual & Customary** • **08 – 340B/ Disproportionate Share Pricing/Public Health Service** • **09 – Other** • **10 – ASP (Average Sale Price)** • **11 – AMP (Average Manufacture Price)** • **12 – WAC (Wholesale Acquisition Cost)** • **13 – Special Patient Pricing**	When submitting a claim via WCS, this field is pre-populated. Use the arrow icon(s) to move to the next/previous Compound Ingredient Basis of Cost Determination segment(s).

3.10 Request Clinic Segment

The fields included in the Request Clinic Segment (see *Figure 3.10-1)* align with the NCPDP Designations.

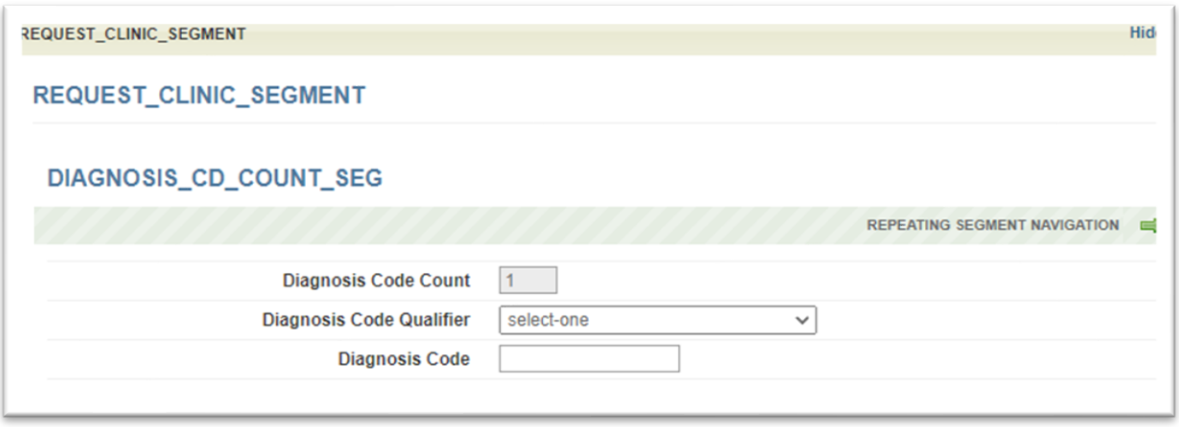


Figure 3.10-1: Request Clinic Segment

> Any time a “Repeating Segment Navigation” is mentioned in the template, there will be an arrow(s) present to move to the next or previous segment.
> For example, to move to the next or previous Diagnosis Code Count segment(s), use the arrow icon(s) ⇦ ⇨.

The following table provides field names, descriptions, and completion instructions for the Request Clinic Segment of the WCS tool.

Field	Description	Completion Instructions
Diagnosis Code Count Segment		
Diagnosis Code Count	Count of diagnosis occurrences.	When submitting a claim via WCS, this field is pre-populated. Use the arrow icon(s) to move to the next/previous Diagnosis Code Count segment(s). **Note:** Maximum of 5 allowed.
Diagnosis Code Qualifier	Code qualifying the Diagnosis Code.	Select the acceptable diagnosis code qualifier from the drop-down list.

Field	Description	Completion Instructions
	Acceptable value: • **02 – ICD-10**	
Diagnosis Code	Code identifying the diagnosis of the member.	Enter the applicable diagnosis (ICD-10) code.

3.11 Submitting a Multiple-Claim Transaction

Multiple-claim transactions may be submitted using the WCS tool. Up to four (4) claims may be submitted for the **same member**, **prescriber, and service provider** with one transaction.

> The Transaction Count field must match the number of claims. When selecting the next claim in a multi-claim transaction, some data will be pre-filled. All other relevant and required data as discussed in previous sections will still be required for completion.

Use the following steps to submit a multi-claim transaction:

1. Select the applicable number in the **Transaction Count** field under the Request Header Segment of the template (see *Figure 3.11-1*.)

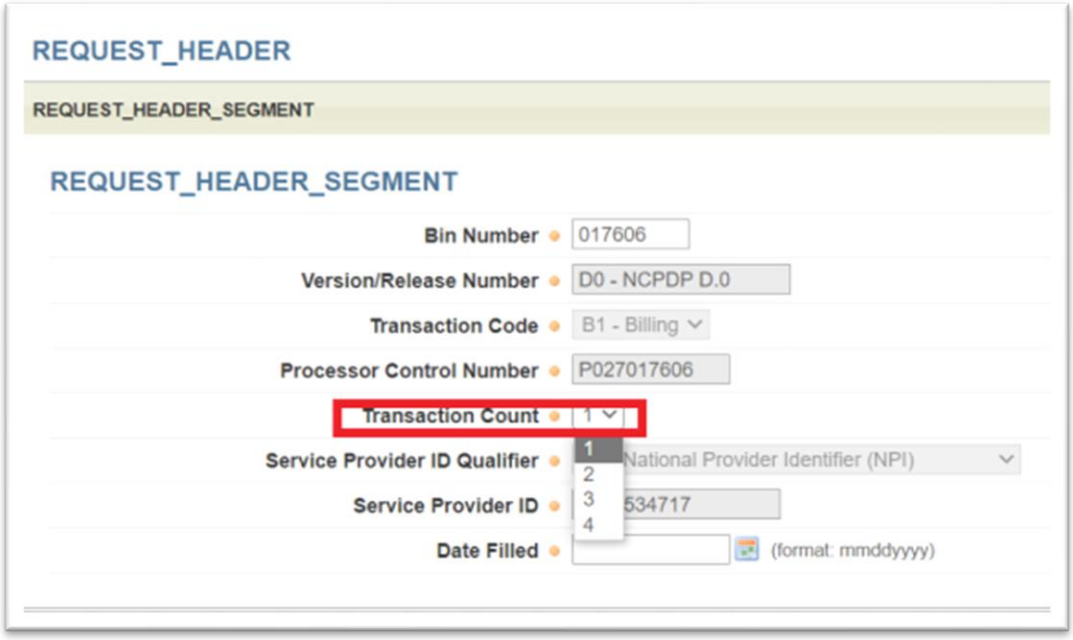


Figure 3.11-1: Transaction Count Drop-Down

2. To access the next or previous claim in a multi-claim transaction, scroll to the bottom of the template screen and select the arrow icons (see *Figure 3.11-2*). Once the data has been entered for the first claim, selecting the right-facing arrow icon will take the user to a new claim template to complete with the date for the next claim.

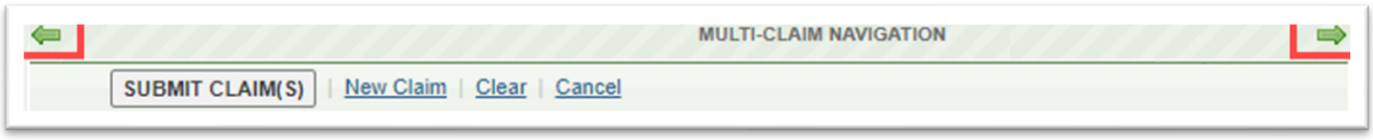


Figure 3.11-2: Sample Claim Entry Template

3. After all claim segments in the transaction have been completed, select Submit Claim(s) to process the additional claim(s). The Claim Submission Response window will appear. See *Figure 4.0-1*.

4.0 Claim Submission Response

The fields included in the Response Header Segment(s) provide information on the adjudicated claim such as Service Provider NPI, Date Filled, Claim Status, Reject Code(s), etc. See *Figure 4.0-1* for an example.

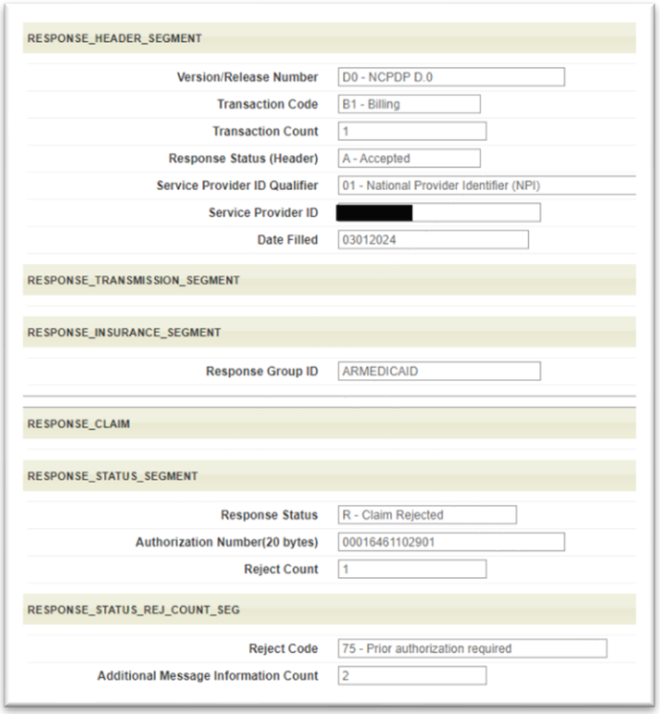


Figure 4.0-1: Claim Submission Response Example

The Claim Response tab shows the status of the claim once submitted.
Valid Claim Response(s):
P – Claim Payable
R – Claim Rejected
If the claim did not "pay," the Reject Code(s) and descriptions are listed on the Response Status Reject Count Segment window.
The fields that appear on the Claim Response window will vary depending on the reason the claim is rejecting.
If the claim did not adjudicate as anticipated and changes/updates are needed to the data initially entered, select the Claim Data tab at the top of the template and make the applicable updates. After the revisions have been completed, select the Submit Claim button to resubmit the claim.

5.0 Other Claim Functions

5.1 Searching for a Claim

Use the following steps to search for a claim:

1. After logging into the WCS tool (see *Section 2.1*) and selecting the applicable Provider ID from the Service Provider Window, users will have the option to either perform a Claim Search or select a Claim Template to submit a claim.
2. To perform a Claim Search for adjudicated claims, enter the relevant **Cardholder ID** and applicable claim **Date of Service** and select the **Search** button. See *Figure 5.1-1*.

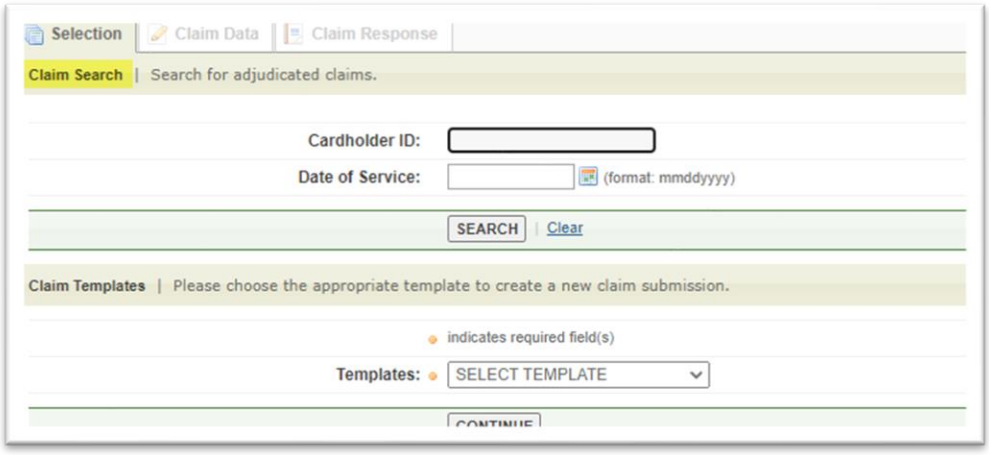


Figure 5.1-1: Claim Search

Both the Cardholder ID and Date of Service fields are required for a Claim Search to be performed.

3. The result window will appear. See *Figure 5.1-2* and *Figure 5.1-3*.
   Note: If no claim(s) are found, the result window still appears but displays “0 claims found.”

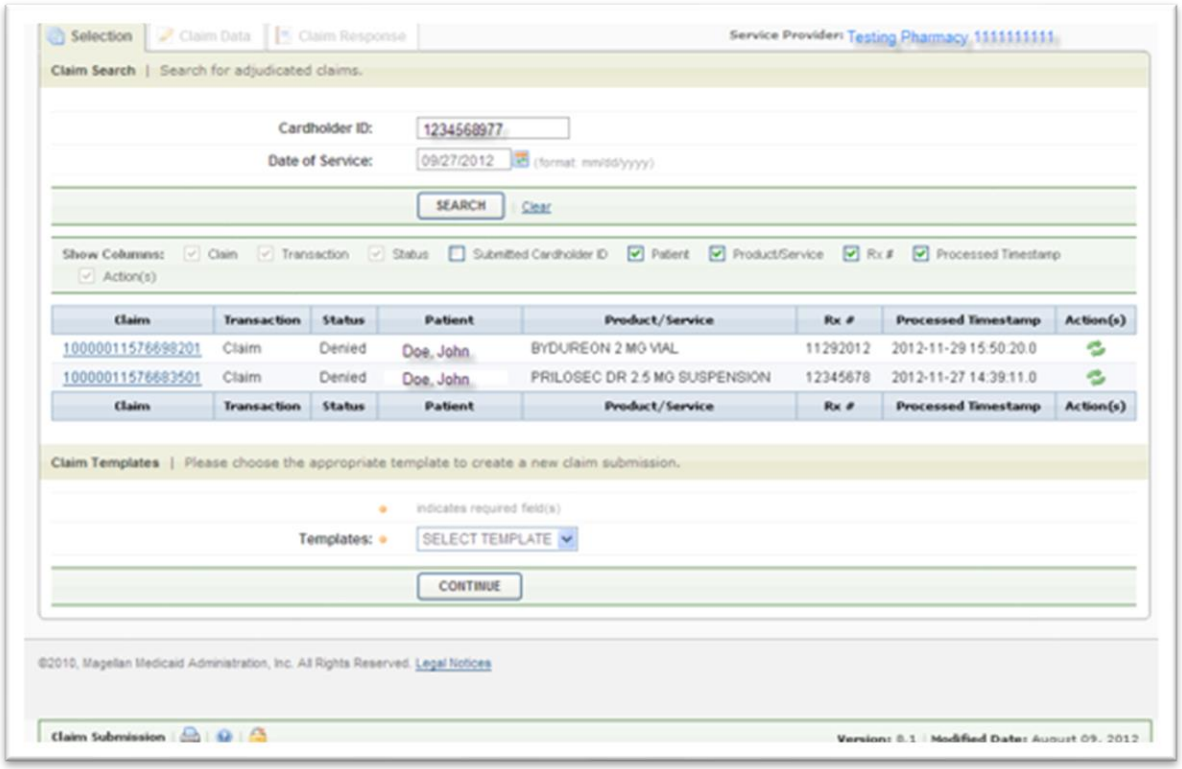


Figure 5.1-2: Adjudicated Claims Search (Claims Found) – Result Window

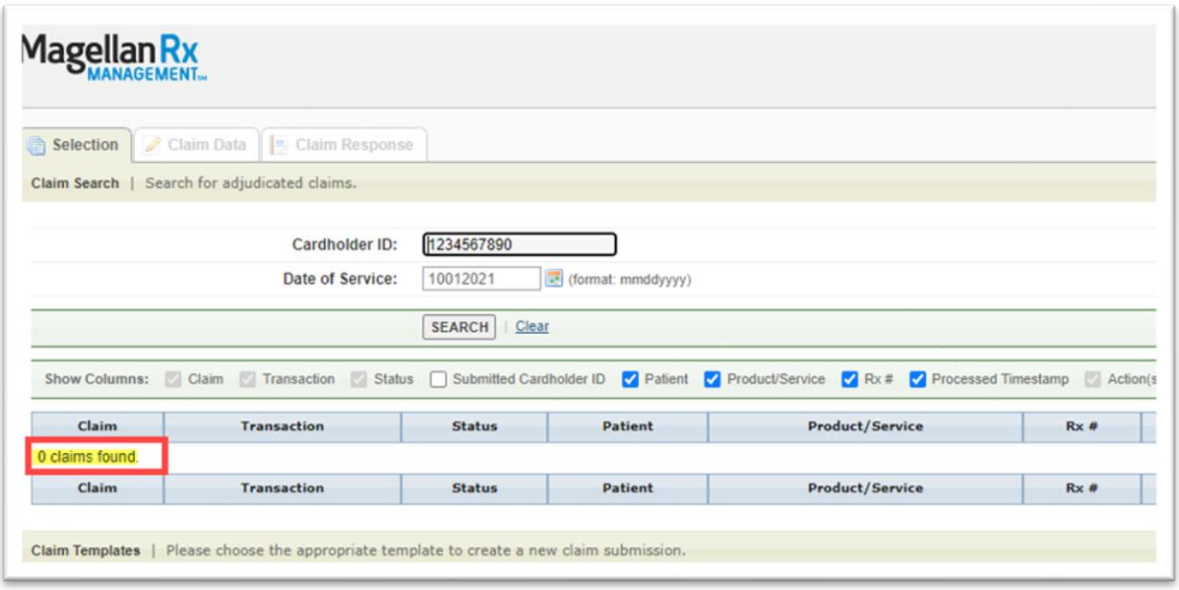


Figure 5.1-3: Adjudicated Claims Search (0 Claims Found) – Result Window

4. Use the checkboxes in the Show Columns area to select/unselect certain fields By changing the selections, the results will only show the fields that have been checked. **Note:** Claim, Transaction, Status, and Action(s) cannot be unselected.
5. To view a claim, select the **Internal Claim Number** hyperlink. The Claim Information window will appear. See *Figure 5.1-4*.
6. To return to the Adjudicated Claims Search Results window, select **Close Window**.
7. To print the claim information, select the **Printer** icon at the bottom of the screen.

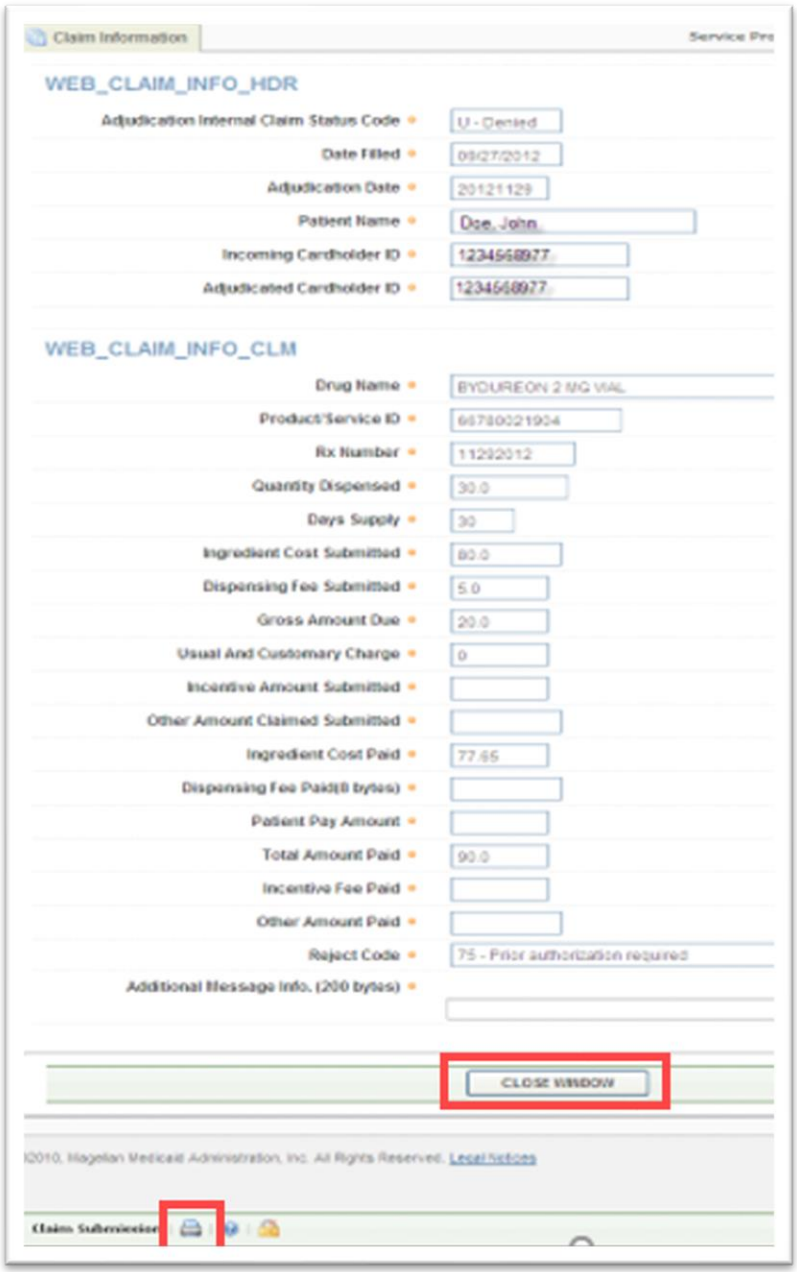


Figure 5.1-4: Claim Information Window

5.2 Reversing a Claim

There are three ways to reverse a claim:

1. A paid claim can immediately be reversed once the claim has been submitted and the Response window is visible.

2. You can select the Reversal template from the Template Selection window (see *Section 3.0*).
3. You can search for a claim using the Cardholder ID and DOS and reverse the claim from the search results.

5.2.1 Reversing a Claim from the Response Window

To reverse a claim directly from the Response window, select **Reverse Claim**. See *Figure 5.2.1.* The claim will then be reversed (see *Figure 5.2.1-2).*

> The Reverse Claim button only appears if the claim reached a "Paid" status. If the claim was rejected or denied, the Reverse Claim button does not appear.

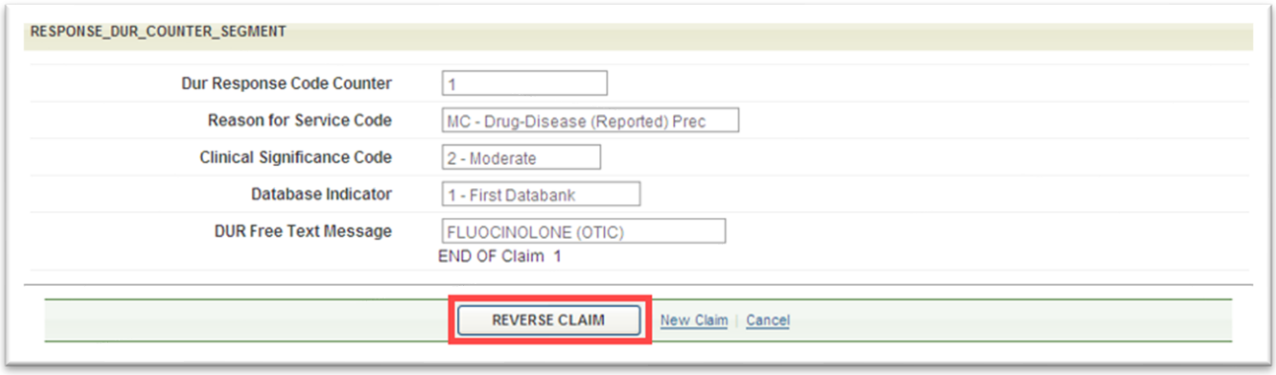


Figure 5.2.1-1: Reverse Claim Button

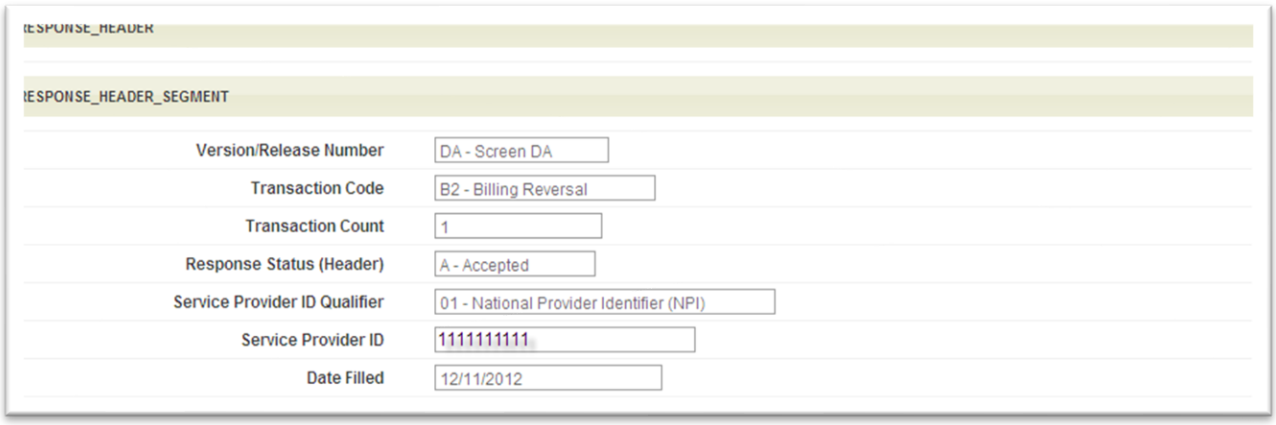


Figure 5.2.1-2: Reversal of Claim

5.2.2 Reversing a Claim using the Reversal Template

1. On the Selection tab, select **WEB_REVERSAL_VD.0** from the Templates drop-down list.

2. Complete the required fields in the Request Header and Request Claim segments. See *Figures 5.2.2.1-1* and *5.2.2.2-1*.

3. After completing the required and pertinent fields, select the **Submit Claim(s)** button (at the top or bottom of the screen).

> All claim fields and values selected or entered in the Reversal Template should pertain to the claim being reversed. New claim information should not be entered or selected.

Request Header Segment (Reversal)

The fields included in the Request Header Segment (Reversal) (see *Figure 5.2.2.1-1*) align with the NCPDP Designations.

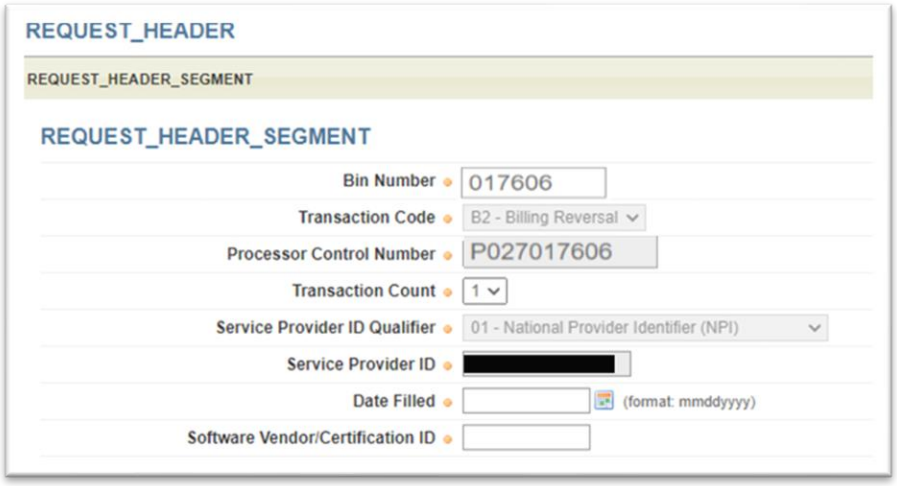


Figure 5.2.2.1-1: Request Header Segment (Reversal)

The following table provides field names, descriptions, and completion instructions for the Request Header Segment (Reversal) of the WCS tool. Red asterisks (*) denote this is a required field.

Field	Description	Completion Instructions
Request Header Segment (Reversal)		
* **BIN**	This is the card issuer or Bank ID used for network routing. • Arkansas Medicaid Rx BIN: **017606**	
* **Transaction Code**	This field denotes the type of transaction being submitted (for example, B1 – Billing, B2 – Reversal).	This field is pre-populated based on the template selected and cannot be manually updated (see *Figure 5.2.2-1*).
* **Processor Control Number**	The number assigned by the processor. • Arkansas Medicaid Rx PCN: **P027017606**	
* **Transaction Count**	The number of transactions in the transmission. Valid values are: • One transaction for compound claim. • Up to four transactions allowed for B1 or B2.	Select the applicable transaction count from the drop-down list.
* **Service Provider ID Qualifier**	This field is defaulted and based upon the Service Provider selected upon secured log-in to Web Claim Submission.	This field is pre-populated and cannot be manually updated.
* **Service Provider ID**	This field is defaulted based on the Service Provider selected upon secured log-in to WCS.	This field is pre-populated and cannot be manually updated.

Field	Description	Completion Instructions
Request Header Segment (Reversal)		
* **Date Filled**	This field denotes the DOS/date filled for the claim being submitted/reversed. • Format: MMDDYYYY	Enter the date or use the Calendar button to select the applicable date.
* **Software Vendor/ Certification ID**	The ID assigned by the switch or processor to identify the software source.	Enter the applicable Software Vendor/Certification ID. **Note:** This field is required when the vendor is certified with the Arkansas Medicaid Rx vendor; otherwise, enter all zeroes.

Request Claim Segment (Reversal)

The fields included in the Request Claim Segment (Reversal) (see *Figure 5.2.2.2-1)* align with the NCPDP Designations.

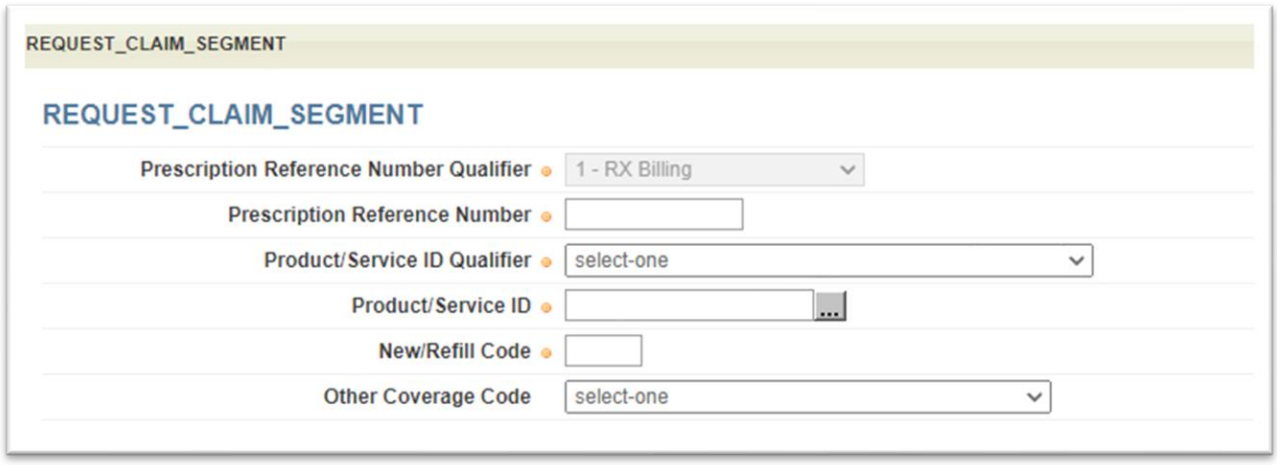


Figure 5.2.2.2-1: Request Claim Segment (Reversal)

Any time a “Repeating Segment Navigation” is mentioned in the template, there will be an arrow(s) present to move to the next or previous segment.
For example, if more than one SCC is needed on a given claim, use the arrow icon(s)  to move to the next or previous SCC segment(s).

The following table provides field names, descriptions, and completion instructions for the Request Claim Segment (Reversal) of the WCS tool. Red asterisks (*) denote this is a required field.

Field	Description	Completion Instructions
Request Claim Segment (Reversal)		
* **Prescription Reference Number Qualifier**	The code qualifying the Product/Service ID.	This field is pre-populated and cannot be manually updated.
* **Prescription Reference Number**	Prescription (Rx) Number assigned by the Service Provider.	Enter the assigned prescription number.
* **Product/Service ID Qualifier**	The code qualifying the Product/Service ID. Accepted values are: • **00 – Not specified** – **Must** select this value for compound claims. • **03 – (NDC)** – This value is used for non-compound claims, medical supplies, and enteral nutrition products.	Select the applicable Product/Service ID Qualifier from the drop-down list.
* **Product/Service ID**	ID of the product dispensed. • Must be an NDC for non-compound claims. • For compound claims, enter **0** in this field.	Enter the applicable NDC for the drug/product being dispensed.

Field	Description	Completion Instructions
Request Claim Segment (Reversal)		
Note: If the NDC is unknown, a search may be performed using the **Search** button  next to the **Product/Service ID** field. A **Product/Service ID Qualifier** is required before using this function.		
* **New/Refill Code**	Code indicating whether the prescription dispensed was a new (original) prescription or a refill. Accepted values are: • **0 – Original/New Fill** • **1-5 – Refill**	Enter the applicable fill number.
Other Coverage Code	Code indicating whether the member has other insurance coverage. Accepted values are: • **0 – Not Specified** • **1 – No Other Coverage Identified** • **2 – Other Coverage, Payment Collected** • **3 – Other Coverage, Claim Not Covered** • **4 – Other Coverage, Payment Not Collected**	Select the applicable OCC from the drop-down list. **Note:** Required for Coordination of Benefits. OCC-8 is not allowed

Request COB Segment (Reversal)

The fields included in the Request COB Segment (Reversal) (see *Figure 5.2.2.3-1*) align with the NCPDP Designations.

> The Request COB and Other Payer segments should only be populated if other coverage exists and is being billed for the member.
> Any time a “Repeating Segment Navigation” is mentioned in the template, there will be an arrow(s) present to move to the next or previous segment.
> For example, if more than one COB/Other Payments Count is needed on a given claim, use the arrow icon(s) ⇦ ⇨ to move to the next or previous COB/Other Payments Count segment(s).

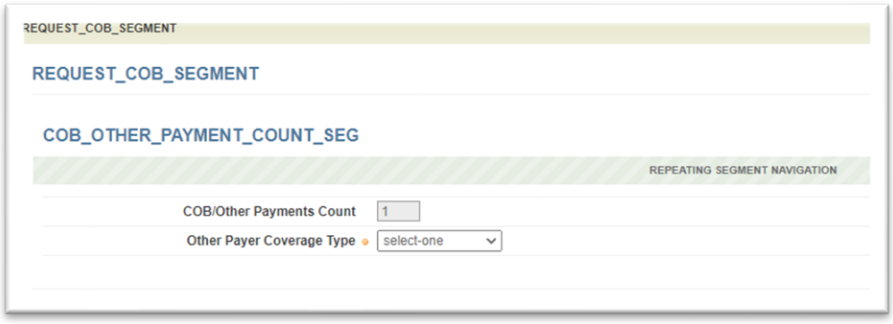


Figure 5.2.2.3-1: Request COB Segment (Reversal)

The following table provides field names, descriptions, and completion instructions for the Request COB Segment (Reversal) of the WCS tool. Red asterisks (*) denote this is a required field.

Field	Description	Completion Instructions
Request COB Segment (Reversal)		
COB/Other Payments Count	Number of third-party payers; maximum of 9.	When submitting a claim via WCS, this field is pre-populated and cannot be manually updated. If there is more than one third-party payer, use the arrow icon(s) to move to the next/previous segment(s). **Note:** Maximum COB segments allowed is 9.
* **Other Payer Coverage Type**	Code identifying the type of Other Payer ID. **Note:** Any value is accepted.	Select the applicable Other Payer Coverage Type from the drop-down list. If there is more than one third-party payer, use the arrow icon(s) to move to the next/previous segment(s). **Note:** This field is required if COB was submitted on the claim.

5.2.3 Reversing a Claim from the Search Results Selection Window

1. Using the Claim Search function, look for the claim to be reversed. Refer to *Section 5.1* for instructions on how to search for a particular claim.
2. After the claim has been found using the Claim Search function and the result window appears (see *Figure 5.2.3-1*).
3. Select the left-facing arrow in the Action(s) column.

Figure 5.2.3-1: Claim Search Result Window

4. The Reversal Template will appear with the required information pre-populated. See *Figure 5.2.3-2*. Select **Reverse Claim(s)** to complete the reversal.

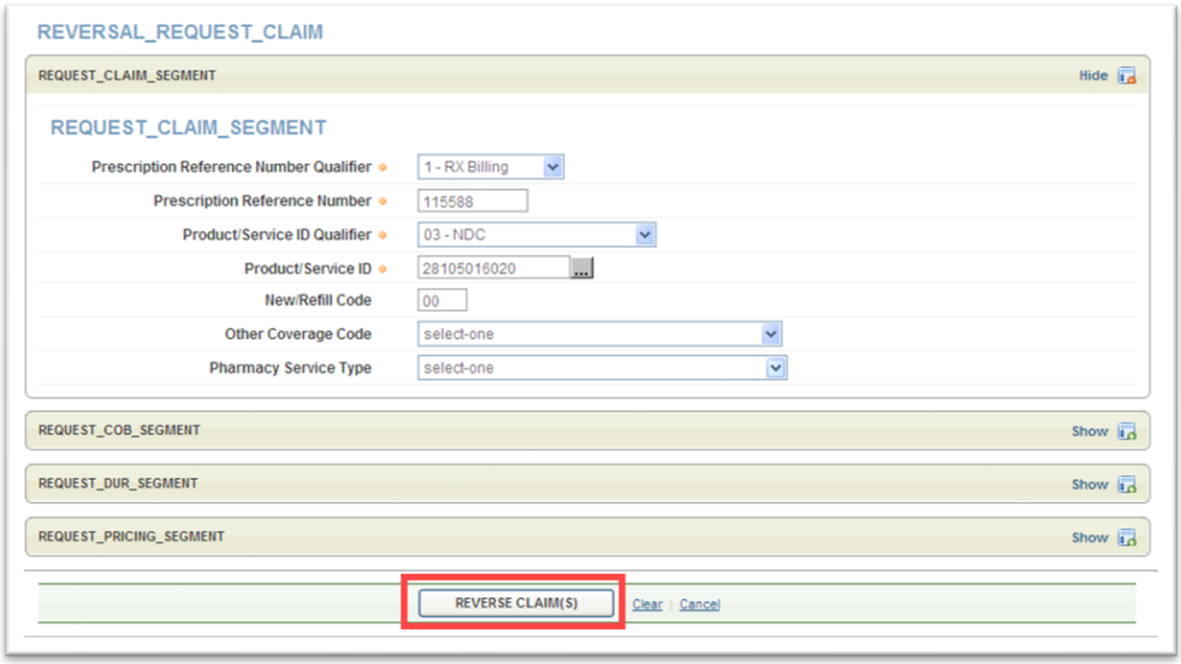


Figure 5.2.3-2: Claim Reversal Data Entry Window

5.3 Resubmitting a Claim from the Search Results Selection Window

1. Using the Claim Search function (see *Figure 5.3.1-1*), enter the required data and then select **Search**. The claim search result window will appear. See *Figure 5.3.1-2*.

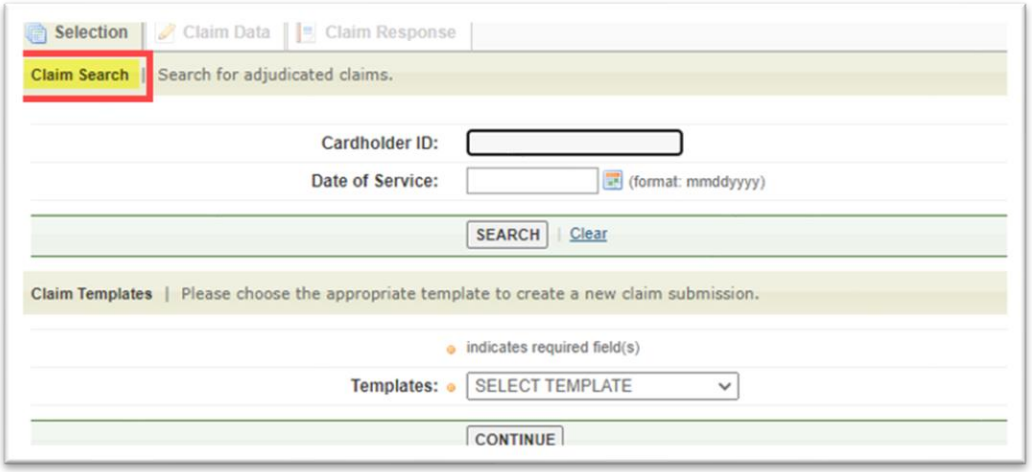


Figure 5.3.1-1: Search Window

2. To resubmit a claim from the claim search results, select the **Resubmit** icon in the Action(s) column. See *Figure 5.3.1-2*. After the icon has been selected, all of the previously submitted fields and values from the initial claim submission will populate.

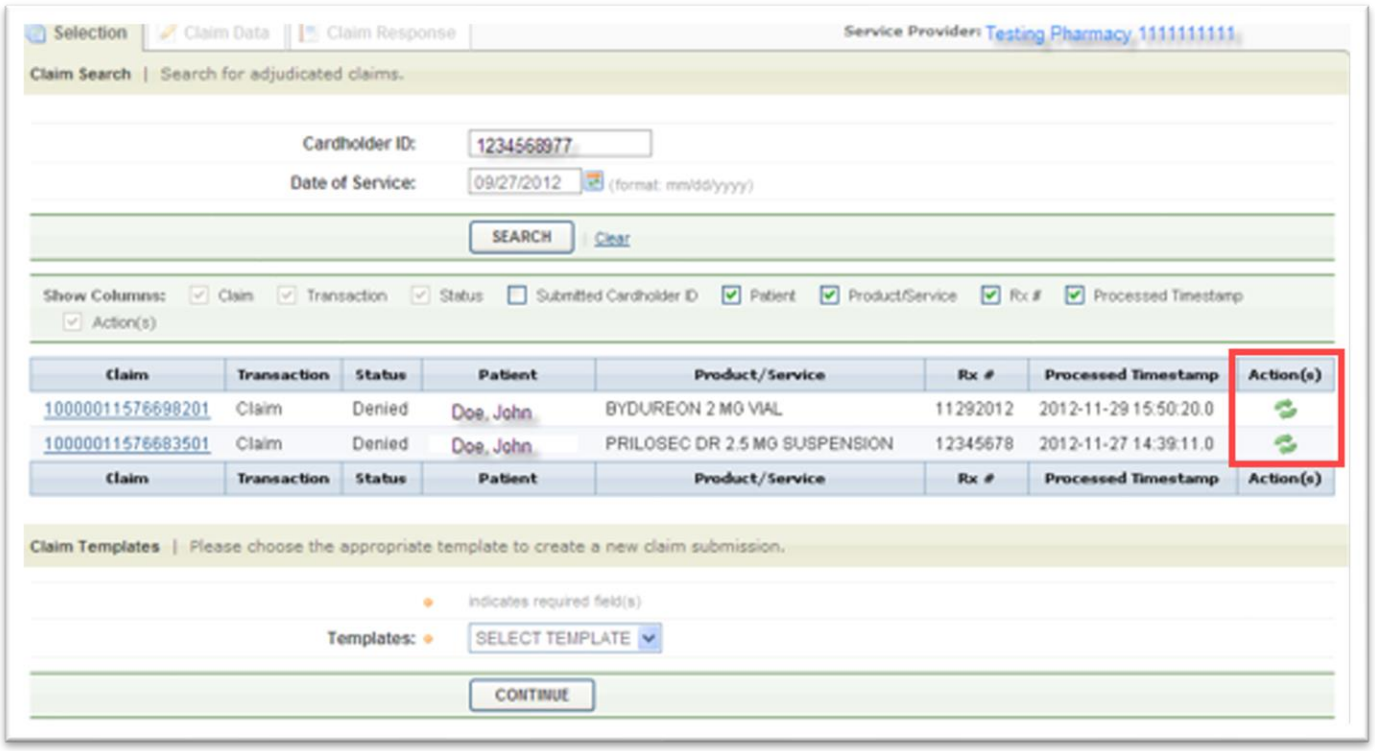


Figure 5.3.1-2: Adjudicated Claims Search – Result Window

6.0 Acronyms

Acronym	Definition
BIC	Benefits Identification Card
BIN	Bank Information Number
CIN	Cardholder Identification Number
COB	Coordination of Benefits
DAW	Dispense as Written
DOB	Date of Birth
DOS	Date of Service
DUR	Drug Utilization Review
HAP	Health Access Programs
HIN	Health Industry Number
ICF	Intermediate Care Facility
LTC	Long Term Care
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NF	Skilled Nursing Facility
NPI	National Provider Identifier
OCC	Other Coverage Code
PA	Prior Authorization
PCN	Processor Control Number
POS	Point of Sale
PPS	Professional Pharmacy Service
SCC	Submission Clarification Code
SNOMED	Systematized Nomenclature of Medicine
U&C	Usual and Customary
WCS	Web Claims Submission
UAC	User Administration Console