TELECOMMUNICATION VERSION 5 QUESTIONS, ANSWERS AND EDITORIAL UPDATES

DOCUMENTATION

Telecommunication Version 5
Questions, Answers and
Editorial Updates

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1.   PURPOSE OF THIS DOCUMENT

This document provides a consolidated reference point for questions that have been posed based on the review and implementation of the NCPDP Telecommunication Standard, Implementation Guide, and Data Dictionary for Version 5. This document also addresses editorial changes made to these documents.

As members reviewed the documents, questions arose which were not specifically addressed in the guides or could be clarified further. These questions were addressed in the Work Group 1 Telecommunication meetings. The question and answer was then posted on the web site under the heading of the various work group session. As questions occurred during several Work Group sessions, it was requested that the questions be consolidated for easier reference. This document consolidates those questions and answers under reference categories.

The categories provide a high level reference for the topic. For example, a category may be a Segment in the format, with a subcategory of a field in that segment. The question and answer is then posed for that field found in that segment. Where appropriate, the question may be the actual heading in the index for ease of research.

Editorial changes include typographical errors, comments that do not match a field value, a reference pointer in error.

NCPDP Telecommunication Standard Version 5.1 was named in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As of October 2ØØØ, Version 5.1 documents are frozen for changes until the Change Request System (CRS) is implemented by the Designated Standards Maintenance Organizations (DSMOs) and the Department of Health and Human Service (DHHS). Editorial or clarification changes, as well as format changes cannot be made to the Version 5.1 documents until put through the change process.

However, NCPDP may make editorial changes to the Version 5.Ø and Version 5.2 and above documents when deemed necessary by the members. These editorial changes are helpful to the implementation of the standard. Many of the changes apply to all the Version 5 and above documents.

To avoid confusion of questions or changes which have been posed in the Version 5.Ø and/or Version 5.2 and above documents, but which are not reflected in the frozen Version 5.1 documents, this reference guide should be used.

This document will continue to be updated as questions and answers or editorial changes are necessary.

Note: within the guide, when dollar fields and amounts are discussed, all digits may be seen for readability. When actually using the field, rules should be followed for the overpunch character, as applicable.

1.1   USE OF THIS DOCUMENT

This document should be used as a reference for the Telecommunication Standard Version 5.1 and the Batch Standard Version 1.1. In the Batch Standard format, the Detail Data Record consists of the NCPDP Data Record, which consists of the Telecommunication Standard record format. Therefore references in this document apply to both standards.

2. REQUEST SEGMENT DISCUSSION

2.1 TRANSACTION HEADER SEGMENT

2.1.1 SOFTWARE VENDOR/CERTIFICATION ID (11Ø-AK)

Usage

Question:
How is Transaction header field 11Ø-AK used?

Response:
This field is used by some processors who certify vendor software before allowing access to their systems. Each payer should publish a provider manual or payer sheet that shows their requirements. One requirement may be certification testing. The field may be populated with an ID per vendor, or per a "chain" or may not be used and therefore space filled.

2.1.2 TRANSACTION COUNT (1Ø9-A9)

Usage

Question:
What is the intent of the new field Transaction Count (1Ø9-A9)?

Response:
This is a new field in Version 5. The definition of Transaction Count (1Ø9-A9) is "Count of transactions in the transmission". Dependent on the transaction type, this field indicates the number (maximum of 4) of transactions (e.g. claims, reversals, et cetera) within a transmission. In previous telecommunication standards, this information was communicated along with the transaction type in the "Transaction Code" field as a combined value.

2.1.3 TRANSACTION HEADER SEGMENT FIELDS NOT MODIFIED IN RESPONSE HEADER SEGMENT

See section *"Response Header Segment Fields Not Modified From Transaction Header Segment"*, *"Usage"* for more information.

2.2 PATIENT SEGMENT

2.2.1 EMPLOYER ID (333-CZ)

Usage

Question:
What is the intent of using Field 333-CZ Employer ID?

Response:
Employer ID (333-CZ) is a new telecommunication field. The definition is "ID assigned to employer" and the field is located in the Patient segment. The intent of supporting this field in our new telecommunication standard is to be prepared for any Health Insurance Portability and Accountability Act (HIPAA) requirements mandating the identification of the employer responsible for the patient's pharmacy benefits.

2.2.2 PATIENT LOCATION (3Ø7-C7)

Question:

Please clarify the definition of the Patient Location (3Ø7-C7) Field. The NCPDP definition of this field is: Code identifying the location of the patient when receiving pharmacy services. In reading this definition, I can draw two distinct meanings. The first would be the patient's place of residence. The second would be the place of service when the drug is dispensed. There is no additional information in the editorial document. However, Workgroup 9 did have discussion related to this field when mapping NCPDP 5.1 to the 837 transaction. What is the intent of this field?

Response:
At this time, the field has two meanings. The payer sheet should clarify the use of the field for that payer. In the future, a Data Element Request Form (DERF) may be submitted to clarify the place where the patient resides versus the place the patient receives the product or service.

2.3   INSURANCE SEGMENT
2.3.1   CARDHOLDER ID (3Ø2-C2)
Question:
Can a cardholder ID contain symbols such as hyphens and apostrophes?

Response:
Yes, printable characters (including symbols) are allowed. Therefore, hyphens and apostrophes may be used. If punctuation characters are used, they must be easily readable to the provider trying to read the cardholder information for example, on a paper or plastic card.

The use of symbols, while a trading partner issue, can lead to confusion on the part of the provider unless they match exactly to information on the member or patient's card. Use of certain symbols may cause problems with the parsing routines in the system programs that must interpret them. Ultimately it will be the payer/processor who will determine the required format of the Cardholder ID field because they must be able to parse and interpret the field.

Please see section "*Transmission/Transaction Syntax*".

2.3.2   FACILITY ID (336-8C)
Assignation/Definition
Question:
Is the Facility ID (336-8C) replacing the Clinic ID (422-DM)?

Response:
Yes.

Question:
How will this field be assigned and who will assign it?

Response:
This field was renamed. It was previously called Clinic ID. Some organizations may assign an internal value. Some payers may assign a value. HIPAA regulations may ultimately determine how this field is used. HIPAA may require CMS to enumerate.

Question:
What is the purpose in a claim submission if a plan or processor requests it?

Response:
Current uses may include reporting, and Assignment of Benefits. May also tie a patient to a physical location.

Question:
What is meant by the definition of "Patient's Clinic/Host Party"?

Response:
The "Patient's Clinic/Host Party" is intended to represent the primary physical location responsible for the patient's medical care.

Question:
Depending on how this field is being used, can this Facility ID change each time a patient goes to a different clinic (e.g. could this be a frequently changing value?)?

Response:
Yes.

Question:
What are of the business requested the use of this field?

Response:
We do not recall the business party that requested this field.

Question:
Does the field Facility ID (336-8C) link to a patient and an insurance plan? Is this field in any way linked or associated with a prescriber? How do you see this field being used in the real world? How would an insurance plan utilize this field?

Response:
No, there is no standard link established between this field and a patient, insurance, or prescriber. This field is typically used to identify long-term or rest home facility. Currently, this is a trading partner issue on how it is used.

2.3.3 PERSON CODE (3Ø3-C3)
<u>Syntax</u>
Question:
Is a Person Code (3Ø3-C3) of "Ø6Ø" the same as "6Ø"?

Response:
No. Person Code (3Ø3-C3) is defined as alphanumeric 3. In an alphanumeric field, every digit has significance, with trailing spaces allowed to be truncated. The value "6Ø" in a three-byte alphanumeric field is actually "6Ø " (six-zero-blank) and is not the same value as "Ø6Ø" (zero-six-zero).

2.3.4 PLAN ID (524-FO)
<u>Usage</u>

Question:
Can you explain briefly how this field is used and what is its purpose?

Response:
The definition of "Plan ID" is "Assigned by the processor to identify a set of parameters, benefit, or coverage criteria used to adjudicate a claim". This is an optional field in both the Insurance Segment (request) and Response Insurance Segment.

In the Response Insurance Segment, we envision the payer using this field to communicate the "network" or "contract method" employed to pay the claim. In the Insurance Segment (request) we envision the provider using this field to communicate the expected "network" or "contract method" for which the claim should be reimbursed.

2.4   CLAIM SEGMENT
2.4.1   ALTERNATE ID (33Ø-CW)
How Does A Pharmacist Know Who Is Going To Pick Up The Prescription?
Question:
"Alternate ID" is a field on the Request Claim segment. If this field is submitted with the prescription claim how does a pharmacist know who is going to pick up the prescription?

 "Alternate ID" Definition:
Person Identifier to be used for controlled product reporting. Identifier may be that of the patient or the person picking up the prescription as required by the governing body.

Response:
"Alternate ID" supports the identification of either the patient or the person picking up the prescription. If "Alternate ID" is used to identify the person picking up the prescription it most likely will be used in the new Controlled Substance Reporting transaction. We envision the controlled substance reporting transaction occurring subsequent to the billing of the claim and post purchase. It is also possible that the "Alternate ID" could be used to identify the patient and submitted simultaneously with the prescription claim.

2.4.2   COORDINATION OF BENEFITS
2.4.2.1 OTHER COVERAGE CODE (3Ø8-C8)
Question:
For Coordination of Benefits (COB) processing - The Other Coverage Code (3Ø8-C8) is on the Claim Segment and is only available for one iteration even though there may be multiple iterations of detailed other payer info on the COB/Other Payments Segment. How does NCPDP propose to handle conditions when the Other Coverage Code reflect (e.g.) that for the primary payer the other coverage is not in effect on Date Of Service (4Ø1-D1), for the secondary payer the other coverage exists/payment collected; and for the tertiary payer the coverage is terminated? I am concerned about any combination of payers that might net different Other Coverage Code values if submitted on a single claim transaction.

Response:
The current values for Other Coverage Code (3Ø8-C8) are

Value	Description	Further Clarification
0	Not specified	
1	No other coverage	
2	Other coverage exists-payment collected	

3	Other coverage exists- claim not covered	Patient has other coverage, but the prior payer (primary, secondary, tertiary) does not cover this product or service.
4	Other coverage exists-payment not collected	Used in a payable response, when payment is zero with 1ØØ% co-payment.
5	Managed care plan denial	The patient has managed care coverage, but the claim was denied.
6	Other coverage denied-not participating provider	There is other coverage, but this provider (pharmacy) is not eligible.
7	Other coverage exists-not in effect on Date of Service	The patient has other coverage, but at the time of service, the coverage was not in effect.
8	Claim is billing for copay	Used in copay only billing. COB/Other Payment Segment may be submitted for Other Payer ID or Date fields.

The word "payment" in these statements does not include any co-payment.

The COB/Other Payments Segment is used for secondary, tertiary, etc claims that have successfully adjudicated with a "P"aid (or "D"uplicate of Paid) or Rejected response from the previous payer(s). The COB/Other Payments Segment is not used when the primary payer "C"aptures the claim.

For the present time, we recommend the following.
- The processor should look for the COB/Other Payments Segment.
- If any of the loops of the COB/Other Payments Segment contain Other Payer Amount Paid (431-DV) greater than zero, the Other Coverage Code (3Ø8-C8) should be 2.
- If **none** of the loops of the COB/Other Payments Segment contain Other Payer Amount Paid (431-DV) greater than zero and one of the loops contains Other Payer Amount Paid (431-DV) of zero, the Other Coverage Code (3Ø8-C8) should be 4.
- If **all** of the loops of the COB/Other Payments Segment contain rejection information, the Other Coverage Code (3Ø8-C8) will not contain 2 or 4. In the rejection information, the NCPDP Reject Codes (511-FB) will further explain the reason for rejection.

Further
- If the Other Coverage Code (3Ø8-C8) is Ø or 1, the COB/Other Payments Segment does not exist.
- If the Other Coverage Code (3Ø8-C8) is 2, the COB/Other Payments Segment is present and at least one of the loops will contain Other Payer Amount Paid (431-DV) greater than zero.
- If the Other Coverage Code (3Ø8-C8) is 3 through 7, the COB/Other Payments Segment may exist and the loops should be interrogated for further information.
- If the Other Coverage Code (3Ø8-C8) is 8, the COB/Other Payments Segment may exist to obtain the Other Payer ID or Other Payer Date fields.

If **any** payment has been received from any number of payers
- Other Coverage Code (3Ø8-C8) is 2

If **no** payment has been received from any number of payers
- Other Coverage Code (3Ø8-C8) is 3 or 4

A Data Element Request Form (DERF) will be submitted in the future to address this business need.

2.4.2.1.1 OTHER PAYER DATE (443-E8)
Question:
On a copay-only COB billing for NCPDP 5.1, there is a need to obtain from the pharmacy information regarding the primary payer and the date that the claim was paid. If the COB segment is not to be used for Other Coverage Code value of '8' (per current version of the FAQ document), how can this information be obtained?

Response:
The NCPDP Telecommunication Standard Version 5.1 does not address this issue. The Version 5 Editorial does provide recommendations for the use of copay only billing and there is an example (20.7) that says trading partners can send payer id and date. This has been addressed in 5.3 and above.

11/2006 – We recognize that this is ambivalent but Version 5.1 is "frozen" under HIPAA and specific guidance was not brought forward in 5.1. The COB/Other Payments Segment may be used in copay only scenarios to relay the Other Payer ID or Other Payer Date fields. Please note that much more specific clarification has been added to Telecom Version DØ.

Usage for More than Nine Coverages in COB:
In the situation where there are more than 9 coverages for a patient, the composite must not be used. Each loop of the COB should show the payment or rejection from the payer. After the 9th payer, the claim is handled manually to subsequent payers.

An error was found in the Data Dictionary where only the following values were listed for Other Payer Coverage Type (338-5C).

Blank	Not Specified
Ø1	Primary
Ø2	Secondary
Ø3	Tertiary
98	Coupon
99	Composite

With the removal of the composite restriction (see previous versions), values Ø4 – Ø9 were needed. These values will be submitted in a DERF, and upon approval, will be available in a future version of the Telecommunication Standard Implementation Guide. The membership will need to decide if the new values can be included in this guide. For the current frozen HIPAA environment, the only choice was to use the default value of "Blank" and the positioning of the Other Payer Coverage Type field within the Coordination of Benefits/Other Payments Segment loops to represent occurrences Ø4 – Ø9. When there are more than 3 additional insurances that must be reported, the sequence of the loops must be in order as
        Ø1 = Primary
        Ø2 = Secondary
        Ø3 = Tertiary
        Blank = Quaternary
        Blank = Quinary
        Blank = Senary
        Blank = Septenary
        Blank = Octonary

Blank = Nonary

A DERF will be submitted to add the values of Ø4 – Ø9 and the work group will decide if those values should be included in this document.

2.4.2.1.2 CLARIFICATION OF OTHER COVERAGE CODE (3Ø8-C8)
Question:
We are requesting assistance from NCPDP in understanding the different values associated with the Other Coverage Code (OCC) field (308-C8) in the V5.1 transaction and the adjudication requirements to use those values.

Response:

Other Coverage Code	Description	Other Fields Submitted	Expected Outcome	Comments
0	Not specified	Submit like standard primary claim	Reject or pay according to coverage rules	From the Version 5 Editorial: If the Other Coverage Code (3Ø8-C8) is Ø or 1, the COB/Other Payments Segment does not exist. If the Other Coverage Code (3Ø8-C8) is 8, the COB/Other Payments Segment may be sent to support the Other Payer ID or Other Payer Date fields.
1	No other coverage	Submit like standard primary claim	Reject or pay according to COB coverage rules	NCPDP: Many processors use their eligibility information as the rule. The claim would reject for other coverage existing from the processor's eligibility information. If available, the other coverage information is very helpful to the pharmacy. If the processor allows the pharmacy to override, it would be a business decision between the two parties. This value should not be used as a default. From the Version 5 Editorial: If the Other Coverage Code (3Ø8-C8) is Ø

				or 1 or 8, the COB/Other Payments Segment does not exist.
2	Other coverage exists-payment collected	Other Payer Amount Paid (431-DV)	Pay or reject according to coverage rules. See the Telecommunication Implementation Guide for Pricing Formulae.	NCPDP: Per the Version 5 Editorial, If the Other Coverage Code (3Ø8-C8) is 2, the COB/Other Payments Segment is present and at least one of the loops will contain Other Payer Amount Paid (431-DV) greater than zero.
3	Other coverage exists- claim not covered	COB Segment is required if payer expects to see Reject Codes.	Pay or reject according to coverage rules	NCPDP: Claim sent to primary - not covered (for example, drug not covered/member not covered/eligible) - submit claim to next payer.
4	Other coverage exists-payment not collected	Other Payer Amount Paid (431-DV) = zero	Pay or reject according to coverage rules.	NCPDP: Similar to OCC2 for example, went to primary and accepted claim, however, 100% copay to member. No payment to pharmacy. From the Version 5 Editorial: If **none** of the loops of the COB/Other Payments Segment contain Other Payer Amount Paid (431-DV) greater than zero and one of the loops contains Other Payer Amount Paid (431-DV) of zero, the Other Coverage Code (3Ø8-C8) should be 4.
5	Managed care plan denial	COB Segment is required if payer expects to see Reject Codes.	Pay or reject according to coverage rules	NCPDP: Similar to OCC3 - this is new to V5.1 - more specific for a managed care plan denial codes. Would usually use OCC3 - dependent upon payer accepting these codes.
6	Other coverage	COB Segment is	Pay or reject	NCPDP: Similar to

	denied-not participating provider	required if payer expects to see Reject Codes.	according to coverage rules	OCC3 - this is new to V5.1 - more specific denial codes.
7	Other coverage exists-not in effect on Date of Service	COB Segment is required if payer expects to see Reject Codes.	Pay or reject according to coverage rules	NCPDP: Similar to OCC3 - this is new to V5.1 - more specific denial codes.
8	Claim is billing for copay	Primary Patient Pay Amount submitted in field Other Amount Claimed Submitted (48Ø-H9) - this value also sent in Gross Amount Due (43Ø-DU)	Pay or reject according to coverage rules When payable reimbursement = Other Amount Claimed Submitted (48Ø-H9)	NCPDP: Copay only claim - based on standard, don't need to send ingredient cost and dispensing fee. From the Version 5 Editorial: If the Other Coverage Code (3Ø8-C8) is Ø or 1, the COB/Other Payments Segment does not exist. If the Other Coverage Code (3Ø8-C8) is 8, the COB/Other Payments Segment may be sent to support the Other Payer ID or Other Payer Date fields. The use of Other Amount Claimed Submitted in the Pricing Segment is the solution for the current environment. The more complete solution exists in the Telecommunication Implementation Guide Version 5.5 with the use of the Other Payer-Patient Responsibility fields.

Usage

Please see "Appendix B. Coordination Of Benefits Explanation For Version 5.1" for information on billing COB in Version 5.1.

2.4.3 DATE OF SERVICE (4Ø1-D1)
Value Returned on Completion Fills
Question:

What is the date of service that will be returned on remittance detail for a "C" Completion transaction? Will it be the Date of Service (4Ø1-D1) or Associated Prescription/Service Date (457-EP)? Hopefully it will be the Date of Service (4Ø1-D1) to avoid claims appearing as duplicates.

Response:
It is our recommendation that the value in the "Date of Service" field 4Ø1-D1 on the response match the value in the "Date of Service" field on the inquiry field.

Dispensing Status	RX Number	Inquiry Date of Service	Transaction Submission Date	Response Date of Service
"Partial"	1234567	Ø4/2Ø/ØØ	Ø4/2Ø/ØØ	Ø4/2Ø/ØØ
"Completion"	1234567	Ø4/21/ØØ	Ø4/21/ØØ	Ø4/21/ØØ
"Completion"	1234567	Ø4/21/ØØ	Ø4/22/ØØ	?

Relationship To Measurement Date
Question:
Is there a relationship between the claim date of service (4Ø1-D1) and the measurement date (494-ZE)? Does the measurement date need to be equal to or less than the claim date of service?

Response:
The "Date of Service" (4Ø1-D1) field "Identifies date the prescription was filled or professional service rendered." The "Measurement Date" (494-ZE) is the "Date clinical information was collected or measured." The Date of Service may be the date the pharmacist counseled a patient. However, the clinical data may have been measured/collected on a prior or later date.

2.4.4 DISCHARGE DATE SUPPORT
Usage
A business need was brought forward to support a Discharge Date in the Telecommunication Standard Version 5.1 environment. Since new fields could not be added to the already approved and HIPAA-named Telecommunication Standard Version 5.1, the membership approved the short-term use of the Prior Authorization Number Submitted (462-EV).

The Discharge Date, in the format of CCYYMMDD may be included in this field. Under Version 5.1 rules, when the Prior Authorization Number Submitted (462-EV) is submitted, the Prior Authorization Type Code (461-EU) must be populated. (This restriction was removed in Version 7.Ø.) It is recommended that the value of 8=Payer Defined Exemption is used when Discharge Date is supported.

It is recommended that payers that need the Discharge Date clearly define the usage in their payer sheet/provider manual. Clarification should be given if a payer needs to support both a prior authorization number AND a discharge date in this field.

2.4.5 FILL NUMBER (4Ø3-D3)
Default?
Question:
Field 4Ø3-D3, Fill Number, is defined as a numeric field. Per the data dictionary the values defined for this field are Ø = Original fill, 1-99 = refill number. Since this field is a numeric field, the default value is zero. According to the recommendations in the standard and implementation guides for field truncation, if an optional field contains its default value, the sender may omit the field entirely. My question is, per the standard, would it be appropriate to omit sending the Fill Number, since it is an optional field, when

the transaction is for the original fill? Would it be reasonable for a processor to assume, since the field has not been submitted, that the transaction was for the original dispense?

Response:
Because Ø is a codified value, not a default value, if the processor requires submission of the Fill Number, it is not appropriate to omit it.

2.4.5.1 FILL NUMBER BE THE SAME FOR PARTIAL AND COMPLETION FILLS
Question:
Why is it recommended that the fill number (field 4Ø3-D3) for a "C" Completion transaction be the same as for the "P" Partial fill transaction? Since the "C" Completion transaction must indicate the Associated Prescription/Service Reference Number (456-EN) as well as Associated Prescription/Service Date (457-EP) isn't that enough to match the "C" Completion transaction to the previous "P" Partial fill transaction?

Response:
Field 4Ø3-D3 is the Fill Number. The "Fill Number" is defined as "Code indicating whether the prescription is an original or a refill". In a vast majority of cases your point is well taken. However, the recommendation to match the "Fill Number" on corresponding "C" Completion and "P" Partial fill transactions results from a business need to ensure accurate matching in the instance in which two prescriptions with the same Associated Prescription/Service Reference Number and Associated Prescription/Service Date occur.

2.4.6 INTERMEDIARY AUTHORIZATION ID (464-EX) AND INTERMEDIARY AUTHORIZATION TYPE ID (463-EW)
2.4.6.1 EXPLAIN DIFFERENCE WITH PRIOR AUTHORIZATION
Question:
If this is used internally in order to override an edit, how is this used differently from a Prior Authorization?

Response:
The definition of "Intermediary Authorization ID" is "Value indicating intermediary authorization occurred".

The definition of "Intermediary Authorization Type ID" is "Value indicating that authorization occurred for intermediary processing".

In Version 3.2, the Prior Authorization fields are used for two purposes, specific help desk phone call requests to alter a claim's adjudication, and to proactively allow the Pharmacist to transmit a predefined standard value to bypass a specific reject, i.e. DUR reject.

In Version 5, these two uses are broken into separate fields. Intermediary Authorization ID/Type fulfills the latter need, thereby allowing the Prior Authorization fields to be used only for the former.

Example:
Today the standing Prior Authorization value of "9991234" may override any DUR edit reject. The same value is used for all patients and drugs. In Version 5, the Pharmacist

places this value in the new Intermediary fields allowing specific patient drug related Prior Authorization values to be placed in the Prior Authorization fields.

A Specific Example
Question:
Can you explain a specific instance or example?

Response:
Here is an example. An intermediary authorization system identifies a non-formulary NDC number on a claim submission. The intermediary rejects the claim with a drug formulary message. The pharmacist overrides the claim with an appropriate entry in the Intermediary Authorization Number field to indicate a desire to submit the prescription with the existing drug submission and therefore override the editing system.

2.4.7 INVALID PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER (455-EM)
Question:
A payer receives a B1 transaction but the Prescription/Service Reference Number Qualifier (455-EM) is sent with the Field ID only and no value. The transaction is rejected because as a payer, I need to know if it is an Rx Billing ("1") or a Service Billing ("2"). The transaction is rejected with all segments required per implementation guide with a Reject code of "16 " M/I Prescription Number. But the dilemma is the Response Claim Segment (22) is required and the Segment ID, Prescription/Service Reference Number Qualifier (455-EM) and Prescription/Service Number (4Ø2-D2) are mandatory fields. What should be in the Prescription/Service Reference Number Qualifier field (if the incoming request contained no value)?

Response:
Spaces are not allowed as the value in the mandatory field of Prescription/Service Reference Number Qualifier (455-EM). When the Prescription/Service Reference Number Qualifier (455-EM) is missing or invalid, the processor system must generate a Transmission Accepted/Transaction Rejected response. The processor system must generate a response with a Prescription/Service Reference Number Qualifier (455-EM) of "1". Prescription/Service Number (4Ø2-D2) must contain a value of Ø (a single zero). The appropriate Reject Codes (511-FB) must be returned for a missing/invalid field. The Reject Code of "R8 " (Syntax Error) may also be used. A Transmission Rejected/Transaction Rejected (header reject noted in the question) does not apply because invalid information in the Claim Segment causes a transaction reject, not a transmission reject.

See also section "*Transmission/Transaction Syntax*", subsection "*Mandatory Qualifiers And Fields – Usage Of Default Values*", subsection "*Usage Of Default (Low-Values) On Mandatory Qualifiers And Fields*".

2.4.8 PROCEDURE MODIFIER CODE (459-ER)
Procedure Modifier Code and NDC
Question:
From a standards perspective is it valid to require the reporting of procedure code modifier(s) with national drug codes?

> Our customer recently began to apply Medicare Part B entitlement editing against incoming pharmacy claims submitted with national drug codes. When

the Part B entitlement is detected, the claim is paid to the pharmacy and the TPL agent for the State reformats the claim into a professional claim and submits the claim under a HCPCS code to Medicare. Medicare will be requiring that these claims be submitted with specific procedure code modifiers before the DMERC Carrier can consider the claim for payment. There are situations where a modifier may/will be necessary for DMERCs to properly process a claim with an NDC code (ie: nebulizer drugs where the KO would be required, waiver of liability modifiers, to name a few cases). Our customer wants us to collect the procedure code modifiers on the initial claim submission so that the procedure code modifiers are available in the event the claim is submitted to Medicare subsequent to payment. These claims are for services rendered to enrollees in State prescription drug programs.

Response:
The standard does not prohibit the reporting of procedure code modifier(s) with National Drug Codes (NDC).

2.4.8.1 WHERE DO I OBTAIN A PROCEDURE MODIFIER CODE LIST?
Question:
"Procedure Modifier Code" is a new field with the definition "Identifies special circumstances related to the performance of the service." The Data Dictionary references HCFA (CMS). Whom do I contact to obtain this information?

Response:
The "Procedure Modifier Codes" are located in the HCPCS section of the HCFA (CMS) website. The web site address is: http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ This will take you to the alpha numeric HCPCS files section that contains all of the codes.

2.4.9   PRODUCT/SERVICE ID (4Ø7-D7)
Format and Usage
Question:
By business partner agreement, a pharmacy wishes to submit Workers' Compensation claims to its billing services provider using the NCPDP Telecom v7.Ø Standard. (This should not need to comply with HIPAA regulations for transaction and code sets.) This is an update to the existing process that currently utilizes RTDS 3B of the NCPDP Telecom v3.2 Standard. The current process uses NDC Number (field 4Ø7-D7) to carry UPC and HRI codes in an 11-digit format. The v5.Ø and subsequent Standard releases have renamed and restructured the field (now Product/Service ID, 11 digits to 19 characters) and include a qualifier for the field, Product/Service ID Qualifier (436-E1). Now that the qualifier is available, should the UPC and HRI values be sent in their native format instead of being reformatted to an 11-digit value?

Response:
For current usage, the 11-digit format should remain the same and be used for UPC (value "Ø1"), HRI (value "Ø2"), and NDC (value "Ø3") qualifier values. If there is a need to utilize the native format of these identifiers, a Data Element Request Form (DERF) should be submitted for the development of a new qualifier.

2.4.10 PRODUCT/SERVICE ID QUALIFIER (436-E1)
CPT Code Usage

Question:
For Medication Therapy Management (MTM) service billing, the MTM CPT codes could be sent along with DUR/PPS codes that further defined the service provided. What would be submitted in the Product/Service ID Qualifier field in that case?

The Version 5 Imp Guide and Editorial guidance states "...when submitting a Billing for Service of DUR/PPS, the Product/Service ID Qualifier (436-E1) contains a value of "Ø6" (DUR/PPS). The Product/Service ID (4Ø7-D7) contains a value of "Ø" since there is not a specific product or service number associated with the qualifier at this time." In order to submit the MTM CPT codes, we would need to use the Product/Service ID Qualifier that corresponded to the CPT codes, though, and not "Ø6". How would MTM claims be submitted?

Response:
CPT-4 use wasn't specifically illustrated in the implementation guide or protocol document with an example. But CPT-4 is a valid value in the Product/Service ID Qualifier field (436-E1).

Recommendation: 1) Transmit a CPT-4-based service claim not tied to a product by populating the Product/Service ID Qualifier with the value for CPT-4 ("Ø7"), and the Product/Service ID field with the actual CPT-4 value. 2) If the need exists to tie the service claim to an actual billed product, also populate the optional Associated Prescription/Service Reference Number (456-EN) and Associated Prescription/Service Date (457-EP) fields.

2.4.11 SCHEDULED PRESCRIPTION ID NUMBER (454-EK)
Is This Field Only For Controlled Substance Reporting Transactions?
Question:
Is this field "only" used for Controlled Substance Reporting (C1) Transactions or can it be present on a Claim or Service Billing (B1) Transaction?

Response:
The definition of "Scheduled Prescription ID Number" is "The serial number of the prescription blank/form". This field is primarily intended to be used on a Controlled Substance Reporting (C1) or Controlled Substance Reporting Rebill (C3) transaction. It may also be submitted on a Billing (B1) transaction.

2.4.12 SUBMISSION CLARIFICATION CODE (42Ø-DK)
Submission Clarification Count (354-NX)
Question:
What Reject Code (511-FB) should be used when the Submission Clarification Code (42Ø-DK) doesn't match the number submitted in the Submission Clarification Code Count (354-NX)?

Response:
Thank you for bringing this to our attention. Submission Clarification Code Count (354-NX) was added in Telecommunication Standard Version 7.Ø. The Reject Code (511-FB) for "Submission Clarification Code Count Does Not Match Number of Repetitions" was mistakenly not included. We will make sure this is added to a future version. For now, Reject Code (511-FB) "NX" "M/I Submission Clarification Code Count" should be used.

Value 9 Encounter Usage

Question:
In the Claim Segment field 42Ø-DK, code 9: is this used for encounter data from providers in a managed care network? If not, what is the purpose of this code?

Response:
It is used to designate the transaction is an encounter versus fee for service.

2.5   COB/OTHER PAYMENTS SEGMENT
2.5.1 COORDINATION OF BENEFITS
<u>Usage</u>
Please see "Appendix B. Coordination Of Benefits Explanation For Version 5.1" for information on billing COB in Version 5.1.

2.5.1.1 OTHER PAYER PAID CLAIM WITH $0 PAYMENT
Question:
What is the correct representation of the COB segment when the other payer adjudicated the claim as a paid claim but with $0.00 payment to the pharmacy (for example, the patient was under deductible and is responsible for the entire cost of the claim)?

> The 5.1 Implementation Guide clearly states **"Either** 'Other Payer Amount Paid' **or** 'Other Payer Reject Count and Code' **will occur**, depending on the outcome of a previous claim or service submitted."

In the event of a zero payment by the other payer(s), must the Other Payer Amount Paid field be sent indicating $0 payment? Or, because Other Payer Amount Paid (431-DV) is optional, can that field be truncated (omitted) - which in turn causes the Other Payer Amount Paid Qualifier (342-HC) to be omitted (can't have a qualifier without the field it qualifies) and the Other Payer Amount Paid Count (341-HB) to be omitted (can't have a count field without any related fields to be counted)?

Response:
When Other Coverage Code is equal to four (4) (Other coverage exists-payment not collected) it is recommended that Other Payer Paid Amount field (431-DV) be submitted even if it is equal to Zero.

2.5.2   OTHER PAYER AMOUNT PAID COUNT (341-HB)
2.5.2.1 REJECT CODE WHEN COUNT DOES NOT MATCH
Question:
What Reject Code (511-FB) should be used when the Other Payer Amount Paid (431-DV) doesn't match the number submitted in the Other Payer Amount Paid Count (341-HB)?

Response:
Thank you for bringing this to our attention. Reject Code for "Other Payer Amount Paid Count Does Not Match Number Of Repetitions" was mistakenly not included. We will make sure this is added to a future version. For now, Reject Code "HB" "M/I Other Payer Amount Paid Count" should be used.

2.5.2.2 OTHER PAYER AMOUNT PAID COUNT AND OTHER PAYER REJECT COUNT FOR THE SAME OTHER PAYER

Question:

What if' 'Other Payer Amount Paid Count' and 'Other Payer Reject Count' and corresponding fields were submitted for the same 'Other Payer'? The imp guide says either one or the other would be sent, I assume not both. If both are sent what would the suggested returned error be, R8 Syntax Error or M/I error for both fields?

Response:

Yes - that is correct - one or the other, but not both for each loop. The M/I reject codes and any other appropriate reject codes should be sent. The Additional Message (526-FQ) can also be used to relay that the provider system should submit paid or reject information on each loop, but not both. The R8 Syntax Error should not be sent by itself without qualification.

2.5.2.3 NEGATIVE AMOUNTS

Question:

Would it be possible for a negative amount (less than zero) to be entered in 'Other Payer Amount Paid' on the claim submit? If so, and the payer will not accept negative amounts, would the M/I error for that field be applicable?

Response:

Yes - all the dollar amounts are signed fields so it is possible to use negative amounts. In some cases, a negative dollar might not be applicable to the business case, but the sign is still supported. The covered entities need to be able to support the sending/receiving of negative dollar amounts, per the standards. The transaction should not be rejected syntactically because a negative amount is sent, although the claim could be rejected based on business rules.

2.5.3 OTHER PAYER AMOUNT PAID QUALIFIER (342-HC)

Question:

We are starting to parse incoming COB segments. It appears that there is come confusion on "Other Payer Amount Paid Qualifier 342-HC". The data dictionary says that a value of "08" in this field should be used for total reimbursement and not as a line item. However, I have seen a number of COB segments where there is loop with "08" for Other Payer Amount Paid Qualifier, but no other loops detailing the line items that make up this total. Is this an incorrect use of this code?

Response:

A single loop with a value of 08 can be used to report the summary of ALL reimbursement received from the Payer. Alternately, individual loops with values other than 08 can be used to report each category of reimbursement in detail. In this case 08 would NOT be used at all. See comments in definition of this field in the Data Dictionary.

2.5.4 OTHER PAYER ID (34Ø-7C)

Enumeration

Question:

What is the source of the values submitted in the Other Payer ID Qualifier (field 339-6C) and Other Payer ID (field 34Ø-7C)?

Response:

"Other Payer ID" is the "ID assigned to the payer". "Other Payer ID Qualifier" is the "Code qualifying the "Other Payer ID"". Both fields are in the COB/Other Payments Segment. "Other Payer ID Qualifier" indicates the defined code values that may be used in this field. These code values are associated with national agencies responsible for enumerating the payers. So, the number that is assigned to the payer is sent in field 34Ø-7C (Other Payer ID), and the code corresponding to the enumerating agency is sent in field 339-6C (Other Payer ID Qualifier).

2.5.5 OTHER PAYER COVERAGE TYPE (338-5C) = "99" (COMPOSITE) AND OTHER PAYER ID (34Ø-7C)

Question:
When the value 99=composite is used in the Other Payer Coverage Type, what is placed in the Other Payer ID? Is it not sent?

Response:
The Other Payer ID Qualifier (339-6C) and Other Payer ID (34Ø-7C) must not be sent when Other Payer Coverage Type (338-5C) is 99 (Composite).

2.5.5.1 SAME OTHER PAYER ID (34Ø-7C) IN DIFFERENT COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT (337-4C) OCCURRENCES

Question:
The recommended COB/Payments Count is (3). What if two or more of these occurs had the same Other Payer ID but different values, either both paid or both rejects or combination? If two or more occurs of the same Other Payer ID should not be sent, what would the suggested error be, syntax or M/I with the Reject Field Occurrence Indicator?

Response:
The recommended maximum amount of the COB/Payments Count is 3. The count of 2 or 3 instances of the same Other Payer ID could occur under different scenarios. Two examples might include the following. One might be that it is possible that a payer may allow themselves to be billed as a primary and secondary, or a secondary and tertiary, or a primary and tertiary (meaning multiple times for the same claim). Another might be if there are three payers and two of these payers use the same processor (for example the same BIN number might be sent for two different payers). If however, due to trading partner determination, a payer does not allow this type of scenario, then the appropriate M/I Reject Codes with the Reject Field Occurrence Indicator (546-4F) should be used. The R8 Syntax Error should not be sent by itself without qualification.

Based on the Other Coverage Code question (see section "*Request Segment Discussion*", subsection "*Claim Segment*", subsection "*Coordination of Benefit*s", subsection "*Other Coverage Code 3Ø8-C8*"), it is recommended that if there are more than three payers, the third occurrence be a composite of the third and higher occurrences.

12/2005 Update – A request to modify the maximum COB/Payments Count from 3 to 9 is being submitted as a Data Element Request Form (DERF). The restriction of the composite has been modified in this document, in the above section.

2.5.6 OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT CODE (352-NQ) AND

QUALIFIER (351-NP)
Question:
What Reject Code (511-FB) should be used when the Other Payer-Patient Responsibility Amount (352-NQ) and Qualifier (351-NP) doesn't match the number submitted in the Other Payer-Patient Responsibility Amount Count (353-NR)?

Response:
Thank you for bringing this to our attention. Other Payer-Patient Responsibility Amount (352-NQ) and Qualifier (351-NP) were added in Telecommunication Standard Version 5.5. The Reject Code for "Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions" was mistakenly not included. We will make sure this is added to a future version. For now, Reject Code (511-FB) "NR" "M/I Other Payer-Patient Responsibility Amount Count" should be used.

2.5.7 PRIMARY HAS PAID MORE THAN SECONDARY WOULD IF THEY WERE PRIMARY
Question:
How to balance a secondary claim when the primary has paid more than secondary would pay. The claim needs a paid response with Patient Pay Amount = Ø and Total Amount Paid = Ø, but the issue is how to make this balance.

Response:
Use Other Payer Amount Recognized (566-J5) with what was submitted or if the amount of the negotiated rate is less than what the Other Payer Amount Submitted was in total, then it must be equal to the negotiated rate, so that the equation balances and a negative amount is not returned to the pharmacy. A negative amount cannot be returned in this situation, as it would incorrectly attempt to collect from the pharmacy money that is not due to the supplemental payer. The supplemental payer response does not negate nor change the previous payer's response. The pharmacy is still allowed to collect the entire amount due from the previous plan's processing.

2.6 DUR/PPS SEGMENT
2.6.1 CLAIM VERSUS SERVICE BILLING
Usage
Question:
What differentiates when a DUR/PPS Segment is submitted with an Rx billing (Prescription/Service Reference Number Qualifier = 1) and when the DUR/PPS Segment is submitted as a separate transaction (Prescription/Service Reference Number Qualifier = 2)? Is it based on whether a Professional Service Fee (477-BE) is submitted?

Response:
A "2" in the "Prescription/Service Reference Number Qualifier" field indicates the submission of a pharmacy claim for a "service" without the dispensing of a product. A "1" in the "Prescription/Service Reference Number Qualifier" field indicates the submission of a pharmacy claim for a dispensing. This may, or may not, include the communication of DUR/PPS Segment information and the submission of a Professional Service Fee Submitted. Therefore a "1" could be a billing for a "Product Dispensing" or a "Product Dispensing/Service combination. See section 4.2 in Version 5 Implementation Guide.

2.6.2 LEVEL OF EFFORT (474-8E) DETERMINATION
Question:

First: If a Payer wants to add a fee for a specific level of effort (field 474-8E), what field do we send that in and what qualifier do we use?

> I assume we would use the Other Payer Amount Claimed field to put the dollar amount in. And the Qualifier (field 479-H8) would be "99".
>> But, couldn't every payer have a different dollar amount for each level of effort? And wouldn't that be difficult for a software provider to have to enter each payers $amount for each level? What are your suggestions?

Second: What if the pharmacy wants to charge an additional fee for a compound, but, the Payer does NOT use the level of effort field? Where would that additional amount be billed? Should it go in the Ingredient cost or the Dispense Fee field?

Response:
We believe you meant Other Amount Claimed Submitted Qualifier (479-H8) and Other Amount Claimed Submitted (48Ø-H9). A level of effort related to a drug dispensing, as in the example of compounds, might be supported in the Other Amount Claimed Submitted with value of 99 (Other). Currently, how this is handled is a trading partner issue.

Regarding the Second item: the additional fee would not go into the Ingredient Cost Submitted (4Ø9-D9). It could go in Dispensing Fee Submitted (412-DC) or Other Amount Claimed Submitted (48Ø-H9), with or without the DUR/PPS Level of Effort (474-8E) defined. Which fields are used is currently defined by trading partner agreement. The payer would set up their client's business rules so that the pharmacy can submit a fee that the payer would recognize.

2.7   PRICING SEGMENT
2.7.1   BASIS OF COST DETERMINATION (423-DN)
Question:
Is there a field to distinguish a 340B pharmacy?

Response:
In today's environment, because the HIPAA-named standards are "frozen", business partners can agree to use Basis of Cost Determination (423-DN) value 9 (Other) to mean 340B pricing, but one cannot mandate this requirement.

There is also guidance in this document for distinguishing long term care pharmacies. See section "*Appendix F. Long-Term Care (LTC) Pharmacy Claims Submission Recommendations For Version 5.1*".

In the approved Telecommunication Standard Version D.0 and above environment, in the Basis of Cost Determination (423-DN), there is a value 8 "34ØB /Disproportionate Share Pricing/Public Health Service". The response field, Basis of Reimbursement Determination (522-FM) has a value of "12" (34ØB/Disproportionate Share/Public Health Service Pricing).

2.7.2   COORDINATION OF BENEFITS
Usage
Please see "Appendix B. Coordination Of Benefits Explanation For Version 5.1" for information on billing COB in Version 5.1.

2.7.3   SALES TAX FIELDS
Format

Question:
How is the format of Percentage Sales Tax Rate Submitted (483-HE) and Percentage Sales Tax Rate Paid (56Ø-AY) expressed?

Response:
These fields are defined as s9(3)v4 allowing values of . ØØØ1% through 1ØØ.ØØØØ%. For the purposes of this example, the overpunch character is shown.

Examples:

A rate of:	Spelled out:	Would be expressed as (without truncation):	Would be expressed as (with truncation):
. ØØØ1%	one ten thousandth of a percent	ØØØØØØA	A
7%	seven percent	ØØ7ØØØ{	7ØØØ{
.5%	five tenths of a percent	ØØØ5ØØ{	5ØØ{
25.75%	twenty five and seventy five one hundredths of a percent	Ø2575Ø{	2575Ø{
1ØØ%	One hundred percent	1ØØØØØ{	1ØØØØØ{

Seven percent (7%) would <u>not</u> be represented as 7Ø{ (.Ø7Ø{).
Note the difference between the expression of .ØØØ1% and 1ØØ%. They are very different expressions and should not be confused.

<u>Usage</u>
Question:
How are the Flat Sales Tax Amount Submitted (481-HA), Percentage Sales Tax Amount Submitted (482-GE), Percentage Sales Tax Rate Submitted (483-HE), and Percentage Sales Tax Basis Submitted (484-JE) used?

Response:
The submission of sales tax is governed by regulatory agencies (state, local, parish, etc).

Note that if a flat rate is needed, for example for administrative costs, the Other Amount Claimed Submitted Count (478-H7), Other Amount Claimed Submitted Qualifier (479-H8), and Other Amount Claimed Submitted (48Ø-H9) should be used. The Other Amount Claimed Submitted Qualifier field contains values for shipping, administrative, delivery, postage, and other costs.

If the sales tax reported is a flat rate, then it is a fixed amount for a certain dollar value (for example for $xxx it is a certain amount). For example, for $1ØØ the flat rate is $1.99. This flat rate is then reported in Flat Sales Tax Amount Submitted (481-HA).

If the sales tax reported is based on a percentage (for example 8.35%, 6.25%), the calculated amount is reported in Percentage Sales Tax Amount Submitted (482-GE). The Percentage Sales Tax Rate Submitted (483-HE) reports the percentage used (8.35%). The Percentage sales Tax Basis Submitted (484-JE) reports on what amount the taxes were calculated (Gross Amount Due, Ingredient Cost, Ingredient Cost plus Dispensing Fee).

In cases where a pharmacy needs to report sales tax based on a flat amount **and** a percentage amount, the Standard does support this usage.

2.7.3.1 PART OF COPAY
Question:
In this scenario would it be true to say the sales tax is part of the members copay?

Example:

Ingredient Cost Paid (5Ø6-F6):	$124.94
Dispensing Fee Paid (5Ø7-F7):	$2.5Ø
Percentage Sales Tax Amount Paid (559-AX):	$1.27
Total Amount Paid (5Ø9-F9):	$123.71
Amount of Copay/Coinsurance (516-FI):	$5.ØØ
Patient Pay Amount (5Ø5-F5):	$5.ØØ
Amount Attributed To Sales Tax (523-FN):	$1.27

To balance the claim:
   Ingredient Cost Paid (5Ø6-F6)
+ Dispensing Fee Paid (5Ø7-F7)
+ <u>Percentage Sales Tax Amount Paid (559-AX) (when applicable)</u>
   Total Amount Paid (5Ø9-F9)
+ Patient Pay Amount (5Ø5-F5)
+ Amount Attributed To Sales Tax (523-FN) (when applicable)

Percentage Sales Tax Amount Paid (559-AX) and Amount Attributed To Sales Tax (523-FN) are the Tax fields. Usually the payer or the patient is responsible for the tax amount. In this claim example, the tax amount is returned in both fields Percentage Sales Tax Amount Paid (559-AX) and Amount Attributed To Sales Tax (523-FN), therefore the claim does not balance.

124.94	123.71
2.5Ø	5.ØØ
1.27	1.27
128.71	129.98

Response:
The definition of Amount Attributed To Sales Tax (523-FN):
> Amount **to be collected from the patient that is *included* in 'Patient Pay Amount' (5Ø5-F5)** that is due to sales tax paid.
>> Examples: The patient may be required to pay some portion of the sales tax on a prescription. If the patient pays 1.5% of the sales tax on a $5Ø.ØØ prescription, this field would reflect: 7E.

The balancing as presented above is incorrect. Removal of "Amount Attributed To Sales Tax (523-FN) (when applicable)" does result in a balanced transaction in which the payer is paying the sales tax, not the patient. For clarity, one should follow the calculation for Total Amount Paid (5Ø9-F9) as it is noted in the NCPDP Data Dictionary:

> **Total Amount Paid (5Ø9-F9)**
> Total amount to be paid by the claims processor (i.e.pharmacy receivable).
>
> Represents a sum of
>> 'Ingredient Cost Paid' (5Ø6-F6),
>> 'Dispensing Fee Paid' (5Ø7-F7),
>> 'Flat Sales Tax Amount Paid' (558-AW),

'Percentage Sales Tax Amount Paid' (559-AX),
'Incentive Amount Paid' (521-FL),
'Professional Service Fee Paid' (562-J1),
'Other Amount Paid' (565-J4),
LESS 'Patient Pay Amount' (5Ø5-F5)
and Other Payer Amount Recognized' (566-J5).

When the calculation is viewed as noted it becomes clear that the fields '**Percentage Sales Tax Amount Paid'** (559-AX) and **Flat Sales Tax Amount Paid'** (558-AW) are c*omponents* of the net payment to the pharmacy.

The definition and calculation of **Patient Pay Amount** (5Ø5-F5) was not detailed as succinctly in the dictionary, however viewing the component fields that include within their definition the notation *'included in Patient Pay Amount (5Ø5-F5)'*, there are 5 fields that are 'included in Patient Pay Amount' and one of these is the questioned field **Amount Attributed to Sales Tax (523-FN).**

Patient Pay Amount (5Ø5-F5)
Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, etc.

517-FH Amount Applied To Periodic Deductible - Amount to be collected from a patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is applied to a periodic deductible.

519-FJ Amount Attributed To Product Selection - Amount to be collected from the patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is due to the patient's selection of drug product.

523-FN Amount Attributed To Sales Tax - Amount to be collected from the patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is due to sales tax paid.

52Ø-FK Amount Exceeding Periodic Benefit Maximum - Amount to be collected from the patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is due to the patient exceeding a periodic benefit maximum.

518-FI Amount Of Copay/Coinsurance - Amount to be collected from the patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is due to a per prescription copay/coinsurance.

These fields define to the provider how Patient Pay Amount (5Ø5-F5) is derived.

If sales tax is to be paid and the patient is responsible for some or all, the amount of tax to be paid should be included in either or both
'Flat Sales Tax Amount Paid' (558-AW),
'Percentage Sales Tax Amount Paid' (559-AX),
and then the portion of these amounts ***to be paid by the patient*** should be noted in
'Amount Attributed To Sales Tax' (523-FN)

If sales tax is to be paid by the processor in total, then either or both 'Flat Sales Tax Amount Paid' (558-AW) and 'Percentage Sales Tax Amount Paid' (559-AX) should be detailed. Amount Attributed to Sales Tax (523-FN) should not be used.

2.7.4 USUAL AND CUSTOMARY CHARGE (426-DQ) DEFINITION
Usage
Question:
Does Usual And Customary Charge (426-DQ) include a dispensing fee? The definition is "Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed." We weren't sure if the "other amounts claimed" referred to field 48Ø-H9, Other Amount Claimed Submitted, or just as a general term.

Response:
The Usual and Customary Charge (426-DQ) represents the value that a pharmacist is willing to accept as their total reimbursement for dispensing the product/service to a cash-paying customer. It does not include Other Amount Claimed Submitted (48Ø-H9), Dispensing Fee Submitted (412-DC), Flat Sales Tax Amount Submitted (481-HA), Percentage Sales Tax Amount Submitted (482-GE), Professional Service Fee Submitted (477-BE), or Incentive Amount Submitted (438-E3). U&C is independent of contracted Dispensing Fee Submitted (412-DC) and Ingredient Cost Submitted (4Ø9-D9).

2.7.4.1 COPAY ONLY USAGE
Question:
One of our clients has begun allowing providers to bill for a copay only. I know what the recommendation is from NCPDP in the Telecommunication Version 5 Questions, Answers and Editorial Updates - page 119 and 120 it states the following

>   Recommendation:
>   'Claim Segment':
>   Other Coverage Code = 8
>
>   Pricing Segment:
>   Other Amount Claims Submitted Count (478-H7) = 1
>   Other Amount Claims Submitted Qualifier (479-H9) = 99
>   Other Amount Claimed Submitted (480-H9) = Copay amount
>   Gross Amount Due (430-DU) = Copay amount.
>
>   The definition of Gross Amount Due is: Total price claimed from all sources.
>
>   This recommendation stays within the intent of the definition of 'Gross Amount Due'.'

This client has chosen to have providers follow the procedure below:
>   all claims billed with a TPL override code 8 must have the actual number of units dispensed in the quantity dispensed field on the claim (NCPDP field number 442-E7). The actual copayment amount should be placed in the usual and customary field on the claim (NCPDP field number 426-DQ).

We have several vendors/providers that are questioning this procedure, stating it is against the 'Standard'. Again, I have read the 'recommendation' but is this way acceptable as well? I am asking so I can have something from NCPDP in case we have to go back to the client and have them change their procedure. This particular client

does not use the Gross Amount Due field and was attempting to make the transition easier for the providers.

Response:
The Usual And Customary field (426-DQ) must be used as defined. The client's usage in this question violates the standard, due to the misuse of the Usual And Customary field.

2.8 PRIOR AUTHORIZATION SEGMENT

2.8.1 AUTHORIZED REPRESENTATIVE FIRST NAME (498-PE) AND AUTHORIZED REPRESENTATIVE LAST NAME (498-PF)

Usage

Question:
Can you briefly explain how these fields are used?
Is this representative of a person who is a "Power of Attorney" if the patient is in a nursing home?

Response:
The definition of "Authorized Representative First Name" is "First name of the patient's authorized representative". The definition of "Authorized Representative Last Name" is "Last name of the patient's authorized representative". Both fields are used in the Prior Authorization (request) segment. These fields are used to identify the name of the person who may have Power of Attorney, a legal guardian, or a court appointed representative for an individual. It may or may not be a representative of a patient in a nursing home.

2.9 COUPON SEGMENT

2.9.1 GUIDANCE

Coupons may be fixed amounts or percentages of total price and may be reimbursed to the pharmacy by the coupon originator or third-party payer. Transactions for coupon processing accommodate electronic conversations between the pharmacy and the coupon originator as well as third-party payers.

To bill a coupon processor, the Coupon Type (485-KE) and Coupon Number (486-ME) fields are mandatory. If applicable, the value amount of the coupon is entered into the Coupon Value Amount (487-NE).

A coupon is used to reduce the patient out of pocket prescription cost – by either reducing the cost of a CASH prescription or the copay from a Third Party payer who allows coupon usage. The coupon processor is the LAST payer. (Note: Some Federal and State programs do not allow the reduction of copays.)

Patients are provided with product coupons from manufacturers and/or may also receive coupons distributed from their third party plan.
- A manufacturer coupon is typically for a specific product and may be found in a magazine, newspaper, etc. Some coupons are provided by manufacturers to the physician – in place of providing free sample products. Regardless of how the patient received the coupon, they must have a prescription for the coupon product. Use of coupons is encouraged for better patient care as

> pharmacies are likely to have a more complete record of medications prescribed by 'other' physicians.
> - Third party plans may provide coupons that are more generic in nature. For example, the patient will get a reduced copay for this fill by switching to a formulary product or it may be more product specific as with the manufacturer coupon.

Programs providing coupons want to 'track' their usage. They do this via the coupon identifier only (if identifier is unique) or by coupon identifier and patient identifiable information. When required, patient identifiable information is generally used to provide patient limitations (e.g. one offer per customer), This often occurs in instances where the coupon identifier is not a unique number (e.g. newspaper or magazine coupon).

Requirements for submission of Patient and Coupon criteria must be specified in the payer sheets or similar communications in order for the submitter to know the patient information required and how the coupon is to be identified to the payer.

The Coupon Segment supports
  1) Free Product - Patient is provided the product at no cost. Manufacturer coupons for a Free Product should be submitted as Primary Billing.
  2) *Price Discount – Patient's out of pocket cost is reduced by a designated coupon amount (e.g. $5.00 off). Please note state or federal regulations may prohibit the use of coupons.*

The Coupon Segment should NOT be used for replacement of inventory since the Telecommunication Standard was not designed to address this. Only one coupon is allowed (one Coupon Segment) per transaction.

2.9.2 COUPON QUESTIONS
Question:
Are there circumstances under which coupons may not be submitted after billing the primary insurance?

Response:
State or federal regulations may prohibit the use of coupons. Please check business trading partner agreements.

Question:
Define 'Free Product'.

Response:
A Free Product is a product, which is dispensed to a patient at no cost. An example of this is the billing to a coupon processor that returns a $Ø.ØØ copay. This is NOT synonymous with the replacement of inventory (or consignment programs) to a provider at no charge. Free product can be billed with or without the Coupon Segment as determined by the processor or third party payer.

Question:
Should the Coupon Segment be used for the replacement of inventory?

Response:
No Replacement programs, such as consignment, do not result in claim billings. NCPDP Telecommunication Standard was not designed to address the replacement of inventory at no cost to a provider.

Question:
Are manufacturer cards the same as coupons?

Response:
No, manufacturer cards are viewed as discount cards or similar to a third party insurer for cash patients. A claim billing is submitted to a manufacturer card processor without the Coupon Segment.

Question:
How will coupon processing accommodate the handling of patient identifiable information?

Response:
Some manufacturer programs track by coupon identifier while others require coupon identifier and patient identifiable information. Patient information is often required in order to provide limitations (e.g. 1 free product per patient). These requirements must be specified in the payer sheets in order for the submitter to determine when to send patient identifiable information with the Coupon Segment.

Question:
Can you process a coupon without using the Coupon Segment?

Response:
Yes, when the processor is responsible for payment of the discount or for payment of the entire prescription. The discount is usually presented in the form of a coupon or an ID card. In either form, the NCPDP ID card data elements are printed on the coupon, i.e. RxBIN, RxGRP, RxPCN, Member ID, and/or a Prior Authorization Number. The Coupon Segment is not necessary, as the processor will adjudicate the discount in real time using the submitted data elements.   The payment for the discount or the entire prescription will be included on the provider's remittance advice.

2.9.3 COUPON EXAMPLES
2.9.3.1 BILLING W/COUPON (FREE PRODUCT) - TRANSACTION CODE B1— BILLING TO COUPON PROCESSOR

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	*61ØØ66*	
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*123456789Ø*	
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*1997Ø92Ø*	September 2Ø, 1997
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*98765bbbbb*	

INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	123456789	ID as required by Coupon Processor

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234567	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø1	NDC
4Ø7-D7	PRODUCT/SERVICE ID	ØØØØ6Ø94228	Clinoril 2ØØmg
	OTHER APPLICABLE PRESCRIPTION CLAIM FIELDS…		

COUPON SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø9	COUPON SEGMENT
485-KE	COUPON TYPE QUALIFIER	Ø2	Free product
486-ME	COUPON NUMBER	123451234512345	

In the case of a Free Product, the U&C of the fill and/or contract rate should be used to determine payment to provider. The coupon generally will have no stated value so in this example we have NOT included a Coupon Value Amount.

If the Coupon Value Amount was submitted for a free product is it assumed that the value matches the U&C value.

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	587{	$58.7Ø
426-DQ	USUAL AND CUSTOMARY CHARGE	587{	$58.7Ø
43Ø-DU	GROSS AMOUNT DUE	587{	$58.7Ø
423-DN	BASIS OF COST DETERMINATION	Ø7	Usual & Customary

Generally there is not a 'contracted rate' for a coupon claim as this is a reduction of the CASH price or final copay that Patient is to pay. For that reason, the example shows billing to be for U&C.

2.9.4 BILLING W/COUPON (FREE PRODUCT) ACCEPTED RESPONSE—PAID

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID

| 2Ø1-B1 | SERVICE PROVIDER ID | *4563663bbbbbbbb* | |
| 4Ø1-D1 | DATE OF SERVICE | *1997Ø92Ø* | September 2Ø, 1997 |

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid

RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	

RESPONSE PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT

The Following Fields are Optional:

5Ø5-F5	PATIENT PAY AMOUNT	*ØØØ{*	$ØØ.ØØ
5Ø6-F6	INGREDIENT COST PAID	*587{*	$58.7Ø
5Ø9-F9	TOTAL AMOUNT PAID	*587{*	$58.7Ø
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	*4*	Usual & Customary Paid as Submitted

Response Pricing Segment is Required for Paid Response; Optional for Captured Response

In above payment response, since this is a Free Product coupon, patient pays nothing and provider is paid the U&C as submitted by the coupon processor. Dispensing Fee or other Fees may be paid to provider depending on contractual agreements.

2.9.5 BILLING W/COUPON (DOLLARS OFF) - TRANSACTION CODE B1—BILLING TO COUPON PROCESSOR

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	*61ØØ66*	
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*123456789Ø*	
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*1997Ø92Ø*	September 2Ø, 1997
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*98765bbbbb*	

INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø4*	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	*123456789*	ID as required by Coupon Processor

CLAIM SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234567	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø1	NDC
4Ø7-D7	PRODUCT/SERVICE ID	ØØØØ6Ø94228	Clinoril 2ØØmg
	OTHER APPLICABLE PRESCRIPTION CLAIM FIELDS…		

COUPON SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø9	COUPON SEGMENT
485-KE	COUPON TYPE QUALIFIER	Ø1	Price Discount
486-ME	COUPON NUMBER	123451234512345	
487-NE	Coupon Value Amount	200{	$2Ø.ØØ

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	587{	$58.7Ø
426-DQ	USUAL AND CUSTOMARY CHARGE	587{	$58.7Ø
43Ø-DU	GROSS AMOUNT DUE	587{	$58.7Ø
423-DN	BASIS OF COST DETERMINATION	Ø7	Usual & Customary

2.9.6   BILLING W/COUPON (DOLLARS OFF) ACCEPTED RESPONSE—PAID

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	1997Ø92Ø	September 2Ø, 1997

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	21	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	P	Paid

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	22	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234567	

RESPONSE PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	23	RESPONSE PRICING SEGMENT

The Following Fields are Optional:

5Ø5-F5	PATIENT PAY AMOUNT	387{	$38.7Ø
5Ø6-F6	INGREDIENT COST PAID	587{	$58.7Ø
5Ø9-F9	TOTAL AMOUNT PAID	2ØØ{	$2Ø.ØØ
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	4	Usual & Customary Paid as Submitted

Response Pricing Segment is Required for Paid Response; Optional for Captured Response

Using the 'dollars off' coupon, the patient copay is reduced by the coupon amount. Coupon processor pays the coupon amount and may pay an additional dispensing fee per contractual agreements.

2.9.7 BILLING TO A COUPON PROCESSOR TO REDUCE A PATIENT COPAY

Billing has occurred to a Third Party which returned a copay. If allowed, the coupon can be used to reduce a patient's copay.

Payment from Prior 'primary' billing was as follows:

RESPONSE PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	23	RESPONSE PRICING SEGMENT

The Following Fields are Optional:

5Ø5-F5	PATIENT PAY AMOUNT	357{	$35.7Ø
5Ø6-F6	INGREDIENT COST PAID	587{	$58.7Ø
5Ø7-F7	DISPENSING FEE PAID	2Ø{	$2.ØØ
5Ø9-F9	TOTAL AMOUNT PAID	25Ø{	$25.ØØ
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	1	Ingr Cost Paid as Submitted

Balancing Data:

Ingredient Cost Paid	58.7Ø	Patient Pay Amount	35.7Ø
Fee Paid	2.ØØ	Total Amount Paid	25.ØØ
Net	6Ø.7Ø	Net	6Ø.7Ø

2.9.8 BILL "PATIENT RESPONSIBILITY AMOUNT" TO COUPON PROCESSOR

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	75Ø267	
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	B1	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	123456789Ø	
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ6Ø22Ø	February 2Ø, 2ØØ6
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	98765bbbbb	

INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT

| 3Ø2-C2 | CARDHOLDER ID | *123456789A11* | Cardholder ID |

The Following Fields are Optional:

| 3Ø3-C3 | PERSON CODE | *1* | Person Code |

PATIENT SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*Ø1*	PATIENT SEGMENT

The Following Fields are Optional:

3Ø4-C4	DATE OF BIRTH	*19620615*	Born June 15, 1962
3Ø5-C5	PATIENT GENDER CODE	*1*	Male
31Ø-CA	PATIENT FIRST NAME	*JOSEPH*	
311-CB	PATIENT LAST NAME	*SMITH*	
322-CM	PATIENT STREET ADDRESS	*123 MAIN STREET*	
323-CN	PATIENT CITY ADDRESS	*MY TOWN*	
324-CO	PATIENT STATE/PROVINCE ADDRESS	*CO*	
325-CP	PATIENT ZIP/POSTAL ZONE	*34567*	

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*Ø7*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	
436-E1	PRODUCT/SERVICE ID QUALIFIER	*Ø3*	NDC
4Ø7-D7	PRODUCT/SERVICE ID	*ØØØØ6Ø94268*	Clinoril 2ØØmg
	And other applicable claim fields		

The Following Fields are Optional:

442-E7	QUANTITY DISPENSED	*3ØØØØ*	3Ø.ØØØ tablets
4Ø3-D3	FILL NUMBER	*Ø*	Original dispensing for RX#
4Ø5-D5	DAYS SUPPLY	*3Ø*	3Ø Days supply
4Ø6-D6	COMPOUND CODE	*1*	Not a compound
4Ø8-D8	DAW/PRODUCT SELECTION CODE	*Ø*	No product selection indicated
46Ø-ET	QUANTITY PRESCRIBED	*3ØØØØ*	3Ø.ØØØ
3Ø8-C8	OTHER COVERAGE CODE	*8*	Claim is billing for a Copay

COUPON SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*Ø9*	COUPON SEGMENT
485-KE	COUPON TYPE QUALIFIER	*Ø1*	Price Discount
486-ME	COUPON NUMBER	*123451234512345*	

The Following Fields are Optional:

| 487-NE | COUPON VALUE AMOUNT | *2ØØ{* | $2Ø.ØØ |

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	*{*	$Ø or field not submitted
412-DC	DISPENSING FEE SUBMITTED	*{*	$Ø or field not submitted
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	*1*	1

479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	*99*	Other
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED	*357{*	$35.7Ø
43Ø-DU	GROSS AMOUNT DUE	*357{*	$35.7Ø
426-DQ	USUAL AND CUSTOMARY CHARGE	*587{*	$58.7Ø

Note: In 5.1 **Copay Only** billing, Pricing Segment fields Other Amount Claimed Submitted and associated Count and Qualifier are used to record Patient Pay Amount from the last processor. This usage allows the result reported in Gross Amount Due to be calculated as defined.

In a 5.1 coupon Copay Only scenario, the COB Segment can be requested to report Other Payer Id or Other Payer Date, however no Other Payer Amount Paid values are applicable to **Copay Only** billing.

COB/OTHER PAYMENTS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø5*	COB SEGMENT
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	*Ø1*	
338-5C	OTHER PAYER COVERAGE TYPE	*Ø1*	Primary

The Following Fields are Optional:

339-6C	OTHER PAYER ID QUALIFIER	*Ø3*	Bin
34Ø-7C	OTHER PAYER ID	*123456*	
443-E8	OTHER PAYER DATE	*2ØØ6Ø22Ø*	February 2Ø, 2ØØ6

2.9.9 BILLING W/COUPON TO REDUCE PATIENT COPAY ACCEPTED RESPONSE—PAID

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ6Ø22Ø*	February 2Ø, 2ØØ6

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid

RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	

RESPONSE PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT

The Following Fields are Optional:

5Ø5-F5	PATIENT PAY AMOUNT	157{	$15.7Ø ($2Ø less than total Patient Pay Amount of prior payer)
5Ø7-F7	DISPENSING FEE PAID	ØØ{	$Ø.ØØ Fee may be paid per trading partner agreement. In this example no fee applies.
563-J2	OTHER AMOUNT PAID COUNT	1	
564-J3	OTHER AMOUNT PAID QUALIFIER	99	Other
565-J4	OTHER AMOUNT PAID	357{	$35.7Ø
5Ø9-F9	TOTAL AMOUNT PAID	2ØØ{	$2Ø.ØØ
518-FI	AMOUNT OF COPAY/COINSURANCE	157{	$15.7Ø

Balancing:

Other Amount Paid	35.7Ø	Patient Pay Amount	15.7Ø	Other Amount Paid	35.7Ø
Dispensing Fee Paid	Ø.ØØ	Total Amount Paid	2Ø.ØØ	Dispensing Fee Paid	Ø.ØØ
				MINUS Patient Pay Amount	-15.7Ø
Total	35.7Ø	Total	35.7Ø	Total Amount Paid	2Ø.ØØ

2.9.10 COUPON NUMBER (486-ME)

Usage

Question:

What is the new Coupon Number (486-ME)? Is the intent simply to start billing on-line manufacturer's medication coupons?

Response:

Field 486-ME Coupon Number is used to communicate the unique number assigned to a coupon to the processor/payer. The coupon number supports the processor's ability to uniquely track and process the economic value of an individual coupon. We envision the coupons being supported by the manufacturers.

2.10 CLINICAL SEGMENT

2.10.1 EXPLICIT DECIMAL POINTS IN DIAGNOSIS CODE (424-DO)

Question:

In V5.1, when submitting an ICD-9 code in field Diagnosis Code (424-DO), must a decimal point always be submitted with the code? Specifically, there are some ICD-9 codes (i.e. 347) that are only three characters and would not have a decimal point if you where to look them up in an ICD-9 codebook. There are also ICD-9 codes that are three character codes (i.e. 493) and would not have a decimal point, however, they can also be further differentiated and would then include the decimal point (i.e. 493.Ø, 493.ØØ, 493.1Ø, etc). Was the intent of V5.1 to allow pharmacies to submit the code, as it would be found in an ICD-9 code reference book, or was the intent of V5.1 to always require a decimal point be submitted?

Response:

No. The Telecommunication Implementation Guide and Data Dictionary are incorrect. Diagnosis code fields must adhere to the owner's code set rules and formats. A Data Element Request Form (DERF) will be submitted to correct this in a future version.

2.10.2 MEASUREMENT UNIT (497-H3)

2.10.2.1 *UNIT WITH DIMENSION*
Question:
Does a document exist identifying which clinical unit (497-H3) is submitted with which clinical dimension (496-H2)?

Response:
NCPDP has not drafted a document aligning a specific Measurement Unit (497-H3) with a specific Measurement Dimension (496-H2) to allow maximum flexibility in using these fields.

2.10.2.2 *VALUE CORRECTION*
Question:
Should the value of 12 for Clinical Unit (497-H3) be milliliters instead of millimeters?

Response:
Field 497-H3 is the "Measurement Unit" field. You identified a typographical error and therefore are correct in stating that this should be "milliliters". We will update the Data Dictionary to correct this item.

2.11 PRESCRIBER SEGMENT
Question:
One of our Clients requires that we receive State license number in the Prescriber id on the incoming claim. We receive licenses that our client assigns along with license numbers from out of state (assigned by other states). Sometimes they are duplicates. Other states use the same numbering scheme as our client. We're looking at resolving the duplicates by requiring the state code be appended to the license number on the incoming claim. Are there any problems with this from a NCPDP compliance standpoint? Would you advise changing the qualifier to be "99" if we append the state code to the License number?

Response:
The recommendation is to use the value 14 (Plan Specific). If a payer with multiple plans supports more than one value of the Prescriber ID Qualifier, the payer sheet should clearly denote which qualifier is to be used with which plan(s). By adding a state ID to the state license number (if not already present), this is no longer the state license number. 367-2N – Prescriber State/ Province Address is available in the future (Telecom C.Ø and above).

2.12 PHARMACY PROVIDER SEGMENT
2.12.1 PROVIDER ID (444-E9)
Question:
The Data Dictionary and the latest version of the Protocol document indicate that 444-E9 Provider ID is a unique ID assigned to the person responsible for the dispensing of the prescription or provision of service. If you interpret this to mean that 444-E9 should be the license number of the pharmacist who dispenses (physically verifies the pills in the vial) then you are left with the problem that most pharmacies typically adjudicate the script *before* it is filled, and there is no way of knowing who the verifying pharmacist will be. Because of this, we've started to consider that it's actually the license number of the Pharmacist In Charge that is expected.

Response:
No, this is a workflow issue and the value in this field is determined by state/federal regulation or trading partner agreement.

3. RESPONSE SEGMENT DISCUSSION

3.1 RESPONSE HEADER SEGMENT

3.1.1 RESPONSE HEADER SEGMENT FIELDS NOT MODIFIED FROM TRANSACTION HEADER SEGMENT

Usage

Question:

Should the fields submitted in the Transaction Header Segment on a request be returned without modification on the Response Header Segment? (Should they be mirrored?)

Response:

Yes. The Response Header Segment contains the field Version/Release Number, Transaction Code, Transaction Count, Service Provider ID Qualifier, Service Provider ID, and Date of Service that are also used in the Transaction Header Segment. The intent of these fields within the Response Header Segment was that the values submitted in these fields on the request from the provider to the payer would be returned **without change** in the response from the payer to the provider. These fields in the Response Header Segment are used by the software system to offer a level of verification at the transmission level that the response is paired to the request. (The Prescription/Service Reference Number in the Response Claim Segment, when applicable, may be used to match as well.)

For example, (*b* denotes a space or blank)

Transaction Header Segment

Field	Field Name	Value
1Ø1-A1	BIN NUMBER	999999
1Ø2-A2	VERSION/RELEASE NUMBER	51
1Ø3-A3	TRANSACTION CODE	B1
1Ø4-A4	PROCESSOR CONTROL NUMBER	*bbbbbbbbbb*
1Ø9-A9	TRANSACTION COUNT	Ø1
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7
2Ø1-B1	SERVICE PROVIDER ID	4563663*bbbbbbbb*
4Ø1-D1	DATE OF SERVICE	2ØØ2Ø811
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*bbbbbbbbbb*

Response Header Segment

Field	Field Name	Value
1Ø2-A2	VERSION/RELEASE NUMBER	51
1Ø3-A3	TRANSACTION CODE	B1
1Ø9-A9	TRANSACTION COUNT	Ø1
5Ø1-F1	HEADER RESPONSE STATUS	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7
2Ø1-B1	SERVICE PROVIDER ID	4563663*bbbbbbbb*
4Ø1-D1	DATE OF SERVICE	2ØØ2Ø811

3.1.2 TRANSACTION RESPONSE STATUS (112-AN)
Usage

Question:
What is the intent of the new Transaction Response Status (112-AN)?

Response:
Transaction Response Status is considered a new field in Version 5 although it is similar in nature to the "Response Status" field in older telecommunication standards. "Transaction Response Status" is defined as "Code indicating the status of the transaction." This field is used by the processor to indicate their response status to the submitted transaction.

3.2 RESPONSE MESSAGE SEGMENT

3.2.1 MESSAGE (5Ø4-F4) AND ADDITIONAL MESSAGE INFORMATION (526-FQ)
Usage
Question:
Currently in Version 3.2, the Message (field 5Ø4-F4) is used in the response transaction to return information. Sometimes if more text information is needed, the Additional Message (526-FQ) field is used. In Version 5, these fields are now in two different segments. Is the usage still the same? It appears that in 5.1 the Message field no longer relates to just one script but rather to the entire transmission. Is this true?

Response:
In Version 3.2, both field 5Ø4-F4 Message and 526-FQ Additional Message Information appeared in the "script" level – meaning that they repeated for each script in a multi-scripted response. For example, in a two-scripted claim, the "Paid" response appeared as the following. Note the Message and the Additional Message fields occur in each script response.

Version 3.2

1Ø2		Version/Release Number
1Ø3		Transaction Code
5Ø1		Response Status
		Optional response header information (Plan ID)
	<GS>	Group separator
	5Ø1	Response Status (Prescription 1)
	5Ø5	Patient Pay Amount
	5Ø6	Ingredient Cost Paid
	5Ø7	Contract Fee Paid
	5Ø8	Sales Tax Paid
	5Ø9	Total Amount Paid
	5Ø3	Authorization Number
	5Ø4	**Message**
		Optional response information (Accum. Ded. Amt, Amt. Applied To Periodic Ded., Incentive Fee Paid, DUR, etc…)
	526	**Additional Message Information**
	<GS>	Group separator
	5Ø1	Response Status (Prescription 2)
	5Ø5	Patient Pay Amount
	5Ø6	Ingredient Cost Paid
	5Ø7	Contract Fee Paid
	5Ø8	Sales Tax Paid
	5Ø9	Total Amount Paid
	5Ø3	Authorization Number
	5Ø4	**Message**

	Optional response information (Accum. Ded. Amt, Amt. Applied To Periodic Ded., Incentive Fee Paid, DUR, etc…)
526	**Additional Message Information**

In Version 5, "multi-script" was replaced with "multiple transactions in a transmission" to reflect that different transaction codes are supported not just prescriptions. The Message field appears in the Response Message Segment. The Response Message Segment occurs at the transmission level – once per transmission. *The usage of the field Message (5Ø4-F4) should no longer be used to relay textual information with each "script". It should be used to relay information about the entire transmission.*

The Additional Message Information field appears in the Response Status Segment. The Response Status Segment occurs per transaction, and therefore can reflect different text for each transaction in a multiple transaction transmission ("multi-scripts" in the old verbiage).

Version 5
Transmission Level

Response Header Segment

Field	Field Name	Mandatory or Optional
1Ø2-A2	VERSION/RELEASE NUMBER	M
1Ø3-A3	TRANSACTION CODE	M
1∅9-A9	TRANSACTION COUNT	M
5Ø1-F1	HEADER RESPONSE STATUS	M
2∅2-B2	SERVICE PROVIDER ID QUALIFIER	M
2Ø1-B1	SERVICE PROVIDER ID	M
4Ø1-D1	DATE OF SERVICE	M

Response Message Segment

111-AM	SEGMENT IDENTIFICATION	M
5Ø4-F4	**MESSAGE**	**O**

….other transmission level Segments…..

Transaction Level

Response Status Segment

111-AM	SEGMENT IDENTIFICATION	M
112-AN	TRANSACTION RESPONSE STATUS	M
5Ø3-F3	AUTHORIZATION NUMBER	O
51Ø-FA	REJECT COUNT	O
511-FB	REJECT CODE	O***R***
546-4F	REJECT FIELD OCCURRENCE INDICATOR	O***R***
547-5F	APPROVED MESSAGE CODE COUNT	O
548-6F	APPROVED MESSAGE CODE	O***R***
526-FQ	**ADDITIONAL MESSAGE INFORMATION**	**O**
549-7F	HELP DESK PHONE NUMBER QUALIFIER	O
55∅-8F	HELP DESK PHONE NUMBER	O

It can be argued that when supporting single transactions in a transmission that use of the Message field can relay information about *the single transaction and the transmission.* However care should be taken since multiple transactions in a transmission do exist and incorrect conclusions could be taken when processing multiple transactions in a transmission if this logic is used.

3.3   RESPONSE INSURANCE SEGMENT

3.3.1   PAYER ID (569-J8)

<u>Usage</u>
Question:
Will the Payer ID Qualifier (568-J7) and Payer ID (569-J8) be the same value for all claims received from the same processor?

Response:
The "Payer ID" is the "ID of the payer". The "Payer ID Qualifier" is the "Code indicating the type of payer ID." We would not make that assumption as a claims processor may run a "Service Bureau" operation in which they support the outsourcing of the pharmacy benefit manager to different payer segments and therefore different payer ID types.

3.3.2   PLAN ID (524-FO)

Usage (See Insurance Segment)

3.4   RESPONSE STATUS SEGMENT

3.4.1   APPROVED MESSAGE CODE (548-6F)

<u>Origin Of The Field</u>
Question:
What is the origin of Approved Message Code (548-6F) in the Response Status Segment?

Response:
Field 548-6F (Approved Message Code) – This is the "Approved Message Code" field. The definition of this field is "Message code, on an approved claim/service, communicating the need for an additional follow-up." This field, along with the "Approved Message Code Count field 547-5F is intended to be used by the processor to indicate an opportunity for a subsequent follow-up action may be appropriate (e.g. a generic may be available, a preferred formulary drug, et cetera) without rejecting the claim. The subsequent follow-up action may result in a higher or additional reimbursement.

3.4.1.1 OCCURRENCE AND NUMBER OF VALUES

Question:
If the "Approved Message Code" field has a recommended occurrence of 5 times, and the number of values that can exist is three (ØØ1, ØØ2, ØØ3), how can it occur 5 times?

Response:
The definition of "Approved Message Code" is "Message code, on an approved claim/service, communicating the need for an additional follow-up." This is a new field and only three code values were created. The maximum occurrences of "5" value is a guideline (a.) anticipating the creation of additional code valued in the future and (b.) does not preclude the use of one of these values more than once in a single response.

3.4.2 MESSAGE (5Ø4-F4) AND ADDITIONAL MESSAGE INFORMATION (526-FQ)
3.4.2.1 USAGE
See section "*Response Message Segment*" for information about the use of these fields.

3.4.3 REJECT CODE (511-FB)
3.4.3.1 FIELD LENGTH EXPANDED
Question:
The Reject Code (511-FB) field is a character length of 3, but the data dictionary does not show the leading zeros. A leading zero on a numeric field can be truncated, but a leading zero on a character field is not (Ø7Ø = 7Ø but "Ø7Ø" is not equal to "7Ø"). Can you tell me if it will be standard practice to include the leading zero on these reject codes?

Response:
For standards prior to Version 5, the Reject Code (511-FB) field was designated as X(2). For version 5, the Reject Code field was expanded to X(3) to support more values. When the Reject Codes were brought forward, they were brought forward as originally defined. In Version 3.2, value "Ø1" (Missing/Invalid BIN) is two digits long and contains "zero one". In Version 5, value "Ø1 " is three digits long and contains "zero one space". Since it is an alphanumeric field, the trailing space may be truncated according to syntax rules.

Other fields which have expanded or changed data type should also be reviewed, according to this practice.

3.4.4 REJECT COUNT (51Ø-FA)
3.4.4.1 HOW MANY REJECT CODES MIGHT BE RECEIVED?
Question:
What is the maximum number for the "reject count" field? Or what is the most amount of reject codes we can expect to receive?

Response:
There is a "Repeating Fields - Maximum Occurrences" section in the Implementation Guide. For field # 51Ø-FA (Reject Count) the maximum number of occurrences is 99. The recommended number of occurrences is <= 5. The "5" is a recommendation only; trading partner requirements will dictate the desired number of occurrences displayed.

3.4.5 RESPONSE WITH ACCEPTED AND REJECTED INFORMATION
3.4.5.1 ALLOWED?
Question:
Can a response transaction contain accepted and rejected information? For example, on an RX Billing (B1), could the response be returned with a Transaction Response Status of "P" (Paid) and in the Response Status Segment, Reject Code and Count fields be included to relay information? Or in another example, could a Reversal (B2) response be "A" (Approved) and Reject Code and Count fields be included?

Response:

No. The Reject Code and Count fields, which are specifically for reject situations, are to be used when the Transaction Response Status = "R" (Rejected). These fields should not be returned for values other than "R".

This question is also addressed in the *"Compound/Multi-Ingredient Processing", "Multi-Ingredient Compounds", "Rejecting One Ingredient"* section of this document.

3.5   RESPONSE CLAIM SEGMENT
3.5.1   PREFERRED PRODUCT ID QUALIFIER (552-AP)
Syntax
Question:
In the Response Claim Segment, the Preferred Product Count (field 551-9F) identifies how many sets of Preferred Product information are returned in the response; will the first fields of every set be Preferred Product ID Qualifier (field 552-AP)?

Response:
The "Preferred Product Count" will tell how many sets exist. This field appears once. The Preferred Product ID Qualifier (552-AP) must occur with each repetition along with the Preferred Product ID (553-AR), Preferred Product Incentive (554-AS), Preferred Product Copay Incentive (555-AT), and Preferred Product Description (556-AU). The Preferred Product ID Qualifier (552-AP) must be present for each iteration. In regards to the sequencing of fields:
*   Mandatory data elements must occur first within the appropriate segment.
*   Optional fields occur after the mandatory fields in a segment.
*   Optional fields may occur in any order in a segment except for those designated with a qualifier on in a repeating group.
Refer to section 2.4 in Version 5 Implementation Guide.

3.6   RESPONSE PRICING SEGMENT
3.6.1   CAPTURED RESPONSE
Question:
Why would the Response Pricing segment be used (optional) in a Billing transaction (or other transaction) when a processor returns a "C"aptured response?

Response:
A "C"aptured response is used when the Processor/PBM accepts the receipt of the transaction but does not render a judgment regarding eligibility or payment, for example. The Processor/PBM may return copayment information. The response copay fields are found in the Response Pricing Segment.

3.6.2   COPAY ONLY VERSUS OTHER PAYER AMOUNT PAID BILLING
Question:
There is a $20.00 patient pay amount that we would like to pay (in other words, we receive a claim that another payer paid $80.00 for a claim with a $20.00 patient copay. If our contracted rate for this claim is $60.00 with no patient copay, is there any way that we could pay the pharmacy for the copay only (keeping mind that this claim was billed with an other coverage code of "2" and not "8")?

Response:

No. The payer sheets should relay whether the plan supports copay only or other payer amount paid billing. Per plan these should not be mixed, as the pharmacy is unable to change the processing method within the same claim.

3.6.3 OTHER PAYER AMOUNT RECOGNIZED (566-J5)
3.6.3.1 OTHER PAYER AMOUNT RECOGNIZED (566-J5) FROM DOWNSTREAM PAYER?
Question:
Should Other Payer Amount Recognized (566-J5) be included in the response from a secondary (or downstream) payer?

Response:
Other Payer Amount Recognized (566-J5) is part of the formula. If the claim submitted Other Payer Amount Paid (431-DV), the answer is yes. If the claim is for a copay only billing, the Other Payer Amount Recognized is not needed.

> **Prescription Response Formula:**
> Ingredient Cost Paid (5Ø6-F6)
> + Dispensing Fee Paid (5Ø7-F7)
> + Incentive Amount Paid (521-FL)
> + Other Amount Paid (565-J4)
> + Flat Sales Tax Amount Paid (558-AW)
> + Percentage Sales Tax Amount Paid (559-AX)
> - Patient Pay Amount (5Ø5-F5)
> - Other Payer Amount Recognized (566-J5)
> --
> = Total Amount Paid (5Ø9-F9)

It is highly recommended that whenever possible, the individual dollar fields should be requested of the sender by the receiver. On the response, the sender should return the individual payment response fields to allow the receiver to reconcile against the requested payment fields. It is recommended that for the dollar fields, if the field is not required or situational in the calculation, that the dollar fields not be sent.

REQUEST PRICING FIELDS			CORRESPONDING RESPONSE PRICING FIELDS	
4Ø9-D9	INGREDIENT COST SUBMITTED		5Ø6-F6	INGREDIENT COST PAID
423-DN	BASIS OF COST DETERMINATION		522-FM	BASIS OF REIMBURSEMENT DETERMINATION
412-DC	DISPENSING FEE SUBMITTED		5Ø7-F7	DISPENSING FEE PAID
433-DX	PATIENT PAID AMOUNT SUBMITTED			*Not applicable*
438-E3	INCENTIVE AMOUNT SUBMITTED		521-FL	INCENTIVE AMOUNT PAID
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT		563-J2	OTHER AMOUNT PAID COUNT
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		564-J3	OTHER AMOUNT PAID QUALIFIER
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED		565-J4	OTHER AMOUNT PAID
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		558-AW	FLAT SALES TAX AMOUNT PAID
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		559-AX	PERCENTAGE SALES TAX AMOUNT PAID
426-DQ	USUAL AND CUSTOMARY			*Not applicable*

	CHARGE			
43Ø-DU	GROSS AMOUNT DUE		5Ø9-F9	TOTAL AMOUNT PAID
			5Ø5-F5	PATIENT PAY AMOUNT
			Fields that are part of Patient Pay Amount:	
			523-FN	AMOUNT ATTRIBUTED TO SALES TAX
			518-FI	AMOUNT OF COPAY/CO-INSURANCE

3.6.3.2 WHEN IS FIELD USED?
Question:
Under what conditions should processors return the Other Payer Amount Recognized (field 566-J5) in their responses? This field is necessary to calculate/validate the Total Amount Paid (field 5Ø9-F9) value returned per the Prescription Formula in sections 4.2.9 and 8.1Ø.

Response:
"Other Payer Amount Recognized" is the "Total dollar amount of any payment from another source including coupons." The processor would return a value in this field after reviewing and accepting a Claim or Service Billing transaction with an entry in the "Other Payer Amount Paid (field 431-DV).

3.6.3.3 WILL IT CONTAIN THE SUM OF ALL OCCURRENCE AMOUNTS?
Question:
In regard to the Response field 566-J5 Other Payer Amount Recognized, will this field contain the sum of all occurrence amounts corresponding to the field 431-DV Other Payer Amount Paid?   If not, the sums of what corresponding fields does field 566-J5 contain?

Response:
According to the definition, Other Payer Amount Recognized is the total dollar amount of any payment from another source including coupons. This field is used in balancing. The Other Payer Amount Field (amount of any payment known by the pharmacy from other sources (including coupons)) is not used in balancing. In looking at the definitions, Other Payer Amount Paid is totaled and included in Other Payer Amount Recognized.

3.6.4 REMAINING BENEFIT AMOUNT (514-FE)
Zeroes and Defaults
The Remaining Benefit Amount should not be returned with zeroes unless there are no benefit dollars remaining. This field should not be defaulted (zero filled), as it would lead the pharmacy to an incorrect conclusion of no benefit dollars remaining. Unlike version 3.2, the value of 99999999 should not be used as a default in this field.

See this field reference in "Editorial Changes Applicable To All Version 5 Data Dictionaries".

3.7   RESPONSE DUR/PPS SEGMENT
3.7.1 DUR RESPONSE DATA

3.7.1.1 WHAT IS THE LENGTH OF THE VERSION 3.2 FIELD DUR RESPONSE DATA (525-FP)?
Question:
What is the length of the "DUR Response Data" field? The description is missing in the data dictionary.

Response:
"DUR Response Data" is NCPDP field # 525-FP and supported in telecommunications Version 3.2. In Version 3.2, the "Response Data" field was really made up of many different fields that occurred, in sequence, three times (e.g. DUR Conflict / Reason for Service Code, Clinical Significance Code, etc.) In total that group of fields were known as the "DUR Response Data". Therefore, since it did not have a unique identity, it was not brought forward into Version 5.Ø.

4. TRANSMISSION/TRANSACTION SYNTAX

4.1 ALPHANUMERIC FIELD EXPANSION

<u>Expansion Of Field Length</u>

Question:
The Reject Code (511-FB) field is a character length of 3, but the data dictionary does not show the leading zeros. Can you tell me if it will be standard practice to include the leading zero on these reject codes? Other Payer ID Qualifier (339-6C) is defined as X(2). Is the leading zero included?

Response:
For standards prior to Version 5, the Reject Code (511-FB) field was designated as X(2). For version 5, the Reject Code field was expanded to X(3) to support more values. When the Reject Codes were brought forward, they were brought forward as originally defined. In Version 3.2, value "Ø1" (Missing/Invalid BIN) is two digits long and contains "zero one". In Version 5, value "Ø1 " is three digits long and contains "zero one space". Since it is an alphanumeric field, the trailing space may be truncated according to syntax rules.

Other Payer ID Qualifier (339-6C) both digits are used. So value "Ø1" (National Payer ID) contains "zero one". Segment Identification, which is X(2) for value "Ø7" (Claim) would contain "zero seven". This is compared to Submission Clarification Code (42Ø-DK) which is 9(2). Value 2 (Other Override) would contain "two" with the zero suppressed since it is a numeric field. Other alphanumeric fields which have expanded or are alphanumeric should also be reviewed, according to this practice.

4.2 COUNT AND COUNTER INFORMATION

<u>Usage</u>

Question: Which fields are required in groupings with Count and Counter fields?

Response: Since the Telecommunication Implementation Guide Version 5.1 is "frozen" under HIPAA, please refer to future versions of the Implementation Guide (Version 5.4 and above), which have more clarification in section "2.4 Repeating Fields – Maximum Occurrences".

For technical parsing, the "count" field groupings will have a "trigger" field that must occur in each iteration or loop of the count. The trigger fields must be present when the Count is used so that the parsing routine can tell when another iteration of a count has occurred. In the excerpt from section 2.4 below, the trigger field(s) is noted in the trigger note.

For technical parsing, the "counter" field groupings use the counter field itself as the trigger. Each iteration or loop of the counter will be designated with the counter field. Within the counter grouping, all or some of the fields may occur from one grouping to the next, in any order. Each grouping may have different combinations of the fields.

A generic example of count and counter scenarios:

Count of "3"

Count field with value 3

Field 1a (trigger)	
	Field 1b
Field 1a (trigger)	
	Field 1b
Field 1a (trigger)	
	Field 1b

Counter of "2"

Actual Counter field with value 1 (trigger)	
	Field 1
Actual Counter field with value 2 (trigger)	
	Field 1
	Field 2

Helpful Hint: Remember that counT ends in T which stands for Total and counteR ends in R that stands for Repeats on every occurrence.

Excerpt From "2.4 Repeating Fields – Maximum Occurrences" with additional clarification

Coordination of Benefits/Other Payments Segment:

The field Coordination of Benefits/Other Payments Count (337-4C) when supported may contain a maximum count of 9 with a recommended count $\leq$ 3. The Count *will contain* a value between 1 and 9 when used and the fields (Other Payer Coverage Type, Other Payer ID Qualifier, et cetera) will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Other Payer Coverage Type must be present for the Count.)

The field Other Payer Amount Paid Count (341-HB) when supported may contain a maximum count of 9 with a recommended count $\leq$ 9. The Count *will contain* a value between 1 and 9 when used and the fields (Other Payer Amount Paid Qualifier and Other Payer Amount Paid) will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Other Payer Amount Paid Qualifier and Other Payer Amount Paid.)

The field Other Payer Reject Count (471-5E) when supported may contain a maximum count of 2Ø with a recommended support of $\leq$ 5. The Count *will contain* a value between 1 and 2Ø when used and Other Payer Reject Code will repeat the number of times the Count specifies. (Trigger: Other Payer Reject Code.)

Claim Segment:

The field Procedure Modifier Code Count (458-SE) when supported may contain a maximum count of 9 with a recommended support of $\leq$ 4. The Count *will contain* a value between 1 and 9 when used and Procedure Modifier Code will repeat the number of times the Count specifies. (Trigger: Procedure Modifier Code.)

DUR/PPS Segment:

The field DUR/PPS Code Counter (473-7E) when supported *may repeat* a maximum of 9 occurrences with a recommended $\leq$ 9 occurrences supported. The counter field indicates which sequential loop of the repetition. For each repetition of the DUR/PPS Code Counter (1, 2, 3, et cetera) the fields Reason for Service Code, Professional Service Code, Result of Service Code, et cetera will occur, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: DUR/PPS Code

Counter. All or some of the fields may occur from one grouping to the next, in any order. Each grouping may have different combinations of the fields.)

Compound Segment:

The field Compound Ingredient Component Count (447-EC) when supported may contain a maximum count of 99 with a recommended support of ≤ 25 ingredients. The Count *will contain* a value between 1 and 99 when used and the fields (Compound Product ID Qualifier, Compound Product ID, Compound Ingredient Quantity, et cetera) will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Compound Product ID Qualifier, Compound Product ID, Compound Ingredient Quantity are all mandatory, as defined in the Segment Quick Reference.)

Pricing Segment:

The field Other Amount Claimed Submitted Count (478-H7) when supported may contain a maximum count of 9 with recommended support of ≤ 3. The Count *will contain* a value between 1 and 9 when used and the fields Other Amount Claimed Submitted Qualifier and Other Amount Claimed Submitted will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Other Amount Claim Submitted Qualifier and Other Amount Claimed Submitted.)

Clinical Segment:

The field Diagnosis Code Count (491-VE) when supported may contain a maximum count of 9 with recommended support of ≤ 5. The Count *will contain* a value between 1 and 9 when used and the fields Diagnosis Code Qualifier and Diagnosis Code will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Diagnosis Code Qualifier and Diagnosis Code.)

The field Clinical Information Counter (493-XE) when supported *may repeat* a maximum of 9 occurrences with a recommended ≤ 5 occurrences supported. The counter field indicates which loop of the repetition, in sequential order. For each repetition of the Clinical Information Counter (1, 2, 3, et cetera...), the fields Measurement Date, Measurement Time, et cetera will occur, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Clinical Information Counter. All or some of the fields may occur from one grouping to the next, in any order. Each grouping may have different combinations of the fields.)

Response Status Segment:

The field Approved Message Code Count (547-5F) when supported may contain a maximum count of 9 with recommended support of ≤ 5. The Count *will contain* a value between 1 and 9 when used and the field Approved Message Code will repeat the number of times the Count specifies. (Trigger: Approved Message Code.)

In a Rejected response, the field Reject Count (51Ø-FA) when supported may contain a maximum count of 99 with recommended support of ≤ 5. The Count *will contain* a value between 1 and 99 when used and the fields Reject Code and Reject Field Occurrence Indicator will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Reject Code.)

Either the reject or approved fields may appear, but not both, based on the response. If the field rejected is not a repeating field, the 'Reject Field Occurrence Indicator' should be eliminated.

Response Claim Segment:
NOTE: If the Preferred Product Count is sent, the Preferred Product ID Qualifier must precede each occurrence of the Preferred Product ID.

The field Preferred Product Count (551-9F) when supported may contain a maximum count of 9 with recommended support of ≤ 6. The Count *will contain* a value between 1 and 9 when used and the fields (Preferred Product ID Qualifier, Preferred Product ID, et cetera) will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Preferred Product ID Qualifier and Preferred Product ID.)

Response Pricing Segment:
The field Other Amount Paid Count (563-J2) when supported may contain a maximum count of 9 with recommended support of ≤ 3. The Count *will contain* a value between 1 and 9 when used and the fields Other Amount Paid Qualifier and Other Amount Paid will repeat the number of times the Count specifies, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: Other Amount Paid Qualifier and Other Amount Paid.)

Response DUR/PPS Segment:
The field DUR/PPS Response Code Counter (567-J6) when supported *may repeat* a maximum of 9 occurrences with a recommended ≤ 9 occurrences supported. The counter field indicates which loop of the repetition, in sequential order. For each repetition of the DUR/PPS Response Code Counter (1, 2, 3, et cetera...), the fields Reason for Service Code, Clinical Significance Code, et cetera will occur, with mandatory/optional requirements as defined in the Segment Quick Reference. (Trigger: DUR/PPS Response Code Counter. All or some of the fields may occur from one grouping to the next, in any order. Each grouping may have different combinations of the fields.)

4.3 DATE FORMAT
Default
Question:
Fields defined as Date format – what is the default? Can Date fields be defaulted to ØØØØØØØØ?

Response:
Fields defined as dates must follow the date format (e.g. CCYYMMDD) given in the data dictionary and implementation guide. A date field cannot default to zeroes, as this is an invalid date. If a pharmacy submits a date of zeroes, the processor should reject it as an invalid date, even if the processor ignores/does not use this field in their processing, but must store this field as part of the original transaction data. In databases that store this field as "date", write routines would fail with a write exception for the invalid date.

If the pharmacy is not submitting the field, the field IDs and field values would not be sent. The processor may choose to ignore this field, if they don't need it, but parsing and storage routines might have problems if the field is sent with invalid data. A processor that returns a date field is held to the same valid date rule.

4.4   FIELD SIZE DIFFERENT IN HIPAA STANDARDS
Usage
Question:
The field sizes in ASC X12N are larger than in NCPDP Telecommunication Standard Version 5.1. An example would be Subscriber ID in the 834 standard at 3Ø bytes and the NCPDP Cardholder ID at 2Ø bytes. What field length should be used?

Response:
The field length used should be the appropriate designation for that standard. The processor must be able to accept the maximum length of a field, as defined in the appropriate implementation guide. The provider may send the length appropriate for the business case.

4.5   FIELD TRUNCATION
4.5.1 ALPHANUMERIC FIELD AND LEADING SPACES
Question:
Can an alphanumeric field contain a space or spaces as the first character(s)? Would these spaces be truncated like trailing spaces could be truncated?

Response:
An alphanumeric field may contain a space or spaces anywhere within the field. For example (where *b* is a space)
>   "ABC*b*DE" or
>   "*bb*ABC*b*DE"
are valid uses of a field with spaces. They are **technically different values**.

Trailing spaces may be truncated. For example,
>   "ABC" and
>   "ABC*bbb*"
are the same value when the trailing spaces are truncated.

Spaces at the beginning of the field must not be truncated. For example,
>   "ABC" and
>   "*bb*ABC"
represent **technically different values** for the same field.

However, while leading spaces are *technically* valid, leading spaces are **not** recommended as one must consider the individual who will key enter the data in question. For example, spaces at the beginning of a Cardholder ID or Group ID appear to be 'white' space on the ID card so it is unlikely that it will be known that a leading space exists.

4.5.2 TRUNCATION OF DOLLAR FIELDS
Question:
We coded our application to be variable and only return necessary data elements. Using the editorial document as a reference, (page 43 Zero Dollar Amounts and page 49 1ØØ% Copayment), we decided not to return Total Payment Amount on a paid response for a 1ØØ% copayment. The element is optional and would contain zeros. We return Patient Pay Amount, Copay and Amount Attributed to Production Selection. We have been following this practice since we implemented in the fall of 2ØØ2.

This week, one of our vendors migrated to 5.1. They were expecting a Total Amount Paid on 1ØØ% Copayment. This expectation was based on page 66 of the Protocol Draft #14.

The clarification concerns Page 66. Under the 1ØØ% Copay section, Total Paid Amount is not listed as a field to return unless the approved amount results in a negative amount. Based on this, we felt our response was correct for 1ØØ% Copay Paid Responses. Reading further under the Other Pricing section, there is a reference to two fields that are mandatory - Patient Pay Amount and Total Amount Paid. Are these fields really mandatory? Do you know what Version/Draft they became mandatory? I have a mix of vendors and chains on 5.1 and have not received any complaints to date. I am reluctant to change based on one Vendor but I want to be compliant.

If you could clarify the correct response for 1ØØ% copay I would appreciate it. Also, for Patient Pay Amount, is it always required even if it is zero. We have some RX's with no copay accessed. Are we to return Patient Pay Amount with zeros in those responses?

Response:
The Implementation Guide supports the truncation of fields. However, further clarification has been created. When the dollar field is supported, a value should always be returned, whether zero or higher. The only time a dollar field is not returned is when it is not supported or it's value cannot be determined. If a dollar field is sent on the request, the response-paired field should be returned so that balancing can occur. See question "*How should zero dollar amounts be handled in a variable transaction?*" See question "*1ØØ% Copay And Negative Amounts*". See also section "*Business Function of Capture*" and "*Pricing Guidelines*".

4.5.3 TRUNCATION OF NON-NUMERIC FIELDS
Question:
Is it proper to "truncate" non-numeric fields? For example, a 2 byte field with a value of "Ø8" is truncated to "8". Is this proper?

Response:

A numeric field can be truncated from "Ø8" to "8". For alpha-numeric fields you cannot truncate in this manner. A field defined as alpha-numeric of two digit length and a value of "Ø8" must be sent as "Ø8" and not "8"

4.5.4 TRUNCATION OF NUMERIC FIELDS
Question:
In the Telecommunication Standard, a field such as Patient Location (3Ø7-C7) is defined as a two-byte numeric with values 1-11. Can I send the leading zeroes in values 1-9 (meaning sending Ø1, Ø2, Ø3..., or 1, 2, 3)?

Response:
Yes. For optional numeric fields used in the Telecommunication Standard, sending the leading zero(es) is permissible, or truncating the leading zero(es) is permissible. For an optional numeric field, a value of Ø1 is the same as 1 and either are permitted. As a further note, when numeric fields are in a mandatory fixed length segment, such as the Transaction Header Segment or Response Header Segment, the numeric fields must be padded with zeroes to the maximum length of the numeric field.

The following verbiage will be added to the Telecommunication Standard and Implementation Guide.
Numeric Truncation:
For optional numeric fields used in the Telecommunication Standard, sending the leading zero(es) is permissible (but not recommended), or truncating the leading zero(es) is permissible (and recommended). For an optional numeric field, a value of Ø1 is the same as 1 and either is permitted. A value of ØØ15 is the same as 15 and either is permitted.

When numeric fields are in a mandatory fixed length segment, such as the Transaction Header Segment or Response Header Segment, the numeric fields must be padded with zeroes to the maximum length of the numeric field.

Alphanumeric Truncation:
For optional alphanumeric fields used in the Telecommunication Standard, sending the trailing space(s) is permissible (but not recommended), or truncating the trailing space(s) is permissible (and recommended). For an optional alphanumeric field, a value of "1 " is the same as "1" and either is permitted. A value of "ØØ1   " is the same as "ØØ1" and either is permitted.

When alphanumeric fields are in a mandatory fixed length segment, such as the Transaction Header Segment or Response Header Segment, the alphanumeric fields must be padded with spaces to the maximum length of the alphanumeric field.

4.5.5 TRUNCATION OF FIELDS IN THE SEGMENT
Question:
If you choose to truncate any fields, does this apply to the entire transaction?

Response:
You should be prepared to support any combination of "Truncated" and "Non-Truncated" field combinations. There is no rule requiring that all fields should be truncated within a transaction. Some fields may be truncated and some may not.

4.6 MANDATORY FIELDS FIRST IN SEGMENTS

4.6.1 NCPDP MANDATORY FIELDS VERSUS A PROCESSOR'S BUSINESS NEED OF MANDATORY FIELDS

Question:

If mandatory fields are sent first in the segment, does this mean only NCPDP standard identified mandatory fields? For instance, if a field is defined as optional in the standard, but a processor has defined it as mandatory for their implementation, is the field sent with the standard mandatory elements or still submitted with the stand defined optional elements?

Response:

The mandatory fields requirement is for the NCPDP defined fields. If that segment is used, the mandatory fields must be used and must come first. A processor may choose to make some of the optional fields mandatory for their business need, but that would not change the order of the mandatory fields.

Question:

Other than sending mandatory fields first followed by optional fields, is there a defined order of submission of fields (i.e. follow the order of the fields in section 5 of the Implementation Guide)? Can a processor define the order of fields?

Response:

By definition, the optional fields may occur in any order except where a field and it's qualifier must occur together, or in a repeating group (where counts/counters are used). There is no defined order to the optional fields, but practice may show that many will use the order defined in the implementation guide. A processor cannot define the order of the fields as this is the Standard and Implementation Guide's responsibility, and the order is already defined by the above rules. However, the processor may send out a payer sheet that would list the fields, hence giving it a particular order. Section 8.1 Overview of the Specification should be used as a reference.

4.7 MANDATORY FIELD ORDER

Question:

Must the mandatory data elements be sent in the order that they are listed in the implementation guide?

Response:

Yes. The Mandatory fields within the segments are listed in a logical and structural order and follow the rules established for the Segment Identification field, qualifier, count and counter fields.

4.8 MANDATORY QUALIFIERS AND FIELDS – USAGE OF DEFAULT VALUES

Usage Of Default (Low-Values) On Mandatory Qualifiers And Fields

Question:

When a qualifier or field qualified is mandatory in a segment, how are default values of zeroes and spaces handled?

Response:

Every field, by its existence, has a default or low value. Numeric fields default to zeroes, alphanumeric default to spaces. In the Data Dictionary, for fields that are code lists, a value of ØØ or 99 or blanks has been created to clarify what the value of "Not Specified" would be. The data fields may be used by other standards that may need a default or low value for the field.

When a field or a qualifier is defined as mandatory in the Telecommunications Standard and Implementation Guide, low values are not acceptable values. If this were allowed, the field filled with zeroes or spaces would function as a placeholder. The field would not function as a needed element. This is not the intention.

If a mandatory qualifier were filled with low values, what would "Not Specified" mean? If a valid qualifier were used and paired with a space-filled field qualified, what would that denote? When a field or a qualifier is mandatory, valid values should be used (non-low values).

If there is an exception to this rule, it is noted for a specific business case in the Implementation Guide. For example, when submitting a Billing for Service of DUR/PPS, the Product/Service ID Qualifier (436-E1) contains a value of "Ø6" (DUR/PPS). The Product/Service ID (4Ø7-D7) contains a value of "Ø" since there is not a specific product or service number associated with the qualifier at this time.

4.9   MAXIMUM LENGTH
4.9.1 REJECT OPTIONAL FIELD AT MAXIMUM LENGTH?
Question:
Is it permissible for a processor/payer to reject an optional field that is submitted at its maximum length? For example, Group ID (3Ø1-C1) is defined as X(15). If the field is submitted "123456789Ø*bbbbb*" (where *b* is a space), can the payer reject the field as too long if they do not support the full field length?

Response:
No, the processor/payer cannot reject an optional field that is submitted to its maximum length. Although the proper truncation of a field is recommended, submitting the maximum length is not an error.

4.9.2 WHAT IS THE MAXIMUM RECORD LENGTH IN VERSION 5?
Question:
What is the maximum record length we can expect for a 5.Ø record? The old maximum length we used was 1712.

Response:
For the purpose of discussion, we will look at the claim submission record. A single Version 5.Ø claim record, with all optional fields and without any truncation or repeating fields, is over 1,7ØØ characters long. Multiply this number by the maximum 4 claims per transaction and the length is well over 6,8ØØ characters. With truncation the claim could be less than 3ØØ characters long. Version 5.Ø is intended to be "truly variable" and suggest that all participants develop their implementation plans accordingly.

4.10 PRINTABLE CHARACTERS
Usage

Question:
What are printable characters?

Response:
All characters in the ASCII chart from 32 - 126 (2Ø – 7E hex), which include:
> <space>
> Ø123456789
> ABCDEFGHIJKLMNOPQRSTUVWXYZ
> ~`!@#$%^&*()_-=+\|{[]}:,<.>/?;'"
> abcdefghijklmnopqrstuvwxyz

See Note below.

The ASCII character codes from Ø - 31 (Ø - 1F hex) are considered to be control characters and are not allowed as data characters in a claim. Likewise, characters higher than ASCII 126 (higher than 7E hex) should not be used because of the 7 data bit Even parity requirement for VISA dial-up transmissions.

The use of characters such as commas, tabs and quotes can interfere with routines used to parse claims data and should be avoided if possible.

Note:
In the Telecommunication Standard, the following is defined:
> ""A/N" = Alpha/Numeric, upper case when alpha, always left justified, space filled, upper case, printable characters.
>> Truncation: "1234ABC44bbbbb" becomes "1234ABC44"".

The Implementation Guide further states
> "Alpha/Numeric, always left justified, space filled. A-Z, Ø-9, and printable characters."

In Telecommunication Standard allows the use of
> <space>
> Ø123456789
> ABCDEFGHIJKLMNOPQRSTUVWXYZ
> ~`!@#$%^&*()_-=+\|{[]}:,<.>/?;'"

The use of lower case letters ASCII 97 - 122 (61 - 7A hex) is not allowed in the Telecommunication Standard format.

Question:
Can characters, i.e.: alpha, numeric and symbols (if allowable) be separated by spaces?

Response:
Yes. Example of embedded and trailing blanks with the truncation rule in effect:
> "ABCbDb-bEbbbb" becomes "ABC D - E"

The same example without truncation in effect:
> "ABCbDb-bEbbbb" remains as "ABC D - E   "

4.11 REJECTING TRANSACTIONS

4.11.1 HOW IS A REJECTION HANDLED WHEN THE PROBLEM IS IN THE HEADER?
Question:
A transaction with multiple claims is rejected by the processor at the header. Do you have to reject each claim in the response?

Response:
In Version 5.Ø "header only" reject transactions don't exist. This was confusing in Version 3.2. In Version 5.Ø, it is recommended that the rejection be at the Response Header and Transaction Response level. However, this is not mandatory.

Please refer to section *"Transmission Response Discussion"* of the Telecommunication Standard.

4.11.2 INVALID VERSION/RELEASE NUMBER (1Ø2-A2), TRANSACTION CODE (1Ø3-A3), OR TRANSACTION COUNT (1Ø9-A9)
Question:
How should a clearinghouse or payer handle rejecting a transaction sent from a provider with an invalid Version/Release Number (1Ø2-A2), Transaction Code (1Ø3-A3), or Transaction Count (1Ø9-A9)?

Response:
The recommendation is that when the Transaction Count (1Ø9-A9) is invalid, the processor system should generate a Transmission Rejected/Transaction Rejected format. The processor system should generate a response with a Transaction Count (1Ø9-A9) of 1 and appropriate Reject Codes (511-FB).

It is possible that the processor system may not respond to this invalid transaction, or may respond with only a string or text message, not in NCPDP format. This would then appear as a timeout to the provider system.

If the Version/Release Number (1Ø2-A2) is garbage (not a valid value, or values for example of "??" or "**"), the processor cannot build an appropriate response. In this case, a timeout at the provider system is appropriate.

If the Transaction Code (1Ø3-A3) is garbage (not a valid value, or values for example of "??" or "**"), the processor system does not know how to build an appropriately formatted response.

If the Transaction Count (1Ø9-A9) is not a valid value (but the Version/Release and Transaction Code are appropriate), it is recommended the Transaction Count contain a value of 1 with the appropriate Response Status Segment containing Reject Codes (511-FB) signifying the invalid Transaction Count field.

4.12 SEGMENT ORDER
Question:
Is there an order to the way segments must appear in a transmission? The Specification and the Implementation Guide show different orders in various sections.
Example1:
> Assume both the Patient Segment and Insurance Segment are used in a Billing (Insurance Segment is Mandatory; Patient Segment is Optional). The

Transaction Header Segment must occur first. Can the Patient Segment, then the Insurance Segment appears, *or* the Insurance Segment, then the Patient Segment – and either order are correct?

Example 2:

In a Billing, both the Claim Segment and Pricing Segment are Mandatory. Can they appear in either order?

Example 3:

In a Reversal, both the Patient Segment and Insurance Segment are optional. Can they appear in either order?

Example 4:

Assume both the Prescriber Segment and the DUR/PPS Segment are used in a Billing (both segments are Optional). Can they appear in either order?

Response:
At the Transmission request level, the Transaction Header Segment must appear first. The Patient Segment and Insurance Segment can be submitted in either order, if both appear, regardless of whether they are mandatory or optional segments. At the Transaction request level, the Group Separator occurs, and then the other segments may occur in any order. Note the Segments may occur only once and according to the rules for that transaction.

At the Transmission response level, the Response Header Segment must appear first. The Response Message Segment and Response Insurance Segment may occur in either order, if both appear, regardless of whether they are mandatory or optional segments. At the Transaction response level, the Group Separator occurs, and then the Response Status Segment through Response Prior Authorization Segment may occur in any order. Note the Segments may occur only once and according to the rules for that transaction.

The receiver cannot force an order of segments.

4.13 SEGMENT STRUCTURE
Question:
Can a Segment Identification (111-AM) be sent without any fields in that segment and not be in error?

Response:
Yes, a Segment Identification (111-AM) can be sent without any fields in that segment **only if** there are no Mandatory fields within the segment.

If the Segment is optional for that transaction and there are no Mandatory fields within that Segment, the Segment Identification (111-AM) can be sent without an error generated. This is not recommended, but is possible.

Section 8.1 of the Telecommunication Standard Specification states,

"It is recommended that the Segment ID field not be submitted if no ensuing fields will be sent. This may occur when all fields in the segment are optional. However, if a transmission contains a Segment ID with no data elements following, a syntax rejection should not result, unless trading partners have

agreed that one or more data elements are necessary to complete the transaction."

In Section 4, it is noted,

"Ignoring irrelevant data that may be supplied by the Originator (i.e., the request may have data in fields not required for a particular plan. This should not create an error)."

Section 2.2 of the Telecommunication Implementation Guide states,

"It is recommended that the Segment Identification field not be submitted if no ensuing fields will be sent in that segment. However, if a transmission contains a Segment Identification with no data elements following, a syntax rejection should not result, unless trading partners have agreed that one or more data elements are necessary in this segment."

The key is that the Segment must be optional for that transaction **and** there must not be any Mandatory fields within that Segment. If the Segment contains Mandatory fields, failure to send the mandatory fields is an error. If the Segment is not used for that transaction, it is an error to send a Segment that is not defined for that transaction.

4.14 ZERO DOLLAR AMOUNTS
Support Of Zero Dollar Amounts
Question:
How Should Zero Dollar Amounts Be Handled In A Variable Transaction?

Response:
The NCPDP Telecommunication Standard Version 5 provides the ability to only send/receive the data necessary to fulfill a business requirement.
In the past, the version 3.2 formats allowed the fixed transaction formats of 3A, 3B, and 3C. Due to the fixed formats, fields that were not needed in the business case still had to be defaulted (zero or space filled) to retain the position in the fixed format.

Version 5 does not bring the fixed formats forward. By adhering to the rules of which segments are required, which fields are mandatory, and only sending/receiving the fields that are optionally needed for the business case, fields that are not needed, should not be sent.

Dollar amounts should not be sent unless needed in the business case. If it is necessary to relay a dollar field that contains zeroes, the field should be sent. It is **not recommended** to relay a dollar field of zeroes to retain a position in a segment. Please see the appropriate segment sections within the Version 5.1 or greater Implementation Guide for clarification.

See also section *"Response Pricing Segment"*, subsection *"Remaining Benefit Amount (514-FE)"*.

5. TRANSLATION OF VERSIONS

5.1 FIXED FORMAT VERSUS VARIABLE FORMAT

Why Is It Important To Move From Fixed Format To A Variable Format?

Question:

Why is it important to move from a fixed format to a variable format with NCPDP Version 5.1?

Response:

Based on member requests for new fields, expanded fields, and new business cases, it was necessary to add new data elements to the data dictionary. With the expansion of data elements, using a fixed format would have created a transaction set that was larger and would need to be supported in each transmission. To take advantage of efficiencies in transmission and to only send the data elements necessary to the business case, a variable format was created.

The Transaction Header Segment retained important routing fields in the same positions (BIN, Processor Control Number, et cetera) so multiple versions could be supported technically.

5.2 VERSION TRANSLATION

5.2.1 FEASIBILITY OF VERSION 3C TO VERSION 5 UPWARD/DOWNWARD COMPATIBILITY

Question:

Can you discuss the feasibility/practicality of Version 3C to Version 5 upward/downward compatibility?

Response:

The upward/downward translation may be possible with analysis. However, the changing sizes, formats, and values must be taken into account, and these changes could make translations difficult or problematic. Also the mapping of different sized dollar fields must be reviewed carefully.

Translation of Version 32 into an RTDS (3A, 3B, 3C) or Version Ø1, a downward translation, was possible because most of the translation involved the repackaging of the data fields into a slightly different format. A Version Ø1 response could be remapped back into a Version 32, 3A, 3B, or 3C response, in many cases. Even a Version Ø1 request translated upward to a Version 32, 3A, 3B, or 3C was possible in some cases, since most of the same data elements, sizes, and values were supported. The data dictionary did not change significantly.

In Version 5, the data dictionary underwent many changes. Analysis would need to account for fields, field sizes, and values that are sent in a Version 5 request and how these would translate downward into a Version 32. Longer field lengths might be truncated. Values that are not supported would either be translated or could not be sent as the Version 32 structure might not support it.

Analysis should include how to support Version 5 response fields that are not supported in lower versions. If the processor/PBM returns a response in Version 5, but the pharmacy sent a Version 32, how are fields that do not exist in Version 32 handled?

What are the translation rules for response fields in Version 5 that do not exist in Version 32? Dropping these fields might be an issue. What about field sizes or values not supported in Version 32; how are these translated?

So it may be possible to translate upward/downward. Careful analysis and clearly defined business rules between partners must be done to evaluate need.

6.   BUSINESS FUNCTION OF CAPTURE
6.1   VALID USES
In Claim/Service Billing, a "C" (Capture) response is supported. NCPDP members have defined the business of capture to be used for:

1. **Intermediary Services** - two valid Intermediary services are:
    a. Provider/Intermediary agreements to provide services such as additional editing, pricing, billing, and payment reconciliation.
    b. Payer/Intermediary agreements to provide some level of editing, pricing, and copay calculation, with the ultimate payer having the option to perform additional edits.
2. **Replacement of manual billing**

The usage of this type of Capture should be used with caution, due to issues of:

- The determination of patient copay
- Most plans today expect patient to pay some portion.
- Many plans vary copay based on brand/generic.
- Drug Databases do not categorize drugs the same way.
- Some drugs/patients are excluded from copays.

To determine copay, providers can attempt to edit and determine copay and submit this on the original claim in the field Patient Paid Amount Submitted (433-DX), *however,*

- The resulting copay may be incorrect.
- This could be considered fraudulent if patient is overcharged.
- There is a problem with the recommendation to echo back the submitted fields.

Therefore, to support replacement of manual billing, the processor should

- Determine the copay and return it as Patient Pay Amount (5Ø5-F5).
- Then calculate Total Amount Paid (5Ø9-F9) using the submitted fields and the determined copay amount.

For example:

Ingredient Cost Submitted (4Ø9-D9)	35.ØØ	Ingredient Cost Paid (5Ø6-F6)	35.ØØ
Dispensing Fee Submitted (412-DC)	3.ØØ	Dispensing Fee Paid (5Ø7-F7)	3.ØØ
Incentive Amount Submitted (438-E3)	1.ØØ	Incentive Amount Paid (521-FL)	1.ØØ
Flat Sales Tax Amount Submitted (481-HA)	.25	Flat Sales Tax Amount Paid (558-AW)	.25
Percentage Sales Tax Amount Submitted (482-GE)	.75	Percentage Sales Tax Amount Paid (559-AX)	.75
Other Amount Claimed Submitted (48Ø-H9)	1.ØØ	Other Amount Paid (565-J4)	1.ØØ
		Patient Pay Amount (5Ø5-F5)	1Ø.ØØ
Gross Amount Due (43Ø-DU)	41.ØØ	Total Amount Paid (5Ø9-F9)	31.ØØ

Patient Pay Amount (5Ø5-F5) is 'real' and Total Amount Paid (5Ø9-F9) is calculated using submitted fields and 'real' copay.

6.2   CAPTURE CONSISTENCY

The use of a "C" (Capture) response should be *consistent* within a **BIN Number** (1Ø1-A1)**/Processor Control Number** (1Ø2-A2) combination. <u>All</u> claims at <u>all</u> times for this **BIN/PCN** combination should be handled the same way. If the processor "P" (Paid) or "R" (Rejected) this claim were it submitted at a different time, a Capture Response should **not** be used. With this consistency, providers should be able to know by trading partner agreement when returned dollar amounts are parroted versus when they are estimated dollar amounts.

Suggested Rule of Thumb:
> Submitted dollar amounts = Response Captured dollar amounts
>> assume parroted values from submission returned
> Submitted dollar amounts not = Response Captured dollar amounts
>> assume estimated values returned

6.3 BUSINESS FUNCTIONS NOT SUPPORTED FOR CAPTURE

The following business functions for Capture are not supported:

- 1ØØ% Copay – This is technically a payment and a "P" (Paid) response should be returned.
- Maintenance Windows – this is a Reject. Suggest use of Reject Code (511-FB) = 96 – *Scheduled Downtime*; however any 9x error code would supply provider with information to reprocess claim later.
- Coordinated Pro-DUR – this business function should take place within a "P" (Paid) or "R"(Rejected) response.
- Product Ordering – this is not a function of a Claim or Service Billing.

7.   PRICING GUIDELINES
7.1   1ØØ% COPAY

When the patient is expected to pay 1ØØ% of processor determined amount as total claim reimbursement, it is recommended the response contain:

Patient Pay Amount (5Ø5-F5) *plus* any of the *applicable* Patient Responsibility fields included in this amount:

- Amount Attributed To Sales Tax (523-FN)
- Amount Applied To Periodic Deductible (517-FH)
- Amount Of Copay/Co-Insurance (518-FI)
- Amount Attributed To Product Selection (519-FJ)
- Amount Exceeding Periodic Benefit Maximum **(**52Ø-FK)

If processor calculates 1ØØ% copay that results in the customer paying more than pharmacy will <u>net</u> for the claim, Total Amount Paid (5Ø9-F9) must be provided *with a negative value* so the sale can be booked correctly.

7.2   1ØØ% COPAY AND NEGATIVE AMOUNTS

Question:
Under what situation would a Total Amount Paid (5Ø9-F9) be sent to the pharmacy with a negative dollar amount?

Response:
In some discount card or unfunded business programs, the patient pays an additional fee that is then deducted from the pharmacy's remittance (the amount the pharmacy is overpaid by the member). The patient pay amount is the normal ingredient cost plus dispensing fee, which represents the normal contracted rate for the pharmacy. In addition, the additional processing fee will be added to the patient pay amount such that the patient pay amount exceeds the payable amount to the pharmacy.

In following the total amount paid calculation, the end result will be a negative total amount paid to the pharmacy. The pharmacy will collect the total amount from the patient and book a negative amount in the pharmacy system. The payer/processor will then deduct the negative amount within the remittance process.

An example is as follows:

5Ø6-F6	Ingredient Cost Paid	19.5Ø	
5Ø7-F7	Dispensing Fee Paid	2.5Ø	
521-FL	Incentive Fee Paid	-------	
565-J4	Other Amount Paid	-------	
	Net Provider Reimbursement		22.ØØ

5Ø5-F5	Patient Pay Amount	24.ØØ
5Ø9-F9	Total Amount Paid	- 2.ØØ

Pharmacies requested a negative fee be returned on the response in order for revenue to be booked correctly at point of sale rather than creating a problem when the pharmacy payment is received with negative dollars. (The X12 835 Remittance Advice standard can handle the negative amounts within that process.)

7.3   OTHER PRICING

- The fields containing the values used to arrive at the final reimbursement must be detailed on the response record.
- If claim submission included the field with a value not equal to zero, then the *corresponding* response field should be returned - even if the response value for that field = zeros.

The following fields should be mandatory on all payment and capture responses:
- Patient Pay Amount (5Ø5-F5)
- Total Amount Paid (5Ø9-F9)

It is the sum of these two fields that determines final provider reimbursement. With both fields present (even when zero) there is no ambiguity regarding the final payment amount of the claim.

If the Transaction Response Status (112-AN) = C (Captured) or Q (Duplicate of Captured), dollar fields should be supplied in the response.

- If the response is a 'true' Capture (i.e. replacement of batch billing, with no edits or pricing), then corresponding response fields should be populated with values as submitted.   *Ideally, processor should provide 'real' copay values on a Capture.   If this is not possible, provider must **know** (by trading partner agreement) the copays to charge and factor that into their system so collection occurs.*
- If the response is captured by an Intermediary who can provide better pricing criteria, the corresponding response fields should be populated with the *probable* values and those values used to determine estimated pricing as noted above. Since the claim has **not** been fully adjudicated, this should remain a capture response.
- When processor is doing maintenance, claims should be rejected.   The recommendation is to use Reject Code (511-FB) = **96** - ***Scheduled Downtime*** however; other 9x codes could be used if the maintenance was not scheduled. The reject code lets the provider know to reprocess the claim at a later time.

7.4   PATIENT PAID AMOUNT SUBMITTED (433-DX)

7.4.1 INTENDED OR ACTUAL?

Question:

What is the official use of the Patient Paid Amount Submitted (433-DX) field? Is it supposed to be the copay from a primary/secondary payer on a secondary/tertiary claim? Or is it meant to represent cash already paid the pharmacy up front? Or something else entirely?

A processor of 3rd party claims, has been trying to use it in both 3.2 and 5.1 claims, wanting the dollar amount to represent the copay returned by the primary (or secondary) payer during a COB transaction. For example, if the claim went to the primary, with 1ØØ.ØØ AWP, 2.ØØ Fee, and 15Ø U&C, and the claim accepted response came back with an accepted cost of 1ØØ.ØØ, with the 2.ØØ fee, and a 25.ØØ copay, the processor wants that 25.ØØ in the Patient Paid Amount Submitted (433-DX) field of the secondary claim to them. Is this correct?

Response:

Patient Paid Amount Submitted (433-DX) is defined in the NCPDP Data Dictionary as, "Amount the pharmacy received from the patient for the prescription dispensed."

After many discussions about the use of this field, WG1 Telecommunication determined that this field should be used, as it is defined, not for intended payment monies, unless state or federal statute or regulation requires the reporting of the Other Payer Amount Paid (431-DV) and patient's cost share from a previous payer. It is recognized that the most appropriate solution exists in Telecommunication Standard Version 5.5 (or above).

7.4.2 IN TERTIARY CLAIM PROCESSING
Question:
I referenced both the current 5.1 Implementation Guide and the Version 5 Questions, Answers and Editorial Updates for an answer.

However, my question revolves around Tertiary COB Processing, and since there are no examples for this type of processing in any of the above-mentioned references, I am hoping that you may be able to help me.

My question is similar or a continuation of the example in the Version 5 Questions, Answers and Editorial Updates to COB scenario 1E on page 149 of the December 2004 release of this document. The scenario that I am trying to mimic is where both the Secondary and Tertiary Payers require both the Other Payer Amount Paid AND Patient Pay Amount when Government Program Requires and both Secondary and Tertiary are Government Programs.

Example 1E shows the value of field (433-DX) Patient Paid Amount Submitted that is submitted to the Secondary is based on the Primary Payment response detailed in Scenario 1B on page 142. This example shows that you would send the value of 200{ ($20.00) in the 433-DX field to the Secondary Payer. Now if there was a Third or Tertiary Payer that required you to send the 433-DX field in addition to the Secondary Payer, what value would you put into this field?

Which would you send to the Tertiary Payer in field (433-DX):
- (a) The value that the Secondary sent back in field 505-F5 in its Response?
- (b) The lowest dollar value that was sent back in field 505-F5 from either the Primary Payer or the Secondary Payer in their respective Responses?
- (c) The sum of the two values that the Primary and Secondary Payers sent back in field 505-F5 in their respective Responses?
- (d) Other?

Response:
The answer is "a). The value that the **Secondary** sent back in field 505-F5 in its Response."

The Patient Pay Amount (5Ø5-F5) from the secondary is the amount that **remains** to be paid by the patient, which triggers the billing to the tertiary payer. This amount is put into the Patient Paid Amount Submitted (433-DX) field in the tertiary claim.

7.5   PAYMENT AMOUNT BASED ON DISPENSED OR INTENDED?
Question:

Do NCPDP standards require the payment amount to be based on the amount actually dispensed, or can the intended amount be used instead?

Response:
No, the standards do not require the payer to pay either way. The determination of the whether the payer will pay based on quantity dispensed or quantity intended to be dispensed is a trading partner decision.

7.6 TRANSACTION FEE CHARGE

Question:
A processor charges a claim transaction fee per claim (is not applied to reversals). In a 1ØØ% copay or zero balance due claim scenario, the pharmacy would actually be in a negative balance after member copay is paid since they must pay the transaction fee (click fee) to the processor. The member in this instance is **not** responsible for the transaction fee and it would not be included in their copay. How could this be shown on a prescription response using the formula?

Response:
There is not a field in the Telecommunication Standard to handle this need at this time. The 835 Remittance Advice provides the ability to account for this fee. If the field is needed on a claim-by-claim basis using the NCPDP formats, the requester should submit a Data Element Request Form (DERF) for this business need.

8. COMPOUND/MULTI-INGREDIENT PROCESSING

8.1 COMPOUND EXAMPLE GUIDANCE

8.1.1 1.1 COMPOUNDED RX BILLING - TRANSACTION CODE B1

The following examples suggest segments & data elements that a processor & provider may use to help define their business rules.

In example 1.1 & 1.2, the provider submits a multi-ingredient compound claim request and the processor will respond rejecting the second ingredient of the compound.

8.1.1.1 A. BRIEF EXAMPLE

Request Segments & Data Elements

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
4Ø7-D7	PRODUCT/SERVICE ID	Ø	Default NDC for Compounds
4Ø6-D6	COMPOUND CODE	2	Compounded Rx
42Ø-DK	SUBMISSION CLARIFICATION CODE	Ø	Not specified

COMPOUND SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	1Ø	COMPOUND SEGMENT

Response Segments & Data Elements

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
112-AN	TRANSACTION RESPONSE STATUS	R	Rejected
51Ø-FA	REJECT COUNT	1	1 Reject Code follows
511-FB	REJECT CODE	7Ø	Product/Service Not Covered
546-4F	REJECT FIELD OCCURRENCE INDICATOR	2	The second ingredient in the compound is rejecting
526-FQ	ADDITIONAL MESSAGE INFORMATION		IngrØ2: Plan Exclusion

8.1.1.2 B. DETAILED EXAMPLE

This example provides further clarification of how the segments & data elements, listed in the "Brief Example", would look in a Request & a Response Transaction.

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	61ØØ66	
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	123456789Ø	
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	1997Ø92Ø	September 2Ø, 1997
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	bbbbbbbbbb	

PATIENT SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**

111-AM	SEGMENT IDENTIFICATION	Ø1	PATIENT SEGMENT

The Following Fields are Optional:

331-CX	PATIENT ID QUALIFIER	99	Other
332-CY	PATIENT ID	ØØ5492368	Patient's ID
3Ø4-C4	DATE OF BIRTH	196ØØ615	Born June 15, 1962
3Ø5-C5	PATIENT GENDER CODE	1	Male
31Ø-CA	PATIENT FIRST NAME	JOSEPH	
311-CB	PATIENT LAST NAME	SMITH	
322-CM	PATIENT STREET ADDRESS	123 MAIN STREET	
322-CN	PATIENT CITY ADDRESS	MY TOWN	
324-CO	PATIENT STATE/PROVINCE ADD	CO	
325-CP	PATIENT ZIP/POSTAL ZONE	34567	
326-CQ	PATIENT PHONE NUMBER	2Ø14658923	
333-CZ	EMPLOYER ID	XYZ123	
334-1C	SMOKER/NON-SMOKER CODE	2	Smoker

INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	123456789	Cardholder ID
3Ø3-C3	PERSON CODE	Ø2	
3Ø6-C6	PATIENT RELATIONSHIP CODE	2	

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234567	
436-E1	**PRODUCT/SERVICE ID QUALIFIER**	**ØØ**	**Default for Compounds**
4Ø7-D7	**PRODUCT/SERVICE ID**	**Ø**	**Default for Compounds**

The Following Fields are Optional:

442-E7	QUANTITY DISPENSED	3Ø	
4Ø3-D3	FILL NUMBER	ØØ	Original dispensing for Rx#
4Ø5-D5	DAYS SUPPLY	15	15 Days supply
4Ø6-D6	**COMPOUND CODE**	**2**	**Compounded Rx**
4Ø8-D8	DAW/PRODUCT SELECTION CODE	1	Substitution not allowed
414-DE	DATE PRESCRIPTION WRITTEN	1997Ø92Ø	September 2Ø, 1997
415-DF	NUMBER OF REFILLS AUTHORIZED	3	3 Refills
419-DJ	PRESCRIPTION ORIGIN CODE	1	Written prescription
42Ø-DK	SUBMISSION CLARIFICATION CODE	Ø	Not specified

PRESCRIBER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø3	Prescriber Segment
466-EZ	PRESCRIBER ID QUALIFIER	12	DEA Number
411-DB	PRESCRIBER ID	AB1234563	Assigned DEA Number

DUR/PPS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø8	DUR/PPS Segment

The Following Fields are Optional:

567-J6	DUR/PPS CODE COUNTER	*1*	1st DUR/PPS activity follows
474-8E	DUR/PPS LEVEL OF EFFORT	*12*	Low level of complexity

COMPOUND SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*1Ø*	COMPOUND SEGMENT
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	*Ø1*	Capsule
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	*1*	Each
452-EH	COMPOUND ROUTE OF ADMINISTRATION	*11*	Oral
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	*Ø5*	5 Ingredients
488-RE	COMPOUND PRODUCT ID QUALIFIER	*Ø3*	NDC
489-TE	COMPOUND PRODUCT ID	*4945227940I*	Estradiol
448-ED	COMPOUND INGREDIENT QUANTITY	*3Ø*	3Ø grams
449-EE	COMPOUND INGREDIENT DRUG COST	*6Ø{*	$6.ØØ
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	*Ø1*	AWP
488-RE	COMPOUND PRODUCT ID QUALIFIER	*Ø3*	NDC
489-TE	COMPOUND PRODUCT ID	*4945227850I*	Estradiol
448-ED	COMPOUND INGREDIENT QUANTITY	*3Ø*	3Ø grams
449-EE	COMPOUND INGREDIENT DRUG COST	*2B*	$Ø.22
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	*Ø1*	AWP
488-RE	COMPOUND PRODUCT ID QUALIFIER	*Ø3*	NDC
489-TE	COMPOUND PRODUCT ID	*4945260600I*	Progesterone
448-ED	COMPOUND INGREDIENT QUANTITY	*3Ø*	3Ø grams
449-EE	COMPOUND INGREDIENT DRUG COST	*15Ø{*	$15.ØØ
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	*Ø1*	AWP
488-RE	COMPOUND PRODUCT ID QUALIFIER	*Ø3*	NDC
489-TE	COMPOUND PRODUCT ID	*4945276500I*	Testosterone
448-ED	COMPOUND INGREDIENT QUANTITY	*3Ø*	3Ø grams
449-EE	COMPOUND INGREDIENT DRUG COST	*1E*	$Ø.15
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	*Ø1*	AWP
488-RE	COMPOUND PRODUCT ID QUALIFIER	*Ø3*	NDC
489-TE	COMPOUND PRODUCT ID	*ØØØØ224Ø8Ø4*	Gelatin Capsules
448-ED	COMPOUND INGREDIENT QUANTITY	*3Ø*	3Ø Each
449-EE	COMPOUND INGREDIENT DRUG COST	*12H*	$1.28
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	*Ø1*	AWP

PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	*226E*	$22.65
412-DC	DISPENSING FEE SUBMITTED	*25Ø{*	$2.5Ø
426-DQ	USUAL AND CUSTOMARY CHARGE	*355{*	$35.5Ø

8.1.2 1.2 COMPOUNDED RX BILLING REJECTED RESPONSE

The Rx Billing from example 1.1 is rejected. The 2nd Ingredient is not covered by the benefit plan.

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.Ø Transaction Standard
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	1997Ø92Ø	September 2Ø, 1997

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	21	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	R	Rejected

The Following Fields, though Optional, are Mandatory for Reject Response:

51Ø-FA	REJECT COUNT	1	1 Reject Code follows
511-FB	REJECT CODE	7Ø	Product/Service Not Covered
546-4F	REJECT FIELD OCCURRENCE INDICATOR	2	The second ingredient in the compound is rejecting

The Following Field is Optional:

526-FQ	ADDITIONAL MESSAGE INFORMATION		IngrØ2: Plan Exclusion

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	22	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REF NUMBER QUALIFIER	1	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REF NUMBER	1234567	

8.1.3   1.3 COMPOUNDED RX BILLING - TRANSACTION CODE B1 – WITH SUBMISSION CLARIFICATION CODE OF Ø8 = PROCESS COMPOUND FOR APPROVED INGREDIENTS

In Example 1.3 & 1.4, the provider submits a multi-ingredient compound claim request and the processor responds that it processed the transaction for the approved ingredients.

This example could be a follow-up transmission as the result of example 1.2 (a rejected claim) or as an initial stand-alone submission (a refill situation).

In the situation where the processor will adjudicate a transaction with a submission clarification code value of "Ø8" (Process Compound for Approved Ingredients); it is assumed that the provider will submit the clarification code of "Ø8" on each transaction where they are requesting payment for approved ingredients.

The providers have requested when possible that the processor return the ingredient number(s) of the non-payable ingredients in the additional message information field (526-FQ). For example, if ingredient #2 is not covered, then the following message could be returned "Clarification Code Accepted, Ing Ø2 Not Covered". If ingredient #2 & #4 are not covered then the following message could be returned "Clarification Code Accepted, Ing Ø2, IngØ4 Not Covered."

8.1.3.1 A. BRIEF EXAMPLE
Request Segments & Data Elements

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
4Ø7-D7	**PRODUCT/SERVICE ID**	*Ø*	**Default for Compounds**
4Ø6-D6	**COMPOUND CODE**	*2*	**Compounded Rx**
42Ø-DK	**SUBMISSION CLARIFICATION CODE**	*8*	**Process Compound for Approved Ingredients**

COMPOUND SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	**SEGMENT IDENTIFICATION**	*1Ø*	**COMPOUND SEGMENT**

Response Segments & Data Elements

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
112-AN	**TRANSACTION RESPONSE STATUS**	*P*	**Paid**
526-FQ	**ADDITIONAL MESSAGE INFORMATION**		**Clarification Code Accepted, Ing Ø2 Not Covered**

8.1.3.2 B. DETAILED EXAMPLE
This example provides further clarification of how the segments & data elements, listed in the "Brief Example", would look in a Request & a Response Transaction.

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	*61ØØ66*	
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*123456789Ø*	
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*1997Ø92Ø*	September 2Ø, 1997
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*bbbbbbbbbb*	

PATIENT SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø1*	PATIENT SEGMENT

The Following Fields are Optional:

331-CX	PATIENT ID QUALIFIER	*99*	Other
332-CY	PATIENT ID	*ØØ5492368*	Patient's ID
3Ø4-C4	DATE OF BIRTH	*196ØØ615*	Born June 15, 1962
3Ø5-C5	PATIENT GENDER CODE	*1*	Male
31Ø-CA	PATIENT FIRST NAME	*JOSEPH*	
311-CB	PATIENT LAST NAME	*SMITH*	
322-CM	PATIENT STREET ADDRESS	*123 MAIN STREET*	
322-CN	PATIENT CITY ADDRESS	*MY TOWN*	
324-CO	PATIENT STATE/PROVINCE ADD	*CO*	
325-CP	PATIENT ZIP/POSTAL ZONE	*34567*	
326-CQ	PATIENT PHONE NUMBER	*2Ø14658923*	
333-CZ	EMPLOYER ID	*XYZ123*	
334-1C	SMOKER/NON-SMOKER CODE	*2*	Smoker

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INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	123456789	Cardholder ID
3Ø3-C3	PERSON CODE	Ø2	
3Ø6-C6	PATIENT RELATIONSHIP CODE	2	

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REF NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION/SERVICE REF NUMBER	1234567	
436-E1	PRODUCT/SERVICE ID QUALIFIER	ØØ	Default for Compounds
4Ø7-D7	PRODUCT/SERVICE ID	Ø	Default for Compounds

The Following Fields are Optional:

442-E7	QUANTITY DISPENSED	3Ø	
4Ø3-D3	FILL NUMBER	ØØ	Original dispensing for Rx#
4Ø5-D5	DAYS SUPPLY	15	15 Days supply
4Ø6-D6	COMPOUND CODE	2	Compounded Rx
4Ø8-D8	DAW/PRODUCT SELECTION CODE	1	Substitution not allowed
414-DE	DATE PRESCRIPTION WRITTEN	1997Ø92Ø	September 2Ø, 1997
415-DF	NUMBER OF REFILLS AUTHORIZED	3	3 Refills
419-DJ	PRESCRIPTION ORIGIN CODE	1	Written prescription
42Ø-DK	**SUBMISSION CLARIFICATION CODE**	**8**	**Process Compound for Approved Ingredients**

PRESCRIBER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø3	Prescriber Segment
466-EZ	PRESCRIBER ID QUALIFIER	12	DEA Number
411-DB	PRESCRIBER ID	AB1234563	Assigned DEA Number

DUR/PPS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø8	DUR/PPS Segment

The Following Fields are Optional:

567-J6	DUR/PPS CODE COUNTER	1	1st DUR/PPS activity follows
474-8E	DUR/PPS LEVEL OF EFFORT	12	Low level of complexity

COMPOUND SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	1Ø	COMPOUND SEGMENT
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	Ø1	Capsule
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	1	Each
452-EH	COMPOUND ROUTE OF ADMINISTRATION	11	Oral
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Ø5	5 Ingredients
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3	NDC
489-TE	COMPOUND PRODUCT ID	494522794Ø1	Estradiol
448-ED	COMPOUND INGREDIENT QUANTITY	3Ø	3Ø grams

449-EE	COMPOUND INGREDIENT DRUG COST	*6Ø{*	$6.ØØ
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	*Ø1*	AWP
488-RE	**COMPOUND PRODUCT ID QUALIFIER**	*Ø3*	**NDC**
489-TE	**COMPOUND PRODUCT ID**	*494522785Ø1*	**Estradiol**
448-ED	**COMPOUND INGREDIENT QUANTITY**	*3Ø*	**3Ø grams**
449-EE	**COMPOUND INGREDIENT DRUG COST**	*2B*	**$Ø.22**
49Ø-UE	**COMPOUND INGREDIENT BASIS OF COST DETERMINATION**	*Ø1*	**AWP**
488-RE	COMPOUND PRODUCT ID QUALIFIER	*Ø3*	NDC
489-TE	COMPOUND PRODUCT ID	*49452Ø6Ø0Ø1*	Progesterone
448-ED	COMPOUND INGREDIENT QUANTITY	*3Ø*	3Ø grams
449-EE	COMPOUND INGREDIENT DRUG COST	*15Ø{*	$15.ØØ
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	*Ø1*	AWP
488-RE	COMPOUND PRODUCT ID QUALIFIER	*Ø3*	NDC
489-TE	COMPOUND PRODUCT ID	*49452765Ø01*	Testosterone
448-ED	COMPOUND INGREDIENT QUANTITY	*3Ø*	3Ø grams
449-EE	COMPOUND INGREDIENT DRUG COST	*1E*	$Ø.15
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	*Ø1*	AWP
488-RE	COMPOUND PRODUCT ID QUALIFIER	*Ø3*	NDC
489-TE	COMPOUND PRODUCT ID	*ØØØØ224Ø8Ø4*	Gelatin Capsules
448-ED	COMPOUND INGREDIENT QUANTITY	*3Ø*	3Ø Each
449-EE	COMPOUND INGREDIENT DRUG COST	*12H*	$1.28
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	*Ø1*	AWP

PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	*226E*	$22.65
412-DC	DISPENSING FEE SUBMITTED	*25Ø{*	$2.5Ø
426-DQ	USUAL AND CUSTOMARY CHARGE	*355{*	$35.5Ø

8.1.4   1.4 COMPOUNDED RX BILLING ACCEPTED RESPONSE—PAID
The Rx Billing from example 1.3 is processed for the approved ingredients.

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*199Ø92Ø*	September 2Ø, 1997

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	**TRANSACTION RESPONSE STATUS**	*P*	**Paid**

The Following Field is Optional:

526-FQ	ADDITIONAL MESSAGE INFORMATION		Clarification Code Accepted, Ing Ø2 Not Covered

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	22	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234567	

RESPONSE PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	23	RESPONSE PRICING SEGMENT

The Following Fields are Optional:

5Ø5-F5	PATIENT PAY AMOUNT	100{	$1Ø.ØØ
5Ø6-F6	INGREDIENT COST PAID	2230{	$22.3Ø
5Ø7-F7	DISPENSING FEE PAID	5Ø{	$5.ØØ
5Ø9-F9	TOTAL AMOUNT PAID	173{	$17.3Ø

8.2 COMPOUND IDENTIFIERS

8.2.1 HOW DO I ENTER AN INGREDIENT IN A COMPOUND THAT DOES NOT HAVE AN IDENTIFIER (FOR EXAMPLE WATER)?

Question:

Identifying each ingredient in a compound is important in order for the ingredients to support the sum total of the quantity.

Response:

The Compound Product ID Qualifier has many values (i.e., NDC, UPC) that should be used when possible. If not, trading partners need to agree on usage. When an ingredient does not have an identifier, it is possible to use the value of ØØ (not specified) in the qualifier and an agreed upon value for the product.

8.3 COMPOUND INGREDIENT CALCULATES TO BE LESS THAN $Ø.ØØ5

Question:

The basic question being raised in this example is if an ingredient in a compound calculates to be less than $Ø.ØØ5 cent for the dosage being prescribed, should optional field Compound Ingredient Drug Cost (449-EE) and Compound Ingredient Basis of Cost Determination (49Ø-UE) be sent for this drug in the compound segment.

For this example the compound will contain 4 ingredients:

NDC	Name	Strength	Pack Sz	Cost	Qty in Cmpd	Ext. Cost
ØØ574-Ø421-25	Hydrocortisone Acetate		25	$56.2Ø	1.5ØØ	$3.372
ØØ395-1619-64	Menthol Crystals		12Ø	$17.56	.Ø6Ø	$0.ØØ87
ØØ395-Ø467-92	Camphor Spirits Sol.		6Ø	$Ø.97	.Ø6Ø	$0.ØØØ97
6Ø432-Ø546-16	Lindane Lotion	1%	48Ø	$47.Ø6	6Ø.ØØ	$5.882

As you can see from the index above, the Camphor Spirits has an extended cost of less than $Ø.ØØ5 (actually less than $Ø.ØØ1). Should optional field 449-EE and 49Ø-UE be sent with this drug because 1) without these fields the compound segment is not recognizable by the processor or 2) the fields should be sent with zeroes in them or should they be omitted all together because 1) the fields would be zero and the Implementation Guide recommends that you truncate leading zeroes and trailing blanks or 2) the Implementation Guide states that these fields are "Optional" and not mandatory for the providers to send in any situation.

Response:
These fields should be sent, even if the Compound Ingredient Drug Cost (449-EE) rounds to zero.

8.4   COMPOUND INGREDIENT DRUG COST (449-EE)

Question:
I know that Copay-Only claims are not supposed to have a D9 (ingredient cost submitted), but the compound guidance says that D9 must be the sum of the individual compound ingredient costs in the compound segment. Am I supposed to infer from this the following?
- IF D9 (submitted ingredient cost) is not supposed to be submitted on a copay-only claim (or if sent, must equal zero),
- AND D9 must equal the sum of the compound ingredient costs in the compound segment,
- THEN a provider should not send the compound segment on a copay-only claim.

Response:
If the claim is a compound and copay only billing and the Compound Segment is submitted, Compound Ingredient Drug Cost (449-EE) could be zero or not submitted. Ingredient Cost Submitted (4Ø9-D9) will be zero.

8.5   COMPOUND INGREDIENT QUANTITY (448-ED)

Question:
How are compounded pills submitted? Compound Ingredient Quantity (448-ED) is associated with each NDC submitted in the Compound Segment. How would a PBM determine the unit of measure being used for the quantity? For example, if 2 and a half 10mg strength pills were compounded, would the quantity in the compound segment for that particular NDC be sent as 2.5 (units) or 25 (mg)?

There is a [Compound] Dispensing Unit Form Indicator (field 451-EG) associated with compounds, but this only refers to the total quantity of the total compound dispensed, not each constituent ingredient.

Response:
The Compound Ingredient Quantity (448-ED) for each ingredient is based on the Compound Product ID (489-TE) for each ingredient. In the case of using 2.5 x 10 mg tablets, the correct quantity dispensed for this ingredient would be 2.5. Eaches are eaches, milliliters are milliliters, and grams are grams. This is the simplest way. It is the same relationship as between Quantity Dispensed (442-E7) and Product/Service ID (4Ø7-D7) in a non-compound claim. There is no provision in the standard for billing 25 mg, as the question above suggests as a solution.

The Compound Dispensing Unit Form Indicator (451-EG) reflects the unit of measure for the final dispensed compound claim of Grams, Milliliters, or Eaches.

8.6   COORDINATION OF BENEFITS

Question:
NCPDP V. 5.1 permits two methods of submitting multi-ingredient compound claims. The State of XX adopted the recommended Option 1 (using the claim and compound segments) but other Third party payers have adopted the most expensive legend drug option. This causes problems for the State when attempting to process these compound drug claims as a secondary payer. What guidance is available for the State to resolve this issue and correctly process these types of pharmacy claims?

Response:
For Pharmacy to Payer: Since Version 5.1 contains multiple methods for submitting compounds, the sending entity has to adjust to which compound method each payer takes.

For Payer to Payer: We are not addressing at this time. There is a WG9 Task Group working on Payer-to-Payer situations.

8.7   DUR FOR COMPOUNDS

Processing
Question:
On compounded claims, does DUR "hit" each drug within the compound?

Response:
Yes, the standard does allow it.

8.8   HOW IS THE MOST EXPENSIVE LEGEND DRUG CALCULATED?

Question:
For compound claim processing, using Scenario A (Most expensive legend drug):
> Submit a compound entering a 2 in the Compound Code (field 4Ø6-D6).
> Submit the Product/Service ID (NDC for example) of the most expensive legend drug (field 4Ø7-D7).
> Enter the sum of all the individual quantities as Quantity Dispensed (field 442-E7).
> Enter the sum of all ingredient costs in the Ingredient Cost Submitted (field 4Ø9-D9).

How is the "most expensive legend drug calculated? Is it the cost of the pack, the cost of the per unit or the cost of the per unit multiplied by the individual quantity in the compound?
> For example:
> Sch 6 Drug A has an AWP of 21.ØØ for a pack of 5Ø (per unit = $Ø.42). The qty dispensed in the compound = 6.
>
> Ø.42 x 6 = $2.52
>
> Sch 6 Drug B has an AWP of 15.9Ø for a pack of 1ØØØ (per unit = $Ø.Ø2). The qty dispensed in the compound = 3ØØØ

Ø.Ø2 x 3ØØØ = $6Ø.ØØ

The pack cost of Drug A > Drug B
The per unit cost of Drug A > Drug B
The per unit x qty cost of Drug A < Drug B

Response:
The intent of this method of compound billing is to report the most expensive legend ingredient. The most expensive legend ingredient is determined by **multiplying the unit cost of each legend ingredient by its quantity in the compound** and reporting the most expensive legend **ingredient's** Product/Service ID (4Ø7-D7).

8.9   MULTI-INGREDIENT COMPOUNDS
8.9.1   REJECTING ONE INGREDIENT
Question:
A processor supports multi-ingredient compounds and receives a Billing transmission for a multi-ingredient compound with three (3) ingredients. One (1) ingredient is not covered. Does the processor reject the transmission? Or can the processor send back a "P" (Paid) response and in text note the ingredient not covered?

Response:
The processor must reject the Billing transmission for the multi-ingredient compound if one or more ingredients are not covered or do not meet business requirements. The processor cannot send back a "P" (Paid) response and in text note the ingredient not covered.

Although structurally the standard might support this scenario, the analysis has not been done to determine the impact on the structure and the fields in the response, for example, the amount fields.

Resubmission of the Billing with the value 8 (Process Compound for Approved Ingredients) in Submission Clarification Code (Field 42Ø-DK) will indicate the pharmacist's acceptance of payment for covered ingredients only.

The processor may support the initial submission of the Billing with the value 8 (Process Compound for Approved Ingredients) in the Submission Clarification Code (Field 42Ø-DK). If the claim meets business criteria, the processor will pay the two (2) ingredients and by process of elimination the pharmacy knows that the third ingredient is not payable. (This might be done in situations where the pharmacy knows the criteria of a benefit plan and knows ahead of time that an ingredient might be rejected.)

If the pharmacy is not sure whether all ingredients will pay and wants to know why one or more would reject, the Submission Clarification Code (Field 42Ø-DK) should not be submitted on the original Billing.

(Similarly, the processor cannot reject the Billing because of one ingredient but send information on the payment of the other two ingredients. Structurally, a Reject response does not support the Response Pricing Segment.)

8.9.2 MULTI-INGREDIENT COMPOUND AND REJECTS
Question:
How do you indicate on the initial rejected response for a multi-ingredient compound transaction which ingredients will not be paid, so the provider will understand which ingredients will be paid, if they decide to submit another transaction with a Submission Clarification Code of 8 (Process Compound For Approved Ingredients)?

Response:
In this compound question, the Missing/Invalid (M/I) reject code may not be specific enough and an appropriate drug-level reject code should be used. In other rejection situations, the M/I reject codes are specific enough.

In the NCPDP Data Dictionary dated September 1999, in Appendix F - Version 5.Ø Reject Codes for Telecommunication Standard, the chart contains a column "Field Number Possibly In Error". This column can be used as guidance for identifying the field in error. For example, Reject Code "7Ø " states that 4Ø7 (Product/Service ID) is possibly in error. Whether billing for a single ingredient or multiple ingredient, reject codes exist to further explain the rejection. Therefore reject codes that refer to similar fields in the Request Claim Segment or the Compound Segment can be used to explain the rejection.

Either of the structures below could be used. In this example, the provider submits 5 ingredients to the processor. The processor sends back 3 rejects. Two rejects are related to compound ingredients and one is not. The processor rejects ingredients three and four.

> Reject Codes related to compound ingredients:
> > Reject Code "7Ø " Product/Service Not Covered (ingredient 3)
> > > Since this claim is a multi-ingredient compound claim, there is only one claim permitted in the transmission, and the Compound Segment is present. The Product/Service Not Covered by default has to reference the Compound Product ID, which by definition is a repeating field and eligible to use the Reject Field Occurrence Indicator field. In this situation, the 'possible field in error' is the Compound Product ID (489-TE).
> > Reject Code "TE " M/I Compound Product ID (489-TE) (ingredient 4)
>
> Reject Code "56 " is not related to compound ingredient rejects, but to another error in the transaction:
> > Reject Code"56 " Non-matched Prescriber ID

> Example 1:

111-AM	SEGMENT IDENTIFICATION	21
112-AN	TRANSACTION RESPONSE STATUS	R
51Ø-FA	REJECT COUNT	3
511-FB	REJECT CODE	7Ø
546-4F	REJECT FIELD OCCURRENCE INDICATOR	3
511-FB	REJECT CODE	TE
546-4F	REJECT FIELD OCCURRENCE INDICATOR	4
511-FB	REJECT CODE	56

Or Example 2:

111-AM	SEGMENT IDENTIFICATION	21
112-AN	TRANSACTION RESPONSE STATUS	R
51Ø-FA	REJECT COUNT	3
511-FB	REJECT CODE	56
511-FB	REJECT CODE	7Ø
546-4F	REJECT FIELD OCCURRENCE INDICATOR	3
511-FB	REJECT CODE	TE
546-4F	REJECT FIELD OCCURRENCE INDICATOR	4

In Example 1, the Reject Codes related to occurrences appear first ("7Ø " and "TE ") and the Reject Code at the transaction level ("56 ") occurs last. In Example 2, the Reject Code at the transaction level ("56 ") occurs first and then any Reject Codes related to occurrences follow ("7Ø " and "TE "). Either method is permitted because parsing routines should interrogate the Reject Code, then look for the next field. If the next field is the Reject Field Occurrence Indicator, the Reject Code is pointing to a field that has a relationship to an occurrence. If the next field is not the Reject Field Occurrence Indicator, the Reject Code stands on it's own (transaction level).

8.9.3 MULTI-INGREDIENT COMPOUNDS AND DUR REJECTS
Question:
What would the rejected response look like for DUR on a multi-ingredient compound transaction, when you are trying to indicate which ingredient in the compound is causing the DUR Alert? Can you indicate that:
- Ingredient 2 matches to the 1st occurrence of DUR Alert Ingredient 3 matches to the 2nd occurrence of DUR Alert
- Ingredient 4 matches to the 3rd occurrence of DUR Alert
- In the DUR Free Text Message Indicate the Rx# of the previous transaction causing the DUR Alert

Response:
The Response DUR/PPS Segment is not set up to "point" to given reject scenarios, so it should not be interpreted as such. Example 7.7.2 in the 5.1 Imp Guide shows that you send the generic Reject Code of "88 " (DUR Reject), you reject anything else (including compound ingredients with M/I), and then the Response DUR/PPS Segment fills in what the DUR situations are. You cannot tie the DUR information syntactically to specific Reject Codes, or a specific Compound Ingredient count occurrence. A possible solution uses the DUR Free Text (544-FY). See examples below.

When the DUR information is related to prescriptions previously sent by this same pharmacy, the Prescription/Service ID, would work to provide more specific detail about the reasons for the DUR information; whereas the Product/Service ID and/or Drug Name is more helpful for a different pharmacy.

Scenario One:
DUR Rejections (Reject Code "88 ") for ingredients within a submitted compound claim can have the ingredient identified in the Reject Field Occurrence Indicator (546-4F). The following example from this guide illustrates that a HIGH DOSE alert REJECTION is applicable. The example showed Reject Code "88 " at the transaction level, which is not incorrect, but is not specific enough. By modifying the example to specifically illustrate

that another Reject Field Occurrence Indicator (546-4F) immediately after the "88 " Reject Code is permitted and refers to the "88 " Reject Code, (occurring immediately above the first 546-4F field), provides greater clarity that the DUR Reject is related to the third ingredient. The second 546-4F refers then to the "EE " code, per the original example, also referencing the 3rd ingredient. Note that even though both the "88 " and the "EE " refer to the 3rd ingredient; each reject code must have the 546-4F field to specify the ingredient number.

Compounded Rx Billing Rejected Response
Billing rejected for processor-identified DUR conflict.

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*1997Ø92Ø*	September 2Ø, 1997
RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected

The Following Fields, though Optional, are Mandatory for Reject Response:

5Ø3-F3	AUTHORIZATION NUMBER	*123456789123456789*	
51Ø-FA	REJECT COUNT	*2*	2 Reject Codes follow
511-FB	REJECT CODE	*88*	DUR reject
546-4F	REJECT FIELD OCCURRENCE INDICATOR	*3*	Ingred #3: Diphenhydramine
511-FB	REJECT CODE	*EE*	M/I Compound Ingredient Drug Cost
546-4F	REJECT FIELD OCCURRENCE INDICATOR	*3*	Ingred #3: Diphenhydramine

The Following Fields are Optional:

549-7F	HELP DESK PHONE NUMBER QUALIFIER	*3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	

RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	

RESPONSE DUR/PPS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*24*	RESPONSE DUR/PPS SEGMENT

The Following Fields are Optional:

567-J6	DUR/PPS RESPONSE CODE COUNTER	*1*	1st DUR conflict follows
439-E4	REASON FOR SERVICE CODE	*HD*	High Dose alert
532-FW	DATABASE INDICATOR	*5*	Other
544-FY	DUR FREE TEXT MESSAGE	*MAX DOSE=6/DAY*	(Up to 3Ø bytes)

This example is accurate, but does not relay a complete picture. Please continue reading.

Scenario Two:
But, even just indicating the occurrence indicator (i.e., the ingredient number) may be difficult for the pharmacist to associate these reject codes and occurrence indicators with the Response DUR/PPS Segment. For example, the Reject Field Occurrence Indicator in the above example states that the DUR Rejection was with the third ingredient. The Response DUR/PPS Segment has the applicable DUR/PPS codes as the FIRST DUR/PPS Segment loop.

Scenario Three:
DUR Alerts that are non-rejections (just a warning message via the Response DUR/PPS Segment) will not get a DUR Reject Code and therefore no DUR Reject Field Occurrence Indicator since these are not rejections. The ingredient within the compound causing the DUR message still needs to be identified for the pharmacist.

Scenario Four:
DUR problems with a newly submitted non-compound claim (lovastatin) may exist with a previously filled multi-ingredient compound claim (clarithromycin tablet in a compound that contains a vehicle and a flavoring agent—the patient cannot tolerate the manufacture's suspension product for some reason). In this case, the ingredient in the profiled compound claim has to be identified in the Response DUR/PPS Segment.

Scenario Five:
An ingredient within a submitted multiple-ingredient compound claim interacts with an ingredient in another previously submitted and paid multiple-ingredient compound claim. In this case, both ingredients (in the new and the old claims) need to be relayed to the pharmacist.

Recommendation:
1) A possible solution is to use the DUR Free Text (544-FY) field contents in the event of a DUR alert with one of the ingredients of the incoming compound claim. Insert the hard coded prefix "ING##", where '##' is replaced with the count number of the applicable ingredient, in front of the system-generated free text message. If the resultant message is longer than the 30 bytes maximum for the field, truncate trailing characters to make 30.

For example, if a high dose alert is generated with the fourth ingredient in the compound, the text field may be, "ING04 MAX DOSE = 6 UNITS/DAY" (28 characters long). If this is not a DUR Reject situation (the transaction is not rejected; no Reject Code 88 is generated or to be returned to the pharmacy), the Reject Code and Reject Field Occurrence Indicator fields do not get populated.

RESPONSE DUR/PPS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*24*	RESPONSE DUR/PPS SEGMENT

The Following Fields are Optional:

567-J6	DUR/PPS RESPONSE CODE COUNTER	*1*	1st DUR conflict follows
439-E4	REASON FOR SERVICE CODE	*HD*	High Dose alert

| 532-FW | DATABASE INDICATOR | *5* | Other |
| 544-FY | DUR FREE TEXT MESSAGE | *ING04 MAX DOSE=6/DAY* | The 4th ingredient in the compound is potentially dosed too high. |

2) If an incoming non-compound claim creates a DUR alert with a compound claim already on file, insert the hard coded prefix "CMPD:" before the system-generated free text message.   If the resultant message is longer than the 30 bytes maximum for the field, truncate trailing characters to make 30.

For example if a drug-drug interaction exists between a non-compound lovastatin claim with the first ingredient (clarithromycin tablet) in a previously submitted compound, "CMPD:CLARITHROMYCIN".

RESPONSE DUR/PPS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*24*	RESPONSE DUR/PPS SEGMENT

The Following Fields are Optional:

567-J6	DUR/PPS RESPONSE CODE COUNTER	*1*	1st DUR conflict follows
439-E4	REASON FOR SERVICE CODE	*DD*	Drug-Drug Interaction
528-FS	CLINICAL SIGNIFICANCE CODE	*1*	Severity Level 1
529-FT	OTHER PHARMACY INDICATOR	*3*	Different pharmacy
53Ø-FU	PREVIOUS DATE OF FILL	*199709Ø1*	September 1, 1997
531-FV	QUANTITY OF PREVIOUS FILL	*3Ø*	
532-FW	DATABASE INDICATOR	*5*	Other
533-FX	OTHER PRESCRIBER INDICATOR	*1*	Same prescriber
544-FY	DUR FREE TEXT MESSAGE	*CMPD: CLARITHROMYCIN TAB 5ØØMG*	The interaction is due to the Clarithromycin in a previously filled multiple ingredient compound claim.

3) If an ingredient in an incoming Multi-Ingredient Compound claim causes a DUR alert due to an ingredient in a profiled, previously-filled compound, the free text message should be "ING## W/CMPD: DRUG NAME". The ingredient number in the submitted claim is displayed first, followed by the indicator that a profiled compound claim is also involved, followed by as much of the drug name, medical condition, or whatever applicable text string as possible within the available 30 bytes.

For example, if the second ingredient (Morphine) in a submitted common compounded oral pain cocktail interacts with the 5th ingredient (Gorillicillin) in a profiled, previously submitted multiple ingredient compound claim, the following is represented:

RESPONSE DUR/PPS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*24*	RESPONSE DUR/PPS SEGMENT

The Following Fields are Optional:

567-J6	DUR/PPS RESPONSE CODE COUNTER	*1*	1st DUR conflict follows
439-E4	REASON FOR SERVICE CODE	*DD*	Drug-Drug Interaction
528-FS	CLINICAL SIGNIFICANCE CODE	*1*	Severity Level 1
529-FT	OTHER PHARMACY INDICATOR	*3*	Different pharmacy
53Ø-FU	PREVIOUS DATE OF FILL	*199709Ø1*	September 1, 1997
531-FV	QUANTITY OF PREVIOUS FILL	*3Ø*	
532-FW	DATABASE INDICATOR	*5*	Other
533-FX	OTHER PRESCRIBER INDICATOR	*1*	Same prescriber

544-FY	DUR FREE TEXT MESSAGE	*INGØ2 W/ CMPD: GORILLICILLIN*	The second ingredient in the submitted compound is in conflict with the Gorillicillin in a previously filled multiple ingredient compound claim.

Note: there is not enough room in the DUR Free Text field to adequately display information on both ingredients from each compound claim.

8.10 ONE INGREDIENT

Question:

Can the Compound Segment be submitted for one ingredient?

Response:

Yes, syntactically the standard supports one ingredient. However, a multi-ingredient compound, when it is required that each ingredient is submitted, must be one transmission containing one transaction, using the Compound Segment.

8.11 ORDER OF COMPOUND INGREDIENTS

Submitted in highest quantity order?

Question:

Should compound ingredients be put in highest usage amount order? (i.e., product A 8Ø%, product B 1Ø%, product C 1Ø%).

Response:

The order of the compound ingredients should not make any difference when submitting a claim.

8.12 PARTIAL FILL COMPOUNDS

Billing for a partial fill compound

Question:

How do I bill for a partial fill of a compound?

Response:

The partial fill of a compound may be handled the same as a partial fill of any other prescription.

8.13 PRODUCT/SERVICE ID (4Ø7-D7) AND PRODUCT/SERVICE ID QUALIFIER (436-E1) IN CLAIM SEGMENT

Question:

Should the Product/Service ID Qualifier be Ø3/NDC or is blank or ØØ/Unspecified acceptable?

When the claim is using the Compound Segment for a multi-ingredient compound and a value of all zeroes is submitted in the Product/ Service ID on the Claim Segment, what is the value of the Product/Service ID Qualifier?

Response:

The Telecommunication Standard Implementation Guide defines in section "*Compound Segment*":

"When billing for multiple ingredients, use the following Claim and Pricing Segment fields:
<u>Product/Service</u> <u>ID</u> (Field 4Ø7-D7) – defaults to zero (<u>Zero means "Ø".)</u>"

Further clarification in this section cites:
"<u>Product/Service ID Qualifier</u> (Field 436-E1) – defaults to "ØØ""

The Product/Service ID must contain a value of "Ø" and Product/Service ID Qualifier must contain a value of "ØØ" when used for multi-ingredient compounds.

8.14 QUANTITY DISPENSED (442-E7)

8.14.1 MULTI-INGREDIENT COMPOUNDS

Question:
When we submit a multi-ingredient compound, what should we put in field Quantity Dispensed (442-E7)? In the Version 7.Ø Imp Guide (and the Version 5 Editorial document) there are directions for what to do with this field when submitting the most expensive ingredient (compound scenario).

Looking at the Examples of billing with the Compound Segment, Quantity Dispensed is not the sum of the individual ingredients and when you look at the detail -- due to some ingredients being tablets and others MLs I don't know how one would be able to summarize this. But that still doesn't tell me what I should put in 442-E7.

Response:
The quantity of the final compounded product goes in this field. If you mix 1ØØ ML of one drug, with 12 tablets of another drug (you crush and mix) with yet another 5Ø ML of another drug and you put all this into 3Ø capsules---the quantity for 442-E7 would be 3Ø. What is put into the bottle that leaves with the patient is 3Ø capsules or 3Ø eaches when reporting.

The use of Quantity Dispensed (442-E7) is the quantity of the final compounded product.

8.14.2 QUANTITY DISPENSED (442-E7) AND COMPOUNDS

Question:
I'm wondering if any of you have run into this as an issue. I found this statement (below) in the Version 5 Questions document, which is causing some issues for us. I have a pharmacy whose software is hard-coded to sum the quantities for all ingredients of a compound and populate Quantity Dispensed (442-E7) with this value whenever they submit a compound using the claim segment (not the new compound segment). It causes denials for some drugs where we have quantity restrictions in place. We have instructed the pharmacy to submit only the quantity for the submitted NDC, not for all of the ingredients in the compound.

We have received pushback, with them saying "this in not consistent with the NCPDP standards", which is hard to argue with, given the statement below. Or is this just a suggestion of how one might submit a compound without using the compound segment, and that it should be decided by the involved business partners?

Do any of you remember the rationale of why the existing (3.x) quantity supply logic for compounds would change going to 5.1? I would think field Quantity Dispensed (442-E7) would only have the quantity submitted sum of all ingredients (or, total ML of solution dispensed, etc) only if the pharmacy submits the new compound segment and the

processor accepts the new compound segment, which would break down the quantity submitted by ingredient.

From the guide:
> ALTERNATE OPTION - OPTION 2 - USING THE CLAIM SEGMENT
> A Compound may also be submitted using the Claim Segment without submitting the Compound segment. Option 1 above is the recommended option. This can be accomplished by using one of the following scenarios:
> Scenario A (Most expensive legend drug):
>> Submit a compound entering a 2 in the Compound Code (field 4Ø6-D6).
>> Submit the Product/Service ID (NDC for example) of the most expensive legend drug (field 4Ø7-D7).
>> Enter the sum of all the individual quantities as Quantity Dispensed (field 442-E7).
>> Enter the sum of all ingredient costs in the Ingredient Cost Submitted (field 4Ø9-D9).
>
> Scenario B (Billing codes):
>> Using the values listed below in the Claim Segment, Product/Service ID (Field 4Ø7-D7) for submission, by trading partner agreement, of the most expensive ingredient for compound ingredient claims.

Response:
The documented way in the Alternate Option section is to use the sum of all the individual quantities. The use of the Compound Segment will resolve the issue. Historically, the pharmacy has submitted the Quantity Dispensed (field 442-E7) of the finished product. The work group believes the wording should be clarified in a future version.

8.15 REJECTING FOR NOT SUPPORTED COMPOUND OPTIONS
8.15.1 THREE METHODS; ONE METHOD SUPPORTED
Question:
What if you do not support Compounds in 5.1? How do you reject this?
Or, what if you support one recommended way and not the others. How do you reject this?

Answer:
At this time, there is not a reject code for "compounds not supported" or a reject code for each of the three methods not supported. Please see "Appendix D. Billing For Compounds" in this document for discussion of the three methods.

It is recommended that
1. If you do not support multi-ingredient compounds (the Recommended Method), the Reject Code (511-FB) to use is "M/I Compound Segment" (PF).
2. If you do not support the Alternate 2 Scenario 1 using the Claim Segment - most expensive legend - the Reject Code (511-FB) to use is M/I Compound Code (2Ø).
3. If you do not support the Alternate 2 Scenario 2 using the Claim Segment - Billing codes/legend drug - the Reject Code (511-FB) to use is M/I Product/Service ID (21).

The Message field (5Ø4-F4) and the Additional Message Information (526-FQ) fields can be used to provide additional explanation.

8.16 REVERSAL TRANSACTION

8.16.1 USE OF PRODUCT/SERVICE ID (4Ø7-D7) AND COMPOUND CODE (4Ø6-D6)

Question:

On a compound billing the Product/Service ID field (4Ø7-D7) on the Claim Segment will have a default value of zero and the NDCs for the compound ingredients will come in on the Compound Segment in the Compound Product ID field (489-TE). On a Reversal transmission, since the Compound Segment is not transmitted, what should I expect to see in the Product/Service ID field - zero or one of the compound ingredients? Also, should the Compound Code field (4Ø6-D6) be utilized in reversal processing?

Response:

The Telecommunication Implementation Guide states that the Product/Service ID "defaults to zero" on the original claim when billing a compound with multiple ingredients. Therefore, on a Reversal, the Product/Service ID must contain the same value as in the original billing. A zero "Ø" would be submitted in the Product/Service ID (4Ø7-D7) field on a Reversal.

Note that since the Product/Service ID is an alphanumeric X(19) field in Version 5, the values of "Ø", "ØØ", "ØØØ", etc are very different values. For the above situation, the value of "Ø" is submitted on the original Claim/Service Billing and on the Reversal. (In Version 3.2 the NDC Number (4Ø7-D7) was a numeric 9(11) field in which case zero (Ø) or zeroes (ØØ) (ØØØØØØ) would all mean the same thing.

The Compound Code (4Ø6-D6) field should not be submitted in the reversal process since the reversal is tying back to the original claim. The Protocol Document, when completed, will note this field as "Not Used".

9.   TRANSACTION DISCUSSION

9.1   ELIGIBILITY TRANSACTION

9.1.1 GROUP SEPARATOR

Question:

The Telecommunication Standard Implementation Guide 5.1 on page 2 it states that "A transmission consists of one or more transactions separated by group separators. With one exception, the Eligibility Verification transmission, which does not use a group separator...." This is also mentioned in the Telecommunication Standard Specification Version 5 Release 1 on page 34.

However, in the Telecommunication Standard Specifications Version 5 Release 1, on page 88 under the Eligibility Verification Response diagram, it shows a group separator in the message.

There appears to be a conflict here. Which one is correct? Does the statement in the Implementation guide apply only to the Eligibility Verification Request or to both the Request and Response?

Response:

The transmission of the Eligibility request does not have a Group Separator. The transmission of the Eligibility response does have a Group Separator, so that all response transmissions can be parsed the same way (with the Response Status Segment coming after the Group Separator). The members discussed putting the Group Separator in the Eligibility request, but determined it was extraneous since the only "transaction level" segment was the Pharmacy Provider Segment and as optional, may not be sent. The Group Separator was therefore not supported in the Eligibility Verification request.

9.2   PRIOR AUTHORIZATION TRANSACTION

9.2.1 NOTABLE CLARIFICATIONS

9.2.1.1 PRIOR AUTHORIZATION CLARIFICATIONS

Please see "Appendix C. Prior Authorization Clarifications" for important information on the use of the Prior Authorization transactions.

9.2.2 PRIOR AUTHORIZATION REQUEST ONLY TRANSACTION

9.2.2.1 RESPONSE STATUSES

Question:

If the Prior Authorization Request Only Transaction is sent and the Prior Authorization is not assigned at that time, then does the Transaction come back with a "C" Captured or an "F" Prior Authorization Deferred? What is the difference between a "C" and "F"?

Response:

"C" is used by the processor to acknowledge receipt of a request but is not making any judgment about the request at this time. "F" is used by the processor to notify the originator of a deferment of a prior authorization request. You can find additional information about deferment in section *"[Prior Authorization](#)"*.

Question:

If the Prior Authorization Request Only Transaction is sent and the Prior Authorization is not assigned at that time, then if you send a Prior Authorization Inquiry Transaction, and if then the Prior Authorization is assigned, what type of Response Status will the claim or service receive? "A" Approved? Would you then need to send a regular billed claim with the Prior Authorization Segment included?

Response:
See Section 7.3 and Section 11 in Version 5 Specification Standard. See also *Appendix C. Prior Authorization Clarifications* in this document.

9.2.3 PRIOR AUTHORIZATION REQUEST AND BILLING TRANSACTION
9.2.3.1 RESPONSE   STATUSES/PRIOR   AUTHORIZATION   NOT ASSIGNED/ASSIGNED
Question:
If the Prior Authorization Request and Billing Transaction is sent and the Prior Authorization is not assigned at that time, then does the transaction come back with a "C" Captured or an "F" Prior Authorization Deferred? What is the difference? Can a Prior Authorization be assigned if this transaction is a "C" Captured?

Response:
If the Prior Authorization is not assigned, the response could be "C" or "F". Refer to Question above answer.

Question:
If the Prior Authorization Request and Billing Transaction is sent and the Prior Authorization is not assigned at that time, then if you send a Prior Authorization Inquiry Transaction, and if then the Prior Authorization is assigned, what type of Response Status will the claim receive? "A" Approved or "P" Paid? Is it automatically billed?

Response:
If the processor's system automatically adjudicates the claim, and the claim is not rejected, a "P" Paid response is returned. Note: Some systems may require the submission of the claim in this scenario. See section 11 in Version 5 Specification Standard.

9.2.3.2 P/A REQUEST AND BILLING – PA NOT REQUIRED
Question:
If a pharmacy submits a Prior Authorization Request and Billing transaction and the processor determines that the billing part of the transaction doesn't require a prior authorization, what response should the processor return? If the processor returns a paid response, it is required to have the prior authorization assigned number and pertinent prior authorization information. If the billing didn't require a PA, how can they return the PA assigned number and pertinent information?

Response:
The Prior Authorization Request and Billing should be rejected in this scenario. For the processor to return a "P"aid response would mean the pertinent PA information is not returned (nor should it be) and this could cause confusion for the pharmacy system. Reject Code "3R " (Prior Authorization Not Required) and "85 " (Claim Not Processed) as well as any other pertinent reject codes should be considered.

9.2.3.3 P/A REQUEST AND BILLING - DEFERRED
Question:
If the processor returns a deferred response on a Prior Authorization Request and Billing transaction, is the processor required to hold the billing and process it if the prior authorization is approved?

Response:
The deferred response was requested by Medicaid agencies. Please consult the processor's provider manual for further information.

It is noted in the Version 5 Editorial document, as a revision to the Telecommunication Standard Implementation Guide, "The processor responds with an "F" (Deferred) response that includes a Prior Authorization Number-Assigned (498-PY) or an Authorization Number (5Ø3-F3). The pharmacy should consult the processor's provider manual for further information."

9.3   REBILL TRANSACTIONS (B3, C3, N3)
9.3.1   DUPLICATE PROCESSING FOR ALL REBILL TRANSACTIONS
Question:
How do you handle duplicates in the case of a Rebill?

> We received a request for clarification of a 'D' response for Rebill transactions. The request was regarding a '"B3"--Rebill (claim/service) but there are also "N3"-- Information Reporting Rebill and "C3"--Controlled Substance Reporting Rebill. Per the Implementation Guide, a duplicate check is based on same Patient, Service Provider ID, Date of Service, Product/Service Reference Number, Prescription/Service Reference Number, and Fill Number. For a reversal, the duplicate check is based on the same Service Provider ID, Date of Service, Product/Service Reference Number, Prescription/Service Reference Number, and Fill Number. All rebills have an implied reversal.

Scenario:
Transaction 1 - A claim is submitted and paid by a processor.
Transaction 2 - The same claim is sent to the processor as a Rebill to correct the Prescriber ID. The processor receives the Rebill and processes the reversal and pays the claim with the different Prescriber ID.

There is a communication-level drop and the provider does not receive the response.

Transaction 3 - The provider sends the Rebill again. The processor applies the duplicate logic and returns a "D" (Duplicate of Paid) response. So far, the process works.

Transaction 4 - The same day the provider realizes that he had entered the wrong days supply and resubmits a Rebill of the same claim but with a corrected days supply.

The processor applies the duplicate logic and returns a "D" (Duplicate of Paid) response. It appears the only way to correct the day's supply is by submitting two transactions.

Discussion:
The correction of fields not included in the duplicate check may be made using the rebill transaction. Because rebills have an implied reversal, it appears that the duplicate value responses do not apply to rebill transactions. Since the same fields are used for a duplicate check and the implied reversal exists, the same problem occurs for Information and Controlled Substance Reporting Rebills as well.

Every transaction has the chance of a communications drop, but in this case, the duplicate response is not needed for the resubmission due to a communications drop.

Response:
Therefore, based on discussions, the members determined that there is no business reason found for the duplicate responses for the rebill transactions. By having duplicate responses in rebills you take away the submitter's ability to modify a field that is not included in the duplicate field check.

The duplicate Transaction Response Status (112-AN) of "D" (Duplicate of Paid) and "Q" (Duplicate of Captured) on Claim/Service Rebill transactions (B3) are not needed.

The Transaction Response Status (112-AN) of "S" (Duplicate of Approved) and "Q" (Duplicate of Captured) for Controlled Substance Reporting Rebill transactions (C3) are not needed.

The Transaction Response Status (112-AN) of "S" (Duplicate of Approved), "Q" (Duplicate of Captured), and "D" (Duplicate of Paid) for Information Reporting Rebill transactions (N3) are not needed.

In the event that a duplicate response is returned, the claim will need to be reversed separately and then resubmitted.

9.3.2 MULTIPLE REBILL TRANSACTIONS IN A TRANSMISSION
Question:
What are the recommended guidelines for supporting multiple rebill (B3, N3, C3) transactions within a transmission?

Response:
A rebill transmission (B3) should follow a combination of the guidelines established in claim or service billing and claim or service reversals, since a rebill is a combination of a billing with an implied reversal. Reversal guidelines have been given. See section "*Claim or Service Reversal*" in the *Specifications*.
An information reporting rebill (N3) should follow a combination of the guidelines established in information reporting and information reporting reversals, since information reporting rebill is a combination of an information reporting with an implied

reversal. Reversal guidelines have been given. See section "*Information Reporting Reversal*" in the *Specifications.*

A controlled substance reporting rebill (C3) should follow a combination of the guidelines established in controlled substance reporting and controlled substance reporting reversals, since a controlled substance reporting rebill is a combination of a controlled substance reporting with an implied reversal. Reversal guidelines have been given. See section *"Controlled Substance Reporting Reversal*" in the *Specifications.*

See also "*Frequently Asked Question*" "What are the recommended guidelines for supporting multiple claim or service reversal (B2) transactions within a transmission?" for guidelines on reversals.

See sections "*Duplicate*" and "*Duplicate Processing for all Rebill Transactions*" for more information.

9.4   REVERSAL TRANSACTION

9.4.1   CLAIM OR SERVICE REVERSAL TRANSACTION (B2)

Fields Used In Reversal Transaction

Question:

In Claim or Service Reversal Transaction (B2), what is the usefulness of fields other than Provider, Rx Number, and Date of Service?

Response:

The intention of Version 5 was to allow flexibility for trading partner needs. In a Claim or Service Reversal, in addition to the mandatory Transaction Header Segment and the Claim Segment, the Patient, Insurance, DUR/PPS, and Pricing Segments are optional. These optional segments allow the trading partners to use other information for tracking a reversal of a claim or service. A processor/PBM may need a Patient ID and Qualifier to track a business need not being met today for a reversal. DUR/PPS information might be sent to a processor/PBM to explain a reversal situation.

9.4.1.1 MULTIPLE CLAIM/SERVICE REVERSAL TRANSACTIONS WITHIN A TRANSMISSION

Question:

What are the recommended guidelines for supporting multiple claim or service reversal (B2) transactions within a transmission?

Response:

The Transaction Header Segment is required, which contains the routing and identification information – BIN Number, Version/Release Number, Transaction Code, Processor Control Number, Transaction Count, Service Provider ID and Qualifier, Date of Service.

Therefore, following the rules to correctly build a multi-reversal transmission, the reversal transaction(s) in this transmission must be

- in the same format (Version/Release Number) and
- sent to the same entity (processor or PBM using the BIN Number and Processor Control Number) and
- for the same pharmacy (Service Provider ID and Qualifier) and
- for the same date (Date of Service).

Optional segments such as the Patient and Insurance segments may be supported. If a processor/PBM needs this information to process a reversal, these segments can be used. Only one Patient and only one Insurance Segment should be submitted per transmission.

If a processor/PBM does not need the Patient and Insurance segments, but the pharmacy wishes to send it, the processor/PBM should ignore the optional information.

Date of Service (4Ø1-D1) is defined as "identifies date the prescription was filled or professional service rendered". Therefore, since the date is in the Transaction Header segment that occurs once (at the transmission level), one to four transactions (at the transaction level) must be for the same date.

It is a recommended business practice that multiple claim or service reversal transactions in a transmission should be for the same patient.

The structure does support multiple claim or service reversals for the same processor/PBM, for the same pharmacy, for the same Date of Service, but for multiple patients. **However, it is recommended that a transmission containing multiple reversals for multiple patients *not* be supported.** Even though the structure supports reversals for multiple patients, the recommendation is that this not be supported.

As with all transmissions, the number of response transactions should match the number of request transactions. The processor/PBM should respond with the appropriate Transaction Response Status codes for the Transaction Count. For example if 3 reversal transactions are within a transmission (Transaction Count = 3), the processor/PBM should respond with a Transaction Count = 3 with three transaction responses, one for each reversal.

For Version 5.6 and higher, the Reject Code (511-FB) value "RV" (Multiple Reversals Per Transmission Not Supported) can be used for Claim/Service Billing Reversals, Rebill transmissions, Controlled Substance Reporting Reversals, and Information Reporting Reversals if the processor does not support multiple reversal transactions within a transmission.

For Version 5.Ø-5.5, Reject Code (511-FB) value "RV" was not yet created. Therefore, the recommendation is to use Reject Code (511-FB) values of "87" (Reversal Not Processed) and "A9" (M/I Transaction Count). The value of "PB" (Invalid Transaction Count For This Transaction Code) may also be used in conjunction with the other values.

See section "*Transaction Types*" subsection *"Claim or Service Reversal",* "*Transaction Request Diagrams*" and "*Transaction Response Diagrams*" in the *Telecommunication Specifications*. See section "*Special Considerations – Transactions, Segments, and Fields*" in the *Implementation Guide*. See section "*Segment Usage Matrices*" in the *Implementation Guide*.

9.5   SERVICE BILLING TRANSACTION

The following Example section provides guidance for using the Billing Transaction (B1) when billing a service without a medication.

9.5.1 BILLING TRANSACTION EXAMPLES
9.5.1.1 SCENARIO USING CPT CODES

Mary Simmons is a 77 year-old female who lives at home and takes seven medications on a regular basis, with doses administered at four different times throughout the day. Her four major diagnoses are diabetes, arthritis, angina and osteoporosis. Because of the complexity of her regimen, she frequently misses doses of her medication. Her daughter is especially concerned and asks the physician for assistance. The patient's physician refers Ms. Simmons to a geriatric pharmacist for evaluation and assistance.

The pharmacist sees the patient and daughter in his private office. The office visit was 45 minutes in length, with 30 minutes face-to-face. He reviews the drug regimen and recommends changes to the prescriber to simplify the regimen. He also prepares a schedule and instructions for the patient to follow to assist adherence to the regimen, and arranges for the medications to be provided in special packaging to enhance compliance.

In this example, CPT4 codes are used. As an alternative, this example could be sent as two transmissions containing one transaction for each 15 minute increment billed.

TRANSACTION HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	610066	BIN
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	123456789Ø	PCN
1Ø9-A9	TRANSACTION COUNT	2	Two occurrences
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1	NPI
2Ø1-B1	SERVICE PROVIDER ID	4563663556bbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ8Ø313	March 13, 2ØØ8
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	98765bbbbb	

PATIENT SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø1	PATIENT SEGMENT

The Following Fields are Optional:

3Ø4-C4	DATE OF BIRTH	193ØØ615	Born June 15, 193Ø
3Ø5-C5	PATIENT GENDER CODE	2	Female
31Ø-CA	PATIENT FIRST NAME	MARY	
311-CB	PATIENT LAST NAME	SIMMONS	
3Ø7-C7	PATIENT LOCATION CODE	1	Home

INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	987654321	Cardholder ID

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	2	Service Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234567	Service Reference Number
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø7	CPT4
4Ø7-D7	PRODUCT/SERVICE ID	Ø115T	15 minutes of initial visit face-

			to-face consultation

PRESCRIBER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø3	PRESCRIBER SEGMENT

The Following Fields are Optional:

466-EZ	PRESCRIBER ID QUALIFIER	Ø1	NPI
411-DB	PRESCRIBER ID	1177882556	

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

477-BE	PROFESSIONAL SERVICE FEE SUBMITTED	15Ø{	$15.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	15Ø{	$15.ØØ
43Ø-DU	GROSS AMOUNT DUE	15Ø{	$15.ØØ

CLINICAL SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	13	CLINICAL SEGMENT

The Following Fields are Optional:

491-VE	DIAGNOSIS CODE COUNT	4	Four occurrences
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1	International Classification of Diseases (ICD9)
424-DO	DIAGNOSIS CODE	25Ø.ØØ	Diabetes
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1	International Classification of Diseases (ICD9)
424-DO	DIAGNOSIS CODE	715	Arthritis
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1	International Classification of Diseases (ICD9)
424-DO	DIAGNOSIS CODE	413.9Ø	Angina
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1	International Classification of Diseases (ICD9)
424-DO	DIAGNOSIS CODE	733.ØØ	Osteoporosis

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	2	Service Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234568	Service Reference Number
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø7	CPT4
4Ø7-D7	PRODUCT/SERVICE ID	Ø117T	15 add-on minutes of face-to-face consultation

PRESCRIBER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø3	PRESCRIBER SEGMENT

The Following Fields are Optional:

466-EZ	PRESCRIBER ID QUALIFIER	Ø1	NPI
411-DB	PRESCRIBER ID	1177882556	

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

477-BE	PROFESSIONAL SERVICE FEE SUBMITTED	15Ø{	$15.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	15Ø{	$15.ØØ
43Ø-DU	GROSS AMOUNT DUE	15Ø{	$15.ØØ

CLINICAL SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	13	CLINICAL SEGMENT
The Following Fields are Optional:			
491-VE	DIAGNOSIS CODE COUNT	4	Four occurrences
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1	International Classification of Diseases (ICD9)
424-DO	DIAGNOSIS CODE	25Ø.ØØ	Diabetes
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1	International Classification of Diseases (ICD9)
424-DO	DIAGNOSIS CODE	715	Arthritis
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1	International Classification of Diseases (ICD9)
424-DO	DIAGNOSIS CODE	413.9Ø	Angina
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1	International Classification of Diseases (ICD9)
424-DO	DIAGNOSIS CODE	733.ØØ	Osteoporosis

9.5.1.1.1 PAID RESPONSE

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	2	Two occurrences
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1	NPI
2Ø1-B1	SERVICE PROVIDER ID	4563663556bbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ8Ø313	March 13, 2ØØ8

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	21	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	P	Paid
The Following Fields are Optional:			
5Ø3-F3	AUTHORIZATION NUMBER	123456789123456789	
526-FQ	ADDITIONAL MESSAGE INFORMATION		
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	6Ø2357Ø862	

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	22	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	2	Service Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234567	Service Reference Number

RESPONSE PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	23	RESPONSE PRICING SEGMENT

The Following Fields are Optional:

| 562-J1 | PROFESSIONAL SERVICE FEE PAID | *15Ø{* | $15.ØØ |
| 5Ø9-F9 | TOTAL AMOUNT PAID | *15Ø{* | $15.ØØ |

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid
The Following Fields are Optional:			
5Ø3-F3	AUTHORIZATION NUMBER	*123456789123456790*	

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*2*	Service Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234568*	Service Reference Number

RESPONSE PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT
The Following Fields are Optional:			
562-J1	PROFESSIONAL SERVICE FEE PAID	*15Ø{*	$15.ØØ
5Ø9-F9	TOTAL AMOUNT PAID	*15Ø{*	$15.ØØ

9.5.2 SCENARIO USING CPT CODES WITH DUR/PPS SEGMENT

Pearl Johnson is an 83 year-old female who is moving in to an assisted living community. During the initial assessment by the nurse, Ms. Johnson reports that she has experienced several falls in recent weeks. Fortunately, serious injury has not yet resulted. Because she takes nine regularly scheduled medications, Ms. Johnson's physician refers her to a geriatric pharmacist for a consultation.

The pharmacist interviews the patient face to face at the assisted living facility for 15 minutes and reviews the drug regimen for medications that may increase the risk of falls. The pharmacist makes recommendations to the prescriber for medication changes to decrease the risk of falls, and suggests that the patient change one of her medications to bedtime instead of morning administration.

This example uses CPT codes with the DUR/PPS Segment.

TRANSACTION HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	*61ØØ66*	BIN
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*123456789Ø*	PCN
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø1*	NPI
2Ø1-B1	SERVICE PROVIDER ID	*4563663556bbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ8Ø313*	March 13, 2ØØ8
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*98765bbbbb*	

PATIENT SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*Ø1*	PATIENT SEGMENT

The Following Fields are Optional:

3Ø4-C4	DATE OF BIRTH	1924Ø615	Born June 15, 1924
3Ø5-C5	PATIENT GENDER CODE	2	Female
31Ø-CA	PATIENT FIRST NAME	PEARL	
311-CB	PATIENT LAST NAME	JOHNSON	
3Ø7-C7	PATIENT LOCATION	5	Rest Home

INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	223345611	Cardholder ID

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	2	Service Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	2233227	Service Reference Number
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø7	CPT4
4Ø7-D7	PRODUCT/SERVICE ID	Ø115T	Initial 15 minutes

PRESCRIBER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø3	PRESCRIBER SEGMENT

The Following Fields are Optional:

466-EZ	PRESCRIBER ID QUALIFIER	Ø1	NPI
411-DB	PRESCRIBER ID	1177882556	

DUR/PPS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø8	DUR/PPS Segment

The Following Fields are Optional:

473-7E	DUR/PPS CODE COUNTER	1	1st DUR activity
439-E4	REASON FOR SERVICE CODE	PN	Prescriber consultation
44Ø-E5	PROFESSIONAL SERVICE CODE	RT	Recommend lab test
441-E6	RESULT OF SERVICE CODE	3A	Recommendation accepted
474-8E	DUR/PPS LEVEL OF EFFORT	11	Lowest level of complexity
473-7E	DUR/PPS CODE COUNTER	2	2nd DUR activity
439-E4	REASON FOR SERVICE CODE	TN	Laboratory test needed
44Ø-E5	PROFESSIONAL SERVICE CODE	PT	Perform laboratory test
441-E6	RESULT OF SERVICE CODE	3A	Recommendation accepted
474-8E	DUR/PPS LEVEL OF EFFORT	12	Service with medium complexity

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT
The Following Fields are Optional:			
477-BE	PROFESSIONAL SERVICE FEE SUBMITTED	15Ø{	$15.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	15Ø{	$15.ØØ
43Ø-DU	GROSS AMOUNT DUE	15Ø{	$15.ØØ

9.5.2.1.1 PAID RESPONSE

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1	NPI
2Ø1-B1	SERVICE PROVIDER ID	4563663556bbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ8Ø313	March 13, 2ØØ8

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	21	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	P	Paid
The Following Fields are Optional:			
5Ø3-F3	AUTHORIZATION NUMBER	123456789123456888	
526-FQ	ADDITIONAL MESSAGE INFORMATION		
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	6Ø2357Ø862	

RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	22	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	2	Service Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	2233227	Service Reference Number

RESPONSE PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	23	RESPONSE PRICING SEGMENT
The Following Fields are Optional:			
562-J1	PROFESSIONAL SERVICE FEE PAID	15Ø{	$15.ØØ
5Ø9-F9	TOTAL AMOUNT PAID	15Ø{	$15.ØØ

10. IMPLEMENTATION GUIDE

10.1 EXAMPLES

10.1.1 OPTIONAL FIELDS

Question:

In the Implementation Guide, several examples (section 7.3, 7.4, 7.7.3, 7.12.2) for Rx billing are missing the optional fields (i.e. qty dispensed, days supply) in the Claim Segment. Is this an oversight?

Response:

The omission of some "optional fields" in the Implementation Examples was intentional. We wanted to provide examples with some "optional fields" and omit other "optional fields" as would be the case in an actual implementation of the Version 5 Standard.

11. EDITORIAL CHANGES APPLICABLE TO ALL VERSION 5 IMPLEMENTATION GUIDES

11.1 CORRECTIONS

11.1.1 PRODUCT ID QUALIFIER OF "NDC"

Question:

In the Implementation Guide, whenever an NDC was used as the product ID qualifier (fields 436-E1 Product/Service ID Qualifier, 475-J9 DUR Co-Agent ID Qualifier, 552-AP Preferred Product ID Qualifier), the value in the examples is shown as Ø1 or 1. The actual value for NDC should be Ø3 per Appendix K.

Response:

You are correct in your statement. We will change this in the Implementation Guide. (The Implementation Guide Version 5.3 and forward have been updated. Please note this correction is applicable to all Version 5 Implementation Guides (Version 5.Ø and forward) as an editorial change.)

Question:

Should the Product/Service ID Qualifier in the Claim Segment in Compound examples be ØØ instead of Ø3?

Response:

That is correct. In the Implementation Guide, the examples "Compounded Rx Billing - Transaction Code B1 (Ø1)" and "Billing Resubmission w/DUR Resolution", in the Claim Segment, the Product/Service ID Qualifier (436-E1) incorrectly had a value of Ø3 (NDC). In a multi-ingredient compound claim, the Product/Service ID and Qualifier default to zeroes in the Claim Segment, per the Implementation Guide. The Compound Segment contains the actual ingredients in the Compound Product ID and Qualifier. This has been corrected in Versions 5.6 and above

11.1.2 SECTION 9 VERSION CHANGES VERSION 5.3 (PUBLISHED MAY, 2ØØØ)

In the Implementation Guide Section 9 "*Version Changes*", the bullet "Miscellaneous NDC Provider Qualifier examples corrected" has been corrected to "Miscellaneous NDC Product/Service ID Qualifier examples corrected". See above question for more information. This has been corrected in Version 5.3 through Version 5.5.

11.1.3 TOTAL AMOUNT PAID (5Ø9-F9) CORRECTION

Question:

In the Implementation Guide for the example responses in sections 7.3.1, 7.7.1, 7.8.1, 7.9.1, 7.12.1 the Total Amount Paid (field 5Ø9-F9) does not appear to be accurate based on the Pricing Formula defined in sections 4.2.9 and 8.1Ø.

Response:

Thank you for bringing this to our attention. The Implementation Guides will be updated to reflect this correction. (The Implementation Guide Version 5.3 and forward have been updated. Please note this correction is applicable to all Version 5 Implementation Guides (V5.Ø and forward) as an editorial change.)

11.1.4 TYPOGRAPHICAL CHANGES

Numerous typographical errors were found in the Implementation Guide examples. These changes have been corrected in Version 6.Ø and may be used as reference in Version 5.1, since the changes do not affect new fields or values. For ease of reference, the changes noted reference the examples in Version 5.1 Implementation Guide. See section "*Appendix A: Typographical Changes Made In Version 6.Ø*".

Question:
In the Version 5.1 Implementation Guide, Example 7.13.3 Reversal Accepted Response – Duplicate, is the Transaction Response Status of "D" correct?

Response:
No. The Transaction Response Status (112-AN) should be "S" for Duplicate of Approved. This change has been made to the Version 6 and above Implementation Guides.

11.2 ENHANCEMENTS

11.2.1 REFERENCES TO THE COMPOUND AND PRIOR AUTHORIZATION IMPLEMENTATION GUIDES

Please see the Telecommunication Implementation Guide Version 5.6 for changes that removed the references to the Compound Implementation Guide. Please see the Telecommunication Implementation Guide Version 7.Ø for the most recent clarifications to Prior Authorization transactions. (The Version 5.6 Implementation Guide incorporated the Prior Authorization Implementation Guide, which was supported in prior versions. However, Versions 7.Ø, 7.1 of the Implementation Guide contains the most complete clarifications and should be used as a reference for Prior Authorization Transactions in Version 5.1. See also Appendix C. Prior Authorization Clarifications.)

Text from prior versions of the Compound Implementation Guide and Prior Authorization Guide was incorporated into the Telecommunication Implementation document as appropriate. In the section "*Request Transaction Segments and Fields*", subsections "*DUR/PPS Segment*" and "*Compound Segment*" have incorporated the pertinent information formerly found in the Compound implementation guide.

Two new frequently asked questions related to compounds were added to the Telecommunication Implementation Guide ("How do I enter an ingredient in a compound that does not have an identifier (for example water)?" and How do I bill for a partial fill of a compound?").

Please note the membership approved a preferred method for billing multi-ingredient compound transactions. The recommended method is the billing of each ingredient using the Claim and Compound Segment.

The alternate methods include

1) Billing for the most expensive legend drug

2) Using Billing codes (999.. numbers)

11.2.2 ADDITIONAL INFORMATION ON MULTIPLE REVERSAL TRANSACTIONS IN A TRANSMISSION

In Version 5.6 Implementation Guide, verbiage for the support of multiple reversal transactions in a transmission has been added. This is to offer more clarification to the support of multiple reversals for Claim or Service Reversals, Controlled Substance Reporting Reversals, Information Reporting Reversals, and Rebill transactions.

Two frequently asked questions related to multiple reversal transactions in a transmission were added ("What are the recommended guidelines for supporting multiple claim or service reversal (B2) transactions within a transmission?" and "What are the recommended guidelines for supporting multiple rebill (B3, N3, C3) transactions within a transmission?").

See section *"Transaction Discussion"*, subsection *"Reversal Transaction"* for frequently asked questions.

11.3 NOTABLE CLARIFICATIONS

11.3.1 PRIOR AUTHORIZATION CLARIFICATIONS

Please see *"Appendix C. Prior Authorization Clarifications"* for important information on the use of the Prior Authorization transactions.

A typographical error was found in section *"Prior Authorization Number-Assigned (462-EV) in Claim Segment"*. The correct field name is Prior Authorization Number Submitted (462-EV).

Telecommunication Version 5 Questions, Answers and Editorial Updates

12. EDITORIAL CHANGES APPLICABLE TO ALL VERSION 5 DATA DICTIONARIES
12.1 CORRECTIONS
12.1.1 APPENDIX F – VERSION 5.Ø REJECT CODES FOR TELECOMMUNICATION STANDARD

The following corrections were made to the Data Dictionary:

Reject Code	Explanation	Corrected Explanation	Field Number Possibly In Error	Corrected Field Number Possibly In Error
Ø1	M/I Bin	M/I Bin Number		
Ø2	M/I Version Number	M/I Version/Release Number		
Ø5	M/I Pharmacy Number	M/I Service Provider ID		
Ø6	M/I Group Number	M/I Group ID		
Ø7	M/I Cardholder ID Number	M/I Cardholder ID		
Ø9	M/I Birth Date	M/I Date Of Birth		
29	M/I Number Refills Authorized	M/I Number of Refills Authorized		
3N	M/I Prior Authorization Number Assigned	M/I Prior Authorization Number-Assigned		
38	M/I Basis of Cost	M/I Basis Of Cost Determination		
62	Patient/Card Holder ID Name Mismatch			Change Field Possibly In Error to 3Ø2-C2 (from 32Ø)
6C	M/I Other Payer ID Qualifier			Change Field Possibly In Error to 339-6C (from 442)
EM	M/I Prescription/Service Reference Number Qualifier			Change Field Possibly In Error to 455-EM (from 445)
PC	M/I Claim Segment	M/I Request Claim Segment		
PD	M/I Clinical Segment	M/I Request Clinical Segment		
PE	M/I COB/Other Payments Segment	M/I Request Coordination of Benefits/Other Payments Segment		
PF	M/I Compound Segment	M/I Request Compound Segment		
PG	M/I Coupon Segment	M/I Request Coupon Segment		
PH	M/I DUR/PPS Segment	M/I Request DUR/PPS Segment		
PJ	M/I Insurance Segment	M/I Request Insurance Segment		
PK	M/I Patient Segment	M/I Request Patient Segment		
PM	M/I Pharmacy Provider Segment	M/I Request Pharmacy Provider Segment		
PN	M/I Prescriber Segment	M/I Request Prescriber Segment		
PP	M/I Pricing Segment	M/I Request Pricing Segment		
PR	M/I Prior Authorization Segment	M/I Request Prior Authorization Segment		
PT	M/I Workers' Compensation Segment	M/I Request Worker's Compensation Segment		

12.1.2 APPENDIX M – VERSION MODIFICATIONS – VERSION 5.2

In the Data Dictionary dated June 2ØØØ, Appendix M. Version Modifications, Version 5.2 incorrectly listed all values for Measurement Dimension and Measurement Unit as being added. For Measurement Dimension, values 18-34 were added. For Measurement Unit, values 15-27 were added. This section was also missing a chart to show the new field Patient E-Mail Address (35Ø-HN) was added. This has been corrected in future versions.

DUR Co-Agent ID
DUR Co-Agent ID (476-H6) had an incorrect Comment. The Comment said DUR Co-Agent ID was qualified by 475-9E. The Comment has been corrected to state it is qualified by 475-J9.

Product/Service ID (4Ø7-D7)

Field Product/Service ID had an incorrect Comment sentence. The qualifier for NDC cited was Ø1=NDC. This has been changed to the following: "Comments: Qualified by 'Product/Service ID Qualifier' (436-E1) If 'Product Service ID Qualifier' (436-E1) is Ø3=NDC."

Reject Code (511-FB) = EM
Appendix F Version 5 Reject Codes for Telecommunication Standard - Reject Code (511-FB) with a value of "EM" (Missing/Invalid Prescription Service Reference Number Qualifier) points to Field ID 445. It should point to Field ID 455.

Reject Code (511-FB) = EF
Appendix F Version 5 Reject Codes for Telecommunication Standard - Reject Code (511-FB) with a value of "EF" (Missing/Invalid Compound Dosage Form Description Code). Corrected the spelling of "Descriptin".

Reject Code (511-FB) = 4E
Appendix F Version 5 Reject Codes for Telecommunication Standard - Reject Code (511-FB) with a value of "4E" (Missing/Invalid Primary Care Provider Last Name) points to Field ID 57Ø. It should point to Field ID 47Ø.

Remaining Benefit Amount (514-FE)
This field had an incorrect Note statement. It read "Note: ØØØØØØØE (No benefit remaining)". This has been corrected to "Note: ØØØØØØØ{ (No benefit remaining)". (The E was replaced with { in the example.) This was corrected in the August 2004 Data Dictionary, but applies to all Data Dictionaries from September 1999 forward.

Version/Release Number (1Ø2-A2) = 51
In the Data Dictionary dated September 1999, the value 51 is missing from the list of values for the Version/Release Number. This has been corrected in future versions.

Reject Code (511-FB) = 95-98 Clarification
In the Data Dictionary dated September 1999, in Appendix F Version 5 Reject Codes for Telecommunication Standard, Reject Codes 95-98 are listed with an asterisk (*95, *96, *97, *98). The asterisk is not part of the reject code, but rather was intended to point to Appendix J – Telecommunication Phases with Flow Charts where these codes were explained further in flow charts. The missing pointer note was an editorial error. The asterisk is not to be sent with these reject codes.

13. EDITORIAL CHANGES APPLICABLE TO ALL VERSION 5 SPECIFICATIONS

13.1 CORRECTIONS

Section 8.2.2.2 Counter Fields

In Version 5.3 and 5.4 Specifications, the table in section *8.2.2.2 Counter Fields* was changed. In the table showing count and counter usage, the Diagnosis Code Count was incorrectly represented. An additional row with Diagnosis Code Qualifier was added. For a count field repetition, the Diagnosis Code Qualifier and Diagnosis Code repeat the number of times the Count specifies.

Section 1Ø.4 Diagram For Two Billing Transactions, Section 1Ø.5, And Section 1Ø.6

In Version 5.6 Specifications, section *1Ø.4 Diagram For Two Billing Transactions*, section *1Ø.5 Diagram For Three Billing Transactions,* and section 1Ø.6 *Diagram For Four Billing Transactions* incorrectly lists the Compound Segment in the second, third, and/or fourth claim/service. This was an error in the diagrams. Billing for multiple ingredients (compounds) transactions may occur only once within a transmission. Multiple ingredient (compound) transactions are limited to one transaction within a transmission.

Section 12.6 General Information For Transmission Accepted/Transaction Rejected

In Version 5.5 Specifications, section 12.6 *General Information For Transmission Accepted/Transaction Rejected Response* was slightly modified. In previous releases, the Response Insurance, Response Pricing, and Response Prior Authorization were listed as not used. This section now correctly notes the Response Pricing and Response Prior Authorization as the two segments not used. This has been modified to match the Response Segment Matrices in the Implementation Guide.

14. GENERAL QUESTIONS

14.1 DOCUMENTATION HISTORY

__Documentation Dates__

Question:

Where do I obtain publication date information of the various version/releases of the Telecommunication Standards?

Response:

On the NCPDP website, in the Members section, under Work Groups, Maintenance and Control, is a document section titled "*Standard and Dictionary Usage Matrix*". This document lists all of the NCPDP standards and implementation guides and their status and approval dates.

14.2 NO LONGER SUPPORTED FIELDS

14.2.1 PRIOR AUTHORIZATION/MEDICAL CERTIFICATION CODE AND NUMBER

Question:

Some fields are no longer supported in Version 5. If I was using one of these fields, is there an alternate field where the same data can be found, specifically Prior Authorization/Medical Certification Code and Number?

Response:

With analysis by the membership, fields that were deleted were determined to be either not used, or not used as intended and there were better alternatives. Information on deleted or renamed fields is available in the Data Dictionary.

Regarding the Prior Authorization/Medical Certification Code and Number, two new fields are to be used. Prior Authorization Type Code (461-EU) contains the values originally found in the Code of deleted field 416. Prior Authorization Number Submitted (462-EV) should be used for the Number of deleted field 416.

14.3 VERSION 5 SURVEY

__An Additional Survey?__

Question:

I thought the Version 5 surveys and the summarization of this information very useful. Does NCPDP have any plans to support another survey now that Version 5.1 is part of the HIPAA regulations?

Response:

NCPDP maintains a spreadsheet called "State of the States". WG1 Telecommunication now maintains a tab on this sheet for commercial (non-Medicaid) processors who wish to publish their intentions of Telecommunication Standard Version 5.1 and Batch 1.1. WG9 Government Programs maintains a tab on this sheet for Medicaid states that wish to publish their intentions.

14.4 WHERE DO I FIND

Please see "Appendix E. Where Do I Find" for information on where to find various subjects in the NCPDP documents.

15. MEDICARE PART D PROCESSING

15.1 INTRODUCTION

This document details information the pharmacy provider will need to know in order to process Medicare Part D claims using the Telecommunication Standard Version 5.1 for billing and expanded eligibility transactions.

15.2 BACKGROUND

In December 2ØØ3, Congress passed the Medicare Prescription Drug Benefit, Improvement and Modernization Act (MMA), allowing Medicare payment to Medicare Part D plans hereafter referred to as the Prescription Drug Plan (PDP) offering coverage beginning January 2ØØ6 of prescription drugs under the new Medicare Part D benefit. The first Notice of Proposed Rulemaking (NPRM) was August 3, 2ØØ4 and the Centers for Medicare and Medicaid Services (CMS) proposed to collect a limited set of data elements for 1ØØ percent of prescription drug claims or events from plans offering Part D coverage. Some comments received on the NPRM voiced concerns over how to track spending and sources of drug claims payments in order to effectively coordinate True Out-Of-Pocket (TrOOP) beneficiary costs. An established TrOOP threshold triggers the beneficiary's catastrophic drug coverage protection. Interested parties met over a period of several months to establish the communication flow from the point of sale for a Medicare Part D transaction to the notification to the PDP of other insurance payments.

15.3 PROCESS OVERVIEW

The transaction originating from the pharmacy provider to the PDP and the response returned from the PDP to the pharmacy provider uses the billing guidelines within the 5.1 Telecommunication Standard Implementation Guide. The response from the PDP utilizes the Message (5Ø4-F4) in the Response Message Segment and Additional Message Information (526-FQ) in the Response Status Segment to provide Other Insurance Coverage information to the pharmacy provider. This transaction route from the pharmacy provider to the PDP may be sent either through a Switch or directly to the PDP.

The Provider transmits all non-primary claims to the Switch, which routes them to the appropriate destination (Secondary, Tertiary, etc Adjudicator, Facilitator)**.** The Facilitator creates and sends reporting transactions containing Secondary, Tertiary, etc. patient's pay amount information to the Primary Adjudicator (Processor). There is a need for the PDP to know the patient's pay amount from all other payers in order to maintain accurate TrOOP totals. These reporting transactions utilize the N1, N2, and N3 transactions, Information Reporting, Information Reporting Reversal, and Information Reporting Rebill. A Facilitator not only functions as a reporter of TrOOP information to the PDP but also as the entity to respond to Eligibility Inquiries, E1 transactions.

The Eligibility transaction (E1) is used to determine patient eligibility. If a patient enrolled in Medicare Part D does not present a Medicare Part D ID card to the pharmacy provider or the pharmacy provider wants to verify coverage, this transaction can be used by the pharmacy provider to determine which plan(s) to bill and if known, in what order. The Facilitator provides this information on the E1 response to the pharmacy provider in Message (5Ø4-F4) and Additional Message Information (526-FQ).

15.4 PROCESSING RULE(S)

1) For Medicare Part D processing using Telecommunication Standard Version 5.1, only one transaction per transmission is permitted because of the need for sequencing the TrOOP updates. The TrOOP should be updated before subsequent claims are processed.

2) A standard response message was created for the B1 and E1 transaction types in order for pharmacy providers to bill the appropriate plans in the proper order for members eligible under Medicare Part D. This response is used to communicate third party billing information to the pharmacy provider. Message (5Ø4-F4) and Additional Message Information (526-FQ) fields support this messaging. Message (5Ø4-F4) is used to communicate the Primary and Additional Insurance billing information to the pharmacy provider on either a B1 response from the PDP or an E1 response from the Facilitator. Overflow messages are communicated in Additional Message Information (526-FQ) with the Brand/generic savings message first (see section "*NCPDP Batch Standards – Medicare-Related Questions*", subsection "*Differential Price and Transitional Assistance*") followed by any additional insurance information not communicated in Message (5Ø4-F4). It is necessary to specify placement of these messages in order to allow for parsing and proper display of the message. Messages are to be returned in a standard format by all PDPs and Facilitators.

3) Mandatory fields in the Eligibility Request (E1) must be used to facilitate optimal matching.

15.5 PROCESSING FLOW FOR PHARMACY PROVIDER INITIATED TRANSACTIONS

1. Transaction B1 – Primary Billing Flow

The flow of the Billing Transaction from the Pharmacy Provider may either pass through a Switch or route directly to the PDP.
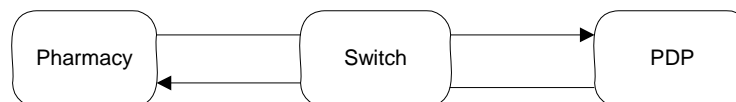
OR
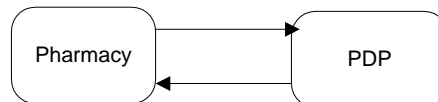
2. Transaction E1 – Eligibility

The flow of the Eligibility Transaction from the Pharmacy Provider may either pass through a Switch or route directly to the Facilitator, based on trading partner agreement.
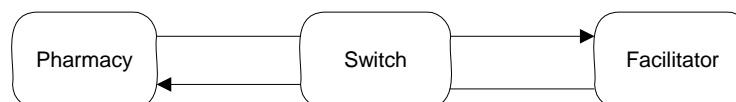
OR (based on trading partner agreement)
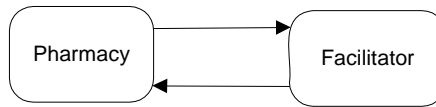
15.6 ELIGIBILITY TRANSACTION FOR MEDICARE PART D
15.6.1 FACILITATOR PROCESS FLOW FOR ELIGIBILITY

As described in the "*Process Overview*" section, the Facilitator will provide Eligibility enrollment responses to requests sent by Pharmacy Providers. This Eligibility enrollment response will be slightly different than a normal Eligibility response from a Processor. In the normal Eligibility Response, the Processor supplies Eligibility information specific to coverage provided under that Plan. In the Medicare Part D Eligibility Response, the Facilitator supplies Eligibility Enrollment information for Medicare Part D coverage and Other Health Insurance coverage via the Eligibility request by the Pharmacy Provider. CMS provides to the Facilitator eligibility enrollment data, which includes plans in which the Beneficiary is enrolled. The Facilitator supports two scenarios of the Eligibility Transactions for Medicare Part D. The two scenarios differ in:
1) The use of the Date of Service (4Ø1-D1) field and
2) The information and structure of the information returned in the Message (5Ø4-F4) and Additional Message Information (526-FQ) fields.

In Scenario 1 of the Eligibility Transaction, the Date of Service (4Ø1-D1) must be the current date that the transaction is submitted.

In Scenario 2 of the Eligibility Transaction, the Date of Service (4Ø1-D1) can be up to 9Ø days prior to or later than the current date. The Facilitator will use the search criteria to find the Part D coverage that has an Effective Date on or before the Date of Service and has a Termination Date after the Date of Service.

In both scenarios, the message fields (5Ø4-F4 and 526-FQ) contain insurance coverage information. However, in Scenario 2 these fields more clearly identify Part D and other health plan coverage and also contain patient information to help avoid mismatches.

The Facilitator uses the following fields from the Eligibility Transaction to match to the Eligibility Enrollment database provided by CMS.

- CARDHOLDER ID (3Ø2-C2) populated as any of:
  - The Health Insurance Claim Number (HICN), Part A, B, or C
  OR
  - Last 4 digits of Patient Social Security Number (SSN)
  OR
  - Entire Patient Social Security Number (SSN)
  OR
  - Railroad Retirement Board Number
- PATIENT ZIP/POSTAL ZONE (325-CP)

- PATIENT LAST NAME (311-CB)
- PATIENT FIRST NAME (31Ø-CA)
- PATIENT GENDER CODE (3Ø5-C5)
- DATE OF BIRTH (3Ø4-C4)

15.6.2 SCENARIO 1
15.6.2.1   ACCEPTED RESPONSE
- Header Response Status (5Ø1-F1) = A (Accepted transmission)
- Transaction Response Status (112-AN) = A (Eligibility Approved)
- Accepted standardized message format (see section "*Scenario 1 Eligibility Response Rules*") must begin in Message (5Ø4-F4) first
  - o Message field (5Ø4-F4) must always begin with "MEDICARE ELIG CHECK;" followed by the primary processor information and secondary processor information, if it fits in its entirety.
- A continuation of coverage information carries over into Additional Message Information (526-FQ). Refer to standardized message format in section "*Scenario 1 Eligibility Response Rules*".
- Must include the phone number of the Facilitator or the Medicare Part D Help Desk in the Help Desk Phone Number (55Ø-8F)
  - o Help Desk Phone Number Qualifier (549-7F) values:
    - ▪ Facilitator: use value 'Ø2'
    - ▪ Medicare Part D Help Desk: use value '99'

      NOTE: This phone number is **different** from the phone number in the parse-able message that is related to each individual payer. This phone number could be used to contact CMS or the Facilitator to advise them that the patient has additional coverage that is NOT currently listed via the Eligibility check or to question this additional coverage in case it SHOULD BE recognized by CMS.

15.6.2.2   REJECTED RESPONSE
- Header Response Status (5Ø1-F1) = A (Accepted transmission)
- Transaction Response Status (112-AN) = R (Eligibility Rejected)
- Rejected standardized message format (see section "*Scenario 1 Eligibility Response Rules*"") must begin in Message (5Ø4-F4)
  - o Message (5Ø4-F4) must always begin with "MEDICARE ELIG CHECK;" followed by any appropriate rejection information from the Facilitator.
  - o The information following the text "MEDICARE ELIG CHECK;" on a reject will not contain parsable information. This will be a free text message.
- If needed, overflow rejection information is to be placed in Additional Message Information (526-FQ).
- Reject Code (511-FB) must be used to provide the most appropriate rejection codes that would assist the pharmacy in correcting patient match errors (e.g. "Ø9 " M/I Date of Birth)
- Must include the phone number of the Facilitator or the Medicare Part D Help Desk in the Help Desk Phone Number (55Ø-8F)
  - o Help Desk Phone Number Qualifier (549-7F) values:
    - ▪ Facilitator: use value 'Ø2'
    - ▪ Medicare Part D Help Desk: use value '99'

NOTE: This phone number is **different** from the phone number in the parse-able message that is related to each individual payer. This phone number could be used to contact CMS or the Facilitator in order to manually obtain eligibility information or clarification on a rejected response.

15.6.3 SCENARIO 1 ELIGIBILITY RESPONSE RULES

1) Each additional individual insurance message must not be split (e.g. ADDINS:1 and ADDINS:2) between the Message (5Ø4-F4) and Additional Message Information (526-FQ) fields.

2) The data should be truncated whenever possible following NCPDP truncation rules:
- BIN value is required and must not be truncated.
- PCN value must not be truncated. Spaces must be sent if no PCN is required by plan.
- If other fields are not required by plan, field names with no data must be sent (e.g. send GP:; when no Group ID is required by plan). It is strongly recommended that the data be truncated.
- ADDINS:2 (and subsequent) must begin immediately after the "&" from the previous ADDINS information **if the data does not overflow into the Additional Message Information (526-FQ) field**. For overflow into the Additional Message Information (526-FQ) field of two or more messages, the second and subsequent messages must begin immediately after the "&" of the previous ADDINS information.

3) The Eligibility Response will begin in byte one of Message (5Ø4-F4) with:
"MEDICARE ELIG CHECK;"

4) Use of Parsing Characters is required as follows when triggered by "MEDICARE ELIG CHECK;" starting in byte one of the Message (5Ø4-F4):
- Colon ":" separates field name from value
- Semi colon ";" separates different fields
- Ampersand "&" separates different additional insurance information or denotes the end of each additional insurance information data or the end of the free text reject message

15.6.4 SCENARIO 1 EXAMPLE OF MESSAGES
KEY:
MEDICARE ELIG CHECK = Medicare Eligibility Check
ADDINS = Additional Insurance
BN = BIN
PN = Processor Control Number
GP = Group ID
ID = Cardholder ID
PC = Person Code
PH = Other Payer Help Desk Phone Number
PRIMARY = Primary Payer

15.6.4.1 EXAMPLE 1: AN ELIGIBILITY ACCEPTED WITH SINGLE PAYER
Message (5Ø4-F4)

```
MEDICARE    ELIG    CHECK;PRIMARY;BN:123456;PN:123456789Ø;GP
:123465789Ø12345;ID:123456789Ø123456789Ø;PC:ØØ1;PH:8ØØ12345
67;&
```

15.6.4.2 EXAMPLE 2: AN ELIGIBILITY ACCEPTED WITH TWO PAYERS
Message (5Ø4-F4)

```
MEDICARE    ELIG    CHECK;PRIMARY;BN:123456;PN:123456789Ø;GP
:123465789Ø12345;ID:123456789Ø123456789Ø;PC:ØØ1;PH:8ØØ12345
67;&
```

Additional Message Information (526-FQ)

```
ADDINS:1;BN:654321;PN:Ø987654321;GP:54321Ø987654321;ID:Ø9876
54321Ø987654321;PC:1ØØ;PH:8ØØ7654321;&
```

Secondary Payer information begins in Additional Message Information (526-FQ) since it cannot be added to Message (5Ø4-F4) in total and according to the Eligibility Response Rules cannot be split between fields. Field length of Message (5Ø4-F4) is 2ØØ bytes. Primary Payer information is 117 bytes and Secondary Payer information is 98 bytes as shown above.

15.6.4.3 EXAMPLE 3: AN ELIGIBILITY ACCEPTED WITH MORE THAN TWO PAYERS
Message (5Ø4-F4)

```
MEDICARE    ELIG    CHECK;PRIMARY;BN:123456;PN:123456789Ø;GP
:123465789Ø12345;ID:123456789Ø123456789Ø;PC:ØØ1;PH:8ØØ12345
67;&
```

Additional Message Information (526-FQ)

```
ADDINS:1;BN:654321;PN:Ø987654321;GP:123465789Ø12345;ID:1234
56789Ø123456789Ø;PC:ØØ1;PH:8ØØ1234567;&ADDINS:2;BN:283499;P
N:293A38BNDI;GP:COSTATE;ID:38473KJ;PC:;PH:8ØØ5553567;&
```

Continue Additional Message Information (526-FQ) with all additional insurance information known

15.6.4.4 EXAMPLE 4: REJECTED RESPONSE CONTAINS THE FOLLOWING:
Message (5Ø4-F4)

```
MEDICARE ELIG CHECK;NO SINGLE MATCH WAS FOUND;&
```

15.6.5 SCENARIO 1 ELIGIBILITY TRANSACTION EXAMPLES
15.6.5.1 ELIGIBILITY VERIFICATION – TRANSACTION CODE E1

TRANSACTION HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	123456	Facilitator BIN
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	E1	Eligibility Verification
1Ø4-A4	PROCESSOR CONTROL NUMBER	123456789Ø	Facilitator PCN
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ6Ø1Ø1	
			January 1, 2ØØ6

| 11Ø-AK | SOFTWARE VENDOR/CERTIFICATION ID | *bbbbbbbbbb* | |

PATIENT SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø1*	PATIENT SEGMENT
3Ø4-C4	DATE OF BIRTH	*19ØØ615*	Born June 16, 194Ø
3Ø5-C5	PATIENT GENDER CODE	*1*	Male
31Ø-CA	PATIENT FIRST NAME	*JOHN*	
311-CB	PATIENT LAST NAME	*DOE*	
322-CM	PATIENT STREET ADDRESS	*123 MAIN STREET*	
323-CN	PATIENT CITY ADDRESS	*MY TOWN*	
324-CO	PATIENT STATE/PROVINCE ADDRESS	*CO*	
325-CP	PATIENT ZIP/POSTAL ZONE	*34567*	Zip Code (5 digit zip)
326-CQ	PATIENT PHONE NUMBER	*2Ø15551234*	

INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø4*	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	*998877665*	The Medicare Part D ID number

15.6.5.2 ELIGIBILITY ACCEPTED RESPONSE WITH MORE THAN TWO PAYERS

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*E1*	Eligibility Verification
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ6Ø1Ø1*	January 1, 2ØØ6

The following Segment, though Optional, is required for Medicare Part D

RESPONSE MESSAGE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*2Ø*	RESPONSE STATUS SEGMENT
5Ø4-F4	MESSAGE	*MEDICARE ELIG CHECK; PRIMARY;BN:123456;PN :38272937AB;GP:12345 6;ID:123456789;PC:;P H:8ØØ1234567;&ADDINS :1;BN:283749;PN:2934 8bbbbb;GP:MDP348;ID: 3827493;PC:;PH:8ØØ12 34567;&*	Response showing three payers.

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*A*	Approved
526-FQ	ADDITIONAL MESSAGE INFORMATION	*ADDINS:2;BN:738287;P N:bbbbbbbbbb;GP:ABC; ID:335128890;PC:ØØ3;*	This is used for overflow from 5Ø4-F4.

		PH:8ØØ2937792;&	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø2	Facilitator Phone Number
55Ø-8F	HELP DESK PHONE NUMBER	4795551234	

15.6.5.3 ELIGIBILITY REJECTED RESPONSE
Eligibility response when a single match is not found.

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	E1	Eligibility Verification
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ6Ø1Ø1	January 1, 2ØØ6

The following Segment, though Optional, is required for Medicare Part D

RESPONSE MESSAGE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	2Ø	RESPONSE STATUS SEGMENT
5Ø4-F4	MESSAGE	*MEDICARE ELIG CHECK; NO SINGLE MATCH WAS FOUND;&*	Cardholder ID not matched

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	21	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	R	Rejected
51Ø-FA	REJECT COUNT	1	1 Reject Code
511-FB	REJECT CODE	Ø7	Patient Cardholder ID Mismatch
526-FQ	ADDITIONAL MESSAGE INFORMATION		This is used for overflow from 5Ø4-F4.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø2	Facilitator Phone Number
55Ø-8F	HELP DESK PHONE NUMBER	4795551234	

15.6.6 SCENARIO 2

15.6.6.1 ACCEPTED RESPONSE
- Header Response Status (5Ø1-F1) = A (Accepted transmission)
- Transaction Response Status (112-AN) = A (Eligibility Approved)
- Accepted standardized message format (see section "*Scenario 2 Eligibility Response Rules*") must begin in Message (5Ø4-F4) first
  - o Message field (5Ø4-F4) must always begin with Patient Information Section, followed by current Part D processor information, and then the first occurrence of any known Future Part D coverage.
  - o Additional Message Information (526-FQ) contains any other coverage information (COB).
- Will include the phone number of the Medicare Part D Help Desk in the Help Desk Phone Number (55Ø-8F). Help Desk Phone Number Qualifier (549-7F) will always be value '99' (Other):

> NOTE: This phone number is **different** from the phone number in the parsable message related to each individual payer. This phone number could be used to contact CMS to advise them that a patient has additional coverage NOT currently listed via the Eligibility check or to question this additional coverage in case it SHOULD BE recognized by CMS.

15.6.6.2   REJECTED RESPONSE

- Header Response Status (5Ø1-F1) = A (Accepted transmission)
- Transaction Response Status (112-AN) = R (Eligibility Rejected)
- Rejected standardized message format (see section "*Scenario 2 Eligibility Response Rules*") must begin in Message (5Ø4-F4)
  - o Message (5Ø4-F4) will contain any appropriate rejection information from the Facilitator.
  - o The information will be a free text message that does not contain parsable information.
- If it exists, overflow rejection information will be placed in Additional Message Information (526-FQ).
- The possible rejects are:
  - o More than one patient found, which uses Reject Code "62" (Patient/Cardholder ID Name Mismatch) with clarifying free text
  - o Cardholder ID matches but first 4 characters of last name do not, which uses Reject Code "62" (Patient/Cardholder ID Name Mismatch)
  - o Patient is found but no Part D coverage is active for the Date of Service (4Ø1-D1) which uses Reject Code "65" (Patient Is Not Covered)
  - o Patient not found, which uses Reject Code "52" (Non-matched Cardholder ID) with clarifying free text.
- Must include the phone number of the Medicare Part D Help Desk in the Help Desk Phone Number (55Ø-8F). Help Desk Phone Number Qualifier (549-7F) will always be value '99' (Other):

> NOTE: This phone number is **different** from the phone number in the parsable message that is related to each individual payer. This phone number could be used to contact CMS in order to manually obtain eligibility information or clarification on a rejected response.

15.6.7 SCENARIO 2 ELIGIBILITY RESPONSE RULES

An accepted Eligibility Response uses a standardized format to embed parsable data in the Message Information (5Ø4-F4) and Additional Message Information (526-FQ) text blocks. This structured information will use the format described below in "Format of Scenario 2 Accepted Response information" and will comply with the following rules:

1) Each data field within the message blocks will be fixed length (as specified in the "Format of Scenario 2 Accepted Response Information").

2) Each data value will be left-justified within its field and right-padded with blanks (*b*) as needed to fill out the specified field length.

3) To aid in readability, each data field will be preceded by a Field ID (such as GP for Group ID). A colon ":" separates the field ID from the actual data value.

4) There is no truncation. All fields will be sent padded to their full length as appropriate.

15.6.8 FORMAT OF SCENARIO 2 ACCEPTED RESPONSE INFORMATION

Message Information Block 5Ø4-F4 (Patient and Part D Plan Information)

This block contains basic patient information, current Part D Plan information, and information about the first instance of any future Part D coverage. The Data Start indicates the physical start of the actual value and the preceding 3 characters indicate the field ID. The Data Length is the actual length of the data exclusive of the data.
Key: *b*=blank

Section or Field Name	Field ID	Data Start	Data Length	Example	Comments
Patient Information Section	This section always starts the first message block (5Ø4-F4).				
Last Name	LN:	4	13	SMITH*bbbbbbbb*	
First Name	FN:	2Ø	1Ø	SAMANTHA*bb*	
Date of Birth	BD:	33	8	194ØØ515	Format: CCYYMMDD
Part D Information Section	This section is always in the first message block (5Ø4-F4). Any coverage primary and/or secondary to Part D appears in the additional message block (526-FQ).				
Level	PD:	44	1	1	Level (i.e. claim sequence), where Ø is primary, 1 is secondary, etc. (The reason for Ø of primary, 1 of secondary, etc is to mirror the ADDINS numbering scheme returning information today.)
BIN	BN:	48	6	123456	
PCN	PN:	57	1Ø	987654321Ø	
Group	GP:	7Ø	15	ABCDEFGHIJKLMNO	
Cardholder ID	ID:	88	2Ø	123456789Ø12345*bbbbb*	
Person Code	PC:	111	3	123	
Help Desk #	PH:	117	1Ø	8ØØ5551212	Format=AAAEEENNNN AAA=Area Code EEE=Exchange Code NNNN=Number
Contract ID	CD:	13Ø	6	123456	
PBP (Prescription Benefit Plan)	PB:	139	3	123	
Effective Date	ED:	145	8	2ØØ6Ø1Ø1	Format: CCYYMMDD
Termination Date	TD:	156	8	2ØØ7Ø1Ø1	Format: CCYYMMDD
CMS Low-Income Cost Sharing (LICS) Level	LC:	167	1	Y	Values: Y=Yes, N=No
Formulary ID	FI:	171	8	12345678	
Future Part D Section	This section reflects next part D coverage, if any, after current coverage. If no future coverage exists, will contain only the Field IDs followed by 8 blanks each.				
Next Medicare Part D Effective Date	FE:	182	8	2ØØ7Ø1Ø1	Format: CCYYMMDD
Next Medicare Part D Termination Date	FT:	193	8	2ØØ71231	Format: CCYYMMDD

Additional Message Information Block 526-FQ (Other Insurance Information)

This block contains information on up to two additional coverage plans that act in coordination with the Part D Plan. The Data Start indicates the physical start of the

actual value and the preceding 3 characters indicate the field ID. The Data Length is the actual length of the data exclusive of the data.

Key: *b*=blank

Section or Field Name	Field ID	Data Start	Data Length	Example	Comments
Other Health Information (first other coverage plan)	If no such plan exists, all Field IDs will still be present but the data fields will be entirely blank.				
Level	OH:	4	1	Ø	Level (i.e. claim sequence), where Ø is primary, 1 is secondary, etc.
BIN	BN:	8	6	987654	
PCN	PN:	17	1Ø	987654321Ø	
Group	GP:	3Ø	15	ONMLKJIHGFEDCBA	
Cardholder ID	ID:	48	2Ø	987654321Ø98765*bbbbb*	
Person Code	PC:	71	3	123	
Relationship Code	RC:	77	1	1	
Help Desk Number	PH:	81	1Ø	8ØØ5559999	Format=AAAEEENNNN AAA=Area Code EEE=Exchange Code NNNN=Number
Other Health Information (second other coverage plan)	If no such plan exists, all Field IDs will still be present but the data fields will be entirely blank.				
Level	OH:	94	1	2	Level (i.e. claim sequence), where Ø is primary, 1 is secondary, etc.
BIN	BN:	98	6	765432	
PCN	PN:	1Ø7	1Ø	987654321Ø	
Group	GP:	12Ø	15	ONMLKJIHGFEDCBA	
Cardholder ID	ID:	138	2Ø	987654321Ø98765*bbbbb*	
Person Code	PC:	161	3	123	
Relationship Code	RC:	167	1	1	
Help Desk Number	PH:	171	1Ø	8ØØ5559999	Format=AAAEEENNNN AAA=Area Code EEE=Exchange Code NNNN=Number

15.6.9 SCENARIO 1 EXAMPLE OF MESSAGES
15.6.9.1 EXAMPLE 1: AN ELIGIBILITY ACCEPTED WITH SINGLE PART D PAYER

Message (5Ø4-F4)
LN:SMITH*bbbbbbbbb***FN:**SAMANTHA*bb***BD:**194ØØ515**PD:**Ø**BN:**123456**PN:**987654321
Ø**GP:**ABCDEFGHIJKLMNO**ID:**123456789Ø12345*bbbbb***PC:**123**PH:**8ØØ5551212**CD:**1
23456**PB:**123**ED:**2ØØ6Ø1Ø1**TD:**2ØØ7Ø1Ø1**LC:**Y**FI:**12345678**FE:***bbbbbbbb***FT:***bbb
bbbbb*

Additional Message (526-FQ)
OH:*b***BN:***bbbbbb***PN:***bbbbbbbbbb***GP:***bbbbbbbbbbbbbbb***ID:***bbbbbbbbbbbbbbbbbbbb
bb***PC:***bbb***RC:***b***PH:***bbbbbbbbbb***OH:***b***BN:***bbbbbb***PN:***bbbbbbbbbb***GP:***bbbbbbbbbbb
bbbb***ID:***bbbbbbbbbbbbbbbbbbbb***PC:***bbb***RC:***b***PH:***bbbbbbbbbb*

15.6.9.2 EXAMPLE 2: AN ELIGIBILITY ACCEPTED WITH PRIMARY PART D AND SECONDARY OTHER

Message (5Ø4-F4)
LN:SMITH*bbbbbbbbb***FN:**SAMANTHA*bb***BD:**194ØØ515**PD:**Ø**BN:**123456**PN:**987654321Ø**GP:**ABCDEFGHIJKLMNO**ID:**123456789Ø12345*bbbbb***PC:**123**PH:**8ØØ5551212**CD:**123456**PB:**123**ED:**2ØØ6Ø1Ø1**TD:**2ØØ7Ø1Ø1**LC:**Y**FI:**12345678**FE:***bbbbbbbb***FT:***bbbbbbbb*

Additional Message Information (526-FQ)
OH:1**BN:**987654**PN:**987654321Ø**GP:**ONMLKJIHGFEDCBA**ID:**987654321Ø98765*bbbbb***PC:**123**RC:**1**PH:**8ØØ5559999**OH:***b***BN:***bbbbbb***PN:***bbbbbbbbbb***GP:***bbbbbbbbbbbbbbb***ID:***bbbbbbbbbbbbbbbbbbbb***PC:***bbb***RC:***b***PH:***bbbbbbbbbb*

15.6.9.3 EXAMPLE 3: AN ELIGIBILITY ACCEPTED WITH PRIMARY OTHER HEALTH INSURANCE, SECONDARY CURRENT PART D, AND FUTURE PART D

Message (5Ø4-F4)
LN:SMITH*bbbbbbbbb***FN:**SAMANTHA*bb***BD:**194ØØ515**PD:**1**BN:**123456**PN:**987654321Ø**GP:**ABCDEFGHIJKLMNO**ID:**123456789Ø12345*bbbbb***PC:**123**PH:**8ØØ5551212**CD:**123456**PB:**123**ED:**2ØØ6Ø1Ø1**TD:**2ØØ7Ø1Ø1**LC:**N**FI:**12345678**FE:**2ØØ7Ø1Ø1**FT:**2ØØ8Ø1Ø1

Additional Message Information (526-FQ)
OH:Ø**BN:**987654**PN:**987654321Ø**GP:**ONMLKJIHGFEDCBA**ID:**987654321Ø98765*bbbbb***PC:**123**RC:**1**PH:**8ØØ5559999**OH:***b***BN:***bbbbbb***PN:***bbbbbbbbbb***GP:***bbbbbbbbbbbbbbb***ID:***bbbbbbbbbbbbbbbbbbbb***PC:***bbb***RC:***b***PH:***bbbbbbbbbb*

15.6.9.4 EXAMPLE 4: AN ELIGIBILITY ACCEPTED WITH PRIMARY PART D, SECONDARY OTHER HEALTH INSURANCE, AND TERTIARY OTHER HEALTH INSURANCE

Message (5Ø4-F4)
Note the PCN for the Part D does not exist.
LN:SMITH*bbbbbbbbb*FN:SAMANTHA*bb***BD:**194ØØ515**PD:**Ø**BN:**123456**PN:***bbbbbbbbbb***GP:**ABCDEFGHIJKLMNO**ID:**123456789Ø12345*bbbbb***P**C:123PH:8ØØ5551212CD:123456PB:123ED:2ØØ6Ø1Ø1TD:2ØØ7Ø1Ø1LC:Y**FI:12345678FE:***bbbbbbbb***FT:***bbbbbbbb*

Additional Message Information (526-FQ)
OH:1**BN:**987654**PN:**987654321Ø**GP:**ONMLKJIHGFEDCBA**ID:**987654321Ø98765*bbbbb***PC:**123**RC:**1**PH:**8ØØ5559999**OH:**2**BN:**876543**PN:**87654321Ø1**GP:**NMLKJIHGFEDCBAZ**ID:**87654321Ø987654321Ø9**PC:**231**RC:**2**PH:**8ØØ5558888

15.6.9.5 EXAMPLE 5: AN ELIGIBILITY REJECTED RESPONSE RESULTING FROM DUPLICATE MATCHES

Message (5Ø4-F4)
MORE THAN ONE PATIENT FOUND. THE FOLLOWING FIELDS COULD CAUSE A UNIQUE MATCH:

NOTE: The Facilitator may add text after the colon indicating which field or fields may assist in providing a unique match.

- o This reject will be accompanied by Reject Code (511-FB) of "62" (Patient/Cardholder ID Name Mismatch)

15.6.9.6 EXAMPLE 6: AN ELIGIBILITY REJECTED RESPONSE RESULTING FROM CARDHOLDER ID MATCHING BUT FIRST 4 CHARACTERS OF LAST NAME NOT MATCHING

Message (5Ø4-F4)
```
PATIENT NOT FOUND-CARDHOLDER ID MATCHED BUT LAST NAME DID
NOT
```
- o This reject will be accompanied by Reject Code (511-FB) of Reject Code "62" (Patient/Cardholder ID Name Mismatch)

15.6.9.7 EXAMPLE 7: AN ELIGIBILITY REJECTED RESPONSE RESULTING FROM INABILITY TO MATCH THE REQUEST DATA TO THE DATABASE

Message (5Ø4-F4)
```
NO PATIENT MATCH FOUND
```

NOTE: The Facilitator may add text to clarify matching criteria.

- o This reject will be accompanied by Reject Code (511-FB) set to "52" (Non-matched Cardholder ID)

15.6.9.8 EXAMPLE 8: AN ELIGIBILITY REJECTED RESPONSE RESULTING FROM A FOUND PATIENT NOT HAVING ACTIVE PART D COVERAGE ON THE DATE OF SERVICE SUBMITTED BUT SUBSEQUENT COVERAGE EXISTS

Message (5Ø4-F4)
```
PATIENT FOUND BUT PART D COVERAGE OUTSIDE SUBMITTED DATE OF
SERVICE
```
- o This reject will be accompanied by Reject Code (511-FB) set to "65" (Patient Not Covered).

15.6.9.9 EXAMPLE 9: AN ELIGIBILITY REJECTED RESPONSE RESULTING FROM A FOUND PATIENT NOT HAVING ACTIVE PART D COVERAGE ON THE DATE OF SERVICE SUBMITTED AND NO SUBSEQUENT COVERAGE EXISTS

Message (5Ø4-F4)
```
PATIENT FOUND BUT PART D COVERAGE OUTSIDE SUBMITTED DATE OF
SERVICE
```
- o This reject will be accompanied by Reject Code (511-FB) set to "65 " (Patient Not Covered).

15.6.10 SCENARIO 2 ELIGIBILITY TRANSACTION EXAMPLES

15.6.10.1   ELIGIBILITY VERIFICATION – TRANSACTION CODE E1

Date of Service is the current date.

TRANSACTION HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	Ø11727	Facilitator BIN
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	E1	Eligibility Verification
1Ø4-A4	PROCESSOR CONTROL NUMBER	2222222222	Facilitator PCN
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ6Ø3Ø1	March 1, 2ØØ6
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	bbbbbbbbbb	

PATIENT SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø1	PATIENT SEGMENT
3Ø4-C4	DATE OF BIRTH	194ØØ615	Born June 16, 194Ø
3Ø5-C5	PATIENT GENDER CODE	1	Male
31Ø-CA	PATIENT FIRST NAME	JOHN	
311-CB	PATIENT LAST NAME	DOE	
322-CM	PATIENT STREET ADDRESS	123 MAIN STREET	
323-CN	PATIENT CITY ADDRESS	MY TOWN	
324-CO	PATIENT STATE/PROVINCE ADDRESS	CO	
325-CP	PATIENT ZIP/POSTAL ZONE	34567	
326-CQ	PATIENT PHONE NUMBER	2Ø15551234	

INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	998877665	The HICN (Health Insurance Claim Number, Part A, B, or C)

15.6.10.2   ELIGIBILITY ACCEPTED RESPONSE WITH TWO PAYERS

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	E1	Eligibility Verification
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ6Ø3Ø1	March 1, 2ØØ6

RESPONSE MESSAGE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	2Ø	RESPONSE STATUS SEGMENT
5Ø4-F4	MESSAGE	LN:DOEbbbbbbbbbbbFN:JOHNbbbbbbbBD:194ØØ615PD:ØBN:123456PN:987654321ØGP:ABC	Medicare Part D as the primary payer.

| | | *DEFGHIJKLMNOID:123 456789Ø123456789ØP C:123PH:8ØØ5551212 CD:123456PB:123ED: 2ØØ6Ø1Ø1TD:2ØØ7Ø1Ø 1LC:YFI:12345678FE :bbbbbbbbFT:bbbbbb bb* | |

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*A*	Approved
526-FQ	ADDITIONAL MESSAGE INFORMATION	*OH:1BN:987654PN:98 76543210GP:ONMLKJI HGFEDCBAID:9876543 210987654321ØPC:12 3RC:1PH:8ØØ5559999 OH:bBN:bbbbbbPN:bb bbbbbbbbGP:bbbbbbb bbbbbbbbbID:bbbbbbb bbbbbbbbbbbbbPC:bb bRC:bPH:bbbbbbbbbb*	This is used to show additional payer(s).
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*99*	Medicare Phone Number
55Ø-8F	HELP DESK PHONE NUMBER	*8ØØ6334227*	

15.6.10.3   ELIGIBILITY REJECTED RESPONSE
Eligibility response when a match is not found.

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*E1*	Eligibility Verification
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ6Ø3Ø1*	March 1, 2ØØ6

RESPONSE MESSAGE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*2Ø*	RESPONSE STATUS SEGMENT
5Ø4-F4	MESSAGE	*NO PATIENT MATCH FOUND*	The Facilitator may add text to clarify matching criteria.

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected
51Ø-FA	REJECT COUNT	*1*	1 Reject Code
511-FB	REJECT CODE	*52*	Non-matched Cardholder ID

526-FQ	ADDITIONAL MESSAGE INFORMATION		This is used for overflow from 5Ø4-F4.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*99*	Medicare Phone Number
55Ø-8F	HELP DESK PHONE NUMBER	*8ØØ6334227*	

15.6.10.4 ELIGIBILITY REJECTED RESPONSE

Eligibility response when a match is found, there is no Medicare Part D coverage on Date of Service submitted. Subsequent Part D coverage may or may not exist.

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*E1*	Eligibility Verification
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ6Ø3Ø1*	March 1, 2ØØ6

RESPONSE MESSAGE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*2Ø*	RESPONSE STATUS SEGMENT
5Ø4-F4	MESSAGE	PATIENT FOUND BUT PART D COVERAGE OUTSIDE SUBMITTED DATE OF SERVICE	

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected
51Ø-FA	REJECT COUNT	*1*	1 Reject Code
511-FB	REJECT CODE	*65*	Patient Not Covered
526-FQ	ADDITIONAL MESSAGE INFORMATION		This is used for overflow from 5Ø4-F4.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*99*	Medicare Phone Number
55Ø-8F	HELP DESK PHONE NUMBER	*8ØØ6334227*	

15.6.10.5 ELIGIBILITY REJECTED RESPONSE

Eligibility response when more than one patient found.

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*E1*	Eligibility Verification
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ6Ø3Ø1*	March 1, 2ØØ6

RESPONSE MESSAGE SEGMENT			

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*2Ø*	RESPONSE STATUS SEGMENT
5Ø4-F4	MESSAGE	*MORE THAN ONE PATIENT FOUND. THE FOLLOWING FIELDS COULD CAUSE A UNIQUE MATCH:*	The Facilitator may add text after the colon indicating which field or fields may assist in providing a unique match.

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected
51Ø-FA	REJECT COUNT	*1*	1 Reject Code
511-FB	REJECT CODE	*62*	Patient/Cardholder ID Name Mismatch
526-FQ	ADDITIONAL MESSAGE INFORMATION		This is used for overflow from 5Ø4-F4.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*99*	Medicare Phone Number
55Ø-8F	HELP DESK PHONE NUMBER	*8ØØ6334227*	

15.7 BILLING TRANSACTION (B1) RESPONSE

15.7.1 BILLING RESPONSE RULES

1) For Medicare Part D processing using Telecommunication Standard Version 5.1, only one transaction per transmission is permitted because:

- There is a need for the sequencing of the TrOOP update before the next claim is processed. The TrOOP should be updated before subsequent claims are processed.
- The Fields, Message (5Ø4-F4) and Additional Message Information (526-FQ) are used to support the secondary/tertiary additional information from the Prescription Drug Plan (PDP). Message (5Ø4-F4) is in the Header Segment and Additional Message Information (526-FQ) is in the Response Message Segment. Since part of the information is at the transmission level (header) and part of the information is at the transaction level, allowing for more than one transaction per transmission would cause a mismatch of data contained in field Message (5Ø4-F4) and Additional Message Information (526-FQ) to exist. As an additional note, new fields were incorporated in Telecommunication Standard Implementation Guide Version C.1 and above for this use.
- The additional insurance message must be displayed in field Message (5Ø4-F4) and overflow information must appear in field Additional Message Information (526-FQ) after the brand/generic processor messages (which are described in section "*NCPDP Batch Standards – Medicare-Related Questions*", subsection "*Differential Price and Transitional Assistance*").

2) Each additional individual insurance message must not be split (e.g. ADDINS:1 or ADDINS:2) between the Message (5Ø4-F4) and Additional Message Information (526-FQ) fields.

3) The data should be truncated whenever possible following NCPDP truncation rules:
- BIN value is required and must not be truncated.
- PCN value must not be truncated. Spaces must be sent if no PCN is required by the plan.

- If other fields are not required by the plan, field names with no data must be sent (e.g. send GP:; when no Group ID is required by the plan). It is strongly recommended that the data be truncated.
- ADDINS:2 (and subsequent) must begin immediately after the "&" from the previous ADDINS information if the data does not overflow into the Additional Message Information (526-FQ) field. For overflow into the Additional Message Information (526-FQ) field of two or more messages, the second and subsequent messages must begin immediately after the "&" of the previous ADDINS information.

4) Use of Parsing Characters is required as follows when triggered by "PRIMARY;" or "ADDINS:1;" starting in byte one of the Message (5Ø4-F4):
- Colon ":" separates field name from value
- Semi colon ";" separates different fields
- Ampersand "&" separates different additional insurance information or denotes the end of each additional insurance information data

5) Placement of any other information that the Processor sends:
- On a PAID response must appear AFTER additional insurance information, beginning in the next available byte of Additional Message Information (526-FQ). The brand/generic savings information will appear first only when the Brand/Generic Savings Amount is greater than zero. In this case the Tag ("CMS") will appear in bytes 1-4 (byte 4 being a space); the Brand/Generic Message will appear in bytes 5-4Ø (byte 4Ø being a space); the Dollar Amount will appear in bytes 41-5Ø (byte 5Ø being a space). The ADDINS information will appear beginning with byte 51. Any remaining processor messaging will appear after the last ADDINS message.
- On a REJECTED response must appear AFTER additional insurance information beginning in the next available byte of Additional Message Information (526-FQ).
- On either a PAID or REJECTED response, if there is no additional insurance information sent, processor messaging will appear in either Message (5Ø4-F4) or Additional Message Information (526-FQ) according to the rules of the standard.

6) Placement of further clarifying Medicare errors the Processor sends:

Due to HIPAA constraints, new Reject Code (511-FB) values cannot be used in the Telecommunication Standard Version 5.1. However, with the advent of the Medicare Part D program, there is a need to clarify reject situations. The use of free text was examined, but with the Additional Insurance information, Brand/Generic Copay information, and processor specific messages, the Message (5Ø4-F4) and Additional Message Information (526-FQ) fields can rapidly be exhausted. The task group determined a codified structure solution allows more flexibility as more clarifying reject situations are recognized. The codified values are the actual Reject Codes going forward in a future version of the External Code List.

- On a REJECTED response after all the above rules have been applied, the Processor may return structured reject codes that further clarify Medicare responses.
- The string is &ECL;RC:### ;RC:### ;RC:### ;&
  - Where ECL is the tag for this section.
  - Where RC is the tag for the field Reject Code.
  - Where ### is the actual Reject Code (511-FB) *value* assigned.

- o The actual Reject Code is **up to three characters** in length.
- o There may be as many Reject Codes as fit or are needed to further explain. (The example string above shows three RC, but there may be as few as one RC or as many as fit in the space available or are needed to explain further.)
- Use of Parsing Characters is required as follows when triggered by "ECL;"
  - o Colon ":" separates field name from value
  - o Semi colon ";" separates different fields
  - o Ampersand "&" denotes the beginning **and** end of the structured reject code information data
- The &ECL;RC:### ;RC:### ;RC:### ;& construction cannot be split. It must appear in its entirety in either field Message (5Ø4-F4) or Additional Message Information (526-FQ).
- The structured reject codes must appear after all other reject messages, including processor specific messages.
- The use of the structured reject codes is to augment the explanation of the current Reject Codes (511-FB). Processors must continue to use the Reject Codes (e.g. as code 41: Submit Bill to Other Processor or Primary Payer, or code 7Ø Product/Service Not Covered) for items that are not covered under Medicare Part D, but the structured reject codes provide for more information until they can be used as true Reject Codes in 511-FB in a later version of the Telecommunication Standard named under HIPAA.

15.7.2 EXAMPLE OF MESSAGES
KEY:
ADDINS = Additional Insurance
BN = BIN
PN = Processor Control Number
GP = Group ID
ID = Cardholder ID
PC = Person Code
PH = Other Payer Help Desk Phone Number
PRIMARY = Primary Payer

15.7.2.1   EXAMPLE 1: A PDP RESPONSE ON A PAID CLAIM WHERE THE RECIPIENT HAS ONE ADDITIONAL INSURANCE PLAN

Message (5Ø4-F4)
```
ADDINS:1;BN:123456;PN:123456789Ø;GP:123456789Ø12345;ID:1234
56789Ø123456789Ø;PC:ØØ1;PH:8ØØ1234567;&
```

Maximum message length for each ADDINS message is 98-bytes. If additional insurance is listed on the patient record, ADDINS message could be repeated. However, each individual ADDINS message must not be split between fields. For example, if ADDINS:1, ADDINS:2, and ADDINS:3 could not fit in Message (5Ø4-F4), ADDINS:1 and ADDINS:2 must be in field 5Ø4-F4 in its entirety and ADDINS:3 must be in the Additional Message Information field (526-FQ), after other processor message (Brand/Generic differential).

15.7.2.2   EXAMPLE 2: A PDP RESPONSE ON A PAID CLAIM WHERE THE RECIPIENT HAS TWO ADDITIONAL INSURANCE PLANS AND BRAND/GENERIC INFORMATION OCCURRENCE

Message (5Ø4-F4)
```
ADDINS:1;BN:123456;PN:123456789Ø;GP:123465789Ø12345;ID:1234
56789Ø123456789Ø;PC:ØØ1;PH:8ØØ1234567;&ADDINS:2;BN:654321;P
N:Ø987654321;GP:54321Ø987654321;ID:Ø987654321Ø987654321;PC:
1ØØ;PH:8ØØ7654321;&
```
Additional Message Information (526-FQ)
```
CMS ESTIMATED BRAND/GENERIC DIFFERENCE: ØØØØ22.55
```

15.7.2.3   EXAMPLE 3: A PDP RESPONSE ON A PAID CLAIM WHERE THE RECIPIENT HAS THREE ADDITIONAL INSURANCE PLANS AND BRAND/GENERIC INFORMATION OCCURRENCE

Message (5Ø4-F4)
```
ADDINS:1;BN:123456;PN:123456789Ø;GP:123465789Ø12345;ID:1234
56789Ø123456789Ø;PC:ØØ1;PH:8ØØ1234567;&ADDINS:2;BN:654321;P
N:Ø987654321;GP:54321Ø987654321;ID:Ø987654321Ø987654321;PC:
1ØØ;PH:8ØØ7654321;&
```
Additional Message Information (526-FQ)
```
CMS ESTIMATED BRAND/GENERIC DIFFERENCE: ØØØØ22.55 ADDINS:3
;BN:283499;PN:293A38BNDI;GP:COSTATE;ID:38473KJ;PC:;PH:8ØØ55
53567;&
```

15.7.2.4   EXAMPLE 4: A PDP RESPONSE ON A PAID CLAIM WHERE THE RECIPIENT HAS THREE ADDITIONAL INSURANCE PLANS AND NO BRAND/GENERIC DIFFERENCE

Message (5Ø4-F4)
```
ADDINS:1;BN:123456;PN:123456789Ø;GP:123465789Ø12345;ID:1234
56789Ø123456789Ø;PC:ØØ1;PH:8ØØ1234567;&ADDINS:2;BN:654321;P
N:Ø987654321;GP:54321Ø987654321;ID:Ø987654321Ø987654321;PC:
1ØØ;PH:8ØØ7654321;&
```
Additional Message Information (526-FQ)
```
ADDINS:3;BN:283499;PN:293A38BNDI;GP:COSTATE;ID:38473KJ;PC:;
PH:8ØØ5553567;&
```

15.7.2.5   EXAMPLE 5: A PDP REJECTS THE CLAIM BECAUSE THEY SHOULD BE BILLED AS A SUPPLEMENTAL PAYER

Reject with code 41: Submit Bill to Other Processor or Primary Payer
The following additional insurance information must be sent when the information is available. In this example Medicare is the Secondary Payer (ADDINS:1). Note, other processor-specified reject messages come after additional insurance information.

Message (5Ø4-F4)

```
PRIMARY;BN:123456;PN:123456789Ø;GP:123465789Ø12345;ID:12345
6789Ø123456789Ø;PC:ØØ1;PH:8ØØ1234567;&ADDINS:1;BN:654321;PN
:Ø987654321;GP:54321Ø987654321;ID:Ø987654321Ø987654321;PC:1Ø
Ø;PH:8ØØ7654321;&
```
Additional Message Information (526-FQ)

PROCESSOR SPECIFIC REJECT MESSAGES WOULD BEGIN HERE

15.7.2.6   EXAMPLE 6: A PDP REJECTS THE CLAIM BECAUSE THEY SHOULD BE BILLED AS A SUPPLEMENTAL PAYER WITH STRUCTURED REJECT CODES

Reject with code 41: Submit Bill to Other Processor or Primary Payer
The following additional insurance information must be sent when the information is available. In this example Medicare is the Secondary Payer (ADDINS:1). Note, other processor-specified reject messages come after additional insurance information. Structured Reject Codes follow (example only).

Message (5Ø4-F4)
```
PRIMARY;BN:123456;PN:123456789Ø;GP:123465789Ø12345;ID:12345
6789Ø123456789Ø;PC:ØØ1;PH:8ØØ1234567;&ADDINS:1;BN:654321;PN
:Ø987654321;GP:54321Ø987654321;ID:Ø987654321Ø987654321;PC:1Ø
Ø;PH:8ØØ7654321;&
```
Additional Message Information (526-FQ)

```
PROCESSOR   SPECIFIC   REJECT   MESSAGES   WOULD   BEGIN   HERE
&ECL;RC:A5;RC:A6;&
```

15.8 BILLING TRANSACTION EXAMPLES
15.8.1 BILLING TRANSACTION – B1 - PRIMARY CLAIM FROM PHARMACY TO PDP

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	*61ØØ66*	PDP BIN
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*123456789Ø*	PDP PCN
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ6Ø313*	March 13, 2ØØ6
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*98765bbbbb*	

PATIENT SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø1*	PATIENT SEGMENT

The Following Fields are Optional:

3Ø4-C4	DATE OF BIRTH	*19320615*	Born June 15, 1932
3Ø5-C5	PATIENT GENDER CODE	*1*	Male
31Ø-CA	PATIENT FIRST NAME	*JOSEPH*	
311-CB	PATIENT LAST NAME	*SMITH*	
3Ø7-C7	PATIENT LOCATION	*Ø*	Not specified

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INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	987654321	Cardholder Id
The Following Fields are Optional:			
3Ø1-C1	GROUP ID	PARTD	

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234567	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3	NDC
4Ø7-D7	PRODUCT/SERVICE ID	ØØØØ6Ø94268	Clinoril 2ØØmg
The Following Fields are Optional:			
442-E7	QUANTITY DISPENSED	3ØØØØ	3Ø.ØØØ tablets
4Ø3-D3	FILL NUMBER	Ø	Original dispensing for RX#
4Ø5-D5	DAYS SUPPLY	3Ø	3Ø Days supply
4Ø6-D6	COMPOUND CODE	1	Not a compound
4Ø8-D8	DAW/PRODUCT SELECTION CODE	Ø	No product selection indicated
414-DE	DATE PRESCRIPTION WRITTEN	2ØØ6Ø312	March 12, 2ØØ6
415-DF	NUMBER OF REFILLS AUTHORIZED	5	5 Refills
3Ø8-C8	OTHER COVERAGE CODE	Ø	Not Specified
429-DT	UNIT DOSE INDICATOR	1	Not unit dose
6ØØ-28	UNIT OF MEASURE	EA	Each

PRESCRIBER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø3	PRESCRIBER SEGMENT
The Following Fields are Optional:			
466-EZ	PRESCRIBER ID QUALIFIER	Ø8	State license
411-DB	PRESCRIBER ID	ØØG2345	

PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT
The Following Fields are Optional:			
4Ø9-D9	INGREDIENT COST SUBMITTED	762{	$76.2Ø
412-DC	DISPENSING FEE SUBMITTED	45{	$4.5Ø
426-DQ	USUAL AND CUSTOMARY CHARGE	9ØØ{	$9Ø.ØØ
43Ø-DU	GROSS AMOUNT DUE	8Ø7{	$8Ø.7Ø
423-DN	BASIS OF COST DETERMINATION	Ø1	AWP

15.8.1.1 *PAID RESPONSE ON PRIMARY CLAIM FROM PDP TO PHARMACY*

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	

| 4Ø1-D1 | DATE OF SERVICE | *2ØØ6Ø313* | March 13, 2ØØ6 |

RESPONSE MESSAGE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*2Ø*	RESPONSE MESSAGE SEGMENT
The Following Fields are Optional:			
5Ø4-F4	MESSAGE	*ADDINS:1;BN:283749;PN:29348bbbbb;GP:MDP348;ID:3827493;PC:;PH:8ØØ1234567;&ADDINS:2;BN:738287;PN:bbbbbbbbbb;GP:ABC;ID:335128889Ø;PC:ØØ3;PH:8ØØ2937792;&*	Standard message for two additional payers.

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid
The Following Fields are Optional:			
5Ø3-F3	AUTHORIZATION NUMBER	*123456789123456789*	
526-FQ	ADDITIONAL MESSAGE INFORMATION	*CMS ESTIMATED BRAND/GENERIC DIFFERENCE: ØØØØ22.55 ADDINS:3;BN:283499;PN:293A38BNDI;GP:COSTATE;ID:38473KJ;PC:;PH:8ØØ5553567;&*	Up to 2ØØ bytes Message for Brand/Generic difference is first followed by one additional payer message. Third payer message was unable to fit completely in 5Ø4-F4 therefore overflowed to 526-FQ.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	
The Following Fields are Optional:			
551-9F	PREFERRED PRODUCT COUNT	*1*	1 Preferred product identified
552-AP	PREFERRED PRODUCT ID QUALIFIER	*Ø3*	NDC
553-AR	PREFERRED PRODUCT ID	*17236Ø569Ø1*	Ibuprofen 6ØØmg tablet

RESPONSE PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT
The Following Fields are Optional:			
5Ø5-F5	PATIENT PAY AMOUNT	*5ØØ{*	$5Ø.ØØ
5Ø6-F6	INGREDIENT COST PAID	*762{*	$76.2Ø
5Ø7-F7	DISPENSING FEE PAID	*45{*	$4.5Ø
557-AV	TAX EXEMPT INDICATOR	*1*	Tax exempt
5Ø9-F9	TOTAL AMOUNT PAID	*3Ø7{*	$3Ø.7Ø
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	*1*	Ingredient cost paid as

			submitted
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	*4ØØ{*	$4Ø.ØØ
518-FI	AMOUNT OF COPAY/COINSURANCE	*1ØØ{*	$1Ø.ØØ

Note: In the above example Messaging is returned in Message (5Ø4-F4) on a PAID response. Message must begin in position one of this field. Message (5Ø4-F4) is a 2ØØ-byte field. If additional bytes are needed, the Additional Message Information (526-FQ) is available. Overflow additional insurance information must be populated in Additional Message Information (526-FQ) AFTER the Brand/Generic Differential message.

15.8.1.2 REJECTED RESPONSE ON PRIMARY CLAIM FROM PDP TO PHARMACY

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ6Ø313*	March 13, 2ØØ6

RESPONSE MESSAGE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*2Ø*	RESPONSE MESSAGE SEGMENT

The Following Fields are Optional:

5Ø4-F4	MESSAGE	*PRIMARY;BN:123456;PN :1234567890;GP:12346 5789Ø12345;ID:123456 789Ø1234567890;PC:ØØ 1;PH:8ØØ1234567;&*	.

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected

The Following Fields are Optional:

51Ø-FA	REJECT COUNT	*3*	
511-FB	REJECT CODE	*41*	Submit Bill To Other Processor Or Primary Payer
511-FB	REJECT CODE	*26*	M/I Unit Of Measure
511-FB	REJECT CODE	*55*	Non-Matched Product Package Size
526-FQ	ADDITIONAL MESSAGE INFORMATION	*NEW PAYER SHEETS EFFECTIVE ON JUNE 1 WILL BE MAILED ON MAY 1*	Processor Specific Message
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT

455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	

15.9.1.3   REJECTED RESPONSE ON PRIMARY CLAIM FROM PDP TO PHARMACY WITH STRUCTURED REJECT CODE

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ6Ø313*	March 13, 2ØØ6

RESPONSE MESSAGE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*2Ø*	RESPONSE MESSAGE SEGMENT

The Following Fields are Optional:

5Ø4-F4	MESSAGE	*PRIMARY;BN:123456;PN :123456789Ø;GP:12346 5789Ø12345;ID:123456 789Ø123456789Ø;PC:ØØ 1;PH:8ØØ1234567;&*	.

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected

The Following Fields are Optional:

51Ø-FA	REJECT COUNT	*3*	
511-FB	REJECT CODE	*41*	Submit Bill To Other Processor Or Primary Payer
511-FB	REJECT CODE	*26*	M/I Unit Of Measure
511-FB	REJECT CODE	*55*	Non-Matched Product Package Size
526-FQ	ADDITIONAL MESSAGE INFORMATION	*NEW PAYER SHEETS EFFECTIVE ON JUNE 1 WILL BE MAILED ON MAY 1&ECL;RC:A5;&*	Processor Specific Message followed by structured reject code for "Not Covered Under Part D Law".
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	

RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	

15.9   STRUCTURED REJECT CODES

This list is maintained in the Version 5 Editorial document for the Reject Codes that can be used in the structured reject code area. These same values are actual Reject Codes (511-FB) that are supported in future versions of the Telecommunication Standard. See the External Code List.

If a submitter wishes **new** Reject Codes be included in the table below, a Data Element Request Form (DERF) must be submitted that specifies that, if the new Reject Codes are approved for the next version of the Telecommunication Standard, <u>it is also requested</u> that the new codes be included in the V5 Editorial Document as well. As part of the normal DERF process, the Work Group 1 Telecommunication attendees will have the opportunity to decide if the codes will be retrofitted into 5.1 (in this table) or not during the full debate and approval process.

Reject Code	Description	Explanation
A5	"Not Covered Under Part D Law"	This reject message would be used for drugs which are excluded from coverage under basic Part D benefits as mandated by the MMA
A6	"This medication may be covered under Part B"	

15.9.1 USE OF REJECT CODE (511-FB) = "A5" OR "A6"
Question:
What rejection(s) is sent for the following two scenarios?

> 1) A drug that may be covered under Medicare Part B, but will never be covered under Medicare Part D (for example, glucometers or CMS Medicare Part D exclusions that may be covered under B)

> 2) A drug that may be covered under Medicare Part B, and if not will be covered under Medicare Part D (for example, Immunosuppressives)

Response:
For Scenario 1 Reject Code "A5" (Not Covered Under Part D By Law) and "A6" (This medication may be covered under Part B) should both be returned. For Scenario 2 only Reject Code "A6" (This medication may be covered under Part B) should be returned.

15.10 STANDARDIZED ADDITIONAL MESSAGES FOR PLANS THAT DO NOT REQUIRE A CALL FOR PRIOR AUTHORIZATION BEFORE APPROVING THE CLAIM

To supplement NCPDP reject codes, we recommend the use of standardized additional messaging to provide additional information to assist pharmacists in taking further action. It is important that the critical elements of these messages be kept intact, if plans decide to implement messaging in free form text. This messaging will result in consistent use of key terms by plans. The standardized additional messaging discussed below focuses on five critical areas: NDC Not Covered (Product/Service Not Covered); Prior Authorization Required; Plan Limitation Exceeded; and transition messaging.

NOTE: Adoption of standardized additional messaging should be implemented in coordination with pharmacist education and other support to ensure that these messages will be routinely accessed by pharmacists. In addition, the education effort should include information concerning the exceptions process (for example, for drugs

not covered under the plan formulary), so that pharmacists can alert beneficiaries and physicians about this process. Many of the messages in NCPDP Telecommunication Standard Implementation Guide Version 5.1 will be displayed in message fields Message (5Ø4-F4) and Additional Message Information (526-FQ) after other mandated Medicare Part D messages (e.g. Other Insurance messages). These are 2ØØ byte fields and some pharmacy systems may not have the ability to display the entire message. The idea is to transmit consistent messages between all plans.

15.10.1 NEW STRUCTURED REJECT CODES

Since these NCPDP Reject Code values cannot be used until the next version of HIPAA, processors should return the code in the Message (5Ø4-F4) or Additional Message Information (526-FQ) field, using the standardized structure built for this purpose, with the free text shown below, or return just the Reject Code or just the message.

Reject Code (511-FB)	Supplementary Message/Notes	Explanation	Acceptable responses

MR	Non Formulary Product	Used when product is not covered by formulary. Need to list covered product alternative in Preferred Product fields or in Additional Message Information field.	Codified response:
			&ECL;RC:MR;&
			in Message field (5Ø4-F4) or Additional Message Information (526-FQ), with name of drug in any of the following
			• Message field (5Ø4-F4)
			• Additional Message Information (526-FQ)
			• Preferred Product Description field (556-AU)
			• Preferred Product ID Qualifier (552-AP) and Preferred Product ID (553-AR)
			OR
			text message containing the words or abbreviation of the words that mean non-formulary and a drug name if allowed by health plan <insert drug name here> in free text (5Ø4-F4, 526-FQ or DUR Free Text (544–FY).
			For illustrative purposes an acceptable message response would be as follows:
			Non-formulary Use <DRUG name>
			OR
			the words or abbreviation of the words Non-Formulary , with name of drug if allowed by the plan, in any of the following fields:
			• text message containing the words or abbreviation of the words that mean non-formulary (5Ø4-F4, 526-FQ and either of the below options for identifying the formulary when allowed by plan:
			  o Preferred Product Description field (556-AU)
			  o Preferred Product ID Qualifier (552-AP) and Preferred Product ID (553-AR)

For Plans who handle claims that meet transition criteria by <u>rejecting</u> the claim with a Reject Code of "75 " (Prior Authorization Required), "79 " (Refill Too Soon), and "88 " (DUR Reject Error), the following are the recommended methods:

Reject Code	Supplementary Message/Notes	Explanation	Acceptable responses
"N7 "	Use Prior Authorization Code Provided During Transition Period	Used to override a drug that has denied, but should be covered during transition period.	Codified response &ECL;RC:N7;PAC:NNNNNNNNNNN;& OR text message containing the words or abbreviation of the words that mean that in order to pay this claim under transition benefit the pharmacy will have to resubmit the claim with the override code provided. For illustrative purposes the following would be considered an acceptable response message example: For Transition Benefit use PAC XXXXXXX (5Ø4-F4 and/or 526-FQ) OR Reject claim with message for pharmacy to call help desk. A phone number should be provided in Help Desk Phone Number (55Ø-8F) and the qualifier, or free text 5Ø4-F4 or 526-FQ
"N8 "	Use Prior Authorization Code Provided For Emergency Fill	Used to override a drug that has denied, but should be covered as an emergency fill	&ECL;RC:N8;PAC:NNNNNNNNNNN;& OR the words or abbreviation of the words "For Emergency Fill use PAC XXXXXXX" in freeform text fields (5Ø4-F4 and/or 526-FQ) OR Reject claim with message for pharmacy to call help desk. A phone number should be provided in Help Desk Phone Number (55Ø-8F) and qualifier, or free text 5Ø4-F4 or 526-FQ
"N9 "	Use Prior Authorization Code Provided For Level of Care Change	Used to override a drug that has denied, but should be covered due to a change in level of care.	&ECL;RC:N9;PAC:NNNNNNNNNNN;& OR the words or abbreviation of the words For Level of Care Change use PAC XXXXXXX in freeform text fields (5Ø4-F4 and/or 526-FQ) OR Reject claim with message for pharmacy to call help desk. A phone number should be provided in Help Desk Phone Number (55Ø-8F) and qualifier, or free text 5Ø4-F4 or 526-FQ

For further clarification of the use of the Prior Authorization Code (PAC) identifier with multiple reject codes, note the PAC identifier appears with the reject code appropriate.

For example (for illustration only):

&ECL;RC:N9;PAC:NNNNNNNNNNN;RC:TP;&

For Plans who handle claims that meet transition criteria by <u>denying</u> the first claim with a reject code (i.e. Non-formulary) and the PBM creates an authorization within their system, so that the pharmacy does not have to send a Prior Authorization

number when resubmitting the claim, the following are the recommended methods:

Reject Code	Supplementary Message/Notes	Explanation	Acceptable responses
"RL "	Transitional Benefit/Resubmit Claim	Used to indicate that the claim denied but the pharmacy can resubmit the claim to get it covered under transition benefit.	Codified response &ECL;RC:RL;PAC:NNNNNNNNNNN;& OR the words or abbreviation of the words "For Transition Benefit resubmit claim" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"TN "	Emergency Fill/Resubmit Claim	Used to indicate that the claim denied but the pharmacy can resubmit the claim to get it covered as an emergency fill change in level of care.	&ECL;RC:TN;PAC:NNNNNNNNNNN;& OR the words or abbreviation of the words "For Emergency Fill resubmit claim" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"TP "	Level of Care Change/Resubmit Claim	Used to indicate that the claim denied but the pharmacy can resubmit the claim to get it covered as a level of care change.	&ECL;RC:TP;PAC:NNNNNNNNNNN;& OR the words or abbreviation of the words "For Level of Care resubmit claim" in freeform text fields (5Ø4-F4 and/or 526-FQ)

15.10.2   NEW STRUCTURED APPROVED MESSAGE CODES

For Plans who handle claims that meet transition criteria <u>by paying the claim</u> upon initial submission the following are the recommended methods:

Approved Message Code (548-6F)	Supplementary Message/Notes	Explanation	Acceptable responses
"ØØ4"	Filled During Transition Benefit	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected outside transition period	&ECL;AC:ØØ4;& OR the words or abbreviation of the words "Paid under transition fill" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"ØØ5"	Filled During Transition Benefit/ /Prior Authorization Required	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected outside transition period	&ECL;AC:ØØ5;& OR the words or abbreviation of the words "Paid under transition fill. PA required" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"ØØ6"	Filled During Transition Benefit /Non-Formulary	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected outside transition period	&ECL;AC:ØØ6;& OR the words or abbreviation of the words "Paid under transition fill. Non-formulary" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"ØØ7"	Filled During Transition Benefit /Other Rejection	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected outside transition period	&ECL;AC:ØØ7;& OR the words or abbreviation of the words "Paid under transition fill. Other reject" in freeform text fields (5Ø4-F4 and/or 526-FQ)

Approved Message Code (548-6F)	Supplementary Message/Notes	Explanation	Acceptable responses
"ØØ8"	Emergency Fill Situation	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected if it did not meet the emergency fill criteria	&ECL;AC:ØØ8;& OR the words or abbreviation of the words "Paid under emergency fill" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"ØØ9"	Emergency Fill Situation/ Prior Authorization Required	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected if it did not meet the emergency fill criteria	&ECL;AC:ØØ9;& OR the words or abbreviation of the words "Paid under emergency fill. PA required" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"Ø1Ø"	Emergency Fill Situation/ /Non-Formulary	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected if it did not meet the emergency fill criteria	&ECL;AC:Ø1Ø;& OR the words or abbreviation of the words "Paid under emergency fill. Non-formulary" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"Ø11"	Emergency Fill Situation/Other rejection	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected if it did not meet the emergency fill criteria	&ECL;AC:Ø11;& OR the words or abbreviation of the words "Paid under emergency fill. Other reject" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"Ø12"	Level of Care Change	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected.	&ECL;AC:Ø12;& OR the words or abbreviation of the words "Paid under level of care change" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"Ø13"	Level Of Care Change/ Prior Authorization Required	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected.	&ECL;AC:Ø13;& OR the words or abbreviation of the words "Paid under level of care change. PA required" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"Ø14"	Level Of Care Change /Non-Formulary	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected.	&ECL;AC:Ø14;& OR the words or abbreviation of the words "Paid under level of care change. Non-formulary" in freeform text fields (5Ø4-F4 and/or 526-FQ)
"Ø15"	Level Of Care Change /Other rejection	Used when payer does not deny claims, but lifts edits or pays a claim that would have normally rejected.	&ECL;AC:Ø15;& OR the words or abbreviation of the words "Paid under level of care change. Other reject" in freeform text fields (5Ø4-F4 and/or 526-FQ)

Recommended Supplementary Clarifying Reject Messages

Related Reject Codes	NCPDP Reject Code Definition	Supplementary Message/Notes
"75 "	Prior Authorization Required	Help desk phone number or fax number (make global) should be populated with the prior authorization help desk number
"76 "	Plan Limitations Exceeded	Define the specific limit that caused the rejection if permitted by plan

Additional Suggested Reject Codes (when permitted by plan)
The following reject codes MAY be used with FREE TEXT messages to further clarify the values of the reject codes

Related Reject Codes	NCPDP Reject Code Definition	Supplementary Message/Notes
"AG "	Days Supply Limitations for Product/Service	Maximum Days Supply = XXX Days
"M4 "	Prescription/Service Reference Number/Time Limit Exceeded	Define the number of Rxs allowed within a given time period
"RN "	Plan Limits Exceeded on Intended Partial Fill Values	Maximum Days Supply = XXX Days
"6Ø "	Product/Service Not covered for Patient Age	Specify Max or min age

15.11 VACCINE BILLING – MEDICARE PART D

15.11.1 TELECOM VERSION 5.1 SUBMISSIONS

The following was submitted to the Version 5 FAQ Task Group:

CMS has released guidance for the Medicare Part D benefit that effective January 1, 2008 the administrative fee for vaccines will be covered under the Part D benefit.

In an effort to accommodate the billing and payment of the vaccine drug and the administrative fee the following approach is submitted for Version 5.1 submissions. This is being submitted to the WG1 Version 5 FAQ Task Group for validation of this approach.

Assumptions

Patient may be responsible for a flat copay or percent coinsurance. The standard Medicare Part D benefit requires only one copay or coinsurance is charged on the total cost of the drug and administrative fee. Other plans may require that one copay is charged on the drug and separate copay is charged on the administrative fee.

The drug and the administrative fee are submitted on one claim transaction.

Provider submits claim with Ingredient cost for vaccine $150.00 in field 409-D9 and dispensing fee of $2.00 in field 412-DC $20.00 administrative fee in field 438-E3 (Incentive fee submitted) in the Pricing segment. They indicate that the claim is being submitted for the administration of a vaccine by including the DUR/PPS segment with 1 in field 473-7E (DUR/PPS Code Counter) and a value of MA (medication administered) in field 440-E5 (professional service code).

The payer responds providing payable Ingredient cost of $150.00 in field 506-F6, dispensing fee paid of $2.00 in field 507-F7, incentive amount paid of $20.00 in field 521-FL. For this beneficiary there is only one flat copay of $5.00 and that is returned in the amount of copay field 518-FI and the patient pay amount field 505-F5.

If the benefit included two copays one $5.00 copay for the vaccine and one $5.00 copay for the administration of the vaccine the total $10.00 copay for the vaccine and the administration copay would be returned in amount of copay field 518-FI and the patient pay amount field 505-F5.

15.11.1.1   GUIDANCE FOR PROCESSING
1. Follow up to CMS on Two Copays
Question: Should the field Amount Attributed to Product Selection (519-FJ) be used for a second copay if there are plans that charge two copays one on the product and one on the administration?

Answer from CMS: "If one vendor is both providing the vaccine and administering, then one cost sharing amount (based on the sum of both charges) is charged, not two. Separate cost sharing amounts are possible only when two claims are coming from two separate providers and these have not been coordinated in any way."

So Amount Attributed to Product Selection is removed from the need suggested in the question.

2. The following messages to accompany the "E5 " (M/I Professional Service Code) and "E3 " (M/I Incentive Amount Submitted) reject messages were approved for use.
If the Incentive Amount Submitted (521-FL) is populated, but the Professional Service Code (44Ø-E5) is not sent and the drug is a vaccine, the claim should be rejected as follows:
- Reject Code: "E5 " (M/I Professional Service Code)
- Additional Message Information: "Prof Svc Code reqd for vaccine Inc Fee"

If the Professional Service Code (44Ø-E5) of "MA" is sent and the Incentive Amount Submitted (521-FL) is not populated (not sent or zeroes) and the drug is a vaccine, the claim should be rejected as follows:
- Reject Code: "E3 " (M/I Incentive Amount Submitted)
- Additional Message Information: "Non 0 value reqd for vaccine admin"

3. Usual and Customary Charge Inclusive of administration fee?
Based on the definition of Usual and Customary Charge, the administration fee should be included. The Usual and Customary Charge (426-DQ) includes the amount the provider would charge the cash customer for the product and the administration of the product.

4. Prescription/Service Reference Number Qualifier
Prescription/Service Reference Number Qualifier (455-EM) – Because a value does not exist for combination of product and service, default field to a value of "1" (Rx Billing).

15.11.2   EXAMPLE – INCENTIVE AMOUNT SUBMITTED AND DUR/PPS SEGMENT SENT ON CLAIM
Example: (Paid Claim - Not intended to show actual contracted values)

TRANSACTION HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	61ØØ66	BIN
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	123456789Ø	PCN
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1	NPI
2Ø1-B1	SERVICE PROVIDER ID	1563663556bbbbb	

4Ø1-D1	DATE OF SERVICE	2ØØ8Ø313	March 13, 2ØØ8
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	98765bbbbb	

PATIENT SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø1	PATIENT SEGMENT

The Following Fields are Optional:

3Ø4-C4	DATE OF BIRTH	193ØØ615	Born June 15, 193Ø
3Ø5-C5	PATIENT GENDER CODE	2	Female
31Ø-CA	PATIENT FIRST NAME	MARY	
311-CB	PATIENT LAST NAME	SIMMONS	

INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	987654321	Cardholder ID

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234567	Prescription Number
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3	NDC
4Ø7-D7	PRODUCT/SERVICE ID	00006496341	Zostavax

The Following Fields are Optional:

442-E7	QUANTITY DISPENSED	1	EA
4Ø3-D3	FILL NUMBER	Ø	Original dispensing for RX#
4Ø5-D5	DAYS SUPPLY	1	1 Days supply
4Ø6-D6	COMPOUND CODE	1	Not a compound
4Ø8-D8	DAW/PRODUCT SELECTION CODE	Ø	No product selection indicated
414-DE	DATE PRESCRIPTION WRITTEN	2ØØ8Ø312	March 12, 2ØØ8
6ØØ-28	UNIT OF MEASURE	EA	Each

PRESCRIBER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø3	PRESCRIBER SEGMENT

The Following Fields are Optional:

466-EZ	PRESCRIBER ID QUALIFIER	Ø1	NPI
411-DB	PRESCRIBER ID	1177882556	

PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	15ØØ{	$15Ø ØØ
412-DC	DISPENSING FEE SUBMITTED	2Ø{	$2.ØØ
438-E3	INCENTIVE FEE SUBMITTED	2ØØ{	$2Ø.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	172Ø{	$172 ØØ
43Ø-DU	GROSS AMOUNT DUE	172Ø{	$172 ØØ
423-DN	BASIS OF COST DETERMINATION	Ø1	AWP

DUR/PPS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø8	DUR/PPS Segment

The Following Fields are normally Optional but are <u>required</u> for Medicare Part D Vaccine claims:

473-7E	DUR/PPS CODE COUNTER	*1*	1st DUR/PPS activity follows
44Ø-E5	PROFESSIONAL SERVICE CODE	*MA*	Medication Administered

Notes:

- Field 455-EM Prescription/Service Reference Number Qualifier – Because a value does not exist for combination of product and service, default field to a value of "1" (Rx Billing).
- The Usual And Customary Charge (426-DQ) includes the amount the provider would charge the cash customer for the product and the administration of the product.

15.11.2.1   PAID RESPONSE

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø1*	NPI
2Ø1-B1	SERVICE PROVIDER ID	*1563663556bbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ8Ø313*	March 13, 2ØØ8

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid
The Following Fields are Optional:			
5Ø3-F3	AUTHORIZATION NUMBER	*123456789123456789*	
526-FQ	ADDITIONAL MESSAGE INFORMATION		
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	

RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	

RESPONSE PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT
The Following Fields are Optional:			
5Ø5-F5	PATIENT PAY AMOUNT	*5Ø{*	$5.ØØ
5Ø6-F6	INGREDIENT COST PAID	*15ØØ{*	$15Ø.ØØ
5Ø7-F7	DISPENSING FEE PAID	*2Ø{*	$2.ØØ
521-FL	INCENTIVE FEE PAID	*2ØØ{*	$2Ø.ØØ
5Ø9-F9	TOTAL AMOUNT PAID	*167Ø{*	$167. ØØ
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	*1*	Ingredient cost paid as submitted
518-FI	AMOUNT OF COPAY/COINSURANCE	*5Ø{*	$5.ØØ

15.11.3   EXAMPLE - REJECTED CLAIM – DUR/PPS MA FIELD SUBMITTED WITHOUT INCENTIVE FEE SUBMITTED FIELD

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**

1Ø1-A1	BIN NUMBER	61ØØ66	BIN
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	123456789Ø	PCN
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1	NPI
2Ø1-B1	SERVICE PROVIDER ID	1563663556bbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ8Ø313	March 13, 2ØØ8
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	98765bbbbb	

PATIENT SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø1	PATIENT SEGMENT
The Following Fields are Optional:			
3Ø4-C4	DATE OF BIRTH	193ØØ615	Born June 15, 193Ø
3Ø5-C5	PATIENT GENDER CODE	2	Female
31Ø-CA	PATIENT FIRST NAME	MARY	
311-CB	PATIENT LAST NAME	SIMMONS	

INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	987654321	Cardholder ID

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234567	Prescription Number
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3	NDC
4Ø7-D7	PRODUCT/SERVICE ID	00006496341	Zostavax
The Following Fields are Optional:			
442-E7	QUANTITY DISPENSED	1	EA
4Ø3-D3	FILL NUMBER	Ø	Original dispensing for RX#
4Ø5-D5	DAYS SUPPLY	1	1 Days supply
4Ø6-D6	COMPOUND CODE	1	Not a compound
4Ø8-D8	DAW/PRODUCT SELECTION CODE	Ø	No product selection indicated
414-DE	DATE PRESCRIPTION WRITTEN	2ØØ8Ø312	March 12, 2ØØ8
6ØØ-28	UNIT OF MEASURE	EA	Each

PRESCRIBER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø3	PRESCRIBER SEGMENT
The Following Fields are Optional:			
466-EZ	PRESCRIBER ID QUALIFIER	Ø1	NPI
411-DB	PRESCRIBER ID	1177882556	

Incentive Fee Submitted (438-E3) was not sent.

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT
The Following Fields are Optional:			
4Ø9-D9	INGREDIENT COST SUBMITTED	15ØØ{	$15Ø ØØ
412-DC	DISPENSING FEE SUBMITTED	2Ø{	$2.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	152Ø{	$152 ØØ
43Ø-DU	GROSS AMOUNT DUE	152Ø{	$152 ØØ
423-DN	BASIS OF COST DETERMINATION	Ø1	AWP

DUR/PPS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø8	DUR/PPS Segment

The Following Fields are Optional:

473-7E	DUR/PPS CODE COUNTER	1	1st DUR/PPS activity follows
44Ø-E5	PROFESSIONAL SERVICE CODE	MA	Medication Administered

15.11.3.1   REJECTED RESPONSE

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1	NPI
2Ø1-B1	SERVICE PROVIDER ID	1563663556bbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ8Ø313	March 13, 2ØØ8

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	21	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	R	Rejected
The Following Fields are Optional:			
51Ø-FA	REJECT COUNT	1	1 Reject Code follows
511-FB	REJECT CODE	E3	M/I Incentive Amount Submitted
526-FQ	ADDITIONAL MESSAGE INFORMATION	Non 0 value reqd for vaccine admin	

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	22	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	1234567	

15.11.4   EXAMPLE - REJECTED CLAIM – INCENTIVE FEE SUBMITTED WITHOUT THE DUR/PPS PROFESSIONAL SERVICE CODE "MA"

TRANSACTION HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	61ØØ66	BIN
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	123456789Ø	PCN
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1	NPI
2Ø1-B1	SERVICE PROVIDER ID	1563663556bbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ8Ø313	March 13, 2ØØ8
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	98765bbbbb	

PATIENT SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø1	PATIENT SEGMENT
The Following Fields are Optional:			
3Ø4-C4	DATE OF BIRTH	193ØØ615	Born June 15, 193Ø
3Ø5-C5	PATIENT GENDER CODE	2	Female

31Ø-CA	PATIENT FIRST NAME	*MARY*	
311-CB	PATIENT LAST NAME	*SIMMONS*	

INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø4*	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	*987654321*	Cardholder ID

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø7*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	Prescription Number
436-E1	PRODUCT/SERVICE ID QUALIFIER	*Ø3*	NDC
4Ø7-D7	PRODUCT/SERVICE ID	*ØØØØ6496341*	Zostavax
The Following Fields are Optional:			
442-E7	QUANTITY DISPENSED	*1*	EA
4Ø3-D3	FILL NUMBER	*Ø*	Original dispensing for RX#
4Ø5-D5	DAYS SUPPLY	*1*	1 Days supply
4Ø6-D6	COMPOUND CODE	*1*	Not a compound
4Ø8-D8	DAW/PRODUCT SELECTION CODE	*Ø*	No product selection indicated
414-DE	DATE PRESCRIPTION WRITTEN	*2ØØ8Ø312*	March 12, 2ØØ8
6ØØ-28	UNIT OF MEASURE	*EA*	Each

PRESCRIBER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø3*	PRESCRIBER SEGMENT
The Following Fields are Optional:			
466-EZ	PRESCRIBER ID QUALIFIER	*Ø1*	NPI
411-DB	PRESCRIBER ID	*1177882556*	

PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT
The Following Fields are Optional:			
4Ø9-D9	INGREDIENT COST SUBMITTED	*15ØØ{*	$15Ø ØØ
412-DC	DISPENSING FEE SUBMITTED	*2Ø{*	$2.ØØ
438-E3	INCENTIVE FEE SUBMITTED	*2ØØ{*	$2Ø.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	*172Ø{*	$172 ØØ
43Ø-DU	GROSS AMOUNT DUE	*172Ø{*	$172 ØØ
423-DN	BASIS OF COST DETERMINATION	*Ø1*	AWP

The DUR/PPS Segment was not sent.

15.11.4.1   REJECTED RESPONSE

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø1*	NPI
2Ø1-B1	SERVICE PROVIDER ID	*1563663556bbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ8Ø313*	March 13, 2ØØ8

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected

The Following Fields are Optional:

51Ø-FA	REJECT COUNT	*1*	1 Reject Code follows
511-FB	REJECT CODE	*E5*	M/I Professional Service Code
526-FQ	ADDITIONAL MESSAGE INFORMATION	Prof Svc Code reqd for vaccine Inc Fee	

RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	

15.11.5 VACCINE COORDINATION OF BENEFITS EXPLANATION FOR VERSION 5.1

Scenario 1A Request– Pharmacy bills claim to primary Part D payer on file for patient		
Scenario 1A Response – Payer responds with paid response to the claim (1ØØ% liability).		
Pharmacy bills secondary insurance after primary responds with paid information. Depending on Secondary Payer rules, COB claim to secondary can be submitted one of three ways. Examples below illustrate Other Payer Amount Paid and Copay Only secondary billing options. Examples are not included for Government Programs requiring full payment disclosure.		
SUBMITTAL OPTION 1	**SUBMITTAL OPTION 2**	
Scenario 1B Other Payer Amount Paid	**Scenario 1C** Copay Only	
The following secondary billing request is based on the 1A Response *(Other Payer Amount Paid = Total Amount Paid from primary response).*	**The following secondary billing request is based on the 1A Response. (Other Amount Claimed Submitted = Patient Pay Amount from primary response).**	
Scenario 1B Request – Pharmacy bills secondary insurance after primary paid response received	**Scenario 1C Request** – Pharmacy bills secondary insurance after primary paid response received	
Depending on the benefit structure of the secondary payer, one of the following two responses may be returned for the 1B billing request.	**Depending on the benefit structure of the secondary payer, one of the following two responses may be returned for the 1C billing request.**	
Scenario 1B.1 Response – Paid response from secondary insurance (incentive amount submitted used in determining secondary payment)	**Scenario 1C.1 Response -** Paid response from secondary insurance (secondary pricing considers incentive amount allowed under that plan in determining secondary payment)	
Scenario 1B.2 Response – Reject response from secondary insurance because Professional Service Code 'MA' submitted, but secondary does not cover administration costs (msg for patient to submit secondary claim via paper)	**Scenario 1C.2 Response** – Reject response from secondary insurance because Professional Service Code 'MA' submitted, but secondary does not cover administration costs (message for patient to submit secondary claim via paper)	

15.11.5.1 SCENARIO 1A REQUEST: PHARMACY BILLS TO PRIMARY PART D INSURANCE DESIGNATED BY PATIENT

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	*61ØØ66*	BIN
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*123456789Ø*	PCN
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø1*	NPI
2Ø1-B1	SERVICE PROVIDER ID	*1563663556bbbbb*	

| 4Ø1-D1 | DATE OF SERVICE | *2ØØ8Ø313* | March 13, 2ØØ8 |
| 11Ø-AK | SOFTWARE VENDOR/CERTIFICATION ID | *98765bbbbb* | |

PATIENT SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø1*	PATIENT SEGMENT

The Following Fields are Optional:

3Ø4-C4	DATE OF BIRTH	*193ØØ615*	Born June 15, 193Ø
3Ø5-C5	PATIENT GENDER CODE	*2*	Female
31Ø-CA	PATIENT FIRST NAME	*MARY*	
311-CB	PATIENT LAST NAME	*SIMMONS*	

INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø4*	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	*987654321*	Cardholder ID

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø7*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	Prescription Number
436-E1	PRODUCT/SERVICE ID QUALIFIER	*Ø3*	NDC
4Ø7-D7	PRODUCT/SERVICE ID	*ØØØØ6496341*	Zostavax
4Ø8-DI	DISPENSE AS WRITTEN/PRODUCT SELECTION CODE	*Ø*	

The Following Fields are Optional:

442-E7	QUANTITY DISPENSED	*1*	EA
4Ø3-D3	FILL NUMBER	*Ø*	Original Dispensing for RX#
4Ø5-D5	DAYS SUPPLY	*1*	1 Days Supply
4Ø6-D6	COMPOUND CODE	*1*	Not a compound
4Ø8-D8	DAW/PRODUCT SELECTION CODE	*Ø*	No product selection indicated
414-DE	DATE PRESCRIPTION WRITTEN	*2ØØ8Ø312*	March 12, 2ØØ8
6ØØ-28	UNIT OF MEASURE	*EA*	Each

DUR/PPS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø8*	DUR/PPS SEGMENT

The Following Fields are normally Optional but are <u>required</u> for Medicare Part D Vaccine claims:

| 473-7E | DUR/PPS CODE COUNTER | *1* | 1st DUR/PPS activity follows |
| 44Ø-E5 | PROFESSIONAL SERVICE CODE | *MA* | Medication Administered |

PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT

The Following Fields are Optional:

| 4Ø9-D9 | INGREDIENT COST SUBMITTED | *15ØØ{* | $15Ø.ØØ |
| 412-DC | DISPENSING FEE SUBMITTED | *5Ø{* | $5.ØØ |

438-DC	INCENTIVE AMOUNT SUBMITTED	*25Ø{*	$25.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	*19ØØ{*	$19Ø.ØØ
43Ø-DU	GROSS AMOUNT DUE	*18ØØ{*	$18Ø.ØØ
423-DN	BASIS OF COST DETERMINATION	*Ø1*	AWP

Notes:
- Field 455-EM Prescription/Service Reference Number Qualifier – Because a value does not exist for combination of product and service, default field to a value of "1" (Rx Billing).
- The Usual And Customary Charge (426-DQ) includes the amount the provider would charge the cash customer for the product and the administration of the product.

15.11.5.1.1 SCENARIO 1A RESPONSE: PAID RESPONSE FROM PRIMARY INSURANCE

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø1*	NPI
2Ø1-B1	SERVICE PROVIDER ID	*1563663556bbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ8Ø313*	March 13, 2ØØ8

RESPONSE MESSAGE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*2Ø*	RESPONSE MESSAGE SEGMENT
5Ø4-F4	MESSAGE	*ADDINS:1;BN:004336;PN: 1234;GP:1234;ID:1234567 89;PC:001;PH:8001234567 ;&*	Freeform message about Other Payer on file.

RESPONSE INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*25*	INSURANCE SEGMENT

The Following Fields are Optional:

524-FO	PLAN ID	*2316*	
568-J7	PAYER ID QUALIFIER	*1*	National Payer ID
569-J8	PAYER ID	*2223345678*	

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid

The Following Fields are Optional:

5Ø3-F3	AUTHORIZATION NUMBER	*123456789123456789*	
526-FQ	ADDITIONAL MESSAGE INFORMATION		
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing

| 4Ø2-D2 | PRESCRIPTION /SERVICE REFERENCE NUMBER | *1234567* | |

RESPONSE PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT

The Following Fields are Optional:

5Ø5-F5	PATIENT PAY AMOUNT	*162Ø{*	$162.ØØ
5Ø6-F6	INGREDIENT COST PAID	*14ØØ{*	$14Ø.ØØ
5Ø7-F7	DISPENSING FEE PAID	*2Ø{*	$2.ØØ
521-FL	INCENTIVE AMOUNT PAID	*2ØØ{*	$2Ø.ØØ
5Ø9-F9	TOTAL AMOUNT PAID	*ØØ{*	$0.ØØ
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	*2*	Ingredient Cost Reduced to AWP Pricing
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	*162Ø{*	$162.ØØ
518-FI	AMOUNT OF COPAY/CO-INSURANCE	*ØØØ{*	$Ø. ØØ

15.11.5.2 SCENARIO 1B REQUEST: PHARMACY BILLS SECONDARY INSURANCE AFTER PRIMARY PAID

Pharmacy submits claim indicating <u>Other Payer Amount Paid</u>
This situation describes a claim submission where the Processor requires the amount paid from the Primary Payer's claim.

TRANSACTION HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	*ØØ4336*	
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*1234*	
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø1*	NPI
2Ø1-B1	SERVICE PROVIDER ID	*1563663556bbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ8Ø313*	March 13, 2ØØ8
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*bbbbbbbbbb*	

INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*Ø4*	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	*123456789*	Cardholder ID

The Following Fields are Optional:

3Ø1-C1	GROUP ID	*1234*	
3Ø3-C3	PERSON CODE	*1*	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	*1*	Cardholder

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*Ø7*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	*1234567*	
436-E1	PRODUCT/SERVICE ID QUALIFIER	*Ø3*	NDC

4Ø7-D7	PRODUCT/SERVICE ID	ØØØØ6496341	Zostavax
3Ø8-C8	OTHER COVERAGE CODE	4	Other coverage exists-payment not collected

DUR/PPS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø8	DUR/PPS SEGMENT

The Following Fields are normally Optional but are required for Medicare Part D Vaccine claims:

473-7E	DUR/PPS CODE COUNTER	1	1st DUR/PPS activity follows
44Ø-E5	PROFESSIONAL SERVICE CODE	MA	Medication Administered

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	15ØØ{	$15Ø.ØØ
412-DC	DISPENSING FEE SUBMITTED	5Ø{	$5.ØØ
438-DC	INCENTIVE AMOUNT SUBMITTED	25Ø{	$25.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	19ØØ{	$19Ø.ØØ
43Ø-DU	GROSS AMOUNT DUE	18ØØ{	$18Ø.ØØ
423-DN	BASIS OF COST DETERMINATION	Ø3	Direct

Billing for Contracted Rate of Secondary with Indication of Amount that has been Paid.
 * Definition of Gross Amt Due only allows for 'the sum of' selected fields as presented in the Pricing Segment. It does NOT allow for the "sum of" the fields *minus* Other Payer Amount Paid.

COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø5	COB SEGMENT
337-4C	COB/OTHER PAYMENTS COUNT	1	One occurrence
338-5C	OTHER PAYER COVERAGE TYPE	Ø1	Primary
339-6C	OTHER PAYER ID QUALIFIER	Ø3	BIN #
34Ø-7C	OTHER PAYER ID	61ØØ66	BIN # of previous payer
443-E8	OTHER PAYER DATE	2ØØ8Ø313	March 13, 2ØØ8
341-HB	OTHER PAYER AMOUNT PAID COUNT	1	One occurrence
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø7	Drug Benefit
431-DV	OTHER PAYER AMOUNT PAID	ØØØ{	$ØØ.ØØ paid

15.11.5.2.1   SCENARIO 1B.1 RESPONSE: PAID RESPONSE FROM SECONDARY INSURANCE (ADMINISTRATION COVERED) - SUBMITTED WITH OTHER PAYER AMOUNT PAID

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1	NPI
2Ø1-B1	SERVICE PROVIDER ID	1563663556bbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ8Ø313	March 13, 2ØØ8

RESPONSE INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	25	INSURANCE SEGMENT

The Following Fields are Optional:

524-FO	PLAN ID	9988	
568-J7	PAYER ID QUALIFIER	1	National Payer ID
569-J8	PAYER ID	12121212	

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	21	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	P	Paid

The Following Fields are Optional:

5Ø3-F3	AUTHORIZATION NUMBER	11122233345678	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	6Ø2357Ø862	

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	22	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx Billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	1234567	

RESPONSE PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	23	RESPONSE PRICING SEGMENT
5Ø5-F5	PATIENT PAY AMOUNT	3ØØ{	$3Ø.ØØ
5Ø6-F6	INGREDIENT COST PAID	145Ø{	$145.ØØ
5Ø7-F7	DISPENSING FEE PAID	3Ø{	$3.ØØ
521-FL	INCENTIVE AMOUNT PAID	2ØØ{	$2Ø.ØØ
566-J5	OTHER PAYER AMOUNT RECOGNIZED	ØØ{	$Ø.ØØ
5Ø9-F9	TOTAL AMOUNT PAID	138Ø{	$138.ØØ
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	2	Ingredient Cost Reduced to AWP Pricing

TOTAL AMOUNT PAID represents a sum of 'Ingredient Cost Paid' (5Ø6-F6), 'Dispensing Fee Paid' (5Ø7-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive Amount Paid' (521-FL), 'Professional Service Fee Paid' (562-J1), 'Other Amount Paid' (565-J4) **less** 'Patient Pay Amount' (5Ø5-F5) and 'Other Payer Amount Recognized' (566-J5).

NOTE: In above example, Secondary covers administration costs and has different contracted rates. Total reimbursement is higher than Primary response. This example represents the ideal situation where both the primary Medicare Part D plan and the secondary commercial plan cover the costs of administration.

15.11.5.2.2 SCENARIO 1B.2 RESPONSE: REJECT RESPONSE – SUBMITTED WITH OTHER PAYER AMOUNT PAID (MESSAGE BENEFICIARY MUST SUBMIT PAPER SECONDARY CLAIM)

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing

1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ8Ø313*	March 13, 2ØØ8

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected

The Following Fields are Optional:

51Ø-FA	REJECT COUNT	*1*	
511-FB	REJECT CODE	*M5*	Requires Manual Claim
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	
526-FQ	ADDITIONAL MESSAGE INFORMATION	*MA NOT COVERED; PATIENT MUST SUBMIT A PAPER CLAIM.*	

NOTE: In above example, Secondary does not cover administration costs and, therefore, rejects the claim advising the pharmacy that the <u>beneficiary</u> must submit a manual secondary claim. The pharmacy collects patient pay based on the primary claim response, thus allowing the pharmacy to collect both drug cost and administration fee. The beneficiary files a paper claim with the secondary plan. However, because the secondary plan will consider only the drug cost when pricing the claim, the N1 transaction generated from paper claim processing will list a patient pay that does not include the non-covered administration cost. As a result, the primary plan may deduct too much from TrOOP. The beneficiary will need to provide the Part D plan with proof of the patient pay amount paid on the primary claim and the reimbursement received from the secondary plan so that the Part D plan can correct the TrOOP amount applicable to this claim.

15.11.5.3 SCENARIO 1C REQUEST: PHARMACY BILLS SECONDARY INSURANCE AFTER PRIMARY PAID – SUBMITTED FOR COPAY ONLY

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	*ØØ4336*	
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*1234*	
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø1*	NPI
2Ø1-B1	SERVICE PROVIDER ID	*1563663556bbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ8Ø313*	March 13, 2ØØ8
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*bbbbbbbbbb*	

INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø4*	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	*123456789*	Cardholder ID

The Following Fields are Optional:

3Ø1-C1	GROUP ID	*1234*	
3Ø3-C3	PERSON CODE	*1*	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	*1*	Child

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø7*	CLAIM SEGMENT

455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	*1234567*	
436-E1	PRODUCT/SERVICE ID QUALIFIER	*Ø3*	NDC
4Ø7-D7	PRODUCT/SERVICE ID	*ØØØØ6496341*	Zostavax
3Ø8-C8	OTHER COVERAGE CODE	*8*	Claim is a billing for a copay

DUR/PPS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*Ø8*	DUR/PPS SEGMENT

The following Fields are normally Optional but are required for Medicare Part D Vaccine claims:

| 473-7E | DUR/PPS CODE COUNTER | *1* | A count of 1 |
| 44Ø-E5 | PROFESSIONAL SERVICE CODE | *MA* | Medication Administered |

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	*1*	1 occurrence
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	*99*	Other
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED	*162Ø{*	$162.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	*19ØØ{*	$19Ø.ØØ
43Ø-DU	GROSS AMOUNT DUE	*162Ø{*	$162.ØØ

In order for the NCPDP Version 5.1 to allow a COPAY ONLY billing, the above recommendation was adopted at the May 2ØØ1 Telecommunication Work Group. No Ingredient Cost or Dispensing fields are expected (however these could be submitted with zeros). This recommendation allows partners to stay in compliance to the definition of Gross Amount Due.

Other Amount Claimed Submitted will be the *entire* Patient Pay Amount. Until a later version of NCPDP Telecomm standard is allowed, "the pieces" of Patient Pay Amount cannot be billed.

15.11.5.3.1   SCENARIO 1C.1 RESPONSE: PAID RESPONSE FROM SECONDARY INSURANCE (ADMINISTRATION COVERED) – SUBMITTED FOR COPAY ONLY

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø1*	NPI
2Ø1-B1	SERVICE PROVIDER ID	*1563663556bbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ8Ø313*	March 13, 2ØØ8

RESPONSE INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*25*	INSURANCE SEGMENT

The Following Fields are Optional:

524-FO	PLAN ID	*9988*	
568-J7	PAYER ID QUALIFIER	*1*	National Payer ID
569-J8	PAYER ID	*12121212*	

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid

The Following Fields are Optional:

5Ø3-F3	AUTHORIZATION NUMBER	*11122233345678*	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	*1234567*	

RESPONSE PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT
5Ø5-F5	PATIENT PAY AMOUNT	*3ØØ{*	$3Ø.ØØ
5Ø6-F6	INGREDIENT COST PAID	*ØØØ{*	$ØØ.ØØ or field not provided
5Ø7-F7	DISPENSING FEE PAID	*ØØØ{*	$ØØ.ØØ or field not provided
563-J2	OTHER AMOUNT PAID COUNT	*1*	Same as submitted
564-J3	OTHER AMOUNT PAID QUALIFIER	*99*	As submitted
565-J4	OTHER AMOUNT PAID	*162Ø{*	$162.ØØ
5Ø9-F9	TOTAL AMOUNT PAID	*132Ø{*	$132.ØØ
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	*Ø*	Ø or field not provided

Since no Ingredient Cost or Fees are submitted on a Copay Only billing, it is not expected that such would be returned. Expectation is that fields will be zero if present or field not present.

However, since OTHER AMOUNT SUBMITTED fields were detailed, recommendation is to supply the corresponding OTHER AMOUNT PAID fields on the response. If a submitted amount is NOT being paid, indicate this with that payment amount of zero.

An assumption has been made that the secondary plan prices the administration cost at their allowed amount since the Incentive Amount Submitted is not included on the billing request. This example represents the ideal situation where both the primary Medicare Part D plan and the secondary commercial plan cover the costs of administration.

15.11.5.3.2 SCENARIO 1C.2 RESPONSE: REJECT RESPONSE FROM SECONDARY INSURANCE – SUBMITTED FOR COPAY ONLY (MESSAGE BENEFICIARY MUST SUBMIT PAPER SECONDARY CLAIM)

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø1*	NPI
2Ø1-B1	SERVICE PROVIDER ID	*1563663556bbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ8Ø313*	March 13, 2ØØ8

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected

The Following Fields are Optional:

51Ø-FA	REJECT COUNT	*1*	
511-FB	REJECT CODE	*M5*	Requires Manual Claim
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	
526-FQ	ADDITIONAL MESSAGE INFORMATION	*MA NOT COVERED; PATIENT MUST SUBMIT A PAPER CLAIM*	

NOTE: In above example, Secondary does not cover administration costs and, therefore, rejects the claim advising the pharmacy that the <u>beneficiary</u> must submit a manual secondary claim. The pharmacy collects patient pay based on the primary claim response, thus allowing the pharmacy to collect both drug cost and administration fee. The beneficiary files a paper claim with the secondary plan. However, because the secondary plan will consider only the drug cost when pricing the claim, the N1 transaction generated from paper claim processing will list a patient pay that does not include the non-covered administration cost. As a result, the primary plan may deduct too much from TrOOP. The beneficiary will need to provide the Part D plan with proof of the patient pay amount paid on the primary claim and the reimbursement received from the secondary plan so that the Part D plan can correct the TrOOP amount applicable to this claim.

15.12 ELECTRONIC PRESCRIBING AND PRESCRIPTION ORIGIN CODE (419-DJ)

From the *Medicare Information for Pharmacists*, dated 03/17/2008

> CMS will begin monitoring the uptake of electronic prescribing in the Part D program by encouraging that Part D sponsors obtain the Prescription Origin Code via the NCPDP 5.1 optional field 419 DJ. We recognize that this field is currently not widely utilized in industry and, therefore, we do not intend to make this a requirement until plan year 2010. CMS also expects to add a new optional field to the PDE record in 2009 that will capture the Prescription Origin Code, and we strongly recommend that Part D sponsors work with their network pharmacies to voluntarily begin using the NCPDP 5.1 optional field 419 DJ in 2009.

During the February 2008 NCPDP Work Group meetings, the members approved further definition to the values of the Prescription Origin Code (419-DJ). The definitions are

Ø	Not Known
1	Written - Prescription obtained via paper.
2	Telephone - Prescription obtained via oral instructions or interactive voice response using a phone.
3	Electronic - Prescription obtained via electrical, digital, magnetic, wireless, optical, electromagnetic or similar capabilities that are computer-to-computer.
4	Facsimile - Prescription obtained via transmission using a fax machine.

The definitions are provided for consistent usage in the industry. For Telecom 5.1 transaction exchanges

- value 3 is to be used for electronic prescribing events
- value Ø is to be used for store transfers

Notes from the discussion: For CMS processing, they will determine unique doctors on their system (there could be different prescriber identifiers on the claim).
0=Store Transfers—the logic is we do not know the original origin. (CMS will need to resolve issue with Medicaids or factor out noise.) Guidance is for the pharmacy to do

whatever is done today, which may cause CMS some noise, which they will factor into data.

There is no change for Telecom 5.1 standard usage; the field will need to be submitted on claims with standard guidance from CMS. On the CMS PDE – plans will report what was submitted on claim. Refill number is on the PDE, refills will be ignored by CMS. CMS will work with Medicaids that do not allow Ø, to allow the Ø in 5.1 to indicate transfers. They would have to modify that the definition of Ø = unspecified to Ø = transfer.

(Note: A DERF was submitted and approved at the November 2ØØ8 work group meetings to clarify the value of 3 to "ePrescribed" and to add the value of 5 for "Pharmacy" for transfers, intrachain transfers, file buys, software upgrades/migrations, and any reason necessary to "give it a new number." This value is also the appropriate value for "Pharmacy dispensing" when applicable such as BTC (behind the counter), Plan B, etc. – but these changes are applicable in Telecom D.Ø and above, not in the current version 5.1.)

15.13 PROVIDER EXCLUSION/DECEASED

Question:
Federal regulations at 42 CFR 1001.1901 preclude Medicare payment for items or services prescribed by a physician or other individual who is excluded from participation in Medicare. The final 2010 call letter provided guidance re: claims for drugs prescribed by these providers. Is there any way prior to D.O to specify a claim is being denied because the prescriber is excluded from Medicare? Is there, perhaps, an existing reject code available in 5.1 that is appropriate in this situation? Also, if there is not suitable coding in D.O, we need to work to develop it.

Response:
For Telecom 5.1, the recommendation is to use Reject Code "71 ", with text of "Prescriber is sanctioned".

(Note: In August 2ØØ9 two new Reject Codes were approved for Telecom Version D.Ø and above usage of "ID Submitted is associated to a Sanctioned Prescriber" and "ID Submitted is associated to a Deceased Prescriber".)

15.14 CONSISTENT REJECT CODE FOR MEDICARE PART D – FDA LIST

Question:
Is there a consistent NCPDP Reject Code and message that can be used by all processors to identify those Medicare D claims rejecting due to the Product/Service ID being an FDA Non-matched NDC?

Response:
This question was received by the NCPDP WG1 Telecommunication FAQ Task Group. Effective 01/01/2010 Medicare Part D Prescription Drug Plans (PDP) may reject claims due to the product/service ID being found on the CMS' non-matched NDC list. These drugs will be identified at the NDC9 (Core9) level on the CMS non-matched NDC file. As entities need to prepare for the effective date, the normal course of discussing during the November 2ØØ9 Work Group meetings will not be timely enough for the industry. The notification was put out to the industry in August 2ØØ9, with disagreement comments with alternatives sent in by October 1, 2ØØ9.

Task Group Recommendation: For the Telecommunication Standard Version 5.1 in use today, the Reject Code "54 " (Non-matched Product/Service ID Number) is to be used with the exact text of "NDC not FDA listed" in the Additional Message Information (526-FQ) field. This recommendation is not required, but is highly recommended to assure consistency and to minimize questions/disruptions to pharmacies with this new edit.

Note Reject Code "70 "(Product/Service Not Covered) should not be used as it is too general.

16. NCPDP BATCH STANDARD

16.1 DELIMITER

Question:

Can we require (as a processor in compliance with the standard) that the submitter delimit each record in the Batch Standard by ASCII Carriage Return Line Feed (CRLF) in addition to the Start and End Text fields? We UNZIP and FTP the transmitted files to our mainframe system before processing and end up with a file of individual 5.1 records. Without the CRLF, we will get continuous string of characters. These widely used utilities already handle the parsing of each record without touching the contents of it based on CRLF. Once in the mainframe file, no extra characters are present at the end of each record. In other words, is the standard to be interpreted in its purest way and no CRLF allowed? Or, does NCPDP allow using an extra character outside of the standard to delimit each batch claim record, similar to a text editor or other commonly used pieces of software?

Response:

No, a payer must not require that a provider include delimiters other than those defined in the standard. The NCPDP Batch Standard Version 1.1 defines the delimiters to be used to separate records contained within a batch submission. The Start and End of Text characters are established to delimit the records within the file, as variable length Detail Records may be sent in the file. No additional delimiters must be required of a provider to fulfill this purpose.

16.2 RESPONSE FORMAT

Question:

When responding to a Batch Standard Version 1.1 transmission is the response format required the same as the response for Telecommunication Standard Version 5.1?

Response:

Yes. The format of the Batch Standard request and response is based on the Telecommunication standard. The Telecommunication Standard Version 5.1 billing claim response would be "wrapped" with the Batch Standard Version 1.1 Header/Detail/Trailer format (envelope).

16.3 SEGMENT DEFINITION

16.3.1 BATCH STANDARD SEGMENT USAGE DIFFERENT THAN TELECOMMUNICATION STANDARD?

Question:

If a processor is using both the Telecommunication Standard Version 5.1 and Batch Standard Version 1.1 can they define different segments and qualifiers to be used in each standard? How would that be communicated to their Trading Partners?

Response:

Yes, via payer sheets, etc.

16.4 TRANSACTION PROCESSING

16.4.1 BATCH PROCESSING – REJECT

Question:

Does the logic for transmission reject apply to Batch Standard Version 1.1? Specifically if the transmission is rejected does it require that all transactions be marked as rejects as well?

Response:
If a reject occurs at the Required Transaction Header Section level of the batch file, the entire batch is rejected (see Batch Implementation Guide). If a reject occurs in the Detail Data Record within the Batch file, then the detail record is rejected. The Detail Data Record may be rejected due to the batch structure (Text Indicator, Segment Identifier, or Transaction Reference Number with some problem, or it may be rejected due to syntax or processing of the NCPDP Data Record.

Once the processing of the NCPDP Data Record occurs, the same structure and syntax rules apply as in the Telecommunication Standard Version 5.1 (for example). As processing of the NCPDP Data Record occurs, the claim or service (for example) may be rejected for various reasons. Note that within the NCPDP Data Record, the transmission level/transaction level applies where there may be one to four transactions within the transmission of one NCPDP Data Record within the Detail Data Record.

For example, the file may contain the following:
Required Transaction Header Section
       Detail Data Record
             Containing one NCPDP Data Record
                    Containing from one to four claim/service transactions

The NCPDP Data Record in the Batch Standard is the same as the "transmission" level in the Telecommunication Standard. The statement above "containing from one to four claim/service transactions" is the same as the discussion in the Telecommunication Standard about multiple claims or services per transmission (using the Transaction Count field).

16.4.2 RESPONSE TIME
Question:
Is there a HIPAA mandate as to what the response time should be on a Batch Standard Version 1.1 transmission?

Response:
No. Quote from the HIPAA Administration Simplification website (http://aspe.hhs.gov/admnsimp/):

> '45 CFR 162.925 states "a health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction." If the standard transaction (e.g., ASC X12N 27Ø/271) is offered in a batch (non-interactive) mode, the health plan has to offer the same or higher level of service as it did for a batch mode of transaction before the standards were implemented by the plan. If a health plan offers the transaction in a real time (interactive) mode, the level of service has to be at least equal to the previously offered level for a real time mode of transaction. If a transaction is offered through Direct Data Entry (DDE), the level of service, again, has to be at least equal to the level offered for the DDE transaction before implementation of the HIPAA standard."'

17. NCPDP BATCH STANDARDS - MEDICARE-RELATED QUESTIONS

This section was added to provide guidance for a uniform processing of Medicare claims. Needs of Medicare were not brought forward for inclusion into Batch Standard Version 1.1, so solutions were created for claims to be processed in this environment until permanent solutions could be found. This section should be used in conjunction with program memorandums or guidance CMS publishes.

17.1 BATCH RESPONSE

Question:
Will Medicare generate batch responses for both accepted and rejected NCPDP claims?

Response:
A Batch 1.1 response will be generated for each claim.

17.1.1 COORDINATION OF BENEFITS

Question:
Will Medicaids be expected to respond to the Batch 1.1 transactions submitted by the DMERCs? If so, will the Medicaid response be to the DMERC or the provider? Or, will the 835 transaction to the provider be sufficient?

Response:
Yes. Medicaid will be generating a batch file containing a response for each request since it is required in the NCPDP Batch Standard Implementation Guide. The response file will be sent back to the submitter, which in this case, is Medicare. Medicaid would send the appropriate ASC X12N 835 transaction to the provider**.**

17.2 COMPOUNDS

17.2.1 SUPPORT OF MODIFIER

Question:
Question from Medicare - How do we support the modifiers for compounds used in Medicare now?

Response:
Per the NCPDP Telecommunication Standard Implementation Guide, there is no order to the list of compounds when reporting using the Compound Segment. Medicare needs to link the KP modifier to a specific compound ingredient, the Compound Ingredient Basis of Cost Determination, field 49Ø-UE, will be used to identify the ingredient that has the KP modifier. For that ingredient this field would have a value of "Ø9" = Other. The use of the "Ø9" would be only for Inhalation Compounds.

Since this is a temporary solution, the recommended permanent solution would be to add a new field to the Compound Segment. The field would have a situational field for Modifier Count and a situational and repeating field for Modifier. The recommended repetitions would be 8. This solution would need to be approved in a future version.

17.2.2 COMPOUND INGREDIENT DRUG COST CALCULATION
Question:

Since the DMERC system will generate a line item for each ingredient, the total of the Compound Ingredient Drug Cost would be used rather than the Gross Amount Due to pay the claim. Is this acceptable?

Response:
This is acceptable since a dispensing fee is paid for only specific procedures and the DMERC will take any fee submitted but will not pay it unless it is for a procedure for which they pay a dispensing fee.

17.2.3 NDC SUPPORT
Question:
What if one of the ingredients in the compound is not an NDC? Would the claim be rejected when the NDC validity was edited?

Response:
Medicare will support that if an NDC was not found on their files and it appeared in the Compound Segment, the claim would not reject for invalid NDC. It was suggested that Medicare should support inert ingredients, since the pharmacies may submit them in compounds.

17.2.4 TYPE OF COMPOUNDS
Question:
How are Nebulizer Compounds identified from Immunosuppressive Compounds?

Response:
The Compound Route of Administration, field 452-EH should be used since it is the route of administration of the complete compound mixture. For Medicare, the value of 3=Inhalation would identify Nebulizer Compounds and the value of 11=Oral would identify Immunosuppressive Compounds.

17.3 DIFFERENTIAL PRICE AND TRANSITIONAL ASSISTANCE
__Guidance__
A pharmacy is to provide to the covered discount card enrollee notification of any differential between the price of a prescribed drug and the lowest priced generic covered discount card drug that is therapeutically equivalent available at that pharmacy. How can this be handled in a standardized way?

The WG1 Version 5 Frequently Asked Questions Task Group reviewed possible solutions. Do the Preferred Products fit this need? The fields are:

555-AT	Preferred Product Copay Incentive	Amount of patient's copay/cost-share incentive for preferred product.
551-9F	Preferred Product Count	Count of preferred product occurrences.
556-AU	Preferred Product Description	Free text message.
553-AR	Preferred Product ID	Alternate product recommended by the plan.
552-AP	Preferred Product ID Qualifier	Code qualifying the type of product ID submitted in 'Preferred Product ID' (553-AR).
554-AS	Preferred Product Incentive	Amount of pharmacy incentive available for substitution of preferred product.

After review, the Task Group determined the Preferred Product fields are for formulary; and therefore not appropriate for this purpose.

2) Use of Amount Attributed To Product Selection (519-FJ).

An example:

A Claim is for $50. Brand is selected. Example shows the current model of "pay the difference" and applying this model to Medicare Discount Card program.

Negotiated rate for brand is $50.
Plan charges .50 for admin fee.
Patient Pay Amount is $50.50.
Generic price is $35.
Patient Pay Amount breaks up into buckets to equal $50.50.
If the Patient had the generic $35.50.
Copay/Coins $35.50.
Amt Att to prod sele $15.00 – difference between brand price of $50 and generic price of $35. This is included in the Patient Pay Amount.
Two added to $50.50, which is the amount the patient is to pay.

If the patient had selected the generic, they could have saved $x amount. They are paying an additional $15 because they chose the brand.

After review, the Task Group determined that the amount returned to the pharmacy could only be an estimate because the processor can only use an average generic price for the drug class, and the processor does not know what generic the pharmacy stocks. Therefore using the Amount Attributed To Product Selection would be inappropriate, since it is an exact amount.

3) There was discussion of using a different Processor Control Number or Group ID to differentiate these discount cards, but this solution was found to not solve the problems above and added more complexity.

4) Could the Remaining Benefit Amount (514-FE) be used for Transitional Assistance? Because this field is used by some processors for information that may be applicable to these patients, this field could not be used. There is a toll-free number that the patient can call to get their balance as well, which is on the card.

5) Use of Additional Message Information (526-FQ). After discussion, the Task Group recommended the Additional Message Information field be used as a short-term solution. The text should be standardized, for parsing routines.

The CMS message(s) should come first before any other additional text information. The standardized message would be as follows:

```
CMS TRANSITIONAL BALANCE REMAINING:     999999.99


CMS ESTIMATED BRAND/GENERIC DIFFERENCE: 999999.99
12345678901234567890123456789012345678901234567890
         1         2         3         4         5


Tag 1-4
Message 5-40
```

```
Dollars 41-50

Tag 51-54
Message 55-90
Dollars 91-100
```

Examples of the dollar amounts:

```
CMS TRANSITIONAL BALANCE REMAINING:      000155.45


CMS ESTIMATED BRAND/GENERIC DIFFERENCE: 000022.59
12345678901234567890123456789012345678901234567890
         1         2         3         4         5


CMS TRANSITIONAL BALANCE REMAINING:      000600.00


CMS ESTIMATED BRAND/GENERIC DIFFERENCE: 001022.55
12345678901234567890123456789012345678901234567890
         1         2         3         4         5
```

It is understood that not all in the industry will be able to support this solution in time for the June 1, 2004 live date, but perhaps could support the solution in the next months, offering a short-term standardized solution through 2006.

It is understood that there are some processors who are using the Remaining Benefit Amount (514-FE) field, as they will not have transitional assistance and benefit cap on the same claim. Using the Remaining Benefit Amount is not out of compliance. There are some processors that will have to use the Remaining Benefit Amount as well as report back transitional assistance. When that situation exists the Remaining Benefit Amount field is not an option for transitional assistance. The pharmacies requested consistency so it was decided that the Remaining Benefit Amount field would not be used some of the time (when the two amounts do not exist together) instead always report back the transitional assistance in the free text message field.

It is recommended to use the Additional Message Information (526-FQ) for both sets of messaging (transitional assistance balance and brand/generic savings). For those processors that do use the Remaining Benefit Amount Field (514-FE) to report the transitional assistance balance, the Additional Message Information (526-FQ) field should be used for the brand/generic message.

The messaging logic should be used by the processor as needed. The message break out suggested uses 50 characters. As such up to 4 such messages could be conveyed in the 200-character field.   There is no FIRST or SECOND message requirement so if processor wishes to convey that the Enrollment Fee was included in the Patient Pay Amount that can be the first and only message. If they wish to convey the following:

```
CMS ESTIMATED BRAND/GENERIC DIFFERENCE:    22.59
CMS ENROLLMENT FEE INCLUDED IN PTNT PAY:   30.00
```

they can do so – in any order. Provider systems need to display this.   Their display of this message may cause it to 'wrap around' or scroll, or they may

chose to parse this to provide a clearer view for their staff and the patients they serve.

Long-Term Solution:
The submission of DERFs for fields and code values to support this business need.

17.4 INDICATE MEDICAID COVERAGE?

Question:
Because some Medicaid States do not submit Medicaid eligibility files to the Medicare carrier, an indication is needed on the NCPDP claim that the patient has Medicaid coverage in order to cross the claims over to Medicaid. Where would this information be populated?

Response:
The Group ID (3Ø1-C1) is to be used to indicate Medicaid coverage. Since this is an alphanumeric field, a unique entry will be used to distinguish a Medicaid indicator and an OCNA number. 1Ø bytes of the 15-byte Group ID field will be used with a 2-character State Postal Code followed by the word "Medicaid". So a Texas Medicaid claim would show, "TXMEDICAID", in the Group ID.

Since this is a temporary solution, the long-term solution will require submission of a DERF to have a new field "Medicaid Indicator" added for a future version of the NCPDP standard.

17.5 MEDICARE CROSSOVER CLAIMS

17.5.1 SUPPORT OF ALLOWED AMOUNT, DEDUCTIBLE AMOUNT, CO-INSURANCE AMOUNT AND CO-PAYMENT AMOUNT

Question:
Claims submitted to Medicare for dual eligible clients (Medicare and Medicaid) will be crossed-over to the Medicaid States by the DMERCs. The Medicaid States have indicated that they need four fields besides the Medicare Paid Amount coming from the DMERCs—1) Medicare's Allowed Amount, 2) Medicare's Deductible Amount, 3) Medicare's Co-insurance Amount and 4) Co-payment Amount. Where will this data be populated?

Response:
For Cross Over claims, the following values should be used in the Other Payer Amount Paid Qualifier (342-HC) field:
>   *Medicare Allowed Amount = 'Ø7'*
>   *Medicare Paid Amount = 'Ø8'*
>   *Deductible Amount = '99'*
>   *Coinsurance Amount= '99'*
>   *Copayment Amount = '99'*

For the reiteration of value '99', the order should always be Deductible Amount followed by Coinsurance Amount and Co-payment Amount. Of these three Amounts, nothing below the last Amount that is needed to be populated should be sent but everything above the last Amount that is needed to be populated, should be sent. In other words, if there is a Deductible Amount and Co-payment Amount to be sent, Coinsurance Amount

will occur after Deductible Amount but with zero $ amounts. Likewise, if there is a Deductible Amount to be sent but no Coinsurance or Co-payment Amounts, the "99" values should not be repeated for Coinsurance and Co-payment Amounts. This is just not a process confined to Medicare passing to Medicaids---Medicare will use this to pass to other insurers.

Since this is a temporary solution, the long-term solution will require submission of a DERF to have new values for Primary Paid Amount, Primary Allowed Amount, Deductible Amount, Coinsurance Amount, and Copay Amount added to the Other Payer Amount Paid Qualifier (342-HC) field for a future version of the NCPDP standard.

03/2006 Update - crossover is not just payer-to-payer; it is also between pharmacy and payer. The above solution can be used between pharmacy and payer, provided the pharmacy is given the deductible, coinsurance and/or copayment amounts to submit to the next payer. This solution can be used in real-time claims submission, as well as batch submission.

17.6 MEDIGAP COVERAGE?

Question:
How will we determine if a NCPDP claim is Medigap? There doesn't seem to be a code in the COB segment indicating that the beneficiary has Medigap coverage.

Response:
Medicare requested the support of fields for Medigap Policy Number (OCNA number) and Medicare ID Number (cardholder number). The Group ID (3Ø1-C1) (which is not used by Medicare) is not large enough to support the Medigap Policy Number. Upon review, the Alternate ID (33Ø-CW) is to be used for the Medigap Policy Number, which is 2Ø-bytes and is part of the Claim Segment. The Medicare ID Number is to be placed in the Cardholder ID (3Ø2-C2).

Since this is a temporary solution, the long-term solution will require submission of a DERF to have a Medigap ID field added to a future version of the NCPDP standard. It was suggested that the DERF request addition of this new field to the Insurance Segment.

17.7 MEDICARE REVERSAL TRANSACTIONS

Question:
Will the DMERCs be accepting and processing reversal transactions? If so, are they planning on sending these transactions to Medicaids through the crossover process?

Response:
No. The DMERCs will not process reversal transactions for NCPDP or 837 claims.

17.8 MEDICARE SECONDARY PAYER (MSP)

Question:
Besides the Amount Paid, Medicare requires that the Original Submitted Amount, the Allowed Amount and Obligated to Accept Amount (same as the Contract Amount) fields be submitted to them from the pharmacy. This situation would be when Medicare is the secondary payer (MSP). Where would this data be populated?

Response:
The Gross Amount Due (43Ø-DU) field from the Pricing Segment will be used by the pharmacy to submit the Original Submitted Amount. Other data will be sent in the COB/Other Payments Segment. Medicare will utilize different qualifier values in Other Payer Amount Paid Qualifier (342-HC). When the qualifier is "Ø7" (Drug Benefit), contract amount will be sent in Other Payer Amount Paid (431-DV). When the qualifier is "Ø8" (Sum of All Reimbursement), Primary Paid Amount will be sent in 431-DV. Finally, when the qualifier is 99 (Other), Primary Allowed Amount will be sent in 431-DV.

Since this is a temporary solution, the long-term solution will require submission of a DERF to have a new values for Obligated to Accept/Contract Amount, Primary Paid Amount, Primary Allowed Amount, Deductible Amount, Coinsurance Amount, and Copay Amount added to the Other Payer Amount Paid Qualifier (342-HC) field for a future version of the NCPDP standard.

17.9 NDC/HCPCS, UNIT OF MEASURE (6ØØ-28), AND RATIO

Question:
For number of services - is this the field quantity dispensed 442-E7 in the Claim Segment? Do we also need to look at Unit Dose Indicator (429-DT) and Unit Of Measure (6ØØ-28) fields in the Claim Segment?

Response:
CMS provides the DMERCs with a chart containing a ratio for each NDC that is used to divide into a field to determine the number of HCPCS "services". CMS would use the Quantity Dispensed (442-E7) to be divided by the ratio to get the number of services.

Question:
Will the Ratio expressed in the Unit of Measure (6ØØ-28) used by NCPDP be converted to the Unit of Measure used by the DMERCs?

Response:
Yes.

17.10 USE OF PRIOR AUTHORIZATION SUPPORTING DOCUMENTATION (498-PP)

(See format for this field under Certificate of Medical Necessity (CMN Form))

Question:
There is a need to send narrative information on a claim that also has a CMN. Besides the need to send CMN information only with no narrative information, there is also a need to send only narrative information with no CMN. How will this be accomplished?

Response:
The first 3 bytes of the 498-PP Prior Authorization Supporting Document field will be an Authorization Information Qualifier with the following values and descriptions:

CMN - Indicates that the Supporting documentation that follows is Medicare required CMN information
NAR - Indicates that the Supporting documentation that follows is Medicare required Narrative Information

NCM - Indicates that the Supporting documentation that follows is both Medicare required CMN and narrative information

Since this is a temporary solution, the long-term solution will require submission of a DERF to have a new Narrative Segment added for a future version of the NCPDP standard.

Question:
Facility name, street address, city, state and zip and Representative Payee information are needed. Currently the facility name and address are being mapped from the authorized representative fields on the Prior Authorization Segment, when the string 'CMN' is in positions 1 thru 3 of the 5ØØ byte narrative field. However, if a Prior Authorization Segment is sent without the string 'CMN', then the data in the authorized representative fields is mapped to the rep. payee fields on the claim. What if the claim has both rep. payee information and requires the facility name and address? Also, what if facility name and address is needed, but a CMN is not?

Response:
This information will go in the Prior Authorization Supporting Documentation (498-PP) field. Currently the first 3 bytes of that field would be used as a Qualifier to indicate what would be populated in the field, the CMN would be in bytes 4-18Ø and the Narrative Information would be in bytes 181-26Ø. The Facility Name, address, city, state and zip code would start with byte 261. (The permanent solution would be to request new fields for Facility for a future version/release of the standard.)

Question:
How do the mandatory fields within the Prior Authorization Segment relate to the use of the PA Supporting Documentation (498-PP) field?

Response:
The mandatory fields must be consistently used. The mandatory fields are Segment Identification (111-AM), Request Type (498-PA), Request Period Date-Begin (498-PB), Request Period Date-End (498-PC), and Basis of Request (498-PD). Besides the Segment Identification the remaining fields are relevant for the Narrative Information and the Facility Information. For Narrative Information and Facility Information the Request Type may be any of the three values (Initial, Reauthorization, and Deferred), the Request Period Date-Begin and Request Period Date-End should default to the Date of Service or the date of submission (DMERC will indicate which to the provider), and the Basis of Request should always be Plan Requirement.

Question:
May modifiers that are needed on compounds (other than inhalation) be added to the PA Supporting Documentation Field (498-PP)? This relates to Medicare Part B and not CMN forms. The following are examples:

GA - Waiver of Liability statement on file
EY - No physician or other licensed health care provider order for this item or service
GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit
GZ - Item or service expected to be denied as not reasonable or necessary
QQ - Claim submitted with a written statement of intent

QV - Item or service provided as routine care in a Medicare qualifying clinical trial

Response:
A new identifier will be added to the Authorization Information Qualifier, which are the first three bytes of the PA Supporting Documentation field, for the CMN current solution. (The future fix to this is the request for the addition of new fields, Procedure Modifier and Modifier Count, to be added to the Compound Segment.)

Note: Current Values Are:

CMN - Indicates that the Supporting documentation that follows is Medicare required CMN information
CNA - Indicates that the Supporting documentation that follows is both Medicare required CMN and narrative information
CFA - Indicates that the Supporting documentation that follows is both Medicare required CMN and Facility Name and address information
CNF - Indicates that the Supporting documentation that follows is Medicare required CMN information, narrative information, and Facility Name and address information
FAC - Indicates that the Supporting documentation that follows is Medicare required Facility Name and address information
FAN - Indicates that the Supporting documentation that follows is Medicare required Facility Name and address information and narrative information
MMN - Indicates that the Supporting documentation that follows is Medicare modifier information and CMN information.
MNA – Indicates that the Supporting documentation that follows is Medicare modifier, Medicare CMN, and Narrative information.
MFA – Indicates that the Supporting documentation that follows is Medicare Modifier information, Medicare CMN information, and Facility Name and Address.
MNF- Indicates that the Supporting documentation that follows is Medicare Modifier information, Medicare CMN information, Narrative, and Facility Name and Address
MAC - Indicates that the Supporting documentation that follows is Medicare Modifier information and Facility Name and Address
MAN - Indicates that the Supporting documentation that follows is Medicare Modifier information, Facility Name and Address, and Narrative information.
MAR - Indicates that the Supporting documentation that follows is Medicare Modifier information and Narrative information.
NAR - Indicates that the Supporting documentation that follows is Medicare required Narrative Information

17.11 UNIQUE FIELD NEEDS

Question:
The field Patient Location (3Ø7-C7) on the Patient Segment does not have a value to indicate End Stage Renal Disease Treatment Facility (CMS POS = 65) that has special implications for a DMERC claim. Where can this information reside?

Response:
Submission Clarification Code (42Ø-DK) values of either 2=Other Override or 99=Other should be used to indicate that this is an ESRD facility. (A new value for ESRD Facility needs to be added to Patient Location (3Ø7-C7) in a future version of the standard.

17.12 CERTIFICATE OF MEDICAL NECESSITY (CMN) FORM

Following is a table that defines the mapping of data elements from the current Medicare forms to the NCPDP Version 5.1 Telecommunication Standard:

CMN field	5.1 field
Certificate Type/Date - Initial	498-PA Request Type-Initial
Certificate Type/Date - Revised	498-PA Request Type- Deferred
	498-PB Request Period Beginning Date
Certificate Type/Date – Re-certification	498-PA Request Type-Reauthorized
	49Ø-PC Request Period End Date
Patient First Name	31Ø-CA Patient First Name
Patient Last Name	311-CB Patient Last Name
Patient Street Address	322-CM Patient Street Address
Patient City	323-CN Patient City
Patient State	324-CO Patient State
Patient Zip	325-CP Patient Zip
Patient Telephone Number	326-CQ Patient Telephone Number
Patient HICN # (Medicare ID Number)	3Ø2-C2 Cardholder ID
Supplier NSC # (Medicare Supplier #)	2Ø2-B2 Service Provider ID Qualifier (Ø4)
	2Ø1-B1 Service Provider ID (Medicare)
Place of Service (See DMERC Supplier list)	3Ø7-C7 Patient Location
Facility Name	336-8C Facility ID
Physician Name	427-DR Prescriber Last Name (only)
Physician Telephone Number	498-PM Prescriber Phone Number
Physician UPIN	466-EZ Prescriber ID Qualifier (Ø6)
	411-DB Prescriber ID (UPIN)
Patient Date of Birth	3Ø4-C4 Date Of Birth
Patient Height	466-H2 Measurement Dimension (16)
	497-H3 Measurement Unit (Ø1 - Inches)
Patient Weight	466-H2 Measurement Dimension (14)
	497-H3 Measurement Unit (Ø3 - Pounds)
Patient Gender	3Ø5-C5 Gender
HCPCS Code	4Ø7-D7 Product Service Id
	436-E1 Product Service ID Qualifier (Ø9)
Diagnosis code (up to 3 occurrences)	424-DO Diagnosis code (ICD9)
	491-VE Diagnosis Code Count (handles 3)
	492-WE Diagnosis Code Qualifier (Ø1)
Name of Person Answering Questions	498-PE Authorized Rep First Name
	498-PF Authorized Rep Last Name

CMN field	5.1 field
Supplier's Charge	426-DQ Usual & Customary Charge

Those fields that did not map to an existing NCPDP Version 5.1 Telecommunication Standard/Batch 1.1 field, were placed in the **PA Supporting Documentation (498-PP)** field with the following format:
Note: Starting with position 181, the following format also includes solutions to processing of Medicare claims.

Description	Field Format	Start	Length	Values	Comments
498-PP Prior Auth Supporting Document		**1**	**5ØØ**		
Data Elements common to all CMNs					
Authorization Information Qualifier	AN	1	3	CMN - Certificate of Medical Necessity CNA - Medicare CMN and Narrative CFA - Medicare CMN and Facility Name and Address CNF - Medicare CMN, Narrative, and Facility Name and Address FAC - Facility Name and Address FAN - Facility Name and Address and Narrative MMN – Modifier and Certificate of Medical Necessity MNA – Modifier and Medicare CMN and Narrative MFA – Modifier and Medicare CMN and Facility Name and Address MNF – Modifier and Medicare CMN, Narrative, and Facility Name and Address MAC – Modifier and Facility Name and Address MAN – Modifier and Facility Name and Address and Narrative MAR – Modifier and Narrative NAR - Narrative	CMN - Indicates that the Supporting documentation that follows is Medicare required CMN information CNA - Indicates that the Supporting documentation that follows is both Medicare required CMN and narrative information CFA - Indicates that the Supporting documentation that follows is both Medicare required CMN and Facility Name and address information CNF - Indicates that the Supporting documentation that follows is Medicare required CMN information, narrative information, and Facility Name and address information FAC - Indicates that the Supporting documentation that follows is Medicare required Facility Name and address information FAN - Indicates that the Supporting documentation that follows is Medicare required Facility Name and address information and narrative information MMN - Indicates that the Supporting documentation that follows is Medicare modifier information and CMN information. MNA – Indicates that the Supporting documentation that follows is Medicare modifier, Medicare CMN, and Narrative information. MFA – Indicates that the Supporting documentation that follows is Medicare Modifier information, Medicare CMN information, and Facility Name and Address. MNF- Indicates that the Supporting documentation that follows is Medicare Modifier information, Medicare CMN information, Narrative, and Facility Name and Address MAC - Indicates that the Supporting documentation that follows is Medicare Modifier information and Facility Name and Address MAN - Indicates that the Supporting documentation that follows is Medicare Modifier information, Facility Name and Address, and Narrative information.

					MAR - Indicates that the Supporting documentation that follows is Medicare Modifier information and Narrative information. NAR - Indicates that the Supporting documentation that follows is Medicare required Narrative Information
Form Identifier	AN	4	6	Ø8.Ø2 - Immunosuppressive Drug CMN or DIF	
Ordering Physician First Name	AN	1Ø	12		
Ordering Physician Address	AN	22	3Ø		
Ordering Physician City	AN	52	2Ø		
Ordering Physician State	AN	72	2		
Ordering Physician Zip	AN	74	15		
Certificate on File Indicator	AN	89	1	Y or N	This certifies that the supplier has a paper copy of the CMN or DIF on file available for the DMERC to review if necessary
Signature Date	DT	9Ø	8	CCYYMMDD	Date the Supplier signed the CMN or DIF form
Question Ø1A - HCPCS	AN	98	11	valid drug HCPCS code	Drug prescribed
Question Ø1B - MG	NØ	1Ø9	4	ØØØ1 thru 9999	Dosage in Milligrams of the Drug prescribed in question Ø1A
Question Ø1C - Times Per Day	NØ	113	2	Ø1 - 99	Frequency of administration of Drug Prescribed in question Ø1A
Question Ø2A - HCPCS	AN	115	11	valid drug HCPCS code spaces are valid	Drug prescribed
Question Ø2B - MG	NØ	126	4	ØØØØ thru 9999	Dosage in Milligrams of the Drug prescribed in question Ø2A
Question Ø2C - Times Per Day	NØ	13Ø	2	ØØ - 99	Frequency of administration of Drug Prescribed in question Ø2A
Question Ø3A - HCPCS	AN	132	11	valid drug HCPCS code spaces are valid	Drug prescribed
Question Ø3B - MG	NØ	143	4	ØØØØ thru 9999	Dosage in Milligrams of the Drug prescribed in question Ø3A
Question Ø3C - Times Per Day	NØ	147	2	ØØ – 99	Frequency of administration of Drug Prescribed in question Ø3A
Question Ø4	AN	149	1	Y or N	Has the Patient had an organ transplant that was covered by Medicare?

Question Ø5A	AN	15Ø	1	spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted? (List most recent transplant) Required if the answer to question 4 is Y
Question Ø5B	AN	151	1	spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted? (List most recent transplant)
Question Ø5C	AN	152	1	spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted? (List most recent transplant)
Question 11	DT	153	8	CCYYMMDD	Date Patient was discharged from the hospital following this transplant surgery
Question 12	AN	161	1	Y or N	Was there a prior transplant failure of this same organ?
Filler	AN	162	19		Space for possible expansion of data required for Immunosuppressive DIF
Data Elements for Medicare Required					

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Narrative Data					
Narrative	AN	181	8Ø	Free Form Text	
Data Elements for Medicare Required Facility name and Address Data					**Required when Patient Location is not Ø1 – Home**
Facility Name	AN	261	27		
Facility Address	AN	288	3Ø		
Facility City	AN	318	2Ø		
Facility State	AN	338	2		
Facility Zip	AN	34Ø	15		
Data elements for Modifier	**AN**	**355**	**25**	**Ø1-25**	**Indicate the 2-byte ingredient number followed by the two-position modifier.**
Filler	AN	38Ø	121		For future use.

18. MODIFICATIONS TO THIS DOCUMENT
18.1 VERSION 2.Ø

Version 2.Ø includes the section "*Mandatory Fields First In Segments*".

It also includes the section "*Mandatory Qualifiers And Fields – Usage of Default Values*".

Version 2.Ø also includes the editorial change to the Specification. The "Diagram for Two (Three or Four) Billing Transactions incorrectly lists the Compound Segment. This was incorrect in the diagrams. Billing for multiple ingredients (compounds) transactions may occur only once within a transmission.

The section "*References To The Compound and Prior Authorization Implementation Guides*" has been added to the section "*Editorial Changes Applicable To All Version 5 Implementation Guides*". This information has also been added to the Version 5.6 Implementation Guide. The information is applicable to all Version 5 Implementation Guides.

The section "*Additional Information On Multiple Reversal Transactions In A Transmission*" has been added to the section "*Editorial Changes Applicable To All Version 5 Implementation Guides*". This information has also been added to the Version 5.6 Implementation Guide. The information is applicable to all Version 5 Implementation Guides.

The section "*Section 9 Version Changes Version 5.3 (Published May, 2ØØØ)*" has been added to the "*Editorial Changes Applicable To All Version 5 Implementation Guides*" section. This shows the correction to a bullet for the Product/Service ID Qualifier of "NDC".

In the "*Response Pricing Segment", "Other Payer Amount Recognized (556-J5)"* section of this document, the section *"Will It Contain The Sum Of All Occurrence Amounts?"* has been added.

In the *"Transaction Header Segment"* section, the section *"Software Vendor/Certification ID (11Ø-AK)", "Usage"* with the question *"How is Transaction header field 11Ø-AK used?"* has been added.

In the "*Claim Segment*" section, "Submission Clarification Code (42Ø-DK)", "*Value 9 Usage*" has been added with the question *"In the Claim Segment field 42Ø-DK, code 9: is this used for encounter data from providers in a managed care network? If not, what is the purpose of this code?"*

In the "*Transmission/Transaction Syntax"* section, the section *"Zero Dollar Amounts" h*as been added with the question *"How Should Zero Dollar Amounts Be Handled In A Variable Transaction?"* The section *"Alphanumeric Field Expansion"* has been added with a question.

The section *"Response Status Segment"* has been added with a question about Reject Code (511-FB).

The section *"Response Message Segment"* has been added with a question about Additional Message Information and Message field usage.

In the section "*Editorial Changes Applicable To All Version 5 Data Dictionaries*", the section "*Version/Release Number (1Ø2-A2) = 51*" has been added. The section "*Product/Service ID*" has been added.

Also in this same section, "*Appendix M – Version Modifications – Version 5.2*" has been added.

In the section "*General Questions*", the section "*Documentation History*", "*Documentation Dates*", question "Where do I obtain publication date information of the various version/releases of the Telecommunication Standards?" has been added.

18.2 VERSION 3.Ø

In the section "*Editorial Changes Applicable to all Version 5 Implementation Guides", "Corrections", "Product ID Qualifier Of "NDC*", a correction has been added clarifying the Product/Service ID Qualifier in the Compound examples in the question "*Should the Product/Service ID Qualifier in the Claim Segment in Compound examples be ØØ instead of Ø3?*"

The section "*Pricing Segment", "Sales Tax Fields", "Usage*" has been added with the question "*How are the Flat Sales Tax Amount Submitted (481-HA), Percentage Sales Tax Amount Submitted (482-GE), Percentage Sales Tax Rate Submitted (483-HE), and Percentage Sales Tax Basis Submitted (484-JE) used?*"

Numerous editorial corrections were made to examples in the Implementation Guide. See section "*Editorial Changes Applicable to all Version 5 Implementation Guides", "Corrections", "Typographical Changes".*

"*Appendix B. Coordination Of Benefits Explanation For Version 5.1"* was added to provide information on billing COB in Version 5.1.

The section *"Notable Clarifications" "Prior Authorization Clarifications"* has been added to the section "*Prior Authorization Transactions*". The section *"Notable Clarifications" "Prior Authorization Clarifications"* has also been added to *"Enhancements" "References to the Compound and Prior Authorization Implementation Guide".* This section has been modified to reflect that although Telecommunication Implementation Guide Version 5.6 had changes to incorporate the Prior Authorization Implementation Guide information, Appendix C and Versions 7.Ø, 7.1 should be used for their breadth of information.

Please note the membership approved a recommended method of processing for Compound (multi-ingredient) prescriptions.

Please see *"Appendix C. Prior Authorization Clarifications"* for important information on the use of the Prior Authorization transactions.

The response in the section *"An Additional Survey?"* has been updated to reflect the WG1 Telecommunication and WG9 Government Programs ongoing efforts.

18.3 VERSION 4.Ø

Version 4.Ø includes "Appendix D. Billing For Compounds" that contains more information about processing Compound transactions. This information is included in the Telecommunication Implementation Guide Version 5.6 and above. This information can be used with any Version 5 and above implementation, as it is clarification and does not affect the specifications.

In example 7.18.1, the Authorization Number (5Ø3-F3) was corrected (see Appendix C. Prior Authorization Clarifications). Information was also added to Section 4.2.12 Prior Authorization Segment in the Telecommunication Implementation Guide Version 7.1 includes information for Request Type (498-PA) = "2" (Reauthorization). See Appendix C. Prior Authorization Clarifications.

18.4 VERSION 5.Ø

The section *"Compound/Multi-Ingredient Processing"* has been added with questions on Quantity Dispensed and rejections. The sections *"Business Function of Capture"* and *"Pricing Guidelines"* have also been added.

A correction to Example 7.13.3 Reversal Accepted – Response Duplicate from the Version 5.1 Implementation Guide has been noted. See "*Editorial Changes Applicable to all Version 5 Implementation Guides", "Corrections",* for the question "*In the Version 5.1 Implementation Guide, Example 7.13.3 Reversal Accepted Response – Duplicate, is the Transaction Response Status of "D" correct?"*

18.5 VERSION 6.Ø

Additional questions were added to the document for Version 6.Ø. The section *"Rebill Transactions (B3, C3, N3)", "Duplicate Processing for All Rebill Transactions"* with the question: *"How do you handle duplicates in the case of a Rebill?"* has been added.

In the *"Response Header Segment"* section, the subsection *"Response Header Segment Fields Not Modified From Transaction Header Segment", "Usage"* has been added with the question *"Should the fields submitted in the Transaction Header Segment on a request be returned without modification on the Response Header Segment? (Should they be mirrored?)"*

Section *"Response Status Segment"* contains a new subsection *"Response With Accepted And Rejected Information", "Allowed?"* with the question *"Can a response transaction contain accepted and rejected information? For example, on an RX Billing (B1), could the response be returned with a Transaction Response Status of "P" (Paid) and in the Response Status Segment, Reject Code and Count fields be included to relay information? Or in another example, could a Reversal (B2) response be "A" (Approved) and Reject Code and Count fields be included?"*

In the section *"Compound/Multi-Ingredient Processing",* a new subsection *"DUR For Compounds", "Processing"* has been added with the question *"On compounded claims, does DUR "hit" each drug within the compound? "* A new subsection has also been added *"Order of Compound Ingredients", "Submitted in highest quantity order?"* with the question *"On compounded claims, does DUR "hit" each drug within the compound?*
Should compound ingredients be put in highest usage amount order? (i.e., product A 8Ø%, product B 1Ø%, product C 1Ø%). "

In the section *"Claim Segment"*, a new subsection *"Product/Service ID (4Ø7-D7)"*, *"Format and Usage"* was added with a question about the usage of the 11-digit format of the codes.

In section *"Transmission/Transaction Syntax"*, a new subsection *"Field Size Different In HIPAA Standards"*, *"Usage"* was added with the question "*The field sizes in ASC X12N are larger than in NCPDP Telecommunication Standard Version 5.1. An example would be Subscriber ID in the 834 standard at 3Ø bytes and the NCPDP Cardholder ID at 2Ø bytes. What field length should be used?* "

A new section was added to the document "*NCPDP Batch Standard"* to answer questions for the implementation of the Batch Standard, with the Telecommunication Standard used as the NCPDP Data Record within the Detail Data Record.

18.6 VERSION 7.Ø

In Version 7.Ø of this document, the subsection "*Count and Counter Information*" was added to the section "*Transmission/Transaction Syntax*".

18.7 VERSION 8.Ø

Additional questions from the Telecommunication Implementation Guide versions were added to this documents. These questions include:

In section "*Compounds/Multi-Ingredient Processing*", subsection "*Compound Identifiers*", "*How do I enter an ingredient in a compound that does not have an identifier (for example water)?*"

In section "*Compounds/Multi-Ingredient Processing*", subsection "*Partial Fill Compounds"*, "How do I bill for a partial fill of a compound?*"

In section *"Reversal Transactions"*, subsection *"Multiple Claim/Service Reversal Transactions Within a Transmission"*, "What are the recommended guidelines for supporting multiple claim or service reversal (B2) transactions within a transmission?"*

In section "*Rebill Transactions (B3, C3, N3)*", subsection "*Multiple Rebill Transactions in a Transmission"*, "What are the recommended guidelines for supporting multiple rebill (B3, N3, C3) transactions within a transmission?"*

In section *"Response Segment Discussion"*, subsection "*Response Pricing Segment"*, subsection "*Captured Response*", "*Why would the Response Pricing segment be used (optional) in a Billing transaction (or other transaction) when a processor returns a "C"aptured response?*"

18.8 VERSION 9.Ø

"Appendix E. Where Do I Find" has been added, with a reference in section *"General Questions"*.

18.9 VERSION 1Ø.Ø

In section "*Pricing Segment*", subsection "S*ales Tax Fields*", the subsection "*Format*" was added with the question "*How is the format of Percentage Sales Tax Rate Submitted (483-HE) and Percentage Sales Tax Rate Paid (56Ø-AY) expressed?*"

In section "*Transmission/Transaction Syntax*", subsection "*Field Truncation*", a subsection "*Truncation of Numeric Fields*" was added with the question "*In the Telecommunication Standard, a field such as Patient Location (3Ø7-C7) is defined as a two-byte numeric with values 1-11. Can I send the leading zeroes in values 1-9 (meaning sending Ø1, Ø2, Ø3..., or 1, 2, 3)?*" Also the subsection "*Printable Character*s", subsection "*Usage*" was added with the questions "*What are printable characters?", and "Can characters, i.e.: alpha, numeric and symbols (if allowable) be separated by spaces?".*

In section *"Transaction Discussion"*, a subsection "*Eligibility Transaction*", subsection "*Group Separator*" was added with the question "*The Telecommunication Standard Implementation Guide 5.1 on page 2 it states that "A transmission consists of one or more transactions separated by group separators….*"

In section *"Compound/Multi-Ingredient Processing*", a subsection "*Reversal Transaction*", subsection "*Use of Product/Service ID (4Ø7-D7) and Compound Code (4Ø6-D6)*" was added with the question "*On a compound billing the Product/Service ID field (4Ø7-D7) on the Claim Segment will have a default value of zero and the NDCs for the compound ingredients will come in on the Compound Segment in the Compound Product ID field (489-TE)….*"

In section "*Request Segment Discussion*", subsection "*Insurance Segment"*, a subsection was added "*Cardholder ID (3Ø2-C2)*" with the question "*Can a cardholder ID contain symbols such as hyphens and apostrophes?*"

18.10 VERSION 11.Ø

A need was defined to relay the Discharge Date of a patient from a hospital setting. Since this need had to be met in the Telecommunication Standard Version 5.1 and the Batch Standard Version 1.1 environment, the membership decided to use the Prior Authorization Number Submitted (462-EV) until a long-term solution was found. See section "*Claim Segment*", subsection "*Discharge Date Support*", "*Usage*".

In section "*Claim Segment*", subsection "*Fill Number (4Ø3-F3)*", a new subsection was added, *"Default?*"

In section "*Transmission/Transaction Syntax*", subsection "*Rejecting Transactions*", the section "*Invalid Version/Release Number (1Ø2-A2), Transaction Code (1Ø3-A3), or Transaction Count (1Ø9-A9)"* was added.

In section "*Prior Authorization Transaction*" subsection "*Prior Authorization Request And Billing Transaction*", two sections were added – "*P/A Request And Billing – PA Not Required*" and "*P/A Request And Billing – Deferred*".

In section "*Editorial Changes Applicable To All Version 5 Data Dictionaries"*, subsection "*Corrections*", a section "*Appendix F – Version 5.Ø Reject Codes For Telecommunication Standard*" has been added.

In section "Claim Segment", subsection "Coordination of Benefits" a new section "Other Coverage Code (3Ø8-C8)" has been added.

The section "Use Of This Document" has been added to the "Purpose Of This Document" section.

18.11 VERSION 12.Ø

In section "*Pricing Segment*", subsection "*Sales Tax Fields*", subsection "*Usage*", the response to the question "H*ow are the Flat Sales Tax Amount Submitted (481-HA), Percentage Sales Tax Amount Submitted (482-GE), Percentage Sales Tax Rate Submitted (483-HE), and Percentage Sales Tax Basis Submitted (484-JE) used?*" has been changed. The original response noted that both flat and percentage fields should not be used in a claim. However, upon further review, the membership felt tax situations that were based on flat and percentage sales tax was possible.

In section "*Pricing Segment*", a new subsection "*Usual And Customary Charge (426-DQ) Definition*" has been added with the question "*Does Usual And Customary Charge (426-DQ) include a dispensing fee?*"

In section "*Pricing Guidelines*", subsection "1ØØ% Copay", a subsection was added "*1ØØ% Copay and Negative Amounts*" with the question "*Under what situation would a Total Amount Paid (5Ø9-F9) be sent to the pharmacy with a negative dollar amount?*"

In this same section, a subsection has been added "*Payment Amount Based on Dispensed or Intended?*" with the question "*Do NCPDP standards require the payment amount to be based on the amount actually dispensed, or can the intended amount be used instead?*"

In section "*Claim Segment*", subsection "*Coordination of Benefits*" a new section "*Other Coverage Code (3Ø8-C8)*" has been clarified further. Please note these changes from the previous version.

In section "*COB/Other Payments Segment*", a new subsection "*Other Payer Amount Paid Count (341-HB)*", subsection "*Reject Code When Count Does Not Match*" has been added with the question "*What Reject Code (511-FB) should be used when the Other Payer Amount Paid (431-DV) doesn't match the number submitted in the Other Payer Amount Paid Count (341-HB)?*" A subsection was added "*Other Payer Amount Paid Count and Other Payer Reject Count for the same Other Payer*". A subsection was added "*Negative Amounts*". A new subsection was added under "*Other Payer ID (34Ø-7C)*" of "*Same Other Payer ID (34Ø-7C) In Different Coordination of Benefits/Other Payments Count (337-4C) Occurrences*".

In section "*Pricing Guidelines*", a new subsection "*Transaction Fee Charge*" has been added with a question about a transaction fee paid by the pharmacy.

In section "*Insurance Segment*", subsection "*Facility ID (338-8C)*" a new question has been added "*Does the field Facility ID (336-8C) link to a patient and an insurance plan? Is this field in any way linked or associated with a prescriber? How do you see this field being used in the real world? How would an insurance plan utilize this field?*"

In "*Appendix B. Coordination Of Benefits Explanation For Version 5.1*", a new subsection "*Questions*", subsection "*Partial Fill*" has been added with the question "*How should Partial Fills be handled for a Coordination of Benefits (COB) billing? How does the reject of "Partial Fill Transaction Not Supported" affect this processing?*"

18.12 VERSION 13.Ø

In section "*Claim Segment*", subsection "*Submission Clarification Code (42Ø-DK)*", subsection "*Submission Clarification Code Count (354-NX)*", a new question "*What Reject Code (511-FB) should be used when the Submission Clarification Code (42Ø-DK) doesn't match the number submitted in the Submission Clarification Code Count (354-NX)?*" has been added.

In section "*COB/Other Payments Segment*", subsection "*Other Payer-Patient Responsibility Amount Code (352-NQ) and Qualifier (351-NP)*", a new question "*What Reject Code (511-FB) should be used when the Other Payer-Patient Responsibility Amount (352-NQ) and Qualifier (351-NP) doesn't match the number submitted in the Other Payer-Patient Responsibility Amount Count (353-NR)?*" has been added.

18.13 VERSION 14.Ø

In section "*Claim Segment*", subsection "*Procedure Modifier Code (459-ER)*", a new question has been added for "*Procedure Modifier Code with NDC*".

In section "*Compound/Multi-Ingredient Processing*", subsection "*Quantity Dispensed (442-E7)*", a new question has been added for "*Quantity Dispensed (442-E7) and Compounds*". A new question has been added for "*Product Service ID Qualifier (461-E1) and Product Service ID (4Ø7-D7)*". A new question has been added for "*Compound Ingredient Calculates to be Less than $Ø.ØØ5.*"

In section "*Field Truncation*", the subsection "*Truncation of Dollar Fields*" has been added.

In section "*COB/Other Payments Segment*", a new question has been added for "*Other Payer Coverage Type (338-5C) Value "99" (Composite) and Other Payer ID (34Ø-7C)*".

In section "*Clinical Segment*", a question has been added for "*Explicit Decimal Points in Diagnosis Code (424-DO)*".

A new section has been added of "*NCPDP Batch Standards - Medicare-Related Questions*". Questions were received from Medicare, and about Medicare processing of pharmacy claims.

In "*Appendix B. Coordination Of Benefits Explanation For Version 5.1*", a section for "*Reporting Out of Pocket Expenses*" has been added that points to the Medicare section for a standard solution to this reporting need. In section *"Pricing Guidelines*", a subsection for "*Patient Paid Amount Submitted (433-DX)*" has been added that discusses the use of this field for intended or actual amounts, and uses the same recommendation as the out of pocket expenses.

18.14 VERSION 15.Ø

In section "*Transmission/Transaction Syntax*", subsection "*Date Format*", subsection "*Default*" was added. In this same section "*Mandatory Field Order*" was added. In this same section "*Segment Order*" was added. In this same section "*Segment Structure*" was added.

In section "*Compound/Multi-Ingredient Processing*", subsection "*Compound Ingredient Quantity (448-ED)*" was added.

In section "*Request Segment Discussion*", subsection "*Insurance Segment*", a subsection "*Person Code*" was added. In this same section, subsection "*Patient Segment*", a subsection "*Patient Location (3Ø7-C7)*" was added.

A typographical error was found in section "*Prior Authorization Number-Assigned (462-EV) in Claim Segment*". The correct field name is Prior Authorization Number Submitted (462-EV). This has been corrected in this document and is noted in section "*Editorial Changes Applicable to all Version 5 Implementation Guides*".

18.15 VERSION 16.Ø

In section "*Compound/Multi-Ingredient Processing*", subsection "*One Ingredient*" was added. Subsection "*How Is The Most Expensive Legend Drug Calculated?*" was added.

In section "*Pricing Segment*", subsection "*Sales Tax Fields*", subsection "*Part of Copay*" was added.

In section "T*ransmission/Transaction Syntax*", subsection "*Maximum Length*", subsection "*Reject Optional Field At Maximum Length?*" was added.

18.16 VERSION 17.Ø

It was noted that guidance in the Telecommunication Standard Implementation Guide Version 5.2 was inadvertently not included in this document. Section "*Response Pricing Segment*", subsection "*Remaining Benefit Amount (514-FE)*" with guidance on zeroes and defaults was added.

In section "*Compound/Multi-Ingredient Processing*", subsection "*Multi-Ingredient Compounds*", subsection "*Multi-Ingredient Compounds and Rejects*" and "*Multi-Ingredient Compounds and DUR Rejects*" was added.

In section "*Field Truncation*", subsection "*Alphanumeric Field and Leading Spaces*" was added.

The following Frequently Asked Question was modified "*Please clarify the definition of the Patient Location (3Ø7-C7) Field.*"

> *In the sentence "In the future, a Data Element Request Form (DERF) may be submitted to clarify the place where the patient resides versus the place the patient receives the product or service." was modified from "(DERF) will" to "(DERF may)".*

In section "*Patient Paid Amount Submitted (433-DX)*", subsection *"Intended or Actual?*" the response was modified from:

Patient Paid Amount Submitted (433-DX) is defined in the NCPDP Data Dictionary as, "Amount the pharmacy received from the patient for the prescription dispensed."

After many discussions about the use of this field, WG1 Telecommunication determined that this field should be used, as it is defined, not for intended payment monies. During the August 2ØØ3 Work Group meetings, the WG1 attendees approved a solution that was approved in Medicare situations (section "NCPDP Batch Standard – Medicare-Related Questions, subsection "Medicare Crossover Claims".) It was felt that "one" solution should be used, even though there may be variation based on the fields that each payer needs in their program. It is recognized that the most appropriate solution, exists in Telecommunication Standard Version 5.5.

The Other Payer Amount Paid Qualifier (342-HC) with loops as appropriate should be used. For the reiteration of value '99', the order should always be Deductible Amount followed by Coinsurance Amount and Copayment Amount. Also, that, of these three Amounts, nothing below the last Amount that is needed to be populated should be sent but everything above the last Amount that is needed to be populated should be sent. In other words, if there is a Deductible Amount and Copayment Amount to be sent, Coinsurance Amount will occur after Deductible Amount but with zero $ amounts. Likewise, if there is a Deductible Amount to be sent but no Coinsurance or Copayment Amounts, the "99" values should not be repeated for Coinsurance and Copayment Amounts.

Use the Other Payer Amount Paid Qualifier (342-HC) field with the values to indicate the information needed:
Medicare Allowed Amount = 'Ø7'
Medicare Paid Amount = 'Ø8'
Deductible Amount = '99'
Coinsurance Amount= '99'
Copayment Amount = '99'

Based on discussions, the above scenario was discussed and it was agreed that this scenario would be used.

Modified to:

Patient Paid Amount Submitted (433-DX) is defined in the NCPDP Data Dictionary as, "Amount the pharmacy received from the patient for the prescription dispensed."

After many discussions about the use of this field, WG1 Telecommunication determined that this field should be used, as it is defined, not for intended payment monies, unless state or federal statute or regulation requires the reporting of the Other Payer Amount Paid (431-DV) and patient's cost share from a previous payer. It is recognized that the most appropriate solution exists in Telecommunication Standard Version 5.5 (or above).

In section "*NCPDP Batch Standard*", subsection "*Delimiter*" was added.

In section "N*CPDP Batch Standards - Medicare-Related Questions*", subsection "*Differential Price and Transitional Assistance*" was added.

18.17 VERSION 18.Ø

A question regarding the Usual And Customary (426-DQ) field and a copay situation has been added to section "*Pricing Segment*", subsection "*Usual And Customary Charge (426-DQ) Definition*".

Questions regarding the determination of Level of Effort have been added "*Level Of Effort Determination (474-8E)*" to section "*Request Segment Discussion*", subsection "*DUR/PPS Segment*".

A section and table clarifying usage of Other Coverage Code values "*Clarification of Other Coverage Code (3Ø8-C8)*" has been added to section "*Request Segment Discussion*", subsection "*Claim Segment*", subsection "*Coordination of Benefits*", subsection "*Other Coverage Code (3Ø8-C8)*". In this subsection, the table listing the Other Coverage Code values was modified. The table listed the values with two-digits. Although the leading zero can be submitted, for consistency, the leading zero was truncated.

A question has been added "*Other Payer Paid Claim With $0 Payment*" to section "*Request Segment Discussion*", subsection "*COB/Other Payment Segment*", subsection "*Coordination of Benefits*".

"*Remaining Benefit Amount (514-FE)*" has been added to section "*Editorial Changes Applicable To All Version 5 Data Dictionaries*". A correction has been made to the Note in this data element.

18.18 VERSION 19.Ø

"*Invalid Prescription/Service Reference Number Qualifier (455-EM)*" has been added to section "*Request Segment Discussion*" subsection "*Claim Segment*".

"*Other Payer Amount Recognized (556-J5) From Downstream Payer?*" has been added to section "*Response Segment Discussion*" subsection "*Response Pricing Segment*".

"*Compound Example Guidance*" was added to section "Compound/Multi-Ingredient Processing".

The NCPDP SNIP Liaison Special Committee prepared more guidance for COB examples. Section "*Appendix B. Coordination Of Benefits Explanation For Version 5.1*" has been revamped with more clarification to the examples that existed. In addition, scenario 1E through 2B were added.

18.19 VERSION 2Ø.Ø

Section "*Pricing Guidelines*", subsection "*Patient Paid Amount Submitted (433-DX)*" added a subsection "*In Tertiary Claim Processing*".

The section "*Medicare Part D Processing*" was added to explain eligibility and billing functions unique to Medicare Part D processing.

18.20 VERSION 21.Ø

Section "*Appendix B. Coordination of Benefits Explanation for Version 5.1*" has been updated with a new subsection "*Usual & Customary (426-DQ)*".

18.21 VERSION 22.Ø

In the section "*Medicare Part D Processing*", corrections were made to the eligibility strings of data in the Message field. The field contained more data than the field size. The data was moved to the Additional Message Information field per the rules.

Example 2: An Eligibility Accepted With Two Payers
Example 3: An Eligibility Accepted With More Than Two Payers
Message (5Ø4-F4)

18.22 VERSION 23.Ø

Section "*Appendix F. Long-Term Care (LTC) Pharmacy Claims Submission Recommendations For Version 5.1*" has been added.

18.23 VERSION 24.Ø

The headings have been numbered.

The support of the composite is removed in section "*Request Segment Discussion*" subsection "*Coordination Of Benefits*", subsection "*Other Coverage Code (3Ø8-C8)"* because of the possible need for more than three payers for patients with Medicare Part D coverage. The entire section below was removed.

Third Occurrence Usage for More than Four Coverages in COB:
Currently in COB where there are more than three **other** payers, the third occurrence must be a composite of the third and higher payers.

For example, when submitting to the fifth payer, to report the information from payer one through payer four, the following is recommended (not all fields shown).

Field ID and Name	Value	Description
When submitting to the third payer, the first occurrence contains the primary (Ø1). The second occurrence contains the secondary (Ø2).		
Other Payer Coverage Type (338-5C)	Ø1	Primary
Other Payer Amount Paid Qualifier (342-HC)	Ø4	Administrative
Other Payer Coverage Type (338-5C)	Ø2	Secondary
Other Payer Amount Paid Qualifier (342-HC)	Ø3	Postage
When submitting to the fourth payer, the first occurrence contains the primary (Ø1). The second occurrence contains the secondary (Ø2). The third occurrence contains the tertiary payer (Ø3).		
Other Payer Coverage Type (338-5C)	Ø1	Primary
Other Payer Amount Paid Qualifier (342-HC)	Ø7	Drug Benefit
Other Payer Coverage Type (338-5C)	Ø2	Secondary
Other Payer Amount Paid Qualifier (342-HC)	Ø7	Drug Benefit
Other Payer Coverage Type (338-5C)	Ø3	Tertiary
Other Payer Amount Paid Qualifier (342-HC)	Ø7	Drug Benefit
When submitting to the fifth payer, the first occurrence contains the primary (Ø1). The second occurrence contains the secondary (Ø2). The third occurrence MUST CONTAIN the composite (99) and sum of all reimbursement (Ø8) of the tertiary and fourth payer.		

Other Payer Coverage Type (338-5C)	Ø1	Primary
Other Payer Amount Paid Qualifier (342-HC)	Ø7	Drug Benefit
Other Payer Coverage Type (338-5C)	Ø2	Secondary
Other Payer Amount Paid Qualifier (342-HC)	Ø7	Drug Benefit
Other Payer Coverage Type (338-5C)	99	Composite
Other Payer Amount Paid Qualifier (342-HC)	Ø8	Sum of all reimbursement

A subsection was added under this section for "*Usage for More than Nine Coverages in COB*:"

Examples were reviewed to correct the Dispensing Fee being included in the Usual & Customary Charge.
- Section "*Billing Transaction Examples", "Billing Transaction – B1 - Primary Claim From Pharmacy to PDP"* Usual And Customary Charge (426-DQ) was modified to $9Ø.ØØ.

18.24 VERSION 25.Ø
Section "N*CPDP Batch Standards - Medicare-Related Questions*", subsection "*Medicare Crossover Claims"* has been updated with a 03/2006 note that the solution is available between pharmacies and payers as well as between payers.

In section "*Request Segment Discussion*", subsection "*Claim Segment*", a section "*Product/Service ID Qualifier (436-E1)"* has been added. A subsection for "*CPT Code Usage*" was added.

In section "*Request Segment Discussion*", subsection "*COB/Other Payments Segment*", subsection "*Coordination of Benefits*", a section "*Other Payer Amount Paid Qualifier (342-HC)*" has been added. A section "*Other Payer Date (443-E8)"* has been added under "Other Coverage Code (3Ø8-C8)".

In section "Compound/Multi-Ingredient *Processing*", a subsection has been added "*Compound Ingredient Drug Cost (449-EE)*".

In section "*Response Segment Discussion*", subsection "*Response Pricing Segment*", a section "*Copay Only Versus Other Payer Amount Paid Billing"* has been added.

In section "*Medicare Part D Processing*", billing sections have been enhanced to support the codified structured solution for Reject Codes.

18.25 VERSION 26.Ø
In section "*Request Segment Discussion*", subsection "*Prescriber Segment*" was added.

In section "*Compound/Multi-Ingredient Processing*", a subsection has been added "*Coordination of Benefits*".

In section "*Request Segment Discussion*", subsection "*COB/Other Payments Segment"*, subsection "*Coordination of Benefits*", a section "*Primary Has Paid More Than Secondary Would If They Were Primary*" has been added.

18.26 VERSION 27.Ø

In sections throughout the document, Other Payer Amount Recognized (566-J5) was mistakenly entered as (556-J5). This has been corrected.

In section *"Medicare Part D Processing"*, Scenario 2 for enhanced Eligibility information was added. Also in the subsection *"Structured Reject Codes"*, a question has been added "*Use Of Reject Code (511-FB) = "A5" or "A6"*". The description of Reject Code (511-FB) value "A6" has been modified from "This medication may be covered under Part B Medication and therefore cannot be covered under the Part D basic benefit for this beneficiary" to "This medication may be covered under Part B". A new subsection *"Standardized Additional Messages for Plans That Do Not Require a Call for Prior Authorization before Approving the Claim"* was added.

In section *"Request Segment Discussion"*, *"Claim Segment"*, *"Coordination of Benefits"*, *"Other Coverage Code"* clarification was made on the use of Other Coverage Code = 8. In this same section *"Clarification Of Other Coverage Code (3Ø8-C8)"*" was also clarified on value Ø and 8. In *"Scenario 1D Request: Pharmacy Bills Secondary Insurance After Primary Paid"* a clarification was made to ending note about the COB Segment. In sections that discuss Other Coverage Code (3Ø8-C8) and the COB/Other Payments Segment, clarification was added that the COB/Other Payments Segment may be sent on copay only billing when needing to relay Other Payer ID or Other Payer Date fields.

In section *"Request Segment Discussion"*, section *"Pharmacy Provider Segment"* was added.

In section *"Request Segment Discussion"*, section *"Coupon Segment"*, subsections *"Guidance"* and *"Coupon Questions"* were added.

18.27 VERSION 28.Ø

In section *"Request Segment Discussion"*, section *"Coupon Segment"*, subsections *"Guidance"* and *"Coupon Questions"* were added to help explain further the sections added in Version 27.Ø.

18.28 VERSION 29.Ø

Request for Guidance was added for Service Billing examples that are billings for a service without a medication to section *"Transaction Discussion"*, section *"Service Billing Transaction"*. A reference to this section was also added in *"Appendix F. Long-Term Care (LTC) Pharmacy Claims Submission Recommendations For Version 5.1"*.

In section *"Medicare Part D"*, section *"Vaccine Billing"* was added for guidance in using Telecommunication Standard Version 5.1.

18.29 VERSION 3Ø.Ø

In section *"Editorial Changes Applicable to all Version 5 Data Dictionaries"*, *"Reject Code (511-FB) = 95-98 Clarification"* was added.

18.30 VERSION 31.Ø

Section *"Appendix G. Workers' Compensation Recommendations"* has been added.
In section *"Medicare Part D"*, section *"Vaccine Billing"* added "*Vaccine Coordination Of Benefits Explanation For Version 5.1*" new examples for guidance in using Telecommunication Standard Version 5.1 with coordination of benefits.

18.31 VERSION 32.Ø

Section "*Medicare Part D Processing*", a subsection "*Electronic Prescribing and Prescription Origin Code (419-DJ)*" has been added for guidance.

18.32 VERSION 33.Ø

Section "*Medicare Part D Processing*", a subsection "*Provider Exclusion/Deceased*" has been added.
Section "*Medicare Part D Processing*", a subsection "*Consistent Reject Code for Medicare Part D – FDA List*" has been added.
Section "*Printable Characters*" has been clarified that "The use of lower case letters ASCII 97 - 122 (61 - 7A hex) is not allowed in the Telecommunication Standard **format.**"

19. APPENDIX A. TYPOGRAPHICAL CHANGES MADE IN VERSION 6.Ø

Segment	Transaction Example V5.1	Field Number	Field Name	Correction	Description of Change
Capture response	7.14.1				Change Pricing Segment to only have copays.
Request Claim Segment	various examples	415-DF	Number of Refills Authorized	Presentation method	Field is 9(2). In examples, show the field as zero suppressed. (In some examples, the leading zero is displayed.)
Response Status	7.2.5, 7.3.2, 7.4.2, 7.5.2, 7.7.2, 7.13.4, 7.14.1, 7.15.3, 7.18.2, 7.24.2	5Ø3-F3	Authorization Number		Auth Number is not mandatory for a reject response. Make Auth Number optional. Reject Count and Code are Mandatory. Use same "presentation" in each example.
Qualifiers	various examples and Segment Discussions		(Patient ID Qlfr, Prescriber ID Qlfr, Other Payer ID Qlfr, DUR Co-Agent ID Qlfr, Compound Ingred Basis of Cost Determination)	Presentation method	Field is x(2). In examples, consistently show the field appropriately. (In some examples, the leading zero is missing.)
Patient	7.2.	322-CN	Patient City Address	323-CN	Correct Field ID.
Pharmacy Provider	7.2.1	449-E9	Provider ID	444-E9	Correct Field ID.
Patient	7.2.1	322-CN	Patient City Address	323-CN	Correct Field ID.
Pharmacy Provider	7.2.1	466-EZ	Provider ID Qualifier	465-EY	Correct Field ID.
	7.2.1	449-E9	Provider ID	444-E9	Correct Field ID.
Insurance	7.3.	313-DC	Cardholder Last Name	313-CD	Correct Field ID.
Insurance	7.5.	313-DC	Cardholder Last Name	313-CD	Correct Field ID.
Response DUR/PPS	7.5.1	473-7E	DUR/PPS Response Code Counter	567-J6	Correct Field ID and Name (9 times).

Telecommunication Version 5 Questions, Answers and Editorial Updates

Segment	Transaction Example V5.1	Field Number	Field Name	Correction	Description of Change
Patient	7.6.	322-CN	Patient City Address	323-CN	Correct Field ID.
DUR/PPS	7.6.	567-J6	DUR/PPS Code Counter	473-7E	Correct Field ID and Name in 2nd transaction.
Compound	7.7 Submission	449-EE	Compound Ingred Drug Cost	intentionally missing	Add a note that for this example, the value of this field was intentionally left off to show an error situation.
	7.7 Paid/Captured Response				Denote that in the Paid/Captured response, that this assumes the drug cost was submitted without the error.
	7.7 Rejected Response	546-4F	Reject Occurrence	Should be 1	Drug Cost missing on ingredient 1, not 3
Compound	7.7 section			optional segment denotation	Denote the Compound Segment as optional. Denote the optional designation of the last two fields in the Cmpd Segment on each iteration.
Compound	7.7.2				
Patient	7.8.	322-CN	Patient City Address	323-CN	Correct Field ID.
Response Pricing	7.8.1	558AW	Flat Sales Tax Amount Paid	558-AW	Add dash to Field ID.
Patient	7.9.	322-CN	Patient City Address	323-CN	Correct Field ID.
Pharmacy Provider	7.9.	449-E9	Provider ID	444-E9	Correct Field ID.
Pharmacy Provider	7.9.	466-EZ	Provider ID Qualifier	465-EY	Correct Field ID.
Pricing Segment	7.11	412-DC	Dispensing Fee Submitted		Add 1ØØ{ in Value column.
Response Claim	7.14.1	557-AU	Preferred Product Description	556-AU	Correct Field ID.

Telecommunication Version 5 Questions, Answers and Editorial Updates

Segment	Transaction Example V5.1	Field Number	Field Name	Correction	Description of Change
Patient	7.19.	322-CN	Patient City Address	323-CN	Correct Field ID.
Clinical	7.19.	949-ZE	Measurement Date	494-ZE	Correct Field ID.
Response Pricing	7.21.1	477-BE	Professional Service Fee Paid	562-J1	Correct Field ID.
Pharmacy Provider	7.22.	449-E9	Provider ID	444-E9	Correct Field ID.
Patient	7.22.	322-CN	Patient City Address	323-CN	Correct Field ID.
Patient	7.23.	322-CN	Patient City Address	323-CN	Correct Field ID.
Patient	7.24.	322-CN	Patient City Address	323-CN	Correct Field ID.
Response Status	7.24.2	459-7F	Help Desk Phone Number Qualifier	549-7F	Correct Field ID.
General review	all examples			optional segment denotation	Verify each example shows the segment as optional or mandatory by consistent nomenclature. Most segments are correct. Just verify.

Other Corrections:

Segment	Transaction Example V5.1	Field Number	Field Name	Correction	Description of Change
Transaction Response Status Segment	7.2.5, all examples			optional segment denotation	Moved Reject Count and Reject Code out of optional section into main section of segment.
Added note at end of example	7.7			added note	Note: In this example, the field 449-EE Cmpd Ingredient Drug Cost was intentionally not submitted to show a rejected situation. In the Reject Response, this error is noted. However, assume the field was submitted with value $1.2Ø for the Captured or Paid Responses below.
Added note at end of example	7.7.1			added note	Note: Assume in this example that the $1.2Ø Compound Ingredient Drug Cost was submitted and this is the payment or captured response.
Compound Segment, added note at end of example	7.7.2			added note	Remove the incorrectly denoted "The Following Fields are Optional:" from the Compound Segment notation. Noted the reject was intentional on the submission. *Noted in the Paid/Captured response that the example reflects the field being sent.* *Noted in the Rejected Response that this assumes the drug cost was missing. Changed the Reject Occurrence Indicator to 1 and changed comment to Tetracycline.*
Compound Segment	7.7.3			optional segment denotation	Compound Segment is optional. Per standard way of denoting segments in the imp guide, the statement "The following fields are optional:" was added, with the table split.
Pricing Segment	7.11	412-DC	Dispensing Fee Submitted	added value	Added the value of 1ØØØ to the Dispensing Fee Submitted Value column.
Response Claim Segment, Response Pricing Segment	7.14.1		Preferred Product fields, Payment fields	removed from segments	Removed the Preferred Product fields from the Response Claim Segment. Removed the payment fields from the Response Pricing Segment.

20. APPENDIX B. COORDINATION OF BENEFITS EXPLANATION FOR VERSION 5.1

The following sections were added to this Editorial document to assist the implementer in a consistent usage of Version 5.1 for Coordination of Benefits (COB).

Please also see section "*Claim Segment*", subsection "*Coordination of Benefits*", "*Other Coverage Code (3Ø8-C8)*" for information.

Scenario 1A Request– Pharmacy bills claim to payer on file for patient		
Scenario 1A Response – Payer rejects claim indicating that patient has other insurance		
Scenario 1B Request – Pharmacy determines other coverage information, enters this to patient profile and bills that payer		
Scenario 1B Response – Payer responds with paid response to the claim:	Total Amt Paid = $41.2Ø Patient Pay Amt =$2Ø.ØØ	
Pharmacy bills secondary insurance after primary responds with paid information. **Depending on Secondary Payer rules, COB claim to secondary can be submitted one of three ways:**		
SUBMITTAL OPTION 1	**SUBMITTAL OPTION 2**	**SUBMITTAL OPTION 3**
Scenario 1C Other Payer Amount Paid	**Scenario 1D** Copay Only	**Scenario 1E** Government Program requiring Full Payment disclosure
Scenario 1C Request – Pharmacy bills secondary insurance after primary paid response received	**Scenario 1D Request** – Pharmacy bills secondary insurance after primary paid response received	**Scenario 1E Request** – Pharmacy bills secondary insurance after primary paid response received
Scenario 1C Response – Paid response from secondary insurance	**Scenario 1D Response** - Paid response from secondary insurance	**Scenario 1E Response** – Paid response from secondary insurance where both Other Payer Amount Paid and Patient Pay Amount from primary claim were submitted

Scenario 2A Request – Pharmacy bills claim to primary payer for patient.	
Scenario 2A Response – Payer responds with a paid response, however, the patient is responsible for full payment. (i.e. patient has not yet met deductible)	
Scenario 2B Request – Pharmacy bills next payer on file for patient submitting Other Coverage Code of 4 to indicate payer has been billed and has paid, but no dollars were collected.	
Scenario 2B Response – Payer responds with paid response providing normal processing response	

20.1 SCENARIO 1A REQUEST: PHARMACY BILLS TO INSURANCE DESIGNATED BY PATIENT

TRANSACTION HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS

1Ø1-A1	BIN NUMBER	610066	
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	1234567890	
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	20010313	March 13, 2ØØ1
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	bbbbbbbbbb	

INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	987654321	Cardholder ID

The Following Fields are Optional:

3Ø1-C1	GROUP ID	1234	
3Ø3-C3	PERSON CODE	3	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	3	Child

CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	1234567	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3	NDC
4Ø7-D7	PRODUCT/SERVICE ID	ØØØØ6Ø94228	Clinoril 2ØØmg
4Ø8-D8	DISPENSE AS WRITTEN/PRODUCT SELECTION CODE	2	Patient has requested Brand

PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	557{	$55.7Ø
412-DC	DISPENSING FEE SUBMITTED	5Ø{	$5.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	7Ø7{	$7Ø.7Ø
43Ø-DU	GROSS AMOUNT DUE	6Ø7{	$6Ø.7Ø
423-DN	BASIS OF COST DETERMINATION	Ø3	Direct

20.2 SCENARIO 1A RESPONSE: REJECT RESPONSE INDICATING OTHER COVERAGE EXISTS

Includes information about Other Payers

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing

1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ1Ø313*	March 13, 2ØØ1

RESPONSE MESSAGE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*2Ø*	RESPONSE MESSAGE SEGMENT
5Ø 4-F4	MESSAGE	*OC: "PRIMARY NAME", "PRIMARY CARRIER GROUP NUMBER", 8ØØ-888-8888*	Freeform message about Other Payer on file.

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected
51Ø-FA	REJECT COUNT	*1*	
511-FB	REJECT CODE	*41*	Submit Bill to Other Payer or Primary Payer
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	
526-FQ	ADDITIONAL MESSAGE INFORMATION	*FOR QUESTIONS REGARDING PRIMARY COVERAGE CALL...AT nnn-nnn-nnnn.*	Additional message space if required.

20.3 SCENARIO 1B REQUEST: PHARMACY BILLS TO OTHER INSURANCE

This occurs *after* pharmacy gets information on other coverage from the patient or payer

TRANSACTION HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø1-A1	BIN NUMBER	*999999*	
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*XYZ*	
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ1Ø313*	March 13, 2ØØ1
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*bbbbbbbbbb*	

INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*Ø4*	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	*998877665*	Cardholder ID

The Following Fields are Optional:

3Ø1-C1	GROUP ID	*3451*	
3Ø3-C3	PERSON CODE	*4*	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	*3*	Child

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	1234567	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3	NDC
4Ø7-D7	PRODUCT/SERVICE ID	ØØØØ6Ø94228	Clinoril 2ØØmg
4Ø8-D8	DISPENSE AS WRITTEN/PRODUCT SELECTION CODE	2	Patient has requested Brand

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

==Pricing fields submitted at contracted rate for this payer.==

4Ø9-D9	INGREDIENT COST SUBMITTED	567{	$56.7Ø
412-DC	DISPENSING FEE SUBMITTED	45{	$4.5Ø
426-DQ	USUAL AND CUSTOMARY CHARGE	7Ø7{	$7Ø.7Ø
43Ø-DU	GROSS AMOUNT DUE	612{	$61.2Ø
423-DN	BASIS OF COST DETERMINATION	Ø1	AWP

20.4 SCENARIO 1B RESPONSE: PAID RESPONSE FROM PRIMARY INSURANCE

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ1Ø313	March 13, 2ØØ1

RESPONSE INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	25	INSURANCE SEGMENT

The Following Fields are Optional:

524-FO	PLAN ID	2316	
568-J7	PAYER ID QUALIFIER	1	National Payer ID
569-J8	PAYER ID	2223345678	

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	21	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	P	Paid

The Following Fields are Optional:

5Ø3-F3	AUTHORIZATION NUMBER	*123456789123456789*	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*8ØØ9986222*	

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	*1234567*	

The Following Fields are Optional:

551-9F	PREFERRED PRODUCT COUNT	*1*	1 Preferred product identified
552-AP	PREFERRED PRODUCT ID QUALIFIER	*Ø3*	NDC
553-AR	PREFERRED PRODUCT ID	*17236Ø569Ø1*	Ibuprofen 6ØØmg tablet

RESPONSE PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT

The Following Fields are Optional:

5Ø5-F5	PATIENT PAY AMOUNT	*2ØØ{*	$2Ø.ØØ
5Ø6-F6	INGREDIENT COST PAID	*567{*	$56.7Ø
5Ø7-F7	DISPENSING FEE PAID	*45{*	$4.5Ø
5Ø9-F9	TOTAL AMOUNT PAID	*412{*	$41.2Ø
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	*1*	Ingredient Cost Paid as Submitted
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	*55{*	$5.5Ø
518-FI	AMOUNT OF COPAY/CO-INSURANCE	*12Ø{*	$12. ØØ
519-FJ	AMOUNT ATTRIBUTED TO PRODUCT SELECTION	*25{*	$2.5Ø

20.5 SCENARIO 1C REQUEST: PHARMACY BILLS SECONDARY INSURANCE AFTER PRIMARY PAID

Pharmacy submits claim indicating Other Payer Amount Paid

This situation describes a claim submission where the Processor requires the amount paid from the Primary Payer's claim.

TRANSACTION HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	*61ØØ66*	
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	*123456789Ø*	
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ1Ø313*	March 13, 2ØØ1
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	*bbbbbbbbbb*	

INSURANCE SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	987654321	Cardholder ID

The Following Fields are Optional:

FIELD	FIELD NAME	VALUE	COMMENTS
3Ø1-C1	GROUP ID	1234	
3Ø3-C3	PERSON CODE	3	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	3	Child

CLAIM SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	1234567	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3	NDC
4Ø7-D7	PRODUCT/SERVICE ID	ØØØØ6Ø94228	Clinoril 2ØØmg
3Ø8-C8	OTHER COVERAGE CODE	2	Other coverage exists-payment collected

PRICING SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

FIELD	FIELD NAME	VALUE	COMMENTS
4Ø9-D9	INGREDIENT COST SUBMITTED	557{	$55.7Ø
412-DC	DISPENSING FEE SUBMITTED	5Ø{	$5.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	7Ø7{	$7Ø.7Ø
43Ø-DU	GROSS AMOUNT DUE	6Ø7{	$6Ø.7Ø*
423-DN	BASIS OF COST DETERMINATION	Ø3	Direct

Billing for Contracted Rate of Secondary with Indication of Amount that has been Paid.
 * Definition of Gross Amt Due only allows for 'the sum of' selected fields as presented in the Pricing Segment.   It does NOT allow for the "sum of" the fields *minus* Other Payer Amount Paid.

COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø5	COB SEGMENT
337-4C	COB/OTHER PAYMENTS COUNT	1	One occurrence
338-5C	OTHER PAYER COVERAGE TYPE	Ø1	Primary
339-6C	OTHER PAYER ID QUALIFIER	Ø3	Bin #
34Ø-7C	OTHER PAYER ID	999999	ID assigned to payer
443-E8	OTHER PAYER DATE	2ØØ1Ø313	March 13, 2ØØ1
341-HB	OTHER PAYER AMOUNT PAID COUNT	1	One occurrence
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø7	Drug Benefit
431-DV	OTHER PAYER AMOUNT PAID	412{	$41.2Ø paid

20.6 SCENARIO 1C RESPONSE: PAID RESPONSE FROM SECONDARY INSURANCE

Submitted with Other Payer Amount Paid

RESPONSE HEADER SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ1Ø313	March 13, 2ØØ1

RESPONSE INSURANCE SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	25	INSURANCE SEGMENT

The Following Fields are Optional:

524-FO	PLAN ID	9988	
568-J7	PAYER ID QUALIFIER	1	National Payer ID
569-J8	PAYER ID	12121212	

RESPONSE STATUS SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	21	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	P	Paid

The Following Fields are Optional:

5Ø3-F3	AUTHORIZATION NUMBER	11122233345678	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	6Ø235Ø862	

RESPONSE CLAIM SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	22	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx Billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	1234567	

RESPONSE PRICING SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	23	RESPONSE PRICING SEGMENT
5Ø5-F5	PATIENT PAY AMOUNT	5{	$ØØ.5Ø Copay
5Ø6-F6	INGREDIENT COST PAID	557{	$55.7Ø
5Ø7-F7	DISPENSING FEE PAID	5Ø{	$5.ØØ
566-J5	OTHER PAYER AMOUNT RECOGNIZED	412{	$41.2Ø
5Ø9-F9	TOTAL AMOUNT PAID	19Ø{	$19.ØØ
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	1	Ingredient Cost Paid as Submitted

TOTAL AMOUNT PAID represents a sum of 'Ingredient Cost Paid' (5Ø6-F6), 'Dispensing Fee Paid' (5Ø7-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive Amount Paid' (521-FL), 'Professional

Service Fee Paid' (562-J1), 'Other Amount Paid' (565-J4) **less** 'Patient Pay Amount' (5Ø5-F5) and 'Other Payer Amount Recognized' (566-J5).

NOTE: In above example, total reimbursement from Secondary provides a different result than total payment from Primary due to different contracted rates.

20.7 SCENARIO 1D REQUEST: PHARMACY BILLS SECONDARY INSURANCE AFTER PRIMARY PAID

Submitted For Copay Only. Processor requires copay only be submitted on the transaction. On a tertiary claim the amount submitted copay remaining would be from the secondary payer.

TRANSACTION HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	61ØØ66	
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	123456789Ø	
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ1Ø313	March 13, 2ØØ1
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	bbbbbbbbbb	

INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	987654321	Cardholder ID

The Following Fields are Optional:

3Ø1-C1	GROUP ID	1234	
3Ø3-C3	PERSON CODE	3	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	3	Child

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	1234567	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3	NDC
4Ø7-D7	PRODUCT/SERVICE ID	ØØØØ6Ø94228	Clinoril 2ØØmg
3Ø8-C8	OTHER COVERAGE CODE	8	Claim is a billing for a copay

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	1	1 occurrence
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	99	Other

48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED	*2ØØ{*	$2Ø.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	*7Ø7{*	$7Ø.7Ø
43Ø-DU	GROSS AMOUNT DUE	*2ØØ{*	$2Ø.ØØ

In order for the NCPDP Version 5.1 to allow a COPAY ONLY billing, the above recommendation was adopted at the May 2ØØ1 Telecommunication Work Group. No Ingredient Cost or Dispensing fields are expected (however these could be submitted with zeros). This recommendation allows partners to stay in compliance to the definition of Gross Amount Due.

Other Amount Claimed Submitted will be the *entire* Patient Pay Amount. Until a later version of NCPDP Telecomm standard is allowed, "the pieces" of Patient Pay Amount cannot be billed.

A COB Segment was not included in the example; however this *could be* used by trading partner agreement if Other Payer ID or Other Payer Date is required.

20.8 SCENARIO 1D RESPONSE: PAID RESPONSE FROM SECONDARY INSURANCE
20.8.1 SUBMITTED FOR COPAY ONLY

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ1Ø313*	March 13, 2ØØ1

RESPONSE INSURANCE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*25*	INSURANCE SEGMENT

The Following Fields are Optional:

524-FO	PLAN ID	*9988*	
568-J7	PAYER ID QUALIFIER	*1*	National Payer ID
569-J8	PAYER ID	*12121212*	

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid

The Following Fields are Optional:

5Ø3-F3	AUTHORIZATION NUMBER	*11122233345678*	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	

RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE	*1234567*	

	NUMBER		

RESPONSE PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT
5Ø5-F5	PATIENT PAY AMOUNT	*5{*	$ØØ.5Ø Copay
5Ø6-F6	INGREDIENT COST PAID	*ØØØ{*	$ØØ.ØØ or field not provided
5Ø7-F7	DISPENSING FEE PAID	*ØØØ{*	$ØØ.ØØ or field not provided
563-J2	OTHER AMOUNT PAID COUNT	*1*	Same as submitted
564-J3	OTHER AMOUNT PAID QUALIFIER	*99*	As submitted
565-J4	OTHER AMOUNT PAID	*2ØØØ*	$2Ø.ØØ
5Ø9-F9	TOTAL AMOUNT PAID	*195{*	$19.5Ø
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	*Ø*	Ø or field not provided

Since no Ingredient Cost or Fees are submitted on a Copay Only billing, it is not expected that such would be returned. Expectation is that fields will be zero if present or field not present.

However, since OTHER AMOUNT SUBMITTED fields were detailed, recommendation is to supply the corresponding OTHER AMOUNT PAID fields on the response. If a submitted amount is NOT being paid, indicate this with that payment amount of zero.

20.9 SCENARIO 1E REQUEST: PHARMACY BILLS SECONDARY INSURANCE AFTER PRIMARY PAID

Submit claim indicating Other Payer Amount Paid AND Patient Pay Amount WHEN GOVERNMENT PROGRAM REQUIRES

Patient presents a prescription at the pharmacy. Patient has coverage under a private health insurance plan and a government program that has a regulatory requirement to receive full disclosure of primary payment. The government program is payer of last resort. Pharmacy submits the prescription to the primary health insurance plan and receives a paid response, including a patient paid amount. Pharmacy submits the prescription to the government program due to secondary coverage. Because of the regulatory requirement, the claim must include:

- Other Coverage Code (3Ø8-C8) = 2
- Other Payer Amount Paid (431-DV) to report other processor payment amount and
- Patient Paid Amount Submitted (433-DX) to report the dollars that the primary reported that the Patient was pay due to copayment/coinsurance/deductible.

This information will be used by the government program to determine appropriate reimbursement and patient out-of-pocket responsibility. (This scenario can only be used when state or federal statute or regulation requires knowledge of full reimbursement by primary.)

For purposes of Example, the Primary Payment response is the response detailed in Scenario 1B. Patient Pay Amount = 2Ø.ØØ and Total Amount Paid = 41.2Ø.

TRANSACTION HEADER SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	61ØØ66	
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	123456789Ø	
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ4Ø524	May 24, 2ØØ4
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	bbbbbbbbbb	

INSURANCE SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	987654321	Cardholder ID

The Following Fields are Optional:

FIELD	FIELD NAME	VALUE	COMMENTS
3Ø1-C1	GROUP ID	1234	
3Ø3-C3	PERSON CODE	3	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	3	Child

CLAIM SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	1234567	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3	NDC
4Ø7-D7	PRODUCT/SERVICE ID	ØØØØ6Ø94228	Clinoril 2ØØmg
3Ø8-C8	OTHER COVERAGE CODE	2	Other coverage exists-payment collected

PRICING SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

FIELD	FIELD NAME	VALUE	COMMENTS
4Ø9-D9	INGREDIENT COST SUBMITTED	557{	$55.7Ø
412-DC	DISPENSING FEE SUBMITTED	5Ø{	$5.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	7Ø7{	$7Ø.7Ø
433-DX	PATIENT PAID AMOUNT SUBMITTED	2ØØ{	$2Ø. ØØ
43Ø-DU	GROSS AMOUNT DUE	6Ø7{	$6Ø.7Ø*
423-DN	BASIS OF COST DETERMINATION	Ø3	Direct

Billing for Contracted Rate of Secondary with Indication of Amount that has been Paid.
 * Definition of Gross Amt Due only allows for 'the sum of' selected fields as presented in the Pricing Segment.   It does NOT allow for the "sum of" the fields *minus* Other Payer Amount Paid.

COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT

FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø5	COB SEGMENT
337-4C	COB/OTHER PAYMENTS COUNT	1	One occurrence

338-5C	OTHER PAYER COVERAGE TYPE	Ø1	Primary
443-E8	OTHER PAYER DATE	2ØØ4Ø524	May 24, 2ØØ4
341-HB	OTHER PAYER AMOUNT PAID COUNT	1	One occurrence
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø7	Drug Benefit
431-DV	OTHER PAYER AMOUNT PAID	412{	$41.2Ø paid

20.10 SCENARIO 1E RESPONSE: PAID RESPONSE FROM SECONDARY INSURANCE WHERE BOTH OTHER PAYER AMOUNT PAID AND PATIENT PAY AMOUNT FROM PRIMARY CLAIM WERE SUBMITTED

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ4Ø524	May 24, 2ØØ4

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	21	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	P	Paid

The Following Fields are Optional:

5Ø3-F3	AUTHORIZATION NUMBER	11122233345678	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	6Ø2357Ø862	

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	22	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx Billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	1234567	

RESPONSE PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	23	RESPONSE PRICING SEGMENT
5Ø5-F5	PATIENT PAY AMOUNT	5{	$ØØ.5Ø Copay
5Ø6-F6	INGREDIENT COST PAID	557{	$55.7Ø
5Ø7-F7	DISPENSING FEE PAID	5Ø{	$5.ØØ
566-J5	OTHER PAYER AMOUNT RECOGNIZED	412{	$41.2Ø
5Ø9-F9	TOTAL AMOUNT PAID	19Ø{	$19.ØØ
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	1	Ingredient Cost Paid as Submitted

TOTAL AMOUNT PAID represents a sum of 'Ingredient Cost Paid' (5Ø6-F6), 'Dispensing Fee Paid' (5Ø7-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive Amount Paid' (521-FL), 'Professional

Service Fee Paid' (562-J1), 'Other Amount Paid' (565-J4) **less** 'Patient Pay Amount' (5Ø5-F5) and 'Other Payer Amount Recognized' (566-J5).

20.11 SCENARIO 2A REQUEST: PHARMACY BILLS TO PRIMARY PAYER

TRANSACTION HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	999999	
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	XYZ	
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ1Ø313	March 13, 2ØØ1
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	bbbbbbbbbb	

INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	998877665	Cardholder ID

The Following Fields are Optional:

3Ø1-C1	GROUP ID	3451	
3Ø3-C3	PERSON CODE	4	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	3	Child

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	1234567	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3	NDC
4Ø7-D7	PRODUCT/SERVICE ID	ØØØØ6Ø94228	Clinoril 2ØØmg
4 Ø8-D8	DISPENSE AS WRITTEN/PRODUCT SELECTION CODE	2	Patient has requested Brand

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	567{	$56.7Ø
412-DC	DISPENSING FEE SUBMITTED	45{	$4.5Ø
426-DQ	USUAL AND CUSTOMARY CHARGE	7Ø7{	$7Ø.7Ø
43Ø-DU	GROSS AMOUNT DUE	612{	$61.2Ø
423-DN	BASIS OF COST DETERMINATION	Ø1	AWP

20.12 SCENARIO 2A RESPONSE: PAID RESPONSE FROM PRIMARY INSURANCE - PATIENT IS RESPONSIBLE FOR 1ØØ% (EXAMPLE

DEDUCTIBLE HAS NOT BEEN MET)

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ1Ø313*	March 13, 2ØØ1

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*P*	Paid

The Following Fields are Optional:

5Ø3-F3	AUTHORIZATION NUMBER	*123456789123456789*	

RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	*1234567*	

RESPONSE PRICING SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*23*	RESPONSE PRICING SEGMENT

The Following Fields are Optional:

5Ø5-F5	Patient Pay Amount	*612{*	$61.2Ø
5Ø6-F6	INGREDIENT COST PAID	*567{*	$56.7Ø
5Ø7-F7	DISPENSING FEE PAID	*45{*	$4.5Ø
5Ø9-F9	Total Amount Paid	*ØØØ{*	$ØØ.ØØ
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	*1*	Ingredient Cost Paid as Submitted
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	*612{*	$61.2Ø

Patient is responsible for full payment according to primary.

20.13 SCENARIO 2B REQUEST: PHARMACY BILLS SECONDARY INSURANCE

Submit claim indicating <u>Other Payer Amount Paid</u>
NOTE: The Other Coverage Code of 4 indicates that NO PAYMENT <u>WAS</u> Collected.
Depending on processor expectation, Other Payer Amt Paid value may need to be provided as zero – or – the entire COB Segment may be deemed unnecessary for processing since the Other Payer Amount Paid value will be zero

TRANSACTION HEADER SEGMENT

Telecommunication Version 5 Questions, Answers and Editorial Updates

FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	BIN NUMBER	61ØØ66	
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	B1	Rx billing
1Ø4-A4	PROCESSOR CONTROL NUMBER	123456789Ø	
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ1Ø313	March 13, 2ØØ1
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	bbbbbbbbbb	

INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø4	INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	987654321	Cardholder ID

The Following Fields are Optional:

3Ø1-C1	GROUP ID	1234	
3Ø3-C3	PERSON CODE	3	Place in family
3Ø6-C6	PATIENT RELATIONSHIP CODE	3	Child

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø7	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	1234567	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3	NDC
4Ø7-D7	PRODUCT/SERVICE ID	ØØØ6Ø94228	Clinoril 2ØØmg
3Ø8-C8	OTHER COVERAGE CODE	4	Other coverage exists-payment NOT collected *(due to primary's deductible)*

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	11	PRICING SEGMENT

The Following Fields are Optional:

4Ø9-D9	INGREDIENT COST SUBMITTED	557{	$55.7Ø
412-DC	DISPENSING FEE SUBMITTED	5Ø{	$5.ØØ
426-DQ	USUAL AND CUSTOMARY CHARGE	7Ø7{	$7Ø.7Ø
43Ø-DU	GROSS AMOUNT DUE	6Ø7{	$6Ø.7Ø*
423-DN	BASIS OF COST DETERMINATION	Ø3	Direct

COB segment may or may NOT be required of the processor in this case

COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	Ø5	COB SEGMENT
337-4C	COB/OTHER PAYMENTS COUNT	1	One occurrence
338-5C	OTHER PAYER COVERAGE TYPE	Ø1	Primary
443-E8	OTHER PAYER DATE	2ØØ1Ø313	March 13, 2ØØ1
341-HB	OTHER PAYER AMOUNT PAID COUNT	1	One occurrence
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø7	Drug Benefit

431-DV	OTHER PAYER AMOUNT PAID	ØØØ{	$ØØ.ØØ

20.14 SCENARIO 2B RESPONSE: PAID RESPONSE FROM SECONDARY INSURANCE

RESPONSE HEADER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø2-A2	VERSION/RELEASE NUMBER	51	5.1 Transaction Standard
1Ø3-A3	TRANSACTION CODE	B1	Rx Billing
1Ø9-A9	TRANSACTION COUNT	1	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	A	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø7	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	4563663bbbbbbbb	
4Ø1-D1	DATE OF SERVICE	2ØØ1Ø313	March 13, 2ØØ1

RESPONSE STATUS SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	21	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	P	Paid
5Ø3-F3	AUTHORIZATION NUMBER	11122233345678	

RESPONSE CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	22	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	Rx Billing
4Ø2-D2	PRESCRIPTION /SERVICE REFERENCE NUMBER	1234567	

RESPONSE PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	23	RESPONSE PRICING SEGMENT
5Ø5-F5	PATIENT PAY AMOUNT	2ØØ{	$2Ø.ØØ Copay
5Ø6-F6	INGREDIENT COST PAID	567{	$56.7Ø
5Ø7-F7	DISPENSING FEE PAID	4Ø{	$4.ØØ
5Ø9-F9	TOTAL AMOUNT PAID	4Ø7Ø{	$4Ø.7Ø
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	1	Ingredient Cost Paid as Submitted
518-FI	AMOUNT OF COPAY/CO-INSURANCE	2ØØ{	$2Ø.ØØ

TOTAL AMOUNT PAID represents a sum of 'Ingredient Cost Paid' (5Ø6-F6), 'Dispensing Fee Paid' (5Ø7-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive Amount Paid' (521-FL), 'Professional Service Fee Paid' (562-J1), 'Other Amount Paid' (565-J4) **less** 'Patient Pay Amount' (5Ø5-F5) and 'Other Payer Amount Recognized' (566-J5).

20.15 PARTIAL FILL QUESTION

Question:
How should Partial Fills be handled for a Coordination of Benefits (COB) billing? How does the reject of "Partial Fill Transaction Not Supported" affect this processing?

Response:

Since there are many combinations (Primary accepts/does not accept Partial Fills/Primary does/does not do online COB, Secondary accepts/does not accept Partial Fills/Secondary does/does not do online COB), it is recommended that COB billing to the secondary (or downstream payer) should not occur until the pharmacy has determined the final resolution of the claim.

20.16 REPORTING OUT OF POCKET EXPENSES

See section "*Medicare Crossover Claims*", subsection "*Support of Allowed Amount, Deductible Amount, Co-insurance Amount and Co-payment Amount*" for information about reporting out of pocket expenses using Other Payer Amount Paid Qualifier (342-HC). This solution is to be used in situations of reporting out of pocket expenses in Version 5.Ø-5.4. In Version 5.5, the Other Payer-Patient Responsibility fields are to be used. The reporting of the out of pocket expenses is not a copay only situation, as the payer needs more than just out of pocket. The program needs to track dollars so they can create the out of pocket total. The program is not paying for copay only but also deductibles.

20.17 USUAL AND CUSTOMARY CHARGE (426-DQ)

Question:
We have a situation where the Provider is submitting the primary claim to the Medicare Discount Program with a different U&C than is being submitted to the secondary claim to XYZ. For example, $85 is the U&C on the primary claim to MDC and $75 is the U&C on the secondary claim to XYZ. All examples in the NCPDP manuals show the same U&C on both the primary and secondary claim. Should the U&C be the same on both the primary and secondary claim?

Response:
Not necessarily. Third party payer specifications may require specific values for adjudication.

21. APPENDIX C. PRIOR AUTHORIZATION CLARIFICATIONS

The following lists the changes made to the Implementation Guide, Version 7.1, but which are applicable to all Version 5 and above guides, as the changes reflect clarifications to explain the prior authorization process. The sections affected in the Implementation Guide are 4.1.6, 4.2.12, 4.4.7, FAQ, and Examples.

4.1.5 Prior Authorization (Transaction Codes P1-P4)
(No change. Section shown for flow.)

> Prior authorization transactions include Request and Billing, Reversal, Inquiry and Request Only. See the Usage Matrix in this document for required segments. Prior authorization transactions in Version 5 allow providers and payers to electronically communicate the need for and approval to dispense special situation medications. Only one transaction per transmission is permitted.

> Prior Authorization reversals are used to reverse the <u>request</u> for authorization, but not any claims submitted against the prior authorization. To reverse a Prior Authorization Request and Billing, reverse the Prior Authorization Request and, if necessary, reverse the billing. The order of reversals may be determined by trading partners.

Change reflects section modification (in total).

4.1.6 Prior Authorization Fields

> <u>Prior Authorization/Medical Certification Code and Number</u> (Field 416-DG)
> Versions 3.2—4.2 combined the Prior Authorization/Medical Certification Code and Number (Field 416-DG). Version 5 and above offers two fields to separately delineate this data.

> The <u>Prior Authorization Type Code</u> (Field 461-EU) defines the type of authorization being requested.

The <u>Prior Authorization Number Submitted</u> (Field 462-EV) contains the value assigned to the authorization. Note: When/If the pharmacy submits a claim or service billing, the value of the field Prior Authorization Number-Assigned (498-PY) **from the processor's response** is placed in the Prior Authorization Number Submitted (462-EV) on the claim or service billing transaction submission.

> The <u>Prior Authorization Number-Assigned</u> (Field 498-PY) is used to communicate to the provider the Prior Authorization number assigned by the processor. This field is returned as part of the Prior Authorization Response Segment.

> In addition, when performing a Prior Authorization Reversal (Transaction Code P2), this field contains the Prior Authorization Number the provider is reversing. This field would be populated when reversing transaction with original responses of "P" (Paid) or "A" (Approved).

4.2.12 Prior Authorization Segment

Prior Authorization Supporting Documentation (Field 498-PP) is used to supply information not included in other data fields that may be required to process the prior authorization transaction.

When Request Type (498-PA) value of "2" (Reauthorization) is used, the Prior Authorization Number-Assigned (498-PY) is populated with the prior authorization number from the original request.

See the **Data Dictionary** for comments under each field for further clarification.

Change reflects section modification (in total).

4.4.7 Response Prior Authorization Segment
Please see the section "*Prior Authorization Transaction Discussion*".

New section to be added to document, before Section 5.

21.1 PRIOR AUTHORIZATION TRANSACTION DISCUSSION
The Prior Authorization transactions have been created to allow a Processor to authorize, authorize and immediately adjudicate the claim or service, defer, or pend the request for review.

Prior Authorization before dispensing prescriptions may be required for (but not limited to) medical exceptions, drug overrides or limitations, or dosage limitations.

21.2 PRIOR AUTHORIZATION REQUEST AND BILLING TRANSACTION USAGE
The pharmacy submits a Prior Authorization Request And Billing to receive approval for the Prior Authorization and to receive payment information. If the processor responds that the Prior Authorization Request and Billing is "P" (Paid) or "D" (Duplicate of Paid), the response will include a Prior Authorization Number-Assigned (498-PY), other pertinent information in the Response Prior Authorization Segment, and payment information in the Response Pricing Segment.

However, when a Prior Authorization Request And Billing receives a "C" (Captured) or "Q" (Duplicate of Capture) response the pharmacy system **will not** receive a Prior Authorization Number-Assigned (498-PY). The pharmacy would receive an Authorization Number (5Ø3-F3) in the Response Status Segment to a "C" (Captured) or "Q" (Duplicate of Capture).

The pharmacy system *may* receive a Prior Authorization Number-Assigned (498-PY) with an "F" (Deferred) response, depending on the processor's requirements. The pharmacy *may* receive an Authorization Number (5Ø3-F3) with an "F" (Deferred) response, depending on the processor's requirements. On an "F" (Deferred), if the processor does not send a Prior Authorization Number-Assigned (498-PY), the pharmacy will receive an Authorization Number (5Ø3-F3) in the response. Later, when the pharmacy inquires about the prior authorization by using a Prior Authorization

Inquiry, the value from the original transaction (Response Status Segment Authorization Number (5Ø3-F3)) would be placed in the request field Authorization Number (5Ø3-F3) in the Prior Authorization Segment.

Chart 1

Prior Authorization Request And Billing				
Response	**Prior Authorization Number-Assigned (498-PY)**	**Authorization Number (5Ø3-F3)**	**Response Prior Authorization Segment (Prior Authorization Information)**	**Response Pricing Segment (Payment Information)**
P-Paid **D- Duplicate Paid**	Yes	No	Yes	Yes
C-Captured **Q-Duplicate Captured**	No	Yes	Yes	Yes
F-Deferred	Processor Defined	Yes-if Prior Authorization Number-Assigned (498-PY) not sent	Yes	Yes
R-Rejected	No	Processor Defined**	No	No

**Note: A processor may choose to return an Authorization Number (5Ø3-F3) on a Rejected response to track the transaction for troubleshooting, customer service reasons. This use of the Authorization Number has no effect on the Prior Authorization, but is simply a way to track a transaction.

21.3 PRIOR AUTHORIZATION REQUEST ONLY TRANSACTION USAGE

The pharmacy submits a Prior Authorization Request Only to receive approval for a prior authorization, without any payment information.

A pharmacy's Prior Authorization Request Only that is "A" (Approved) or "S" (Duplicate of Approved) should receive a response that includes a Prior Authorization Number-Assigned (498-PY) and other information in the Response Prior Authorization Segment. The pharmacy will not receive any payment information.

When a Prior Authorization Request Only receives a "C" (Captured) or "Q" (Duplicate of Capture) response, the pharmacy system **will not** receive a Prior Authorization Number-Assigned (498-PY). The pharmacy would receive an Authorization Number (5Ø3-F3) in the Response Status Segment to a "C" (Captured) or "Q" (Duplicate of Capture).

The pharmacy system *may* receive a Prior Authorization Number-Assigned (498-PY) with an "F" (Deferred) response, depending on the processor's requirements. On an "F" (Deferred) response, if the processor does not send a Prior Authorization Number-Assigned (498-PY), the pharmacy will receive an Authorization Number (5Ø3-F3) in the response. Later, when the pharmacy inquires about the prior authorization by using a Prior Authorization Inquiry, the value from the original transaction (Response Status Segment-- Authorization Number (5Ø3-F3)) would be placed in the request field Authorization Number (5Ø3-F3) in the Prior Authorization Segment.

Chart 2

Prior Authorization Request Only				
Response	**Prior Authorization Number-Assigned (498-PY)**	**Authorization Number (5Ø3-F3)**	**Response Prior Authorization Segment (Prior Authorization Information)**	**Response Pricing Segment (Payment Information)**
A-Approved **S- Duplicate Approved**	Yes	No	Yes	Yes
C-Captured **Q-Duplicate Captured**	No	Yes	Yes	Yes
F-Deferred	Processor Defined	Yes-if Prior Authorization Number-Assigned (498-PY) not sent	Yes	Yes
R-Rejected	No	Processor Defined**	No	No

**Note: A processor may choose to return an Authorization Number (5Ø3-F3) on a Rejected response to track the transaction for troubleshooting, customer service reasons. This use of the Authorization Number has no effect on the Prior Authorization, but is simply a way to track a transaction.

21.4 PRIOR AUTHORIZATION INQUIRY TRANSACTION USAGE

The pharmacy submits a Prior Authorization Inquiry to receive a status on a *previously submitted Prior Authorization Request And Billing* or *a previously submitted Prior Authorization Request Only*. A Prior Authorization Inquiry is submitted for a previously submitted Prior Authorization Request And Billing or Prior Authorization Request Only that was "C" (Captured).

The Prior Authorization Inquiry transaction supports multiple responses, but the responses are actually tied back to the originally requested transaction. The originally requested transaction is either a Prior Authorization Request And Billing or a Prior Authorization Request Only. The valid responses are the values applicable to either of those transactions.

If the initial request was a Prior Authorization Request And Billing that was not "P" (Paid) or "R" (Rejected) initially (meaning follow up was required) or a time out situation occurred, the subsequent Prior Authorization Inquiry would receive a response that was acceptable for the initial Prior Authorization Request & Billing - "P" (Paid), "C" (Captured), "F" (Deferred), or "R" (Rejected).

Chart 3

Fields Sent By a Pharmacy in a Prior Authorization Inquiry Based on the Response to the original Prior Authorization Request And Billing		
Original Response on the Prior Authorization Request And Billing	**Prior Authorization Number-Assigned (498-PY) in Prior Authorization Segment**	**Authorization Number (5Ø3-F3) in Prior Authorization Segment**
P-Paid	Yes	No
C-Captured	No	Yes
F-Deferred	Yes-if sent by processor	Yes-if sent by processor
R-Rejected Not applicable. There is no inquiry on a rejected PA Request and Billing		

Chart 4
Response to Chart 3.

Fields Returned by the Processor in a Prior Authorization Inquiry Response Based on the original PA Request And Billing		
Processor Response	**Prior Authorization Number-Assigned (498-PY)**	**Authorization Number (5Ø3-F3)**
P-Paid or D-Duplicate of Paid	Yes	No
C-Captured or Q-Duplicate of Capture	No-unless the status of the original request has changed. Please see response according to result of adjudication of original request	Yes
F-Deferred	Processor Defined	Yes-if Prior Authorization Number-Assigned (498-PY) not sent
R- Reject	No	Processor Defined**

> **Note: A processor may choose to return an Authorization Number (5Ø3-F3) on a Rejected response to track the transaction for troubleshooting, customer service reasons. This use of the Authorization Number has no effect on the Prior Authorization, but is simply a way to track a transaction.

If the initial request was a <u>Prior Authorization Request Only</u> that was not approved or rejected initially (meaning follow up was required) or a time out situation occurred, the subsequent <u>Prior Authorization Inquiry</u> would receive a response that was acceptable for the initial Prior Authorization Request Only - "A" (Approved), "C" (Captured), "F" (Deferred), or "R" (Rejected).

Chart 5

Fields Sent in by Pharmacy in a Prior Authorization Inquiry Based on the Response to an original Prior Authorization Request Only		
Original Response on the Prior Authorization Request Only	**Prior Authorization Number-Assigned (498-PY)**	**Authorization Number (5Ø3-F3)**
A-Approved	Yes	No
C-Captured	No	Yes
F-Deferred	Yes-if sent by processor	Yes-if sent by processor
R-Rejected Not applicable. There is no inquiry on a rejected PA Request and Billing		

Chart 6
Response to Chart 5.

Fields Returned by the Processor in a Prior Authorization Inquiry Response Based on the original PA Request Only		
Processor Response	**Prior Authorization Number-Assigned (498-PY)**	**Authorization Number (5Ø3-F3)**
A-Approved	Yes	No
C-Captured	No-unless the status of the original request has changed. Please see response according to result of adjudication of original request	Yes
F-Deferred	Processor Defined	Yes-if Prior Authorization Number-Assigned (498-PY) not sent
R-Rejected	No	Processor defined**

**Note: A processor may choose to return an Authorization Number (5Ø3-F3) on a Rejected response to track the transaction for troubleshooting, customer service reasons. This use of the Authorization Number has no effect on the Prior Authorization, but is simply a way to track a transaction.

21.5 PRIOR AUTHORIZATION REVERSAL TRANSACTION USAGE

The Prior Authorization Reversal is used to back out the request for authorization, but not any claims submitted against the prior authorization. To reverse a Prior Authorization Request And Billing, paid billings should be reversed before the prior authorization is reversed. The pharmacy should submit a Claim or Service Reversal (Transaction Code = B2) before submitting a Prior Authorization Reversal request. If there are no Claims or Services paid for the Prior Authorization in question, the processor should accept the Prior Authorization Reversal for the prior authorization only. The only reversals that should be submitted would be for those transactions that received a "P" (Paid), "A" (Approved) or "C" (Captured) response.

The pharmacy would submit the Prior Authorization Number-Assigned (498-PY) in the Prior Authorization Reversal for those transactions with original responses of "P" (Paid) or "A" (Approved) and the Authorization Number (5Ø3-F3) for those transactions with an original response of "C" (Captured).

21.6 FIELD CLARIFICATION

21.6.1 PRIOR AUTHORIZATION NUMBER-ASSIGNED (498-PY) IN RESPONSE PRIOR AUTHORIZATION SEGMENT) AND AUTHORIZATION NUMBER (5Ø3-F3) IN RESPONSE STATUS SEGMENT

This section explains the usage of Prior Authorization Number-Assigned (498-PY) in the response returned by the processor, in a prior authorization situation.

For a Prior Authorization Request And Billing
The processor would return a Prior Authorization Number-Assigned (498-PY) in a "P" (Paid) or "D" (Duplicate of Paid) response.

For a Prior Authorization Request Only

> The processor would return a Prior Authorization Number-Assigned (498-PY) in an "A" (Approved) or "S" (Duplicate of Approved) response.

> ### *For a Prior Authorization Request And Billing AND a Prior Authorization Request Only*
> The processor would return an Authorization Number (5Ø3-F3) in a "C" (Capture) or "Q" (Duplicate of Capture) response and **not** return a Prior Authorization Number-Assigned (498-PY). The Authorization Number (5Ø3-F3) would be used in a Prior Authorization Inquiry transaction to ask for the status of the prior authorization.

> Some processors may return a Prior Authorization Number-Assigned (498-PY) in an "F" (Deferred) response. If Prior Authorization Number-Assigned (498-PY) is not returned, then Authorization Number (5Ø3-F3) must be returned.

> Note: When/If the pharmacy submits a subsequent claim or service billing, the value of the field Prior Authorization Number-Assigned (498-PY) is placed in the in the Prior Authorization Number Submitted (462-EV) on the claim or service billing transaction.

> ### *For a Prior Authorization Inquiry Only*
> Use the guidelines above depending on whether the initial transaction was a Prior Authorization Request And Billing, or a Prior Authorization Request Only.

> A Prior Authorization Inquiry must be sent with a Prior Authorization Number-Assigned (498-PY) or Authorization Number (5Ø3-F3).

21.6.2 AUTHORIZATION NUMBER (5Ø3-F3) IN PRIOR AUTHORIZATION SEGMENT
This section explains the usage of Authorization Number (5Ø3-F3) in the request submitted by the pharmacy, in a prior authorization situation.

> ### *For a Prior Authorization Request And Billing AND a Prior Authorization Request Only*
> The Authorization Number (5Ø3-F3) is not needed for submission of a Prior Authorization Request And Billing OR a Prior Authorization Request Only.

> ### *For a Prior Authorization Inquiry Only*
> The Authorization Number (5Ø3-F3) would be submitted in a Prior Authorization Inquiry Only when the pharmacy was seeking a status for a previously sent Prior Authorization Request And Billing *or* Prior Authorization Request Only that received a "C" (Capture) or "Q" (Duplicate of Capture) response or a "F" (Deferred) response where the Prior Authorization Number-Assigned (498-PY) was not returned.

For a Prior Authorization Reversal

The Authorization Number (5Ø3-F3) is supported in a submission of a Prior Authorization Reversal for "C" (Capture) responses only.

21.6.3 PRIOR AUTHORIZATION NUMBER SUBMITTED (462-EV) IN CLAIM SEGMENT

This field is used only in transaction activities for claims and services associated with an approved Prior Authorization request. It is **NOT** used in a Prior Authorization Request And Billing or a Prior Authorization Request Only since the pharmacy is only seeking an approval.

When the pharmacy submits a claim or service billing for which a Prior Authorization has been granted, the Prior Authorization Number Submitted (462-EV) should be submitted with the transaction in the Claim Segment. Likewise, should the provider submit a reversal of a paid claim or service billing (in which payment was predicated on an approved Prior Authorization), the Prior Authorization Number Submitted (462-EV) should be submitted with the transaction in the Claim Segment.

The Prior Authorization Number Submitted (462-EV) on the claim or service billing should contain the value from the Prior Authorization Number-Assigned (498-PY) in the Response Prior Authorization Segment that was returned from the processor in the Prior Authorization Request And Billing OR the Prior Authorization Request Only. The Prior Authorization Number-Assigned (498-PY) would have been returned with a "P" (Paid) or "D" (Duplicate of Paid) response or with an "A" (Approved) or "S" (Duplicate of Approved) response.

21.7 SCENARIO EXAMPLES

The following illustrates a couple of the transaction scenarios discussed above, shown in tabular format. Treat each as a completely separate case.

21.7.1 PRIOR AUTHORIZATION REQUEST AND BILLING RESPONSES

The pharmacy requests a Prior Authorization Request And Billing (seeking approval and payment information). The following choice of responses would be sent by the processor.

- The processor responds with a "P" (Paid) or "D" (Duplicate of Paid) response. The payment information is included in the Response Pricing Segment. The Prior Authorization Number-Assigned (498-PY) and pertinent prior authorization information is returned in the Response Prior Authorization Segment.

Or

- The processor responds with a "C" (Captured) or "Q" (Duplicate of Capture) response. The processor is still evaluating the prior authorization. The processor includes an Authorization Number (5Ø3-F3) in the response. The pharmacy will later submit a Prior Authorization Inquiry with the Authorization Number (5Ø3-F3) in the Prior Authorization Segment.

<div align="center">Or</div>

- The processor responds with a "F" (Deferred) response that includes a Prior Authorization Number-Assigned (498-PY) or an Authorization Number (5Ø3-F3). The pharmacy should consult the processor's provider manual for further information.

<div align="center">Or</div>

- The processor responds with a "R" (Rejected) response, the pharmacy should examine the reject codes and messages. The transaction may include missing/invalid information, or the processor may be denying the Prior Authorization Request And Billing.

Scenarios for Prior Authorization Request And Billing

1. The pharmacy requests a Prior Authorization Request And Billing (seeking approval and payment information).

   The processor responds with a "C" (Captured) or "Q" (Duplicate of Capture) response that includes an Authorization Number (5Ø3-F3).

   The pharmacy later submits a Prior Authorization Inquiry with the Authorization Number (5Ø3-F3) in the Prior Authorization Segment.

   The processor has completed it's evaluation of the original request and responds with a "P" (Paid) or "D" (Duplicate of Paid) response. The payment information is included in the Response Pricing Segment. The Prior Authorization Number-Assigned (498-PY) and pertinent prior authorization information are returned in the Response Prior Authorization Segment.

<div align="center">Or</div>

   The processor responds with a "C" (Captured) or "Q" (Duplicate of Capture) response. The processor is still evaluating the prior authorization. The pharmacy will later submit another Prior Authorization Inquiry with the Authorization Number (5Ø3-F3) in the Prior Authorization Segment.

   If the processor responds with another "C" (Captured) (or "Q" (Duplicate of Capture)) response, the same Authorization Number as the original would be returned to the pharmacy. The processor should not return a new Authorization Number (5Ø3-F3).

<div align="center">Or</div>

   The processor has completed its evaluation of the original request and responds with an "F" (Deferred) response that includes a Prior Authorization Number-Assigned (498-PY) or an Authorization Number (5Ø3-F3). The pharmacy should consult the processor's provider manual for further information.

Or

The processor has completed its evaluation of the original request and responds with an "R" (Rejected) response. The pharmacy should examine the reject codes and messages. The transaction may include missing/invalid information, or the processor may be denying the original Prior Authorization Request And Billing.

2. The pharmacy submits a Prior Authorization Request And Billing (seeking approval and payment information.)

The processor responds with a "P" (Paid) or "D" (Duplicate of Paid). The payment information is included in the Response Pricing Segment. The Prior Authorization Number-Assigned (498-PY) and pertinent prior authorization information is returned in the Response Prior Authorization Segment.

To reverse the claim or service billing, the pharmacy submits a Claim or Service Reversal with the Prior Authorization Number Submitted (462-EV) in the Claim Segment.

The processor responds with an "A" (Approved) or "S" (Duplicate of Approved) and backs out the payment.

To reverse the prior authorization, the pharmacy submits a Prior Authorization Reversal with the Prior Authorization Number Submitted (462-EV) in the Claim Segment.

The processor responds with an "A" (Approved) or "S" (Duplicate of Approved) and backs out the authorization only.

*Note if claim reversal has not been initiated by the pharmacy, the Prior Authorization Reversal request would receive an "R" (Rejected) response by the processor. The pharmacy should reverse the paid billings before requesting a prior authorization reversal.

3. The pharmacy submits a Prior Authorization Request And Billing (seeking approval and payment information.)

The processor responds with a "P" (Paid). The payment information is included in the Response Pricing Segment. The Prior Authorization Number-Assigned (498-PY) and pertinent prior authorization information is returned in the Response Prior Authorization Segment. However, a timeout occurs and the pharmacy does not receive the prior authorization/payment response.

The pharmacy must submit the same Prior Authorization Request And Billing transaction. (The pharmacy did not receive an Authorization Number (5Ø3-F3) since there was a timeout and therefore cannot send a Prior Authorization Inquiry to learn the status.)

21.7.2 PRIOR AUTHORIZATION REQUEST ONLY RESPONSES

The pharmacy requests a Prior Authorization Request Only (seeking approval, no payment information). The following choice of responses would be sent by the processor.

- The processor responds with an "A" (Approved) or "S" (Duplicate of Approved) response, with a Prior Authorization Number-Assigned (498-PY) given.

Note: When/If the pharmacy submits a claim or service billing, the value of the field Prior Authorization Number-Assigned (498-PY) returned from the processor is placed in the Prior Authorization Number Submitted (462-EV) on the claim or service billing transaction submission.

Or

- The processor responds with a "C" (Captured) or "Q" (Duplicate of Capture) response. Note, the Prior Authorization Number-Assigned (498-PY) is not returned (this field is not applicable in a capture). The Authorization Number (5Ø3-F3) is returned by the processor.

Or

- The processor responds with a "F" (Deferred) response that includes a Prior Authorization Number-Assigned (498-PY) or an Authorization Number (5Ø3-F3). The pharmacy should consult the processor's provider manual for further information.

Or

- The processor responds with a "R" (Rejected) response, the pharmacy should examine the reject codes and messages. The transaction may include missing/invalid information, or the processor may be denying the Prior Authorization Request Only.

Scenarios for Prior Authorization Request Only

1. The pharmacy submits a Prior Authorization Request Only (only seeking approval, not payment information).
   The processor responds with an "A" (Approved) or "S" (Duplicate of Approved) response, with a Prior Authorization Number-Assigned (498-PY) given. However, a timeout occurs and the pharmacy does not receive the prior authorization response.
   > The pharmacy must submit the same Prior Authorization Request Only transaction. (The pharmacy did not receive an Authorization Number (5Ø3-F3) since there was a timeout and therefore cannot send a Prior Authorization Inquiry to learn the status.)

2. The pharmacy submits a Prior Authorization Request Only (only seeking approval, not payment information).
   The processor responds with a "C" (Captured) or "Q" (Duplicate of Capture) response. Note, the Prior Authorization Number-Assigned (498-PY) is not returned (this field is not applicable in a capture). The Authorization Number (5Ø3-F3) is returned.
   > The pharmacy later submits a Prior Authorization Inquiry with the Authorization Number (5Ø3-F3).
   > > The processor has completed its evaluation of the original request and responds with an "A" (Approved) or "S" (Duplicate of

Approved) response. The Prior Authorization Number-Assigned (498-PY) along with other important information is returned.

Or

The processor responds with a "C" (Captured) or "Q" (Duplicate of Capture) response. The processor is still evaluating the prior authorization. The pharmacy will later submit another Prior Authorization Inquiry with the Authorization Number (5Ø3-F3). The same Authorization Number as the original would be returned to the pharmacy. The processor should not return a new Authorization Number (5Ø3-F3).

Or

The processor has completed its evaluation of the original request and responds with an "F" (Deferred) response that includes a Prior Authorization Number-Assigned (498-PY) or an Authorization Number (5Ø3-F3). The pharmacy should consult the processor's provider manual for further information.

Or

The processor has completed its evaluation of the original request and responds with an "R" (Rejected) response. The pharmacy should examine the reject codes and messages. The transaction may include missing/invalid information, or the processor may be denying the original Prior Authorization Request Only.

3. The pharmacy submits a Prior Authorization Request Only (only seeking approval, not payment information).
   The processor responds with a "C" (Captured) or "Q" (Duplicate of Capture) response. Note, the Prior Authorization Number-Assigned (498-PY) is not returned (this field is not applicable in a capture). The Authorization Number (5Ø3-F3) is returned.
   To reverse the prior authorization, the pharmacy submits a Prior Authorization Reversal with the Authorization Number (5Ø3-F3). This is to reverse the prior authorization only no paid billings have been made.
   The processor responds with an "A" (Approved) or "S" (Duplicate of Approved) and backs out the Prior Authorization Request Only.

21.8 NEW FREQUENTLY ASKED QUESTIONS

Q: The initial transaction is a Prior Authorization Request Only. The pharmacy submits a Prior Authorization Inquiry for a status. What is the difference between a Prior Authorization Inquiry response of "C" (Capture) and "A" (Approved)?

ANS: A Capture response says the processor is still evaluating the original Prior Authorization Request Only. An approved response says the original Prior Authorization Request Only is approved and the response will include the Response Prior Authorization Segment information to be used in future transactions.

Q: Once the Prior Authorization Number is assigned, on subsequent refills, can you just submit the Prior Authorization in the Prior Authorization Number Submitted field in the Claim Segment, or do you need to keep sending the P/A segment with the P/A value in the Prior Authorization Number Assigned field?
Or do both segments need to contain the P/A?
When would you send the P/A number in the Claim segment only? Only when it is not obtained electronically or once it was obtained electronically?

ANS: For claim or service billing transactions (including refills), once a Prior Authorization Number-Assigned (498-PY) has been granted, the value returned by the processor in this field (Prior Authorization Number-Assigned (498-PY) (of the Response Prior Authorization Segment)) should be sent in the Prior Authorization Number Submitted (462-EV) (in the Claim Segment) on each claim or service billing.

Q: Will each different 'C' Captured response of a *'P/A Inquiry'* transaction come back with a unique Authorization Number (5Ø3-F3) or does it come back with the same one each time regardless of how many times you submit the 'P/A Inquiry' transaction and receive responses?
Another way of asking this question is:
Do you use the original Authorization Number from the *first* 'C' Captured response from the *'Request and Billing'* transaction over and over again if you keep sending 'P/A Inquiry' transactions, or would you send an Authorization Number from the *most recent 'P/A Inquiry'* transaction response on the 'P/A Inquiry' transactions?

ANS: The processor should return the same Authorization Number (5Ø3-F3) in a Capture situation. The pharmacy should submit the same Authorization Number (5Ø3-F3) on each Prior Authorization Inquiry for that Captured transaction.

21.9 EXAMPLE CHANGES

The following examples were modified to present correct models for Prior Authorization transactions.

7.16 PA Request and Billing – Transaction Code P1
Added blurb:
This is an initial request for prior authorization approval with payment information. Prior Authorization Segment contains the requested period dates.
Removed Prior Authorization Number-Assigned (498-PY) from table.

7.16.2 P/A Request & Billing Accepted Response – Paid
Added blurb:
The pharmacy receives prior authorization and payment information in the response.

7.16.3 P/A Request & Billing Rejected Response
Added blurb:
The pharmacy receives the response from the processor that the product or service is not covered. The preferred product information is returned. A Help Desk number is available for follow up questions.

7.16.4 P/A Request & Billing Duplicate Response

Added blurb:
The pharmacy receives a duplicate paid response. The information is the same as 7.16.2.

7.17 P/A Reversal – Transaction Code P2
Added blurb:
The pharmacy wishes to reverse the prior authorization that was previously processed. This is a request to reverse just the prior authorization. If claim or service billings were billed with this prior authorization, the claim or service billings would need to be reversed first; then the prior authorization reversed.
Removed the Claim Segment because the claims are to be reversed separately.

7.17.1 P/A Reversal Accepted Response – Captured, Approved
Removed the Response Claim Segment because the claims are to be reversed separately.

7.18 P/A Inquiry – Transaction Code P3
Added blurb:
New scenario. The pharmacy has submitted a PA Request And Billing sometime in the past, and received a captured response. The pharmacy is now submitting a PA Inquiry to determine the outcome, using the Authorization Number (5Ø3-F3) received during the PA Request And Billing conversation.
Removed all fields from PA Segment except Segment ID, Request Type, Request Period Begin and End, and Auth Number.

7.18.1 P/A Inquiry Accepted Response – Captured
Added blurb:
The original PA Request And Billing received a "C" Captured response. The pharmacy submits an inquiry as to the status. The processor is still evaluating the original PA Request And Billing and sends a "C" Captured response back to the pharmacy.

Also, the Authorization Number (5Ø3-F3) returned on the Captured response is the same as submitted (9876545678) per section 4.5.3.1.1 Scenarios for Prior Authorization Request And Billing.

7.18.2 P/A Inquiry Accepted Response – Paid
The processor is responding that the original PA Request And Billing has been approved and payment information is included. The processor assigns an Authorization Number to conversation. The processor returns payment, as well as prior authorization information, including a Prior Authorization Number-Assigned (498-PY).

7.19 P/A Request Only – Transaction Code P4
Added blurb:
New scenario. The pharmacy is requesting a prior authorization approval only (no payment). The Prior Authorization Segment includes the prior authorization period date and other information.

7.19.1 P/A Request Only Accepted Response –Approved
Added blurb:
The processor responds that the request for prior authorization has been approved, with appropriate prior authorization information.

Removed Capture from the heading and the Transaction Response Status and Note. Keep 498-PY.

7.19.2 P/A Request Only Rejected Response
Added blurb:
The processor is not approving the request for a prior authorization, as the product is not covered.

22.   APPENDIX D. BILLING FOR COMPOUNDS

The following sections begin at section 4.2.1.5 of the Version 5.6 Implementation Guide. The information can be used with the Version 5 and above implementations as this is only clarifying information and does not change the specifications. See also the section "*Compound/Multi-Ingredient Processing*".

22.1 TWO OPTIONS TO DESIGNATE A COMPOUND

22.1.1   RECOMMENDED OPTION - OPTION 1 – USING THE CLAIM AND COMPOUND SEGMENTS

A Compound may be submitted using the Compound segment with multiple iterations of the Compound Product ID Qualifier, Compound Product ID and other repeating fields – one iteration for each ingredient in the compound. This transaction allows the pharmacy to submit any/all of the ingredients included in the preparation of the compound. This process is described in paragraph one of this section. (4.2.11). Option 1 is the recommended option.

Advantages:
>   Ability to perform DUR.
>   Ability to claim manufacturers rebates for all ingredients
>   Ability to minimize rebate disputes.
>   Ability to perform accurate pricing per ingredient.

22.1.2 ALTERNATE OPTION - OPTION 2 – USING THE CLAIM SEGMENT

A Compound may also be submitted using the Claim Segment without submitting the Compound segment. Option 1 above is the **recommended** option.
This can be accomplished by using one of the following scenarios:

Scenario A (Most expensive legend drug):
Submit a compound entering a 2 in the Compound Code (field 4Ø6-D6).
Submit the Product/Service ID (NDC for example) of the most expensive legend drug (field 4Ø7-D7).
Enter the sum of all the individual quantities as Quantity Dispensed (field 442-E7).
Enter the sum of all ingredient costs in the Ingredient Cost Submitted (field 4Ø9-D9).

Scenario B (Billing codes):
Using the values listed below in the Claim Segment, Product/Service ID (Field 4Ø7-D7) for submission, by trading partner agreement, of the most expensive ingredient for compound ingredient claims.

The Compound prescription claims may continue to use the following billing code values for legend and/or scheduled drugs:

Legend, non-scheduled   99999999999
Schedule II   99999999992
Schedule III   99999999993
Schedule IV   99999999994
Schedule V   99999999995
Miscellaneous compounds   99999999996

Either scenario of Option 2 may be used when trading partners do not support multiple-ingredient billing.

23. APPENDIX E. WHERE DO I FIND

Answers May Be Found In The Following Documents

- Telecommunication Standard Version 5.1
- Telecommunication Implementation Guide Version 5.1
- Data Dictionary
- Telecommunication Version 5 Questions, Answers, and Editorial Updates (the "Editorial" document)
- Protocol For Version 5.1 (the "Protocol" document) – in draft status on the WG1 webpage
- Future versions of the Telecommunication Standard Implementation Guide

Additional Information May Be Found In The Following Documents

Telecommunication Standard and Implementation Guide Version 5.2 and above

Although the usage of new fields or field changes in Version 5.2 and above is not allowed in the implementation of Version 5.1, the Version 5.2 and above documents may provide additional clarification, as additional verbiage has been added (COB, Prior Authorization, et cetera). This verbiage is usually included in the Version 5 Editorial document.

Particular Topics May Be Found In The Following Documents

What Transactions Are Supported For What Business Purposes?

Transaction Discussion
> Section 6 of Specifications

Transaction Types
> Section 7 of Specifications

Special Considerations - Transactions, Segments, and Fields
> Section 4 of Implementation Guide

What Fields Changed?

Old Field Name Cross Reference
> Section V of Data Dictionary

New Field Name Cross Reference
> Section VI of Data Dictionary

Deleted Data Elements Not Supported in Version 5
> Section VII of Data Dictionary

Which Fields Are Allowed In Which Segments?

Request and Response Quick Reference
> Section 5 of Implementation Guide

Where Do The Segments Belong?

Segment Usage Matrix
> Section 3 of Implementation Guide

Transmission Request Diagrams
> Section 1Ø of Specifications

Transmission Response Diagrams
> Section 12 of Specifications

What Are The Valid Responses For Each Transmission?

Transmission Response Discussion

Section 11 of Specifications
Response Segment Matrices
　　Section 3 of Implementation Guide
Response Transactions
　　Section 4 of Implementation Guide

Recommended Use Of Dollar Fields And Calculated Amounts?
Special Considerations - Transactions, Segments, and Fields
　　Section 4 of Implementation Guide
Frequently Asked Questions
　　Section 8 of Implementation Guide

Explain The Syntax Rules For Version 5
Document Conventions
　　Section 8 of Specifications
Generally Accepted and Common Practices
　　Section 2 of Implementation Guide

Count And Counter Fields – Explanation and Usage?
Repetition and Multiple Occurrences
　　Section 8 of Specifications
　　Examples
　　　　Billing W/ Insurance COB - Transaction Code B1, Section 7 of Implementation Guide
　　Examples
　　　　Billing W/ Submitted DUR Override - Transaction Code B1, Section 7 of Implementation Guide
　　Examples
　　　　Compounded Rx Billing - Transaction Code B1 (Ø1), Section 7 of Implementation Guide
　　Frequently Asked Questions
　　　　Section 8 of Implementation Guide

What Has Changed In Version 5.1, 5.2, et cetera?
Appendix A
　　Section 13 of Specifications
Version Changes
　　Section 9 of Implementation Guide
Version Modifications
　　Section M of Data Dictionary

What If I Have A New Question?
Send the question to NCPDP Council Office at ncpdp@ncpdp.org

24. APPENDIX F. LONG-TERM CARE (LTC) PHARMACY CLAIMS SUBMISSION RECOMMENDATIONS FOR VERSION 5.1

24.1 INTRODUCTION (PURPOSE)

This NCPDP *LTC Pharmacy Claims Appendix* is intended to provide practical guidance for providers and payers handling pharmacy claims for LTC residents—especially those residents who are Medicare Part D beneficiaries. This paper is focused on the use of the NCPDP Telecommunication Standard Version 5.1. Any issues that pertain to the NCPDP Batch Standard Version 1.1 will be noted as applicable.

24.2 BACKGROUND

In December 2003, Congress passed the Medicare Prescription Drug Benefit, Improvement and Modernization Act (MMA), allowing Medicare payment to Medicare Advantage organizations, Prescription Drug Plan (PDP) sponsors, Programs for the All-Inclusive Care of the Elderly (PACE) plans, and Cost Plans (Part D plans), offering coverage beginning January 2006 of prescription drugs under the new Medicare Part D benefit. Payers and LTC Pharmacy providers need to coordinate to ensure that the CMS objectives of the Part D program are met successfully. A large segment of Part D enrollees will comprise the entire population of dual-eligible beneficiaries, many of whom are LTC residents.

Beginning in 2006, the majority of claims processed for LTC residents will shift from state Medicaid processors to a much larger number of Prescription Drug Plans (PDPs). It is critical that all providers and payers who are transacting pharmacy claims for LTC residents are doing so using the same codes and field values to signal that claims are indeed for LTC residents. We also strive to ensure that the unique dispensing circumstances for the special population of the frail elderly are being communicated uniformly.

HIPAA is relevant to the Medicare Part D program in that Part D sponsors, prescribers, and dispensers will be considered covered entities if they meet the definition of a covered health care provider, health plan, or health care clearinghouse. (*See* 45 C.F.R. § 160.103) As covered entities, these entities will be subject to the HIPAA electronic transactions and code set regulations, which adopted the NCPDP Telecommunication Standard Version 5.1 for all named HIPAA transactions. For example, they must use Version 5.1 for claims processing, eligibility determination, and the other transactions. (See 45 C.F.R. Pt. 162). Therefore, providers and payers must accomplish these goals using the existing NCPDP Telecommunication Standard Version 5.1 per the Medicare Modernization Act regulations.

24.3 CENTERS FOR MEDICARE/MEDICAID SERVICES (CMS) DEFINITION OF A LONG TERM CARE FACILITY

Definition of LTC, per final Part D regulations from CMS (page 129):

> *"We have expanded the definition of the term ³long-term care facility² in §423.100 of our final rule to encompass not only skilled nursing facilities, as defined in section 1819(a) of the Act, but also any medical institution or nursing facility for which payment is made for institutionalized individuals under Medicaid, as defined in section 1902(q)(1)(B) of the Act.... Such an expansion would include ICFs/MR and inpatient psychiatric hospitals along with skilled nursing and nursing facilities in the definition of a long-term care facility, provided those facilities meet the requirements of a medical institution that receives Medicaid payments for institutionalized individuals under section1902(q)(1)(B) of the Act."*

24.4 ISSUES AND RECOMMENDATIONS

24.4.1 PROVIDER CONTRACTS

Providers and payers may have multiple and different contracts that refer to different formularies and reimbursement terms. One contract may be for ambulatory retail. One may be for LTC. Yet another may be for Home Infusion services. It is important that the provider attempt to signal which contract should be invoked for any claim real-time during the adjudication event.

How do we know we have a LTC transaction?

There is an industry need to identify the patient location because of Medicare Part D.

There are four types of potential patient-PDP-contract circumstances:

- Actual LTC (recognized by CMS for unique Part D dispensing and MTM circumstances, encompassed in definition above)

- Assisted Living (CMS recommends to the Medicare Part D Plans unique dispensing considerations be made to the pharmacies that is ultimately the plans' decision http://www.ascp.com/medicarerx/docs/NonLTCFAccessQA.pdf)

- Home Infusion Therapy (HIT) (includes product and nursing services)

- Ambulatory/Retail/Other (product only at retail rate)

The "care" of long-term care (LTC) is specified by the setting that the patient resides in. The setting that the patient resides in can be reasonably established using the field *Patient Location Code 307–C7* in Version 5.1 of the Telecommunication Standard.

Unfortunately, the range of values in this data field do not cleanly and fully encompass the variety of care settings in our industry and map cleanly to that variety that qualify as LTC in the CMS definition.

Certain care settings that qualify as LTC are not represented in the available Version 5.1 Telecommunication Standard code set. To avoid confusion, it is recommended that only one code be used for qualifying LTC and one code for assisted living.

    RECOMMENDATION:

Patient Location Code--3Ø7-C7

For a LTC resident use code 3 = Nursing home. This code is broad enough to encompass all claims for patients who reside in LTC facilities (refer to CMS LTC definition).

For an assisted living resident use code 5 = Rest Home. CMS is encouraging PDPs to identify residents in Assisted Living Facilities (ALF), and if the resident is currently receiving special packaging or services, the PDPs may need to uniquely identify assisted living residents.

For a HIT patient use code 1 = Home. However, if the patient is receiving HIT but resides at an assisted living facility, it is recommended to use code 5 = Rest Home. In this circumstance, also use *Level of Service Code 418-DI* and value 6 = In Home Service.

24.4.2 SPECIAL PACKAGING

LTC pharmacies typically dispense oral solid medication (e.g., tablets) in a unit-dose package. This is what CMS refers to as special packaging services. (See http://www.cms.hhs.gov/pdps/LTC_guidance.pdf)

LTC pharmacies commonly repackage pills purchased in bulk bottles into unit dose cards and containers to allow for storage in special patient drawers in medication carts at the facility for nurse administration.

Providers may also need to refer to their trading partner agreements and/or provider communications for specific billing requirements for unit dose.

> **RECOMMENDATION:**
> *429-DT – Unit Dose Indicator*
> Use value 2 = Manufacturer Unit Dose
> Use value 3 = Pharmacy Unit Dose
>
> Manufacturer unit-dose National Drug Codes (NDCs) are prevalent in LTC dispensing. Therefore, they should be included in any PDP formulary when the drug itself is covered.

24.4.3 LEAVE OF ABSENCE (LOA) MEDICATIONS

LOA medications refers to separate dispensing of small quantities of medications for take-home use allowing residents to leave the facility for weekend visits, holidays, etc. When filed for reimbursement, these LOA medications must be identifiable to avoid rejections for duplication or refill too soon.

> **RECOMMENDATION:**
> *Submission Clarification Code 420-DK*
> Use value 3 = Vacation Supply. The pharmacist is indicating that the cardholder has requested a vacation supply of the medicine.

24.4.4 MEDICATION MISSING OR PATIENT "SPITS OUT"

The medication cannot be located, has been dropped, or has been "spit out" by the resident.

> **RECOMMENDATION:**
> *Submission Clarification Code 420-DK*
> Use value 4 = Lost Prescription. The pharmacist is indicating that the cardholder has requested a replacement of medication that has been lost.

24.4.5 EMERGENCY BOX DISPENSING OPERATIONS

A new order is administered with a starting dose from the emergency kit (which is provided in a secure box with consignment inventory by the pharmacy). The emergency dose is billed. Then a subsequent order for a full supply of the same medication is filled. This claim may be denied for payment.

Because of the timing of communications between LTC pharmacy and nursing home, often the first fill after the emergency dose may in fact be adjudicated before the pharmacy learns that the emergency dose has been withdrawn by the nurse. Therefore, we need separate clarification for the emergency dose itself and the first full dispensing that occurs following the emergency dose. These fills may be adjudicated in any order beyond the pharmacy's control.

Emergency Box (Ebox)/Starter dose claim submission scenarios

1) 4 days supply was administered out of the ebox and a 30 days supply was delivered by the pharmacy. Pharmacy bills the 30 days supply and then receives the notification from the facility for the 4 days supply that was administered out of the ebox after the 30 days supply was billed. If the 4 days supply is submitted as a separate claim it can potentially hit refill too soon, duplicate claim or max therapy/quantity edits. (Note: many times the 4 days supply and the 30 days supply have the same fill date) Use of the Level of Service Code 418-DI=3 on the 4 days supply claims allows the PBM to override these edit/denials.
2) 4 days supply was administered out of the ebox and a 30 days supply was delivered by the pharmacy. Pharmacy bills the 4 days supply as a separate claim and then bills the 30 days supply as a separate claim. The 30 days supply claim can potentially hit refill too soon, duplicate claim or max therapy/quantity edits. (Note: many times the 4 days supply and the 30 days supply have the same fill date). Use of the Submission Clarification Code 420-DK=6 on the 30 days supply allows the PBM to override these edits/denials.
3) 4 days supply was administered out of the ebox at the LTC Facility and a 30 days supply was delivered by the LTC pharmacy to the LTC Facility. The pharmacy bills for 34 days supply as one claim. This can potentially hit a max days supply edit if the days supply allowed is less than 34 days.

24.4.5.1 *CLARIFYING THE EMERGENCY DOSE ITSELF (MEDS REMOVED BY NURSE FROM EBOX)*

> **RECOMMENDATION:**
> *Level of Service Code 418-DI*
> Use value 3 = Emergency This will signal appropriate pharmacy service needed to override duplicate or refill too soon edits.

24.4.5.2 *CLARIFYING THE FIRST FILL FOLLOWING THE EMERGENCY DOSE*

RECOMMENDATION:
Submission Clarification Code 420-DK
Use value 6 = Starter Dose. The pharmacist is indicating that the previous medication was a starter dose and now additional medication is needed to continue treatment.

This characterizes the first full dispensing for the medication that is occurring after the nurse withdrew this medication from the emergency box (ebox). The naming of this clarification code as "Starter Dose" is confusing at a glance because it is really used to clarify the first fill after the starter dose.

24.4.6 LTC ADMISSIONS

A patient is admitted into nursing home. His or her medications may have been filled prior to admission at a retail pharmacy. Subsequently, this newly admitted LTC resident's medication claims are denied for "Refill Too Soon".

The resident transfers to and from a facility due to illness. Medications are previously filled prior to transfer and discontinued. The medications do not follow the patient to the new facility due to regulatory and compliance issues. The same medications may be re-ordered upon readmission to the facility.

RECOMMENDATION:
Reason for Service Code 439-E4
Use value NP = New Patient Processing
(Note: If there is an interpretation that all three DUR fields are a logical grouping and are required by either the processor or pharmacy software, it is recommended that the Value of 00 be used for fields Professional Service Code (440-E5) and Result of Service (441-E6). For Professional Service Code (440-E5) value of 00= No intervention and for Result of Service (441-E6) value of 00= Not Specified.)

Utilization of NP could result in logic that meets transition requirements. For example, if a plan states that it will allow a new admit to have a non-formulary drug for 30 days as part of the transition plan, the pharmacy could submit Reason for Service Code 439-E4=NP and the PBM could create logic that will override the denial, allowing for the transition period.

24.4.7 ON-LINE WINDOW FOR SUBMISSION OF NEW AND REJECTED CLAIMS

A patient in a LTC setting may have claims that need to be adjudicated retroactive to an earlier date. The eligibility setting in LTC is different than in a regular retail environment. While there is no consensus on how long that period should be, most participants agreed that some minimum number of back days is required to accomplish acceptable business results.

RECOMMENDATION:

> The Reversal and Claim Submission windows should be the same. A claim window of 60-70 days would at least allow pharmacies and payers to work product claims across adjacent calendar months.

24.5 IMPLEMENTATION OF CHANGES REQUESTED

The recommendations listed above are provided to enable automation of claims override; however, based on trading partner agreements they might not be utilized. Providers may need to refer to their trading partner agreements and/or provider communications for specific billing overrides.

24.6 SERVICE BILLING

Request for Guidance was added for Service Billing examples that are billings for a service without a medication to section *"Transaction Discussion",* section *"Service Billing Transaction".*

25. APPENDIX G. WORKERS' COMPENSATION RECOMMENDATIONS

25.1 DISPENSING PHARMACIST LICENSE NUMBER

NCPDP Telecommunication Standard version 5.1 supports the communication of this identifier in the Pharmacy Provider Segment, which is used to identify the pharmacist.

NCPDP Field ID	NCPDP Field Name	Values Supported
111-AM	Segment Identification	02-Pharmacy Provider Segment
465-EY	Provider ID Qualifier	02 state license
444-E9	Provider ID	

25.2 REPORTING TIME IN WORKERS' COMPENSATION CLAIMS FOR COMPOUNDED PRESCRIPTIONS

When billing for workers' compensation prescriptions that require the pharmacist or their agent bill for compounding separately (i.e. ingredients separate from the pharmacist's time), where would the pharmacist transmit the "time" involved to compound?

In the NCPDP Telecommunication Standard used for claims adjudication, the field **DUR/PPS Level of Effort (474-8E)** is to be used. The DUR/PPS Level of Effort is a "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." The values for this field are levels, from the lowest to the highest level of effort. See the NCPDP Data Dictionary for the appropriate values for this field.

DUR/PPS Segment	
Field	Field Name
111-AM	SEGMENT IDENTIFICATION
473-7E	DUR/PPS CODE COUNTER
439-E4	REASON FOR SERVICE CODE
44Ø-E5	PROFESSIONAL SERVICE CODE
441-E6	RESULT OF SERVICE CODE
474-8E	**DUR/PPS LEVEL OF EFFORT**
475-J9	DUR CO-AGENT ID QUALIFIER
476-H6	DUR CO-AGENT ID