TELECOMMUNICATION VERSION D AND ABOVE
QUESTIONS, ANSWERS AND
EDITORIAL UPDATES

DOCUMENTATION

See important update in section “Quantity Prescribed [460-ET]”

November 2019

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November 2019
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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 Version D and above, the Data Dictionary, and the External Code List. 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.

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

Important Note: In July 2007 the NCPDP Telecommunication Standard Implementation Guide Version D.0 was published. Editorial changes were made until April 2009 and are noted in “Appendix A. History of Document Changes”, “Version D.0”, “Editorial Corrections”. Implementers should verify they are using the version of the implementation guide that has the editorial corrections noted below.

Any further modifications will be noted in this document. Business needs brought forward and further changes to the implementation guide will result in future versions. Editorial or clarification changes to the implementation guide, as well as format changes will be made to future versions of the Telecommunication standard. Clarifications that affect implementation of Telecommunication Standard Implementation Guide Version D.0 will be cited in this document.

NCPDP Telecommunication Standard Implementation Guide Version D.0 was named in Final Rule published January 16, 2009 for the Health Insurance Portability and Accountability Act (HIPAA).

It should be noted that values may be added/changed/deleted in the External Code List on a quarterly basis. This allows the industry to adapt to business needs when values are needed.

The topics are in categories which provide a high level reference. 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.

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 REPUBLICATION OF TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE VERSION D.0 JULY 2009

1.1.1 SCHEDULED PRESCRIPTION ID NUMBER (454-EK)

Scheduled Prescription ID Number (454-EK) has been changed from “Not used” to “Required if necessary for state/federal/regulatory agency programs” in Claims and Service Billings, Information Reporting, and their Rebills, Prior Authorization Request and Billing (Claim, Service), and Predetermination of Benefits transactions. The previous versions of Telecommunication Implementation Guide supported the use of the field. This was brought to NCPDP’s attention by NYS Medicaid. NCPDP provided background to the Office of e-Health Standards and Services with the request to correct the implementation guide named in HIPAA in 2009. The request was granted. See http://www.ncpdp.org/Resources/HIPAA under Implementation Guide Corrections banner.
Note that Telecom D.1 and above were also updated, with the inclusion of the Controlled Substance Reporting transaction specifications.

1.2 Republication of Telecommunication Standard Implementation Guide Version D.0 August 2010

1.2.1 Benefit Stage Formula

New CMS requirements for Part D multi-ingredient compound claims (which represent a very small percentage of pharmacy claims) introduce a possible scenario where the standard Benefit Stage formula no longer balances. This scenario would occur if multi-ingredient compound prescription claims submitted by a pharmacy to a primary Medicare Part D payer contained some ingredients that cannot be covered by Part D due to regulation – and the plan chooses to offer enhanced benefits to cover some/all of the remaining ingredients. This imbalance was found as part of the industry building examples for multi-ingredient compounds to comply with Medicare Part D regulations. The formula was modified to include Other Payer Amount Recognized (566-J5) and clarifying guidance was added in section "Response Pricing Segment".

The Telecommunication Standard Implementation Guide Version D.0 (and above) has been modified to clarify the Benefit Stage formula as follows (additions shown in highlight):

Telecommunication Implementation guide clarification:
Benefit Stage Amount (394-MW) –
The sum of all submitted Benefit Stage Amounts must equal the sum of Patient Pay Amount (505-F5), Other Payer Amount Recognized (566-J5) and Total Amount Paid (509-F9).
(Calculation: Sum Benefit Stage Amount occurrences 1 through 4 = Patient Pay Amount (505-F5) + Other Payer Amount Recognized (566-J5) + Total Amount Paid (509-F9)).

Note: If a plan chooses to pay for non-Medicare Part D ingredients in a compound that also contains a payable Medicare Part D ingredient, the Benefit Stage Amount (394-MW) will reflect the correct amount attributed to Medicare Part D benefit stage, but it will not equal the sum of Patient Pay Amount (505-F5) and Other Payer Amount Recognized (566-J5) and Total Amount Paid (509-F9).

Multi-ingredient compounds only: When plans chose to cover ingredients under an enhanced plan that are not Medicare Part D covered drugs, the Benefit Stage balancing formula does not apply, due to the sum of the Patient Pay Amount (505-F5), Total Amount Paid (509-F9) and Other Payer Amount Recognized (566-J5) being greater than the amounts covered under the Medicare D benefit.

If using Other Payer-Patient Responsibility Amount (352-NQ) as the basis for your coordination of benefit payment, no change is required to Benefit Stage calculation.

1.2.2 Denote Individual Amounts of Patient Financial Responsibility as Reported from a Previous Payer

Section "Denote Individual Amounts of Patient Financial Responsibility as Reported from a Previous Payer" had an invalid reference to sales tax, and Amount Attributed to Product Selection/Brand Drug (134-UK), which should not apply to Service Billings. The Telecommunication Standard Implementation Guide Version D.0 (and above) has been modified to

For example, in an original claim or service billing, the primary payer returns amounts in the Amount Attributed to Product Selection/Brand Drug (134-UK) and Amount Attributed to Sales Tax (523-FN) Amount
of Copay (518-FI). The pharmacy submits the claim or service billing to the secondary payer. The amounts in these two fields are then reflected in two occurrences of the Other Payer-Patient Responsibility Amount, with the Qualifier reflecting one occurrence with a value of “02” (Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by a previous payer) and a second occurrence with a value of “05” (Amount of Copay (518-FI) as reported by previous payer).

NCPDP provided background to the Office of e-Health Standards and Services with the request to correct the implementation guide named in HIPAA in 2009. The request was granted. See http://www.ncpdp.org/Resources/HIPAA under Implementation Guide Corrections banner.

1.3 ENHANCEMENT OF TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE VERSION D.0 NOVEMBER 2012

1.3.1 QUANTITY PRESCRIBED (460-ET)

04/29/2019 Update:
No decision regarding the situational rule or version has been made by the HHS CMS National Standards Group.

01/2019 Update:
An NPRM has been published and is available at https://www.govinfo.gov/content/pkg/FR-2019-01-31/pdf/2019-00554.pdf The NPRM requires covered entities to use the Quantity Prescribed (460–ET) field in the August 2007 Version of the NCPDP Telecommunication Standard Version D.0 for retail pharmacy transactions for Schedule II drugs.

08/2013 Update:
The original industry requested implementation timeframe for Quantity Prescribed was 01/2014. THIS IS NOW ON HOLD PENDING REGULATORY APPROVAL PROCESSES. The Telecommunication Standard Version D.0 of 08/2010 continues to be the ONLY HIPAA-approved version. See http://www.ncpdp.org/Resources/HIPAA under the banner Implementation Guide Corrections for updated information when it is available. NCPDP will use the NCPDP NOW and other mechanisms to notify the industry.

Background:
In November 2012 NCPDP published an enhancement of the Telecommunication Standard Implementation Guide Version D.0. The enhanced guide contains a publication date of “November 2012”. In the guide in section “Appendix A. History of Document Changes”, “Version D.0”, “November 2012 Enhancement”, the following entry appears:

Quantity Prescribed (460-ET) for claim billings was changed from “not used” to “situational” for Schedule II dispensing under the following situational circumstance “Required for all Medicare Part D claims for drugs dispensed as Schedule II. May be used by trading partner agreement for claims for drugs dispensed as Schedule II only.” (This modification was made to Claim Billing/Encounter, Claim Rebill, Prior Authorization Request And Billing (Claim)).

11/2012:
NCPDP provided a request to the Office of e-Health Standards and Services to publish regulatory notice about the implementation guide enhancement in preparation for a 01/2014 implementation. The industry was preparing for the 01/2014 use of Quantity Prescribed (460-ET) in the billing transactions. In 2012 and 2013, requests for HIPAA rule making notifications were sent to OESS and NCVHS. DSMO Change Request 1182 was filed and approved. In 03/2013, NCPDP received approval from OESS to proceed with industry outreach and the timeframe. However in 08/2013 important updated information was provided.

Initially OESS thought they could publish a notice announcing the change in the Federal Register and responded that way in a letter to NCPDP. In early summer 2013, the HHS Office of General Counsel (OGC) advised OESS that this could not be a federal register notice. OESS created an Interim Final Rule (IFC) per ACA section 1104 on
Administration Simplification. OGC advised OESS that ACA did not apply to this situation and the Telecommunication change would have to go through the full rulemaking (Notice of Proposed Rule Making (NPRM) and Final Rule) process. NCPDP is following up to determine if there is a timely alternative. This delay in rulemaking has delayed the industry requested January 2014 implementation date. All entities should put on hold the implementation of Quantity Prescribed changes pending the regulatory process outcome. We will update the industry with additional information as soon as it is available.

Editorial Correction:
Note, in the original November 2012 publication of the Telecommunication Standard Implementation Guide Version D.0, an editorial error was present in the section “Transmission Structure”, “Request Segment Matrices By Field Within Segment” where the Quantity Prescribed was not changed to “Q” on the Claim Billing column. This has been corrected.

1.4 USE OF THIS DOCUMENT

This document should be used as a reference for the Telecommunication Standard Version D.0 and above, the Batch Standard Version 1.2 and the Medicaid Subrogation Implementation Guide Version 3.0 as applicable. In the Batch Standard format, and the Medicaid Subrogation Implementation Guide (when used in batch mode), the Detail Data Record consists of the NCPDP Data Record, which consists of the Telecommunication Standard record format. Therefore references in these documents apply to all three standards as applicable.

1.4.1 HOW SOON SUPPORT THIS DOCUMENT?

Question:
Once the Version D Editorial is published, how soon do implementers need to support?

Response:
When the Version D Editorial is published, it is effective for use immediately unless the specific section or response lists an effective date.

See “Appendix G. Support of This Document”.

1.4.2 MEDICAID SUBROGATION EDITORIAL DOCUMENT

In July 2011, the NCPDP Medicaid Subrogation Standard Implementation Guide Version 3.0 Questions, Answers and Editorial Updates was published based on Work Group 9 (WG9) Government Programs recommendations. This document should be consulted for specific guidance. It is noted that general information about Telecommunication segments, data fields, etc. that is contained in this document should be consulted as well.

1.5 NCPDP IMPORTANT EXTERNAL CODE LIST (ECL) INFORMATION

During the May 2010 Joint Technical Work Group meeting of the Maintenance and Control Work Group, the ECL Implementation Task Group was formed to develop an ECL implementation process as it applied to the Telecommunication Standard Version D.0 and above. The purpose of this task group was to facilitate consistent adoption of the approved ECL versions within a reasonable, workable timeframe, across all industry participants.


This document provides the process to request additions, modifications, and deletions to the data element values existing in the External Code List (ECL). It provides the rules governing the procedures and steps for this process and maintenance of the ECL as approved by the NCPDP Board of Trustees. In addition, this
document outlines the Telecommunication ECL implementation time table used to facilitate consistency across the industry.

This document contains an ECL Publication and Implementation Chart to provide key dates in which full ECL Publications and ECL Emergency Values should be implemented across all industry participants supporting the NCPDP Telecommunication Standard.

See the NCPDP Emergency Telecommunication External Code List Value Addendum document (http://www.ncpdp.org/Members/Standards-Lookup) under External Code Lists. The addendum is listed under a quarterly ECL for the list of values approved for emergency implementation and the ECL Publication and Implementation Chart.

1.6 NCPDP Recommendations for 4Rx Usage in Medicare Part D Processing Documents

During the August 2011 Joint Technical Work Group meeting, WG1 Telecommunication approved the reference and linkage in this document to the NCPDP Recommendations for Effective 4Rx Usage in Medicare Part D Processing documents.

A Centers for Medicare and Medicaid Services (CMS) directive entitled “Clarification of Unique BIN (or BIN/PCN) Requirements as of January 1, 2012 [§423.120(c)(4) as revised by CMS-4085-F]” released on November 12, 2010 provided clarification of Unique BIN (or BIN/PCN) requirements. This directive covered the required assignment and exclusive use of unique routing and beneficiary identifiers for the Medicare Part D program. Implementing this directive consistently in the industry is the subject of the above documents.

The intent of these provisions is to ensure that:
1. Pharmacies can routinely identify situations in which they are billing a Medicare Part D claim and
2. Payers supplemental to Medicare Part D can properly coordinate benefits on Part D claims.

It is important to note that this documentation only addresses the matching and the consistent use of the 4Rx data to accept or reject transactions in processing. It does not address how benefits are established. Transactions that are rejected for reasons other than the 4Rx matching are out of scope.

The term “4Rx” refers to

- RxBIN - Part D Rx Bank Identification Number (BIN)
- RxPCN - Part D Rx Processor Control Number (PCN)
- RxGroup - Part D Rx Group and
- RxID - Part D Rx ID for the beneficiary

NCPDP explored with CMS the possibility of a transition period through the end of February 2012 to minimize year end member disruption. If an extension is granted this documentation will be updated to reflect the new final implementation date, however plans may implement at any point prior to this date.

The NCPDP Recommendations for Effective 4Rx Usage in Medicare Part D Processing documents can be found at http://www.ncpdp.org/Resources/Medicare-Part-D.

1.7 NCPDP Emergency Preparedness Resource

1 Document is included in this packet of information.
The NCPDP Emergency Preparedness Information document provides guidance for the pharmacy industry for resources available during a declared emergency. The intended audience is healthcare industry providers who would need resource information for eligibility and claims processing affecting displaced individuals. It is available at http://www.ncpdp.org/Resources/Emergency-Preparedness under NCPDP Industry Guidance banner. Other guidance on patient demographic information during displacement is given. References to the Prior Authorization Number Submitted (462-EV) are available in the NCPDP External Code List.
2  EDITORIAL CORRECTIONS CITED IN TELECOM D.0

Editorial changes were made directly into the NCPDP Telecommunication Standard Implementation Guide Version D.0 until April 2009 and are noted in “Appendix A. History of Document Changes”, “Version D.0”, “Editorial Corrections” of the guide. Any further modifications will be noted in this document.

The following are corrections made which are cited in the NCPDP Telecommunication Standard Implementation Guide Version D.0.

Field DUR Additional Text (570-NS) was inadvertently left off the Response DUR/PPS Segment in sections
- “Response DUR/PPS Segment (Claim Billing or Encounter) (Transmission Accepted/Transaction Paid)”
- “Response DUR/PPS Segment (Claim Rebill) (Transmission Accepted/Transaction Paid)”

In the matrix section, Segment - field Facility ID (336-BC) was corrected to (336-8C). Preferred Product Description (551-9F) was corrected to (556-AU), Amount of Copay (518-F1) was corrected to (518-F1).

Inadvertent editorial errors were corrected (fields designated as not used, but “Mandatory/Situation” column had an “S” or “Q” instead of “N”, or fields with “S” designation should have been “Q”.)

Prescription/Service Reference Number Qualifier (455-EM) – a mandatory field has a guidance note in some of the transactions, but not all. The guidance note has been added to all.

Date Prescription Written (414-DE) in Information Reporting Rebill – the situation was inadvertently not consistent with Information Reporting.

In the Response Message Segment and Response Status Segment, when a transmission does not support more than one transaction, the reference to >1 has been removed in the Transaction Count (109-A9) and Additional Message Information (526-FQ) – Eligibility Verification and Prior Authorization transactions.

Response Prior Authorization Segment inadvertently was listed in the table heading as Mandatory even though all other references were for a situational segment. The table heading has been changed in
- Response Prior Authorization Segment (Claim Billing or Encounter) (Transmission Accepted/Transaction Rejected)
- Response Prior Authorization Segment (Service Billing) (Transmission Accepted/Transaction Rejected)
- Response Prior Authorization Segment (Claim Rebill) (Transmission Accepted/Transaction Rejected)
- Response Prior Authorization Segment (Service Rebill) (Transmission Accepted/Transaction Rejected)

Inadvertent editorial errors were corrected in Preferred Product Description (556-AU) for Prior Authorization Inquiry (Claim) situation, and Response Status Segment note on Prior Authorization Inquiry Response (Deferred).

In section “Transmission Examples”, section “Billing – Transaction Code B1 – Coordination of Benefits Scenarios Pharmacy Bills to Insurance Designated By Patient”, subsection “Scenario 2 Response: Secondary Insurance Pays The Claim Submitted With Net Other Payer-Patient Responsibility Amount” and “Scenario 3 Response: Secondary Insurance Pays The Claim Submitted With The “Pieces” Of Other Payer-Patient Responsibility Amount” the Ingredient Cost Paid and/or Dispensing Fee Paid was correctly listed in the Value column, but the Comments column was incorrect.

In section “Transmission Examples”, section “Compounded Rx Billing - Transaction Code B1 (01) – Coordination of Benefits Scenario”, subsection “Secondary Insurance Pays The Claim Submitted With Amount Paid By Other Payer”, the Basis of Reimbursement Determination incorrectly showed a value of “1”. It was changed to “3” to match the comment.
3 REQUEST SEGMENT DISCUSSION

3.1 CLAIM SEGMENT (07)

3.1.1 DAYS SUPPLY (405-D5)

Question:
How do you set the days supply for a recurring medication that has a long period between dosing or administering (such as once every 120 days, 180 days, etc...) that is dispensed as a single dose? How do you keep a long days supply from causing a misrepresentation of the claim as mail order?

Response:
The actual days supply (in this case days between dosing) is to be sent in order to properly apply DUR edits. The pharmacy system vendor and the processor must be able to support 3 digits in the Days Supply as the standard supports 3 digits. Days Supply should not be used as a determination for the type of pharmacy setting. Pharmacy Service Type (147-U7) is used for identifying the type of pharmacy submitting the claim.

3.1.2 DISPENSE AS WRITTEN (408-D8) VALUE 9 DURING TRANSITION

Question:
XYZ Medicaid and a commercial plan have requested to begin utilizing DAW 9 for plan mandated brand medications. (This is in line with D.0 implementation.) The current option of DAW codes does not agree with the reasoning for using a brand over the generic. Utilizing the DAW 9 will give pharmacies a way to differentiate these plan mandated brands for purposes of calculating their generic compliance rates in addition, it will allow pharmacies to receive proper pricing without having to get the brand name drug prior approved therefore the patient’s and the pharmacies services will go uninterrupted.

Another state currently utilizes DAW 9 which was approved by NCPDP members. It is not mandatory for pharmacies to use, it is optional. They have received positive feedback from community’s pharmacies thus far. This request is for other entities to do the same.

Background:
The dictionary for version 5.1 of 09/1999 has a note in value 9.

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Other -This value is reserved and currently not in use. NCPDP does not recommend use of this value at the present time. Please contact NCPDP if you intend to use this value and document how it will be utilized by your organization.</td>
</tr>
</tbody>
</table>

The dictionary for version D.0 where value 9 has been enhanced:

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Substitution Allowed By Prescriber but Plan Requests Brand - Patient’s Plan Requested Brand Product To Be Dispensed - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the plan’s formulary requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.</td>
</tr>
</tbody>
</table>

Response:
Other entities may use the value 9 during transition from version 5.1 to version D.0 as long as 1) the entity uses the DAW 9 as approved; 2) the entity uniquely identifies the plan, and 3) the entity gives a lead time to the pharmacies to implement.

3.1.3 OTHER COVERAGE CODE (308-C8)

3.1.3.1 SUBMITTING TO MULTIPLE PAYERS?

Claim Segment contains the Other Coverage Code (308-C8) and can only submit it once per claim/transaction. If pharmacy submits to 3 payers, the following scenario is feasible:

- Payer 1 rejects claim for Member not having coverage effective on date of service (previously used OCC=7 in 5.1 claims)
- Payer 2 gets the claim as an OCC=3 and processes claim but member is fully in deductible, resulting in $0 payment to pharmacy (from plan)
• Payer 3 only accepts OCC 2, 3, and 4 (no 8s). Pharmacy therefore submits (?) using OCC=4. When processing claim, will process a 50% co-insurance

How is the pharmacy supposed to submit the data above? Since only a single OCC can be submitted, I would expect the pharmacy to submit to 3rd payer using OCC=4. But in this case, we lose the reject being processed by payer 1. We aren’t expecting the Reject code loops for OCC 2, 4, and 8. Should pharmacy submit those anyway with the payer 1 reject(s) in their own respective loop? Or should the pharmacy maintain OCC 4 logic and just mark other payer amount from payer 1 as $0 (or even excluding all other payer and patient responsible loops)?

I can’t think of situations where different payers may need OCC 2 vs. OCC 8 (not sure I can even phrase that situation understandably). But in the case above, I need to know what to expect from the pharmacy. I’m hoping the answer is that the OCC is based on what was processed and or returned from latest payer (so payer 2 gets OCC 3, payer 3 gets OCC 4, and if a payer 4 is there, they get OCC 2/8).

Response:
It is up to the processor to enforce clean integrity though trading partner agreements. See the Other Coverage Code section of the Telecommunication Implementation Guide.

3.1.3.2 NON-COB CLAIMS

Question:
The Other Coverage Code (308-C8) is defined as “Code indicating whether or not the patient has other insurance coverage” and is a Situational Field. Can a payer require the pharmacy to submit the Other Coverage Code field on non-COB claims, and if so, when should the value “0-Not specified by patient” be used instead of “1-No other coverage”?

Response:
A payer can require submission of Other Coverage Code (OCC) (308-C8) on all claims.

A value of 0 (Not Specified by Patient) may be used as a default value for a primary claim when OCC is required per the payer sheet.

As per the Telecommunication Standard Implementation Guide, a value of 1 (No Other Coverage) must not be used as a default value. The value of 1 may be used:
• On a claim to a payer who requires pharmacy providers to validate the presence of other coverage for every prescription filled. By sending a value of 1 the pharmacy is indicating they have exhausted all means of determining pharmacy benefit coverage and no other coverage is identified.
• On a claim when the payer denies with reject code 41 (Submit Bill to Other Processor or Primary Payer) and the payer provides no or insufficient other coverage information to the pharmacy and the pharmacy has exhausted all means of identifying the other coverage information necessary to bill another processor.

Added: March 2018

3.1.3.3 GOVERNMENT COB?

Question:
Can all of the Other Coverage Codes (308-C8) be used by the SPAP? Or should it be restricted to 0 – 4 as it is for the Medicaid payers using government COB processing? My company provides adjudication services for payers that wrap around patient responsibilities (e.g. payer of last resort, SPAPs, state funded programs). The programs are “government programs” in that they are made available through local, state and Federal funds. Currently, we use OCC 8, copayment only billing; we also require the COB segment of other payer information. The D.0 guidance is recommending use of OCC 2. My specific question was “what is the definition of “government programs”? And, given the above clarification, can we still mandate (and use) OCC 8 for COB billing?
Response:
The allowed Other Coverage Code (308-C8) values are specific to the COB method required by the payer. The payer sheet must indicate only one COB processing method and cannot request the provider to alter the COB method based on the previous payer’s response. Once established in the Payer Sheet, it is not an option to change the COB processing method unless the current Payer Sheet is replaced.

For coordination of benefit claims, an Other Coverage Code (308-C8) value and the COB segment are always submitted, where the Other Payer Coverage Type, Other Payer Date, Other Payer ID Qualifier, and Other Payer ID identify the previous payer(s). The specific COB processing method determines which financial fields are required.

The COB processing methods include:

1. **Other Payer Amount Paid only**
   - Other Coverage Code (308-C8) values of ‘2’ (Other coverage exists-payment collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received) and ‘4’ (Other coverage exists-payment not collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received)

2. **Other Payer Patient Responsibility Amounts only**
   - Other Coverage Code (308-C8) value of ‘8’ (Claim is billing for patient financial responsibility only - Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient’s current benefit status, product selection or network selection)

3. **Other Payer Amount Paid and Other Payer Patient Responsibility Amount (Government COB - Full Disclosure)**
   - Other Coverage Code (308-C8) values of ‘2’ (Other coverage exists-payment collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received) and ‘4’ (Other coverage exists-payment not collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received)
   - As outlined within the NCPDP v5.1 Editorial document sections 7.4 PATIENT PAID AMOUNT SUBMITTED (433-DX) and 20.9 SCENARIO 1E REQUEST: PHARMACY BILLS SECONDARY INSURANCE AFTER PRIMARY PAID, full disclosure COB can only be used when state or federal statute or regulation requires knowledge of full reimbursement by previous payer(s). The request for documentation of government regulation or policy for full disclosure is for the protection of the provider’s obligation to not disclose contractual rates to others. It is not NCPDP’s place to determine whether a regulation or policy language meets full disclosure, but is instead a trading partner issue.

Regardless of the COB method the Other Coverage Code (308-C8) value of ‘3’ (Other Coverage Billed – claim not covered - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment denied because the service is not covered) is used to designate all prior payers returned a rejected claim response. The associated Reject Code(s) (511-FB) are transmitted in the Other Payer Reject Code (472-6E) field in the COB segment.

For further clarification on the use of Other Coverage Code (308-C8) values, please refer to the table in section “Other Payer Reject Code (472-6E)”.

### 3.1.3.4 OTHER COVERAGE CODE (308-C8) TO SUBMIT WHEN ONE OTHER PAYER HAS PAID $0?

Question:
For Other Coverage Code (308-C8) = 04, at least 1 prior payer has paid $0. How does the provider convey this message?

1. By submitting any value for Other Payer Amount Paid Qualifier (342-HC) and $0 in Other Payer Amount Paid (431-DV) OR
2. By not submitting fields Other Payer Amount Paid Qualifier (342-HC) and Other Payer Amount Paid (431-DV).

This question is for government COB (also applies to OPAP billing).

Response:
When the response from the previous payer contains a $0 value for Patient Pay Amount (505-F5), the $0 value must be reported in the corresponding Other Payer-Patient Responsibility Amount (352-NQ) when submitting to subsequent payers. Other Payer-Patient Responsibility Amount (352-NQ) must be associated with the applicable Other Payer-Patient Responsibility Qualifier(s) (351-NP), based on payer sheet requirements. If not otherwise specified, the Other Payer-Patient Responsibility Qualifier (342-HC) value of “06” (Patient Pay Amount (505-F5) as reported by previous payer) should be sent.

When the response from the previous payer contains a $0 value as Total Amount Paid (509-F9), the $0 value must be reported in the Other Payer Amount Paid (431-DV) field when submitting to subsequent payers. At a minimum, the Other Payer Amount Paid (431-DV) should be associated with Other Payer Amount Paid Qualifier (342-HC) value of “07” (Drug Benefit).

Please reference section “Specific Segment Discussion”, subsection “Request Segments”, subsection “Coordination of Benefits/Other Payments Segments” in the Telecommunication Implementation Guide as it indicates that $0 is a valid value to send.

The transmission of the two data elements (Other Payer-Patient Responsibility Amount (352-NQ) and Other Payer Amount Paid (431-DV)) is the only way to identify the claim is intended for processing as a Government COB claim. If the processor is expecting Government COB and Other Payer-Patient Responsibility Amount (352-NQ) is not present the process should reject the claim with Reject Code (511-FB) value of “NQ” (M/I Other Payer-Patient Responsibility Amount).

This was added to Telecommunication Standard Version E.0.

### 3.1.3.5 OTHER COVERAGE CODE WHEN DRUG BENEFIT AMOUNT IS ZERO

**Question:**
When the payer requires the Other Payer Amount Paid (431-DV) values to be submitted on the COB claim, and the payer only recognizes the Drug Benefit (OPAP Qualifier = 07) amount, which Other Coverage Code (308-C8) value should be submitted when the Other Payer Amount Paid Drug Benefit amount is zero ($0) and additional Other Payer Amount Paid values greater than zero ($0) are reported? For example:

<table>
<thead>
<tr>
<th>Bill to Primary Submitting Tax Amounts</th>
<th>Primary Pays 6% Tax and Flat Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>409-D9 Ingredient Cost Submitted</td>
<td>$95.00</td>
</tr>
<tr>
<td>412-DC Dispensing Fee Submitted</td>
<td>$5.00</td>
</tr>
<tr>
<td>482-GE Percentage Tax Amount Submitted</td>
<td>$6.00</td>
</tr>
<tr>
<td>483-HE Percentage Sales Tax Rate Submitted</td>
<td>6.00%</td>
</tr>
<tr>
<td>484-JE Percentage Sales Tax Basis Submitted</td>
<td>3 – IC + Fee</td>
</tr>
<tr>
<td>481-HA Flat Sales Tax Amount Submitted</td>
<td>$0.20</td>
</tr>
<tr>
<td>426-DQ</td>
<td>Usual and Customary Charge</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>430-DU</td>
<td>Gross Amount Due</td>
</tr>
<tr>
<td>423-DN</td>
<td>Basis of Cost Determination</td>
</tr>
</tbody>
</table>

**PRIMARY RESPONSE Pricing Segment**

<table>
<thead>
<tr>
<th>512-FC</th>
<th>Amount Attributed to Periodic Deductible</th>
<th>$82.30</th>
</tr>
</thead>
<tbody>
<tr>
<td>523-FN</td>
<td>Amount Attributed to Sales Tax</td>
<td>$0.00</td>
</tr>
<tr>
<td>505-F5</td>
<td>Patient Pay Amount</td>
<td>$82.30</td>
</tr>
<tr>
<td>509-F9</td>
<td>Total Amount Paid</td>
<td>$5.14</td>
</tr>
<tr>
<td>506-F6</td>
<td>Ingredient Cost Paid</td>
<td>$79.80</td>
</tr>
<tr>
<td>507-F7</td>
<td>Dispensing Fee Paid</td>
<td>$2.50</td>
</tr>
<tr>
<td>559-AX</td>
<td>Percent Sales Amount Paid</td>
<td>$4.94</td>
</tr>
<tr>
<td>560-AY</td>
<td>Percent Sales Tax Rate Paid</td>
<td>6.00%</td>
</tr>
<tr>
<td>561-AZ</td>
<td>Percent Sales Tax Basis Paid</td>
<td>3 – IC + Fee</td>
</tr>
<tr>
<td>558-AW</td>
<td>Flat Sales Tax Amount Paid</td>
<td>$0.20</td>
</tr>
<tr>
<td>574-2Y</td>
<td>Plan Sales Tax Amount</td>
<td>$5.14</td>
</tr>
<tr>
<td>575-EQ</td>
<td>Patient Sales Tax Amount</td>
<td>$0.00</td>
</tr>
<tr>
<td>522-FM</td>
<td>Basis of Reimbursement Determination</td>
<td>8 – Contract Pricing</td>
</tr>
</tbody>
</table>
Response:
Other Coverage Code (308-C8) value of “2” (Other coverage exists-payment collected) must be submitted. In the example above, even though drug benefit paid was 0 there were other amounts paid by the previous payer.

If multiple payers have been billed and at least one has paid with Total Amount Paid (509-F9) greater than 0, Other Coverage Code will be 2 regardless of additional payer responses. This means the sum of all Other Payer Amount Paid (431-DV) values for at least one previous payer will be greater than 0, regardless of which Other Payer Amount Paid values the COB payer may leverage for reimbursement determination.

### 3.1.4 Prescription Origin Code (419-DJ)

For reference, this is the definition and valid values of the field.
419-DJ – Prescription Origin Code

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code indicating the origin of the prescription.</td>
<td>9(1)</td>
</tr>
</tbody>
</table>

Values:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not Known</td>
</tr>
<tr>
<td>1</td>
<td>Written - Prescription obtained via paper.</td>
</tr>
<tr>
<td>2</td>
<td>Telephone - Prescription obtained via oral instructions or interactive voice response using a phone.</td>
</tr>
<tr>
<td>3</td>
<td>Electronic - Prescription obtained via SCRIPT or HL7 Standard transactions, or electronically within closed systems</td>
</tr>
<tr>
<td>4</td>
<td>Facsimile - Prescription obtained via transmission using a fax machine.</td>
</tr>
<tr>
<td>5</td>
<td>Pharmacy - This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, intrachain transfers, file buys, software upgrades/migrations, and any reason necessary to &quot;give it a new number.&quot; This value is also the appropriate value for &quot;Pharmacy dispensing&quot; when applicable such as BTC (behind the counter), Plan B, established protocols, pharmacists authority to prescribe etc.</td>
</tr>
</tbody>
</table>

“established protocols, pharmacists authority to prescribe” was approved 05/2012. Per the ECL implementation recommendations, the modification is available with the 10/2013 annual implementation schedule.

“, or electronically within closed systems” was approved 08/2014. Per the Emergency ECL implementation recommendations, the modification is available to be used 04/01/2015.

The Prescription Origin Code (419-DJ) contains the value that represents the method in which the pharmacy originally received the prescription from the prescriber. Any subsequent changes or modifications to the original prescription do not change the Prescription Origin Code (419-DJ). Once a prescription is assigned an origin code, the Prescription Origin Code (419-DJ) value is retained for the life of that Prescription/Service Reference Number (402-D2).

3.1.4.1 IMPORTANT NOTE

Effective Date: June 6, 2012
Clarifications to the use of the Prescription Origin Code values are contained in the May 2012 publication date of this document, effective with the notice to the industry of June 6, 2012.

Effective Date: October 15, 2013
The modification to the External Code List description for Prescription Origin Code value 5 (Pharmacy), will be published in the July 2012 ECL document and effective as of the October 15, 2013 annual implementation date. For industry consistency, implementers must be prepared to support this change as of this date.

Effective Date: April 1, 2015
The modification to the External Code List description for Prescription Origin Code value 3 (Electronic) “, or electronically within closed systems” was approved 08/2014. Per the Emergency ECL implementation recommendations, the modification is available to be used 04/01/2015.

3.1.4.2 TRANSFERS

Question:
What Prescription Origin Code is used in a transfer from one pharmacy to another? Would the Rx dispense at the receiving pharmacy be coded the same as it was originally coded at the sending pharmacy? Would internal transfers between pharmacies on the same closed system be handled the same?

For example, if ABC Pharmacy dispenses a prescription that was coded with an origin of "Fax", and the Rx was subsequently transferred to a different pharmacy, would the new Rx transmitted at the new pharmacy code the Rx as "Fax" also, since this was the original designation?
Response:
As of January 1, 2012 all transfers of prescriptions between pharmacies including traditional transfers, intrachain transfers, and file-buys should use a Prescription Origin Code of 5 (Pharmacy - This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional 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.). Use this value as soon as practical for the Prescription Origin Code when the prescription being billed has been transferred from another pharmacy, irrespective of the method used for such a transfer.

Question:
Does the pharmacy dispensing the prescription use an origin code of “2” when they transmit the prescription because they received it by telephone, or do they submit an origin code of “5” because it was a traditional pharmacy-to-pharmacy transfer?

Response:
As of January 1, 2012 all transfers of prescriptions between pharmacies including traditional transfers, intrachain transfers, and file-buys should use a Prescription Origin Code of 5 (Pharmacy - This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional 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.). Use this value as soon as practical for the Prescription Origin Code when the prescription being billed has been transferred from another pharmacy, irrespective of the method used for such a transfer.

3.1.4.3 USE OF PRESCRIPTION ORIGIN CODE

Question:
If a prescriber sends an electronic prescription to a pharmacy, but the pharmacy is not “electronically prescribing-enabled yet” and the intermediary drops the prescription to fax, what Prescription Origin Code value would the pharmacy use on the claim submission?

Response:
Because the prescription was received at the pharmacy via fax the Prescription Origin Code is 4 and will remain a 4 throughout the life of the prescription number.

Question:
Relating to incentive or disincentive with regard to e-prescriptions for prescribers when a pharmacy must phone to clarify or change information on a prescription. Prescribers will be dis-incentivized if they transmit a prescription electronically and a pharmacy changes it to a telephone order as a result of calling to clarify or change something. Also, if a plan sponsor audits a pharmacy that has a telephone order, then contacts the prescriber only to learn that the prescriber electronically sent the order, pharmacies may have the entire payment retracted and deemed an “improper payment”.

Response:
Because the prescription was received via e-prescribing the Prescription Origin Code is 3 and will remain a 3 throughout the life of the prescription number.

Question:
Relating to laws for Control II Substances (C II aka C-2) that can legally only be written prescriptions (and hopefully e-prescriptions in the near future).

If a pharmacy phones the prescriber to clarify an order or must make a change if allowed by state and federal
law, the resulting origin by current recommendations is “2” telephone. Since telephone orders for C II’s are not allowed, the pharmacy is transmitting information that is not a legal representation of the prescription order.

Response:
Because the prescription was received via written form the Prescription Origin Code is 1 and will remain a 1 throughout the life of the prescription number.

Question:
We are an Intermediate Care Facility for Individuals with Intellectual Disabilities and have an in-house pharmacy that solely serves the clients that live on campus. We recently had our first Prescription Origin Code Audit request from xyz. Our facility is considering allowing the medical staff to fax orders to the pharmacy instead of requiring that a nurse bring the order to the pharmacy. My question is:

  If the pharmacy and facility are on the same campus and orders are faxed to the pharmacy (pharmacy retains faxed copy) and the written order is placed in the client’s chart, what POC is used? Does the written order have to remain in the pharmacy for a “written” Prescription Origin Code?

Response:
Because the prescription was received at the pharmacy via fax the Prescription Origin Code is 4 and will remain a 4 throughout the life of the prescription number.

Question:
Relating to an electronic prescription with quantity of “1 tube” requiring telephone clarification prior to dispensing, per NCPDP this script should be an origin code 2 because it required a phone call to prescriber.

  1. How does this practice impact tracking of electronic prescribing implementation?
  2. Prescriber Incentives?
  3. Disincentives?
  4. Prescriber Audits?
  5. Pharmacy audits?

Response:
Because the prescription was received via e-prescribing the Prescription Origin Code is 3 and will remain a 3 throughout the life of the prescription number. This should have no negative impact on tracking of electronic prescribing implementation.

Question:
Relating to a written Rx with Prescriber Dispense as Written (DAW 1) on Rx needing telephone clarification. How does NCPDP statement vs. any state laws or plan requirements that DAW-1 must be on a written script only? (e.g. x Medicaid, y Medicaid)

Response:
Because the prescription was received via written form the Prescription Origin Code is 1 and will remain a 1 throughout the life of the prescription number.

Question:
There is a standard written authorization/protocol from a medical director to give flu shots, and when they have a patient that wants a flu shot they write it up on a telephone blank. Is Prescription Origin Code 1 (Written) because the protocol is written – and the pharmacy then “writes the order”, or 2 (Telephone) because the pharmacy transcribes the information on a telephone Rx pad just as they would if a prescriber called in the order?

Response:
As we understand this it appears to be pharmacist protocol which should have a Prescription Origin Code of “5”
Pharmacy and will remain a ‘5’ throughout the life of the prescription number.

### 3.1.5 PRODUCT/SERVICE ID/QUALIFIER IN COMPOUNDS

**Question:**
Per the implementation guide, the alphanumeric field Product/Service ID (407-D7) used for compounds states it should be “0”. Our assumption is that “00” and “0” are not the same due to truncation rules outlined earlier in the implementation guide. We would like to know for sure that “00” should not be accepted for this field in a compound situation. At this time, we are assuming it should only be a single “0” and therefore will reject if two zeros are sent.

From the implementation guide:
- When billing for multiple ingredients, use the following Claim and Pricing Segment fields:
  - Product/Service ID (407-D7) – defaults to zero. (Zero means “0”.)
  - Product/Service ID Qualifier (436-E1) – defaults to “00”

  The Product/Service ID must contain a value of “0” and Product/Service ID Qualifier must contain a value of “00” when used for multi-ingredient compounds.

**Response:**
This is correct. When billing for multiple ingredients, Claim Segment fields:
- **Product/Service ID** (407-D7) – defaults to zero. (Zero means “0”.) – This means a single 0 is the only acceptable content.
- **Product/Service ID Qualifier** (436-E1) – defaults to “00” – This means two zeroes – 00 is the only acceptable content.

Also, Reject Code “8G” was approved for clarification (Feb 2010)

<table>
<thead>
<tr>
<th>8G</th>
<th>Product/Service ID (407-D7) Must Be A Single Zero “0” For Compounds</th>
<th>407-D7</th>
</tr>
</thead>
</table>

### 3.1.6 ROUTE OF ADMINISTRATION (995-E2) AND SNOMED CODES

Telecom D.0 and above uses the SNOMED CT terminology for the Route of Administration. The National Library of Medicine (NLM) has created a subset of Route of Administration concepts for NCPDP implementers for now. The subset is available at [http://www.ncpdp.org/Members/Standards-Lookup](http://www.ncpdp.org/Members/Standards-Lookup) - choose “SNOMED Route of Administration”. As of 08/2010, NLM is working on browser and subset functions. At the point that NLM supports these functions, NCPDP will cease making a subset available.

Status as of 08/2010 from NLM:
During a review of the route of administration hierarchy, it was found that the current list is very flat, which does not allow the ability to use subsumption to identify related routes (e.g. the gastrointestinal route and all its related children). Also, the current route of administration list includes techniques for administration as well as routes, which do not belong in that hierarchy. Examples here include Inhalation, which is ambiguous as the route can be nasal, intratracheal, etc. These techniques will probably be moved to a new technique hierarchy that is being developed. However, this does not preclude someone from using these terms in a reference set specifically created for a particular purpose, it is just important for folks to know that things like injection, inhalation, instillation, etc. are techniques that have associated routes, but are not routes in and of themselves.

Additionally, based on input from the FDA, a number of new route concepts have been submitted to IHTSDO and are under review. So other than more terms, a corrected set of relationships and removal of inappropriate concepts, there are no real changes.
As for how often it will be updated, that is dependent on whether there has been a request for changes to the hierarchy.

NLM has a website which addresses some frequently asked questions: http://www.nlm.nih.gov/research/umls/Snomed/snomed_faq.html

A new version of SNOMED CT is released every 6 months. If there have been accepted requests during that time, then that would be the release cycle. The release dates are approximately January 31 and July 31.

In “Appendix H. Route of Administration Transition” in the Telecom Imp Guide -
The NA means that SNOMED did not feel there was a code for “miscellaneous”. So there is no mapping.

Value 14 defined is as C444364. This is an alphanumeric value where the rest are numeric. In using the browser below, it looks like 424494006 for infusion may be the more correct. We may have gotten an incorrect code.

This browser may be helpful.
http://snomed.vetmed.vt.edu/sct/menu.cfm

10/2011 Update
The Route of Administration subset is now available publically from the NLM SNOMED CT web site at http://www.nlm.nih.gov/research/umls/licensedcontent/snomedctfiles.html. As before, it was derived from the SNOMED CT route of administration values hierarchy in the latest international release of SNOMED CT (2011 Jul 31).

Since the first release of the Route of Administration subset, the hierarchy has gone through a substantial reorganization (through an IHTSDO project) and remodeling to more appropriately represent true routes of administration, such that now ONLY routes are represented and concepts that had represented techniques for administration (such as by inhalation, by injection) were moved.

Originally when NCPDP was given Route of Administration, there was a code 385218009 for Injection. On the July 2010 file, 424109004 for Injection appeared. The 424109004 code has been moved to the procedure hierarchy. The second, 385218009, represents a dose form and is not part of the Route of Administration hierarchy.

This information has also been placed in Appendix H Route of Administration Transition in the Telecommunication Standard Implementation Guide version D.9.

03/2012 Update
Originally when NCPDP was given Route of Administration, code 26643008 was given for Mouth/Throat. The code should be 26643006 (Oral).

Prior to Version C.4, Compound Route of Administration was used. In Version C.4, Compound Route of Administration wasunsetted. Route of Administration, supported in Version C.4 and above, uses the SNOMED values – column “High Level”. Corrections or modifications since 2007 are noted.

<table>
<thead>
<tr>
<th>NCPDP</th>
<th>Description</th>
<th>High level</th>
<th>High level description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Buccal</td>
<td>54471007</td>
<td>Buccal route (qualifier value)</td>
</tr>
<tr>
<td>2</td>
<td>Dental</td>
<td>372449004</td>
<td>Dental route (qualifier value)</td>
</tr>
<tr>
<td>2</td>
<td>Dental</td>
<td>372449004</td>
<td>Dental route (qualifier value)</td>
</tr>
<tr>
<td>3</td>
<td>Inhalation</td>
<td>112239003</td>
<td>By inhalation (route) (qualifier value)</td>
</tr>
</tbody>
</table>
Telecommunication Version D and Above Questions, Answers and Editorial Updates

<table>
<thead>
<tr>
<th>NCPDP</th>
<th>Description</th>
<th>High level</th>
<th>high level description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>NLM: This concept has been retired and moved to the techniques hierarchy as it is not a route, but a &quot;method&quot; of administration. Suggest users map this to one of the children under 447694001 – respiratory tract route</td>
</tr>
<tr>
<td>4</td>
<td>Injection</td>
<td>385218009</td>
<td>By injection (route) qualifier value</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corrected to</td>
<td>NLM: This concept has been retired and moved to the techniques hierarchy as it is not a route but a method. Users need to specify the actual physical route (i.e. intramuscular, intravenous, etc.)</td>
</tr>
<tr>
<td>5</td>
<td>Intraperitoneal</td>
<td>38239002</td>
<td>Intraperitoneal route (qualifier value)</td>
</tr>
<tr>
<td>6</td>
<td>Irrigation</td>
<td>47056001</td>
<td>By irrigation (route) (qualifier value)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corrected to</td>
<td>NLM: This concept has been retired and moved to the techniques hierarchy as it is not a route but a method. Users need to specify the actual physical route (i.e. intraperitoneal, ocular, etc.)</td>
</tr>
<tr>
<td>7</td>
<td>Mouth/Throat</td>
<td>26643008</td>
<td>Oral route (qualifier value)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corrected to</td>
<td>NLM: This concept has been retired and moved to the techniques hierarchy as it is not a route but a method. Users need to specify the actual physical route (i.e. intraperitoneal, ocular, etc.)</td>
</tr>
<tr>
<td>8</td>
<td>Mucous Membrane</td>
<td>419874009</td>
<td>Submucosal route (qualifier value)</td>
</tr>
<tr>
<td>9</td>
<td>Nasal</td>
<td>46713006</td>
<td>Nasal route (qualifier value)</td>
</tr>
<tr>
<td>10</td>
<td>Ophthalmic</td>
<td>54485002</td>
<td>Ophthalmic route (qualifier value)</td>
</tr>
<tr>
<td>11</td>
<td>Oral</td>
<td>26643006</td>
<td>Oral route (qualifier value)</td>
</tr>
<tr>
<td>12</td>
<td>Other/Miscellaneous</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Otic</td>
<td>10547007</td>
<td>Otic route (qualifier value)</td>
</tr>
<tr>
<td>14</td>
<td>Perfusion</td>
<td>C444364</td>
<td>By infusion (route) qualifier value</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corrected to</td>
<td>NLM: This concept has been retired and moved to the techniques hierarchy as it is not a route but a method. Users need to specify the actual physical route (i.e. intraperitoneal, ocular, etc.)</td>
</tr>
<tr>
<td>15</td>
<td>Rectal</td>
<td>37161004</td>
<td>Per rectum (route) (qualifier value)</td>
</tr>
<tr>
<td>16</td>
<td>Sublingual</td>
<td>37839007</td>
<td>Sublingual route (qualifier value)</td>
</tr>
<tr>
<td>17</td>
<td>Topical</td>
<td>419464001</td>
<td>Iontophoresis route (qualifier value)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corrected to</td>
<td>NLM: This concept has been retired and moved to the techniques hierarchy as it is not a route but a method. Users need to specify the actual physical route (i.e. intraperitoneal, ocular, etc.)</td>
</tr>
<tr>
<td>18</td>
<td>Transdermal</td>
<td>372464004</td>
<td>Intradermal route (qualifier value)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corrected to</td>
<td>NLM: This concept has been retired and moved to the techniques hierarchy as it is not a route but a method. Users need to specify the actual physical route (i.e. intraperitoneal, ocular, etc.)</td>
</tr>
<tr>
<td>19</td>
<td>Translingual</td>
<td>37839007</td>
<td>Sublingual route (qualifier value)</td>
</tr>
<tr>
<td>20</td>
<td>Vaginal</td>
<td>16857009</td>
<td>Per vagina (route) (qualifier value)</td>
</tr>
<tr>
<td>21</td>
<td>Enteral</td>
<td>417985001</td>
<td>Enteral route (qualifier value)</td>
</tr>
<tr>
<td>22</td>
<td>Ophthalmic</td>
<td>54485002</td>
<td>Ophthalmic route (qualifier value)</td>
</tr>
<tr>
<td>23</td>
<td>Urethral</td>
<td>90028008</td>
<td>Urethral route (qualifier value)</td>
</tr>
</tbody>
</table>

Please see “Appendix E. Route of Administration Questions”.

### 3.1.7 Date of Service (401-D1)

**Question:**

It has become evident that some in the industry are interpreting the definition of the date the "prescription was dispensed" inconsistently. Based on reports and discussions, several parties are populating the date of service based on when they are actually submitting the billing transaction. One of the main issues seems to be on some COB claims where the primary and secondary claims have a different date of service. We are wondering if clarification can be added to the editorial guide. It seems that the date of service should either be when the prescription is determined to be ready to be picked up, or when it’s actually dispensed (initially in the case of LTC or partial fill situations). At a minimum, the date of service should not change between a primary and supplemental claim billings for the same fill and should not represent the date of billing. The example in the data dictionary indicates that date of service is tied to the act of dispensing.
From the July 2007 Data Dictionary:
Date of Service (401-D1) Identifies date the prescription was dispensed or professional service rendered or subsequent payer began coverage following Part A expiration in a long-term care setting only. Examples: If the prescription was dispensed on April 22, 2000, this field would reflect 20000422.

Response:
The Date of Service (401-D1) is the date the prescription was dispensed or professional service rendered or the date a subsequent payer began coverage following Part A expiration in a long-term care setting only. The Date of Service must not change between a primary and supplemental claim billing. The Date of Service is set by the dispensing pharmacy and reflects the date/time zone of the service location. Processors need to be able to accept valid next day dates of service based on the pharmacy’s time zone.

3.1.8 UNIT OF MEASURE (600-28) AND MULTI-INGREDIENT COMPOUNDS
Due to confusion in reporting a multi-ingredient compound, it is strongly recommended that Unit of Measure (600-28) in the Claim Segment not be sent for a multi-ingredient compound. In the Compound Segment, Compound Dispensing Unit Form Indicator (451-EG) is mandatory and conveys the same information.

If an entity is currently using both Unit of Measure (600-28) in the Claim Segment and Compound Dispensing Unit Form Indicator (451-EG) in the Compound Segment, the equivalent values should be used in both. (It is recognized that the code values aren’t identical in both fields, but the definitions are consistent.)

We do not recommend any modifications to the use of Special Packaging Indicator (429-DT).

A DERF will be submitted in the future to specify new situation for 600-28 – Unit of Measure.

3.1.9 LEVEL OF SERVICE
Question:
A patient resides in their home and receives special pharmacy services identical to long term care beneficiaries with the exception of emergency kits. Since extra services including special packaging, delivery services, etc. occur for these patients, identifying them differently would facilitate claims processing appropriate to the services they receive. How do I identify them on a claim?

Response:
Use Level of Service (418-DI) with a value of “6” - In-Home Service—provision of care in patient’s place of residence until new ECL value “7” – Medical at home with special pharmacy services identical to Long Term Care beneficiaries with the exception of emergency kits is available in the 10/2017 ECL.

3.1.10 SUBMISSION CLARIFICATION CODE (SCC)
The SCC is a code indicating the pharmacy is clarifying the claim submission or resubmission. For example, it provides additional clarification as to why the transaction is being submitted where under normal circumstances the claim may not be covered. The SCC may be submitted proactively to prevent or reactively to override a reject. The SCC can also indicate the submission type (e.g. 340B, Encounter, Split Bill), so that the processor has enough information to process the transaction or initiate any downstream processes.

3.1.10.1 SHORTENED DAYS SUPPLY SCC VALUES
Question:
What Submission Clarification Code (420-DK) values are used to request an override for a shortened days supply claim for medications not already defined in Section 9.5 Appropriate Dispensing (Short Cycle) for LTC?

Response:
As a result of shortened day supply dispensing becoming more prevalent, there was a need to assign discrete values for Submission Clarification Code (420-DK) for identified business cases. Amongst other edits, claims for shortened days supply could incur utilization edits based upon day supply threshold and there may be plan or regulatory requirements to apply other benefit rules such as a pro-rated copay.

The chart below outlines the different business cases where shortened days supply could occur and the appropriate distinct SCC values that apply. These values are recommended for use with the annual ECL implementation in October 2020. In the interim, the value of 47 (Shortened Days Supply Dispensed Only used to request an override to plan limitations when a shortened days supply is being dispensed) should be used.

<table>
<thead>
<tr>
<th>Business Case for Shortened Day Supply</th>
<th>Business Case Description for Shortened Day Supply</th>
<th>Submission Clarification Code (420-DK) Value (as of October 2020 ECL annual Implementation)</th>
<th>Value Description (as of October 2020 ECL annual implementation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synchronization Fill</td>
<td>Synchronization of the dates across multiple prescriptions to allow a patient to get all their medications refilled at the same time.</td>
<td>61</td>
<td>Synchronization Fill – Shortened Days Supply Used to request plan benefit allowances be applied to the shortened days supply necessary to synchronize the dates of service across multiple medications.</td>
</tr>
<tr>
<td>Same drug same strength NDC change</td>
<td>Used to tie together claim transactions to align with plan benefit parameters when the same drug same strength is dispensed with different NDC numbers.</td>
<td>62</td>
<td>Shortened Days Supply of Same Drug, Strength and Dosage Form with Multiple NDCs Dispensed. Used to request an override to plan limitations and/or copay benefits when there are multiple claim billing transactions for same drug and strength due to NDC change(s).</td>
</tr>
<tr>
<td>Mail Order Delay</td>
<td>A non-mail order pharmacy attempts to dispense a prescription when a mail order supply has already been processed and not yet received by the patient.</td>
<td>63</td>
<td>Mail Order Delay - Shortened Days Supply Used to request plan benefit allowances be applied to the shortened days supply for continuity of care when the mail order fill is in progress.</td>
</tr>
<tr>
<td>Trial Fill</td>
<td>A trial fill is generally a new medication for the patient dispensed as a shortened day supply to confirm effectiveness.</td>
<td>64</td>
<td>Trial Fill – Shortened Days Supply Used to request plan benefit allowances be applied to the shortened days supply for purposes of a trial fill.</td>
</tr>
<tr>
<td>Not Otherwise Specified Above</td>
<td>A distinct value for the business case has not yet been defined.</td>
<td>47</td>
<td>Other - Shortened Days Supply Only used to request plan benefit allowances be applied to the shortened days supply not otherwise defined in a distinct shortened days supply value.</td>
</tr>
</tbody>
</table>

Note: Submission Clarification Code value 48 will continue to be available for use for a dispensing subsequent to a Shortened Days Supply Dispensing.

3.1.10.2 APPROVED MESSAGE CODE AND SHORTENED DAYS SUPPLY SCC

Question:
Which Approved Message Code (548-6F) should be returned when a payer has adjusted a copayment based upon receiving Submission Clarification Code value ‘62-Shortened Days Supply Same Drug, Strength and Dosage Form with Multiple NDCs Dispensed’?

Response:
The plan should return an Approved Message Code value 023 – ‘Prorated copayment applied based on days supply. Plan has prorated the copayment based on days supply’.

**3.2 Compound Segment (10)**
See section “Multi-Ingredient Compound Processing”.

**3.3 Coordination of Benefits Segment (05)**
See section “Coordination of Benefits Information”.
See section “Pricing Segment Contains Values ‘as if’ the Claim was Primary” for clarifying information.

**3.4 Insurance Segment (04)**

**3.4.1 Medicaid Indicator (360-2B)**

**Question:**
Do I use the 2 digit alphabetic “State Code” or the numeric “NCPDP State Code” column for the values for the Medicaid Indicator field?

**Response:**
The Medicaid Indicator uses the two character “State Code” column for the State Postal Code (TX, TN, IL, etc.). The “NCPDP State Code” column two digit numerics are used in identifiers (like the first two digits of the NCPDP Provider ID or other identifiers) when used in check digit routines.

**3.4.2 Medicaid ID Number (115-N5) and Cardholder ID (302-C2)**

**Question:**
Clarification of the use of Medicaid ID Number (115-N5) - the Implementation Guide indicates that this field is “Required, if known, for Claim Billing/Encounter Request Transactions when a patient has Medicaid coverage”. Because Cardholder ID is a mandatory field, this would seem to imply that a Medicaid Agency that uses the Medicaid ID Number as their Cardholder ID must also require the same ID number to be submitted in Medicaid ID Number (115-N5). Using both Cardholder ID and Medicaid ID might make sense for managed Medicaid or Dual Eligibles because they would have 2 distinct ID numbers, but in the Medicaid FFS world it does not make sense to send the exact same information in 2 fields within the same segment.

**Response:**
The first situation has been clarified in Telecom Imp Guide version D.7 and above: Required, if known, when patient has Medicaid coverage and Medicaid ID has not been provided in Cardholder ID (302-C2).
(The second situation does not change.)

**3.4.3 Medigap ID (359-2A) Use**

**Question:**
What is the intended use of the Medigap ID Field 359-2A?

**Answer:**
Field 359-2A Medigap ID was added to the NCPDP Telecommunication Standard Version D.0 to enable pharmacy providers to communicate information regarding a Medicare Part B recipient’s supplemental coverage as part of the pharmacy claim billing (B1) transaction. Medigap policies do not work with Medicare Parts C or D, therefore this field is basically limited to use for the submission of Part B drug claims.
Pharmacy claims for Part B DME drugs and supplies can be submitted to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) using the NCPDP Telecommunication Standard. If the pharmacy is aware that the patient has Medicaid or other Medicare Supplemental (i.e. Medigap) coverage, the following fields should be populated when using the NCPDP D.0 transaction for billing the DME MAC to allow them to crossover bill the supplemental payer:

- **301-C1 Group ID**: This field should contain the 5 byte CMS assigned Coordination of Benefits Agreement (COBA) ID number for the supplemental (Medigap or Medicaid) insurer
- **359-2A Medigap ID**: This field should contain the recipient’s Medigap policy ID number
- **360-2B Medicaid Indicator**: This field should contain the 2 character State Postal Code identifying the Medicaid agency where Medicaid coverage exists
- **361-2D Provider Accept Assignment Indicator**: This field should contain the single character code (Y or N) indicating if the provider accepts assignment
- **115-N5 Medicaid ID Number**: This field should contain the patient’s Medicaid ID number

Field usage and examples:

<table>
<thead>
<tr>
<th>Field</th>
<th>NCPDP Field Format</th>
<th>Medicaid Use</th>
<th>Medigap Use</th>
<th>Example</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>301-C1 Group ID</td>
<td>x(15)</td>
<td>Yes</td>
<td>Yes</td>
<td>5####</td>
<td>5 byte CMS assigned COBA ID number for the supplemental insurer (participating Medigap and Medicaid agencies will have these)</td>
</tr>
<tr>
<td>359-2A Medigap ID</td>
<td>x(20)</td>
<td>No</td>
<td>Yes</td>
<td>1234567890</td>
<td>Patient’s Medigap policy ID number</td>
</tr>
<tr>
<td>360-2B Medicaid Indicator</td>
<td>x(2)</td>
<td>Yes</td>
<td>No</td>
<td>TX</td>
<td>2 character State Postal Code where Medicaid coverage exists</td>
</tr>
<tr>
<td>361-2D Provider Accept Assignment Indicator</td>
<td>x(1)</td>
<td>Yes</td>
<td>Yes</td>
<td>Y</td>
<td>Y = Yes N=No Providers are required to accept assignment when billing DME MACs.</td>
</tr>
<tr>
<td>115-N5 Medicaid ID Number</td>
<td>X(20)</td>
<td>Yes</td>
<td>No</td>
<td>9876543210</td>
<td>Patient’s Medicaid ID number</td>
</tr>
</tbody>
</table>

### 3.5 Patient Segment (01)

#### 3.5.1 Place of Service (307-C7) and Patient Residence (384-4X)

In Telecommunication Version 5.1, Patient Location Code (307-C7) exists. In Telecommunication Version D.0, changes have resulted in two fields:

- Place of Service (307-C7)
- Patient Residence (384-4X)

<table>
<thead>
<tr>
<th>Version 5.1 Patient Location (307-C7)</th>
<th>Version D.0 Place of Service (307-C7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Home</td>
<td>1 - Pharmacy</td>
</tr>
<tr>
<td>3 - Nursing Home</td>
<td>3 - School</td>
</tr>
<tr>
<td>4 - Long Term /Extended Care</td>
<td>4 - Homeless Shelter</td>
</tr>
<tr>
<td></td>
<td>And numerous other values</td>
</tr>
</tbody>
</table>

Since most of the locations in Version 5.1 are Residences, a Task Group was formed to make a recommendation for industry agreement for mapping from Patient Location Code to Patient Residence. This was accepted by the November 2009 Work Group meeting as industry consensus for consistent transition.

Providers may want to consider allowing for 3 fields in their Patient records during the transition year:

- Patient Location (307-C7*) $\rightarrow$ 5.1
- Place of Service (307-C7) $\rightarrow$ D.0
- Patient Residence (384-4X) $\rightarrow$ D.0
<table>
<thead>
<tr>
<th>Patient Location (307-C7)</th>
<th>Red arrow - non-direct map</th>
<th>Patient Residence (384-4X)</th>
<th>Additional Description</th>
<th>Used by LTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Not specified</td>
<td>&lt;----&gt;</td>
<td>0 - Not Specified</td>
<td>Other patient residence not identified below.</td>
<td></td>
</tr>
<tr>
<td>1 - Home</td>
<td>&lt;----&gt;</td>
<td>1 - Home</td>
<td>Location, other than a hospital or other facility, where the patient receives drugs or services in a private residence.</td>
<td>Y</td>
</tr>
<tr>
<td>NOTE: Multiple values here</td>
<td>Mapped to ONE value here</td>
<td></td>
<td>A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative service but does not provide the level of care or treatment available in a hospital <strong>For Medicare Part B use only.</strong></td>
<td></td>
</tr>
<tr>
<td>2 - Inter Care</td>
<td>&lt;----&gt;</td>
<td>2 - Skilled Nursing Facility</td>
<td>A facility which primarily provides residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than intellectually disabled individuals.</td>
<td>Y</td>
</tr>
<tr>
<td>7 - Skilled Care Facility</td>
<td>&lt;----&gt;</td>
<td>2 - Skilled Nursing Facility</td>
<td>A facility which primarily provides residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than intellectually disabled individuals.</td>
<td></td>
</tr>
<tr>
<td>8 - Sub-Acute Care Facility</td>
<td>&lt;----&gt;</td>
<td>2 - Skilled Nursing Facility</td>
<td>A facility which primarily provides residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than intellectually disabled individuals.</td>
<td></td>
</tr>
<tr>
<td>9 - Acute Care Facility</td>
<td>&lt;----&gt;</td>
<td>2 - Skilled Nursing Facility</td>
<td>A facility which primarily provides residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than intellectually disabled individuals.</td>
<td></td>
</tr>
<tr>
<td>NOTE: Multiple values here</td>
<td>Mapped to ONE value here</td>
<td></td>
<td>Congregate residential facility with self-contained living units providing assessment of each resident’s needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.</td>
<td>Y</td>
</tr>
<tr>
<td>3 - Nursing Home</td>
<td>&lt;----&gt;</td>
<td>3 - Nursing Facility</td>
<td>A facility which primarily provides residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than intellectually disabled individuals.</td>
<td></td>
</tr>
<tr>
<td>4 - Long Term /Extended Care</td>
<td>&lt;----&gt;</td>
<td>3 - Nursing Facility</td>
<td>A facility which primarily provides residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than intellectually disabled individuals.</td>
<td>Y</td>
</tr>
<tr>
<td>5 - Rest Home</td>
<td>&lt;----&gt;</td>
<td>4 - Assisted Living Facility</td>
<td>Congregate residential facility with self-contained living units providing assessment of each resident’s needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.</td>
<td>Y</td>
</tr>
<tr>
<td>6 - Boarding Home</td>
<td>&lt;----&gt;</td>
<td>6 - Group Home</td>
<td>Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community. A facility, other than a patient’s home, in which palliative and supportive care for terminally ill patients and their families are provided.</td>
<td></td>
</tr>
<tr>
<td>11 - Hospice</td>
<td>&lt;----&gt;</td>
<td>11 - Hospice</td>
<td>A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component. <strong>For Medicare Part B use only.</strong></td>
<td></td>
</tr>
<tr>
<td>10 - Outpatient - group feels this value is not representative of a residence so no mapping done.</td>
<td></td>
<td>No one was aware of edits associated with this value. <strong>Providers may wish to clear this value.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 - Inpatient Psychiatric Facility</td>
<td>&lt;----&gt;</td>
<td>8 - Psychiatric Facility – Partial Hospitalization</td>
<td>A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician. <strong>Not applicable to Pharmacy Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>8 - Psychiatric Facility – Partial Hospitalization</td>
<td></td>
<td>A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility. <strong>Not applicable to Pharmacy Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Location (307-C7)</td>
<td>Red arrow - non-direct map</td>
<td>Patient Residence (384-4X)</td>
<td>Additional Description</td>
<td>Used by LTC</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------------</td>
<td>---------------------------</td>
<td>-----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>9 - Intermediate Care Facility/ Individuals with Intellectual Disabilities</td>
<td></td>
<td>A facility which primarily provides health-related care and services above the level of custodial care to intellectually disabled individuals but does not provide the level of care or treatment available in a hospital or SNF.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 - Residential Substance Abuse Treatment Facility</td>
<td></td>
<td>A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board. Not applicable to Pharmacy Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 - Psychiatric Residential Treatment Facility</td>
<td></td>
<td>A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment. Not applicable to Pharmacy Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 - Comprehensive Inpatient Rehabilitation Facility</td>
<td></td>
<td>A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services. Not applicable to Pharmacy Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 - Homeless Shelter</td>
<td></td>
<td>A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). Not applicable to Pharmacy Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 - Correctional Institution</td>
<td></td>
<td>A facility that provides treatment and rehabilitation of offenders through a program of penal custody.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

During the May 2010 Work Group meetings, the following was approved for inclusion into the External Code List.

### 384-4X - Patient Residence

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
<th>Standard/Version Formats</th>
<th>Field Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code identifying the patient’s place of residence.</td>
<td>9(2)</td>
<td>T,V,A</td>
<td>Used in Telecommunication Standard Version B.0 or greater but not in lower versions. Used in Post Adjudication Standard Version 2.0 or greater but not in lower version.</td>
</tr>
</tbody>
</table>

Values:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not Specified=Other patient residence not identified below.</td>
</tr>
<tr>
<td>1</td>
<td>Home= Location, other than a hospital or other facility, where the patient receives drugs or services in a private residence.</td>
</tr>
<tr>
<td>2</td>
<td>Skilled Nursing Facility= A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative service but does not provide the level of care or treatment available in a hospital. For Medicare Part B use only.</td>
</tr>
<tr>
<td>3</td>
<td>Nursing Facility= A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than intellectually disabled individuals.</td>
</tr>
<tr>
<td>4</td>
<td>Assisted Living Facility= Congregate residential facility with self-contained living units providing assessment of each resident’s needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.</td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>5</td>
<td>Custodial Care Facility=A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component. <strong>For Medicare Part B use only.</strong></td>
</tr>
<tr>
<td>6</td>
<td>Group Home=Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.</td>
</tr>
<tr>
<td>7</td>
<td>Inpatient Psychiatric Facility=A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician. <strong>Not applicable to Pharmacy Benefits</strong></td>
</tr>
<tr>
<td>8</td>
<td>Psychiatric Facility—Partial Hospitalization=A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility. <strong>Not applicable to Pharmacy Benefits</strong></td>
</tr>
<tr>
<td>9</td>
<td>Intermediate Care Facility/Individuals with Intellectual Disabilities =A facility which primarily provides health-related care and services above the level of custodial care to intellectually disabled individuals but does not provide the level of care or treatment available in a hospital or SNF.</td>
</tr>
<tr>
<td>10</td>
<td>Residential Substance Abuse Treatment Facility=A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board. <strong>Not applicable to Pharmacy Benefits</strong></td>
</tr>
<tr>
<td>11</td>
<td>Hospice= A facility, other than a patient’s home, in which palliative and supportive care for terminally ill patients and their families are provided.</td>
</tr>
<tr>
<td>12</td>
<td>Psychiatric Residential Treatment Facility=A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment. <strong>Not applicable to Pharmacy Benefits</strong></td>
</tr>
<tr>
<td>13</td>
<td>Comprehensive Inpatient Rehabilitation Facility=A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services. <strong>Not applicable to Pharmacy Benefits</strong></td>
</tr>
<tr>
<td>14</td>
<td>Homeless Shelter=A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). <strong>Not applicable to Pharmacy Benefits</strong></td>
</tr>
<tr>
<td>15</td>
<td>Correctional Institution=A facility that provides treatment and rehabilitation of offenders through a program of penal custody.</td>
</tr>
</tbody>
</table>

During the February 2019 Work Group meetings, the Group Home description was changed to the following:

Group Home=A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).

The description for Code 15 was changed to the following:

Prison/Correctional Facility=A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.

### 3.5.2 Species

**Question:**

What level of the SNOMED code set should be used to support the species data element?

**Response:**

The highest level of SNOMED CT® codes should be used to identify the specific species (organism). The table below shows the most common pet species as identified by the American Veterinary Medical Association (AVMA) with the recommended SNOMED CT® code and text. This list is not inclusive and other species can be supported such as exotic species and should follow the same guidance of using the highest level of SNOMED CT® code. Trading partners are encouraged to work together to incorporate codes that are not listed below.
3.6 Pricing Segment (11)

3.6.1 340B Processing

Question:
How do I designate 340B claims?

Response:

While some pharmacies are able to determine a claim for a 340B product at point of service, others are not. If pharmacies are able to determine prior to providing the service, the Submission Clarification Code (420-DK) value “20” (340B Claim) is used.

The Basis of Cost Determination (423-DN) has a value “08” (340B/Disproportionate Share Pricing/Public Health Service). The response field, Basis of Reimbursement Determination (522-FM) has a value of 12 (340B/Disproportionate Share/Public Health Service Pricing).

The Submission Clarification Code is used to describe the claim; the Basis of Cost Determination and Basis of Reimbursement Determination describe the price.

03/2013 Editorial Note:
Basis of Cost Determination (423-DN) value “08” definition prior to October 2011:
340B /Disproportionate Share Pricing/Public Health Service - The 340B Drug Pricing Program from the Public Health Service Act, sometimes referred to as “PHS Pricing” or “602 Pricing” is a federal program that requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics, and hospitals (termed “covered entities”) at a reduced price.

After October 2011:

340B /Disproportionate Share Pricing/Public Health Service - Price available under Section 340B of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 340B (a)(10) and those made through the Prime Vendor Program (Section 340B(a)[8]). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation.

Basis of Reimbursement Determination (522-FM) value 12 definition prior to October 2011:

340B/Disproportionate Share/Public Health Service Pricing - The 340B Drug Pricing Program from the Public Health Service Act, sometimes referred to as “PHS Pricing” or “602 Pricing” is a federal program that requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics, and hospitals (termed “covered entities”) at a reduced price.

After October 2011:

340B/Disproportionate Share/Public Health Service Pricing - Price available under Section 340B of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 340B (a)(10) and those made through the Prime Vendor Program (Section 340B(a)[8]). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation.

Question:

Several State Medicaid agencies are now, or will be requiring a value of 20 in the Submission Clarification Code field 420-DK AND a value of 8 in the Basis of Cost Determination field 423-DN to identify 340B claims. Is there anything in the NCPDP standard that would prevent this? Is there a recommendation from NCPDP as to how the claims should be processed?

Response:

There is nothing in the NCPDP Telecommunication Standard Billing transaction (B) that would prevent the use of both fields and requested values on the same claim. However, the use of the fields together or by themselves is based on the specific 340B model and contractual relationships of the involved entities. In the NCPDP Telecommunication Standard Information Reporting transaction (N), only the Submission Clarification Code (420-DK) field is available for use.

The value of 20 in the Submission Clarification Code (420-DK) field indicates “340B - Indicates that, prior to providing service, the pharmacy has determined the product being billed is purchased pursuant to rights available under Section 340B of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 340B (a)(10) and those made through the Prime Vendor Program (Section 340B(a)[8]).”

A value of 8 in the Basis of Cost Determination (423-DN) field indicates “340B /Disproportionate Share Pricing/Public Health Service - Price available under Section 340B of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 340B (a)(10) and those made through the Prime Vendor Program (Section 340B(a)[8]). Applicable only to submissions for Medicaid and other state or federal programs when required by law or regulation and when the payer and/or processor has communicated a unique RxBIN or unique RxBIN/RxPCN combination to distinguish these from other lines of business that do not meet the requirement.”

By definition, the Basis of Cost Determination field describes the Ingredient Cost Submitted in the pricing segment of the claim. Therefore, utilization of the Basis of Cost Determination value 08 requires submission of the 340B price in the Ingredient Cost Submitted field.
In general, the Submission Clarification Code (Field 420-DK) value of 20 would be submitted on the point of service real time claim when required by trading partner agreement to indicate whether the claim submitted is for a drug within the provider’s physical inventory that was purchased pursuant to rights under the 340B Drug Pricing Program. This code, which is independent of claim pricing, can also be used within the post-dispensing Information Reporting transaction to convey the drug dispensed was purchased through the 340B Drug Pricing Program. However, implementation of NCPDP’s methods, particularly the retrospective method via the Information Reporting transaction has not been widely adopted for a variety of reasons. Some of these reasons include the prohibitive development cost for lack of scalability, state budget constraints to updating MMIS processes, Medicaid Drug Rebate Program invoicing timing does not align with retrospective/virtual inventory processes, inconsistent usage of NCPDP standards by applicable stakeholders, and the storage of necessary data across disparate systems. NCPDP has called upon HRSA to encourage all stakeholders to work with NCPDP and its proven process to continuously improve our framework.

For additional information refer to NCPDP’s 340B Information Exchange Reference Guide.

### 3.6.2 Pricing Segment Contains Values ‘as if’ the Claim was Primary

Section “Clarification of Net Amount Due in Coordination of Benefits” of this document states:

> The purpose of the formulae is to provide clarification on how providers should balance the claim submission and how processor/payers should determine the ‘net’ value that is being billed. This is critical in coordination of benefits (COB) scenarios since the Pricing Segment contains values ‘as if’ the claim was primary and the Other Payer values are contained in the Coordination of Benefits/Other Payments Segment.

Contractual agreements would determine the required elements within the Pricing Segment for each payer. This means the Pricing Segment could be the same or may be different between the primary and subsequent payer submissions. Refer to section “Clarification of Net Amount Due in Coordination of Benefits” and examples in section “Transmission Examples”, subsection “Billing Transaction Code B1 Coordination of Benefits” in the NCPDP Telecommunication Implementation Guide VD.0.

### 3.6.3 Billing Transaction For Free Fills

**Question:**
What is the appropriate standard method for pharmacies to submit a billing transaction for 'free' fills?

**Response:**
The pharmacy provider would submit the applicable pricing fields as determined by the plan’s payer sheet and contractual agreements. The basis of the “free fill” would determine whether a value of $0 would apply and in which field it would be submitted. The processor needs to be prepared to support $0 as a valid value in any of the pricing fields. If the pharmacy elects to charge $0 as their usual and customary retail price for the specific product and dispensed quantity, then Usual and Customary (426-DQ) would be submitted as $0.

**Example Scenarios:**

- **Usual and Customary (426-DQ) = $0**
  - Pharmacy initiated free product program and elected to charge $0 as their usual and customary price for the specific product and dispensed quantity.
  - Other fees may apply based on contractual agreements

- **Gross Amount Due (430-DU) = $0**
  - Pharmacy price matched or applied special patient pricing, where their usual and customary price is not $0
  - Basis of Cost Determination (423-DN) should be submitted as 13 – Special Patient Pricing
• Ingredient Cost (409-D9) = $0
  – Pharmacy is dispensing free product, where their usual and customary price is not $0
  – Other fees may apply based on contractual agreements

The claim should not be rejected just because there is a $0 in any of the following fields: Usual and Customary (426-DQ), Gross Amount Due (430-DU), or Ingredient Cost (409-D9). The processor will process the claim according to contractual agreements and return paid fields according to the pricing formula.

3.6.4 PROVIDER FEES

Question:
A Medicaid Governmental Agency has a business need to capture a flat $0.10 provider fee on all pharmacy claims adjudicated. It is important to note that this business need was instituted by legislative statute requiring that a provider fee be assessed for each prescription filled in the state or shipped into the state, as mandated by R.S. 46:2625 and is considered a provider fee. It is also a requirement that this fee be reported in a distinct field as any payments received for this charge are not considered revenue of the provider but as state revenue. What field would NCPDP suggest MMIS use for the reporting of this provider fee? This claim information will also be transmitted via encounter claim on to the fiscal intermediary for documenting the fee was reported/paid.

Response:
Similar circumstances have occurred in KY and AL with flat per prescription charges that were remitted by the pharmacy to the State. It is believed this provider fee falls into the same category and recommend the use of the Flat Sales Tax Amount Submitted (481-HA) and Flat Sales Tax Amount Paid (558-AW) fields.

Note - for Medicare Part D Claims, it is acceptable for the fee to be charged in the Flat Sales Tax field on the claim and it should be reported on the PDE as part of the calculations within the Sales Tax field. WG9 Medicare Part D FAQ Task Group will request CMS issue a memo that plans should do one of the following when the claim contains a percentage sales tax or flat sales tax greater than the statutory amount for the Per Prescription Provider Fee (currently at $0.10):
  • Pay only the flat sales tax amount per prescription fee (currently at $0.10)
  • Reject the claim. This may cause member disruption.

3.7 FACILITY SEGMENT (14)

Question:
What are the recommendations regarding the informational content of field 336-8C Facility ID? Should Facility ID be required in order for the Facility Segment to be included in a claim?

Response:
At this point, there is no industry-approved validation on Facility ID (336-8C) since there is no industry standard Facility ID. The Facility ID does not have a qualifier field. It is recommended for consistency that the only values to be included in this field would be an NPI number if the facility has an NPI.

3.8 PRESCRIBER SEGMENT (03)

Question:
When a patient goes into the pharmacy for the OTC drug called plan B (it is a birth control drug), if a plan benefit covers it (implying the claim must be submitted to the PBM/Payer for coverage), is there an industry standard on which NPI should be included in the Prescriber ID field? Pharmacy? Pharmacist? Prescriber?

Response:
No, there is no current industry standard for this situation. A short term and a long term solution has been developed to address this situation.

**Short Term** - In the situation when the plan benefit covers a product without a prescription, neither a Prescriber ID nor Prescriber ID Qualifier should be sent. If the processor requires the submission of a Prescriber ID due to editing rules, use Qualifier ID value “14” – Plan Specific with the plan defined value. NCPDP recommends as a best practice a single value of zero (0) in the Prescriber ID field for this situation. Alternatively, based upon trading agreement, the Pharmacy NPI (Type 2) and the Qualifier of “01” may be submitted as the Prescriber ID.

Note – This guidance does not apply when the plan benefit requires a prescription even though the product may be OTC.

**Long Term** (next version of the standard): A qualifier of “18” has been added to the Prescriber ID Qualifier code list. When used, the Prescriber ID (411-DB) must be a single zero (0).
4  **RESPONSE SEGMENT DISCUSSION**

4.1  **RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT (28)**

See section “Coordination of Benefits Information”.

4.2  **RESPONSE PATIENT SEGMENT (29)**

Question:
In section 28 of the imp guide, Response Patient Segment is denoted as being used in eligibility transactions for Medicare Part D. Why is the Response Patient Segment also allowed to be used in other transactions?

28.2.2 RESPONSE PATIENT SEGMENT
This segment is used for Medicare Part D Eligibility transactions to provide patient name and date of birth in order to provide additional patient information. This information could assist in the verification that the eligibility information returned is indeed the patient for which the eligibility request was intended.

This segment is returned only when the patient has had Medicare Part D eligibility at some point within the Facilitator’s files and within the search parameters established. The data returned is based on information within the Facilitator’s files and not on information sent on the Eligibility Request.

Patient First Name (310-CA) – will contain the first name of the patient as known on the Facilitator’s files.

Response:
The section has been rewritten in Telecom Version D.7 and above. It is included here as clarification.

Rewritten:
28.2.2 RESPONSE PATIENT SEGMENT
This segment is used in response transactions to return or confirm demographic information. (Refer to Matrix section for transactions used.) This information could assist in the verification that the patient information returned is indeed for the patient for whom the transaction request was intended.

An example would be multiple birth/same sex when the first name initial is the same. The entire first name would be returned to clarify.

**For Medicare Part D eligibility transactions:**
This segment is used for Medicare Part D Eligibility transactions to provide patient name and date of birth in order to provide additional patient information. This information could assist in the verification that the eligibility information returned is indeed the patient for which the eligibility request was intended.

This segment is returned only when the patient has had Medicare Part D eligibility at some point within the Facilitator’s files and within the search parameters established. The data returned is based on information within the Facilitator’s files and not on information sent on the Eligibility Request.

Patient First Name (310-CA) – will contain the first name of the patient as known on the Facilitator’s files.

Patient Last Name (311-CB) - will contain the last name of the patient as known on the Facilitator’s files.

Date of Birth (304-C4) - will contain the birth date of the patient as known on the Facilitator’s files.

4.3  **RESPONSE PRICING SEGMENT (23)**

4.3.1  **AMOUNT ATTRIBUTED TO PROCESSOR FEE (571-NZ)**

Question:
The plan is a discount card plan in which the plan wishes to charge a membership fee and/or a processing fee on the claim transaction to the patient. The intent is for the patient to pay for the claim and the membership fee and/or processing fee to the pharmacy. The result is a claim with a negative Total Amount Paid (509-F9) value. The Definition of the Amount Attributed to Processor Fee (571-NZ) field is “Amount to be collected from the patient that is included in Patient Pay Amount (505-F5) that is due to the processing fee imposed by the
Telecommunication Version D and Above Questions, Answers and Editorial Updates

processor”. Based upon this definition is this the appropriate field to return the amount for a membership fee and/or processing fee?  The concern is based upon the phrase “imposed by the processor”.

Response:
Yes, the intent of the field is that processor is managing the fee, whether enrollment or per transaction.

The enrollment fee must be received as a part of the response to a valid claim billing (product or service) transaction. The Telecom Standard does not support the use of a pharmacy billing transaction to facilitate the collection of an enrollment fee without an actual claim (product or service) being billed.

Examples:

**BILLING - TRANSACTION CODE B1**

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<td>00</td>
<td>D.0 Transaction Format</td>
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<td>PROCESSOR CONTROL NUMBER</td>
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<td>109-A9</td>
<td>TRANSACTION COUNT</td>
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<td>One occurrence</td>
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<td>National Provider Identifier (NPI)</td>
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<td>Store A</td>
</tr>
<tr>
<td>401-D1</td>
<td>DATE OF SERVICE</td>
<td>20100122</td>
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<td>110-AK</td>
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**PATIENT SEGMENT**

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</thead>
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<td>SEGMENT IDENTIFICATION</td>
<td>01</td>
<td>PATIENT SEGMENT</td>
</tr>
<tr>
<td>304-C4</td>
<td>DATE OF BIRTH</td>
<td>19620615</td>
<td>Born June 15, 1962</td>
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<tr>
<td>305-C5</td>
<td>PATIENT GENDER CODE</td>
<td>1</td>
<td>Male</td>
</tr>
<tr>
<td>310-CA</td>
<td>PATIENT FIRST NAME</td>
<td>MICKEY</td>
<td>Mickey is patient’s first name</td>
</tr>
<tr>
<td>311-CB</td>
<td>PATIENT LAST NAME</td>
<td>MOUSE</td>
<td>Mouse is patient’s last name</td>
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</tbody>
</table>

**INSURANCE SEGMENT**

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<td>INSURANCE SEGMENT</td>
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<td>302-C2</td>
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**CLAIM SEGMENT**

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<td>405-D5</td>
<td>DAYS SUPPLY</td>
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<td>30 Days supply</td>
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<tr>
<td>406-D6</td>
<td>COMPOUND CODE</td>
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<td>Not a compound – required D.0</td>
</tr>
<tr>
<td>408-D8</td>
<td>DISPENSE AS WRITTEN</td>
<td>0</td>
<td>Required D.0 – No Product Selection Indicated</td>
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<tr>
<td>414-DE</td>
<td>DATE PRESCRIPTION WRITTEN</td>
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**PRESCRIBER SEGMENT**

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<td>SEGMENT IDENTIFICATION</td>
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<td>PRESCRIBER SEGMENT</td>
</tr>
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**PRICING SEGMENT**

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<td>PRICING SEGMENT</td>
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<td>INGREDIENT COST SUBMITTED</td>
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<td>$65.70</td>
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<tr>
<td>412-DC</td>
<td>DISPENSING FEE SUBMITTED</td>
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<td>$3.00</td>
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<tr>
<td>426-DQ</td>
<td>USUAL AND CUSTOMARY CHARGE</td>
<td>707{</td>
<td>$70.70</td>
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</tbody>
</table>
Here is another example where a one-time membership fee of $30 was assessed in addition to a $1 processor fee.

**4.3.2 BASIS OF REIMBURSEMENT DETERMINATION (522-FM)**

**Question:**

With the lawsuit concerning the change from AWP based on Direct, there are payers who are rewriting contracts which base the pricing to be transmitted to be based on Direct + a certain percentage and fee. In the D.0 standard, there is no value for Direct in the Basis of Reimbursement Determination. What value should be used when “Direct” pricing is the basis for reimbursement?

**Response:**

For D.0, if “Direct” pricing is to be returned, for Basis of Reimbursement Determination, a value of 8 (Contract Pricing) could be used if the other more specific values do not apply. A DERF for version D.0 will be submitted to add a value for “Direct” in the Basis of Reimbursement Determination. If approved, if the External Code List dated after this value is added is used, the new value for “Direct” would be used.
4.3.2.1 ADJUST THE INGREDIENT COST PAID AND DISPENSING FEE PAID?

Question:
How do you adjust the ingredient cost paid and dispensing fee paid when reimbursement is based on patient pay versus contracted rate?

Response:
The claim can be adjusted by using the Basis of Reimbursement Determination (522-FM) value 15 (Patient Pay Amount) indicating that the Ingredient Cost Paid is based on Patient Pay Amount. Refer to Telecommunication Implementation Guide Example 34.63 Billing - Transaction Code B1 - Reimbursement Based on Patient Pay Amount (505-F5) which contains dispensing fee paid and ingredient cost paid with informational fields and Total Amount Paid of $0.

4.3.3 BENEFIT STAGE

See section “Appendix D. Medicare Part D Topics”, subsection “Benefit Stage Rules and Examples”.

Question:
Can a non-Medicare Part D payer return Benefit Stage data?

Response:
Only Medicare Part D plans are to return Benefit Stage information on the response. If another business need comes forward, a DERF can be submitted.

Question:
Is the pharmacy required to calculate the Benefit Stage amount if the fields are not provided by the payer?

Response:
No. The intent of the fields is as a pass through.

4.3.4 HEALTH PLAN-FUNDED ASSISTANCE AMOUNT (129-UD)

Question:
(Payer) has the ability to apply FSA amounts (where/when applicable) to reduce patient’s responsibility from an adjudicated claim real time and without a separate transaction (i.e. secondary and separate debit card transaction). It appears that none of the dollar fields currently support including those dollar amounts. As such, if (Payer) were to apply the FSA dollars to reduce the patient responsibility at POS then the patient pay formula will not balance out. Can Health Plan-Funded Assistance Amount (129-UD) be used?

Response:
If the dollars are entirely plan funded, Health Plan-Funded Assistance Amount (129-UD) can be used. If the dollars are not entirely plan funded, Health Plan-Funded Assistance Amount (129-UD) cannot be used.

4.3.5 TOTAL AMOUNT PAID (509-F9) NEGATIVE?

Question:
Can Total Amount Paid be returned with a negative dollar amount?

Response:
Yes. See “Amount Attributed to Processor Fee (571-NZ)” with example.

Currently there are two known business cases where Total Amount Paid (509-F9) may be returned as a negative value. These business cases include cash discount card programs and transaction click fees.

Cash Discount Card Programs
The program administrator may charge the patient a per claim administration fee or a program enrollment fee. These fees should be returned in the Amount Attributed to Processor Fee field (571-NZ). Since the program administrator is collecting these fees, the amount would also be reflected as a negative Total Amount Paid (509-F9) value.

- Cash Discount programs are not insurance and may not be properly coordinated by payers as other insurance. CMS does not consider discount plans as other coverage. From D.0 Implementation Guide section 28.2.6.4.1.1 Example 1 Brand Selection:
  - “When the Amount Attributed to Processor Fee (571-NZ) is greater than zero resulting in a negative payment to the provider, the claim is reversed and billed to the next payer as Primary using the appropriate Other Coverage Code (308-C8) value.”

- In order to clearly identify a cash discount claim so coordination does not occur with other insurance, it is recommended that processors return ‘ZRS’ in the Payer ID (569-J8) and a Payer ID Qualifier (569-J7) value of “99” - Other. The Payer ID of ZRS should be returned on all Cash Discount claim responses, regardless of the Total Amount Paid value.
  - The value of ZRS was derived from the new field Adjudicated Payment Type (A28-ZR) available with NCPDP Telecommunication Standard vD.3.
    - ZR = field ID
    - Value of S = Cash Discount
  - Claims submitted with the Medicare D BIN/PCN and paid under the cash discount/negotiated price program will be further identified with one of the following Benefit Stage Qualifiers
    - 70 = Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing
    - 80 = Non-Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing.

If the provider is not able to identify the previous claim as cash discount, a negative Other Payer Amount Paid value may result in the member not being able to have coordinated benefits.

Transaction Click Fees Question:

Looking for clarification on how to process a COB Scenario 1(OPAP) claim when the previous payer is charging “click fees” on 100% Patient Pay claims, resulting in a negative Total Amount Paid (509-59). We are seeing several Third Parties are rejecting when we send a negative in the Other Payer Amount Paid field (431-DV). They cover the drug, the only reason they are rejecting is due to the negative amount being sent in OPAP field (431-DV).

This has become a big issue since D.0 started and it’s definitely affecting Medicaid and Government patients. Since it’s mainly happening with Government plans and you cannot not bill their primary and can’t charge them on covered claim, the only option would be to recommend the patient to another pharmacy where they could run into the same issue. I was hoping for a transaction type resolution.

Transaction click fees would apply when the processor is charging a fee per transaction.

- The transaction fee would appear as a negative Total Amount Paid (509-F9) value only in the situation where the fee is passed onto the patient and patient liability is 100%.
  - In this situation, the processor would return the fee in the Amount Attributed to Processor Fee field (571-NZ) and balance Total Amount Paid (509-F9) accordingly.
- If the transaction fee is passed onto the provider, and returned on the B1 claim response, the response must balance and financials identified appropriately.
- To promote consistency and mitigate COB claims processing issues, it is recommended that processors not return the click fee in the Total Amount Paid but to use the PLB segment in the 835 to report click fees. (Added Version 20)
To promote consistency and mitigate COB claims processing issues, it is recommended that processors use the PLB segment in the 835 to report click fees.

If trading partner agreement allows for click fee to be returned on the response, a negative Other Payer Amount Paid value may result in the member not being able to have coordinated benefits.

Supplemental payers should accept a negative Other Payer Amount Paid and process accordingly. Please recognize the COB claim may be processed using their primary claim processing logic which may result in the pharmacy not being reimbursed for the click fee. (Added Version 20)

If multiple payers have been billed and none have returned Total Amount Paid (509-F9) > 0 and at least one has returned Total Amount Paid <= 0, Other Coverage Code will be 4 regardless of any additional payer rejections. (Added Version 20)

If multiple payers have been billed and at least one has returned Total Amount Paid (509-F9) > 0 and at least one has returned Total Amount Paid <= 0, then Other Coverage Code will be 2 regardless of additional payer responses. (Added Version 20)

Note: Contractual agreements may also result in a negative Total Amount Paid where this amount would not be represented as Amount Attributed to Processor Fee. (Added Version 20)

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<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Other coverage exists—payment not collected</td>
<td>If multiple payers have been billed and none have returned Total Amount Paid (509-F9) &gt; 0, but at least one has returned Total Amount Paid &lt;= 0, Other Coverage Code will be 4 regardless of any additional payer rejections. Coordination of Benefits/Other Payments Segment is required.</td>
<td>Governmental / Non-Governmental Receiver of Claim OPAP Required from at least one payer however anyone who paid should have done so with OPAP of zero (100% copay). When submitted with OCC 4, OPAP (as zero) must be submitted. If at least one payer however anyone who paid should have done so with OPAP of less than or equal to zero. When submitted with OCC 4, OPAP value must be submitted as zero or less than zero.</td>
</tr>
</tbody>
</table>

4.3.6 RESPONSE PROCESSING GUIDELINES

In Telecom D.4, section “Response Processing Guidelines”, “Pricing Guidelines (Claim/Service)”, “Patient Financial Responsibility (Claim)” and “Patient Financial Responsibility (Service)” clarification has been added that Patient Pay Amount (505-F5) must always be returned as well as any non-zero component fields. Return of zero value component fields is situational as defined in the implementation guide. For example:

26.2.4 Patient Financial Responsibility (Claim)

Patient Pay Amount (505-F5) must always be returned as well as any non-zero component fields. Return of zero value component fields is situational as defined in the implementation guide. In the examples, zero suppression has been applied. In other examples, the zero value fields may be included when necessary for clarification of the calculation.

Section “Response Pricing Segment”, “Patient Pay Amount (505-F5) Formula” has also been clarified. Patient Pay Amount (505-F5) must always be returned as well as any non-zero component fields. When the patient pay amount is 100%, the response must contain Patient Pay Amount (505-F5) plus any of the applicable non-zero component Patient Responsibility fields included in this amount. Otherwise, return of zero value component fields is situational as defined in the implementation guide.

And
4.3.7 Negative Patient Pay Values

Background:
The below patient pay response fields are listed as signed values, which would indicate the value may be negative. There are however, Data Dictionary comments which indicate certain fields do not support negative values. The comments appear to be inconsistent across synonymous fields.

For example:
- Field 134-UK (Amt Attributed to Product Selection/Brand Drug) indicates the field does not support negative values
- Field 135-UM (Amount Attributed to Product Selection/Non-Preferred Formulary Selection) and Field 136-UN (Amount Attributed to Product Selection/Brand Non-Preferred Formulary) do not make a reference to the negative value restriction.

Further conflict may be present, as the field definitions would indicate the value would not be negative, however the reference to the negative restriction is not within the comments (e.g. amount attributed to periodic deductible, amount attributed to periodic benefit max, etc).

As a result of these inconsistencies, we are unable to determine if it is appropriate to return a negative value in any of the components of Patient Pay, except for field 129-UD - Health Plan Funded Assistance Amount. The specific business case of concern is negative values returned in field 136-UN Amount Attributed to Product Selection/Brand Non-Preferred Formulary, where the specific benefit has been categorized as a copay incentive for fills dispensed in greater than 31 day supply. There have been cases where sum of the components of patient pay, result in a negative patient pay amount. Additionally, when the prescription is further coordinated with downstream payers, the COB claim often rejects due to the negative dollar value reported with the Other Payer Patient Responsibility Amount Qualifier of “11.”

Question:
Is there a component field of Patient Pay Amount (505-F5) that can be used to represent a patient copay incentive that is a negative value?

Response:
No, there is not a component field of Patient Pay Amount that can be used to represent a patient copay incentive that is a negative value. Other than Health Plan Funded Assistance Amount (129-UD), any patient financial responsibility reduction needs to be calculated outside of the claim response and the claim response should contain the net amount.

4.3.8 Brand Medically Necessary

Question:
What defines when a Brand (134-UK) penalty would apply to the patient liability amount?

Response:
Plan benefit designs, while they allow a Dispense As Written (DAW)/Product Selection Code (408-D8) value of “1” (Substitution Not Allowed by Prescriber), may still pass on the cost difference between the brand and generic to the patient. This cost differential would be represented in the appropriate field:
- Amount Attributed to Product Selection/Brand Drug (134-UK), or
- Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) or
- Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN).
This allows the pharmacy to dispense the prescription as written per regulatory agency requirements.

Question:
If the COB payer’s coverage policy is limited to copay (“05”), co-insurance (“07”), Deductible (“01”), benefit max (“04”), coverage gap (“12”) and health plan funded amount (“09”) how should the COB payer treat the Brand (“02”) Other Payer-Patient Responsibility Amount that was returned by the previous payer?

Response:
If the COB payer is a government entity requiring full disclosure, restricted by regulation to only support specific Other Payer-Patient Responsibility Amount Qualifier (351-NP) values and cannot pass the cost on to the patient and cannot reject the claim; they may default to their Other Payer Amount Paid (OPAP) logic. This would enable the claim to be paid using the difference between the COB payer’s allowed amount/contracted amount and the Other Payer Amount Recognized (566-J5).

Alternatively the COB payer could include coverage through the DAW Prior Authorization process for the Other Payer-Patient Responsibility Amount Qualifier (351-NP) values “02” (Amount Attributed to Product Selection/Brand Drug), “08” (Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection) and “11” (Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection).

For a long term solution, review regulations to align with current benefit designs within the pharmacy industry.

### 4.4 RESPONSE STATUS SEGMENT (21)

#### 4.4.1 ADDITIONAL MESSAGE INFORMATION

**4.4.1.1 ADDITIONAL MESSAGE INFORMATION CONTINUITY (131-UG)**

I have questions regarding the new free text message approach in Version D.0. Basically, I'm curious about the use of the qualifier in field 132-UH, Additional Message Information Qualifier. Based on the qualifier definitions that I found, each value represents "the XXX line of free form text with no pre-defined structure" where XXX is first, second, third, etc. The data dictionary states that each value can only occur once per transaction and must be ordered sequentially. The Implementation Guide states that there is a maximum of nine occurrences within a transaction. I guess my concern is with the interpretation of "line" within the context of the message. The reason I'm asking questions is because we had a couple different developers read the NCPDP information and they both came up with different interpretations. My concern now is that some processors may interpret the "line" concept of the qualifier differently without more guidance.

In the NCPDP documents, it looks like the intention is not to require separated, readable lines that are self-contained in 40 characters, but it does use a counter for each line. From the examples in the Implementation Guide (Sections 28.2.5.3.3 through 28.2.5.3.7), I'm not seeing the benefit of the continuity field, 131-UG. In all examples, the "readable" free text message is concatenated into one line without any additional formatting such as an implied space or hard return.

By the way, I don't interpret the Additional Message Information Continuity field, 131-UG, as part of the Additional Message (526-FQ) text stream. It is simply a flag directing me on how I can display the text stream. As such, I wouldn't expect someone to interpret the "raw data free text message" as shown in the examples with the "+" text character embedded in the message. I would only display the text in the 526-FQ field and would not include any text from another field.

If a processor wanted to return two statements that were longer than the 40 characters provided by a single message field with the intended "readable" output to be displayed as:
Mary had a little Lamb, whose fleece was white as snow. And everywhere that Mary went, the lamb was sure to go.

For additional information please call the helpdesk at 1-800-333-4444.

**Option A -**
I’m wondering if the processor might properly return a response with the following sequence of fields?

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Value</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>111-AM</td>
<td>SEGMENT IDENTIFICATION</td>
<td>21</td>
<td>RESPONSE STATUS SEGMENT</td>
</tr>
<tr>
<td></td>
<td>Other fields</td>
<td></td>
<td></td>
</tr>
<tr>
<td>130-UF</td>
<td>ADDITIONAL MESSAGE INFORMATION COUNT</td>
<td>7</td>
<td>(Number of 526-FQ fields that are returned)</td>
</tr>
<tr>
<td>132- UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>&quot;01&quot;</td>
<td>(Line 1)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;MARY HAD A LITTLE LAMB, &quot;</td>
<td>(Denotes a continuation of the sentence)</td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>&quot;+&quot;</td>
<td></td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;WHOSE FLEECE WAS WHITE AS SNOW. &quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>Space</td>
<td>(Optional denotes end of sentence)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;AND EVERYWHERE THAT MARY WENT, &quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>&quot;+&quot;</td>
<td>(Denotes a continuation of the sentence)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;THE LAMB WAS SURE TO GO.&quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>Space</td>
<td>(Optional denotes end of sentence)</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>&quot;02&quot;</td>
<td>(Line 2)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;FOR ADDITIONAL INFORMATION PLEASE CALL &quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>&quot;+&quot;</td>
<td>(Denotes a continuation of the sentence)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;THE HELPDESK AT &quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>&quot;+&quot;</td>
<td>(Denotes a continuation of the sentence)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;1-800-333-4444.&quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>Space</td>
<td>(Optional denotes end of sentence)</td>
</tr>
</tbody>
</table>

**NCPDP: Option A is incorrect.**
This potential implementation fails to consistently follow two situational requirements defined in the Implementation Guide for each repetition:

Additional Message Information Qualifier (132-UH) must be present when Additional Message Information (526-FQ) is used. This can be found in the multiple discussions of situational requirements of the Response Status Segment by transaction, including sections 6.4.1.2.6, 7.5.1.5.5, and many others.

Additional Message Information Continuity (131-UG) must not be present when there is no continuation of the message text from the current repetition to the next repetition of Additional Message Information (526-FQ). This is also found in the sections mentioned above and is further clarified in the note made at the end of the paragraph in section 33.14.2.5.1.3. Further, this is consistent with an alphanumeric field containing only a space having the space suppressed and the resulting empty field not being included as just a field identifier in a transmission.

**Option B -**
Or, if the processor thinks a qualifier is required for every instance of the 526-FQ field, would this be correct?

NCPDP: Option B is incorrect.

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Value</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>111-AM</td>
<td>SEGMENT IDENTIFICATION</td>
<td>21</td>
<td>RESPONSE STATUS SEGMENT</td>
</tr>
<tr>
<td>......</td>
<td>Other fields</td>
<td></td>
<td></td>
</tr>
<tr>
<td>130-UF</td>
<td>ADDITIONAL MESSAGE INFORMATION COUNT</td>
<td>7</td>
<td>(Number of 526-FQ fields that are returned)</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>&quot;01&quot;</td>
<td>(Line 1)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;MARY HAD A LITTLE LAMB, &quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>&quot;+&quot;</td>
<td>(Denotes a continuation of the sentence)</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>&quot;01&quot;</td>
<td>(Line 1)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;WHOSE FLEECE WAS WHITE AS SNOW. &quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>Space</td>
<td>(Optional denotes end of sentence)</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>&quot;01&quot;</td>
<td>(Line 1)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;AND EVERYWHERE THAT MARY WENT, &quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>&quot;+&quot;</td>
<td>(Denotes a continuation of the sentence)</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>&quot;01&quot;</td>
<td>(Line 1)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;THE LAMB WAS SURE TO GO.&quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>Space</td>
<td>(Optional Denotes end of sentence)</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>&quot;02&quot;</td>
<td>(Line 2)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;FOR ADDITIONAL INFORMATION PLEASE CALL &quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>&quot;+&quot;</td>
<td>(Denotes a continuation of the sentence)</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>&quot;02&quot;</td>
<td>(Line 2)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;THE HELPDESK AT &quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>&quot;+&quot;</td>
<td>(Denotes a continuation of the sentence)</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>&quot;02&quot;</td>
<td>(Line 2)</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>&quot;1-800-333-4444.&quot;</td>
<td></td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>Space</td>
<td>(Optional denotes end of sentence)</td>
</tr>
</tbody>
</table>

NCPDP: Option B is incorrect.

This is slightly more correct than Option A in that it recognizes the need to include the Additional Message Information Qualifier (132-UH) before each Additional Message Information (526-FQ), but fails to obey the field definition requirement that the value in 132-UH cannot be repeated in the same transaction response. The problem with invalid repetitions of 131-UG when continuation is not intended and the field is not properly populated is also included.

NCPDP: Option C is correct.

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Value</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>111-AM</td>
<td>SEGMENT IDENTIFICATION</td>
<td>21</td>
<td>RESPONSE STATUS SEGMENT</td>
</tr>
<tr>
<td>......</td>
<td>Other fields</td>
<td></td>
<td></td>
</tr>
<tr>
<td>130-UF</td>
<td>ADDITIONAL MESSAGE INFORMATION COUNT</td>
<td>6</td>
<td>(Number of 526-FQ fields that are returned)</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>&quot;01&quot;</td>
<td>(Line 1)</td>
</tr>
</tbody>
</table>
**NCPDP: Option C is correct.**

This is correct and reflects the two methods by which large text strings will be broken into 40 character segments.

The processor’s use of algorithms to locate the proper place to break strings between words or sentences as shown with the nursery rhyme in the first 4 segments should not be expected, but may be applied. If the processor does employ such logic, there must be no expectation that the provider will insert spaces at either end of continued messages and so they must be included in the message text sent.

The last two segments are what should be expected from a processor that uses simple 40 character segment breaks that may occur in the middle of a word.

How these two messages are formatted for display by a pharmacy practice management system is then at the sole discretion of the system. For instance, if it is determined by the vendor and the vendor’s client(s) that a small scrolling window using variable typeface that typically shows 3 lines of 45-55 characters is preferred, there is no reason that system should be expected to do anything differently.

See also section “Additional Message Information Examples”.

---

**Additional Message Information**

<table>
<thead>
<tr>
<th>Code</th>
<th>Information Type</th>
<th>Message Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>MARY HAD A LITTLE LAMB, Up to 40 Bytes</td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>+ Continuation character</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>02 Used for second line of free form text with no pre-defined structure.</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>WHOSE FLEECE WAS WHITE AS SNOW. Up to 40 Bytes (Note presence of a leading space.)</td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>+ Continuation character</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>03 Used for third line of free form text with no pre-defined structure.</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>AND EVERYWHERE THAT MARY WENT, Up to 40 Bytes (Note presence of a leading space.)</td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>+ Continuation character</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>04 Used for fourth line of free form text with no pre-defined structure.</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>THE LAMB WAS SURE TO GO. Up to 40 Bytes</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>05 Used for fifth line of free form text with no pre-defined structure.</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>FOR ADDITIONAL INFORMATION PLEASE CALL T Up to 40 Bytes</td>
</tr>
<tr>
<td>131-UG</td>
<td>ADDITIONAL MESSAGE INFORMATION CONTINUITY</td>
<td>+ Continuation character</td>
</tr>
<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>06 Used for sixth line of free form text with no pre-defined structure.</td>
</tr>
<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>HE HELPDESK AT 1-800-333-4444. Up to 40 Bytes</td>
</tr>
</tbody>
</table>
4.4.1.2 **USE OF ADDITIONAL MESSAGE INFORMATION FOR NEXT AVAILABLE DATE OF SERVICE**

A new field of Next Available Fill Date (B04-BT to be approved) was added to Telecom version D.9. To support the need to send a structure with the next available date of service, a new value of “10” was added to Additional Message Information Qualifier (132-UH). If prior to Telecom version D.9, the next available date of service is sent on a rejected response - in Claim Billing/Encounter, Predetermination of Benefits, Claim Rebill, and Prior Authorization Request And Billing transactions – to send a structured response, the Additional Message Information Qualifier (132-UH) of “10” is used, with the date in format CCYYMMDD in the Additional Message Information (526-FQ).

4.4.1.3 **ADDITIONAL MESSAGE INFORMATION QUALIFIER (132-UH) APPEAR MORE THAN ONCE?**

**Question:**
Can Additional Message Information Qualifier (132-UH) appear more than once in a segment in a transaction?

**Response:**

The Additional Message Information Count (130-UF) occurs only once; it does not repeat (see section “Structure Quick Reference”). Additional Message Information Count (130-UF) contains the total number of occurrences of the Additional Message Information Qualifier (132-UH). The Count cannot contain a value greater than the highest number of defined qualifier values of the Additional Message Information Qualifier (132-UH) in the NCPDP External Code List. See NCPDP Telecommunication Implementation Guide sections “Additional Message Information Fields” and “Standard Conventions”, subsection “Repetition and Multiple Occurrences”, subsection “Additional Message Information Count”. (Note: If the count field was allowed to occur multiple times in a segment, it would, per the standard, be a counter field. This is not the case.)

4.4.2 **DUPLICATE TRANSACTION**

**Question:**
I work with our pharmacy benefit program at xxxx; ABC is our PBM. We have experienced overpayment situations when a second almost identical claim is submitted, however it doesn’t qualify as an NCPDP duplicate claim - possibly due to a new Rx number being assigned, or due to a different fill number. However, the prescription could be considered a duplicate, considering the rest of the fields. We have other situations when a point of sale claim will process, and a direct paper claim is submitted; if the pharmacy NCPDP ID or NPI is not provided on the direct claim, the second claim will process as all the criteria is not identical; meanwhile, there doesn’t seem to be another edit in place to stop the second claim from paying.

Does NCPDP believe the fill-too-soon logic would stop these otherwise duplicate claims? Or, how would NCPDP anticipate processors generally stop or minimize similar overpayments?

I was hoping you, or one of your peers, might have found a smart way to minimize claim overpayments that may otherwise be considered duplicates, but don’t meet the duplicate claim requirements.

**Response:**

NCPDP duplicate response logic is to be followed whenever the exact criteria for duplicate have been met (See section “Duplicate Transactions” of Telecommunication Standard Version D.0). If a processor suspects a duplicate but the criteria do not exactly match that which is used for a duplicate, the processor is to return a Reject Code “83” (Duplicate Paid/Captured Claim) and if possible, message to the sender the field(s) that triggered that reject.

4.4.3 **REJECT CODE (511-FB) “70” AND “MR”**

In Telecommunication Implementation Guide Version D.3, Reject Code (511-FB) value “70” was modified from “Product Service ID Not Covered” to “Product/Service Not Covered – Plan/Benefit Exclusion” and value “MR”
was modified from “Drug Not On Formulary” to “Product Not on Formulary”. Sections “Appendix G Two Way Communication to Increase the Value of On-Line Messaging” and “Transmission Examples” were updated with the modified description. Value “MR” was also added to Appendix G. The clarification of these reject code values is available to implementers in the January 2010 External Code List.

4.5 RESPONSE INSURANCE SEGMENT (25)

4.5.1 NETWORK REIMBURSEMENT ID (545-2F)

Question:
If an entity has claims for different lines of business or contracts which are processed by the same payer/processor, what mechanism is available to allow the line of business or contract under which the claim paid to be communicated in the claim response?

Response:
For Version D.0 of the Telecommunication Standard, the field Network Reimbursement ID (545-2F) can be used to communicate this information. Its’ definition is “Field defined by the processor. It identifies the network, for the covered member, used to calculate the reimbursement to the pharmacy.” Note that this is a situational field whose use and value would be determined by trading partner agreement.

Added May 2018

4.6 RESPONSE CLAIM SEGMENT (22)

4.6.1 PREFERRED PRODUCT COST SHARE INCENTIVE (555-AT)

Question:
There is confusion regarding the value being returned in Preferred Product Cost Share Incentive (555-AT). The definition indicates that the value returned in this field is the amount of patient’s copay/cost-share incentive. Can clarification be provided as to what this value truly reflects as pharmacies are seeing values that align with copays, patient pay amounts, and cost differentials between the billed product and the preferred product.

Response:
The value reflects the estimated Patient Pay Amount (505-F5) for the preferred product.

Added May 2019 – Telecommunication FAQ TG
5 TYPEOGRAPICAL ERRORS

5.1 TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE FIELDS

5.1.1 ADDITIONAL MESSAGE INFORMATION EXAMPLES

In section “Additional Message Information Fields”:

The raw data free text message for Example 2

“HELP DESK TO ASSIST WITH QUESTIONS. ASK FOR SHELLY SMITH.” was changed to

“HELP DESK TO ASSIST WITH QUESTIONS.”

“ASK FOR SHELLY SMITH.”

And the readable was modified to two lines.
HELP DESK TO ASSIST WITH QUESTIONS.
ASK FOR SHELLY SMITH.

The raw data free text message for Example 3

“PRIOR AUTHORIZATION EXPIRATION 12/31/200+7. FOR CONTINUATION OF SERVICE, CONTACT+
PRESCRIBER.” was changed to

“PRIOR AUTHORIZATION EXPIRATION 12/31/200” + “7. FOR CONTINUATION OF SERVICE, CONTACT” +
“PRESCRIBER.”

The raw data free text message for Example 5

“NEXT AVAILABLE DATE OF SERVICE = 12/31/2007 WIT+H PRIOR AUTHORIZATION EXPIRING” was changed to

“NEXT AVAILABLE DATE OF SERVICE = 12/31/2007 WI” + “TH PRIOR AUTHORIZATION EXPIRING”

See also Section “Response Status Segment (21)”, subsection “Additional Message Information Continuity (131- UG)”. This has been corrected in version E.0.

5.1.2 DATE OF SERVICE (401-D1)

Section “Transmission Examples”, “Eligibility Medicare Part D to Facilitator - Request”, “Scenario 6 – Adjusted Request to Scenario 5” the Date of Service (401-D1) was August 1, 2006. It was supposed to be November 1, 2006 per the text. It has been corrected in Version D.3 and above.

5.1.3 HELP DESK PHONE NUMBER QUALIFIER (549-7F)

In the matrices, Help Desk Phone Number Qualifier was inadvertently identified as (550-7F). It has been corrected to (549-7F).

In some of the transaction charts, Help Desk Phone Number Qualifier (549-7F) situation had a typo that referred to the Number as (550-8F) instead of (550-8F) – “Required if Help Desk Phone Number (550-8F) is used.” This has been corrected in version D.5.

5.1.4 INTERNAL CONTROL NUMBER (993-A7)

In the chart for Coordination of Benefits/Other Payments Segment (Claim Rebill), Internal Control Number (993-A7) was switched with Other Payer Date (443-E8).

<table>
<thead>
<tr>
<th>Field</th>
<th>COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>337-4C</td>
<td>COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT</td>
</tr>
</tbody>
</table>
This has been corrected in Version D.4.

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>111-AM</td>
<td>SEGMENT IDENTIFICATION</td>
</tr>
<tr>
<td>337-4C</td>
<td>COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT</td>
</tr>
<tr>
<td>338-5C</td>
<td>OTHER PAYER COVERAGE TYPE</td>
</tr>
<tr>
<td>339-6C</td>
<td>OTHER PAYER ID QUALIFIER</td>
</tr>
<tr>
<td>340-7C</td>
<td>OTHER PAYER ID</td>
</tr>
<tr>
<td>443-E8</td>
<td>OTHER PAYER DATE</td>
</tr>
<tr>
<td>993-A7</td>
<td>INTERNAL CONTROL NUMBER</td>
</tr>
</tbody>
</table>

### 5.1.5 Other Coverage Code (308-C8)

**Question:** In the D.0 Imp Guide on page 751, looks like we have a typo. We say "When Other Coverage Code > 8,..." when I think it should state "When Other Coverage Code = 8,..." I think that should be equal, not greater than.

When Other Coverage Code > 8, the Coordination of Benefits/Other Payments Segment must be viewed to determine the Patient Responsibility Amount from the prior payer. In coordination of benefits processing, the Pricing Segment appears as it would exist for a PRIMARY CLAIM. Processor must use Coordination of Benefits/Other Payments Segment fields to determine billing amount.

**Response:**
This is a typo; it should be = 8. This was corrected in Telecommunication Standard Version E.0.

### 5.1.6 Other Payer Coverage Type (338-5C)

In section 28.2.10 RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT, the sentence “Other Payer Coverage Type (355-NT) – will contain the other payer’s level of coverage for the patient, such as primary, secondary, tertiary, etc.” has the incorrect field number. The correct field number is 338-5C. This has been corrected in version D.3 of the implementation guide.

### 5.1.7 Quantity Prescribed (460-ET)

In some “Transmission Examples” in the Telecom Imp Guide, the field Quantity Dispensed (460-ET) was included. This field is not used in Claim Billing. It has been removed from these examples in version D.5.

### 5.1.8 Repeating Designation

In various places the designation “N***R***” or “Q***R***” were missing an asterisk. It has been corrected.

### 5.1.9 Route of Administration (995-E2)

In the examples in the implementation guide, the old values (two digit codes) were inadvertently left. In a future version of the implementation guide (D.3), this has been corrected to SNOMED codes which are the correct value set to be used. For example,
5.2 **TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE SEGMENTS**

### 5.2.1 General

In section “Request Segment Matrices by Field within Segment” shading was inadvertently missing from not used cells in the Coordination of Benefits/Other Payments Segment for Eligibility Verification and Predetermination of Benefits. Shading was also corrected in the Prescriber Segment and the DUR/PPS Segment in the Prior Authorization Reversal (Claim/Service) and Prior Authorization Inquiry. Shading was also corrected in the Response Claim Segment in a Controlled Substance Reporting Reversal for Rejected/Rejected cells.

In section “Response Insurance Segment (Information Reporting) (Transmission Accepted/Transaction Approved)” rows marked “N” (Not used) were inadvertently designated with “S” (Situational) instead of “N”.

These changes were corrected in Version D.3 and above.

### 5.2.2 Claim Segment

An editorial correction was made to Product/Service ID (407-D7) that had the exact same note as Product/Service ID Qualifier (436-E1). “Mandatory. Must contain the Product/Service ID (436-E1) value from original Billing.” This was corrected to “Mandatory. Must contain the Product/Service ID (407-D7) value from original Billing.” This was corrected in version D.5 and above.

### 5.2.3 Coupon Segment

#### 5.2.3.1 PRIOR AUTHORIZATION REQUEST AND BILLING TRANSACTION

In Telecom D.0, the Coupon Segment is inadvertently omitted from the Prior Authorization Request And Billing transaction. As the lack of this segment is more than just an editorial correction, a workaround must be used for Version D.0. If a Prior Authorization Request And Billing function requires a Coupon Segment, the Prior Authorization Request transaction should be sent. The Claim Billing transaction can then be sent with the Coupon Segment included.

The Coupon Segment was added to the Prior Authorization Request And Billing transaction in Version D.7.

### 5.2.4 Clinical Segment

In section “Repeating Data Elements”, subsection “Request Segments”, “Clinical Segment”, “Diagnosis Code Count”, the Clinical Information Counter fields were not tabbed correctly in the chart. They are displayed correctly below. This change was made in Version D.5 and above.

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>491-VE</td>
<td>Diagnosis Code Count</td>
</tr>
<tr>
<td>492-WE</td>
<td>Diagnosis Code Qualifier</td>
</tr>
<tr>
<td>424-DO</td>
<td>Diagnosis Code</td>
</tr>
<tr>
<td>493-XE</td>
<td>Clinical Information Counter</td>
</tr>
<tr>
<td>494-ZE</td>
<td>Measurement Date</td>
</tr>
<tr>
<td>495-H1</td>
<td>Measurement Time</td>
</tr>
<tr>
<td>496-H2</td>
<td>Measurement Dimension</td>
</tr>
<tr>
<td>497-H3</td>
<td>Measurement Unit</td>
</tr>
<tr>
<td>499-H4</td>
<td>Measurement Value</td>
</tr>
</tbody>
</table>

### 5.2.5 Patient Segment

In the Controlled Substance Reporting Reversal transaction, the Patient Segment chart was omitted. It has been added (version D.3).
In the Information Reporting Reversal diagrams, the Patient Segment was inadvertently included. The Patient Segment is not used in this transaction. It has been removed (version D.3).

**5.2.6 PURCHASER SEGMENT**
In the Controlled Substance Reporting transaction, a “Note” on the Purchaser Segment inadvertently referenced the Patient Segment. It has been corrected to Purchaser Segment.

**5.2.7 RESPONSE CLAIM SEGMENT**

**5.2.7.1 MEDICAID SUBROGATION CLAIM BILLING OR ENCOUNTER**
A typo was corrected. Response Claim Segment (Medicaid Subrogation Claim Billing or Encounter) (Transmission Accepted/Transaction Paid) table had “Response Insurance Segment” in the table heading. It has been changed to “Response Claim Segment”. This was corrected in Telecom version D.6 and above.

**5.2.7.2 PRIOR AUTHORIZATION REQUEST AND BILLING RESPONSE**
The following verbiage inadvertently appeared in Notes on Response Claim Segment on a Prior Authorization Request And Billing Response (Rejected). The information appears correctly in Notes on Response Coordination of Benefits/Other Payers Segment on a Prior Authorization Request And Billing Response (Rejected). This was corrected in Telecom version D.5 and above.

1. If the identity of the patient is partially verified and the Prior Authorization Request And Billing is rejected due to a non-match of field verification, then the Other Payer information is not sent.
2. If the Prior Authorization Request And Billing is rejected because it should be submitted to other payer(s) first, that Other Payer information should be sent, if known.
3. If the Prior Authorization Request And Billing is rejected due to benefit design limitations, then subsequent Other Payer information should be sent, if known.

If the Prior Authorization Request And Billing rejects for other reasons than above, Other Payer information is not sent.

If additional payer(s) for this patient is not known, the Other Payer information is not sent.

If additional payer(s) for this patient is known, the following may be sent:
- Other Payer ID (340-7C) and Other Payer ID Qualifier (339-6C),
- Other Payer Group ID (992-MJ),
- Other Payer Processor Control Number (991-MH),
- Other Payer Cardholder ID (356-NU).

In addition, if any of the following three fields are sent:
- Other Payer Processor Control Number (991-MH),
- Other Payer Cardholder ID (356-NU),
- Other Payer Group ID (992-MJ),
then the Other Payer ID (340-7C) and Other Payer ID Qualifier (339-6C) must be sent.

**5.2.8 RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT**
In the Prior Authorization Reversal matrix, the Response Coordination of Benefits/Other Payers Segment was inadvertently copied with field designations. This segment is not used in PA Reversal and was changed to all shaded in Version D.3 and above.

**5.3 TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE**
Examples

5.3.1 BILLING – TRANSACTION CODE B1 – COORDINATION OF BENEFITS SCENARIO PHARMACY BILLS TO SECONDARY WHICH MEETS DESIGNATION AS GOVERNMENT PAYER, PATIENT REQUESTS BRAND

Typos were corrected in section “Transmission Examples”, “Billing – Transaction Code B1 – Coordination of Benefits Scenario Pharmacy Bills To Secondary Which Meets Designation As Government Payer, Patient Requests Brand”. This has been corrected in Telecom Version D.6.

<table>
<thead>
<tr>
<th>351-NP</th>
<th>OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER</th>
<th>R</th>
<th>01-05</th>
<th>Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Amount of Copay (518-Fi) as reported by previous payer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>351-NP</td>
<td>OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER</td>
<td>R</td>
<td>02-11</td>
<td>Amount of Coinsurance (572-4U) as reported by previous payer. Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.</td>
</tr>
</tbody>
</table>

And the Note was added:

<table>
<thead>
<tr>
<th>136-UN</th>
<th>AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION</th>
<th>Q</th>
<th>250/</th>
<th>$25.00</th>
</tr>
</thead>
</table>

Note: Product Selection cost is NOT being paid by the secondary payer, but they are returning this for patient to pay.

5.3.2 BILLING – TRANSACTION CODE B1 – COORDINATION OF BENEFITS SCENARIOS PHARMACY BILLS TO INSURANCE DESIGNATED BY PATIENT

Example “Billing – Transaction Code B1 – Coordination of Benefits Scenarios Pharmacy Bills To Insurance Designated By Patient” inadvertently listed Quantity Dispensed (442-E7) twice and in one subsection was missing Dispense As Written (408-D8).

5.3.3 BILLING - TRANSACTION CODE B1 - COB SCENARIO - PHARMACY BILLS REPORTING AMOUNT PAID BY PREVIOUS PAYER ONLY

Example “Billing - Transaction Code B1 - COB Scenario - Pharmacy Bills Reporting Amount Paid by Previous Payer Only”, “Secondary Response – Paid”, Basis of Reimbursement Determination (522-FM) was listed twice. The row with value 14 has been deleted. This has been corrected in Telecom D.8.

5.3.4 CONTROLLED SUBSTANCE REPORTING (GENERAL) EXAMPLES

Telecommunication Standard Implementation Guide Version D.6 and below, some Controlled Substance Reporting (General) transaction examples contained a patient phone number, which was a not used field at the time.

5.3.5 EXAMPLES USING MEDIGAP ID (359-2A)

Section “Transmission Examples”, some Medicare examples were corrected. The value “TXMEDICAID” in Medigap ID (359-2A) should have been removed and the state added with the use of the Medicaid Indicator (360-2B). Provider Accept Assignment Indicator (361-2D) was added.

- “Billing – Transaction Code B1 with Additional Documentation Segment”
- “Billing – Transaction Code B1 with Facility Information”
- “Billing – Transaction Code B1 with Narrative Information”
- “Billing – Transaction Code B1 with Facility Information and Narrative Information”
- “Billing – Transaction Code B1 with Additional Documentation and Narrative Information”

5.4 APPENDIX A. HISTORY OF DOCUMENT CHANGES CORRECTIONS

Version 48
November 2019
*** OFFICIAL RELEASE ***
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Page: 61
In the Telecommunication Standard Implementation Guide, in this appendix in subsection Version C.4 changes, Submission Clarification Code (420-DK) was noted with new values. The list was incorrect. The External Code List is correct; just this list in the appendix was incorrect. This has been noted in version D.3 appendix. The corrected statement is:

- **14** = Long Term Care Leave of Absence - The pharmacist is indicating that the cardholder requires a short-supply of a prescription due to a leave of absence from the Long Term Care (LTC) facility.
- **15** = Long Term Care Replacement Medication - Medication has been contaminated during administration in a Long Term Care setting.
- **16** = Long Term Care Emergency box (kit) or automated dispensing machine – Indicates that the transaction is a replacement supply for doses previously dispensed to the patient after hours.
- **17** = Long Term Care Emergency supply remainder - Indicates that the transaction is for the remainder of the drug originally begun from an Emergency Kit.
- **18** = Long Term Care Patient Admit/Readmit Indicator - Indicates that the transaction is for a new dispensing of medication due to the patient’s admission or readmission status.

### 5.5 External Code List Notables

#### 5.5.1 Reject Code (511-FB) List
This list inadvertently listed “7F” and “7G” with similar descriptions. Value “7F” will be removed

“7F” – Future date not allowed for Date of Birth

“7G” – Future Date not Allowed for DOB

#### 5.5.2 Prescription/Service Reference Number (455-EM) Value “3”
455-EM Prescription/Service Reference Number Qualifier added value “3” (Non-Prescription Product) in version D.1. It was inadvertently left out of the External Code List. It was added in the 201410 External Code List version. It is effective for version D.1 and above.
6 GENERAL QUESTIONS

6.1 BIN AND IIN

Question:
New 8 digit IIN’s (ex. 12345600) are currently being reported in plan payer sheets. To ensure standardization of processes across the pharmacy industry, can guidance be provided on how the 8-digit value should be handled within NCPDP Transactions?

Response: Use the first 6 digits of the IIN as the BIN even if the first digit(s) is a zero.

6.2 HOW SOON SUPPORT THIS DOCUMENT?

Question: Once the Version D Editorial is published, how soon do implementers need to support?

Response: When the Version D Editorial is published, it is effective for use immediately unless the specific section or response lists an effective date.

6.3 PRINTABLE CHARACTERS

To clarify, the statement in the Telecommunication Implementation Guide “The use of lower case letters ASCII 97 - 122 (61 - 7A hex) is not allowed in the Telecommunication Standard” is actually stating “The use of lower case letters ASCII 97 - 122 (61 - 7A hex) is not allowed in the Telecommunication Standard format.”

6.4 REJECT CODE GUIDANCE

See “Appendix A – Reject Codes for 511-FB” in the NCPDP External Code List for guidance on the use of reject codes.

6.4.1 TELECOMMUNICATION PHASES WITH FLOW CHART

This was originally in the Data Dictionary section “Appendix C – Telecommunication Phases with Flow Charts” and was moved into this document.

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Description</th>
<th>Reject Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No Dial Tone. Call Telephone Company</td>
<td>91</td>
</tr>
<tr>
<td>2</td>
<td>Ring No Answer, Check Phone Number, And Call Network</td>
<td>92</td>
</tr>
<tr>
<td>3</td>
<td>Busy, Try Again</td>
<td>93</td>
</tr>
<tr>
<td>4</td>
<td>No Carrier From Network. Try Again</td>
<td>94</td>
</tr>
<tr>
<td>5</td>
<td>Logon Unsuccessful. Try Again</td>
<td>95</td>
</tr>
<tr>
<td>6</td>
<td>No ENQ. Try Again</td>
<td>96</td>
</tr>
<tr>
<td>7</td>
<td>No Response From Network. Call Network</td>
<td>97</td>
</tr>
<tr>
<td>8</td>
<td>Bad Response From Network. Try Again</td>
<td>98</td>
</tr>
<tr>
<td>9</td>
<td>NCPDP Standard Response</td>
<td></td>
</tr>
</tbody>
</table>
### WHEN SHOULD REJECT CODE 84 BE USED?

**Question:**
When should Reject Code 84 “Claim Has Not Been Paid/Captured” be used?

**Response:**
Reject code 84 (Claim Has Not Been Paid/Captured) dates back to NCPDP Telecommunication Standard v1. It has been noted that the original intent of this reject code was for B2 reversal transactions where the processor was not able to match the submitted Service Provider ID (201-D1), Date of Service (401-D1), and RX Number (402-D2) to a paid/captured claim within their system.

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Description</th>
<th>Reject Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Time Out</td>
<td>95</td>
</tr>
<tr>
<td>2</td>
<td>Scheduled Downtime</td>
<td>96</td>
</tr>
<tr>
<td>3</td>
<td>Connection to payer is down</td>
<td>98</td>
</tr>
<tr>
<td>4</td>
<td>Payer Unavailable</td>
<td>97</td>
</tr>
</tbody>
</table>

The issue is many claims processors are using reject code 84 on B1 versus B2 rejected responses. In many cases, the reject code count is 1, where only reject code 84 is returned. As a result, the entity receiving reject code 84 (pharmacy and downstream payers) is not able to interpret what the conflict is. In a COB situation, this places the beneficiary at risk, as the downstream payer will not accept the COB claim and the pharmacy is unable to...
identify the specific conflict to be able to resolve the primary rejection. Due to the resulting confusion Reject Code 84 will be sunset 10/2016.

Recommendations for Transition from Use of Reject Code 84 which will Sunset 10/2016:

1. Processors should return the most distinct reject code(s) that correlates to rejected B1 claim or B2 reversal transaction. See section “Improving the value of the claim response with additional messaging” and the Field Limitation/Explanation section of the reject code table within the ECL.

2. In situations where the processor is unable to process the B1 or B2 transaction due to an internal system error, the appropriate system unavailable reject code should be returned (e.g.: 90, 92, 95, 96, 97, 98, 99). When applicable, the date/time in which the system will be available should be returned in the Additional Message field (526-FQ) to mitigate transaction bottlenecks and allow the pharmacy to appropriately schedule resubmitting the transaction.

3. Processors should limit the use of non-descript reject code 85 – “Claim Not Processed” as it provides no direction to the pharmacy, downstream payer or patient as to what the conflict may be.

Effective with the 2015 Annual ECL Implementation, processors should begin using new reject code 31 – “No matching paid claim found for reversal request” for B2 transactions where the matching B1 cannot be found.

6.4.3 Prescriber ID Rejections

Question:
When state law allows Interns and Residents to write prescriptions under the supervision of the Supervising or Attending Physician, and the Intern/Resident has signed the prescription as the prescriber, regardless of the state laws for designation of supervising physician on the prescription hard copy, what should be is submitted as the Prescriber ID (411-DB)?

Response:
When the intern/resident where state law requires a supervising physician is prescribing and signing the prescription for the medication/service for which they are authorized, the ID (i.e. Type 1 NPI) of the intern/resident who is prescribing and signing the prescription would be submitted as the Prescriber ID (411-DB).

Question:
If the practitioner who signed the prescription (i.e. prescriber) does not meet the payer’s prescriber enrollment requirements (such as CMS-4159) and state law requires a supervising or attending physician be associated to the prescriber, can the supervising or attending physician’s ID be submitted as the Prescriber ID (411-DB)?

Response:
No. The Prescriber ID (411-DB) submitted must represent the practitioner who signed the prescription and correlate to the below additional prescriber data elements, when submitted.

- Prescriber Last Name (427-DR)
- Prescriber First Name (364-2J)
- Prescriber Phone Number (498-PM)
- Prescriber Street Address (365-2K)
- Prescriber City Address (366-2M)
- Prescriber State/Province Address (367-2N)
- Prescriber Zip/Postal Code (368-2P)
As a result of a POS denial for prescriber enrollment, a new prescription may be required from a covered prescriber. This would also apply to other prescriber types where a supervising physician or a Collaborative Practice Agreement applies per state law. The Prescriber ID (411-DB) would be represented as defined below.

- The practitioner with prescriptive authority per state regulations not requiring a supervising physician is prescribing and signing the prescription for the medication/service for which they are authorized.
  - Prescriber ID (411-DB) – contains the practitioner with prescriptive authority who is prescribing and signing the prescription for the medication/service
- The resident where state law may require a supervising physician is prescribing and signing the prescription for the medication/service for which they are authorized.
  - Prescriber ID (411-DB) – contains the resident who is prescribing and signing the prescription for the medication/service
- The nurse practitioner/physician assistant is prescribing and signing the prescription for the medication/service for which they are authorized.
  - Prescriber ID (411-DB) – contains the nurse practitioner/physician assistant who is prescribing and signing the prescription for the medication/service
- The physician and nurse practitioner/physician assistant have a Collaborative Practice Agreement. The nurse practitioner/physician assistant is prescribing and signing the prescription for the medication/service for which they are authorized. A physician is supervising the nurse practitioner/physician assistant (direct or indirect).
  - Prescriber ID (411-DB) – contains the nurse practitioner/physician assistant who is prescribing and signing the prescription for the medication/service
- The pharmacist is allowed to prescribe without a Collaborative Practice Agreement. The pharmacist is prescribing and signing the prescription for the medication/service for which they are authorized.
  - Prescriber ID (411-DB) – contains the pharmacist who is prescribing and signing the prescription for the medication/service
- The physician and pharmacist have a Collaborative Practice Agreement. The pharmacist is prescribing and signing the prescription for a medication/service for which they are authorized.
  - Prescriber ID (411-DB) – contains the pharmacist who is prescribing and signing the prescription for the medication/service
- When a pharmacist administers the medication/service which requires a prescription/prescription order/protocol per state law (such as vaccines)
  - Whoever signed the prescription/prescription order/protocol for the medication/service would be identified in Prescriber ID (411-DB). See 1-6 above.
  - Provider ID (444-E9) - could contain the pharmacist who is administering a vaccine/service.

**Question:**
Can further distinction be applied to reject code 56: Non-Matched Prescriber ID, to allow the pharmacy to identify what the payer/processor is attempting to match the submitted ID to?

**Response:**
To address the current ambiguity associated with reject code 56, the following new reject code and description will be available as of the October 2016 annual ECL implementation.
Reject code 56 should be used when there is not a more distinct reject code available to describe the un-matched situation and the submitted ID meets the applicable formatting/check digit for the submitted Prescriber ID qualifier (466-EZ), however the ID submitted is not found within the processor’s prescriber data file. When reject code 56 is returned, the processor should reference within the Additional Message field (526-FQ) the specific non-matched condition. For example, until the new reject code is available, the following message would be placed in the Additional Message field (526-FQ):

- Prescriber NPI submitted not found within processor’s NPI file

Reject Code 56 should not be used when the submitted ID is found however additional prescriber validation rules are not able to locate associated prescriber IDs. For example, the submitted NPI is found however the processor is not able to locate the prescriber’s DEA number. In this situation, the processor should return the applicable prescriber DEA reject code (44-46).

Question:
There are various provider exclusion files maintained by government entities, such as OIG excluded providers, Medicaid exclusions, CMS preclusions, etc. Can Reject Code A1 be used regardless of which exclusion file contains the submitted Provider/Prescriber ID?

Response:
In the situation where the prescriber is found to be excluded regardless of the file source, it is recommended to return reject code A1 (ID Submitted Is Associated With An Excluded Prescriber).

For Medicare Part D prescription claims, the following files maintained by government entities, should be validated for provider exclusion status.

- OIG List of Excluded Individuals and Entities (LEIE)
- GSA (General Service Administration)/ SAM (System for Award Management)
- CMS Precluded Provider
- Medicaid State Exclusion File (for MMP’s)

In the event of discrepancies across these files, if a provider is listed on any of the files as an active exclusion, treat the provider as excluded.

The specific file in which the exclusion was determined should be referenced in the Additional Message Information (526-FQ) field. It is important for this field to be populated as it will provide additional clarifying information to the pharmacy regarding the source of the reject. To ensure consistency in the identification of these file sources, the following terms should be used.

- “OIG”: OIG List of Excluded Individuals and Entities (LEIE)
- “GSA/SAM”: GSA (General Service Administration)/ SAM (System for Award Management)
- “CMS Precluded Provider” : CMS Precluded Provider (until otherwise specified by CMS)
- “State Medicaid”: Medicaid State Exclusion File (for MMP’s)

Example messages:
“Prescriber Found on the OIG File”
“Prescriber Found on the GSA/SAM File”
“Prescriber Found on the CMS Precluded Provider File”
“Prescriber Found on the State Medicaid File”
**Question:**
What reject code should be used for an N transaction submitted to the Part D Plan where the 'SOFTWARE VENDOR' field (110-AK) is not TROOP or TROOPBATCH?

**Response:**
Because the N transaction is not limited to sole use by the Transaction Facilitator and other entities such as 340B may submit an N transaction to the Part D plan, if the plan does not accept N transactions from a source other than the Transaction Facilitator, they should reject with 1X "Vendor Not Certified For Processor/Payer".

### 6.4.5 WHICH NCPDP ECL VALUES (REJECT CODE, SCC, APPROVED MESSAGE CODE) SHOULD BE USED FOR MEDICAID ORDERING REFERRING PROVIDER REQUIREMENTS

**Question:**
Which reject code should be used when Medicaid Ordering Referring Provider requirements have not been met?

**Response:**
As of 1/1/18 with the creation of two new reject codes specific to this scenario, NCPDP recommends the use of the following reject codes:

- **889 (Prescriber Not Enrolled in State Medicaid Program)** when the Prescriber ID (411-DB) submitted is not enrolled in a State Medicaid program
- **890 (Pharmacy Not Enrolled in State Medicaid Program)** when the Service Provider ID (201-B1) submitted is not enrolled in a State Medicaid program

Note: Prior to 1/1/18, the recommendation was to use reject code 71 (Prescriber ID is Not Covered).

<table>
<thead>
<tr>
<th>Reject Code</th>
<th>Submission Clarification Code</th>
<th>Approved Message Code</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>889</td>
<td>55 - Prescriber Enrollment in State Medicaid Program has been validated. Value Limitation: Used when overriding rejection for Prescriber Not Enrolled in State Medicaid Program.</td>
<td>045 - Prescriber active enrollment with Medicaid Fee For Service/MCO required. Flagged for retrospective review. Value Limitation: Value returned only if Submission Clarification Code 55 (Prescriber Enrollment in State Medicaid Program has been validated) was accepted.</td>
<td>8R – Submission Clarification Code Value Not Supported (This reject code would be returned if the payer does not support point of service overrides for this business case.)</td>
</tr>
<tr>
<td>890</td>
<td>56 - Pharmacy Enrollment in State Medicaid Program has been validated. Value Limitation: Used when overriding rejection for Pharmacy Not Enrolled in State Medicaid Program.</td>
<td>046 - Pharmacy active enrollment with Medicaid Fee For Service/MCO required. Flagged for retrospective review. Value Limitation: Value returned only if Submission Clarification Code 56 (Pharmacy Enrollment in State Medicaid Program has been validated) was accepted.</td>
<td>8R – Submission Clarification Code Value Not Supported (This reject code would be returned if the payer does not support point of service overrides for this business case.)</td>
</tr>
</tbody>
</table>

Refer to Appendix F in this document for reject code descriptions and use for Medicare Part D.

*Added 12/2016 – BP*

*Updated 5/2019 – Definition of a Valid Prescriber TG*
6.4.6 RPh Prescriptive Authority Validation

Question:
Which NCPDP Reject Codes, Submission Clarification Codes and Approved Message Codes should be used when a conflict in prescriptive authority validation occurs? For example, RPh prescriptive authority for oral contraceptives may have a patient age restriction associated to it.

Response:
Reject Code:
As of the ECL Emergency Implementation Date of July 1, 2017, in the situation where prescriptive authority criteria have not been met, it is recommended to return reject code 876 - Prescriptive Authority Restrictions Apply, Criteria Not Met. Additionally, the specific criteria which is not met should be referenced in the Additional Message Information field (526-FQ). For example, “Rx Auth criteria not met for patient age” or “Prescriber can only prescribe X QTY per state reg”. This reject code replaces previous guidance to use reject code 71 (Prescriber ID Not Covered) for these business cases.

Submission Clarification Code (SCC):
If the pharmacy is able to validate prescriptive authority criteria has been met and the plan supports an override, Submission Clarification Code 42 (Prescriber ID Submitted is valid and prescribing requirements have been validated), may be submitted.

Approved Message Code (AMC):
As of the ECL Emergency Implementation Date of July 1, 2017, a plan should return 44 (Plan’s Prescriber data base determined prescriptive authority criteria not met, flagged for retrospective review) when SCC 42 is accepted for reject code 876. This approved message code allows the pharmacy to identify claims at audit risk. This e-new approved message code replaces previous guidance to use AMC 32 (Plan’s Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted, flagged for retrospective review).

6.4.7 Service Provider ID

Question:
Should a Medicare Part D plan reject if the submitted Service Provider ID (pharmacy) is on the Precluded Provider List?

Response:
The below information is based on information outlined within the 2020 CMS rule, CMS FAQs and the availability of NCPDP reject codes:
- If the claim is processed under the Part C benefit (Part A/B), the claim must reject.
  - Reject Code 930 - ID Submitted Is Associated To A Precluded Pharmacy, should be returned.
- If the claim is processed under the Part D benefit, the claim will not reject based on the pharmacy’s precluded provider status. However, the plan may choose to remove the pharmacy from its network.
  - Reject code 40 - Pharmacy Not Contracted With Plan/Processor On Date Of Service’ or other applicable pharmacy network specific reject code, should be returned.

6.5 Syntax Error

Question:
What constitutes a syntax error?

Response:
Syntax errors encompass all errors that are associated with the parsing of the transmission. The purpose of a syntax error in the standard is to call out an error in the structure of the transmission as opposed to an error in the data associated with the transmission. Best practice for handling a syntax error is to recognize that it applies only to structural errors within a transmission and must be accompanied if possible by the location (e.g. byte count, the last parsable field) within the transmission at which the syntax error was encountered. Syntax error does not apply to the data content of a properly parsable field. In this case an M/I or more specific reject code should be returned.

6.6 NOT USED DATA ELEMENT

Question:
For a Telecommunication transaction, if a data element is defined as "NOT USED" in the implementation guide and on the "Request" transaction a "NOT USED" data element is present; then RECEIVER of the transaction is required to reject the transaction?

Response:
Yes. See also the ECL - section APPENDIX A - REJECT CODES For 511-FB.

6.7 VACCINE ADMINISTRATION

See section “Vaccine Administration”.

6.8 ICD-9 VERSUS ICD-10 INFORMATION

Clarification on when the ICD-9 is appropriate and when the ICD-10 is appropriate based on HIPAA regulations for transactions and code sets is available at http://www.cms.gov/Medicare/Coding/ICD10/index.html

For information on ICD-9 and ICD-10 implementation, see FAQs on CMS website at https://questions.cms.gov/

Click on FAQs link at the top of the page. Use the “Browse by Group” and choose “Coding” “ICD-10”. (As of version 24 of this document, FAQs 7579, 8246, 8248, 8252 were of interest for timing.)

6.9 ICD-10 SUBMISSION

ICD-10 codes should not be transmitted with a decimal. It is only appropriate to reject the claim if the decimal is included.

The guidance from the External Code List is below:

“From the code set maintainer: The ICD codes do have a decimal; however, for transaction/submission of the codes the decimal is not included in the code.

The reporting of the decimal between the third and fourth characters is unnecessary because it is implied. (Field is alphanumeric; count from left to right for the third and fourth characters.)

Preciseness is designated with the number of digits to the right of the implied decimal point.

Example:

O26851 Spotting complicating pregnancy, first trimester
O26852 Spotting complicating pregnancy, second trimester
O26853 Spotting complicating pregnancy, third trimester
O26859 Spotting complicating pregnancy, unspecified trimester

The above may be displayed with a decimal point (e.g. O26.851) but are transmitted without the decimal point.”

6.10 NUMBER OF DIAGNOSIS CODE FIELDS

Question:
How should the Telecommunication Diagnosis Code fields be used when the standard allows a count of 5 and currently does not specify whether the associated values are at the medication or patient level and the SCRIPT standard supports a Primary and Secondary diagnosis code at the medication level?

Response:
The primary and secondary diagnosis codes as provided in the eRX should be the first 2 diagnosis codes submitted. Any additional diagnosis codes would then follow, up to a maximum of 5.

6.11 Minimum and Maximum Field Length

Question: In order to be compliant with the Standard, do I have to be able to send and receive the minimum and maximum field length?

Response: When receiving a message, the maximum length of each field must be supported. When sending a message, the maximum length of each field is not required to be sent except when the data element being sent is required to mirror the data received. Intermediaries are required to support sending and receiving the maximum length of each field. The length of each field is defined in the NCPDP Data Dictionary and additional guidance may be found in the schema, implementation guide or External Code List (ECL). The best practice is to support sending and receiving the minimum and maximum field lengths.

6.12 Unique Device Identifier Conversion

Question: How do I convert a Unique Device Identifier – Device Identifier Portion (UDI-DI) to an NCPDP 11-Digit UPC?

Response: Please see NCPDP’s Product Identifiers Standard Section 7: Frequently Asked Questions - 7.5

6.13 Drug Recalls

Partial Lot Recall – DUR Reason for Service Code (439-E4)
Manufacturers specifically recall a lot/lot number. Within the processor system, the product (NDC) will be flagged as being recalled. A specific DUR Reason for Service code was created to notify pharmacies when the drug/product being dispensed is part of a partial lot recall and there is additional information provided in the Response DUR/PPS Segment to communicate the potential safety concern associated with the product.

- (439-E4) Reason for Service: ‘DP’ – “Partial Lot Drug Recall Warning” (Used for Informational DUR Only - No response is required)

Information on the recall, including affected lot numbers if available, is returned in the DUR text message field(s).

All Lot Recall - Reject Code (511-FB)
In the case where all lots of the NDC have been recalled, the processor will return a unique rejection code to return to the pharmacy to indicate the product has been recalled.

- (511-FB) Reject Code: ‘944’ – All Lots of Drug/Product Recalled
Information on the recall, if available, is returned in the 526-FQ Additional Message Information field.

Added November 2018

6.14 CLAIM ADJUDICATION PROCESS FOR OPIOID UTILIZATION RULES

Question:
Section 1004 of H.R.6, commonly referred to as the “SUPPORT for Patients and Communities Act”, requires states to implement the following:

Safety edits (as specified by the State) for subsequent fills for opioids and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the State plan (or under a waiver of the State plan) is prescribed a subsequent fill of opioids in excess of any limitation that may be identified by the State.

Safety edits (as specified by the State) on the maximum daily morphine equivalent that can be prescribed to an individual enrolled under the State plan (or under a waiver of the State plan) for treatment of chronic pain and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the plan (or waiver) is prescribed the morphine equivalent for such treatment in excess of any limitation that may be identified by the State; and

A claims review automated process (as designed and implemented by the State) that monitors when an individual enrolled under the State plan (or under a waiver of the State plan) is concurrently prescribed opioids and – benzodiazepines; or antipsychotics.

Is there any NCPDP guidance on the claim adjudication process for opioid utilization rules, such as the ones mandated of Medicaid programs under the SUPPORT Act?

Response:
The Opioid Utilization Scenarios Matrix (Section 7.6 of this document) outlines recommendations for various point of sale scenarios where an opioid limitation has been exceeded. The following sections may be of interest for Medicaid programs looking to implement the safety edits required under the SUPPORT Act:

7.6.2 MME HARD STOP; POS OVERRIDE NOT ALLOWED; PRESCRIBER TO CALL PLAN (POTENTIALLY >200)

7.6.3 MME PRESCRIBER CARE COORDINATION REQUIRED (90-200, OR >90)

7.6.4 DUPLICATIVE THERAPY SOFT EDIT - LONG ACTING OPIOIDS

7.6.5 SOFT STOP FOR CONCURRENT USE OF CONFLICTING DRUG CATEGORIES (E.G.; OPIOIDS & BENZODIAZEPINES, OPIOIDS & BUPRENOHRPHINE, OPIOIDS & ANTIPSYCHOTICS)

Additionally, it should be noted that CMS released a memo on August 5, 2019, providing guidance for state Medicaid programs on the implementation of the required Drug Utilization Review (DUR) provisions included in the SUPPORT Act. Plans should also refer to this bulletin for additional information regarding the required safety edits, including comments on interpretation.


Added November 2019
7 GUIDANCE FOR OPIOID LIMITS

7.1 OVERVIEW
This guidance was developed as a result of published requirements under the Medicare Part D program and state legislation and regulation. It provides a foundational structure for communicating opioid limitations through the claim billing transaction that could be applied to any payer with similar opioid patient safety initiatives. This guidance provides recommendations on the use of the applicable NCPDP Telecommunication data elements and code values for defined scenarios to achieve the expected results.

The guidance below is divided into several parts:

- Background Information
- Available NCPDP fields and External Code List (ECL) values that can be used to communicate claim rejections and overrides.
- A scenario matrix which outlines which NCPDP fields and ECL values are recommended for particular utilization scenarios.

7.2 BACKGROUND INFORMATION

7.2.1 MEDICARE PART D BACKGROUND
The Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter announces new strategies to further help Medicare Part D plan sponsors prevent and address opioid overuse.

Additional information can be found at:


Below is a summary of some key points in the 2019 opioid overutilization policies to which the NCPDP claims adjudication guidance would apply.

- Opioid naïve patients:
  - Limit initial opioid prescription fills for the treatment of acute pain to no more than a 7 days supply
  - As the plan may not know of exemptions prior to this initial fill, pharmacies may submit these exemptions on the claim or by contacting the plan’s help desk

- Opioid Cumulative MME & Care Coordination
  - Plan sponsors should implement an opioid care coordination edit at 90 MME per day as a formulary-level safety edit based on the beneficiary’s cumulative MME per day across their opioid prescriptions
  - Pharmacists should consult with the prescriber, document the discussion, and if prescriber intent is confirmed, use the appropriate overrides to relay that information to the plan
Additionally, plans have the option to invoke an edit at 200 MME or above that may only be overridden with a Prior Authorization unless the exemptions outlined in the 2019 guidance apply.

### 7.2.2 State and Plan Background

There is a variety of limits applied by states or plans to the dispensing of immediate and extended release opioid prescriptions, including but not limited to days supply, quantity, and dosing at the current or cumulative fill levels that may be based on condition, patient age or treatment history. Due to these variables, there are multiple fields that could be used to communicate the conflict within the claim response or exception criteria within the claim request. The following guidance outlines the communication detail which should be used to ensure standardization and expected outcomes using existing External Code List values.

### 7.2.3 Medicaid and CHIP Background

In August 2019, The Center for Medicaid and CHIP Services published the State Guidance for Implementation of Medication Drug Utilization Review (DUR) provisions included in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act. (SUPPORT Act). In part, the guidance addressed required implementation of the provisions in the Support Act regarding claim reviews at the point of sale (POS).

Additional information can be found at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib080519-1004.pdf

Refer to the Opioid Utilization Scenarios chart in Section 7.6 below, for a comprehensive view of specific opioid limits and scenarios.

### 7.3 Specific NCPDP Claim Response Fields and Values Used for Opioid Utilization Edits Guidance

#### 7.3.1 Reject Codes (511-FB)

The reject code (511-FB) returned should communicate the conflict with as much specificity as possible.

<table>
<thead>
<tr>
<th>ECL Effective Date</th>
<th>S11-FB</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now</td>
<td>76</td>
<td>Plan Limitations Exceeded</td>
</tr>
<tr>
<td>Now</td>
<td>7X</td>
<td>Days Supply Exceeds Plan Limitations</td>
</tr>
<tr>
<td>Now</td>
<td>AG</td>
<td>Days Supply Exceeded for Product/Service</td>
</tr>
<tr>
<td>20190101</td>
<td>927</td>
<td>Days Supply Limits Exceeded For Product/Service for Patient Age</td>
</tr>
<tr>
<td>Now</td>
<td>9G</td>
<td>Quantity Dispensed Exceeds Maximum Allowed</td>
</tr>
<tr>
<td>Now</td>
<td>75</td>
<td>Prior Authorization Required (may be used when drug formulary status is set as prior authorization required)</td>
</tr>
<tr>
<td>20190101</td>
<td>922</td>
<td>Morphine Milligram Equivalent (MME) Exceeds Limits*</td>
</tr>
<tr>
<td>20190101</td>
<td>923</td>
<td>Morphine Milligram Equivalent (MME) Exceeds Limits for Patient Age*</td>
</tr>
<tr>
<td>ECL Effective Date</td>
<td>S11-FB</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------</td>
<td>-------------</td>
</tr>
<tr>
<td>20190101</td>
<td>925</td>
<td>Initial Fill Days Supply Exceeds Limits</td>
</tr>
<tr>
<td>20190101</td>
<td>926</td>
<td>Initial Fill Days Supply Exceeds Limits for Patient Age</td>
</tr>
<tr>
<td>20190101</td>
<td>928</td>
<td>Cumulative Fills exceed limits</td>
</tr>
<tr>
<td>Now</td>
<td>G4</td>
<td>Prescriber must contact plan</td>
</tr>
<tr>
<td>Now</td>
<td>88</td>
<td>DUR Reject Error</td>
</tr>
<tr>
<td>Now</td>
<td>80</td>
<td>Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria</td>
</tr>
<tr>
<td>Now</td>
<td>9C</td>
<td>Professional Service Code Value Not Supported</td>
</tr>
<tr>
<td>Now</td>
<td>9D</td>
<td>Result of Service Code Value Not Supported</td>
</tr>
<tr>
<td>Now</td>
<td>569</td>
<td>Provide Notice: Medicare Prescription Drug Coverage and Your Rights</td>
</tr>
<tr>
<td>20190101</td>
<td>943</td>
<td>DUR may not be overridden at Point of Sale, prescriber to initiate coverage determination.</td>
</tr>
<tr>
<td>Now</td>
<td>828</td>
<td>Plan/Beneficiary Case Management Restriction In Place</td>
</tr>
<tr>
<td>Now</td>
<td>M2</td>
<td>Recipient Locked In (Will be sunset 10-15-2020)</td>
</tr>
<tr>
<td>20201015</td>
<td>979</td>
<td>Patient Locked Into Specific Prescriber(s)</td>
</tr>
<tr>
<td>20201015</td>
<td>980</td>
<td>Patient Locked Into Specific Pharmacy(s)</td>
</tr>
</tbody>
</table>

### 7.3.1.1 SPECIFIC REJECT CODE DISCUSSION
Rejects 922 & 923 may be used for either single-claim or cumulative claim MME limits for opioids. Reject code 924 (Cumulative dose exceeded across multiple prescriptions) should only be used for non-opioid cumulative dosing limits.

Reject code 88 may be used to alert the pharmacy that the reject requires pharmacist intervention and a drug utilization review:
- If the 88 has been returned for a hard stop edit where POS overrides are not allowed, the processor should
  - Return reject code G4 “Prescriber must contact Plan” to indicate the prescriber can initiate a request for an override.

Reject Code 943 may be used to indicate that the DUR information is for informational purposes only, and may not be overridden at POS. This code is not intended to be used for CMS Medicare Part D. Alternatively, the most specific hard stop reject can be returned with the appropriate opioid reject code, in which case the rejection will be identified at the pharmacy as a hard reject.
- When Reject Code 75 (Prior Authorization Required) is returned, Reject Code 88 (DUR Reject Error) would only be returned when alerting to a different DUR exception.
7.3.2 Reason for Service Code (439-E4)

The Reason for Service Code(s) is determined by the payer/processor based on the specific utilization threshold edits that apply to the claim. The value(s) returned on the claim response would then be submitted as the Reason for Service Code(s) on a claim resubmission that is intended to respond to the DUR conflict(s).

<table>
<thead>
<tr>
<th>ECL Effective Date</th>
<th>439-E4</th>
<th>Description</th>
<th>Recommended Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now</td>
<td>HD</td>
<td>High Dose</td>
<td>Single Claim MME Limit</td>
</tr>
<tr>
<td>20190101</td>
<td>HC</td>
<td>High Cumulative Dose</td>
<td>Cumulative Claim MME Limit</td>
</tr>
<tr>
<td>Now</td>
<td>MX</td>
<td>Excessive Duration</td>
<td>Day Supply Limit, or Cumulative Fill Limit</td>
</tr>
<tr>
<td>Now</td>
<td>EX</td>
<td>Excessive Quantity</td>
<td>Quantity Limit</td>
</tr>
<tr>
<td>Now</td>
<td>ER</td>
<td>Overuse</td>
<td>Days Supply Limit, Cumulative Fill Limit, MME Limit</td>
</tr>
<tr>
<td>Now</td>
<td>DD</td>
<td>Drug-Drug Interaction</td>
<td>Concurrent use between an opioid and a benzodiazepine or buprenorphine.</td>
</tr>
<tr>
<td>Now</td>
<td>TD</td>
<td>Therapeutic</td>
<td>Duplicative Therapy Soft Edit – Long Acting Opioids</td>
</tr>
</tbody>
</table>

Effective 01/01/2019, if MME or other opioid limits are the result of the member filling prescriptions from multiple pharmacies (poly pharmacy) and/or obtaining prescriptions from multiple prescribers (poly-prescriber), then the Other Pharmacy Indicator (529-FT) and/or Other Prescriber Indicator (533-FX) may be returned with the appropriate value(s) in the Response DUR Segment with the primary DUR Reason for Service Code. The additional DUR Reason for Service code(s) may be returned below, which allows for additional messaging capabilities to the pharmacy through the DUR Free Text (544-FY) or DUR Additional Message fields (570-NS):

<table>
<thead>
<tr>
<th>ECL Effective Date</th>
<th>439-E4</th>
<th>Description</th>
<th>Recommended Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>20190101</td>
<td>MP</td>
<td>Poly-Pharmacy Detected</td>
<td>See above</td>
</tr>
<tr>
<td>20190101</td>
<td>MR</td>
<td>Poly-Prescriber Detected</td>
<td>See above</td>
</tr>
</tbody>
</table>

7.3.3 Other Pharmacy Indicator (529-FT), Other Prescriber Indicator (533-FX)

When the opioid utilization conflict is the result of the beneficiary filling prescriptions from multiple pharmacies (poly pharmacy) and/or obtaining prescriptions from multiple prescribers (poly-prescriber), Reason for Service Codes HC: High Cumulative Dose, MP: Poly Pharmacy Detected and/or MR: Poly Prescriber Detected may be returned.

To alert the pharmacist and prescriber that clinical research and evaluation outside their system may be necessary, the applicable Other Pharmacy Indicator and/or Other Prescriber Indicator should also be returned on the claim response.

Other Pharmacy Indicator (529-FT)

<table>
<thead>
<tr>
<th>ECL Effective Date</th>
<th>529-FT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now</td>
<td>1</td>
<td>Your Pharmacy</td>
</tr>
</tbody>
</table>
7.3.4 **APPROVED MESSAGE CODE (548-6F)**

Approved Message Codes are returned to indicate an override condition resulted in a Paid response. From a clinical drug utilization review perspective, this information is critical to the pharmacist during the prescription verification process.

In order to clearly communicate the point of service override was accepted for the opioid utilization conflict, new Approved Message Code (548-6F) External Code List values are needed.

In the situation where the override was the result of the medical necessity or coverage determination process between the prescriber and the plan, Approved Message Code 34 – Prior Authorization on File, should be returned. This will eliminate unnecessary clinical review steps between the pharmacist and the prescriber if the Paid response includes the original Reason for Service Code value. Without the Approved Message Code, the pharmacist does not have any visibility to the override process that occurred between the prescriber and the plan.

<table>
<thead>
<tr>
<th>ECL Effective Date</th>
<th>548-6F</th>
<th>Value Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing</td>
<td>34</td>
<td>Prior Authorization Approval On File</td>
</tr>
<tr>
<td>20191015</td>
<td>47</td>
<td>Result of Service Code Accepted</td>
</tr>
<tr>
<td>20191015</td>
<td>48</td>
<td>Diagnosis Code Accepted</td>
</tr>
</tbody>
</table>

7.3.5 **ADDITIONAL MESSAGE INFORMATION QUALIFIER (132-UH)**

The Additional Message Information Qualifier can be used to communicate specific information within the Additional Message Information field (526-FQ) such as next available fill date and maximum quantity allowed. Please refer to the External Code List for the most current available values and usage restrictions.

<table>
<thead>
<tr>
<th>ECL Effective Date</th>
<th>132-UH</th>
<th>Additional Message Information Qualifier Description</th>
<th>Transaction Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>20110101</td>
<td>01-09</td>
<td>Used for free form text with no pre-defined structure</td>
<td>R,P</td>
</tr>
<tr>
<td>20151015</td>
<td>10</td>
<td>Next Available Fill Date</td>
<td>R</td>
</tr>
<tr>
<td>20161015</td>
<td>11</td>
<td>Date Prior Authorization Ends</td>
<td>P</td>
</tr>
<tr>
<td>20161015</td>
<td>12</td>
<td>Maximum qty allowed over the designated time period</td>
<td>P</td>
</tr>
</tbody>
</table>
## 7.3.6 Additional Message Information (526-FQ)

When used with an Additional Message Information Qualifier (132-UH) value of 01-09, the Additional Message Information field is a free text field that can be used to communicate information specific to the rejection encountered, including the limitation that was exceeded and any instructions for requesting an override either at POS or through a PA process. Please refer to the table above for the

<table>
<thead>
<tr>
<th>ECL Effective Date</th>
<th>132-UH</th>
<th>Additional Message Information Qualifier Description</th>
<th>Transaction Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>20161015</td>
<td>13</td>
<td>Maximum days supply allowed over the designated time period. e.g.: 90 day supply allowed per year would be returned as &quot;90,365&quot;.</td>
<td>P</td>
</tr>
<tr>
<td>20181015</td>
<td>14</td>
<td>Maximum Age - Maximum age at which the product/service is covered and maximum age qualification. Maximum Age Qualifications: Y = Years, D = Days. Format = Age Value, Age Qualification e.g.: 18,Y (18 years); 180,D (180 days).</td>
<td>R</td>
</tr>
<tr>
<td>20181015</td>
<td>15</td>
<td>Maximum Quantity - Maximum amount allowed as the dispensed quantity (442-E7) for the specific fill.</td>
<td>R</td>
</tr>
<tr>
<td>20181015</td>
<td>16</td>
<td>Maximum Days Supply - Maximum amount allowed as the days supply quantity (405-D5) for the specific fill.</td>
<td>R</td>
</tr>
<tr>
<td>20181015</td>
<td>17</td>
<td>Maximum Fills - Maximum amount allowed as the number of fills covered under the specific benefit parameter. Payer's claim history may be leveraged to determine accumulated fills allowed.</td>
<td>R</td>
</tr>
<tr>
<td>20181015</td>
<td>18</td>
<td>Maximum Dollar Amount – Maximum dollar amount allowed under the specific benefit parameter.</td>
<td>R</td>
</tr>
<tr>
<td>20181015</td>
<td>19</td>
<td>Remaining Quantity - Remaining amount to a maximum quantity limit based on quantity amounts accumulated.</td>
<td>R,P</td>
</tr>
<tr>
<td>20181015</td>
<td>20</td>
<td>Remaining Days Supply - Remaining amount to a maximum days supply limit based on days supply accumulated. For example: days supply remaining on a transition fill.</td>
<td>R,P</td>
</tr>
<tr>
<td>20181015</td>
<td>21</td>
<td>Remaining Fills - Remaining amount to a maximum number of fill limitation based on the number of fills accumulated. Payer's claim history may be leveraged to determine accumulated fills allowed. For example: number of fills remaining before mandatory mail order applies.</td>
<td>R,P</td>
</tr>
<tr>
<td>20181015</td>
<td>22</td>
<td>Minimum Age - Minimum age at which the product/service is covered and minimum age qualification. Minimum age qualifications: Y = years, D = days. Format = Age Value, Age Qualification e.g.: 18,Y (18 years); 180,D (180 days).</td>
<td>R</td>
</tr>
<tr>
<td>20181015</td>
<td>23</td>
<td>Minimum Quantity - Minimum amount allowed as the dispensed quantity (442-E7) for the specific fill.</td>
<td>R</td>
</tr>
<tr>
<td>20181015</td>
<td>24</td>
<td>Minimum Day Supply - minimum amount allowed as the days supply quantity (405-D5) for the specific fill.</td>
<td>R</td>
</tr>
<tr>
<td>20181015</td>
<td>25</td>
<td>Minimum Dollar Amount - Minimum dollar amount allowed under the specific benefit parameter.</td>
<td>R</td>
</tr>
</tbody>
</table>
type of information and specific limitations and values that can be returned in this field when used with Additional Message Information Qualifier (132-UH) values greater than 09.

7.3.7 **HELP DESK TELEPHONE NUMBER (550-AF)**
If it is a hard stop rejection which requires a prior authorization to override the rejection, the phone number to request a PA may also be provided in the response to the pharmacy in the Help Desk Telephone Number (550-AF) field.

7.3.8 **DUR FREE TEXT MESSAGE (544-FY) & DUR ADDITIONAL TEXT (570-NS)**
The DUR Free Text Message (544-FY) & DUR Additional Text (570-NS) fields may be used to provide the pharmacy with information specific to the DUR rejection and reason for service encountered. If the rejection is a soft stop rejection that may be overridden by pharmacy-submitted DUR/PPS codes, then these message fields may be used to communicate the acceptable codes to override the rejection, when appropriate.

For additional information on how to most appropriately use the messaging field types, please refer to “Improving the Value of the Claim Response with Additional Messaging”.

7.4 **CLAIM BILLING REQUEST FIELDS AND VALUES USED TO SUPPORT OPIOID UTILIZATION EDIT OVERRIDES**

7.4.1 **DIAGNOSIS CODE (424-DO)**
Many states and plans allow for diagnosis-specific exceptions or exemptions from opioid restrictions. In the event that a state allows for these exceptions, the submitted diagnosis code should be used by payers and processors to allow for an override at point of service when the diagnosis code value submitted meets the exception criteria (e.g. Cancer, Chronic Pain).

7.4.2 **LONG TERM CARE EXEMPTIONS TO OPIOID POLICY – PATIENT RESIDENCE CODE (384-4X)**
If an exemption for an opioid restriction is allowed based solely upon the member residing in a Long Term Care facility, then the payer can identify these members based upon the submitted Patient Residence Code (384-4X). For further clarification, please refer to “HOW DO WE KNOW WE HAVE A LTPAC TRANSACTION?” in this document.

7.4.3 **DUR/PPS SEGMENT (111-AM)**
If the diagnosis code is not available to submit on the claim, or the diagnosis code does not align to the allowed exception criteria (e.g. Hospice, Palliative Care, the fields within the DUR/PPS segment of the claim request may be used to support a point of service override. These fields include:

- **DUR Reason for Service Code (439-E4):** This Reason for Service Code in the claim request shall match the Reason for Service Code that would be returned in the rejected response.
- **Professional Service Codes (440-E5)**
- **Result of Service Codes (441-E6)**

7.4.3.1 **DUR PROFESSIONAL SERVICE CODE (440-E5)**
The following Professional Service Codes identify the type of pharmacist intervention that occurred to address the clinical conflict presented by the payer/processor. Based upon allowed plan or regulatory guidance, the following actions may be taken, and the codes may be submitted to request an override at point of service following an appropriate drug utilization review process.
7.4.3.2 DUR RESULT OF SERVICE CODE (441-E5)

Based upon allowed plan or regulatory exceptions, the following codes may be submitted to request an override at point of service following an appropriate drug utilization review process. Specific Result of Service Codes accepted as exceptions to opioid utilization edits may be based on plan requirements.

<table>
<thead>
<tr>
<th>ECL Effective Date</th>
<th>441-E6</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now</td>
<td>1A</td>
<td>Dispensed As Is, False Positive</td>
</tr>
<tr>
<td>Now</td>
<td>1B</td>
<td>Dispensed Prescription As Is</td>
</tr>
<tr>
<td>Now</td>
<td>1G</td>
<td>Dispensed with Prescriber Approval</td>
</tr>
<tr>
<td>20190101</td>
<td>4B</td>
<td>Dispensed, Palliative Care</td>
</tr>
<tr>
<td>20190101</td>
<td>4C</td>
<td>Dispensed, Hospice</td>
</tr>
<tr>
<td>20190101</td>
<td>4D</td>
<td>Dispensed, Cancer Treatment</td>
</tr>
<tr>
<td>20190101</td>
<td>4E</td>
<td>Dispensed, Chronic Pain</td>
</tr>
<tr>
<td>20190101</td>
<td>4F</td>
<td>Dispensed, Exempt Per Prescriber</td>
</tr>
<tr>
<td>20190101</td>
<td>4G</td>
<td>Dispensed, Surgery/Trauma</td>
</tr>
<tr>
<td>20190101</td>
<td>4H</td>
<td>Dispensed, Hospital Admission/Discharge</td>
</tr>
<tr>
<td>20190101</td>
<td>4J</td>
<td>Dispensed, Patient Is Not Opioid Naive</td>
</tr>
<tr>
<td>20190101</td>
<td>4K</td>
<td>Prescriber Specialty Exemption-Oncology or non-hospice Palliative Care</td>
</tr>
<tr>
<td>20190101</td>
<td>4L</td>
<td>Prescriber Specialty Exemption-Hospice</td>
</tr>
</tbody>
</table>

7.5 CLAIM BILLING REQUEST FIELDS NOT RECOMMENDED FOR OPIOID UTILIZATION EDIT OVERRIDES

7.5.1 SUBMISSION CLARIFICATION CODE (420-DK)

While the submission clarification code (SCC) is used to override certain claim rejections, existing values and definitions do not support the pharmacy workflow and clinical objective necessary to ensure patient safety and access to care as it relates to these opioid safety edits.

7.5.2 PRIOR AUTHORIZATION NUMBER SUBMITTED (462-EV)

Some payers allow the Prior Authorization Number Submitted to override a reject at point of service. There is no standard NCPDP set of external code values for this field. Therefore, the codes being used in this field may vary from payer to payer. The use of the Prior Authorization Number Submitted field also does not support the pharmacy workflow and clinical objective necessary to ensure patient safety and access to care as it relates to these opioid safety edits.
7.6 Opioid Utilization Scenarios Matrix

The following table provides claim scenarios where an opioid point of service limitation has been exceeded. While the scenarios and point of service override codes provided below are in many instances specific to the limitations outlined in CMS guidance for Medicare Part D, these best practices should be used for other plan, state, or regulatory programs with similar requirements. Each section begins with a specific opioid limitation and the information that should be submitted in the claim request and response, followed by variations on that scenario where either no point of service exception criteria has been submitted on the claim request, a point of service override has been attempted on the claim request, or an approved coverage determination exists. Alternate workflows will occur when the clinician(s) determine the prescribed dose needs to be adjusted to align with plan criteria.

The below scenarios are associated to the following higher level categories:

A. Opioid Naive Days Supply Limitation
B. MME Hard Stop; POS Override Not Allowed; Prescriber to Call Plan (e.g., >=200)
C. MME Prescriber Care Coordination Required (e.g., 90-199.99, or >=90)
D. Duplicative Therapy Soft Edit – Long Acting Opioids
E. Soft Stop for Concurrent Use of Conflicting Drug Categories (e.g.; Opioids & Benzodiazepines, Opioids & Buprenorphine, Opioids & Antipsychotics)
F. Member Opioid/Benzodiazepine Lock-In

Additional References:
• Only the code values are shown in the matrix below. Code value descriptions are referenced above.
• Code values listed without commas indicate all values would be used for the condition
• Code values listed with commas (,) indicate any one or combination of the values listed could be used, based on the plan’s coverage rules
• Reject Code 569 is specific to the Medicare Part D program
• Opioid Naive scenarios are specific to Medicare Part D, however the same processes and codes can be utilized for state or plan imposed days supply limits for initial prescriptions for acute pain. For state and plan days supply limits, other DUR Results of Service Codes (listed above), diagnosis codes, or other overrides may be appropriate for use.
• Per Payer Discretion indicates that claim may be returned as either paid or rejected with the most specific codes available based on specific payer policies.

Important Medicare Part D Guidance
• It is critical to recognize that CMS has specified certain exemptions for Medicare Part D (e.g. cancer, palliative care). In the scenarios shown below, if a CMS specified exemption is submitted on a claim, the exemption must override any rejects or edits related to exceeding an MME threshold.
• In the case of the MME edit limitations, using the ‘G4’ reject code combined with the “S69” reject code should indicate that the prescriber or the beneficiary must contact the plan. The absence of the G4 reject code indicates that Pharmacist Care Coordination is allowed.
• Per Payer Processor Discretion, claims submitted with a Hospice DUR/PPS code or with a Prescriber specialty exemption of hospice will most likely be rejected for a coverage determination for Part A/Hospice versus Part D.
## 7.6.1 OPIOID NAÏVE DAY SUPPLY LIMITATION

<table>
<thead>
<tr>
<th>No</th>
<th>Opioid Utilization Scenario</th>
<th>Claim Request</th>
<th>Claim Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reason for Service Code (Professional Service Code, Result of Service Code, Diagnosis Code (ICD10))</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transaction Response Status</td>
<td>Approved Message Code</td>
</tr>
<tr>
<td>A1</td>
<td>The claim exceeds the Opioid Naïve days supply with no exemption criteria submitted on the claim.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>A2</td>
<td>The RPh reviews the patient’s medication history or consults another source and determines that the patient is not opioid naïve.</td>
<td>MX or MR or R0</td>
<td>N/A</td>
</tr>
<tr>
<td>A3</td>
<td>The RPh consults with the prescriber and determines that the patient is not opioid naïve.</td>
<td>MX or MR or R0</td>
<td>N/A</td>
</tr>
<tr>
<td>A4</td>
<td>The RPh consults with the prescriber or other source and confirms the patient is under hospice care.</td>
<td>MX or MR or R0</td>
<td>N/A</td>
</tr>
<tr>
<td>A5</td>
<td>The RPh consults with the prescriber or other source and confirms the patient is under palliative care.</td>
<td>MX or MR or R0</td>
<td>N/A</td>
</tr>
<tr>
<td>A6</td>
<td>The RPh consults the prescriber, performs a medication review, or consults another source and confirms the patient has cancer.</td>
<td>MX or MR or R0</td>
<td>N/A</td>
</tr>
<tr>
<td>A7</td>
<td>The RPh consults the prescriber, performs a medication review, or consults another source and determines that the drug is prescribed for chronic pain.</td>
<td>MX or MR or R0</td>
<td>N/A</td>
</tr>
<tr>
<td>----</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>A8</td>
<td>Submitted Result of Service code does not meet exception criteria.</td>
<td>MX</td>
<td>M0 or MR or R0</td>
</tr>
<tr>
<td>A9</td>
<td>Submitted diagnosis code meets coverage criteria.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>A10</td>
<td>Submitted diagnosis code does not meet coverage criteria.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>A11</td>
<td>Submitted diagnosis code may meet coverage criteria, but field 424-D0 is not used by plan.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>A12</td>
<td>Prescriber initiates Coverage Determination Request, which is approved.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Some payers may choose to return a DUR Reason for Service Code(s) on a paid claim where the DUR alert has been overridden by DUR/PPS codes.
<table>
<thead>
<tr>
<th>No</th>
<th>Opioid Utilization Scenario</th>
<th>Claim Request</th>
<th>Claim Response</th>
<th>(Per Payer/Processor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1</td>
<td>The claim exceeds the morphine equivalent dosing limitation with no exemption criteria submitted on the claim. If no known exemptions, the prescriber must contact the plan for a PA.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>B2</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for palliative care.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0 or R0</td>
<td>4B</td>
</tr>
<tr>
<td>B3</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for cancer.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0 or R0 or MR</td>
<td>4D</td>
</tr>
<tr>
<td>B4</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of cancer or non-hospice palliative care.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0 or R0</td>
<td>4K</td>
</tr>
<tr>
<td>B5</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of hospice.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0 or R0</td>
<td>4L</td>
</tr>
<tr>
<td>B6</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber approval.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0</td>
<td>1G</td>
</tr>
</tbody>
</table>
### Claim Request

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B7</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed per the pharmacist's review.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0 or R0</td>
<td>1A or 1B</td>
<td>N/A</td>
<td>R(eject)</td>
<td>N/A</td>
<td>88 G4 943** 569 9D 922</td>
<td>HD or HC +/- MP +/- MR</td>
<td>&lt;Blank&gt; = Fill Level 1,2,3 = Cumulative Level</td>
</tr>
<tr>
<td>B8</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for hospice care.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0 or R0</td>
<td>4C</td>
<td>N/A</td>
<td>Per Payer/Processor Discretion</td>
<td>Per Payer/Processor Discretion</td>
<td>Per Payer/Processor Discretion</td>
<td>Per Payer/Processor Discretion</td>
<td>Per Payer/Processor Discretion</td>
</tr>
<tr>
<td>B9</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for cancer, sickle cell, or any other disease state identified as exempt by state and/or federal law.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>ICD-10 code(s) for accepted conditions</td>
<td>P(aid)</td>
<td>48</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>B10</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for a non-exempt diagnosis.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>ICD-10 code(s) &lt;&gt; accepted conditions</td>
<td>R(eject)</td>
<td>N/A</td>
<td>88 G4 943** 569 80 922</td>
<td>HD or HC +/- MP +/- MR</td>
<td>&lt;Blank&gt; = Fill Level 1,2,3 = Cumulative Level</td>
</tr>
<tr>
<td>B11</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for an exempt indication, but the plan does not use diagnosis codes.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Any ICD-10</td>
<td>R(eject)</td>
<td>N/A</td>
<td>88 G4 943** 569 521 922</td>
<td>HD or HC +/- MP +/- MR</td>
<td>&lt;Blank&gt; = Fill Level 1,2,3 = Cumulative Level</td>
</tr>
</tbody>
</table>

### Claim Response

<table>
<thead>
<tr>
<th></th>
<th>112-AN</th>
<th>548-6F</th>
<th>511-FB</th>
<th>439-E4</th>
<th>529-FT</th>
<th>533-FX</th>
<th>(Per Payer/Processor)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>B12</td>
<td>The claim is submitted with an approved coverage determination on file.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>P(aid)</td>
<td>34</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Some payers may choose to return a DUR Reason for Service Code(s) on a paid claim where the DUR alert has been overridden by DUR/PPS codes.

**Effective October 15, 2019, Reject Code 943 (DUR may not be overridden at Point of Sale, prescriber to initiate coverage determination) replaces the combination of reject codes 88 (DUR Reject Code) and G4 (Prescriber must contact plan).
### Telecommunication Version D and Above Questions, Answers and Editorial Updates

#### 7.6.3 MME Prescriber Care Coordination Required (90-200, or >90)

<table>
<thead>
<tr>
<th>Claim Request</th>
<th>Claim Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>439-E4</td>
<td>112-AN</td>
</tr>
<tr>
<td>440-ES</td>
<td>548-6F</td>
</tr>
<tr>
<td>441-ES</td>
<td>511-FB</td>
</tr>
<tr>
<td>424-DO</td>
<td>439-E4</td>
</tr>
<tr>
<td></td>
<td>529-FT</td>
</tr>
<tr>
<td></td>
<td>533-FX</td>
</tr>
<tr>
<td></td>
<td>(Per Payer/ Processor)</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>The claim exceeds the morphine equivalent dosing limitation with no exemption criteria submitted on the claim. Barring any exemptions, the pharmacy must coordinate care with the prescriber.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>R(eject)</td>
<td>N/A</td>
<td>88 569 922</td>
<td>HD or HC +/- MP +/- MR</td>
<td>&lt;Blank&gt; = Fill Level 1,2,3 = Cumulative Level</td>
<td>&lt;Blank&gt; = Fill Level 1,2 = Cumulative Level</td>
<td>IF NO KNOWN EXEMPTIONS, PRESCRIBER CARE COORDINATION REQD</td>
</tr>
<tr>
<td>C2</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for palliative care.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0 or R0</td>
<td>4B</td>
<td>N/A</td>
<td>P(aid)</td>
<td>47</td>
<td>N/A</td>
<td>HD or HC +/- MP +/- MR</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>C3</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for cancer.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0 or R0 or MR</td>
<td>4D</td>
<td>N/A</td>
<td>P(aid)</td>
<td>47</td>
<td>N/A</td>
<td>HD or HC +/- MP +/- MR</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>C4</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of cancer or non-hospice palliative care.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0 or R0</td>
<td>4K</td>
<td>N/A</td>
<td>P(aid)</td>
<td>47</td>
<td>N/A</td>
<td>HD or HC +/- MP +/- MR</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>C5</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of hospice.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0 or R0</td>
<td>4L</td>
<td>N/A</td>
<td>Per Payer/ Processor Discretion</td>
<td>Per Payer/ Processor Discretion</td>
<td>Per Payer/ Processor Discretion</td>
<td>Per Payer/ Processor Discretion</td>
<td>Per Payer/ Processor Discretion</td>
<td>Per Payer/ Processor Discretion</td>
<td></td>
</tr>
<tr>
<td>C6</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber approval.</td>
<td>HD or HC</td>
<td>M0</td>
<td>1G</td>
<td>N/A</td>
<td>P(aid)</td>
<td>47</td>
<td>N/A</td>
<td>HD or HC</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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Published November 2019

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<table>
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</tr>
</thead>
<tbody>
<tr>
<td>C7</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed per the pharmacist’s review.</td>
<td>+/- MP +/- MR</td>
<td>HD or HC M0 or R0 1A or 1B</td>
<td>N/A</td>
<td>R(eject) N/A 88 569 922 HD or HC +/- MP +/- MR</td>
<td>&lt;Blank&gt; = Fill Level 1,2,3 = Cumulative Level</td>
<td>&lt;Blank&gt; = Fill Level 1,2 = Cumulative Level</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>C8</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for hospice care.</td>
<td>HD or HC +/- MP +/- MR</td>
<td>M0 or R0 4C</td>
<td>N/A</td>
<td>Per Payer/Processor Discretion Per Payer/Processor Discretion Per Payer/Processor Discretion Per Payer/Processor Discretion Per Payer/Processor Discretion</td>
<td>Per Payer/Processor Discretion</td>
<td>Per Payer/Processor Discretion</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>C9</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for cancer, sickle cell, or any other disease state identified as exempt by state and/or federal law.</td>
<td>N/A N/A N/A</td>
<td>Any ICD-10 code(s)</td>
<td>P(aid) 48</td>
<td>88 569 922 HD or HC +/- MP +/- MR</td>
<td>&lt;Blank&gt; = Fill Level 1,2,3 = Cumulative Level</td>
<td>IF NO KNOWN EXEMPTIONS. PRESCRIBER CARE COORDINATION REQD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C10</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for a non-exempt diagnosis.</td>
<td>N/A N/A N/A</td>
<td>Any ICD-10 code(s) &lt;&gt; accepted conditions</td>
<td>R(eject) N/A 88 569 922 HD or HC +/- MP +/- MR</td>
<td>&lt;Blank&gt; = Fill Level 1,2,3 = Cumulative Level</td>
<td>IF NO KNOWN EXEMPTIONS. PRESCRIBER CARE COORDINATION REQD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C11</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for an exempt indication, but the plan does not use diagnosis codes.</td>
<td>N/A N/A N/A</td>
<td>Any ICD-10</td>
<td>R(eject) N/A 88 569 922 HD or HC +/- MP +/- MR</td>
<td>&lt;Blank&gt; = Fill Level 1,2,3 = Cumulative Level</td>
<td>IF NO KNOWN EXEMPTIONS. PRESCRIBER CARE COORDINATION REQD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C12</td>
<td>The claim is submitted with an approved coverage determination on file.</td>
<td>N/A N/A N/A</td>
<td>Any ICD-10</td>
<td>P(aid) 34</td>
<td>N/A N/A N/A N/A N/A N/A</td>
<td>N/A N/A</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Some payers may choose to return a DUR Reason for Service Code(s) on a paid claim where the DUR alert has been overridden by DUR/PPS codes.
### 7.6.4 DUPLICATIVE THERAPY SOFT EDIT - LONG ACTING OPIOIDS

<table>
<thead>
<tr>
<th>No</th>
<th>Opioid Utilization Scenario</th>
<th>Claim Request</th>
<th>Claim Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reason for Service Code</td>
<td>Professional Service Code</td>
<td>Result of Service Code</td>
</tr>
<tr>
<td>D1</td>
<td>Concurrent use for a current claim for a long acting opioid is found with another long acting opioid in the patient's history.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>D2</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for palliative care.</td>
<td>TD</td>
<td>M0 or R0</td>
</tr>
<tr>
<td>D3</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for cancer.</td>
<td>TD</td>
<td>M0 or R0 or MR</td>
</tr>
<tr>
<td>D4</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of cancer or non-hospice palliative care.</td>
<td>TD</td>
<td>M0 or R0 or MR</td>
</tr>
<tr>
<td>D5</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of hospice.</td>
<td>TD</td>
<td>M0 or R0</td>
</tr>
<tr>
<td>D6</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber approval.</td>
<td>TD</td>
<td>M0</td>
</tr>
<tr>
<td>----</td>
<td>-----------------------------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>D7</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed per payer/processor or CMS defined exception.</td>
<td>TD</td>
<td>Per Payer/Processor Discretion</td>
</tr>
<tr>
<td>D8</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for hospice care.</td>
<td>TD</td>
<td>M0 or R0</td>
</tr>
<tr>
<td>D9</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for cancer, sickle cell, or any other disease state identified as exempt by state and/or federal law.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>D10</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for a non-exempt diagnosis.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>D11</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for an exempt indication, but the plan does not use diagnosis codes.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>D12</td>
<td>The claim is submitted with an approved coverage determination on file.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### 7.6.5 Soft Stop for Concurrent Use of Conflicting Drug Categories (e.g., Opioids & Benzodiazepines, Opioids & Buprenorphine, Opioids & Antipsychotics)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td>Concurrent use between the incoming claim and a conflicting product(s) is found for the current claim.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>R(eject)</td>
<td>N/A</td>
<td>88 569</td>
<td>DD</td>
<td>1,2, or 3</td>
<td>1 or 2</td>
<td>N/A</td>
</tr>
<tr>
<td>E2</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for palliative care.</td>
<td>DD</td>
<td>M0 or R0</td>
<td>4B</td>
<td>N/A</td>
<td>P(aid)</td>
<td>47</td>
<td>N/A</td>
<td>DD</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>E3</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for cancer.</td>
<td>DD</td>
<td>M0 or R0 or MR</td>
<td>4D</td>
<td>N/A</td>
<td>P(aid)</td>
<td>47</td>
<td>N/A</td>
<td>DD</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>E4</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of cancer or non-hospice palliative care.</td>
<td>DD</td>
<td>M0 or R0</td>
<td>4K</td>
<td>N/A</td>
<td>P(aid)</td>
<td>47</td>
<td>N/A</td>
<td>DD</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>E5</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of hospice.</td>
<td>DD</td>
<td>M0 or R0</td>
<td>4L</td>
<td>N/A</td>
<td>Per Payer/ Process Discretion</td>
<td>Per Payer/ Process Discretion</td>
<td>Per Payer/ Process Discretion</td>
<td>Per Payer/ Process Discretion</td>
<td>Per Payer/ Process Discretion</td>
<td>Per Payer/ Process Discretion</td>
<td></td>
</tr>
<tr>
<td>E6</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber approval.</td>
<td>DD</td>
<td>M0</td>
<td>1G</td>
<td>N/A</td>
<td>P(aid)</td>
<td>47</td>
<td>N/A</td>
<td>DD</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>E7</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed per payer/processor or CMS defined exception.</td>
<td>DD</td>
<td>Per Payer/ Process Discretion</td>
<td>Per Payer/ Process Discretion</td>
<td>N/A</td>
<td>P(aid)</td>
<td>47</td>
<td>N/A</td>
<td>DD</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>----</td>
<td>--------------------------------------------------------------------------------------------</td>
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<td>-----------------------------</td>
<td>--------------------------</td>
<td>----------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>E8</td>
<td>The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for hospice care.</td>
<td>DD</td>
<td>M0 or R0</td>
<td>4C</td>
<td>N/A</td>
<td>Per Payer/Processor Discretion</td>
<td>Per Payer/Processor Discretion</td>
<td>Per Payer/Processor Discretion</td>
<td>Per Payer/Processor Discretion</td>
<td>Per Payer/Processor Discretion</td>
<td>Per Payer/Processor Discretion</td>
<td>P(aid)</td>
</tr>
<tr>
<td>E9</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for cancer, sickle cell, or any other disease state identified as exempt by state and/or federal law.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>ICD-10 code(s) &lt;&gt; accepted conditions</td>
<td>P(aid)</td>
<td>48</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1 or 2</td>
</tr>
<tr>
<td>E10</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for a non-exempt diagnosis.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>ICD-10 code(s) &lt;&gt; accepted conditions</td>
<td>R(reject)</td>
<td>N/A</td>
<td>88 569 80</td>
<td>DD</td>
<td>1,2, or 3</td>
<td>1 or 2</td>
<td>N/A</td>
</tr>
<tr>
<td>E11</td>
<td>The claim is submitted with a diagnosis code indicating the claim is being dispensed for an exempt indication, but the plan does not use diagnosis codes.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Any ICD-10</td>
<td>R(reject)</td>
<td>N/A</td>
<td>88 569 521</td>
<td>DD</td>
<td>1,2, or 3</td>
<td>1 or 2</td>
<td>N/A</td>
</tr>
<tr>
<td>E12</td>
<td>The claim is submitted with an approved coverage determination on file.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>P(aid)</td>
<td>34</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Version 48
November 2019
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### 7.6.6 MEMBER LOCK-IN (E.G. OPIOID, BENZODIAZEPINE OR OTHER TARGETED DRUG)

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</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>The member is locked into a specific pharmacy and is attempting to fill an opioid, benzodiazepine or other targeted drug at a different pharmacy.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>R(eject)</td>
<td>N/A</td>
<td>M2** 980**</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>F2</td>
<td>The member is locked into a specific prescriber and is attempting to fill an opioid, benzodiazepine or other targeted drug written by a different prescriber.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>R(eject)</td>
<td>N/A</td>
<td>M2** 979**</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>F3</td>
<td>The member is attempting to fill an opioid, benzodiazepine or other targeted drug that is not covered per a beneficiary case management restriction.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>R(eject)</td>
<td>N/A</td>
<td>828</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>F4</td>
<td>The member has exceeded the daily dosage as set by a beneficiary case management restriction.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>R(eject)</td>
<td>N/A</td>
<td>828 88 G4 943*</td>
<td>HD</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>F5</td>
<td>The member has exceeded the MME limit for the claim as set by a beneficiary case management restriction.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>R(eject)</td>
<td>N/A</td>
<td>828 88 G4 943*</td>
<td>HD/HC</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**NOTE:** There are no known point of sale overrides allowed for the lock-in scenarios and no examples are being provided.

*Effective October 15, 2019, Reject Code 943 (DUR may not be overridden at Point of Sale, prescriber to initiate coverage determination) replaces the combination of reject codes 88 (DUR Reject Code) and G4 (Prescriber must contact plan).*
**Effective October 15, 2020, Reject Codes 980 (Patient Locked Into Specific Pharmacy(s)) and 979 (Patient Locked Into Specific Prescriber(s)) may be used in place of reject code M2 (Recipient Locked In. Contact Plan.). Reject code M2 will be sunset as of October 15, 2020.
8 NCPDP BATCH STANDARD

8.1 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 D.0 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 1.2 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.

8.2 RESPONSE FORMAT

Question: When responding to a Batch Standard Version 1.2 transmission is the response format required the same as the response for Telecommunication Standard Version D.0?

Response: Yes. The format of the Batch Standard request and response is based on the Telecommunication standard. The Telecommunication Standard Version D.0 billing claim response would be “wrapped” with the Batch Standard Version 1.2 Header/Detail/Trailer format (envelope).

8.3 SEGMENT DEFINITION

8.3.1 BATCH STANDARD SEGMENT USAGE DIFFERENT THAN TELECOMMUNICATION STANDARD?

Question: If a processor is using both the Telecommunication Standard Version D.0 and Batch Standard Version 1.2 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.

8.4 TRANSACTION PROCESSING

8.4.1 BATCH PROCESSING – REJECT

Question: Does the logic for transmission reject apply to Batch Standard Version 1.2? 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 D.0 (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).
9 LONG-TERM AND POST-ACUTE CARE (LTPAC) PHARMACY CLAIMS SUBMISSION RECOMMENDATIONS FOR VERSION D.0

9.1 INTRODUCTION (PURPOSE)
This section is intended to provide practical guidance for providers and payers handling pharmacy claims for Long Term and Post-Acute Care (LTPAC) residents.

9.2 BACKGROUND
For most pharmacy types, key partners in ensuring accurate and timely dispensing of medications include the prescriber, patient, pharmacy and payer. Long Term and Post-Acute Care (LTPAC) pharmacies are defined by NCPDP as pharmacies dispensing medicinal preparations delivered to patients residing within an intermediate or skilled nursing facility, including intermediate care facilities for the intellectually disabled, hospice, assisted living facilities, group homes, other forms of congregate living arrangements and patients serviced in their homes through the CMS Home and Community Based Waivers as authorized in §1915(c) of the Social Security Act. LTPAC pharmacies coordinate the dispensing and billing of medications for residents of LTPAC facilities (facilities) through interactions with two additional partners, the facility and the patient responsible party. Most requests to fill a medication are sent to the LTPAC pharmacy from a facility in which the patient resides. Little, if any, communication occurs between the pharmacy and the patient, with communications for payment of applicable copayments and/or non-covered items usually occurring directly between the LTPAC pharmacy and the patient responsibly party.

The Centers for Medicare/Medicaid Services (CMS) requires LTPAC pharmacies meet certain additional guidelines, which are addressed within trading partner agreements, in order for a pharmacy to regularly dispense to a LTPAC resident. This section will explain some of the processing allowances to facilitate billing for some of these situations. Payers and LTPAC pharmacies need to coordinate to ensure the CMS objectives of the Medicare Part D program are met successfully. A large segment of Medicare Part D enrollees comprise the entire population of dual-eligible beneficiaries, many of whom are LTPAC residents.

It is critical that all providers and payers, including Prescription Drug Plans (PDPs), Medicare Advantage Plans (MA-PDs), Commercial and Medicaid who are transacting pharmacy claims for LTPAC residents are doing so using the same field values to signal that claims are indeed for LTPAC residents. The pharmacy also strives to ensure that the unique dispensing circumstances for the special population of the frail elderly are being communicated uniformly.

CENTERS FOR MEDICARE/MEDICAID SERVICES (CMS) DEFINITION OF A LONG TERM CARE FACILITY

Final Part D regulations from CMS (page 129) note: "We have expanded the definition of the term "long-term care facility" 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(a)(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 section 1902(a)(1)(B) of the Act."

9.3 ISSUES AND RECOMMENDATIONS

9.3.1 PROVIDER CONTRACTS
Providers and payers may have multiple and different contracts that refer to different formularies and reimbursement terms. It is important that the provider attempt to signal which contract should be invoked for any real-time claim during the adjudication event.

**9.3.2 HOW DO WE KNOW WE HAVE A LTPAC TRANSACTION?**

**9.3.2.1 QUALIFYING THE PATIENT**

CMS requires the Patient Residence Code be included on all Medicare Part D Prescription Drug Events (PDEs). The pharmacy must provide this information on all Part D claims. For consistency in claims adjudication, it is recommended that the Patient Residence be the field that all pharmacies and payers, including Medicare Part D, Medicaid and Commercial, use as the key designation of where the patient resides.

The "care" of long-term post-acute care (LTPAC) is specified by the setting in which the patient resides. The setting that the patient resides in can be reasonably established using the field Patient Residence (384-4X).

Multiple care settings that qualify as LTPAC are represented in the available Telecommunication Standard Version D.0 value set. To reduce confusion, it is recommended that only two Patient Residence values be used for qualifying LTPAC and only one value be used for Assisted Living.

Prior to the CMS requirement for Appropriate Dispensing in Long Term Care, NCPDP recommended the use of Patient Residence value 3 to identify all types of long term care facilities. CMS waived, via the Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Changes; Final Rule, the appropriate dispensing in long term care requirement for patients that reside in Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID) as well as for patients in Institutes for Mental Disease (IMD). As such, the Patient Residence values for ICF/IID and IMD should no longer be sent as Patient Residence value 3.

Another data element is available that indicates that the submitter of the claim attests that the facility is a CMS Part D defined facility. This attestation occurs by placing the value Y in the field CMS Part D Defined Qualified Facility (997-G2). This field was created in a proactive attempt to allow flexibility if CMS were ever to include Assisted Living Patients in the definition of a skilled facility.

**9.3.2.2 QUALIFYING THE PHARMACY SERVICE**

The pharmacy service type is specified using the field Pharmacy Service Type (147-U7).

The place the pharmacy service is performed is specified using the field Place of Service (307-C7). As the service referenced in Medicare Part D, Medicaid and Commercial claims is dispensing, this field should always indicate “pharmacy”; this field should not reflect the location in which the patient resides.

**RECOMMENDATION:**

For LTC claim submissions, industry practice is to submit all recommended fields to create consistent submission standard across all payers. Plans must not reject claims because they do not use one or more of these fields (see Section "Standard Conventions", subsection "Character Set Designation Truncation"). Several fields work in tandem to identify and qualify various combinations of pharmacy service and patient level of care; recommendations for common facility types are below.

**Long Term Care Facility**

*Patient Residence (384-4X)*

For a LTC resident in an Intermediate Care Facility for the Individuals with Intellectual Disabilities (ICF/IID) or Institute for Mental Disease (IMD) use value 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities).
For a LTC resident (excluding those residents in ICF/IID or IMD) use value 3 (Nursing Facility). This value is broad enough to encompass all claims for patients who reside in LTPAC facilities, but should be used only for those LTC residents in LTC facilities other than ICF/IID or IMD (refer to CMS LTC definition).

**CMS Part D Defined Qualified Facility (997-G2)**
For a facility that meets the CMS DEFINITION OF A LONG TERM CARE FACILITY use value = Y

**Place of Service (307-C7)**
For a pharmacy service dispensed from the pharmacy use value 1 (Pharmacy)

**Pharmacy Service Type (147-U7)**
Please refer to the most current implemented version of the External Code List for valid Pharmacy Service Type values. Any of these values may be received in a LTPAC claim.

**Assisted Living Facility**
Although patients in an Assisted Living Facility (ALF) may be regularly serviced by pharmacy types other than Long Term Post-Acute Care, many Assisted Living Facilities look to LTPAC pharmacies to package the medications in a manner that promotes compliance and safety.

**Patient Residence (384-4X)**
For an Assisted Living Facility (ALF) resident, use value 4 (Assisted Living Facility). CMS is encouraging PDPs to identify residents in ALFs, and if the resident is currently receiving special packaging or services, the PDPs may need to uniquely identify assisted living residents receiving special packaging or services.

**Place of Service (307-C7)**
For a pharmacy service dispensed from the pharmacy use value 1 (Pharmacy)

**Pharmacy Service Type (147-U7)**
Please refer to the most current implemented version of the External Code List for all valid values. Plans should be aware that they may receive Assisted Living Facility claims from any available “Pharmacy Service Type”.

**Home Infusion Therapy**
Home Infusion Therapy (HIT) services may be provided in the patient’s home or in an ALF.

**Patient Residence (384-4X)**
For a home based HIT patient use value 1 (Home).
For an ALF resident, use value 4 (Assisted Living Facility).

**Place of Service (307-C7)**
For a pharmacy service dispensed from the pharmacy use value 1 (Pharmacy).

**Pharmacy Service Type (147-U7)**
For a Home Infusion Therapy Provider Service use value 3.

**Home and Community Based:**
From Medicaid.gov:
Within broad Federal guidelines, States can develop home and community-based services waivers (HCBS Waivers) to meet the needs of people who prefer to get long-term care services and support in their home or community, rather than in an institutional setting. In 2009, nearly one million individuals were receiving services under HCBS waivers.

*Patient Residence (384-4X)*
For a home based patient use value 1 (Home).

*Place of Service (307-C7)*
For a pharmacy service dispensed from the pharmacy use value 1 (Pharmacy).

*Pharmacy Service Type (147-U7)*
Please refer to the most current implemented version of the External Code List for all valid values.

*Level of Service (418-DI)*
Use value 7 (Medical at home with special pharmacy services identical to Long Term Care beneficiaries with the exception of emergency kits)

### 9.3.3 Special Packaging
LTPAC pharmacies typically dispense oral solid medication (e.g., tablets, capsules, caplets) in a unit dose package. This is what CMS refers to as special packaging services. Pharmacies and facilities often refer to the package types as blister packs or bingo cards.

LTPAC 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.

Multi-drug packaging that increases patient medication compliance is prevalent in the LTPAC service settings. This type of drug packaging contains all of the pills that are taken at a particular time and date, (ex. 8am on MM/DD/CCYY) in individual envelopes or pill bubbles.

Providers may also need to refer to their trading partner agreements and/or provider communications for specific billing requirements for unit dose, multi-drug, and other custom packaging.

**RECOMMENDATION:**
*Special Packaging Indicator (429-DT)*
Please refer to the most current implemented version of the External Code List for all valid values.

### 9.3.4 Leave of Absence Medications
Leave of Absence (LOA) medication 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 may need to be identified as such in order to avoid rejections for duplication, refill too soon or rejects with similar intent.

**RECOMMENDATION:**
*Submission Clarification Code (420-DK)*
For a LTPAC resident use value 14 (Long Term Care Leave of Absence) - The pharmacist is indicating the cardholder requires a short-fill of a prescription due to a leave of absence from the LTPAC facility.
Unless trading partner agreements indicate otherwise, for an ALF resident or other ambulatory patient circumstance use value 3 (Vacation Supply) - The pharmacist is indicating the cardholder requires a short-fill of a prescription due to a leave of absence from the ALF or other facility.

**9.3.5  MEDICATION LOST, DROPPED, OR PATIENT “SPITS OUT”**
As the administration of medications in the LTPAC environment involves parties other than the patient, there is a need for a LTPAC pharmacy to send a trigger to a payer to let them know if a dispensing is occurring earlier than otherwise scheduled due to possible contamination in the LTPAC environment. Common reasons for this are that the medication was dropped either by the nursing staff or patient, or the medication was “spit out”.

RECOMMENDATION:

*Submission Clarification Code (420-DK)*
For a LTPAC resident use value 15 (Long Term Care Replacement Medication) - Medication has been contaminated during administration in an LTPAC facility.

Unless trading partner agreements indicate otherwise, for an ALF resident or other ambulatory patient circumstance use value 4 (Lost/Damaged Prescription) - The pharmacist is indicating the cardholder has requested a replacement of medication that has been damaged or lost.

**9.3.6  EMERGENCY BOX / KIT DISPENSING OPERATIONS**
Emergency Box/Kit (referred to as E-Kit in this document) are storage units for some of the most commonly used and/or time critical medications consumed by LTPAC residents. E-Kits can be either a box stocked with medications or a remote automated dispensing system for first/STAT dose. These kits are stocked by the LTPAC pharmacy without patient specific orders and located at the Nursing Home. The ability to fill E-Kits is one of the conditions that CMS require PDPs and MA-PPDs include in their Long Term Care pharmacy agreements. Although expressly required by CMS, medications can be used from E-Kits for patients with any payer type (including, but not limited to, Medicaid and Commercial claims).

Nursing homes and LTPAC pharmacies are subject to state regulations about how E-Kits are dispensed and how drugs are administered from the E-Kit. As a result of varying regulations and practices within pharmacies, there are some differences in how a pharmacy may bill the E-Kit claims. There are also some locations where it is acceptable to have E-Kits in ALFs.

When a nursing home removes a dose from an E-Kit to administer to a patient, they communicate this action to the pharmacy, and the pharmacy will submit an E-Kit claim to the payer. E-Kit claims that are submitted to a payer are patient specific, and are generally submitted for a shortened day supply. When a subsequent fill of the medication taken from the E-Kit is dispensed to the patient from the pharmacy, the pharmacy may identify this completion / remainder fill as such on the claim.

In order to ensure an efficient means of communicating the E-Kit dispensing and request for Refill Too Soon override, two submission clarification codes exist to clarify the situations. Due to the timing of communications between the LTPAC 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 or completion dispensing that occurs following the emergency dose. These fills may be adjudicated in any order beyond the pharmacy’s control. While there are two Submission Clarification Codes related to E-Kit dispensing, there are additional variations as to when, how and if these SCCs are used.
Below are some E-Kit billing situations:

- Pharmacy may bill the E-Kit claim before billing the completion fill
- Pharmacy may bill the E-Kit claim after filling the completion fill
- Pharmacy may bill the E-Kit claim, and a separate claim for a full day supply ordered, rather than billing a completion fill
- Pharmacy may proactively include the SCC 16 or 17 when relevant to the dispensing, or may only send these values as appropriate based on dispensing, when the payer rejects the claim for a refill too soon or reject with similar intent.
- Patient may have multiple claims billed for E-Kit doses on the same day because the patient needed medication before the next facility mandated delivery time.
- Other situations may exist that are not stated above.

Below are examples of how the Emergency Box/Kit Starter dose claim submission scenarios may arise:

- 4 days supply was administered out of the E-Kit 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 E-Kit after the 30 days supply was billed. If the 4 days supply is submitted as a separate claim it can potentially trigger refill too soon, duplicate claim or max therapy/quantity edits.
- 4 days supply was administered out of the E-Kit 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 trigger refill too soon, duplicate claim or max therapy/quantity edits.
- 4 days supply was administered out of the E-Kit at the LTPAC facility and a 30 days supply was delivered by the LTPAC pharmacy to the LTPAC facility. The pharmacy bills for 34 days supply as one claim. This can potentially trigger a max days supply edit if the days supply allowed is less than 34 days.

**CLARIFYING THE EMERGENCY DOSE ITSELF (MEDS REMOVED BY NURSE FROM E-KIT)**

**RECOMMENDATION:**

Submission Clarification Code (420-DK)

Use value 16 (Long Term Care Emergency box (kit) or automated dispensing machine) – Indicates the transaction is a replacement supply for doses previously dispensed to the patient.

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**CLARIFYING THE FIRST FILL FOLLOWING THE EMERGENCY DOSE**

This characterizes the first full or completion fill dispensing for the medication that is occurring after the nurse withdrew this medication from the emergency box (E-Kit).

**RECOMMENDATION:**

Submission Clarification Code (420-DK)

Use value 17 (Long Term Care Emergency supply remainder) - Indicates the transaction is for the remainder of the drug originally begun from an Emergency Kit.

**9.3.7 LTPAC ADMISSIONS AND READMISSIONS**

To ensure patient safety, many states have regulations that result in Nursing Home requirements that medications be filled in a uniform manner of packaging for patients in their facilities. This ensures the pharmacy is packaging and labeling the medications in a manner that complies with the nursing home’s policy and fits into the medication carts used in the nursing home. Due to prescriptions filled prior to admission or re-admission,
these dispensings may result in a “Refill Too Soon” reject or a reject with similar intent, if filled within plan RTS billing parameters. Pharmacies may opt to submit this override proactively for patients that meet the new admission / readmission criteria or may submit this value to override a related reject.

RECOMMENDATION:
Submission Clarification Code (420-DK)
Use value 18 (Long Term Care Patient Admit/Readmit Indicator) - Indicates the transaction is for a new dispensing of medication due to the patient’s admission or readmission status.

9.3.8 COVERAGE ENDS FOR MEDICARE PART A RESIDENT BEFORE MEDICATION SUPPLY IS USED
While in a skilled stay, patients residing in a nursing home are covered under the Medicare Part A benefit. Once the skilled stay ends, a patient may have coverage through a different payer. The pharmacy may not be made aware of the change in coverage status until after it occurs. This may result in charges billed to the nursing home / Med A stay for days not covered under the Med A stay. In these situations, the pharmacy may opt to split the patient’s bill so that portion covered under the Part A stay is billed to the nursing home / Med A, and the portion covered under the new payer is billed to the new payer.

Example - Pharmacy dispenses a 30 day supply of medications to a Medicare Part A resident on March 15th. On April 3rd the resident’s level of care transitions from Medicare Part A coverage to their Part D coverage. The Part A benefit which is a per-diem benefit only covers the resident’s medications through April 3rd. As of April 4th, the resident still has 10 days’ worth of medications that are not paid for by the Medicare Part A benefit. Instead of returning these 10 days’ worth of medications to the pharmacy, the pharmacy bills the new insurer as of April 4 for a 10 day supply of medications and no dispensing fee is submitted and the original transaction is also adjusted to reflect the proper days supply.

RECOMMENDATION:
Submission Clarification Code (420-DK)
Use value 19 (Split Billing) - indicates the quantity dispensed is the remainder billed to a subsequent payer when Medicare Part A no longer applies. Used only in long term care settings.

Dispensing Fee Submitted (412-DC)
The submitted amount of the dispensing fee for a split bill must = “$0.00.” If a dispensing fee is submitted by the pharmacy and accepted by the payer, the payer should reduce the dispensing fee to $0.00.

CMS has corresponded with the following advice regarding the “Split Billing” practice when LTPAC residents move from the Part A to the Part D benefit:
“There is no regulatory citation but this is not inconsistent with our guidance.”

9.3.9 ON-LINE WINDOW FOR SUBMISSION OF NEW AND REJECTED CLAIMS
A patient in a LTPAC setting may have claims that need to be adjudicated retroactive to an earlier date. The eligibility setting in LTPAC 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:
Federal regulations at §423.505 Contract provisions specify the window for LTPAC claims submission. The regulation states, “Effective contract year 2010, provide that pharmacies located in, or having a contract with, a long-term care facility (as defined in §423.100) must have not less than 30 days, nor more than 90 days, to submit to the Part D sponsor claims for reimbursement under the plan.” Although the regulation allows as few as 30 days, it is recommended that the full 90 days for claims submission be observed by all payers.
9.3.10 Predetermination of Benefits

All pharmacy settings need to operate in a manner where the patient and drug benefit is known just before dispensing of services actually occurs. If the patient and drug benefit does not support the prescription dispensing request for any variety of reasons, whether they be eligibility, formulary, or Drug Utilization Review (DUR), then the pharmacy needs to adjust their service appropriately.

LTPAC pharmacies have at least three contributing operational circumstances that impact whether adjudication can proceed successfully before dispensing:

1. Routine medications delivered in smaller days supplies:
   Certain care settings operate best when the pharmacy delivers medications to LTC residents in smaller and more frequent increments, such as 7-day or 14-day supplies of medications. Unfortunately, the common reimbursement model for prescription plans is a monthly supply with a single dispensing fee, and then a single monthly copay or coinsurance to the beneficiary. Pharmacies ideally would like to “predetermine” that a monthly supply is covered by the drug plan before the initial short supply is sent. Then later when a month’s worth of medications have been dispensed, to formally and confidently adjudicate the prescription for a full month supply, with a date of service set to the date of the initial fill.

2. Preadmission activities, and mid-cycle coverage updates:
   Before dispensing medication for a recent admission, or after receiving coverage updates from the facility, a pharmacy can predetermine coverage on the medications before the next cycle of medication dispensing occurs.

3. Coordination of therapy change circumstances:
   Pharmacies often need to predetermine that a drug is non-formulary, requires prior authorization, or has quantity and/or days supply limitations before contacting the prescriber or family or LTPAC facility to confidently recommend and help coordinate any therapy change.

RECOMMENDATION:
All LTPAC pharmacy software producers and all insurers who have a significant number of customers who operate LTPAC pharmacies, and serve beneficiaries in the LTPAC setting should embrace and implement the Predetermination of Benefits transaction in D.0.

9.3.11 Date of Service for LTPAC Billing Claim

With respect to post consumption billing, the Date of Service may be the initial fill date in the billing cycle or the billing date. It is preferred to utilize the initial fill date as the Date of Service so that refill too soon rejections are less likely to occur on a subsequent fill. When Split Billing, the Date of Service should be for the day after the Medicare Part A stay no longer applies.

9.3.12 Cycle Fills

For ease of administration, some nursing homes may require that all resident maintenance medications be dispensed on a regular cycle (e.g. all medications are dispensed on the first of every month, first Tuesday of every month, etc.). When patients are prescribed a medication mid-cycle, or multiple fills are needed in a month to complete the cycle, the subsequent cycle fill may result in a Refill Too Soon reject or rejection with similar intent.

RECOMMENDATION:

Submission Clarification Code (420-DK)

Use value 48 - Fill Subsequent to a Shortened Days Supply Fill - only used to request an override to plan limitations when a fill subsequent to a shortened days supply is being dispensed.
Note – Although it is unlikely the initial fill prior to the cycle fill would reject, if it does reject due to Refill Too Soon or Plan Limitations it would be appropriate to use SCC 47 - Shortened Days Supply Fill - only used to request an override to plan limitations when a shortened days supply is being dispensed.

9.3.13 BACK UP PHARMACIES
As previously noted, CMS requires that PDPs and MA-PDs include Long Term Care specific contractual requirements. Pharmacies that regularly dispense to Long Term Care Patients must meet those requirements. However, there are situations in which a non-LTPAC pharmacy may need to dispense to patients in Long Term Care facilities. The results of the CMS outreach and industry discussions on this topic are below.

Question:
Are non-LTPAC network pharmacies eligible to submit prescription drug claims for Part D members in the LTPAC setting?

There are circumstances where a retail pharmacy is providing services to a LTPAC resident such as:
- The patient residence value is equal to LTPAC.
- The pharmacy service type submitted is not equal to LTPAC
- The non-LTPAC network pharmacy does not meet the LTPAC performance and service criteria.
- The pharmacy is contracted with the Part D plan sponsor/PBM to perform only non-LTPAC network pharmacy services.

Response:
Per CMS, “nothing in CMS’ policy requires that a claim from a retail pharmacy servicing a LTC beneficiary be denied.” Furthermore “If denial of these pharmacy claims results in beneficiaries losing timely access to Part D drugs, Part D sponsors may be subject to compliance actions.”

Per Chapter 5 of the Medicare Prescription Drug Benefit Manual, the appropriate action for the Part D sponsor to take when a pharmacy (not in the Part D sponsor’s network of LTC pharmacies) dispenses into the LTC setting is to contract the pharmacy into the Part D sponsor’s network of LTC pharmacies. When the Part D sponsor is unable to contract the pharmacy into its network of LTC pharmacies AND the Part D sponsor has no other pharmacy in its network of LTC pharmacies that can service the beneficiary, the Part D sponsor should contact CMS for assistance.

The provision of emergency first doses for a LTC resident, the filling of prescriptions for a LTC resident while on a leave-of-absence from the LTC facility, or the dispensing by a specialty pharmacy of a drug that is only available from a specialty pharmacy does not alone create a situation requiring participation in a Part D sponsor’s network of LTC pharmacies.

9.4 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.

9.5 APPROPRIATE DISPENSING (SHORT CYCLE) FOR LTC

9.5.1 DISPENSING METHODOLOGIES FOR LTC IN PPACA
Effective Date: January 1, 2012
Within the Patient Protection Affordable Care Act (PPACA), reduction in waste related to dispensing of prescription drugs to patient residing in a long term care facility is mandated in 2012. The specific section that applies to this mandate under the Part D program is:

SEC. 3310. REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.
(a) IN GENERAL.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:
“(3) REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES.—The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA–PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2012.

In order to assist plans in tracking the dispensing methodologies as required by CMS, NCPDP recommends the use of Submission Clarification Code (420-DK) values of 16 or 21-36 and Special Packaging Indicator (429-DT) values be included on claim submissions, with Date of Service (401-D1) starting 01/01/2012, coming from a pharmacy serving a Part D LTC beneficiary.

NCPDP recommends that in the event that a plan chooses to reject a claim when the Submission Clarification Code (420-DK) and Special Packaging Indicator (429-DT) are in conflict with one another the Reject Code (511-FB) value “597” (LTC Dispensing type does not support the packaging type) should be returned. The Reject Code will specifically indicate that the dispensing submission clarification code and package type are in conflict. NCPDP anticipates the approval of a new Reject Code for use with claims for dates of fill 01/01/2012 or later. Providers may encounter situations where a drug has been rejected due to the conflict between the submission clarification code and dispensing package type, based on the prescriber’s directions, and may need an override to allow the claim to process. Plan sponsors need to create a process and procedure to allow for this situation.

9.5.2 SUBMISSION CLARIFICATION CODE COMBINATIONS AND REJECTIONS
CMS released guidance (4144-F) in 2011 regarding the appropriate dispensing of prescription drugs for Medicare Part D beneficiaries residing in LTC facilities. Pharmacies must dispense all brand oral solid drugs for Part D patients residing in LTC facilities in 14-day or less increments. NCPDP, CMS, and pharmacy providers developed a Short Cycle Validity Matrix (WG14 Members page - http://www.ncpdp.org/members/Work-Group.aspx?ID=wg14) for valid Submission Clarification Code (SCC) and Special Packaging Indicator (SPI) combinations for use in the submission of these types of prescriptions.

Pharmacies must dispense brand oral solid drugs for Part D patients residing in a LTC facility in 14-day or less increments. An applicable LTC appropriate dispensing claim must have Patient Residence equal to 3 (Nursing Facility), with the appropriate SCC and SPI values, for brand oral solid drugs. The impacted NCPDP fields are:

Patient Residence (384-4X) - Value 3 (Nursing Facility)
Submission Clarification Code Count (354-NX)
Submission Clarification Code (420-DK) - Values based on NCPDP matrix
Special Packaging Indicator (429–DT) - Values based on NCPDP matrix

Note, the regulatory requirement to dispense in 14 day or less increments is not directly linked to billing in equivalent increments.
**Current Practice:**
NCPDP Telecommunication Standard recommends the use of Submission Clarification Codes (SCC) (420-DK) to identify emergency fills, or other unique LTC Billing situations. The values are listed below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Long Term Care Leave of Absence - The pharmacist is indicating that the cardholder requires a short-fill of a prescription due to a leave of absence from the Long Term Care (LTC) facility.</td>
</tr>
<tr>
<td>15</td>
<td>Long Term Care Replacement Medication - Medication has been contaminated during administration in a Long Term Care setting.</td>
</tr>
<tr>
<td>16</td>
<td>Long Term Care Emergency box (kit) or automated dispensing machine – Indicates that the transaction is a replacement supply for doses previously dispensed to the patient.</td>
</tr>
<tr>
<td>17</td>
<td>Long Term Care Emergency supply remainder - Indicates that the transaction is for the remainder of the drug originally begun from an Emergency Kit.</td>
</tr>
<tr>
<td>18</td>
<td>Long Term Care Patient Admit/Readmit Indicator - Indicates that the transaction is for a new dispensing of medication due to the patient’s admission or readmission status.</td>
</tr>
</tbody>
</table>

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Appropriate Brand Oral Solid Drug: As defined in §423.154 42 of CFR Parts 417, 422, and 423 Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Changes are defined as solid oral doses of brand name drugs with the exclusion of:

- Solid oral doses of antibiotics; or
- Solid oral doses that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist patients with compliance (for example, oral contraceptives).

Note, although the CMS mandate applies to Brand Oral Solid Drugs as defined above, if a pharmacy chooses to short cycle dispense generic medications, they may choose to submit (but are not required to submit) the same Submission Clarification Codes developed for short cycle brand oral solid drugs. Claims should not reject based solely on the inclusion of these codes, instead the payer should ignore.

**Claims submission recommendations:**

**Plans should continue to accept the usage of these codes (SCC 14-18) to identify unique dispensing situations.**

When one of the above unique dispensing situations occurs for a short cycle medication, the following must be used in combination:

- SCC of 14, 15, 17 – Appropriate Brand Oral Solid Drugs must be sent with SCC 21 through 36
- SCC of 14, 15, 17 – Appropriate Brand Oral Solid Drugs not submitted with SCC 21 through 36 will reject with NCPDP Reject Code “613”
- SCC of 14, 15, 17 – Appropriate Brand Oral Solid Drugs submitted with SCC 16 will reject with NCPDP Reject Code “613”
- SCC 16 – Appropriate Brand Oral Solid Drugs are applicable for LTC Short Cycle
- SCC 16 – Appropriate Brand Oral Solid Drugs submitted with SCC 14, 15, or 17 will reject with NCPDP Reject Code “613”
- SCC 18 – Appropriate Brand Oral Solid Drugs must be sent with SCC 16, or 21 through 36
- SCC 18 – Appropriate Brand Oral Solid Drugs not submitted with SCC 16, or 21 through 36 will reject with NCPDP Reject Code “613”
- SCC 21 or 36 – Appropriate Brand Oral Solid Drugs sent with SCC 22 through 35 will reject with NCPDP Reject Code “613”
- SCC 22 through 35 – Appropriate Brand Oral Solid Drugs are applicable for LTC Short Cycle
- SCC 22 through 35 – Appropriate Brand Oral Solid Drugs sent with SCC 21 or 36 will reject with NCPDP Reject Code “613”
- SCC 16 or 21-36 - Appropriate Brand Oral Solid submitted and an SCC of 16 or 21-36 is not submitted will Reject Code “613”
- SCC 16 or 22-35 - When multiple combinations of SCC 16 or 22-35 are received they may be rejected in 2013 with Reject Code “612” but must be rejected in 2014
• All other SCC values are acceptable to be sent in conjunction with SCC 21-36 because they are intended to over-ride rejections or convey information unrelated to short cycle dispensing.

Submission Clarification Code values appropriate for LTC Short Cycle:

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>LTC Emergency Box (kit) or automated dispensing machine – Indicates that the transaction is a replacement supply for doses previously dispensed to the patient.</td>
</tr>
<tr>
<td>21</td>
<td>LTC dispensing: 14 days or less not applicable - Fourteen day or less dispensing is not applicable due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e. vacation supply, leave of absence, E-Kit, spitter dose). Medication quantities are dispensed as billed.</td>
</tr>
<tr>
<td>22</td>
<td>LTC dispensing: 7 days - Pharmacy dispenses medication in 7 day supplies</td>
</tr>
<tr>
<td>23</td>
<td>LTC dispensing: 4 days - Pharmacy dispenses medication in 4 day supplies</td>
</tr>
<tr>
<td>24</td>
<td>LTC dispensing: 3 days - Pharmacy dispenses medication in 3 day supplies</td>
</tr>
<tr>
<td>25</td>
<td>LTC dispensing: 2 days - Pharmacy dispenses medication in 2 day supplies</td>
</tr>
<tr>
<td>26</td>
<td>LTC dispensing: 1 day - Pharmacy or remote (multiple shifts) dispenses medication in 1 day supplies</td>
</tr>
<tr>
<td>27</td>
<td>LTC dispensing: 4-3 days - Pharmacy dispenses medication in 4 day, then 3 day supplies</td>
</tr>
<tr>
<td>28</td>
<td>LTC dispensing: 2-2-3 days - Pharmacy dispenses medication in 2 day, then 2 day, then 3 day supplies</td>
</tr>
<tr>
<td>29</td>
<td>LTC dispensing: daily and 3-day weekend - Pharmacy or remote dispensed daily during the week and combines multiple days dispensing for weekends</td>
</tr>
<tr>
<td>30</td>
<td>LTC dispensing: Per shift dispensing - Remote dispensing per shift (multiple med passes)</td>
</tr>
<tr>
<td>31</td>
<td>LTC dispensing: Per med pass dispensing - Remote dispensing per med pass</td>
</tr>
<tr>
<td>32</td>
<td>LTC dispensing: PRN on demand - Remote dispensing on demand as needed</td>
</tr>
<tr>
<td>33</td>
<td>LTC dispensing: 7 day or less cycle not otherwise represented</td>
</tr>
<tr>
<td>34</td>
<td>LTC dispensing: 14 days dispensing - Pharmacy dispenses medication in 14 day supplies</td>
</tr>
<tr>
<td>35</td>
<td>LTC dispensing: 8-14 day dispensing method not listed above - 8-14-Day dispensing cycle not otherwise represented</td>
</tr>
<tr>
<td>36</td>
<td>LTC Dispensing: dispensed outside short cycle - Medicare Part D coverage was determined post dispensing</td>
</tr>
</tbody>
</table>

The above are the only valid SCC values to be submitted on the PDE to represent short cycle claims.

Reject Code values appropriate for LTC Short Cycle:

<table>
<thead>
<tr>
<th>Reject Code</th>
<th>Explanation</th>
<th>Field # Possibly In Error</th>
<th>Field Limitation or Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>597</td>
<td>LTC Dispensing Type Does Not Support The Packaging Type</td>
<td>420-DK, 429-DT</td>
<td></td>
</tr>
<tr>
<td>612</td>
<td>LTC Appropriate Dispensing Invalid Submission Clarification Code (SCC) Combination</td>
<td></td>
<td>Used when more than one Submission Clarification Code value of 16 or 22-35 are submitted.</td>
</tr>
<tr>
<td>613</td>
<td>The Packaging Methodology Or Dispensing Frequency Is Missing Or Inappropriate For LTC Short Cycle</td>
<td></td>
<td>Used when the payer has determined this claim meets the definition of appropriate dispensing in Long Term Care and the packaging methodology or dispensing frequency is missing or inappropriate for LTC short cycle.</td>
</tr>
</tbody>
</table>
9.5.2.1 PLAN SUPPORT OF SUBMISSION CLARIFICATION CODE

Question:
If an SCC code is submitted on a claim but the plan does not require it, should they deny based solely on its submission? Some plans have asked LTC pharmacies to submit the codes identifying dispensing methodology in order to correctly determine dispensing fees. These SCC codes were originally added for use with short cycle dispensing but the standard does not prohibit use outside short cycle. Pharmacies have updated their systems to send the appropriate clarification code on all claims rather than attempting manual intervention at point of sale or plan specific coding. Due to the submission of these clarification codes, pharmacies are receiving numerous rejections from plans (mainly commercial) indicating they do not support the SCC code. Pharmacies are removing the SCC code and resubmit in order for the claims to adjudicate. Should this be the case or should the plan ignore the unsolicited SCC code and adjudicate based on the requested information?

I thought that unsolicited data was to be ignored but does the use of reject code 8R – Submission Clarification Code value not supported, negate that?

Response:
Whether or not SCC values are supported by a payer, the payer should not reject LTC claims submitted with SCC values of 21 thru 36 based solely on the inclusion of these codes.

9.5.3 APPROPRIATE DISPENSING AND INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICFIID) AND INSTITUTE OF MENTAL DISEASE (IMD)

CMS waives the 14-day or less dispensing requirements for pharmacies when they service Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICFIID) and Institute of Mental Disease (IMD). In the claim transaction there is a distinct patient residence value 9 assigned to ICFIID to identify the patient residence accordingly on the claim historically the payer has not utilized this value and instead it is common practice across the industry for payers to require the provider to identify these facilities as Nursing Facility value 3.

In order to insure that pharmacy claims for residents of an ICFMR facility are reimbursed correctly, and the short cycle dispense requirements are waived, it is imperative that the industry recognize the Patient Residence (384-4X) ICFMR value 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities= A facility which primarily provides health-related care and services above the level of custodial care to individuals with Intellectual Disabilities but does not provide the level of care or treatment available in a hospital or SNF) and discontinue the use of 3 (Nursing Facility = A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.). The payers must accept the Patient Residence (384-4X) value 9 for ICFIID/IMD and apply appropriate LTC rules across all payers while excluding these from the Medicare Part D short cycle dispensing requirement.
10 COORDINATION OF BENEFITS INFORMATION

10.1 CLARIFICATION OF NET AMOUNT DUE IN COORDINATION OF BENEFITS

In Telecom D.4, the following was clarified

FROM:

Prescription And Service Pricing Formulae

Question: What Are The Prescription And Service Pricing Formulae?

Response:

Prescription Formula Claim Request:


---------------------------------------------

= Gross Amount Due (430-DU)
- Patient Paid Amount Submitted (433-DX)
- Other Payer Amount Paid (431-DV)

(Result is net amount due)

Note: Net amount due as defined above is applicable to primary and COB claims in which Other Payer Amount Paid (431-DV) is submitted. Net amount due for COB claim billings for Other Payer-Patient Responsibility Amount equals sum of the parts of other payer-patient responsibility amount(s).

Net amount due for Coordination of Benefit (COB) Claims:

For COB claims net amount due must be calculated using the “Other Payer” fields within the Coordination of Benefits/Other Payments Segment.

- If the COB processing is based on “Other Payer Amount Paid”, then net amount due is calculated as noted above and all applicable Other Payer Amount Paid values are summarized to determine the amount the provider has already been (or will be) paid for the claim.
- If the COB processing is based on “Other Payer-Patient Responsibility Amounts”, the net amount due is the sum of the ‘payable components of the Other Payer-Patient Responsibility values provided from the LAST payer.

As noted in section “Specific Segment Discussion”, “Response Segments”, “Response Pricing Segment”, “Healthcare Reimbursement Account (HRA), Health Savings Accounts (HSAs), and Healthcare Flexible Spending Account (FSA)”, Scenario 2B-2:Secondary Insurance Pays the Detailed Patient Responsibility Claim Resulting in Reduced Patient Responsibility” – if the COB payer is not paying all components of the prior Patient Responsibility Amounts, the unpaid components must be sent back for the patient to pay or the claim must be rejected.

Prescription Formula Response:

- Patient Pay Amount (505-F5)
- Other Payer Amount Recognized (566-J5)

-------------------------------------------------------

= Total Amount Paid (509-F9)

Service Claim Request Formula:

Professional Service Fee Submitted (477-BE) + Flat Sales Tax Amount Submitted (481-HA) + Percentage Sales Tax Amount Submitted (482-GE) + Other Amount Claimed Submitted (480-H9)

-------------------------------------------------------

= Gross Amount Due (430-DU)
- Patient Paid Amount Submitted (433-DX)
- Other Payer Amount Paid (431-DV)

(Result is net amount due)
Note: Net amount due as defined above is applicable to primary and COB services in which Other Payer Amount Paid (431-DV) is submitted. Net amount due for COB service billings for Other Payer-Patient Responsibility Amount equals sum of the parts of other payer-patient responsibility amount(s).

Net amount due for Coordination of Benefit (COB) Claims:
For COB claims net amount due must be calculated using the “Other Payer” fields within the Coordination of Benefits/Other Payments Segment.

- If the COB processing is based on “Other Payer Amount Paid”, then net amount due is calculated as noted above and all applicable Other Payer Amount Paid values are summarized to determine the amount the provider has already been (or will be) paid for the claim.
- If the COB processing is based on “Other Payer-Patient Responsibility Amounts”, the net amount due is the sum of the ‘payable components of the Other Payer-Patient Responsibility values provided from the LAST payer.

As noted in section “Specific Segment Discussion”, “Response Segments”, “Response Pricing Segment”, “Healthcare Reimbursement Account (HRA), Health Savings Accounts (HSAs), and Healthcare Flexible Spending Account (FSA)”, Scenario 2B-2:Secondary Insurance Pays the Detailed Patient Responsibility Claim Resulting in Reduced Patient Responsibility” – if the COB payer is not paying all components of the prior Patient Responsibility Amounts, the unpaid components must be sent back for the patient to pay or the claim must be rejected.

Service Response Formula:

<table>
<thead>
<tr>
<th>Professional Service Fee Paid (562-J1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Flat Sales Tax Amount Paid (558-AW)</td>
</tr>
<tr>
<td>+ Percentage Sales Tax Amount Paid (559-AX)</td>
</tr>
<tr>
<td>+ Other Amount Paid (565-J4)</td>
</tr>
<tr>
<td>- Patient Pay Amount (505-F5)</td>
</tr>
<tr>
<td>- Other Payer Amount Recognized (566-J5)</td>
</tr>
<tr>
<td>------------------------------</td>
</tr>
<tr>
<td>= Total Amount Paid (509-F9)</td>
</tr>
</tbody>
</table>

TO

Prescription And Service Pricing Formulae

Question: What Are The Prescription And Service Pricing Formulae?

Response:

The purpose of the formulae is to provide clarification on how providers should balance the claim submission and how processor/payers should determine the ‘net’ value that is being billed. This is critical in coordination of benefits (COB) scenarios since the Pricing Segment contains values ‘as if’ the claim was primary and the Other Payer values are contained in the Coordination of Benefits/Other Payments Segment.

Prescription Formula Claim Request:

<table>
<thead>
<tr>
<th>Ingredient Cost Submitted (409-D9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Dispensing Fee Submitted (412-DC)</td>
</tr>
<tr>
<td>+ Incentive Amount Submitted (438-E3)</td>
</tr>
<tr>
<td>+ Other Amount Claimed Submitted (480-H9)</td>
</tr>
<tr>
<td>+ Flat Sales Tax Amount Submitted (481-HA)</td>
</tr>
<tr>
<td>+ Percentage Sales Tax Amount Submitted (482-GE)</td>
</tr>
<tr>
<td>------------------------------</td>
</tr>
<tr>
<td>= Gross Amount Due (430-DU)</td>
</tr>
<tr>
<td>- Patient Paid Amount Submitted (433-DX)</td>
</tr>
<tr>
<td>- Other Payer Amount Paid (431-DV)</td>
</tr>
<tr>
<td>(Result is net amount due)</td>
</tr>
</tbody>
</table>

Note: Net amount due as defined above is applicable to primary and/or COB claims in which Other Payer Amount Paid (431-DV) is submitted (further clarification below for COB).

For Coordination of Benefit (COB) claims net amount due must be derived using the “Other Payer” fields within the Coordination of Benefits/Other Payments Segment.

- If COB processing is based on “Other Payer Amount Paid” the processor should determine what has been paid by prior payers. This is accomplished by summarizing ‘like’ Other
Payer Amount Paid dollars across prior payers and then using these values against ‘like’ contractual amounts to reduce that liability for the current payer.

- This means drug benefit dollars paid should be used to reduce drug benefit dollars that would be paid if primary; delivery dollars paid would reduce delivery dollars if such contractual agreement exists, etc.
- If delivery is not part of the agreement with the COB payer, the dollars paid for delivery cannot be used to reduce drug benefit costs since provider has the obligation to provide the service.

Once the applicable Other Payer Amount Paid dollars have been properly summarized, net amount due is the result of the calculation noted above.

- If COB processing is based on “Other Payer-Patient Responsibility Amounts”, the net amount due is the sum of the payable components of the Other Payer-Patient Responsibility values from the last payer as determined by Other Payer Coverage Type (338-5C) (i.e. Primary, Secondary, etc.) that returned a paid response. When reimbursement is based on the Other Payer-Patient Responsibility Amount, Basis of Reimbursement Determination (522-FM) value 14 would be returned on the response.

As noted in section “Specific Segment Discussion”, “Response Segments”, “Response Pricing Segment”, “Healthcare Reimbursement Account (HRA), Health Savings Accounts (HSAs), and Healthcare Flexible Spending Account (FSA)”, Scenario 2B-2:Secondary Insurance Pays the Detailed Patient Responsibility Claim Resulting in Reduced Patient Responsibility” – if the COB payer is not paying all components of the prior Patient Responsibility Amounts, the unpaid components must be sent back for the patient to pay or the claim must be rejected.

**Prescription Formula Response:**

\[
\begin{align*}
\text{Ingredient Cost Paid} & \quad (506-F6) \\
+ \text{Dispensing Fee Paid} & \quad (507-F7) \\
+ \text{Incentive Amount Paid} & \quad (521-FL) \\
+ \text{Other Amount Paid} & \quad (565-J4) \\
+ \text{Flat Sales Tax Amount Paid} & \quad (558-AW) \\
+ \text{Percentage Sales Tax Amount Paid} & \quad (559-AX) \\
\text{- Patient Pay Amount} & \quad (505-F5) \\
\text{- Other Payer Amount Recognized} & \quad (566-J5)
\end{align*}
\]

\[
\begin{align*}
\text{=} \quad \text{Total Amount Paid} \quad (509-F9)
\end{align*}
\]

**Service Claim Request Formula:**

\[
\begin{align*}
\text{Professional Service Fee Submitted} & \quad (477-BE) \\
+ \text{Flat Sales Tax Amount Submitted} & \quad (481-HA) \\
+ \text{Percentage Sales Tax Amount Submitted} & \quad (482-GE) \\
+ \text{Other Amount Claimed Submitted} & \quad (480-H9)
\end{align*}
\]

\[
\begin{align*}
\text{=} \quad \text{Gross Amount Due} \quad (430-DU) \\
\text{- Patient Paid Amount Submitted} & \quad (433-DX) \\
\text{- Other Payer Amount Paid} & \quad (431-DV)
\end{align*}
\]

(Result is net amount due)

Net amount due as defined above is applicable to primary and/or COB claims in which Other Payer Amount Paid (431-DV) is submitted (further clarification below for COB).
For Coordination of Benefit (COB) claims net amount due must be derived using the “Other Payer” fields within the Coordination of Benefits/Other Payments Segment.

- If COB processing is based on “Other Payer Amount Paid” the processor should determine what has been paid by prior payers. This is accomplished by summarizing ‘like’ Other Payer Amount Paid dollars across prior payers and then using these values against ‘like’ contractual amounts to reduce that liability for the current payer. Once the applicable Other Payer Amount Paid dollars have been properly summarized, net amount due is the result of the calculation noted above.

- If COB processing is based on “Other Payer-Patient Responsibility Amounts”, the net amount due is the sum of the payable components of the Other Payer-Patient Responsibility values from the last payer as determined by Other Payer Coverage Type (338-5C) (i.e. Primary, Secondary, etc.) that returned a paid response. When reimbursement is based on the Other Payer-Patient Responsibility Amount, Basis of Reimbursement Determination (522-FM) value 14 would be returned on the response.

As noted in section “Specific Segment Discussion”, “Response Segments”, “Response Pricing Segment”, “Healthcare Reimbursement Account (HRA), Health Savings Accounts (HSAs), and Healthcare Flexible Spending Account (FSA)”, Scenario 2B-2:Secondary Insurance Pays the Detailed Patient Responsibility Claim Resulting in Reduced Patient Responsibility — if the COB payer is not paying all components of the prior Patient Responsibility Amounts, the unpaid components must be sent back for the patient to pay or the claim must be rejected.

**Service Response Formula:**

\[
\text{Professional Service Fee Paid (562-J1)} + \text{Flat Sales Tax Amount Paid (558-AW)} + \text{Percentage Sales Tax Amount Paid (559-AX)} + \text{Other Amount Paid (565-J4)} - \text{Patient Pay Amount (505-F5)} - \text{Other Payer Amount Recognized (566-J5)} = \text{Total Amount Paid (509-F9)}
\]

**10.1.1 PAYABLE COMPONENTS OF OTHER PAYER-PATIENT RESPONSIBILITY AMOUNTS**

**Question:**

Above, it states

If COB processing is based on "Other Payer-Patient Responsibility Amounts", the net amount due is the sum of the payable components of the Other Payer-Patient Responsibility values from the last payer as determined by Other Payer Coverage Type (338-5C) (i.e. Primary, Secondary, etc.) that returned a paid response.

We believe the "payable components" are determined by the COB payer in accordance with the business partner agreement, but since we couldn't find any other reference to this in the documentation, we want to confirm that this is true. As an example, we (as the COB payer) may define the Amount of Copay (351-NP value 05) as a payable component, but may define the Amount Attributed to Product Selection/Non-Preferred Formulary Selection (351-NP value 08) as a non-payable component. Is this correct?

**Response:**

Yes, the COB payer can determine what Other Payer-Patient Responsibility Amount(s) are payable or non-payable based on benefit structure. However, any non-payable components must be paid by the patient or when the COB payer (e.g. Medicaid) cannot charge remainder to the patient the claim must be rejected.
10.2 THREE OPTIONS FOR COORDINATION OF BENEFITS

10.2.1 ONLY THREE OPTIONS ALLOWED?

Question:
During the various Task Group calls regarding Telecom D.0 secondary claims pricing, three possible ways to process these claims have been discussed, as follows:

a. Secondary Plan Pay is equal to Primary Plan Pay minus sum of Other Payer Amount Paid (OPAP)
b. Secondary Plan Pay is determined using sum of Other Payer-Patient Responsibility Amount (OPPRA) as Secondary Drug Cost
c. Compare the results of options a and b, using lesser-of as the secondary drug cost (government programs)

Question:
Are options a, b, and c the only valid options in D.0, or are we free to develop additional pricing formulas? For example:

a. Secondary Plan Pay is determined using Primary Drug Cost minus sum of OPAP as Secondary Drug Cost.

Example:

<table>
<thead>
<tr>
<th>Option</th>
<th>Primary Drug Cost</th>
<th>OPAP</th>
<th>Coinsurance</th>
<th>Secondary Drug Cost</th>
<th>Primary Plan Pay</th>
<th>Secondary Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>100</td>
<td>40</td>
<td>10%</td>
<td>n/a</td>
<td>90</td>
<td>Primary Plan Pay - OPAP = 50</td>
</tr>
<tr>
<td>d)</td>
<td>100</td>
<td>40</td>
<td>10%</td>
<td>60</td>
<td>n/a</td>
<td>Secondary Drug Cost - (Secondary Drug Cost * Coinsurance) = 54</td>
</tr>
</tbody>
</table>

Revised Question & Example – approved by submitter:
When the plan is non-primary, is the patient pay amount calculated or determined before or after the other payer amount paid is recognized?

Example:

<table>
<thead>
<tr>
<th>Option</th>
<th>Drug prior to other payer reduction</th>
<th>Member Liability</th>
<th>Other Payer Amount Paid (OPAP)</th>
<th>Patient Pay Calculation</th>
<th>Patient Pay Amount</th>
<th>Total Amount Paid Calculation</th>
<th>Total Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Member liability applied to drug before to other payer reduction</td>
<td>$100.00</td>
<td>10%</td>
<td>$40.00</td>
<td>$100.00 * 10%</td>
<td>$10.00</td>
<td>$100.00 - $40.00 - $10.00 = $50.00</td>
</tr>
<tr>
<td>d)</td>
<td>Member liability applied to drug other payer reduction</td>
<td>$100.00</td>
<td>10%</td>
<td>$40.00</td>
<td>($100.00 - $40.00) * 10%</td>
<td>$6.00</td>
<td>$100.00 - $40.00 - $6.00 = $54.00</td>
</tr>
</tbody>
</table>

Response:
It is the plan benefit design that determines if the patient pay is calculated before or after the reduction of other payer amount recognized. The pricing formulae as defined in the Standard must be followed in order to return a balanced claim response.

10.2.2 MULTIPLE COB OPTIONS PER BIN/PCN?

Question:
We have a need to know as a secondary payer if the primary payer adjudicated the claim but paid nothing to the pharmacy or rather the patient paid all of it. We want to do one benefit if the patient has copay and another if the patient is paying the full amount. Under 5.1 we can’t do this but under D.0 it appears we can. I was referred to section 33.6.5 of the imp guide. The example used the COB segment for Patient Responsibility Billing. The
example uses some of the “pieces” but not all of them. Are we allowed to require all of the pieces so that I can add them up and know the patients total out-of-pocket or is that not allowed? In the example provided (assuming it references the previous claim example to a primary payer) the 3 pieces included in the COB (deductible, copay and product selection) all add up the patients pay amount from the prior payer. My question is what if there are more pieces (e.g. portion attributable to the coverage gap or some other reason not related to part – d at all, there are after all 13 qualifiers for 351-NP). Can I require in my implementation those corresponding Other Payer-Patient Responsibility Amount values and their related qualifiers)?

Response:
Per payer sheet guidance, the payer sheet for a specific BIN/PCN would dictate which COB method is required by the payer. Only one COB method can be used per payer sheet. A plan may not switch from one COB method to another COB method on a claim by claim basis. For Other Payer-Patient Responsibility billing the payer sheet can request either the total patient pay amount be submitted using Other Payer-Patient Responsibility Amount Qualifier (351-NP) with a qualifier value of “06” (Patient Pay Amount (505-F5) as reported by previous payer) or each of the component pieces of patient pay be submitted with their applicable qualifier. Note: NCPDP recommends the use of the component pieces however if the components do not sum to patient pay amount, the use of Other Payer-Patient Responsibility Amount Qualifier (351-NP) value of “06” is allowed.

10.2.2.1 COMPONENT PIECES NOT SUM TO PATIENT PAY AMOUNT?

Question:
When wouldn’t the component pieces sum to the patient pay amount? Don’t the component pieces have to sum to the patient pay amount in order to create a balanced claim response?

Response:
The following situations may present incomplete reporting of the components of patient pay and result in inconsistencies with coordination of benefit claims processing.

- Improper building of the response transaction from the previous payer.
- ECL versioning per payer may result in the inability for the response pricing components to be mapped to the detailed vD.0 Other Payer-Patient Responsibility Amount qualifiers, for example:
  - The provider cannot determine if the values returned in the Amount of Copay/Coinsurance (518-FI) field of a v5.1 claim response should be reported as the Other Payer-Patient Responsibility Amount Qualifier (351-NP) as “05” (Amount of Copay) or “07” (Amount of Coinsurance) on the vD.0 coordination of benefit claim.

10.3 OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) VALUE FOR SALES TAX

In order to appropriately bill sales tax amounts to a downstream payer, any tax amount paid by previous payers must also be reported. DERF 000953 was submitted and approved in the May 2010 Work Group meetings to add a value to Other Payer Amount Paid Qualifier (342-HC). The value is available in the June 2010 NCPDP External Code List.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Sales Tax - An Indicator which signifies the dollar amount paid by the other payer which is related to Sales Tax.</td>
</tr>
</tbody>
</table>
### Price Attributes

<table>
<thead>
<tr>
<th>Drug AWP Cost</th>
<th>Primary Does Not Pay Tax/Secondary Calculates 6% Tax</th>
<th>Primary Pays 3% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient.</th>
<th>Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax/Exempt (431-DV Tax Amount Paid Not Considered)</th>
<th>Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>$95.00</td>
<td>$95.00</td>
<td>$95.00</td>
<td>$95.00</td>
<td>$95.00</td>
</tr>
<tr>
<td><strong>Tax Rate Submitted</strong></td>
<td>6.00%</td>
<td>6.00%</td>
<td>6.00%</td>
<td>6.00%</td>
</tr>
<tr>
<td><strong>Primary Rate (AWP - X%)</strong></td>
<td>-16.00%</td>
<td>-16.00%</td>
<td>-16.00%</td>
<td>-16.00%</td>
</tr>
<tr>
<td><strong>Primary Fee</strong></td>
<td>$2.50</td>
<td>$2.50</td>
<td>$2.50</td>
<td>$2.50</td>
</tr>
<tr>
<td><strong>Primary Tax Rate Paid</strong></td>
<td>0.00%</td>
<td>3.00%</td>
<td>6.00%</td>
<td>6.00%</td>
</tr>
<tr>
<td><strong>Primary Tax Paid</strong></td>
<td>$0.00</td>
<td>$2.47</td>
<td>$4.94</td>
<td>$4.94</td>
</tr>
<tr>
<td><strong>Primary Receivable</strong></td>
<td>$57.30</td>
<td>$59.77</td>
<td>$62.24</td>
<td>$61.00</td>
</tr>
<tr>
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### Basis of Reimbursement Determination

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**Telecommunication Version D and Above Questions, Answers and Editorial Updates**

#### Bill to Primary Submitting Tax Amounts

- **Primary Does Not Pay Tax/Secondary Calculates 6% Tax**
- **Primary Pays 3% Tax/Secondary Calculates 6% Tax**
- **Primary Pays 6% Tax/Secondary Calculates 6% Tax**
- **Primary Pays 6% Tax/Tertiary Tax Exempt (431-DV Tax Amount Paid Not Considered)**
- **Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax**

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<table>
<thead>
<tr>
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| SECONMDY Pricing Segment       | Primary Does Not Pay Tax/Secondary | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary Tax Exempt (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |

| Ingredient Cost Submitted      | 409-D9                            | $95.00                                                                      | $95.00                                                         | $95.00                                                      |
| Dispensing Fee Submitted       | 412-DC                            | $5.00                                                                       | $5.00                                                         | $5.00                                                      |
| Percentage Tax Amount Submitted| 482-GE                            | $6.00                                                                       | $6.00                                                         | $6.00                                                      |
| Percentage Sales Tax Rate Submitted | 483-HE                        | 6.00%                                                                       | 6.00%                                                        | 6.00%                                                      |
| Percentage Sales Tax Basis Submitted | 484-JE                         | 3 – IC + Fee                                                                | 3 – IC + Fee                                                 | 3 – IC + Fee                                               |
| Gross Amount Due               | 430-DU                            | $106.00                                                                     | $106.00                                                      | $106.00                                                   |
| Basis of Cost Determination    | 423-DN                            | 01 - AWP                                                                    | 01 - AWP                                                     | 01 - AWP                                                   |

| SECONMDY COB Segment           | Primary Does Not Pay Tax/Secondary | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary Tax Exempt (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |

| Coordination Of Benefits/Other Payments Count | 337-4C                           | 1                                                                           | 1                                                              | 1                                                            |
| Other Payer Coverage Type       | 338-SC                            | 1                                                                           | 1                                                              | 1                                                            |
| Other Payer Id Qualifier        | 339-6C                            | 3                                                                           | 3                                                              | 3                                                            |
| Other Payer Id                  | 340-7C                            | 123456                                                                      | 123456                                                        | 123456                                                      |
| Other Payer Date                | 443-E8                            | 20090201                                                                    | 20090201                                                      | 20090201                                                   |

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### SECONDARY RESPONSE Pricing Segment

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### TERTIARY Pricing Segment

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<th>Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary Tax Exempt (431-DV Tax Amount Paid Not Considered)</th>
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**Calculates 6% Tax**

**Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax**

**Primary Pays 3% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient.**

**Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary Tax Exempt (431-DV Tax Amount Paid Not Considered)**

**Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax**

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### TERTIARY RESPONSE Pricing Segment

<table>
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<th>Parameter</th>
<th>20090201</th>
<th>20090201</th>
<th>20090201</th>
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<tbody>
<tr>
<td>Amount of Copay</td>
<td>$2.00</td>
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<td>Amount Attributed to Sales Tax</td>
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<td>$0.06</td>
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<td>Percent Sales Amount Paid</td>
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<td>$5.83</td>
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<tr>
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<td>6.00%</td>
<td>6.00%</td>
<td>7.00%</td>
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<tr>
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<td>3 – IC + Fee</td>
<td>3 – IC + Fee</td>
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<td>Other Payer Amount Recognized</td>
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<td>Patient Sales Tax Amount</td>
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<td>$0.00</td>
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<tr>
<td>Tax Exempt Indicator *</td>
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<td></td>
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<tr>
<td>Basis of Reimbursement Determination</td>
<td>8 – Contract Pricing</td>
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### Net Amount Due

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<td>Script Total Sales Tax</td>
<td>$88.25</td>
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<td>$88.19</td>
<td>$89.08</td>
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<td>Script Sell Price</td>
<td>$83.25</td>
<td>$83.25</td>
<td>$83.25</td>
<td>$83.25</td>
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</table>
* If Percent tax Amount is submitted to the payer, unless a Tax Exempt Indicator applies, the payer must return a percent tax amount paid value, even if the value is $0, the percent sales tax rate and percent sales tax basis. If a Tax Exempt Indicator applies, the applicable tax exempt value must be returned, however the percent sales tax amount paid, basis and rate do not have to be returned.

<table>
<thead>
<tr>
<th>Tax Exempt Indicator Value</th>
<th>Definition</th>
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<tbody>
<tr>
<td>1</td>
<td>Payer/Plan is tax exempt</td>
</tr>
<tr>
<td>3</td>
<td>Patient is tax exempt</td>
</tr>
<tr>
<td>4</td>
<td>Plan/Payer and patient are tax exempt</td>
</tr>
</tbody>
</table>
10.4 OTHER PAYER COVERAGE TYPE (338-5C) IS UNKNOWN

Question:
Our clients are not always able to resolve a discrepancy in a patient’s other payer information. For example, they may have two other payers listed for a member as primary at a single point in time. We want to make sure we identify all known other payer information back to the provider to help them in the COB process. We would like to make sure it is compliant with the standard to return both other payers with the same Other Payer Coverage Type (338-5C) value on a response. The provider would then have the information for both other payers and could work with the patient to resolve. We have reviewed the NCPDP documentation and cannot find any language that would prevent us from returning two other payers as primary if that is the patient TPL information that we have received from a client. Could you please validate that this situation would be NCPDP compliant?

Response:
In the situation where the processor is provided other primary coverage(s) for a member, however the specific order in which these plans should be billed is not known, the processor should identify the Other Payer Coverage Type (338-5C) as BLANK – NOT SPECIFIED, within the Response Coordination of Benefit/Other Payers Segment.

Other Payer ID Count (355-NT) = the number of loops. This only is allowed in the Response COB/Other Payers Segment.

Other Payer Coverage Type (338-5C) – as the External Code List defines valid values of blank, 1, 2 or 3, occurrence 1, 2, and/or 3 could contain blank as a valid value. The pharmacy would then need to work with the patient and the plans to determine what the order really should be.

Response Coordination of Benefits/Other Payers Segment

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
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<tbody>
<tr>
<td>355-NT</td>
<td>Other Payer ID Count</td>
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<tr>
<td>338-SC</td>
<td>Other Payer Coverage Type</td>
</tr>
<tr>
<td>339-SC</td>
<td>Other Payer ID Qualifier</td>
</tr>
<tr>
<td>340-7C</td>
<td>Other Payer ID</td>
</tr>
<tr>
<td>991-MH</td>
<td>Other Payer Processor Control Number</td>
</tr>
<tr>
<td>356-NU</td>
<td>Other Payer Cardholder ID</td>
</tr>
<tr>
<td>992-MJ</td>
<td>Other Payer Group ID</td>
</tr>
<tr>
<td>142-UV</td>
<td>Other Payer Person Code</td>
</tr>
<tr>
<td>127-UB</td>
<td>Other Payer Help Desk Phone Number</td>
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<tr>
<td>143-UW</td>
<td>Other Payer Patient Relationship Code</td>
</tr>
<tr>
<td>144-UX</td>
<td>Other Payer Benefit Effective Date</td>
</tr>
<tr>
<td>145-UU</td>
<td>Other Payer Benefit Termination Date</td>
</tr>
</tbody>
</table>

10.5 OTHER AMOUNT PAID (565-J4) AND COB

Question:
In a COB claim, if a patient is in the deductible phase and Payer1 has agreed to pay for some Delivery Fee (or any 'Other Amount Paid'), what is the proper response data Payer1 should send back and what should the Pharmacy submit for the COB Segment in the request to Payer2?

PRIMARY CLAIM

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ingredient Cost Submitted</td>
<td>94.00</td>
</tr>
<tr>
<td>Dispensing Fee Submitted</td>
<td>5.50</td>
</tr>
<tr>
<td>Other Amount Claim Submitted (Delivery)</td>
<td>12.00</td>
</tr>
<tr>
<td>Other Amount Claim Submitted (Compound)</td>
<td>9.00</td>
</tr>
<tr>
<td>Incentive Amount Submitted</td>
<td>10.00</td>
</tr>
<tr>
<td>Percent Sales Tax Amount</td>
<td>4.70</td>
</tr>
<tr>
<td>Percent Sales Tax Basis</td>
<td>02</td>
</tr>
<tr>
<td>Percent Sales Tax Rate</td>
<td>0.05</td>
</tr>
<tr>
<td>Gross Amount Due</td>
<td>135.20</td>
</tr>
<tr>
<td>Usual and Customary</td>
<td>105.00</td>
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</table>

SECONDARY CLAIM

<table>
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<tr>
<th>Field Name</th>
<th>Value</th>
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<tbody>
<tr>
<td>Ingredient Cost Submitted</td>
<td>94.00</td>
</tr>
<tr>
<td>Dispensing Fee Submitted</td>
<td>5.50</td>
</tr>
<tr>
<td>Other Amount Claim Submitted (Delivery)</td>
<td>12.00</td>
</tr>
<tr>
<td>Other Amount Claim Submitted (Compound)</td>
<td>9.00</td>
</tr>
<tr>
<td>Incentive Amount Submitted</td>
<td>10.00</td>
</tr>
<tr>
<td>Percent Sales Tax Amount</td>
<td>4.70</td>
</tr>
<tr>
<td>Percent Sales Tax Basis</td>
<td>02</td>
</tr>
<tr>
<td>Percent Sales Tax Rate</td>
<td>0.05</td>
</tr>
<tr>
<td>Gross Amount Due</td>
<td>135.20</td>
</tr>
<tr>
<td>Usual and Customary</td>
<td>105.00</td>
</tr>
</tbody>
</table>
**Response:**
The Response Pricing Segment should be determined by the specific benefit and contractual agreement and must adhere to the NCPDP Pricing Formula. To accurately report the amounts paid in the Other Payer Amount Paid field (431-DV) in a COB Other Payer Coverage Type occurrence, a specific order of Other Payer Amount Paid Qualifiers (342-HC) must be followed.

- Order is based on the payment being associated to provider versus state revenue, and the dispensing of a product versus value added services.
- Drug Benefit is the end result, after all Other Payer Amount Paid values are subtracted from Total Amount Paid (509-F9)

<table>
<thead>
<tr>
<th>COB CLAIM 342-HC REPORTING ORDER</th>
<th>342-HC OTHER PAYER AMOUNT PAID QUALIFIER VALUE</th>
<th>DESCRIPTION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>Sales Tax - An Indicator which signifies the dollar amount paid by the other payer which is related to Sales Tax.</td>
<td>Neither Product nor Service, not part of Sales. Any tax amount paid by the previous plan(s) should be the 1st amount reported to downstream payer. If payer does not pay tax then they cannot use taxes paid by prior payer(s) to reduce payment obligations or used towards other payer amount recognized amount reported. The product cannot be dispensed without the compound prep.</td>
</tr>
<tr>
<td>2</td>
<td>09</td>
<td>Compound Preparation Cost – An indicator which signifies the dollar amount paid by the other payer which is related to the preparation of the compound.</td>
<td>Value Added Service</td>
</tr>
<tr>
<td>3</td>
<td>01</td>
<td>Delivery – An Indicator which signifies the dollar amount paid by the other payer which is related to the delivery of a product or service.</td>
<td>Value Added Service</td>
</tr>
<tr>
<td>4</td>
<td>02</td>
<td>Shipping – An indicator which signifies the dollar amount paid by the other payer which is related to the transportation of a product.</td>
<td>Value Added Service</td>
</tr>
<tr>
<td>5</td>
<td>03</td>
<td>Postage – An indicator which signifies the dollar amount paid by the other payer which is related to the mailing of a product.</td>
<td>Value Added Service</td>
</tr>
</tbody>
</table>
Administrative – An indicator which signifies the dollar amount paid by the other payer which is related to administrative activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance.

Incentive - An indicator which signifies the dollar amount paid by the other payer which is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g. collection of survey data, counseling plan enrollees, vaccine administration).

Drug Benefit – An indicator which signifies the dollar amount paid by the other payer which is related to the plan’s drug benefit.

END RESULT of subtracting all Other Payer Amount Paid values from Total Amount Paid (509-F9)

In the situation when the payer’s Total Amount Paid (509-F9) is less than the sum of the Other Amounts Paid (565-J4) + Incentive Amount Paid (521-FL) + Tax Amount Paid (559-AX + 558-AW – 523-FN) values, the Other Payer Amount Paid (431-DV) values reported for that COB Other Payer Coverage Type (338-5C) occurrence should be subtracted from Total Amount Paid (509-F9) and reported in the COB claim in the specific order outlined above.

The below steps outline a consistent process to report the Other Payer Amount Paid (431-DV) values in the Other Payer Coverage Type occurrences, regardless of the values returned in the payer’s response pricing segment.

- For each unique Other Payer Amount Paid (431-DV) value to be calculated, steps (1 – 6) should be performed before the Other Payer Amount Paid Drug Benefit (07) can be calculated (step 7).
- The values listed under each step are associated to building the Other Payer Coverage Type occurrence (i.e. when billing to the tertiary)
- Note: NCPDP Telecommunication Standard limits the Other Amount Paid Count (563-J2) to 3. To illustrate detailed explanations for each Other Amount Paid Qualifier value listed in the January 2011 ECL, field 565-J4 is repeated 5 times in the below example.

<table>
<thead>
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<th>FIELD ID</th>
<th>PRIMARY RESPONSE PRICING</th>
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<td>506-F6</td>
<td>INGREDIENT COST PAID</td>
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<tr>
<td>507-F7</td>
<td>DISPENSING FEE PAID</td>
<td>$5.00</td>
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<tr>
<td>565-J4</td>
<td>OTHER AMOUNT PAID (Delivery)</td>
<td>$0.00</td>
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<tr>
<td>565-J4</td>
<td>OTHER AMOUNT PAID (Shipping)</td>
<td>$0.00</td>
</tr>
<tr>
<td>565-J4</td>
<td>OTHER AMOUNT PAID (Postage)</td>
<td>$0.00</td>
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<tr>
<td>565-J4</td>
<td>OTHER AMOUNT PAID (Administrative)</td>
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<tr>
<td>565-J4</td>
<td>OTHER AMOUNT PAID (Compound)</td>
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<tr>
<td>521-FL</td>
<td>INCENTIVE AMOUNT PAID</td>
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<tr>
<td>559-AX</td>
<td>PERCENTAGE SALES TAX AMOUNT PAID</td>
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<tr>
<td>561-AZ</td>
<td>PERCENTAGE SALES TAX BASIS PAID</td>
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<td>560-AY</td>
<td>PERCENTAGE SALES TAX RATE PAID</td>
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<td>566-J5</td>
<td>OTHER PAYER AMOUNT RECOGNIZED</td>
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<td>505-F5</td>
<td>PATIENT PAY AMOUNT</td>
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<td>518-F1</td>
<td>AMOUNT OF COPAY</td>
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<td>523-FN</td>
<td>AMOUNT ATTRIBUTED TO TAX</td>
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<td>517-FH</td>
<td>AMOUNT APPLIED TO PERIODIC DEDUCTIBLE</td>
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<td>509-F9</td>
<td>TOTAL PAID AMOUNT</td>
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<tr>
<td>574-2Y</td>
<td>PLAN SALES TAX AMOUNT</td>
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<td>575-EQ</td>
<td>PATIENT SALES TAX AMOUNT</td>
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### Telecommunication Version D and Above Questions, Answers and Editorial Updates

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<tr>
<td>431-DV</td>
<td>Other Payer Amount Paid - Delivery</td>
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<tr>
<td>431-DV</td>
<td>Other Payer Amount Paid - Shipping</td>
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<td>431-DV</td>
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<td>431-DV</td>
<td>Other Payer Amount Paid - Administrative</td>
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<td>431-DV</td>
<td>Other Payer Amount Paid - Compound</td>
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<td>Other Payer Amount Paid - Incentive</td>
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<td>431-DV</td>
<td>Other Payer Amount Paid - Drug Benefit</td>
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<td>565-J4</td>
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<td>565-J4</td>
<td>Other Amount Paid (Compound)</td>
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<td>Incentive Amount Paid</td>
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<td>Percentage Sales Tax Basis Paid</td>
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<td>Percentage Sales Tax Rate Paid</td>
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### Filed ID | Tertiary Claim COB Segment
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<td>Other Payer Amount Paid - Compound</td>
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<td>431-DV</td>
<td>Other Payer Amount Paid - Incentive</td>
</tr>
<tr>
<td>431-DV</td>
<td>Other Payer Amount Paid - Sales Tax</td>
</tr>
<tr>
<td>431-DV</td>
<td>Other Payer Amount Paid - Drug Benefit</td>
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<td>338-SC</td>
<td>Other Payer Coverage Type 02</td>
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<td>431-DV</td>
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<td>431-DV</td>
<td>Other Payer Amount Paid - Shipping</td>
</tr>
<tr>
<td>431-DV</td>
<td>Other Payer Amount Paid - Postage</td>
</tr>
<tr>
<td>431-DV</td>
<td>Other Payer Amount Paid - Administrative</td>
</tr>
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</table>
### Telecommunication Version D and Above Questions, Answers and Editorial Updates

<table>
<thead>
<tr>
<th>431-DV</th>
<th>OTHER PAYER AMOUNT PAID - COMPOUND</th>
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<td>OTHER PAYER AMOUNT PAID - INCENTIVE</td>
<td>$2.50</td>
</tr>
<tr>
<td>431-DV</td>
<td>OTHER PAYER AMOUNT PAID - SALES TAX</td>
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</tr>
<tr>
<td>431-DV</td>
<td>OTHER PAYER AMOUNT PAID : DRUG BENEFIT</td>
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</tr>
</tbody>
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#### Other Payer Amount Paid (431-DV) Reporting Order

**Example = Other Payer Coverage Type 02 Occurrence**

<table>
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<tr>
<th>Step #</th>
<th>Action</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1. [10] Tax Amount = 559-AX</td>
<td>$4.45</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. [09] Compound = 558-AW - 523-FN</td>
<td>$5.00</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. [01] Delivery = 565-J4</td>
<td>$8.00</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
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<td>4. [01] Shipping = 565-J4 [01 Shipping]</td>
<td>$0.00</td>
<td>N/A</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. [01] Postage = 565-J4 [01 Postage]</td>
<td>$2.00</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. [04] Administrative = 565-J4 [01 Administrative]</td>
<td>$0.00</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. [05] Incentive = 521-FL [Incent Amount Paid]</td>
<td>$5.00</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Determine like &quot;OPAP Values from ALL Prior Payers&quot;</td>
<td>$5.00</td>
<td>$5.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>Determine &quot;Actual Amount Paid&quot; for current payer</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$8.00</td>
<td>$0.00</td>
<td>$2.00</td>
<td>$0.00</td>
<td>$5.00</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>• &quot;Response Amount Paid&quot; [step 1] minus &quot;OPAP from ALL Prior Payers&quot; [step 2]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If results &lt; 0, set to 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Determine &quot;Previously Reported OPAP Amount&quot; for current payer.</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ADD all Other Payer Amount Paid values previously uniquely reported (steps 1-6 completed), for current payer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10.6 **OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) VALUES SUNSETTED**

**Question:**
We’re currently finalizing the requirements for our D.0 implementation, and we’ve come across a change between 5.1 and D.0 that is causing us some consternation. We’re trying to figure out how to handle the elimination of values “08” and “99” in field Other Payer Amount Paid Qualifier (342-HC), which we’re using in v5.1 to identify the Other Payer Amount Paid and the Other Payer Allowed Amount. We were using these codes for our MSP (Medicare Secondary Payer) claims, and we’re considering submitting a DERF to have the code values added back in, but there must have been a reason these values were removed from D.0, in that there may be other fields that can be used to calculate these amount.
Response:
This is the process in place today:
1. The Allowed amount is submitted using qualifier 08
2. The Paid amount is submitted using qualifier 07
3. The Co-insurance amount is submitted using qualifier 99
4. The Deductible (when applicable) is submitted using qualifier 99

These above data elements, provide full disclosure of the previous payer’s payment response. In D.0 full disclosure is available for government programs with the applicable legislation in place via the following method:

Other Payer-Patient Responsibility Amount (352-NQ) and Other Payer-Patient Responsibility Amount Qualifier (351-NP)
Values:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. The following dollar amount is the amount of the patient’s responsibility applied to the patient’s plan periodic deductible liability.</td>
</tr>
<tr>
<td>02</td>
<td>Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.</td>
</tr>
<tr>
<td>03</td>
<td>Amount Attributed to Sales Tax (523-FN) as reported by previous payer. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription.</td>
</tr>
<tr>
<td>04</td>
<td>Amount Exceeding Periodic Benefit Maximum (520-FK) as reported by previous payer. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded.</td>
</tr>
<tr>
<td>05</td>
<td>Amount of Copay (518-FI) as reported by previous payer. Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient’s plan co-pay liability by another/previous payer.</td>
</tr>
<tr>
<td>06</td>
<td>Patient Pay Amount (505-F5) as reported by previous payer. Used to indicate the provider is submitting the amount reported by a prior payer as the patient’s responsibility.</td>
</tr>
<tr>
<td>07</td>
<td>Amount of Co-insurance (572-4U) as reported by previous payer. Co-insurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient’s current benefit status, product selection or network selection.</td>
</tr>
<tr>
<td>08</td>
<td>Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer.</td>
</tr>
<tr>
<td>09</td>
<td>Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer.</td>
</tr>
<tr>
<td>10</td>
<td>Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.</td>
</tr>
<tr>
<td>11</td>
<td>Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.</td>
</tr>
<tr>
<td>12</td>
<td>Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.</td>
</tr>
<tr>
<td>13</td>
<td>Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.</td>
</tr>
</tbody>
</table>

Other Payer Amount Paid (431-DV) and Other Payer Amount Paid Qualifier (342-HC)
Values:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Delivery – An indicator which signifies the amount paid for the costs related to the delivery of a product or service.</td>
</tr>
<tr>
<td>02</td>
<td>Shipping – The amount paid for transportation of an item.</td>
</tr>
<tr>
<td>03</td>
<td>Postage – The amount paid for the mailing of an item.</td>
</tr>
<tr>
<td>04</td>
<td>Administrative – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance.</td>
</tr>
<tr>
<td>05</td>
<td>Incentive-Used to indicate an additional fee or compensation paid to the provider by another payer as an inducement for an action taken by the provider; this might be a collection of survey data or counseling to plan enrollees.</td>
</tr>
<tr>
<td>06</td>
<td>Cognitive Service – Used to indicate pharmacist interaction with patient or caregiver beyond the traditional dispensing/patient instruction activity. For example, therapeutic regimen review, recommendation for additional, fewer, or different therapeutic choices.</td>
</tr>
<tr>
<td>07</td>
<td>Drug Benefit – An indicator which signifies when the dollar amount paid by the other payer has been paid as part of the drug benefit plan.</td>
</tr>
<tr>
<td>09</td>
<td>Compound Preparation Cost – the amount paid for the preparation of the compound</td>
</tr>
</tbody>
</table>

Note: The allowed amount would be the sum of the above fields.

The response from the primary payer using the NCPDP Telecommunication version D.0 billing transaction is real-time and the amount received in the response is the actual amount of payment and the provider’s contracted amount. The pharmacy provider then uses the primary response to send the claim to Medicare as the secondary
**Telecommunication Version D and Above Questions, Answers and Editorial Updates**

payer. NCPDP understands that Medicare as the secondary payer is required by regulation to receive the amount that the other payer has paid, the amount allowed from the other payer and the amount that the provider is obligated to accept as payment in full. Since the primary claim’s response was real-time the following should be used to determine the needed amounts:

- Submitted amount is equal to Gross Amount Due (430-DU) on the NCPDP D.0 Billing claim
- Other Payer Amount Paid (431-DV) is used in conjunction with Other Payer Amount Paid Qualifier (342-HC) to determine the amount paid by the other payer.
- Other Payer-Patient Responsibility Amount (352-NQ) is used in conjunction with Other Payer-Patient Responsibility Amount Qualifier (351-NP) to determine the financial obligation of the beneficiary from the other payer.
- Add the sum of the Other Payer Amount Paid (431-DV) and Other Payer-Patient Responsibility Amount (352-NQ) to determine the allowed amount and the amount the provider is obligated to accept.
- The financial amount returned in Total Amount Paid (509-F9) of the POS response is the contracted amount between the provider and the payer, and will match what is returned on the ASC X12 835 remittance file. Since NCPDP Telecommunication v5.1 and D.0 claims processing is real-time, Obligated to Accept as Full (OTAF) payment variance does not apply.

Example: A pharmacy submits a claim to payer ABC for $100. The pharmacy has a contract with the payer that states they will pay $80 for the claim. Due to the beneficiary having a deductible that all but $10 has been met and a copay of $10, the pharmacy is actually only paid $60 and is expected to collect the remaining $20 dollars from the beneficiary.

In the secondary D.0 claim the following fields would be submitted and used in the calculations necessary:

<table>
<thead>
<tr>
<th>FIELD</th>
<th>FIELD NAME</th>
<th>SEGMENT</th>
<th>VALUE</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>430-DU</td>
<td>GROSS AMOUNT DUE</td>
<td>CLAIM</td>
<td>1000</td>
<td>$100.00</td>
</tr>
<tr>
<td>342-HC</td>
<td>OTHER PAYER AMOUNT PAID QUALIFIER</td>
<td>COB</td>
<td>07</td>
<td>DRUG BENEFIT</td>
</tr>
<tr>
<td>431-DV</td>
<td>OTHER PAYER AMOUNT PAID</td>
<td>COB</td>
<td>600</td>
<td>$60.00</td>
</tr>
<tr>
<td>351-NP</td>
<td>OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER</td>
<td>COB</td>
<td>01</td>
<td>AMOUNT APPLIED TO PERIODIC DEDUCTIBLE (517-FH) AS REPORTED BY PREVIOUS PAYER</td>
</tr>
<tr>
<td>352-NQ</td>
<td>OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER</td>
<td>COB</td>
<td>100</td>
<td>$10.00</td>
</tr>
<tr>
<td>351-NP</td>
<td>OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER</td>
<td>COB</td>
<td>05</td>
<td>AMOUNT OF COPAY (518-FI) AS REPORTED BY PREVIOUS PAYER</td>
</tr>
<tr>
<td>352-NQ</td>
<td>OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER</td>
<td>COB</td>
<td>100</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

For MSP Calculations:

1. The Allowed amount = sum of Other Payer Amount Paid (431-DV) amounts (qualifiers applicable to MSP benefit) + sum of Other Payer-Patient Responsibility Amount (352-NQ) amounts
2. The Paid amount = sum of the Other Payer Amount Paid (431-DV) amounts (qualifiers applicable to the MSP benefit, e.g. 07 Drug Benefit)
3. The Co-insurance amount = Other Payer-Patient Responsibility Amount (352-NQ) amount where Other Payer-Patient Responsibility Amount Qualifier (351-NP) = “07” (Amount of Coinsurance (572-4U) as reported by previous payer)
4. The Deductible amount = Other Payer-Patient Responsibility Amount (352-NQ) amount where Other Payer-Patient Responsibility Amount Qualifier (351-NP) = “01” (Amount Applied to Periodic Deductible (517-FH) as reported by previous payer)

### 10.6.1 Medicaid Allowed Amount and Prescription Response Formula

Section 28.2.6 RESPONSE PRICING SEGMENT of the Telecommunication Standard outlines the Prescription Response Formula as:

- Ingredient Cost Paid (506-F6)
- Dispensing Fee Paid (507-F7)
- Incentive Amount Paid (521-FL)
- Other Amount Paid (565-J4)
- Flat Sales Tax Amount Paid (558-AW)
Providers depend on consistent use of this formula to validate the B1 claim response balances. There are situations in which this balancing does not occur.

One specific example is a Medicaid claim, where Medicaid policy language may require the Medicaid Allowed amount be reported in the Ingredient Cost Paid (F6) and Dispensing Fee (F7) fields, regardless of what the final reimbursement may be returned in Total Amount Paid (F9) and Patient Pay Amount (F5). This may occur when the provider’s usual and customary is lower than the Medicaid allowed amount, or the beneficiary is within a spenddown (deductible phase) and the U&C versus the Medicaid allowed amount applies.

**Question:**
Must the B1 Paid claim response follow the Prescription Response Formula as outlined within the Telecommunication Guide?

**Response:**
Yes, the Prescription Response Formula is to be followed.

**Question:**
If the Prescription Response Formula must be followed, is there a manner in which the plan can also report their Allowed Amount, if required by state/federal law or program policy?

**Response:**
1. Yes, use the two informational fields below for reporting the plan’s allowed amount, within the situations defined in each field. The actual reimbursement amounts should be returned within the claim balancing fields (Ingredient Cost Paid, Dispensing Fee Paid) so the formula balances.
2. See also the Telecommunication Implementation Guide for information on the use of the Usual and Customary Charge field. The Basis of Reimbursement Determination value 4 (Usual & Customary Paid as Submitted) would reflect the claim reimbursed based on the submitted U&C value. (Note there are examples in the Telecommunication Implementation Guide that show this use of Basis of Reimbursement Determination.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>148-U8</td>
<td>INGREDIENT COST CONTRACTED/REIMBURSABLE AMOUNT</td>
</tr>
<tr>
<td>149-U9</td>
<td>DISPENSING FEE CONTRACTED/REIMBURSABLE AMOUNT</td>
</tr>
</tbody>
</table>

**10.7 OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) VALUE 99?**

**Question:**
Is there an ECL DERF to reinstate the value of 99=Other for field 342-HC Other Payer Amount Paid Qualifier? (No) We have a 99=Other for both 479-H8 - Other Amount Claimed Submitted Qualifier and 564-J3 - Other Amount Paid Qualifier. However, if these values are ever used we have no way to report these values to downstream payers in Other Payer Amount Paid Qualifier (342-HC).
### Definition of Field

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Value Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Delivery Cost - An indicator which signifies the amount claimed for the costs related to the delivery of a product or service.</td>
<td>Used only in Telecommunication Standard Versions 9.0 through C.4. Value was deleted and cannot be used in higher versions.</td>
</tr>
<tr>
<td>02</td>
<td>Shipping Cost - The amount claimed for transportation of an item.</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Postage Cost - The amount claimed for the mailing of an item.</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Administrative Cost - An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance.</td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>Compound Preparation Cost Submitted - The amount claimed for the preparation of the compound.</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Other - Different from those implied or specified</td>
<td></td>
</tr>
</tbody>
</table>

### 564-J3 - Other Amount Paid Qualifier

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Value Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Delivery - An indicator which signifies the dollar amount paid for the costs related to the delivery of a product or service.</td>
<td>Used only in Telecommunication Standard Versions 9.0 through C.4. Value was deleted and cannot be used in higher versions.</td>
</tr>
<tr>
<td>02</td>
<td>Shipping - The amount paid for transportation of a product.</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Postage - The amount paid for the mailing of a product.</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Administrative - An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance.</td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>Compound Preparation Cost Paid - The amount paid for the preparation of the compound.</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

### 342-HC - Other Payer Amount Paid Qualifier

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Value Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Delivery – An indicator which signifies the dollar amount paid by the other payer which is related to the delivery of a product or service.</td>
<td>Used only in Telecommunication Standard Versions 9.0 through C.4. Value was deleted and cannot be used in higher versions.</td>
</tr>
<tr>
<td>02</td>
<td>Shipping – An indicator which signifies the dollar amount paid by the other payer which is related to the transportation of a product.</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Postage – An indicator which signifies the dollar amount paid by the other payer which is related to the mailing of a product.</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Administrative – An indicator which signifies the dollar amount paid by the other payer which is related to administrative activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance.</td>
<td></td>
</tr>
<tr>
<td>05</td>
<td>Incentive-An indicator which signifies the dollar amount paid by the other payer which is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g. collection of survey data, counseling plan enrollees, vaccine administration).</td>
<td></td>
</tr>
<tr>
<td>06</td>
<td>Cognitive Service – An indicator which signifies the dollar amount paid by the other payer which is related to the pharmacist’s interaction with a patient or caregiver</td>
<td></td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
<td>Value Limitation</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>07</td>
<td>Drug Benefit – An indicator which signifies the dollar amount paid by the other payer which is related to the plan's drug benefit.</td>
<td>Used only in Telecommunication Standard Versions 9.0 through C.4. Value deleted and cannot be used in higher versions.</td>
</tr>
<tr>
<td>08</td>
<td>Sum of All Reimbursements</td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>Compound Preparation Cost – An indicator which signifies the dollar amount paid by the other payer which is related to the preparation of the compound.</td>
<td>Used only in Telecommunication Standard Versions 9.0 through C.4. Value was deleted and cannot be used in higher versions.</td>
</tr>
<tr>
<td>10</td>
<td>Sales Tax - An Indicator which signifies the dollar amount paid by the other payer which is related to Sales Tax.</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Coupon</td>
<td>Used only in Telecommunication Standard Versions 9.0 through C.4. Value was deleted and cannot be used in higher versions.</td>
</tr>
<tr>
<td>99</td>
<td>Other</td>
<td>Used only in Telecommunication Standard Versions 9.0 through C.4. Value was deleted and cannot be used in higher versions.</td>
</tr>
</tbody>
</table>

Response:
For vD.0 claims, 99 is not a valid value for Other Payer Amount Paid Qualifier (342-HC). If the value 99 is used in Other Amount Claimed Submitted Qualifier (479-H8) and Other Amount Paid Qualifier (564-J3) this could only be communicated to downstream payers as drug benefit (07) or cognitive service (06), which could negatively impact the pharmacy or patient.

Starting now and until the annual ECL implementation date in October 2012, the value of 99 Other Amount Claimed Submitted Qualifier (479-H8) and Other Amount Paid Qualifier (564-J3) should be restricted to v5.1 Copay Only coordination of benefit claims. To eliminate coordination of benefit claims processing transition issues, no other claim response transactions should include the value “Other” (99) in Other Amount Paid Qualifier (564-J3).

### 10.8 Like Amounts Submitted as Incentive Fee

**Question:**
When a downstream payer receives an Other Payer Amount Paid Qualifier (342-HC) and Other Payer Amount Paid (431-DV) for Incentive Fee how does the current payer recognize 'like' amounts submitted as incentive fee (vaccine, counseling, data collection, etc...) When the definition of the value indicates multiple actions? Do we need more specific qualifiers?

**Response:**
Submit a DERF to create a new value for Other Payer Amount Paid Qualifier (342-HC), Other Amount Paid Qualifier (564-J3) and Other Amount Claimed Submitted Qualifier (478-H8), for Medication Administration Fee. *(DERF 001084 was approved August 2012).*

When looking at like amounts for Medicare Part D, unless there is a mechanism to identify that the incentive fee amount from prior payer is solely for vaccine administration, the incentive fee dollars must not be included in MSP calculations. Once the new qualifier value for Other Payer Amount Paid Qualifier (342-HC) for Medication Administration Fee is available then the amount in the associated Other Payer Amount Paid (431-DV) must be included in MSP calculations.

A new qualifier specific to the Medication Administration Fee was added (value 11) for the following fields:
- Other Amount Claimed Submitted Qualifier (477-H8)
- Other Amount Paid Qualifier (564-J3)
- Other Payer Amount Paid Qualifier (342-HC)
To standardized the field in which a medication administration fee can be identified, and to mitigate COB claims processing risks, changes to support the new qualifiers are available in Telecommunication Standard Version E.1.

10.9 DRUG BENEFIT

Question:
We would like clarification as to how a COB claim shall be submitted if we receive payer sheets that state the only value that the plan would like to receive for “Other Payer Amount Paid Qualifier” (342-HC) is “07” Drug Benefit. Is there a standard way (any recommendation from NCPDP) to process a COB claim in this scenario? For example: If 07 Drug Benefit is sent, should the Other Payer Amount Paid Qualifiers (i.e. 01 Delivery) also be sent with the expectation that the plan will ignore (will not reject) all other qualifiers except the 07 Drug Benefit? OR should the 07 Drug Benefit only be sent and not other qualifiers (i.e. 01 Delivery) and amounts? Also, should the excluded Other Payer Amount Paid amounts be subtracted from the Total Amount Paid to derive at the 07 Drug Benefit amount that will be reported to the downstream payer?

Response:
As of vD.0, there is not an Other Payer Amount Paid Qualifier (342-HC) value which represents the aggregate or sum of all reimbursements, therefore the downstream payer must accept all qualifiers submitted for Other Payer Amount Paid (431-DV) and ignore values that are not applicable to the benefit or trading partner agreement.

NCPDP Telecommunication Standard vD.0 Implementation Guide section: 28.1.10.3
“Note: Other Payer Amount Paid is in the Coordination of Benefits/Other Payments Segment, not the Pricing Segment.

Processors and third party programs determine the rules for which fields are required or situational, in light of the situations defined in this document. All other fields submitted would be ignored by the processor. If a pharmacy system chooses to send in more fields than are required or situational by the processor, these fields would be ignored. It is recommended that especially for the dollar fields, if the field is not required or situational in the calculation, that the dollar field not be sent.”

To clarify the above when processing COB claims:
The financial fields within the COB Segment are considered pass through fields, where the provider is reporting what was received from the previous payers’ responses. Descriptive qualified values identify the other payers’ patient responsibility amounts, amounts paid to the provider, and when applicable the Medicare D benefit stage amounts. These financial amounts are either a direct map from the previous payer’s response (Other Payer Patient Responsibility Amount, Benefit Stage Amount), or require specific mapping rules (Other Payer Amount Paid, see Question 1). The COB payer sheet may note that the benefit or trading partner agreement considers specific qualified values however; the payer sheet cannot restrict which qualified values can be submitted.

Other Payer-Patient Responsibility Amount COB billing may either be based on:
- Method 1 - Other Payer-Patient Responsibility Amount Qualifier (351-NP) value of 06 Patient Pay (505-F5) Amount as reported by previous payer or
- Method 2 -Other Payer-Patient Responsibility Amount Qualifiers (351-NP) not equal to 06

While the payer sheet can restrict whether Method 1 or Method 2 is required it cannot restrict the Other Payer-Patient Responsibility Amount Qualifier’s for Method 2. Additionally in the event that Method 2 is required and the previous payer does not return a balanced response, a process needs to be available to allow the claim to adjudicate with the Other Payer-Patient Responsibility Amount Qualifier 06.
Telecommunication Version D and Above Questions, Answers and Editorial Updates

It is recommended that the payer sheet reflect the payer’s policy towards usage of Other Payer-Patient Responsibility Amount Qualifier 06. For example: “After D.0 compliance date, qualifier 06 usage will be monitored and auditable as the component detail for Patient Pay Amount is the required COB method.”

Other Payer Amount Paid Qualifier (342-HC) values of 08 – Sum of All Reimbursements and 99 – Other, were sunsetted as of Telecommunication vD.0. These non-descript values were eliminated to ensure all Other Payer Amount Paid (431-DV) values reported were appropriately labeled, allowing the downstream payer to calculate payment based on the benefits that can be coordinated (e.g. Drug Benefit, Incentive, Delivery, Administrative, Postage, Cognitive Services, Compound Preparation, Sales Tax) and trading partner agreement. Downstream payers must leverage the itemized Other Payer Amount Paid (431-DV) values and cannot require the provider to sum all reimbursements as Drug Benefit (07).

To ensure consistency within the Telecommunication standard and COB claims adjudication, an ECL DERF will be submitted to sunset the reject code value “7S” – Other Payer Amount Paid Qualifier Not Supported.

10.10 OTHER PAYER REJECT CODE (472-6E)

The situation on Other Payer Reject Code (472-6E) has been clarified from “Required when the payer in this occurrence has denied the payment for the billing, designated with Other Coverage Code (308-C8) = 3 (Other Coverage Billed – claim not covered)” to “Required when the payer in this occurrence has denied the payment for the billing.” The reference to Other Coverage Code value of 3 caused an assumption that Other Coverage Code must be 3. This was modified in Telecom Version D.9. The Other Coverage Code chart in the Telecom Version D.9 was also updated and included here.
This table lists the situations stated for the Claim Billing/Encounter environment. These rules also apply to other transactions that use the Other Coverage Code (308-C8) in similarly defined situations.

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
<th>COB Segment</th>
<th>OPAP</th>
<th>OPPRA</th>
<th>Reject Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not specified by patient</td>
<td>No</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>1</td>
<td>No other coverage</td>
<td>No</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2</td>
<td>Other coverage exists/billed-payment collected</td>
<td>Yes</td>
<td>Governmental / Non-Governmental Receiver of Claim</td>
<td>Non-Governmental Receiver of Claim</td>
<td>Governmental Receiver of Claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Required from at least one payer and at least one payer value must be other than zero. In the case of multiple payers, OPAP (even if zero) must be submitted for all payers who paid.</td>
<td>Required for all payers who paid</td>
<td>For OCC 2 one payer had to pay the claim with a receivable to pharmacy. OTHER payers may have rejected so Reject Codes are required for those billed who did reject.</td>
</tr>
<tr>
<td>3</td>
<td>Other Coverage Billed – claim not covered</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>ALL payers must have rejected so each payer should be represented by individual payer loops containing Reject codes</td>
</tr>
<tr>
<td>4</td>
<td>Other coverage exists–payment not collected</td>
<td>Yes</td>
<td>Governmental / Non-Governmental Receiver of Claim</td>
<td>Non-Governmental Receiver of Claim</td>
<td>Governmental Receiver of Claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Required from at least one payer however anyone who paid should have done so with OPAP of zero (100% copay). When submitted with OCC 4, OPAP (as zero) must be submitted.</td>
<td>Required for all payers who paid</td>
<td>For OCC 4 one payer had to pay the claim with a pharmacy receivable of zero. OTHER payers may have rejected so Reject Codes are required for those billed who did reject.</td>
</tr>
<tr>
<td>8</td>
<td>Claim is billing for patient financial responsibility only</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Required for all payers who paid</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not used for patient financial responsibility only billing.</td>
<td></td>
<td>For OCC 8 one payer had to pay the claim. OTHER payers may have rejected so Reject Codes are required for those billed who did reject.</td>
</tr>
</tbody>
</table>

(05/2014: Editorial note this table has been updated in Telecommunication Standard Implementation Guide version E6 – this is for future use.)
10.11 **OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT (352-NQ)**

**Question:**
As a payer of last resort, will the Other Payer-Patient Responsibility Amount be processed to each payer? If so, do you know if the payers will be paying and making the provider whole as it pertains to copays? (example below)

For the example below we say that the first payer the patient had a total copay of $16.00 and by the time it got to payer 3 we are going to assume that the zero being sent means that they paid the $16.00. Can you confirm this for us?

1. Payer 1: Count = 3, PR = $7, Payer 2 PR = $5, Payer 3 PR = $4. SUM = $16.00
2. Payer 2: Count = 0, PR =$0, Payer 2 PR = $0, Payer 3 PR = $0 SUM = $0.00
3. Payer 3: Count = 1, PR = $0, Payer 2 PR = $0 Payer 3 PR = $0 SUM = $0.00

**Response:**
COB methods may differ between payers where secondary may require Other Payer Amount Paid (OPAP) and tertiary requires Other Payer-Patient Responsibility Amount (OPPRA). Each plan’s benefits will apply where the patient responsibility amount may not be zero and may actually be higher than the previous payer’s patient responsibility amount.

- For COB processing based on Other Payer-Patient Responsibility Amounts (352-NQ) the net amount due is the *sum* of the payable components of the Other Payer-Patient Responsibility values from
  - the LAST payer
  - as determined by the Other Coverage Type (338-5C) (i.e. Primary, Secondary, etc.)
  - that returned a PAID response

- When reimbursement is based on the Other Payer-Patient Responsibility Amount:
  - Basis of Reimbursement Code (522-FM) “14” is to be returned

- When the Patient has a responsibility amount from the prior payer that may not be included in the benefit structure of the COB plan, the COB payer must process via one of the following methods:
  - Pay the Patient Responsibility claim as submitted including all components of Other Payer-Patient Responsibility Amounts.
  - Pay the Patient Responsibility claim, reimburse for appropriate components of Patient Pay Amount and those NOT paid by the plan are passed back to the Patient as Patient Pay Amount (505-F5) and its component fields.
  - Reject the claim with the appropriate reject code.

**Coordination of Benefit claim example:**
- The secondary payer requires Other Payer Amount Paid (431-DV) and returns a Patient Pay Amount (505-F5) higher than the primary payer’s Patient Pay Amount
- The tertiary payer requires Other Payer-Patient Responsibility Amount (352-NQ) and returns a Patient Pay Amount (505-F5) greater than $0

<table>
<thead>
<tr>
<th>Pricing Segment</th>
<th>Primary Sub</th>
<th>Pricing Segment</th>
<th>Secondary Submission for Other Payer Amount Paid</th>
<th>Pricing Segment</th>
<th>Tertiary Submission for Other Payer Patient Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>409-D9</td>
<td>Ingredient Cost Submitted</td>
<td>95.00</td>
<td>409-D9 Ingredient Cost Submitted</td>
<td>93.00</td>
<td>409-D9 Ingredient Cost Submittted</td>
</tr>
<tr>
<td>412-DC</td>
<td>Dispensing Fee Submitted</td>
<td>5.00</td>
<td>412-DC Dispensing Fee Submitted</td>
<td>6.00</td>
<td>412-DC Dispensing Fee Submittted</td>
</tr>
<tr>
<td>430-DU</td>
<td>Gross Amount Due</td>
<td>100.00</td>
<td>430-DU Gross Amount Due</td>
<td>99.00</td>
<td>430-DU Gross Amount Due</td>
</tr>
<tr>
<td>426-DQ</td>
<td>Usual and Customary</td>
<td>105.00</td>
<td>426-DQ Usual and Customary</td>
<td>105.00</td>
<td>426-DQ Usual and Customary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pricing Segment</th>
<th>Claim Segment</th>
<th>Pricing Segment</th>
<th>Tertiary Submission for Other Payer Patient Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>308-CB</td>
<td>Other Coverage Code</td>
<td>2</td>
<td>308-CB Other Coverage Code</td>
</tr>
<tr>
<td>COB Segment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>337-4C</td>
<td>COB/Other Payments Count</td>
<td>1</td>
<td>337-4C COB/Other Payments Count</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>338-5C</td>
<td>Other Payer Coverage Type</td>
<td>01</td>
<td>338-5C Other Payer Coverage Type</td>
</tr>
</tbody>
</table>
Question: What is the appropriate reject code a PBM should use when a claim with an Other Payer Patient Responsibility Amount (352-NQ) value greater than $999,999.99 is received?

Answer: Currently, NQ (M/I Other Payer Patient Responsibility Amount) is the appropriate reject code for this situation. Additionally, the processor should return messaging for clarification regarding the reject. Effective 10/15/2020, a new reject code is available (945-High Dollar Amount Is Not Supported) and should be returned in conjunction with the NQ reject and additional messaging on D.0 claim transactions for this scenario.

Added February 2019
When a downstream payer uses Government COB, must the pharmacy send the Other Payer Amount Paid (OPAP) and Other Payer Patient Responsibility Amounts (OPPRA) from all previous payers or just the last payer?

Response:
The net amount due on an OPPRA COB claim is the sum of the Other Payer Patient Responsibility Amount (352-NQ) from the last payer who returned a paid response. For OPAP COB the downstream payer must sum the Other Payer Amount Paid (431-DV) from all previous payers. So in a government COB claim, it is not necessary to send the OPPRA amount(s) from all previous payers, as the OPPRA amount(s) from the last payer that returned a paid response is the only one necessary to calculate the net amount due. However, it is necessary to send the OPAP from all previous payers.

Added August 2017 (BP)

Question:
How should COB payers populate Basis of Reimbursement Determination (522-FM) when Government COB is used?

Response:
For Government COB, the recommendation is to populate the Basis of Reimbursement Determination based on the method used to determine COB pricing (patient responsibility and pharmacy reimbursement amounts). If reimbursement is based on OPPRA COB, use value ‘14 - Other Payer-Patient Responsibility Amount’. Any other values used for Basis of Reimbursement Determination would indicate reimbursement was calculated based on OPAP COB.

Added November 2019 (BP)

10.14 OPPRA AND OTHER COVERAGE CODE VALUE 3

Question:
When a COB claim is submitted using the Other Payer Patient Responsibility Amount (OPPRA) COB method with Other Coverage Code 3, what financial fields does the pharmacy submit and are there any special requirements for the payer’s response?

Response:
OCC=3 is used when all previous payers reject a claim in all COB methods (OPAP, OPPRA and Govt). The COB segment in this case will not contain any financial information (i.e. OPAP or OPPRA fields) but must contain at least one reject code. The Payer will use the financial information from the Pricing Segment to adjudicate the claim. The financial information in the Pricing Segment is the pricing for the claim “as if” primary.

As far as guidance for how the downstream payer responds to an OCC=3 claim, they will use their own business rules to process. Some payers may use the reject codes from the primary claim to determine how/if they pay a claim. For example, if the primary payer rejected because the drug was not on formulary, the secondary may choose to reject as well to enforce the primary payer’s formulary and keep their costs down. However if the primary rejected because the member was not covered, the secondary will likely adjudicate as if primary and use their own benefit rules to determine coverage and payment.

Added August 2017 (BP)

10.15 PROCESSOR VS. PHARMACY RESPONSIBILITY FOR AGGREGATING OTHER PAYER AMOUNTS

Question:
There are issues around the usage of, correlation of, aggregation of, and response of data submitted between payers and pharmacy involved in COB claims. There appears to be 2 ways to handle Other Payer-Patient Responsibility amounts when multiple payers are involved in claims processing.

**Response:**

1. When **Other Payer Amount Paid repetitions only** COB submission is required, the COB payer must SUMMARIZE like values in the Other Payer Amount Paid (431-DV) across all prior payers for processing. This means that Drug Benefit dollars paid will be summarized for all payers. Any other types of values (delivery dollars, incentives, administrative, etc.) are summarized with other like values, and applied based on third party agreements.

2. When **Other Payer-Patient Responsibility Amount repetitions only** COB is required, the COB payer must first identify the payer with the highest Other Payer Coverage Type (338-5C) value. If Other Payer-Patient Responsibility Amounts do not exist in this COB loop, the COB payer must determine whether to identify the next highest Other Payer Coverage Type (338-5C) value or reject the claim. Once the highest Other Payer Coverage Type (338-5C) value with Other Payer-Patient Responsibility Amounts is determined, ONLY these Other Payer-Patient Responsibility Amounts should be interrogated for payment. The COB payer may pay all of the components or some of the components and return the remaining dollars for the patient to pay; or reject the claim.

3. When **Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage repetitions (Government Programs)** is required for submission, COB payer should determine which method they wish to use for processing and then follow the appropriate calculation method noted in items 1 or 2 above.

**Question:**

For a government COB, the payer can pay either patient responsibility amount that was returned from the last prior payer that returned a paid response or pay based on other payer paid amount. Now if the last payer that did return a paid response, also did not return patient responsibility amount (No patient responsibility qualifier and amount was sent by the provider to the government COB payer to indicate patient responsibility amount returned from last payer that paid the claim). In this case, is a government COB payer safe to assume that $0 needs to be paid as allowed amount (there is no patient responsibility remaining on the claim) and any dispensing/incentive fee needs to be paid on top of that based on the contract between the provider and the government COB payer.

**Response:**

When the response from the previous payer contains a $0 value for Patient Pay Amount (505-F5), the $0 value must be reported in the corresponding Other Payer-Patient Responsibility Amount (352-NQ) when submitting to subsequent payers. Other Payer-Patient Responsibility Amount (352-NQ) must be associated with the applicable Other Payer-Patient Responsibility Qualifier(s) (351-NP), based on payer sheet requirements. If not otherwise specified, the Other Payer-Patient Responsibility Qualifier (342-HC) value of “06” (Patient Pay Amount (505-F5) as reported by previous payer) should be sent.

When the response from the previous payer contains a $0 value as Total Amount Paid (509-F9), the $0 value must be reported in the Other Payer Amount Paid (431-DV) field when submitting to subsequent payers. At a minimum, the Other Payer Amount Paid (431-DV) should be associated with Other Payer Amount Paid Qualifier (342-HC) value of “07” (Drug Benefit).

Please reference section “Specific Segment Discussion”, subsection “Request Segments”, subsection “Coordination of Benefits/Other Payments Segments” in the Telecommunication Implementation Guide as it indicates that $0 is a valid value to send.

The transmission of the two data elements (Other Payer-Patient Responsibility Amount (352-NQ) and Other Payer Amount Paid (431-DV)) is the only way to identify the claim is intended for processing as a Government
COB claim. If the processor is expecting Government COB and Other Payer-Patient Responsibility Amount (352-NQ) is not present the processor should reject the claim with Reject Code (511-FB) value of “NQ” (M/I Other Payer-Patient Responsibility Amount).

This was added to Telecommunication Standard Version E.0.

10.16 PATIENT PAID AMOUNT SUBMITTED (433-DX)

10.16.1 ACCOUNTING FOR MONIES PAID TO THE PATIENT?

Question:
In the March 2010 Data Dictionary, the Patient Paid Amount Submitted (433-DX) has the following comment:
This field is not used in coordination of benefit transactions to pass patient liability information to a downstream payer. See Other Payer-Patient Responsibility Amount (352-NQ).

Does this mean that any money paid by the patient to the pharmacy prior to submission of the claim would have to be accounted for by the primary payer?

Response:
While this field has rare usage, this could be used to reduce the contracted amount by what the patient has paid for the claim prior to adjudication (e.g. Spenddown). The amount paid by the patient is submitted in Patient Paid Amount Submitted (433-DX). The payer should respond with the Patient Paid Amount Submitted value in the Other Payer Amount Recognized (566-J5) field thus allowing Total Amount Paid (509-F9) to balance.

10.16.2 RECEIVING PATIENT PAID AMOUNT SUBMITTED (433-DX) WHEN PREVIOUS PAYER PAID THE CLAIM?

Question:
As a COB payer would we receive Patient Paid Amount Submitted (433-DX) when a previous payer has paid the claim using Patient Paid Amount Submitted (433-DX)?

Response:
No, NCPDP vD.0 does not support the use of Patient Paid Amount Submitted (433-DX) in COB processing. Based on the NCPDP definition and the defined situations Patient Paid Amount Submitted (433-DX) must only be used in single payer situations to report the monies actually paid to the pharmacy.

10.16.3 RECEIVING PATIENT PAID AMOUNT SUBMITTED (433-DX) WHEN PREVIOUS PAYER REJECTED THE CLAIM?

Question:
Similarly, if the previous payer(s) rejected the claim, would we (as a COB payer) then receive this field?

Response:
No, because the Patient Paid Amount Submitted (433-DX) is a requirement for the previous benefit, as a result of the rejection the patient would not have paid anything to the pharmacy.

The NCPDP Telecommunication Standard provides an alternate method to support spend down or patient deductible requirements, eliminating the need for the provider to submit amounts paid by the patient in Patient Paid Amount Submitted (433-DX) prior to claim adjudication. The processor would maintain the patient financial responsibility accumulators and return the appropriate values in the following response fields; Amount Applied to Periodic Deductible (517-FH), Remaining Deductible Amount (513-FD) and Accumulated Deductible Amount (512-FC)). In order to support deductible/spend down in a COB situation and to avoid confusion, the WG1 COB Task Group recommends that Patient Paid Amount Submitted (433-DX) be sunsetting in a future version. WG1 Telecommunication approved the recommendation to sunset Patient Paid Amount Submitted (433-DX) in August 2011; the Task Group will to create the DERF.
10.17 COORDINATION OF BENEFITS SEGMENT (05) VS. PRICING SEGMENT (11)

**Question:** XYZ Medicaid is looking for clarification on how new fields within the Coordination of Benefits Segment (05) are to be used. Currently, when pharmacies are billing Medicaid for Copay, and the Other Coverage Code indicator (308-C8) is equal to ‘02’ (Other coverage exists-payment collected) or is equal to ‘08’ (claim is billing for Copay), the pharmacies are directed to enter the ‘Copay’ in the Patient Paid Amount Submitted (433-DX) field. Our understanding is this has been an industry 'standard'. Additionally, XYZ business rules require that an other insurance payment (greater than zero) would accompany the copay (433-DX).

The Patient Paid Amount Submitted (433-DX) field still remains an active qualified field in the Pricing Segment (11) in the Telecommunication Standard Implementation Guide Version D. However, with the definition of “Amount the pharmacy received from the patient for the prescription dispensed”, it appears that the new Coordination Of Benefits fields “Other Payer-Patient Responsibility Amount Qualifier” (351-NP) and “Other Payer-Patient Responsibility Amount” (352-NQ) should be taking the place of 433-DX.

**Response:** In version 5.1, Patient Paid Amount Submitted (433-DX) was used in two different ways 1) for monies paid by the patient to the pharmacy prior to submission of the claim and 2) limited to government programs to report patient copay in some coordination of benefit situations. This caused confusion.

In version D.0, we added new fields in the COB Segment to support patient responsibility (Other Payer-Patient Responsibility Amount Qualifier”(351-NP) and Other Payer-Patient Responsibility Amount (352-NQ)) to report the amount of the cost share of the patient. Patient Paid Amount Submitted (433-DX) is only to be used to relay monies paid by the patient to the pharmacy prior to submission of the claim. This is different than patient responsibility dollars from the previous payer.

In version D.0 OCC function remains the same. Section 28.1.9.2 Other Coverage Code provides further clarification of the use of this field and segments.

10.18 COORDINATION OF BENEFITS AND PRIOR AUTHORIZATION

10.18.1 HOW SHOULD MEDICARE AND MEDICAID HANDLE THE PROCESSING OF BENZODIAZEPINE AND BARBITURATES?

See section “Medicare Part D/Medicaid Benzodiazepine and Barbiturate Claims Processing Risks”.

10.19 MEDICAID PAY ONLY APPLICABLE COMPONENTS?

**Question:** Can the XYZ Medicaid pay the components that are only applicable to them and disregard the rest of the components (instead of passing it to patient)?

**Response:** No. The payer must always return a balanced response; therefore when the COB payer is paying based on Other Payer-Patient Responsibility Amount they must either:

- Pay the sum of the component pieces
- Reject the claim when specific components of Other Payer-Patient Responsibility Amounts are not supported
- Pass the unpaid other payer-patient responsibility amounts to the patient
- Or continue accepting the lump sum of patient pay as the Other Payer-Patient Responsibility Amount (352-NQ) with the Other Payer-Patient Responsibility Amount Qualifier (351-NP) value of ’06’ (Patient Pay Amount (505-F5) as reported by previous payer).
Refer to the following for supporting documentation:

- The “Specific Segment Discussion” section 28.2.6.5.4.7 found on page 753 of the August 2010 NCPDP Telecommunication Implementation Guide vD.0.
- Section “Clarification of Net Amount Due in Coordination of Benefits”.

10.20  RESPONSE  COORDINATION OF BENEFITS/OTHER PAYERS

SEGMENT (28)
See section “Coordination of Benefits Information”.

10.20.1 OTHER PAYER COVERAGE TYPE (338-5C) AND PROCESSING FOR MID-STREAM PAYERS

Question:
Scenario 1: Plan E is the 5th payer in a series of other payers. Plan E knows that 2 more payers exist after their processing (F & G). Several scenarios pose issues:
If, for some reason, the pharmacy doesn’t process the 4 payers before E, and only processes A and C, is it safe to assume pharmacy will send to plan E using Other Payer Coverage Type (338-5C) values for the first 2 payers as 01 and 02? To the pharmacy, this implies that plan E is tertiary. When responding to the claim, what should plan E respond with when including Other Payer F and G? The Other Payer Coverage Type (338-5C) values can be sent based on either pharmacy knowledge of order, or based on plan data: Since plan E is processing 3rd instead of 5th, can send Other Payer Coverage Type (338-5C) of 04 and 05, or could send back 06 and 07. Which should it send back?

Scenario 2: Plan E is once again the 5th payer. Pharmacy submits a non-COB claim to plan E, which rejects and provides other health information (OHI) back to pharmacy. Since plan E can only send back 3 other payers (but there are 4), which 3 should it send back? A, B, and C, or the 3 immediately before it: B, C, D? Does industry have a preference? Our business owners think it should be the 3 immediately before plan E, and if plan B knows about plan A, they can in turn reject and provide their data (thus, if everyone knows about everyone else, eventually plan E will process correctly in position). If industry wants top-down reporting of OHI, then we’ll have to change our course of action.

Response:
If payer is paying the claim, the payer should only send other health information (OHI) for the payers that follow them. If the payer is rejecting the claim, the payer should send OHI from the top down (what the payer has in their file as it pertains to OHI). If there are multiple claims in the transmission the payer is to send the same 3 OHI payers on all claims.

10.20.2 INGREDIENT COST PAID (506-F6) AND TOTAL PATIENT RESPONSIBILITY AMOUNT FROM LAST PAYER

Question:
Ingredient Cost Paid (506-F6) (Required if this value is used to arrive at the final reimbursement).

If the claim is being paid for patient responsibility only billing, is it mandatory that this field contains total patient responsibility amount from last payer?
There is a requirement that provider needs to be made whole (paid entirely) for patient responsibility only billing.
In that case, which of the 2 is true?
1. Allowed amount + dispensing fee should be equal to total patient responsibility amount from last payer
2. Allowed amount should be equal to total patient responsibility amount from last payer. The dispensing fee should be additional amount on top of that.

Response:
When COB processing is based on Other Payer-Patient Responsibility Amounts (352-NQ), the net amount due is the sum of the payable components of the Other Payer-Patient Responsibility values from:

- the LAST payer
- as determined by the Other Coverage Type (338-5C) (i.e. Primary, Secondary, etc.)
- that returned a PAID response

Basis of Reimbursement Determination (522-FM) is defined as “Code identifying how the reimbursement amount was calculated for ‘Ingredient Cost Paid’ (506-F6).” Therefore when reimbursement is based on the Other Payer-Patient Responsibility Amount, the value of “14” (Other Payer-Patient Responsibility Amount) is to be returned. As a result, Ingredient Cost Paid (506-F6) becomes the sum of Other Payer-Patient Responsibility Amounts (352-NQ).

The contractual agreement between the COB payer and the provider determines whether a dispensing fee applies to Other Payer-Patient Responsibility Amount coordination of benefit claims. Any contracted dispensing fees should be returned in the Dispensing Fee Paid (507-F7) field. Based on the contractual agreement, other applicable payments (delivery, incentive, tax, etc.) would be returned in their respective response pricing fields.

10.21 TRANSITION OF VERSIONS AND COB

New vD.0 Reject Codes offer distinct messaging associated to specific reject scenarios. In the situation where the primary payer returns new vD.0 Reject Code values and the non-primary payer does not recognize/accept these new Reject Code values, coordination of benefit claims processing issues may occur. Situations may occur when the non-primary payer is still processing v5.1 transactions or, when processing vD.0 transactions but supporting an earlier version of the External Code List (ECL).

Recommendation: A mapping of the vD.0 Reject Code values back to the comparable less descriptive v5.1 Reject Code values, allowing the COB claim to process as normal must be supported. This mapping can be implemented by either the processor or the provider. Please refer to the Reject Code Mapping table below.

Reject Code Mapping

**HIGH RISK: Most Commonly Used Reject Codes**

<table>
<thead>
<tr>
<th>D.0 Reject Code</th>
<th>Explanation</th>
<th>5.1 Reject Code</th>
<th>5.1 Reject Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1</td>
<td>No patient match found</td>
<td>52</td>
<td>Non-Matched Cardholder ID</td>
</tr>
<tr>
<td>S06</td>
<td>Provide Beneficiary with CMS Notice of Appeal Rights</td>
<td>70</td>
<td>Product/Service Not Covered</td>
</tr>
<tr>
<td>71</td>
<td>Compounds Not Covered,</td>
<td>70</td>
<td>Product/Service Not Covered</td>
</tr>
<tr>
<td>A5</td>
<td>Not Covered Under Part D Law</td>
<td>70</td>
<td>Product/Service Not Covered</td>
</tr>
<tr>
<td>A6</td>
<td>This Medication May Be Covered Under Part B</td>
<td>70</td>
<td>Product/Service Not Covered</td>
</tr>
<tr>
<td>MR</td>
<td>Product Not On Formulary</td>
<td>70</td>
<td>Product/Service Not Covered</td>
</tr>
<tr>
<td>7X</td>
<td>Days Supply Exceeds Plan Limitation</td>
<td>76</td>
<td>Plan Limitations Exceeded</td>
</tr>
</tbody>
</table>

**MODERATE RISK:**

<table>
<thead>
<tr>
<th>D.0 Reject Code</th>
<th>Explanation</th>
<th>5.1 Reject Code</th>
<th>5.1 Reject Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S82</td>
<td>M/I Fill Number</td>
<td>17</td>
<td>M/I Fill Number</td>
</tr>
<tr>
<td>S85</td>
<td>Fill Number Value Not Supported</td>
<td>17 M/I Fill Number</td>
<td></td>
</tr>
<tr>
<td>7W</td>
<td>Number of Refills Authorized Exceed allowable Refills</td>
<td>17</td>
<td>M/I Fill Number</td>
</tr>
<tr>
<td>S12</td>
<td>Compound Code Value Not Supported</td>
<td>20</td>
<td>M/I Compound Code</td>
</tr>
<tr>
<td>8K</td>
<td>DAW Code Value Not Supported</td>
<td>22</td>
<td>M/I (DAW)/ Product Selection Code</td>
</tr>
<tr>
<td>S56</td>
<td>Unit Of Measure Value Not Supported</td>
<td>26</td>
<td>M/I Unit Of Measure</td>
</tr>
<tr>
<td>8R</td>
<td>Submission Clarification Code Value Not Supported</td>
<td>34</td>
<td>M/I Submission Clarification Code</td>
</tr>
<tr>
<td>S60</td>
<td>Pharmacy Not Contracted in Retail Network</td>
<td>40</td>
<td>Pharmacy Not Contracted With Plan DOS</td>
</tr>
<tr>
<td>S61</td>
<td>Pharmacy Not Contracted in Mail Order Network</td>
<td>40</td>
<td>Pharmacy Not Contracted With Plan DOS</td>
</tr>
<tr>
<td>S62</td>
<td>Pharmacy Not Contracted in Hospice Network</td>
<td>40</td>
<td>Pharmacy Not Contracted With Plan DOS</td>
</tr>
<tr>
<td>S63</td>
<td>Pharmacy Not Contracted in Veterans Administration Network</td>
<td>40</td>
<td>Pharmacy Not Contracted With Plan DOS</td>
</tr>
<tr>
<td>S64</td>
<td>Pharmacy Not Contracted in Military Network</td>
<td>40</td>
<td>Pharmacy Not Contracted With Plan DOS</td>
</tr>
</tbody>
</table>
WORKERS’ COMPENSATION AND COB

10.22 PROVIDE GUIDANCE FOR HANDLING WORKERS’ COMPENSATION PAYER AS PRIMARY, THAT IS NOT REQUIRED TO SEND TELECOM D.0

Question:
Workers’ Compensation payer is primary and does not require the claim transaction to be in the Telecom D.0 format and patient has additional coverage that is required to be HIPAA compliant and only accept D.0 claim transactions. Can the secondary payer accept a version 5.1 claim transaction from the pharmacy and still be in compliance with HIPAA? If not how should the claim be submitted to the secondary payer?

Response:
Prior to the January 1, 2012 NCPDP vD.0 compliance date, the provider can submit and the payer must accept NCPDP v5.1 claims. Until such time Workers’ Compensation claims are covered under the HIPAA rules for electronic claims processing, when processed electronically, any version of the NCPDP Telecommunication Standard may be used. To facilitate standardization of pharmacy claims processing and ensure proper coordination of benefits, NCPDP strongly recommends that Workers’ Compensation claims processed electronically should adhere to the most current NCPDP Telecommunication Standard version approved under HIPAA.

As of January 1, 2012, in the event that the Workers’ Compensation claim is not processed as NCPDP vD.0 and a NCPDP vD.0 coordination of benefit claim to a HIPAA covered entity is required, when:

- The Other Payer-Patient Responsibility Amount (352-NQ) is required, the Other Payer-Patient Responsibility Qualifier (351-NP) value of “06” (Patient Pay Amount (505-FS) as reported by previous payer) should be used alone to report the patient pay on vD.0 coordination of benefit claims.
  - The qualifier of “06” is required in this situation as the response pricing components cannot be mapped to the detailed vD.0 Other Payer-Patient Responsibility Amount qualifiers, for example:
    - The provider cannot determine if the value returned in the Amount of Copay/Coinsurance (518-FI) field of a v5.1 claim response should be reported as the Other Payer-Patient Responsibility Amount Qualifier (351-NP) of “05” (Amount of Copay) or “07” (Amount of Coinsurance) on the vD.0 coordination of benefit claims.

- The Other Payer Amount Paid (431-DV) is required; the provider should calculate the Other Payer Amount Paid values in the order specified in section 9.5 of the NCPDP vD.0 Editorial Document. Drug Benefit is the end result, after all other Other Payer Amount Paid values are subtracted from Total Amount Paid (509-F9).
  - Other Amount Claimed Submitted Qualifier (479-H8) and Other Amount Paid Qualifier (564-J3) the value of “99” (Other) is a valid value for v5.1 claims. The value of “99” however, cannot be used to report the Other Payer Amount Paid (431-DV) value on vD.0 coordination of benefit claims. If an appropriate Other Payer Amount Paid value is not reported in the claim, the
categorization of the amount may be Drug Benefit “07” or Cognitive Service “06”, which may negatively impact the provider or patient. This may not reflect the original intent of the Other Payer Amount Paid dollar amount.

- To ensure any Other Amount Paid (565-J4) value(s) returned by the payer (e.g. Workers’ Compensation) in a v5.1 response are reflected appropriately in the subsequent vD.0 coordination of benefit claim, the Other Amount Paid Qualifier (479-H8) value of “99” (Other) must not be used.

10.23 REVERSALS AND COB

Question:
Please clarify the “appropriate back-out order” for COB reversals.

Response:
Coordination of Benefit reversals: Reversal requests for COB claims should be submitted in the reverse order of the claim billing request (example: claim billing occurred as Primary, Secondary then Tertiary, reversal order should be Tertiary, Secondary, Primary). COB claim reversals must contain the Coordination Of Benefits/Other Payments Segment and include the Other Payer Coverage Type in order to facilitate the proper order especially in instances where one processor is the payer for multiple levels of coverage.

A rejected reversal for a COB claim may need to be addressed by alternative processes in order to maintain financial integrity for the claim associated to each payer (Tertiary, Secondary, Primary).

(Note the above applies to claims and other Telecommunication transactions that support reversal functionality.)

10.24 DOLLAR FIELD NOT RECEIVED

Question:
If a pharmacy does not receive a dollar field from a previous payer that is required by a downstream payer, does the pharmacy have to send the dollar field to the downstream payer?

Response:
No the pharmacy cannot send what they have not received from a previous payer.

Question:
If a pharmacy does not send a dollar field to a downstream payer because they did not receive it from an upstream payer, what assumptions can be made by the downstream payer?

Response:
The downstream payer will need to make their own business assumptions when these dollar fields are not provided.
11 RECOMMENDATIONS FOR CLAIM REVERSAL PROCESSING FOR TELECOMMUNICATION VERSION D.0

The following chapter is intended to provide guidance for anticipated future industry requirements regarding reversal processing. This guidance will be added to a future Telecommunication Standard Implementation Guide version. For processing using Telecommunication Standard Implementation Guide version D.0, these recommendations can currently be implemented but are not mandated until the use of the future Telecommunication Standard Implementation Guide version is named in regulation.

11.1 CURRENT INFO ON CLAIM REVERSAL PROCESSING FOR TELECOMMUNICATION VERSION D.0

The Telecommunication Standard Implementation Guide Version D.0 does not clearly state the criteria to match a Claim Reversal to a previously paid Claim Billing. What it does provide is:

- How to build a multi-Reversal transmission - Section 10 “Reversal Information” in Telecommunication Standard Implementation Guide
- Detail of Claim Reversal fields - Section 10.3 “Claim Reversal Request Segments” and 10.4 “Claim Reversal Response Diagrams and Segments” lists all D.0 fields with the majority noted as “not used”.

Note: for the purposes of this discussion, the term “processor” may be seen as the plan, the payer, the Pharmacy Benefit Manager, etc. – the entity (or contracted entity) to perform the functions of claims adjudication. This may be one or more entities.

11.2 WHY IS GUIDANCE NEEDED?

In order to assist with current Claim Reversal processing issues reported by both processors and providers, we are providing ‘best practice’ recommendations for Telecommunication Standard Version D.0 Claim Reversal processing.

1. List of the MAXIMUM fields allowed in a Claim Reversal
   - Other than Transaction Code “B2” (Claim Reversal), the fields sent on a Claim Reversal should mimic fields submitted on the original Claim Billing unless otherwise noted by processor due to a processing change since time of claim.
   - The processor may on the Claim Billing response provide updated information for the pharmacy to use in future claim and reversal processing, such as Group ID, Cardholder ID.
   - The Product/Service ID sent on the Claim Reversal should be the same value as what was submitted on the Claim Billing.

2. Criteria for MATCHING a Claim Reversal transaction to its associated Claim Billing
   Critical Match criteria that should always be used:
   - Service Provider ID (202-B2) (pharmacy identifier)
   - Prescription/Service Reference Number (402-D2)
   - Date of Service (401-D1)

   If more than one paid claim exists, further criteria that should be used as ‘tie-break’ criteria include:
   - Fill Number (403-D3) – can delineate two similar Pharmacy, Prescription, Date of Service approved Claim Billings where one was a regular dispensing fill and the other a subsequent dispensing such as a vacation supply or other special circumstance causing the Fill Number to be incremented by the pharmacy.
Telecommunication Version D and Above Questions, Answers and Editorial Updates

- Other Coverage Code (308-C8) - only used to delineate claim paid as primary from similar one by Pharmacy, Prescription, Date of Service that was paid as coordination of benefits.
- Other Payer Coverage Type (338-SC) – only available on coordination of benefits Claim Billing and thus the Claim Reversal.
  - If two Approved Claim Billings are on file a primary claim will not contain this field. The secondary and beyond Claim Billings will contain this field.
  - When multiple Approved claims by Pharmacy, Prescription, Date of Service exist and identity different coverage levels, this field is used to match to the right coordination of benefits Claim Billing – Secondary or Tertiary, Secondary or Quaternary, etc.

3. Fields on a Claim Reversal that are **not** recommended for matching the Claim Reversal to the Claim Billing and why.

**CARDHOLDER ID**
If a processor wishes to use Cardholder ID, it should be done as a secondary level match. Since there is not a universal unique member ID, numerous members within various health plans can have the same member ID. Matching on Pharmacy ID, Prescription Number and Date of Service will generally narrow the search with noted fields already providing the means to identify the specific Claim Billing to be reversed.
- Cardholder ID may be a Family ID. The Claim Reversal transaction does not allow for Person Codes, Date Of Birth, Name fields etc. that are used to identify the specific member within a family. As such there could be multiple member profiles to check whereas Pharmacy ID, Prescription number and Date of Service with noted tie break fields should ultimately yield one Approved Claim Billing.
- Discount programs and some ‘on the fly’ eligibility result in numerous individuals with the same non-unique Cardholder ID since the field is mandatory on a Claim Billing. In these scenarios the Cardholder ID should **not** be used for matching.

**GROUP ID**
- There are instances where the Group ID is used to route a claim within a processing system to the appropriate platform to find the Approved Claim Billing.
- When Group ID is returned in a claim response, the value should be used in future claim and reversal processing by the pharmacy.
- The recommendation is to allow processors whose business needs require and use the field for internal routing however it is recommended to **not** use field in the match criteria to determine a specific Claim Billing that is to be reversed.

**PRODUCT/SERVICE ID**
- Although this field is mandatory on a Claim Reversal it is **not required as part of the match criteria** for the Claim Reversal to the Claim Billing.
- While the same Product/Service ID that was billed should be included on the reversal, it has been found that this is **not** always industry practice which causes a rejected reversal when the field is included in match criteria.

4. **Recommended time frame for Reversal processing**
- Medicare Part D requires a reversal window of a minimum of 90 days.
- Some programs allow up to a year or more.
- NCPDP recommends that processors **allow a minimum** of 30 days from the date the claim processed for a reversal to occur.

Telecommunication Standard **future** version considerations to be aware of:
1. There has been a request for a new transaction identifier in a future version of the Telecommunication Standard (on the submission and response) to facilitate the matching of a Claim Reversal to a Claim Billing.
   - There are various uses of existing transaction ID fields, so to not conflict with current usage, the WG1 Transaction ID Task Group is examining a new field with concise usage.
12 NCPDP MEDICAID SUBROGATION STANDARD

12.1 Typographical Errors

Example “Compounded Rx Claim and Response” contains an error. Product/Service ID Qualifier (436-E1) contained 03 instead of 00. It has been corrected in the October 2010 republication.
13 WORKERS’ COMPENSATION-SPECIFIC INFORMATION

See also section “Coordination of Benefits Information”, subsection “Workers’ Compensation and COB”.

13.1 WORKERS’ COMPENSATION AND REPACKAGED NDCs

The following applies to all state workers’ compensation agencies that have a regulatory requirement (state fee schedule) that the billing provider is to submit the NDC of the original or underlying medication product that has been repackaged for distribution/dispensing.

In an effort to establish correct pricing for repackaged drugs, various state workers’ compensation agencies are adding a billing requirement for reporting of the original or underlying NDC of the repackaged drugs.

For paper submissions

NCPDP has approved an update to the NCPDP Manual Claim Forms Reference Implementation Guide (version 1.1 dated April 2012) providing a standardized method for reporting the original/underlying NDC on the NCPDP Workers’ Compensation/Property and Casualty Universal Claim Form (WC-UCF).

Since reporting of the original or underlying NDC of the repackaged drugs is 1) a state regulatory issue and 2) appears to be proliferating across many states the Jurisdictional Field 5 (WC-UCF Field 61) is to be used for this purpose, when required by regulation.

Pharmacy Benefit Managers/Processors/Plans must reflect the use of these fields to pharmacies/providers when governed by the use of these state regulations for Workers’ Compensation state fee schedules.

For electronic billing

NCPDP has approved the use of these existing fields in the NCPDP Telecommunication Standard version D.0

- Originally Prescribed Product/Service ID Qualifier (453-EJ) value of “03” (National Drug Code (NDC))
- Originally/underlying Prescribed Product/Service Code (445-EA) contains the actual (original) NDC
- The Product/Service ID Qualifier (436-E1) contains the value of “03” (National Drug Code (NDC)) and Product/Service ID (407-D7) contains the actual dispensed (repackaged) NDC.

Pharmacy Benefit Managers/Processors/Plans who support Payer Sheets to pharmacies/providers must reflect the use of these fields when governed by state regulations for Workers’ Compensation state fee schedules. Intermediaries/third party administrators that are involved in the processing of workers’ compensation bills must provide this same support.

Note: The Basis of Reimbursement Determination (522-FM) will clarify which reimbursement method the processor used in adjudicating the bill.
14 IMPROVING THE VALUE OF THE CLAIM RESPONSE WITH ADDITIONAL MESSAGING

14.1 BACKGROUND
Disclaimer: This replaces Appendix G Two Way Communication to Increase the Value of On-Line Messaging from the Telecommunication Standard Implementation Guide.

For electronic messaging to be effective, pharmacists and coordination of benefit claims processing systems must be able to understand the reason the message was sent, be able to interpret the meaning of that message easily, and be able to perform some action based on that interpretation.

Instances of messages that are not clear and effective can occur at various points in the processing of prescription drug claims. For example, pharmacy systems do not always translate the NCPDP Reject Codes into the specified NCPDP reject messages. This can lead to confusion in interpreting the displayed reject message, because the message that is presented to the user may not be the same message expected by the processor. Additionally, downstream coordination of benefit payers only have access to the reject code returned by the previous payer where interpretation may be compromised if further clarification of the reject was returned as text within the Additional Information Message (526-FQ) field.

Claims processing systems sometimes populate free text fields with text that duplicates the reject code translations or DUR/PPS information, resulting in redundant information and message fatigue. Processors should leverage the specified reject code(s) for the conflict that occurs and use caution sending messages that are redundant, not specific, or are otherwise unrelated to the claim’s payment or clinical status. Messages on every claim transaction can lead to a phenomenon called “Alert Fatigue” and could decrease the perceived importance of more “relevant” messages. That is, if every paid prescription claim gets four messages returned—or even just one—the pharmacist may become desensitized to noticing and acting upon relevant messages.

Plan rejections and supplementary messages can often be incomplete, leaving the pharmacist without a recommended course of action. For example, an NCPDP Reject Code of “76” (Plan Limitations Exceeded) without an accompanying free text message explaining the limitation does not provide enough information for the pharmacist to take action. Likewise, “Fill Too Soon” rejects sometime do not inform the pharmacist of the next available dispensing date, while “Drug Not Covered” rejections do not always supply the names of the covered alternatives.

Reject codes caused by eligibility problems collectively have a high degree of occurrence. These errors are primarily due to incomplete or inaccurate eligibility data that the health plan/employer supplied to the claims processor. When a processor cannot find a match in their eligibility files using the submitted claim information, the exact data element that is causing the problem is not always known. Therefore, the processor will often send multiple reject codes to the pharmacy, even though there may be only one error on the claim. For example, if the Cardholder ID field was submitted with an error, the processor would be unable to identify the patient, but may also be unable to identify the specific cause of the error, because errors in any of several fields (i.e. Group Number, BIN number) can cause misidentified/unidentified cardholders. As a result, the processor should send an error message for each field that may have erroneous data. Some processors utilize other submitted data elements, like Date of Birth and Gender Code to find a “best two out of three” match. Transmittal of such information from pharmacy to processor is subject to covered entity interpretation under the HIPAA regulations and beyond the scope of this discussion.

14.2 SPECIFIC DATA FIELD USE RECOMMENDATIONS
Claims processors:
- Be more specific in the information relayed to the pharmacist. Pharmacists want messages to be relevant and actionable.
Use the most specific Reject Code(s) possible.
Eliminate unnecessary free text messages.
Populate the Help Desk Telephone Number field (550-8F) with the applicable phone number for the pharmacist to call for additional assistance. If multiple phone numbers exist for different issue types (technical claim support versus clinical prior authorization support), return the most appropriate phone number for the situation at hand. Do not put the Help Desk Phone number in the message field itself.
Use only standard abbreviations in the Additional Message Information field (526-FQ). Keep the messages succinct. The NCPDP Reject Code translations must not be placed in this field.
Target DUR/PPS inter-pharmacy conflicts (rather than intra-pharmacy conflicts) and all DUR/PPS messages should remain in the Response DUR/PPS Segment.
Use the Additional Message Information field (526-FQ) to explain sudden changes in coverage issues, such as an increase in copayment for a non-preferred drug product.
The URL field (987-MA) should be populated in the response transaction whenever possible to provide electronic address for additional prior authorization information.
Do not send leading zeroes in front of alphanumeric values such as Reject Codes when they do not exist. A leading zero on a numeric field can be truncated, but a leading zero on an alphanumeric field is not (070 is equal to 70 but “070” is not equal to “70” or “70 “).

Software vendors:
- Display the entire Additional Message Information field (526-FQ). Show the standard definitions for the NCPDP Reject Codes.
- If the Help Desk Telephone Number (550-8F) is populated, present it to the pharmacist.

New fields and new values for old fields are introduced in the NCPDP Telecommunication Standard Implementation Guide. The NCPDP External Code List (ECL) will always contain a comprehensive listing of valid Reject Code values and definitions. Some specific use recommendations of these fields are highlighted in the table below, along with possible alternative Reject Codes and recommended supplemental messages that may be transmitted in the Additional Message Information field (526-FQ). In the table, the Reject Code in question is listed in the first row, but the definition is not repeated. Supplemental messages, if any, which should be used with the Reject Code, are listed in the last column. However, a supplemental message is not always needed, as the standard definition of the Reject Code may be self-explanatory.

These recommendations are intended as guidelines, not mandates, for use in pharmacy and claim processing systems to increase the value of messaging. Their use is highly recommended, but not required. Additional operational and system improvements are beyond the scope of this document, and are not discussed here.

### 14.2.1 BENEFIT- OR PLAN-GENERATED REJECTIONS

**REJECT CODE “76” (PLAN LIMITATIONS EXCEEDED)**

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“76”</td>
<td>Plan Limitations Exceeded</td>
<td>Define the specific limit that caused the rejection.</td>
</tr>
<tr>
<td>“7X”</td>
<td>Days Supply Exceeds Plan Limitation</td>
<td>“MAXIMUM DAYS SUPPLY = XXX DAYS.”</td>
</tr>
<tr>
<td>“73”</td>
<td>Additional Fills Are Not Covered</td>
<td>“NEW PRESCRIPTION REQUIRED” or “NO FURTHER CLAIMS FOR THIS PRODUCT ARE ALLOWED”</td>
</tr>
<tr>
<td>“78”</td>
<td>Cost Exceeds Maximum</td>
<td>“MAXIMUM AMOUNT = $XXX”</td>
</tr>
<tr>
<td>“81”</td>
<td>Claim Too Old</td>
<td>“SUBMIT DATE &gt; NN DAYS FROM DATE OF SERVICE”</td>
</tr>
</tbody>
</table>
### Related Reject Codes

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“AG”</td>
<td>Days Supply Limitations for Product/Service</td>
<td>“MAXIMUM DAYS SUPPLY = XXX DAYS.”</td>
</tr>
<tr>
<td>“M4”</td>
<td>Prescription/Service Reference Number/Time Limit Exceeded</td>
<td>Define the number of prescriptions allowed within a given time period</td>
</tr>
<tr>
<td>“RN”</td>
<td>Plan Limits Exceeded on Intended Partial Fill Values</td>
<td>“MAXIMUM DAYS SUPPLY = XXX DAYS.”</td>
</tr>
<tr>
<td>“70”</td>
<td>Product/Service Not Covered – Plan/Benefit Exclusion</td>
<td>“SPECIFIC PLAN EXCLUSION”</td>
</tr>
<tr>
<td>“MR”</td>
<td>Product Not On Formulary</td>
<td>Formulary Alternatives/Preferred Products Available</td>
</tr>
<tr>
<td>“60”</td>
<td>Product/Service Not Covered for Patient Age</td>
<td>“MAXIMUM (or MINIMUM) AGE = NN YEARS”</td>
</tr>
<tr>
<td>“61”</td>
<td>Product/Service Not Covered for Patient Gender</td>
<td></td>
</tr>
<tr>
<td>“66”</td>
<td>Patient Age Exceeds Maximum Age</td>
<td>“MAXIMUM PATIENT AGE = XX YEARS”</td>
</tr>
<tr>
<td>“9G”</td>
<td>Quantity Dispensed Exceeds Maximum Allowed</td>
<td>“MAXIMUM QUANTITY = XXX”</td>
</tr>
</tbody>
</table>

### 14.2.1.2

**REJECT CODE “79” (FILL TOO SOON)**

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“79”</td>
<td>Fill Too Soon</td>
<td>“NEXT AVAILABLE DATE OF SERVICE = MM/DD/CCYY”</td>
</tr>
</tbody>
</table>

### 14.2.1.3

**REJECT CODE “52” (NON-MATCHED CARDHOLDER ID)**

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“52”</td>
<td>Non-Matched Cardholder ID</td>
<td>Since this code is often transmitted with other Reject Codes, an example of a supplementary message is: “ONE OR MORE OF THESE REASONS MAY APPLY.”</td>
</tr>
<tr>
<td>“ZZ”</td>
<td>Cardholder ID submitted is inactive. New Cardholder ID on file.</td>
<td>Indicates patient is covered, but claim requires the new Cardholder ID. This will keep the claim data clean and will assist in the TrOOP Facilitation N1 matching process. When claim rejects with this code, the processor must return the new Cardholder ID in field 302-C2 in the Response Insurance Segment.</td>
</tr>
</tbody>
</table>

### 14.2.1.4

**REJECT CODE “69” (DATE OF SERVICE AFTER COVERAGE TERMINATED)**

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“69”</td>
<td>Date of Service After Coverage Terminated</td>
<td>“TERMINATED MM/DD/CCYY.”</td>
</tr>
</tbody>
</table>

### 14.2.1.5

**REJECT CODE “68 “ (DATE OF SERVICE AFTER COVERAGE EXPIRED)**

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“68”</td>
<td>Date of Service After Coverage Expired</td>
<td>“COVERAGE EXPIRED MM/DD/CCYY.”</td>
</tr>
<tr>
<td>“66”</td>
<td>Patient Age Exceeds Maximum Age</td>
<td>“MAXIMUM PATIENT AGE = XX YEARS.”</td>
</tr>
</tbody>
</table>

### 14.2.1.6

**REJECT CODE “70” (PRODUCT/SERVICE NOT COVERED – PLAN/BENEFIT**

Version 48
November 2019
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### EXCLUSION

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“70”</td>
<td>Product/Service Not Covered – Plan/Benefit Exclusion</td>
<td>“SPECIFIC PLAN EXCLUSION.”</td>
</tr>
<tr>
<td>“MR”</td>
<td>Product Not On Formulary</td>
<td>Formulary Alternatives/Preferred Products Available</td>
</tr>
<tr>
<td>“60”</td>
<td>Product/Service Not Covered for Patient Age</td>
<td>“MAXIMUM (OR MINIMUM) AGE = NN YEARS”</td>
</tr>
<tr>
<td>“61”</td>
<td>Product/Service Not Covered for Patient Gender</td>
<td></td>
</tr>
<tr>
<td>“63”</td>
<td>Institutionalized Patient Product/Service ID Not Covered</td>
<td></td>
</tr>
<tr>
<td>“73”</td>
<td>Additional Fills Are Not Covered</td>
<td>“NEW PRESCRIPTION REQUIRED” or “NO FURTHER CLAIMS FOR THIS PRODUCT ARE ALLOWED”</td>
</tr>
<tr>
<td>“AC”</td>
<td>Product Not Covered Non-Participating Manufacturer</td>
<td>Identify the covered manufacturer(s).</td>
</tr>
<tr>
<td>“AH”</td>
<td>Unit Dose Packaging Only Payable For Nursing Home Recipients</td>
<td></td>
</tr>
<tr>
<td>“AJ”</td>
<td>Generic Drug Required</td>
<td></td>
</tr>
</tbody>
</table>

* Use the Response Claim Segment to provide the Preferred Product ID (553-AR), its Qualifier (552-AP), Description (556-AU), Incentive (554-AS) and Copay/Coinsurance Incentive (555-AT) whenever applicable, with the Preferred Product Count (551-9F). If multiple preferred products are possible, use the Preferred Product Count (551-9F) field, populating it with the correct number of products and repeat the above fields as needed.

#### 14.2.1.7 REJECT CODE “06” (M/I GROUP ID)

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“06”</td>
<td>M/I Group ID</td>
<td>Since this code is often transmitted with other reject codes, an example of a supplementary message is: “ONE OR MORE OF THESE REASONS MAY APPLY.”</td>
</tr>
<tr>
<td>“RD”</td>
<td>Mismatched Cardholder/Group ID-Partial to Completion</td>
<td></td>
</tr>
</tbody>
</table>

#### 14.2.1.8 REJECT CODE “19” (M/I DAYS SUPPLY)

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“19”</td>
<td>M/I Days Supply</td>
<td>Do not use this reject code for claims that exceed a days supply limitation – use Reject Code “76” and indicate the maximum days supply in the Message fields.</td>
</tr>
</tbody>
</table>

#### 14.2.1.9 REJECT CODE “88” (DUR REJECT ERROR)

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
</table>
| “88”                 | DUR Reject Error             | Note that the Response DUR/PPS Segment does not indicate which of the potentially multiple DUR/PPS alerts caused the rejection—one or more of the other alerts may just be informational warning messages. Consider indicating in the Additional Message Information field (526-```
### Related Reject Codes

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“65”</strong> (PATIENT IS NOT COVERED)</td>
<td>Product/Service Not Covered for Patient Age</td>
<td>“MAXIMUM PATIENT AGE FOR THIS DRUG IS XX YEARS.”</td>
</tr>
<tr>
<td>“61”</td>
<td>Product/Service Not Covered for Patient Gender</td>
<td></td>
</tr>
<tr>
<td>“63”</td>
<td>Institutionalized Patient Product/Service ID Not Covered</td>
<td></td>
</tr>
<tr>
<td>“66”</td>
<td>Patient Age Exceeds Maximum Age</td>
<td>“MAXIMUM PATIENT AGE FOR THIS DRUG IS XX YEARS.”</td>
</tr>
</tbody>
</table>

### Related Reject Codes

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“07”</strong> (M/I CARDHOLDER ID)</td>
<td>M/I Cardholder ID</td>
<td>Since this code is often transmitted with other reject codes, an example of a supplementary message is: “ONE OR MORE OF THESE REASONS MAY APPLY.”</td>
</tr>
<tr>
<td>“RD”</td>
<td>Mismatched Cardholder/Group ID-Partial to Completion</td>
<td></td>
</tr>
<tr>
<td>“ZZX”</td>
<td>Cardholder ID submitted is inactive. New Cardholder ID on file.</td>
<td>Indicates patient is covered, but claim requires the new Cardholder ID. This will keep the claim data clean and will assist in the TrOOP Facilitation N1 matching process. When claim rejects with this code, the processor must return the new Cardholder ID in field 302-C2 in the Response Insurance Segment.</td>
</tr>
</tbody>
</table>

### Related Reject Codes

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“54”</strong> (NON-MATCHED PRODUCT/SERVICE ID NUMBER)</td>
<td>Non-Matched Product/Service ID Number</td>
<td>Example “NO ACTIVE NDC NUMBER FOUND.”</td>
</tr>
<tr>
<td>“55”</td>
<td>Non-Matched Product Package Size</td>
<td></td>
</tr>
<tr>
<td>“77”</td>
<td>Discontinued Product/Service ID Number</td>
<td>If a replacement ID and date are known, “SUPERCEDED BY NNNNN-NNNN-NN ON MM/DD/YY.”</td>
</tr>
</tbody>
</table>

### Related Reject Codes

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“75”</strong> (PRIOR AUTHORIZATION REQUIRED)</td>
<td>Prior Authorization Required</td>
<td>Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears.</td>
</tr>
</tbody>
</table>
### Related Reject Codes

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The URL field (987-MA) should be populated in the response transaction whenever possible.</td>
</tr>
<tr>
<td>“3W”</td>
<td>Prior Authorization in Process</td>
<td>“REQUESTED ON MM/DD/CCYY.” Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. The URL field (987-MA) should be populated in the response transaction whenever possible.</td>
</tr>
<tr>
<td>“3X”</td>
<td>Authorization Number Not Found</td>
<td>Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. The URL field (987-MA) should be populated in the response transaction whenever possible.</td>
</tr>
<tr>
<td>“3Y”</td>
<td>Prior Authorization Denied</td>
<td>Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. The URL field (987-MA) should be populated in the response transaction whenever possible.</td>
</tr>
<tr>
<td>“G4”</td>
<td>Physician must contact plan</td>
<td>Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. The URL field (987-MA) should be populated in the response transaction whenever possible.</td>
</tr>
<tr>
<td>“G5”</td>
<td>Pharmacist must contact plan</td>
<td>Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. The URL field (987-MA) should be populated in the response transaction whenever possible.</td>
</tr>
</tbody>
</table>

#### 14.2.1.14 REJECT CODE “09” (M/I DATE OF BIRTH)

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“09”</td>
<td>M/I Date Of Birth</td>
<td>Since this code is often transmitted with other reject codes, an example of a supplementary message is: “ONE OR MORE OF THESE REASONS MAY APPLY.”</td>
</tr>
</tbody>
</table>

#### 14.2.1.15 REJECT CODE “51” (NON-MATCHED GROUP ID)

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“51”</td>
<td>Non-Matched Group ID</td>
<td>Since this code is often transmitted with other reject codes, an example of a</td>
</tr>
</tbody>
</table>
supplementary message is: “ONE OR MORE OF THESE REASONS MAY APPLY.”

14.2.1.16  REJECT CODE “41” (SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYER)
See also section “Dual Eligibility”.

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“41”</td>
<td>Submit Bill to Other Processor or Primary Payer</td>
<td>If known, return the other payer routing instructions: BIN, Processor Control Number, Submitted Group, Member ID</td>
</tr>
<tr>
<td>“620”</td>
<td>This Product/Service may be covered under Medicare Part D</td>
<td></td>
</tr>
<tr>
<td>“621”</td>
<td>This Medicaid Patient is Medicare Eligible</td>
<td></td>
</tr>
<tr>
<td>“A6”</td>
<td>This Product/Service May Be Covered Under Medicare Part B</td>
<td></td>
</tr>
<tr>
<td>“AE”</td>
<td>QMB Bill Medicare</td>
<td></td>
</tr>
</tbody>
</table>

14.2.2  OTHER NOTABLE REJECT CODES

14.2.2.1  REJECT CODE “83” (DUPLICATE PAID/CAPTURED CLAIM)

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“83”</td>
<td>Duplicate Paid/Captured Claim</td>
<td>“CHANGE FILL NUMBER IF MULTIPLE DISPENSINGS ARE REQUESTED ON SAME DAY.”</td>
</tr>
</tbody>
</table>

14.2.2.2  REJECT CODE “92” (SYSTEM UNAVAILABLE/HOST UNAVAILABLE)

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“92”</td>
<td>System Unavailable/Host Unavailable</td>
<td></td>
</tr>
<tr>
<td>“90”</td>
<td>Host Hung Up</td>
<td></td>
</tr>
<tr>
<td>“91”</td>
<td>Host Response Error</td>
<td></td>
</tr>
<tr>
<td>“95”</td>
<td>Time Out</td>
<td></td>
</tr>
<tr>
<td>“96”</td>
<td>Scheduled Downtime</td>
<td>“EXPECTED TO RESUME AT HH:MM EST” or CST, MST, PST, EDT, CDT, MDT, PDT as appropriate based on the processor’s location.</td>
</tr>
<tr>
<td>“97”</td>
<td>Payer Unavailable</td>
<td></td>
</tr>
<tr>
<td>“98”</td>
<td>Connection to Payer Is Down</td>
<td>“EXPECTED TO RESUME AT HH:MM EST” or CST, MST, PST, EDT, CDT, MDT, PDT as appropriate based on the processor’s location.</td>
</tr>
<tr>
<td>“99”</td>
<td>Host Processing Error</td>
<td></td>
</tr>
</tbody>
</table>

14.2.2.3  REJECT CODE “85” (CLAIM NOT PROCESSED)

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“85”</td>
<td>Claim Not Processed</td>
<td>Whenever possible more specific Reject Codes should be used. If “85” is used, recommend including explanation as to why the claim is not processing.</td>
</tr>
</tbody>
</table>

14.2.2.4  REJECT CODE “87” (CLAIM NOT PROCESSED)
Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes
--- | --- | ---
“87” | Reversal Not Processed | Whenever possible more specific Reject Codes should be used. An additional Reject Code should be returned with “87” to identify the specific error. Alternately Reject Code “30” or “31” could be used as of 10/2015.
“84” | Claim Not Paid/Captured | This reject code was intended for use with B2 transactions, where the processor was not able to identify the matching B1 claim (referenced fields: 201-B1, 401-D1, 402-D2). Due to the non-distinct description associated to reject code 84 and the availability of reject code 31 as of 10/2015, reject code 84 will be sunset as of 10/2016.
“30” | Reversal outside processor reversal window. | Additional Message could include the allowed reversal window timeframe.
“31” | No matching paid claim found for reversal request. | Reversal within reversal window but corresponding paid claim not found.

14.2.2.5  
**REJECT CODE “53” (NON-MATCHED PERSON CODE)**

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“53”</td>
<td>Non-Matched Person Code</td>
<td>Since this code is often transmitted with other reject codes, an example of a supplementary message is: “ONE OR MORE OF THESE REASONS MAY APPLY.”</td>
</tr>
</tbody>
</table>

14.2.2.6  
**REJECT CODE “40” (PHARMACY NOT CONTRACTED WITH PLAN)**

These additional Reject Codes would provide the type of pharmacy network through which the drug would be covered.

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“G6”</td>
<td>Pharmacy Not Contracted in Specialty Network</td>
<td>Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears.</td>
</tr>
<tr>
<td>“G7”</td>
<td>Pharmacy Not Contracted in Home Infusion Network</td>
<td>Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears.</td>
</tr>
<tr>
<td>“G8”</td>
<td>Pharmacy Not Contracted in Long Term Care Network</td>
<td>Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears.</td>
</tr>
<tr>
<td>“G9”</td>
<td>Pharmacy Not Contracted in 90 Day Retail Network (this message would be used when the pharmacy is not contracted to provide a 90 days supply of drugs)</td>
<td>Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears.</td>
</tr>
</tbody>
</table>

If a given processor’s Payer Sheet indicates a specific field is required for the claim to process and that field is not submitted, the appropriate field “M/I” Reject Code must be returned in the Reject Response and its appropriate Explanation/Definition displayed for the pharmacist.
14.2.2.7 **REJECT CODE “608” (STEP THERAPY)**

<table>
<thead>
<tr>
<th>Related Reject Codes</th>
<th>NCPDP Reject Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“608”</td>
<td>Step Therapy, alternate drug therapy required prior to use of submitted product service ID</td>
<td>In addition, the payer/plan must return the alternate drug therapy in Additional Message Information (526-FQ) and/or Preferred Product Description (556-AU). Example: “ALTERNATE DRUG THERAPY: (return generic drug name, specific therapeutic class description).”</td>
</tr>
</tbody>
</table>

14.3 **DUR/PPS-GENERATED REJECTIONS**

Claims processing systems should develop methods to provide a different set of criteria for DUR/PPS Alerts detected when the claims for the interacting drugs originate from the same pharmacy versus DUR/PPS Alerts detected due to claims where the interacting drugs are dispensed at different pharmacies. In some instances, DUR/PPS Alerts are based on information on a claims processor’s patient profile—data possibly collected from multiple sources. Responses for same-pharmacy DUR/PPS Alerts (that is, the information was obtained from the same pharmacy submitting the claim) should be significantly downgraded as compared to Alerts generated due to other pharmacy-submitted or other profiled data. One possible answer is the development of three-tier DUR/PPS responses:

- Tier 1 = Other Pharmacy
- Tier 2 = Same Pharmacy within the a chain DUR/PPS
- Tier 3 = Same Pharmacy DUR/PPS

Processors should consider utilizing a restrictive hierarchal approach to DUR/PPS Responses such as the following DUR/PPS:

- Hard Reject: This level should be used for a small subset of Alerts. Only a processor-assigned Prior Authorization can override “Hard Rejections”. Recommendations from industry, database providers, Pharmacy and Therapeutics Committees, specialty providers and groups, and other sources should be followed to define this subset of Alerts, but the decision of which Alerts actually fall into this category should be left to the plan sponsors, due to processor liability concerns.
- Soft Reject: This level should be used for other severe or major DUR/PPS Alerts. Processor-assigned Prior Authorizations and pharmacist-submitted NCPDP DUR/PPS codes can override these rejections.
- Message Only Alerts: This level should be used for the remaining DUR/PPS Alerts that are deemed necessary to warn the pharmacist of potential patient harm. Claims are not rejected, but the processor provides information to make the pharmacist aware of potential problems and allow the pharmacist to make an informed decision whether or not to continue with the claim. Lack of any additional claim activity (i.e. Claim Reversal) assumes the pharmacist has judged that the warning(s) is/are of no significance for the patient. Message Only Alerts should be used cautiously to minimize alert fatigue situations due to message overload.
- No Alerts: At this level, DUR/PPS Alerts are generated by the processor, but not returned to the pharmacy. This allows retrospective analysis of DUR/PPS Alerts, where the processor has determined that the immediate patient risk is minimal (low severity Alerts). This level can also be used for those Alerts otherwise downgraded due to same pharmacy detection or the transmission of applicable DUR/PPS codes with the claim.

It is prudent to note that even a statistically insignificant drug-drug interaction can be significant in any given patient. Patients do experience low incidence and minor severity problems, and when this occurs, it is significant to them. There are always outliers in any study that attempts to categorize DUR/PPS Alerts based on statistical probabilities. There are degrees of occurrence for every drug-drug interaction, and a problem does not “always happen” or “never happens” in every patient. All stakeholders must recognize the need to balance the risk of
suppression of DUR/PPS messages in the interest of reducing noise to the risk of individual patient significance and harm of even low risk DUR/PPS Alerts.

Information fields in the Claim Submission should be used whenever possible when a pharmacist’s in-house system detects a drug-drug interaction, but in the pharmacist’s professional judgment, it is decided that the interaction is of minimal risk to the patient and the product should be dispensed. Some systems provide the capability for the pharmacist to document this decision internally. These documentations usually include the description of the problem, the identity of the person making the decision, and the result of the decision. The NCPDP Telecommunication Standard Implementation Guide contains the following fields in its Response DUR/PPS Segment that should map to these documentations: Reason for Service Code (439-E4), Professional Service Code (440-E5), Result of Service Code (441-E6), and DUR Co-Agent ID (476-H6).

In situations in which the pharmacist decides to transmit a claim that he/she knows will trigger a DUR/PPS Alert, the DUR/PPS fields should be populated with the correct codes and transmitted to the processor with the claim. If the Claims Processing system has functionality built around these fields and codes, it then searches the claims and clinical databases, plus the patient demographic information on file to determine if DUR/PPS problems exist. Then the processor should compare these submitted codes to criteria on the claims processing system to determine if the defined DUR/PPS Alert response should be reduced or suppressed entirely.

The NCPDP Telecommunication Standard Implementation Guide does not differentiate between a Hard Reject and a Soft Reject. Both situations simply generate a Reject Code of “88” (DUR Reject Error) and claims processors should populate the DUR/PPS Segment with the appropriate values. In the event that a DUR/PPS Reject is transmitted to the pharmacy and the pharmacist desires to override the rejection, the pharmacist should use the four PPS fields above and retransmit the claim. If the rejection was a “Soft Reject,” then this action may override the rejection. If it will not override the rejection, the pharmacist can always call the phone number provided in the claim transaction’s Help Desk Telephone Number field (550-8F) and request an authorization that will override the rejection. The pharmacist should first attempt a second transaction using the DUR/PPS codes—it may avert the need to call the Help Desk. Pharmacy systems can be built to facilitate the population of these DUR/PPS fields. All DUR/PPS Alerts have the Reason for Service Code (439-E4) populated for each Alert. The value from the processor automatically should be placed in this same field when building the claim re-submittal transaction. Then the pharmacist should be presented a list of values for the Professional Service Code (440-E5) and Result of Service Code (441-E6) fields to transmit. If the system programmer wants to further enhance the system, the available values in these latter two fields can be reduced to only those codes that apply for a given Reason for Service Code, thereby minimizing the long list of codes from which a pharmacist must choose.²

Implementation of these recommendations is voluntary. There is value in streamlining the on-line message functionality that exists within the NCPDP Telecommunication Standard Implementation Guide. Selected benefits of more meaningful and actionable messages include improved patient quality of care and saved time by all parties in researching and interpreting such messages.

14.4 Participating Organizations

NCPDP would like to thank the following organizations that provided input and comments in the original writing of this appendix. The organizations listed below should not be considered as endorsers for the content but rather contributors to information contained within this section.

- America’s Health Insurance Plans (AHIP)
- Academy of Managed Care Pharmacy (AMCP)
- American Pharmacists Association (APhA)
- Blue Cross Blue Shield Association (BCBSA)

² See NCPDP Data Dictionary and External Code List for list of values.
14.5 **LONG TERM CARE TRANSITION, EMERGENCY SUPPLY AND CHANGE IN LEVEL OF CARE MESSAGING FOR REJECTED AND PAID CLAIMS**

14.5.1 **BACKGROUND**

There is an ongoing need for an industry wide methodology for response messaging for claims that meet the transition period/emergency supply/change in level of care criteria.

**CMS Transition Guidance in Summary**

**CMS TRANSITION PERIOD REQUIREMENT**

*Non-LTC:* “The minimum transition process standards described in Section I will apply to beneficiaries obtaining their drugs in a retail setting (or via home infusion, safety-net, or I/T/U pharmacies). However, we clarify that, in the retail setting, the one-time, temporary supply of non-formulary Part D drugs – including Part D drugs that are on a plan’s formulary but require prior authorization or step therapy under a plan’s utilization management rules – must be for at least 30 days of medication, unless the prescription is written by a prescriber for less than 30 days. Plans should note that, outside the long term care setting, such a temporary fill may be a one-time fill only.”

*LTC:* “The minimum transition process standards described in Section I will apply to beneficiaries obtaining their drugs in a long-term care setting. The temporary supply of non-formulary Part D drugs – including Part D drugs that are on a plan’s formulary but require prior authorization or step therapy under a plan’s utilization management rules – for a new enrollee in a LTC facility must be for at least 31 days (unless the prescription is written for less than 31 days). We are requiring a 31-day transition supply given that many LTC pharmacies and facilities dispense medications in 31-day increments. However, unlike in the retail setting, plans must honor multiple fills of non-formulary Part D drugs, including Part D drugs that are on a plan’s formulary but require prior authorization or step therapy under a plan’s utilization management rules, as necessary during the entire length of the 90-day transition period.”

**CMS EMERGENCY SUPPLY REQUIREMENT**

*Non-LTC:* No CMS requirement (however plans may choose to offer this for non-LTC claims)

*LTC:* “Since, as a matter of general practice, LTC facility residents must receive their medications as ordered without delay, Part D plans must cover an emergency supply of non-formulary Part D drugs for LTC facility residents as part of their transition process. During the first 90 days after a beneficiary’s enrollment, he or she will receive a transition supply via the process described above. However, to the extent that an enrollee in a LTC setting is outside his or her 90-day transition period, the plan must still provide an emergency supply of non-formulary Part D drugs – including Part D drugs that are on a plan’s formulary but require prior authorization or step therapy under a plan’s utilization management rules – while an exception is being processed. These emergency supplies of non-formulary Part D drugs – including Part D drugs that are on a plan’s formulary but require prior authorization or step therapy under a plan’s utilization management rules – must be for at least 31 days of medication, unless the prescription is written by a prescriber for less than 31 days. We are requiring a 31-day emergency supply given that many LTC pharmacies and facilities dispense medications in 31-day increments.”

**CMS CHANGE IN LEVEL OF CARE REQUIREMENT**
"In addition to circumstances impacting new enrollees who may enter a plan with a medication list that contains non-formulary Part D drugs, other circumstances exist in which unplanned transitions for current enrollees could arise and in which prescribed drug regimens may not be on plan formularies. These circumstances usually involve level of care changes in which a beneficiary is changing from one treatment setting to another. For example, beneficiaries who enter LTC facilities from hospitals are sometimes accompanied by a discharge list of medications from the hospital formulary, with very short term planning taken into account (often under 8 hours). Similar situations may exist, for example, for beneficiaries who are discharged from a hospital to a home; for beneficiaries who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary; for beneficiaries who give up hospice status to revert to standard Medicare Part A and B benefits; for beneficiaries who end a long-term care facility stay and return to the community; and for beneficiaries who are discharged from psychiatric hospitals with medication regimens that are highly individualized. For these unplanned transitions, beneficiaries and providers must clearly avail themselves of plan exceptions and appeals processes. We have streamlined the grievance, coverage determination, and appeals process requirements in order to ensure that beneficiaries receive quick determinations regarding the medications they need. In all cases, we make it clear that a Part D plan sponsor is required to make coverage determinations and re-determinations as expeditiously as the enrollee’s health condition requires. In addition, and as described above, current enrollees entering LTC settings from other care settings will be provided emergency supplies of non-formulary drugs — including Part D drugs that are on a plan’s formulary but require prior authorization or step therapy under a plan’s utilization management rules”.

In the 2007 guidance CMS states: "... we strongly encourage point-of-sale notification of enrollees about transition supplies by pharmacists".

Earlier versions of this document including version 5.1 guidance recommended multiple methodologies for handling transition claims that included rejecting the claim with a message indicating resubmission of a Prior Authorization Code or resubmitting the claim and paying with a structured (5.1) approved message or Approved Message Code (548-6F) related to transition supply D.0.

On August 27, 2010, CMS provided in the memo titled “Part D Transition Policy Reminder” stating that “... CMS has found that sponsors adopting the “hard edit” approach ... are at the most risk for being found non-compliant because the sponsor’s administration of the transition policy is reliant on the pharmacist effectuating the coverage of a transition supply by inputting an override code. When sponsors and/or their processors adopt the “hard edit” approach, sponsors must either ensure that their contracted pharmacies apply the override code or put in place other internal controls to ensure the beneficiary does not leave the pharmacy without the transition supply required under Medicare rules.”

In order to be compliant with CMS intent that all members receive their transition supply, NCPDP recommends that plans should pay the claims with the appropriate Approved Message Code (548-6F) related to transition supply, instead of rejecting and providing a Prior Authorization Code and/or requiring the pharmacy to resubmit the claim. This ensures consistency between the Long Term Care (LTC) and retail community.

Medicare Part D plans are not prohibited from denying a drug claim that meets transition criteria during the transition period provided the plan clearly identifies the reason for the denial and return all appropriate Reject Codes.

It is expected that based on the appropriate Approved Message Code (548-6F) the member or in long term care settings, the pharmacy will initiate timely appropriate follow-up to ensure that the member will continue to receive the prescribed drug or an alternative therapy after the transition days supply has been exhausted.
Plans should ensure that the member receives a transition notice and all other communications related to transition supply as required by CMS.

### 14.5.1.1 WHEN PRIOR AUTHORIZATION NUMBER (498-PY) REQUIRED
In some situations of a Claim Billing, the payer requires the pharmacy to submit a Prior Authorization Number in order to receive payment for the claim if rejected outside the transition/emergency supply/level of care change. An example of a situation may include a Benefit Transition Period that allows for payment of claims, for a period of time that would normally reject.

When paying the claim, the processor must return the Approved Message Code (548-6F) field with the appropriate value listed below:
- “005” Dispensed During Transition Benefit/Prior Authorization Required
- “009” Emergency Supply Situation/Prior Authorization Required
- “013” Level of Care Change/Prior Authorization Required

### 14.5.1.2 TRANSITION AND SAFETY-RELATED REJECTS
From CMS:

“We note that although Part D plans may implement quantity limits for safety purposes or drug utilization edits that are based upon approved product labeling during a beneficiary’s transition period, to the extent that the prescription is dispensed for less than the written amount due to a plan edit, plans must provide refills for that transition supply (up to a 30-day supply in a retail setting and a 90-day supply in a long-term care setting). For example, if a beneficiary presents at a retail pharmacy with a prescription for one tablet per day for 30 days and a plan has a quantity limit edit in place that limits the days supply to 14 per prescription for safety purposes, the beneficiary would receive a 14-day supply (consistent with the safety edit). At the conclusion of the 14-day supply, the beneficiary should be entitled to another 14-day supply while he/she continues to pursue an exception with the Part D plan, or a switch to a therapeutic alternative that is on the plan’s formulary.”

In some situations of a Claim Billing, the payer may have rejected the claim due to safety related issues if outside the transition/emergency supply/level of care change. It is recommended that during the transition/emergency supply/level of care period that the claim is paid.

When paying the claim, the processor must return the Approved Message Code (548-6F) field with the appropriate value listed below:
- “007” Dispensed During Transition Benefit/Other Reject
- “011” Emergency Supply Situation/Other Rejection
- “015” Level of Care Change/Other Rejection

### 14.5.2 CLAIMS PAID DUE TO CMS INITIAL ELIGIBILITY TRANSITION PERIOD
It is recommended that plans use the most descriptive Approved Message Codes when utilizing soft edits for purposes of applying transition benefits.

#### 14.5.2.1 APPROVED MESSAGE CODE “004” (DISPENSED DURING TRANSITION BENEFIT)
If during the transition period a claim is not rejected (claim is paid) and the processor paid the claim by setting edits to soft, the plan must notify the pharmacy using one of the following Approved Message Codes (548-6F).

In addition, the plan must notify the pharmacy why the claim would have rejected using the appropriate mapped Reject Code in one of the response message fields to increase the value of the messaging.
14.5.3 CLAIMS PAID DUE TO CMS EMERGENCY SUPPLY REQUIREMENT

**APPROVED MESSAGE CODE “008” (EMERGENCY SUPPLY SITUATION)**

If a claim that meets emergency supply criteria is not rejected (claim is paid) and the processor paid the claim by setting errors to soft, the plan must notify the pharmacy using one of the following Approved Message Codes (548-6F). In addition, the plan must notify the pharmacy why the claim would have rejected using the appropriate mapped Reject Code in one of the response message fields to increase the value of the messaging.

<table>
<thead>
<tr>
<th>Approved Message Codes (548-6F)</th>
<th>NCPDP Approved Message Code Definition</th>
<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“009”</td>
<td>Emergency Supply Situation/ Prior Authorization Required</td>
<td>Mapped when Reject Code “75” (Prior Authorization Required) is overridden</td>
</tr>
<tr>
<td>“010”</td>
<td>Emergency Supply Situation/ Non-Formulary</td>
<td>Mapped when Reject Code “61” (Product/Service Not Covered For Patient Gender), “60” (Product/Service Not Covered For Patient Age), “70” (Product/Service Not Covered – Plan/Benefit Exclusion) is overridden</td>
</tr>
<tr>
<td>“011”</td>
<td>Emergency Supply Situation/Other rejection (e.g. Step Therapy, Benefit Maximum, Generic First Requirement, and Non-safety related DUR)</td>
<td>Mapped when Reject Code “76” (Plan Limitations Exceeded), “78” (Cost Exceeds Maximum), “80” (Drug-Diagnosis Mismatch), “88” (DUR Reject Error) is overridden</td>
</tr>
</tbody>
</table>

14.5.4 CLAIMS PAID DUE TO CMS CHANGE IN LEVEL OF CARE REQUIREMENT

**APPROVED MESSAGE CODE “012” (LEVEL OF CARE CHANGE)**

If a claim that meets level of care change criteria is not rejected (claim is paid) and the processor paid the claim by setting errors to soft, the plan must notify the pharmacy using one of the following Approved Message Codes (548-6F). In addition, the plan must notify the pharmacy why the claim would have rejected using the appropriate mapped Reject Code in one of the response message fields to increase the value of the messaging.

<table>
<thead>
<tr>
<th>Approved Message Codes (548-6F)</th>
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<th>Supplementary Message/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“012”</td>
<td>Emergency Supply Situation/Other rejection (e.g. Step Therapy, Benefit Maximum, Generic First Requirement, and Non-safety related DUR)</td>
<td>Mapped when Reject Code “76” (Plan Limitations Exceeded), “78” (Cost Exceeds Maximum), “80” (Drug-Diagnosis Mismatch), “88” (DUR Reject Error) is overridden</td>
</tr>
<tr>
<td>“013”</td>
<td>Level Of Care Change/ Prior Authorization Required</td>
<td>Mapped when Reject Code “75” (Prior Authorization Required) is overridden</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>“014”</td>
<td>Level Of Care Change/Non-Formulary</td>
<td>Mapped when Reject Code “61” (Product/Service Not Covered For Patient Gender), “60” (Product/Service Not Covered For Patient Age), “70” (Product/Service Not Covered – Plan/Benefit Exclusion) is overridden</td>
</tr>
<tr>
<td>“015”</td>
<td>Level Of Care Change/Other rejection (e.g. Step Therapy, Benefit Maximum, Generic First Requirement, and Non- safety related DUR)</td>
<td>Mapped when Reject Code “76” (Plan Limitations Exceeded), “78” (Cost Exceeds Maximum), “80” (Drug-Diagnosis Mismatch), “88” (DUR Reject Error) is overridden</td>
</tr>
</tbody>
</table>
15 MULTI-INGREDIENT COMPOUND PROCESSING
See also section “Appendix C. Medicare Part D and Multi-Ingredient Compound Processing”.

15.1 CORRECT TELECOM VERSION?

Question:
What is the Telecom version for multi-ingredient claims?

Response:
HIPAA covered entities submitting electronic transactions are required to use the Telecommunication Standard Version D.0 using the Compound Segment and the submission of all ingredients (up to 25), and following the compound requirements.

Workers’ Compensation multi-ingredient electronic claims are not covered under HIPAA and may use any version of Telecom since Version 3.3, however the industry recommends Version D.0 be used for consistency.

15.2 LEAVE OFF INGREDIENTS THAT ARE IDENTIFIABLE BY THE PHARMACY AND THE PAYER?

Question:
When using the Telecommunication Standard version D.0 multi-ingredient claim, should we leave off ingredients that are not paid for, like cream bases, empty capsules and fillers which are necessary to prepare the compounds, etc.? NOTE: This question assumes that all ingredients in the compound are identifiable by the pharmacy and the payer.

Response:
In general, it is best to report all ingredients so that DUR can be performed. If an ingredient product ID is identifiable but not covered by the payer, best practice is for the payer to reject the claim and identify at the ingredient level those ingredients that are not covered by using the Reject Code(s) and Reject Field Occurrence Indicator. This allows the pharmacy the option to resubmit the claim with the Submission Clarification Code of 8 (Process compound for approved ingredients).

15.3 COMPOUND INGREDIENT QUANTITY (448-ED) SMALLER THAN 3 DIGITS OF PRECISION TO THE RIGHT OF THE DECIMAL

Question:
I have a question about compound claims and the Reject Code value “ED” (M/I Compound Ingredient Quantity). When a compound is prepared where one of the ingredients is actually measured more in the microgram range, it is possible for the value in Compound Ingredient Quantity (448-ED) to amount to less than .0005 gram (or milliliter): while it is clearly outlined in the Imp Guide that it is allowed and actually required for a compound ingredient to be reported even if the cost of that ingredient rounds to $0.00, I cannot find any specific recommendations or guidelines on what to do if the quantity similarly would round to 0.000.

Response:
DERF 001073/ECL 000120 requesting new Reject Codes and new value for Compound Ingredient Basis of Cost Determination was approved in August 2012.

Reject Codes:
“615” = “Compound Ingredient Basis Of Cost Determination value “14” required when Compound Ingredient Quantity is 0 but cost is greater than $0”.
“616” = “Submission Clarification Code 8 required when Compound Ingredient Quantity is 0”.

Compound Ingredient Basis of Cost Determination:
“14” = “Cost basis on unreportable quantities”.

Version 48
November 2019
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The following scenarios are given for using the new values.

1. **Scenario 1: The pharmacy submits a claim with an ingredient Compound Ingredient Quantity (448-ED) of 0 and cost is $0 and new value of Compound Ingredient Basis Of Cost Determination is not sent.**
   a. The processor does not know if the 0 in quantity was an intentional 0 (unreportable) quantity by the pharmacy.
   b. The processor can:
      i. Accept the claim and pay $0 on this ingredient.
      ii. The processor is assuming the 0 quantity submission was intentional 0 (unreportable).
      iii. Reject at the ingredient level (using Reject Code Occurrence Indicator and Reject Code new value of)
         1. “616” (Submission Clarification Code 8 required when Compound Ingredient Quantity is 0).
            a. Action is for pharmacy to resubmit claim with SCC 8.
               i. By sending the SCC 8 and the fact that the payer rejected previously for “616”, the payer is to not reject the claim based on the 0 quantity but ignore the ingredient for compound pricing.

2. **Scenario 2: The pharmacy submits a claim with an ingredient Compound Ingredient Quantity (448-ED) of 0 and cost submitted based on contractual relationship (cost is > $0) and new value of Compound Ingredient Basis Of Cost Determination is not sent.**
   a. The processor does not know if the 0 in quantity was an intentional 0 (unreportable) quantity by the pharmacy.
   b. The processor can:
      i. Accept the claim and pay cost submitted on this ingredient.
      ii. Reject at the ingredient level (using Reject Code Occurrence Indicator and Reject Code new value of)
         1. “615” (Compound Ingredient Basis Of Cost Determination value “14” required when Compound Ingredient Quantity is 0 but cost is greater than $0).
            a. Action is for the pharmacy to resubmit claim with new value of Compound Ingredient Basis Of Cost Determination.
               i. By sending the new value, the pharmacy is noting intentional 0 (unreportable) quantity and providing the cost. The payer is to not reject the claim based on the 0 quantity and to price this ingredient based on contractual relationship.

3. **Scenario 3: The pharmacy submits a claim with an ingredient Compound Ingredient Quantity (448-ED) of 0 and cost is $0 and new value of Compound Ingredient Basis Of Cost Determination is sent.**
   a. By sending the new value, the pharmacy is noting an intentional 0 (unreportable) quantity and providing the cost of $0.
      i. The payer is to not reject the claim based on the 0 quantity but ignore the ingredient for compound pricing.

4. **Scenario 4: The pharmacy submits a claim with an ingredient Compound Ingredient Quantity (448-ED) of 0 and cost submitted based on contractual relationship (cost is > $0) and new value of Compound Ingredient Basis Of Cost Determination is sent.**
   a. By sending the new value, the pharmacy is noting an intentional 0 (unreportable) quantity and providing the cost.
      i. The payer is to not reject the claim based on the 0 quantity and to price this ingredient based on contractual relationship.
DERF 001074 requesting to increase the size of Compound Ingredient Quantity from 9(7)v999 (10 digits) to 9(7)v9999999 (14 digits) in a future version was approved in August 2012.

### 15.4 Compound Ingredient Modifier Code (363-2H)

**Question:**
Is there information about the Compound Ingredient Modifier Code (363-2H)?

**Response:**
The field was added for Medicare Part B needs. There is a counter (Compound Ingredient Modifier Code Count (362-2G)) so multiple codes per ingredient can be sent. The Compound Ingredient Modifier Code (363-2H) occurs per ingredient. See section 33.14.2.4.4 Compound Segment, subsection 33.14.2.4.4.1 Compound Ingredient Component Count of the Implementation Guide.

According to CMS:
The file available from CMS has both the modifiers and HCPCS codes in the same file. The modifiers are the two byte elements in the spreadsheet found in the first 409 rows. The HCPCS codes start at row 411 and are 5 bytes the first byte being alpha followed by 4 numerics. The link is:

2010 Alpha-Numeric HCPCS File:

2010 HCPCS Corrections:

### 15.5 Basis of Reimbursement (423-DN) and Multi-Ingredient Compounds

**Question:**
Is the use of fields Basis of Cost Determination (423-DN) and Compound Ingredient Basis of Cost (490-UE) mutually exclusive? If so, should field Basis of Reimbursement Determination (522-FM) be returned on compound claim responses?

**Response:**

1. In a multi-ingredient compound request, Basis of Cost Determination (423-DN) may be irrelevant.
   a. If all Compound Ingredient Basis of Cost (490-UE) are the same, use the same value in Basis of Cost Determination (423-DN).
   b. If a plan requires Basis of Cost Determination (423-DN), recommend use value 9 (Other).

2. In a multi-ingredient compound response, Basis of Reimbursement (522-FM), recommend use value 8 (Contract Pricing) unless a more specific value applies.

3. It is recommended that the individual payer sheets designate the value for both these fields for multi-ingredient compounds.

### 15.6 Unit of Measure (600-28) and Multi-Ingredient Compounds

See section “Unit of Measure (600-28) and Multi-Ingredient Compounds”.

### 15.7 Recommendations on the Submission of Identifiable Ingredients that are Not Recognized by the Payer

1. It is recommended that the correct Product/Service ID Qualifier (436-E1) value be supported for the Product/Service ID (407-D7).
a. It has been identified that entities may not be supporting the valid qualifier values for the types of products exchanged in compounds. This may be a long term implementation modification. However the industry needs to move to use the correct ID and Qualifier pair.

b. **Recommendation if the processor does not support the code list (does not support the value for the Product/Service ID Qualifier):**
   i. It is recommended the processor identify on the payer sheets which Product/Service ID Qualifiers are supported. If an ingredient has a qualifier value that is not supported by the processor, it is recommended that procedures for how the pharmacy is to be able to submit the claim and be reimbursed for ingredients that are covered be handled between trading partners.

2. **There is an NDC code for the product, but it is not in the pharmacy or the processor’s drug file.**
   a. Someone in the supply chain should insure that the identifier is loaded timely into the drug file.
   b. May be payer-specific or drug compendia-specific and is time-consuming to update the drug file(s).
   c. **Recommendation for identification of product:**
      i. The processor may not know enough about the product to contact their compendia. The pharmacy has the product in hand to contact the manufacturer. *The pharmacy could provide information about the product to the processor so the processor could follow up with their compendia.*
      ii. The pharmacy or the processor should contact the manufacturer and their compendium.
      iii. The manufacturer should share their information with the compendia to update all drug file(s).

3. **There is a UPC code for the product; the product does not have an NDC. It is not in the drug file.**
   a. Compendia list products that only have UPCs on their files.
   b. Private label product identifiers have to be shared with entities in the entire supply chain. Whether private label or not, there is a distributor. The distributor (pharmacy chain, buying group) should have relationships with the compendia.
   c. **Recommendation for identification of product:**
      i. For this recommendation, manufacturer or distributor is the entity that applies for the UPC. Repackaged products are not included in this recommendation.
      ii. The processor may not know enough about the product to contact their compendia. The pharmacy has the product in hand to contact the manufacturer or distributor. *The pharmacy could provide information about the product to the processor so the processor could follow up with their compendia.*
      iii. The pharmacy or the processor should contact the manufacturer or distributor and their compendium.
      iv. The manufacturer or distributor should share their information with the compendia to update all drug file(s).

**15.8 CORRELATE COMPLEXITY IN COMPOUNDING AND DUR/PPS LEVEL OF EFFORT (474-8E)**

**Question:**
What is the best way to correlate the complexity in compounding to the commonly used DUR/PPS Level of Effort (474-8E)?

**Response:**
For current Telecommunication Version D.0 usage: DUR/PPS Level of Effort (474-8E) values 16-22 are available for use by willing trading partners for compound prescription claims effective October 15, 2017. The usage of these values is described with examples below.

**Note:** active pharmaceutical ingredients (APIs) also include commercial products.
ECL Value 16
Low Level Complexity: Non-sterile compounding, non-hazardous compound active pharmaceutical ingredients (API), 2 or more active ingredients combined in a simple one step procedure. For example, two commercial creams being mixed together.

Example:
The pharmacist receives a RX for a combination of Retin A and hydrocortisone cream. The dermatologist asks for the compound to be one tube of Retin A mixed evenly with one tube of hydrocortisone.

ECL Value 17
Mid-Level Complexity Non-Hazardous: Non-sterile compounding, non-hazardous compound active pharmaceutical ingredients (API), whereby two or more API are mixed together with added complexity of melting, diluting, solubilizing, heating, two phase mixing, aliquot, with final form being something other than a simple cream. For example, suppository, troche, capsule, rapid dissolve tablet, inhaler, spray, etc.

Example:
The pharmacist receives a RX for a suppository of diphenhydramine, metoclopramide, and lorazepam. The pharmacist would need to separately weigh the ingredients, solubilize the powders, mix them, melt suppository base, incorporate evenly the API into the base, pour the base into suppository molds, let cool, correct for air pockets, remove from mold, wrap or package appropriately, and dispense.

ECL Value 18
Mid-Level Complexity Hazardous: Non-sterile but manipulating hazardous active pharmaceutical ingredients (API). When working with hazardous API, the pharmacist must follow State and Federal Regulations specific to compounding of hazardous API. Special training, documentation, and experience are required in order to compound hazardous API.

Example:
The pharmacist receives a RX for a topical cancer medication such as fluorouracil, mixed with imiquimod. The API for the fluorouracil would have to be weighed in the appropriate laboratory environment as specified by State and Federal Regulations. The regulations could include a pressurized room, air flow hood, proper gowning, washing, body protection, and filter systems. The two API powders would be solubilized, and then mixed into a cream base in the proper percentages as specified by the RX. The final product would be tubed and capped in the appropriate pressurized lab area, and then released to the dispensary for dispensing.

ECL Value 19
High Level Non-Hazardous: Non-sterile to Sterile compounding with non-hazardous active pharmaceutical ingredients (API). Involves high complexity due to sterile compounding. The pharmacist must follow State and Federal Regulations and compound in the appropriate pressurized room. Appropriate testing as per State and Federal Regulations for sterile compounding must be implemented.

Example:
Pharmacist receives a RX for a combination of dexamethasone and Marcaine, to be mixed into one single use vial.

ECL Value 20
High Level Hazardous: Non-sterile to Sterile compounding with hazardous active pharmaceutical ingredients (API). Involves a high complexity due to sterile hazardous compounding. The pharmacist and facility must follow all State and Federal Regulations that pertain to compounding and testing of final product in a sterile environment with hazardous commercial products.

Example:
Pharmacist receives a RX for a combination of testosterone and estradiol, to be mixed into one single use vial.
ECL Value 21
High Level Non-Hazardous Sterile: Sterile to Sterile compounding with non-hazardous active pharmaceutical ingredients (API). All State and Federal Regulations pertaining to compounding a sterile product shall be followed including testing.

Example:
The pharmacist would receive a RX for gentamicin sterile nasal irrigation solution. The pharmacist would need to take a vial of gentamicin injection solution and mix it with sterile water for irrigation. The entire procedure would be performed in the appropriate pressurized room, with proper safety precautions.

ECL Value 22
High level Hazardous Sterile: Sterile to Sterile compounding with hazardous active pharmaceutical ingredients (API). This is the highest level of complexity. The pharmacist and facility must follow all State and Federal Regulations that pertain to compounding and testing of final product in a sterile environment with a sterile API.

Example:
The pharmacist receives a RX for preparation of a chemotherapy treatment for intravenous infusion.

15.9 Compound Ingredient Product Identifier and Qualifier Use

Effective Date: October 15, 2015

As of the July 2014 publication of the External Code List new Reject Code (511-FB) values are available. Annual implementation effective date is October 15, 2015.

“771” (Compound contains unidentifiable ingredient(s); Submission Clarification Code override not allowed)

“772” (Compound contains not covered ingredient(s); Submission Clarification Code override not allowed)

These new Reject Code values notify the pharmacy that the processor does not recognize or does not cover one or more ingredient(s) of the compound. The pharmacy cannot resubmit the claim with a Submission Clarification Code to override this edit. If one of these new Reject Code values is received, in order to service the patient, the pharmacy and the payer will need to collaborate according to trading partner agreement. This guidance is not indicating which value must be used, but if the processor will not process the claim with the ingredient(s) that to them are unidentifiable, the use of these Reject Code values lets the pharmacy know to not attempt to retry sending the compound claim by using the Submission Clarification Code 8 as an override.

Note that when Reject Code value “771” or “772” are sent, the corresponding Reject Field Occurrence Indicator (546-4F) should also be included to help identify the ingredient(s) in question.

Example 1: Pharmacy submits the claim with industry-recognized valid product IDs and the corresponding qualifiers but the processor does not support a qualifier value

A claim with 4 ingredients:

- 3 products are recognized that are covered and payable and
- 1 product and qualifier pair is not supported by the processor (ex: UPC, a device identified by HRI)

Process Options:

1. The pharmacy knows the valid product(s) being submitted.
2. The processor may choose to
   a. Ignore the products for which they do not support the qualifier value
   b. OR allow Submission Clarification Code 8 and continue processing claim
i. The processor should use reject code 515 – Compound Product ID Qualifier Submitted Not Supported and corresponding Reject Field Occurrence Indicator (546-4F)

c. OR reject for the products for which they do not support the qualifier value

3. If the processor cannot pay the claim because the unsupported ingredient (e.g. concern of inability to perform DUR checking, safety, etc. of the unidentified ingredient):
   a. The processor should use Reject Code “771” (Compound Contains Unidentifiable ingredient(s); Submission Clarification Code override Not Allowed),
      i. If desired, the processor should use any other reject codes to support this rejection (i.e. 8Z, 8J, 515). It is not recommended “21” (M/I Product/Service ID) because it is not specific enough.
      ii. The corresponding Reject Field Occurrence Indicator (546-4F) should also be sent.

Notes:

1. Although the pharmacist has the choice of removing an ingredient from the claim before adjudication processing occurs in order to service the patient, this practice is not recommended and these examples are not providing any guidance as to whether that should or should not happen. In order to service the patient, the pharmacy and the payer should collaborate according to their trading partner agreement.

2. Upon receipt of the claim with Submission Clarification Code 8, the processor should have logic to ignore ingredients with valid qualifier values they do not support to allow further processing of the claim. Note, the claim may still reject for other reasons, but not for the 1 product and qualifier pair that is not supported by the processor.

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**Figure 1 for Example 1:** Pharmacy submits the claim with industry-recognized valid product IDs and the corresponding qualifiers but the processor does not support a qualifier value

**Example 2:** Pharmacy submits the claim with industry-recognized valid product IDs and the corresponding qualifiers.
A claim with 4 ingredients:
• 3 products are recognized that are covered and payable and
• 1 product is recognized and not covered (ex: a non-formulary product, non-covered HRIs (non-covered qualifier))

Process Options:
1. The pharmacy knows the valid product(s) being submitted.
2. The processor may choose to
   a. ignore the products they do not cover
   b. OR allow Submission Clarification Code 8 and continue processing claim, or
      i. The processor should use the appropriate Reject Codes for that ingredient (e.g. “MR” (Product Not on Formulary) or “70” (Product/Service Not Covered-Plan Benefit Exclusion), etc..) along with Reject Field Occurrence Indicator (546-4F) to identify the ingredient(s) rejected.
      ii. Or Reject Code “9Y” (Compound Product ID Qualifier Submitted Not Covered) could be used if appropriate to relay that product(s) with this qualifier value are not covered along with Reject Field Occurrence Indicator (546-4F) to identify the ingredient rejected.
   c. OR reject for the product(s) they recognize but do not cover
3. **If and only if** the Processor considers the recognized, but not covered ingredient(s) to render the entire claim unpayable
   a. The processor should return Reject Code “772” (Compound contains not covered ingredient(s); Submission Clarification Code override not allowed)
      i. If desired, the processor should use any other reject codes to support this rejection (i.e. “82”, “81”, “515”, etc.)
      ii. The corresponding Reject Field Occurrence Indicator (546-4F) should also be sent.

Notes:
1. Although the pharmacist has the choice of removing an ingredient from the claim before adjudication processing occurs in order to service the patient, this practice is not recommended and these examples are not providing any guidance as to whether that should or should not happen. In order to service the patient, the pharmacy and the payer should collaborate according to their trading partner agreement.
2. In this example, the term “unpayable” means the processor is unable to return a “Paid” response.
3. Upon receipt of the claim with Submission Clarification Code 8, the processor should have logic to **ignore ingredients with valid qualifier values they do not support** to allow further processing of the claim. Note, the claim may still reject for other reasons, but not for the 1 product and qualifier pair that is not supported by the processor.
15.10 USE OF THE COMPOUND SEGMENT FOR THE BILLING OF 2 COMMERCIALLY AVAILABLE PRODUCTS

Business Case: A payer is requiring the use of the Compound Segment for the billing of 2 commercially available products, commonly two different strengths of a drug (e.g. palivizumab, blood factors) that cannot be compounded to a single product. The purpose of using the compound segment is for the payer to manage prescription claim limits per time period and patient copays on a single claim versus a separate claim for each product dispensed.

Question: What is the definition of a Compound or Compounding?

Response: Refer to the definition of a Compound in the ECL – “Customized medication prepared in a pharmacy by combining, mixing, or altering of ingredients (but not reconstituting) for an individual patient in response to a licensed practitioner’s prescription.” The billing of multiple ingredients which are not combined, mixed or altered by a pharmacy is not a compound and the compound segment must not be used. Also, refer to Support of a Single Ingredient Compound Section 28.1.12.5 (Version D.0)

Question: Can the Compound Segment be used to submit a single claim for multiple products that cannot be compounded to a single product and must be dispensed as distinct products?
**Response:** The compound segment is for reporting more than one ingredient combined together in the fulfillment of a prescription order. The payer’s request to use the compound segment does not comply with the compound definition or the standard. The two drugs are not compounded together in this scenario.

**Question:** If the Compound Segment cannot be used in this scenario, is there a means within the NCPDP Standard for the payer to manage the prescription claim limits and patient copay amounts across the unique claim billing transactions for each product?

**Response:** The initial reject will likely be for a duplicate therapy. The appropriate DUR code (possibly AD or 1B) may need to be sent. The payer may support an override via a prior authorization in order to account for copays, claim limits, dispensing fees, etc. A pharmacy may need to work with the payer for resolution.

*Added December 2016-BP*
16 VACCINE SERVICES – PHARMACY BENEFIT BILLING & PROCESSING
Effective Date: August 2015 in preparation for the flu season

16.1 OVERVIEW
This chapter outlines business cases to vaccine and administration in NCPDP Telecommunication Version D. 0 Claim Billing (B1/B3) transaction scenarios. The sections discuss primary and coordination of benefits of claim in processing related to vaccine and administration, and then provide questions and examples in explanation.

Use of Service Billing for billing of administration was discussed in great detail. While the Service Billing transactions (S1/S3) support the billing of a service only, it does not support the identification of the billed service (vaccine administration) and the associated product (vaccine product that is administered). The B1/B3 transactions do support the identification of both the vaccine product and administration. To maintain standardization across the industry and to support coordination of benefits claims processing, NCPDP recommends the use of a single B1/B3 transaction for the billing of the vaccine product and the vaccine administration.

In the situation where the vaccine product does not have an associated cost (e.g. free product) and the billed charges are for vaccine administration and product dispensing only, since the identification of the vaccine product is necessary, NCPDP recommends the use of a single B1/B3 transaction with the Basis of Cost Determination value “15” (Free product or no associated cost).

See also section “Billing Transaction For Free Fills”.

16.2 NEW/MODIFIED CODE VALUES
16.2.1 REJECT CODES
The new Reject Codes (added as of 01/2015 External Code List) referenced in this chapter fall under the October 2016 annual implementation date. Until the Reject Codes are available for use, it is recommended that the processor return the Reject Code Description as a text message in the Message (504-F4) or Additional Message Information (526-FQ) fields.

<table>
<thead>
<tr>
<th>Reject Code</th>
<th>Reject Code Description</th>
<th>Explanation/Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>816</td>
<td>Pharmacy benefit exclusion, may be covered under patient’s medical benefit</td>
<td>Processor to return name and payer ID (if available) of medical benefit carrier within the Additional Message Information (526-FQ)</td>
</tr>
<tr>
<td>817</td>
<td>Pharmacy benefit exclusion, covered under patient’s medical benefit</td>
<td></td>
</tr>
<tr>
<td>818</td>
<td>Medication administration not covered, plan benefit exclusion</td>
<td></td>
</tr>
<tr>
<td>R0</td>
<td>Professional Service Code of “MA” required for vaccine Incentive Fee Submitted</td>
<td>Note: Existing Reject Code; modification to description approved in November 2014.</td>
</tr>
</tbody>
</table>
Note related to Medicare programs: Plans/processors should determine the applicable hierarchical rule sets to apply coverage determination (e.g. Medicare B versus D) edits versus vaccine medical benefit edits.

16.2.2 NEW BASIS VALUES

Basis of Cost Determination (423-DN) and Compound Ingredient Basis of Cost Determination (490–UE)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Free product or no associated cost</td>
</tr>
</tbody>
</table>

Basis of Reimbursement Determination (522-FM)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Ingredient cost paid based on submitted Basis of Cost Free Product</td>
</tr>
</tbody>
</table>

16.3 PHARMACY BENEFIT BILLING — PRIMARY VACCINE CLAIMS

16.3.1 QUESTION: WHEN BILLING A VACCINE CLAIM TO A PHARMACY BENEFIT USING THE NCPDP TELECOMMUNICATION STANDARD, WHAT ARE THE RESPONSIBILITIES OF THE PHARMACY?

Response:
When billing a vaccine claim to the pharmacy benefit, using the NCPDP Telecommunication Standard, the pharmacy responsibilities include:

1. Always identify the vaccine via the Product/Service ID and Qualifier (436-E1 and 407-D7)
2. Identify the billed quantity via the Quantity Dispensed (442-E7)
3. Identify the requested product reimbursement amount in the Ingredient Cost Submitted (409-D9)
4. Identify the requested dispensing fee reimbursement in the Dispensing Fee Submitted (412-DC)
5. Submit a Usual & Customary Charge (426-DQ)
6. Determine if
   1. Billing for a “Vaccine Product only” or
   2. Billing for a “Vaccine Product and Administration” or
   3. Billing for “Administration of a Vaccine Product with no associated product cost”
7. Submit an “MA” (Medication Administered) in the Professional Service Code (440-E5) if the vaccine is going to be administered
8. Submit an amount in the Incentive Amount Submitted (438-E3) when seeking reimbursement for the administration of the vaccine,
9. Determine if billing request was approved (Transaction Response Status (112-AN) of “P”, “D”, “C”, or “Q”) or denied (Transaction Response Status of “R”) and review messages to determine vaccine administration “next steps”.
16.3.2 **QUESTION: HOW DO I DETERMINE THE SUBMITTED VALUE IN THE USUAL & CUSTOMARY CHARGE FOR VACCINE PRODUCT AND ADMINISTRATION CLAIM BILLING?**

**Response:**

The Usual & Customary Charge determination must follow these scenarios:

− Billing for reimbursement of a Vaccine Product only – Follow definition for Usual & Customary Charge and submit value that represents the vaccine product and associated dispensing.

− Billing for reimbursement of the Vaccine Product and Administration – Follow definition for Usual & Customary and submit value that represents the vaccine product, associated dispensing and administration fee.

− Billing for reimbursement of the Administration of a Vaccine Product with no associated product cost - Follow definition for Usual & Customary Charge and submit value that represents the product dispensing and administration.

16.3.3 **QUESTION: SHOULD THE USUAL & CUSTOMARY CHARGE ON THE BILLING REQUEST RESUBMISSION REMAIN UNCHANGED? ALTERNATIVELY, SHOULD THE ADMINISTRATION FEE BE REMOVED?**

**Scenario:**

− A pharmacy submits a billing request for a Vaccine Product and Administration.

− The pharmacy benefit processor rejects the billing request and indicates the Administration is not reimbursable.

− The pharmacy decides to administer the vaccine and forego the Administration fee reimbursement.

− The pharmacy resubmits the billing request without the Incentive Amount Submitted or “MA” in the Professional Service Code.

**Response:**

In this scenario, the pharmacy may resubmit the billing request with the appropriate Usual & Customary Charge.

16.3.4 **QUESTION: WHAT ACTIONS ARE EXPECTED OF THE PHARMACY IN THE SCENARIO IN WHICH A BILLING REQUEST FOR A VACCINE...**
**Product and Administration was Rejected by the Pharmacy Benefit Processor to Indicate that the Product is Reimbursable and the Administration Fee is Not Reimbursable?**

**Response:**
When the pharmacy benefit processor denies the combined vaccine product and administration as not reimbursable, the pharmacy may determine that vaccine product only reimbursement is acceptable. In this scenario, the pharmacy must remove the “MA” (Medication Administered) from the Professional Service Code and remove the Incentive Amount Submitted (or submission of zero dollars) before re-submitting the billing request.

**16.3.5 Question:** Should the Submitted “Date of Service” Reflect the Date of the Billing Request or the Date in Which the Vaccine is Administered?

**Response:**
The submitted Date of Service must follow these scenarios:
- Billing for reimbursement of a Vaccine Product only – The Date of Service is the date that the vaccine product was dispensed.
- Billing for reimbursement of the Vaccine Product and Administration - The Date of Service is the date that the vaccine is administered.
- Billing for reimbursement of the Administration of a Vaccine Product with no associated product cost – The Date of Service is the date that the vaccine is administered.

**16.3.6 Question:** Can NCPDP Provide Inbound Billing Request Examples (Header, Claim, DUR/PPS, and Pricing Segments) for the Following Three Vaccine Claim Billing Examples?

1) Billing for reimbursement of Vaccine Product only
2) Billing for reimbursement of Vaccine Product and Administration
3) Billing for reimbursement of Administration of a Vaccine Product with no associated product cost

**Response:**
1) **Billing for reimbursement of Vaccine Product only**

*Only pertinent segments are shown.*

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<th><strong>Transaction Header Segment</strong></th>
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<tbody>
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<tr>
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<td>103-A3</td>
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<td>104-A4</td>
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<td>109-A9</td>
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<td>202-B2</td>
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<tr>
<td>201-B1</td>
</tr>
<tr>
<td>401-D1</td>
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<td>110-AK</td>
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<table>
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<th><strong>Claim Segment</strong></th>
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<tr>
<td>215-D1</td>
</tr>
<tr>
<td>216-D1</td>
</tr>
</tbody>
</table>
**Notes:**
- When billing for a Product (without an administration ),
  - The submitted Transaction Code is a “B1” (Billing).
  - The claim Pricing Segment follows the Prescription Claim Request Formula.
  - The Product/Service ID Qualifier should be submitted with a value of the correct product (in this example “03” (NDC) and the Product/Service ID contain the NDC Number of the vaccine).
  - The Days Supply should be submitted with a value of “1”.
  - The Quantity Dispensed should be submitted with the value that represents the quantity of drug product administered.
  - The Professional Service Code of “MA” would not be sent.
  - An Incentive Amount associated to the administration is not submitted because the pharmacy is billing for the product only.

2) **Billing for reimbursement of the Vaccine Product and Administration**

   *Only pertinent segments are shown.*
### Claim Segment

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Cat</th>
<th>Value</th>
<th>Comments</th>
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<tbody>
<tr>
<td>111-AM</td>
<td>SEGMENT IDENTIFICATION</td>
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<td>07</td>
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</tr>
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<td>01</td>
<td>Rx billing</td>
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<td>M</td>
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<td>NDC</td>
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<tr>
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<td>66521011510</td>
<td>Fluvirin 2012-2013</td>
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<tr>
<td>442-E7</td>
<td>QUANTITY DISPENSED</td>
<td>R</td>
<td>500</td>
<td>0.5 (ML)</td>
</tr>
<tr>
<td>403-D3</td>
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<td>R</td>
<td>0</td>
<td>Original dispensing for RX#</td>
</tr>
<tr>
<td>405-D5</td>
<td>DAYS SUPPLY</td>
<td>R</td>
<td>1</td>
<td>1 Days supply</td>
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<tr>
<td>406-D6</td>
<td>COMPOUND CODE</td>
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<td>1</td>
<td>Not a compound</td>
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<tr>
<td>408-D8</td>
<td>DISPENSE AS WRITTEN (DAW)/PRODUCT</td>
<td>R</td>
<td>0</td>
<td>No product selection indicated</td>
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<tr>
<td>414-DE</td>
<td>DATE PRESCRIPTION WRITTEN</td>
<td>R</td>
<td>20130915</td>
<td>September 15, 2013</td>
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### DUR/PPS Segment

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<td>DUR/PPS Segment</td>
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<td>473-7E</td>
<td>DUR/PPS CODE COUNTER</td>
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<td>1st DUR activity</td>
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<tr>
<td>440-E5</td>
<td>PROFESSIONAL SERVICE CODE</td>
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<td>MA</td>
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### Pricing Segment

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<td>PRICING SEGMENT</td>
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<tr>
<td>409-D9</td>
<td>INGREDIENT COST SUBMITTED</td>
<td>R</td>
<td>347</td>
<td>$14.79</td>
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<tr>
<td>412-DC</td>
<td>DISPENSING FEE SUBMITTED</td>
<td>Q</td>
<td>50$f</td>
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<tr>
<td>438-E3</td>
<td>INCENTIVE AMOUNT SUBMITTED</td>
<td>Q</td>
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<td>$20.00</td>
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<tr>
<td>426-DQ</td>
<td>USUAL AND CUSTOMARY CHARGE</td>
<td>Q</td>
<td>350$f</td>
<td>$35.00</td>
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<tr>
<td>430-DU</td>
<td>GROSS AMOUNT DUE</td>
<td>R</td>
<td>397$f</td>
<td>$39.79</td>
</tr>
<tr>
<td>423-DN</td>
<td>BASIS OF COST DETERMINATION</td>
<td>Q</td>
<td>01</td>
<td>AWP</td>
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</tbody>
</table>

Notes:

Version 48
November 2019
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Page: 183
When billing for a Product and Administration:

- The submitted Transaction Code is a “B1” (Billing).
- The submitted Prescription/Service Reference Number Qualifier (455-EM) is a “1” (Rx Billing)
- The claim Pricing Segment follows the Prescription Claim Request Formula.
- The Product/Service ID Qualifier should be submitted with a value of the correct product (in this example “03” (NDC) and the Product/Service ID contain the NDC Number of the vaccine).
- The Days Supply should be submitted with a value of “1”.
- The Quantity Dispensed should be submitted with the value that represents the quantity of drug product administered.
- The DUR/PPS Segment, with a “MA” (Medication Administered) in the Professional Service Code, is submitted to identify that the product was administered.
- The Incentive Amount Submitted is submitted to identify the pharmacy’s charge for the vaccine administration.

3) Billing for reimbursement of Administration of a Vaccine Product with no associated product cost

In the situation where the vaccine product does not have an associated cost (e.g. free product) and the billed charges are for vaccine administration and product dispensing only, since the identification of the vaccine product is necessary, NCPDP recommends the use of a single B1/B3 billing transaction with the Basis of Cost Determination value “15” (Free product or no associated cost).

Only pertinent segments are shown.

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**TRANSACTION HEADER SEGMENT**

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<td>M</td>
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<td>SOFTWARE VENDOR/CERTIFICATION ID</td>
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**CLAIM SEGMENT**

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<tr>
<td>111-AM</td>
<td>SEGMENT IDENTIFICATION</td>
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<td>07</td>
<td>CLAIM SEGMENT</td>
</tr>
<tr>
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<td>NDC</td>
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<td>407-D7</td>
<td>PRODUCT/SERVICE ID</td>
<td>M</td>
<td>66521011510</td>
<td>Fluvirin 2012-2013</td>
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<td>QUANTITY DISPENSED</td>
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<td>0.5 (ML)</td>
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<td>403-D3</td>
<td>FILL NUMBER</td>
<td>Q</td>
<td>0</td>
<td>Original dispensing for RX#</td>
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</tbody>
</table>
**Notes:**
- When billing for Administration of a Vaccine Product with no associated product:
  - The submitted Transaction Code is an “B1” (Claim Billing)
  - The submitted Prescription/Service Reference Number Qualifier (455-EM) is a “1” (Rx Billing)
  - The claim pricing segment follows the Prescription Claim Request Formula.
  - The Product/Service ID Qualifier should be submitted with a value of the correct product (in this example “03” (NDC) and the Product/Service ID contain the NDC Number of the vaccine).
  - The Days Supply should be submitted with a value of “1”
  - The Quantity Dispensed should be submitted with the value that represents the quantity of drug product administered
  - The DUR/PPS Segment, with a “MA” (Medication Administered) in the Professional Service Code, is submitted to identify that the product was administered.
  - The Incentive Amount Submitted is submitted to identify the pharmacy is seeking reimbursement for the administration of the product.
  - Basis of Cost Determination should be submitted with the value “15” (Free product or no associated cost)

### 16.3.7 Question: When Submitting a Prescription Billing Request for a Vaccine, What Value Should a Pharmacy Submit in the Days Supply?

**Response:**
When billing for a vaccine, it is recommended that the dispenser submit a value of 1 in the Days Supply.
16.3.8 **Question:** Which NDC Should be Submitted in a Vaccine Billing Request when a Vaccine Has an Outer Package NDC and an Inner Package NDC?

**Response:**
The inner package NDC (the smallest package size provided with a unique NDC by the manufacturer) should be billed. For example, packages that have distinct inner package components will have a unique identifier on each component. If the company saleable unit is a box of 10 vials, the box of 10 vials will have an identifier that is different than the identifier on each vial. Refer to the *NCPDP Product Identifiers Standard Implementation Guide*.

16.4 **Pharmacy Benefit Processing – Primary Claims**

**16.4.1 Question:** When processing a Vaccine Billing Request using the NCPDP Telecommunication Standard, what are the responsibilities of the pharmacy benefit processor?

**Response:**
The responsibilities of the pharmacy benefit processor, when processing a vaccine billing request using the NCPDP Telecommunication Standard, are as follows:

- Identify the billing request scenario (Note: An “MA” (Medication Administered) in the Professional Service Code is the trigger that indicates if the billing request is also for a vaccine administration):
  1. Billing for reimbursement of **Vaccine Product only** or
  2. Billing for reimbursement of **Vaccine Product and Administration** or
  3. Billing for reimbursement of **Administration of a Vaccine Product with no associated product cost**

- Determine appropriateness of billing request scenario based on plan benefit design:
  1. Vaccine product and administration covered under the pharmacy benefit
  2. Vaccine product covered, administration not covered under pharmacy benefit
  3. Vaccine product covered only when administered by the billing provider
  4. Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage not known
  5. Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage is known, but vaccine coverage unknown
  6. Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage for vaccine is known

- If claim billing request scenario is covered under the pharmacy benefit determine reimbursement structure. For example:
  1. Calculate product reimbursement
     1. Calculate Ingredient Cost Paid
     2. Calculate Dispensing Fee Paid
  2. Determine if vaccine administration fee is “Bundled” or “Separate”
     a. If “Bundled Reimbursement”, use Incentive Amount Paid to balance total reimbursement
     b. If “Separate Reimbursement”, calculate Incentive Amount Paid
  3. Calculate tax responsibilities
  4. Calculate Patient Pay Amount (Patient’s financial responsibility)
5. Calculate Total Amount Paid (Pharmacy receivable)
   – If claim billing request scenario is not covered under the pharmacy benefit determine appropriate reject code(s)

### 16.4.1.1 REJECT SCENARIO MATRIX

<table>
<thead>
<tr>
<th>Billing Request Scenario for Vaccines</th>
<th>Vaccine product and administration covered under pharmacy benefit</th>
<th>Vaccine product covered, administration not covered under pharmacy benefit</th>
<th>Vaccine product covered only when administered by the billing provider</th>
<th>Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage not known</th>
<th>Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage is known, but vaccine coverage unknown</th>
<th>Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage for vaccine is known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine Product only: Professional Service Code not equal to “MA” Incentive Fee equal to $0 or not sent</td>
<td>N/A</td>
<td>N/A</td>
<td>“E3” (M/I Incentive Amount Submitted) and “E5 (M/I Professional Service Code), and Message: Vaccine administration by the billing provider required</td>
<td>“70” (Product/Service Not Covered – Plan benefit exclusion)</td>
<td>“816” (Pharmacy benefit exclusion, may be covered under patient’s medical benefit.)</td>
<td>“817” (Pharmacy benefit exclusion, covered under patient’s medical benefit.)</td>
</tr>
<tr>
<td>Vaccine Product and Administration: Professional Service Code equal to “MA” Incentive Fee is greater than or equal to $0</td>
<td>N/A</td>
<td>“818” (Medication administration not covered, plan benefit exclusion)</td>
<td>N/A</td>
<td>“70” (Product/Service Not Covered – Plan benefit exclusion)</td>
<td>“816” (Pharmacy benefit exclusion, may be covered under patient’s medical benefit.)</td>
<td>“817” (Pharmacy benefit exclusion, covered under patient’s medical benefit.)</td>
</tr>
<tr>
<td>Vaccine Administration &amp; Other Applicable Fees: Ingredient Cost equal to $0, Basis of Cost Determination equal to “15”, Professional Service Code equal to “MA” Incentive Fee greater than or equal to $0</td>
<td>N/A</td>
<td>“818” (Medication administration not covered, plan benefit exclusion)</td>
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<td>“70” (Product/Service Not Covered – Plan benefit exclusion)</td>
<td>“816” (Pharmacy benefit exclusion, may be covered under patient’s medical benefit.)</td>
<td>“817” (Pharmacy benefit exclusion, covered under patient’s medical benefit.)</td>
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*Return Medical carrier information in the Additional Message Information (526-FQ)*
### Billing Request Scenario for Vaccines

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<tr>
<th>Scenario Description</th>
<th>Vaccine product and administration covered under pharmacy benefit</th>
<th>Vaccine product covered, administration not covered under pharmacy benefit</th>
<th>Vaccine product covered only when administered by the billing provider</th>
<th>Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage not known</th>
<th>Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage is known, but vaccine coverage unknown</th>
<th>Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage for vaccine is known</th>
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</thead>
<tbody>
<tr>
<td><strong>Intent of Billing Request</strong></td>
<td><strong>Unknown:</strong> Incentive Fee greater than $0, Professional Service Code not equal to MA</td>
<td>• “R0” (Professional Service Code of “MA” required for vaccine Incentive Fee Submitted)</td>
<td>• “ES” (M/I Professional Service Code)</td>
<td>• “70” (Product/Service Not Covered – Plan benefit exclusion)</td>
<td>• “816” (Pharmacy benefit exclusion, may be covered under patient’s medical benefit.)</td>
<td>• “817” (Pharmacy benefit exclusion, covered under patient’s medical benefit.)</td>
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<tr>
<td></td>
<td><strong>Intent of Billing Request</strong></td>
<td>• “E3” (M/I Incentive Amount Submitted)</td>
<td>• “818” (Medication administration not covered, plan benefit exclusion)</td>
<td>• “E3” (M/I Incentive Amount Submitted)</td>
<td>• “70” (Product/Service Not Covered – Plan benefit exclusion)</td>
<td>• “817” (Pharmacy benefit exclusion, covered under patient’s medical benefit.)</td>
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<tr>
<td></td>
<td><strong>Unknown:</strong> Incentive Fee not sent, Professional Service Code equal to MA</td>
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<td></td>
<td>Return Medical carrier information in the Additional Message Information (526-FQ)</td>
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**Note:** The new Reject Codes of “816”, “817”, “818” are not available for use until 10/15/2016. Until the Reject Codes are available for use, it is recommended that the processor return the Reject Code description as a text message in the Message (504-F4) or Additional Message Information (526-FQ) fields.

#### 16.4.2 QUESTION: WHEN PROCESSING A BILLING REQUEST FOR A VACCINE, WHAT VALUE IS RECEIVED IN THE DAYS SUPPLY?

**Response:**
When processing a prescription billing request for a vaccine a value of “1” should be expected in the Days Supply.

#### 16.4.3 QUESTION: WHEN PROCESSING A CLAIM FOR A VACCINE PRODUCT AND ADMINISTRATION, WHAT IS MEANT BY THE TERMS “BUNDLED REIMBURSEMENT” OR “SEPARATE REIMBURSEMENT”?

**Response:**
- “Bundled Reimbursement” refers to the scenario in which the contractual agreement applies a single reimbursement rate for the vaccine product and administration. The total reimbursement does not distinguish separate reimbursements for the vaccine product and administration service. NCPDP
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recommends that the pharmacy benefit processor calculate the vaccine product reimbursement first and use the Incentive Amount Paid to balance the financials.

“Separate Reimbursement” refers to the scenario in which the contractual agreement separates the reimbursement rates for the vaccine product and administration.

16.4.4 Question: Can NCPDP provide response examples (Claim, DUR/PPS, and Pricing segments) for the following scenarios?

1. Billing for reimbursement of the Vaccine Product and Administration – Bundled Reimbursement
2. Billing for reimbursement of the Vaccine Product and Administration - Separate Reimbursement

Response:

1. Billing for reimbursement of the Vaccine Product and Administration – Bundled Reimbursement
   - The Ingredient Cost Paid is $12.51
   - The Dispensing Fee Paid is $2.00
   - The contracted Bundled Reimbursement is $30.00
   - The Incentive Amount Paid is $15.49 ($30.00 (Bundled Reimbursement) less $12.51 (Ingredient Cost Paid) less $2.00 (Dispensing Fee Paid) equals $15.49 (Incentive Amount Paid)

Only pertinent segments are shown.

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### Telecommunication Version D and Above Questions, Answers and Editorial Updates

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### Billing for reimbursement of the Vaccine Product and Administration – Separate Reimbursement

- The Ingredient Cost Paid is $12.51
- The Dispensing Fee Paid is $2.00
- The Incentive Amount Paid is $20.00

*Only pertinent segments are shown.*

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</table>

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November 2019
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Page: 190
16.4.5 **Question: When processing a bundled payment claim, can the Incentive Amount Paid be $0.00 or a negative dollar amount?**

**Response:**
Yes, the Incentive Amount Paid can be $0.00 or a negative dollar amount when processing a bundled payment because this field is used for balancing.

16.4.6 **Question: When processing a pharmacy billing request for a vaccine when the pharmacy benefit processor knows the patient’s medical benefit covers the vaccine product, what information is returned by in the claim?**

**Response:**
In this scenario, the pharmacy benefit processor must return new Reject Code “817” (Pharmacy benefit exclusion, covered under patient’s medical benefit) and return the name and Payer ID (if available) of the medical benefit carrier within the Additional Message Information (526-FQ). Until the new Reject Code is available, the processor should return Reject Code: “70” (Product not covered, plan benefit exclusion) with additional messaging indicating coverage is available under the medical benefit.

16.4.7 **Question: Does the telecommunication standard support the billing from a single provider the vaccine product and the administration via separate transaction types?**

**Response:**
Yes, but while the Service transactions (S1/S3) support the billing of a service only, they do not support the identification of the billed service (vaccine administration) and the associated product (vaccine product that is administered). The Claim Billing transaction (B1) does support the identification of both the vaccine product and administration. To maintain standardization across the industry and to support coordination of benefits claims processing, NCPDP recommends the use of a single billing transaction for the billing of the vaccine product and the vaccine administration. Please refer to billing request example # 2 “Billing for reimbursement of the Vaccine Product and Administration”.

In the situation where the vaccine product does not have an associated cost (e.g. free product) and the billed charges are for vaccine administration and product dispensing only, since the identification of the vaccine product is necessary, NCPDP recommends the use of a single claim billing transaction with the Basis of Cost Determination value “15” (Free product or no associated cost).
16.5 COORDINATION OF BENEFIT CLAIMS PROCESSING

16.5.1 QUESTION: WHAT VALUE DOES THE PHARMACY ASSIGN TO THE OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) TO REPORT THE VACCINE ADMINISTRATION FEE (INCENTIVE AMOUNT PAID) PAID BY THE PREVIOUS PAYER?

Response:
In Telecommunication Standard Version D.0, a value of "05" (Incentive) should be submitted in the Other Payer Amount Paid Qualifier. Available in Telecommunication Standard Version E.1 and above, a value of "11" (Medication Administration) would be submitted in the Other Payer Amount Paid Qualifier (342-HC).

Note, the Other Payer Amount Paid values are reported based on the defined Total Amount Paid (509-F9) back-out order outlined within the section “Other Amount Paid (565-J4) and COB.” Drug Benefit is calculated after all other amounts paid (e.g. Incentive Fee) have been backed out of Total Amount Paid (509-F9).

16.5.2 QUESTION: CAN NCPDP PROVIDE OTHER PAYER AMOUNT PAID COB CLAIM EXAMPLES (COB METHOD 1) FOR THE FOLLOWING TWO SCENARIOS?

- Billing for reimbursement of the Vaccine Product and Administration, and primary benefit was a bundled payment
- Billing for reimbursement of the Vaccine Product and Administration, and primary benefit was a separate payment

Response:
1. Billing for reimbursement of the Vaccine Product and Administration, and primary benefit was a bundled payment

   Primary claim response where bundled payment of $30 is represented across the response pricing fields

   - The Ingredient Cost Paid is $12.51
   - The Dispensing Fee Paid is $2.00
   - The contracted bundled reimbursement is $30.00
   - The Incentive Amount Paid is $15.49 ($30.00 (bundled reimbursement) less $12.51 (Ingredient Cost Paid) less $2.00 (Dispensing Fee Paid) equals $15.49 (Incentive Amount Paid))

   Only pertinent segments are shown.

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**DUR/PPS SEGMENT**

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</table>

**November 2019**

***OFFICIAL RELEASE***

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Page: 193
Secondary Payer applies separate payments (versus bundled payment) for vaccine drug product and administration. Negotiated price $12.51 + $2.00 + $20.00 = $34.51
- The Secondary’s Ingredient Cost Paid Allowed Amount is $12.51
- The Secondary’s Dispensing Fee Paid Allowed Amount is $2.00
- The Secondary’s Incentive Amount Paid Allowed Amount is $20.00
- The Secondary’s Other Payer Amount Recognized = $20.00 ($15.49 Primary Incentive Fee + $4.51 Primary Drug Benefit)

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<td>342-HC</td>
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Net amount to the pharmacy (Primary Bundled Payment/Secondary Separate Payment):
Primary Total Amount Paid (509-F9): $20.00
Secondary Total Amount Paid (509-F9): $14.51
Secondary Patient Pay Amount (S05-F5): $0.00
Net Amount: $34.51

Alternate Scenario:
Secondary payer applies bundled payment (versus separate payment) for vaccine drug product and administration.
Negotiated bundled payment = $30.00
   - The Secondary’s Ingredient Cost Paid allowed amount is calculated as $12.51
   - The Secondary’s Dispensing fee allowed amount is calculated as $2.00
   - The Secondary’s Incentive Amount Paid Allowed amount is calculated as $15.49
   - The Secondary’s Other Payer Amount Recognized = $20.00 ($15.49 Primary Incentive Fee + $4.51 Primary Drug Benefit)

Net amount to the pharmacy (Primary Bundled Payment/Secondary Bundled Payment):
Primary Total Amount Paid (S09-F9): $20.00
Secondary Total Amount Paid (S09-F9): $10.00
Secondary Patient Pay Amount (S05-F5): $0.00
Net Amount: $30.00

2. Billing for reimbursement of the Vaccine Product and Administration and primary benefit was a separate payment
Primary claim response where separate payments apply to vaccine product and dispensing and vaccine administration
Negotiated price $12.51 + $2.00 + $20.00 = $34.51
   - The Ingredient Cost Paid is $12.51
   - The Dispensing Fee Paid is $2.00
   - The Incentive Amount Paid is $20.00

Only pertinent segments are shown.
Primary Claim Response Pricing Segment:
COB Claim to Secondary Payer:

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<td>308-C8</td>
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**TRANSACTION HEADER SEGMENT**

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**DUR/PPS SEGMENT**

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Telecommunication Version D and Above Questions, Answers and Editorial Updates

473-7E  DUR/PPS CODE COUNTER  R  1  1st DUR activity
440-E5  PROFESSIONAL SERVICE CODE  Q  MA  Medication Administered

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<tr>
<td>431-DV</td>
<td>OTHER PAYER AMOUNT PAID</td>
<td>Q</td>
<td>200/</td>
<td>$20.00</td>
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Secondary Payer applies separate payments (versus bundled payment) for vaccine drug product and administration. Negotiated price $12.51 + $2.00 + $20.00 = $34.51
- The Secondary’s Ingredient Cost Paid Allowed Amount is $12.51
- The Secondary’s Dispensing Fee Paid Allowed Amount is $2.00
- The Secondary’s Incentive Amount Paid Allowed Amount is $20.00
- The Secondary’s Other Payer Amount Recognized = $24.51 ($20.00 Primary Incentive Fee + $4.51 Primary Drug Benefit)

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Net Amount to the pharmacy (Primary Separate Payment /Secondary Separate Payment):

Primary Total Amount Paid (509-F9): $24.51
Secondary Total Amount Paid (509-F9): $10.00
Secondary Patient Pay Amount (505-F5): $0.00
Net Amount: $34.51

Alternate Scenario:
Secondary payer applies bundled payment (versus separate payment) for vaccine drug product and administration.
Negotiated bundled payment = $30.00
  - The Secondary’s Ingredient Cost Paid allowed amount is calculated as $12.51
  - The Secondary’s Dispensing fee allowed amount is calculated as $2.00
  - The Secondary’s Incentive Amount Paid allowed amount is calculated as $15.49
  - The Secondary’s Other Payer Amount Recognized = $20.00 ($15.49 Primary Incentive Fee + $4.51 Primary Drug Benefit)
    o Primary payer incentive amount paid was $20.00, however the Incentive Fee under the secondary’s bundled payment amount is $15.49, therefore incentive amount recognized is $15.49
    o Drug benefit amount recognized is $4.51
Secondary Patient Pay Amount (505-F5): $ 0.00
Net Amount: $34.51

16.5.3 QUESTION: WHAT VALUE SHOULD THE PHARMACY BENEFIT PROCESSOR RECOGNIZE IN THE OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) WHEN PROCESSING A COB BILLING REQUEST FOR A VACCINE PRODUCT AND ADMINISTRATION?

Response:
In Telecommunication Standard Version D.0, a value of “05” (Incentive) should be recognized in the Other Payer Amount Paid Qualifier. Available in Telecommunication Standard Version E.1 and above, a value of “11” (Medication Administration) should be recognized in the Other Payer Amount Paid Qualifier, and the value of “05” would not be used in this situation.
17 UNIVERSAL CLAIM FORM (UCF)

17.1 EXPANDED DOLLAR AMOUNTS

Question:
How do I submit a dollar amount over $999,999.99 using the UCF?

Response:
When existing standard field lengths are not adequate to support business needs, trading partners should come to an agreement on how to utilize the Universal Claim Form for claim submission. This may include adding additional characters to a field. For example, drug costs in excess of $999,999.99 may require adding additional characters to the Ingredient Cost Submitted (UCF Field 81) and/or other currency fields. Trading partners should consider other downstream processes and data exchanges that may be impacted or may not support these larger dollar amounts.

Added May 2019 – Expanded Dollar Fields TG
18 APPENDIX A. MODIFICATIONS TO THIS DOCUMENT

18.1 VERSION 2.0
Section “Typographical Errors” was added.

18.2 VERSION 3.0
IMPORTANT: Section “Republication of Telecommunication Standard Implementation Guide Version D.0” was added.

18.3 VERSION 4.0
Section “Date of Service (401-D1)” was added to the section “Typographical Errors”. Section “Printable Characters” added a clarification.

Section “Long-Term Care (LTC) Pharmacy Claims Submission Recommendations for Version D.0” was added.

18.4 VERSION 5.0
In section “Typographical Errors”, the following were noted:
In the Controlled Substance Reporting transaction, a “Note” on the Purchaser Segment inadvertently referenced the Patient Segment. It has been corrected to Purchaser Segment.
In the matrices, Help Desk Phone Number Qualifier was inadvertently identified as (550-7F). It has been corrected to (549-7F).
In various places the designation “N***R***” or “Q***R***” were missing an asterisk. It has been corrected.

Subsection “Claim Segment (07)” has been added.
Subsection “Patient Segment (01)” has been added.
Section “Response Segment Discussion” has been added.

18.5 VERSION 6.0
Subsection “Response Status Segment (21)” has been added.
In section “Typographical Errors”, the following were noted:
In the Controlled Substance Reporting Reversal transaction, the Patient Segment chart was omitted. It has been added (version D.3).
In the Information Reporting Reversal diagrams, the Patient Segment was inadvertently included. The Patient Segment is not used in this transaction. It is deleted (version D.3).

In this section, under “Telecommunication Standard Implementation Guide Segments”, “General” subsection has been added.

In this section “Appendix A. History of Document Changes Corrections” was added.

18.6 VERSION 7.0
Question “Pricing Segment (11)”, “Clarification of net amount due in Coordination of Benefits” has been added. This verbiage has been added to Telecom D.4.
Subsection “Response Processing Guidelines” has been added to “Response Pricing Segment (23)”. This verbiage has been added to Telecom D.4.
Subsections “Reject Code Guidance” and “Syntax Error” have been added.
Question “Benefit Stage” has been added.
Question “Health Plan-Funded Assistance Amount (129-UD)” has been added.
Question “Processor vs. Pharmacy Responsibility for Aggregating Other Payer Amounts” was added.
Question “Other Payer Coverage Type (338-SC) and Processing for Mid-Stream Payers” was added.
18.7 Version 8.0

An editorial correction was cited for the “Response Coordination of Benefits/Other Payers Segment”. An editorial correction was cited for “Internal Control Number (993-A7)”. An editorial correction was cited for “Quantity Prescribed (460-ET)”. An editorial correction was cited for “Clinical Segment”.

The section “Compound Segment (10)” was added.

Section “Pricing Segment (11)”, subsection “Clarification of net amount due in Coordination of Benefits” was updated.

Subsection “Other Payer Amount Paid Qualifier (342-HC) Values Sunsetted” was added.

Section “Insurance Segment (04)”, “Medicaid Indicator (360-2B)” was added.

Section “Appendix C. Medicare Part D and Multi-ingredient Compound processing” was added as guidance only. More guidance for Patient Residence was added from the May 2010 Work Group meetings in section “Place of Service (307-C7) and Patient Residence (384-4X)”.

Section “340B Processing” was added.

In section “Typographical Errors”, Help Desk Phone Number Qualifier situation referred to the Number with field ID (550-F8).

18.8 Version 9.0

IMPORTANT: Section “Republication of Telecommunication Standard Implementation Guide Version D.0”, subsection “August 2010” was added.

Section “Appendix D. Medicare Part D Topics” was added.

To the extent possible, Coordination of Benefits questions and topics (excluding Medicare Part D) were moved to section “Coordination of Benefits Information”.

Questions “Three Options for Coordination of Benefits?” and “Multiple COB Options Per BIN/PCN?” were added to the “Coordination of Benefits Information” section.

Section “Other Coverage Code (308-C8)” was added to the “Request Segment Discussion” section.

Section “Not Used Data Element” was added to the “General Questions” section.

Section “Other Payer Amount Paid Qualifier (342-HC) Values for Sales Tax” was added.

In section “Other Payer Amount Paid Qualifier (342-HC) Values Sunsetted”, the MSP calculation statements were incorrect. It said:

For MSP Calculations:

1. The Allowed amount = sum of Other Payer Amount Paid (431-DV) amounts (qualifiers applicable to MSP benefit) + sum of Other Payer-Patient Responsibility Amount (352-NQ) amounts
2. The Paid amount = sum of the Other Payer Amount Paid (431-DV) amounts (qualifiers applicable to the MSP benefit, e.g. 07 Drug Benefit)
3. The Co-insurance amount = Other Payer-Patient Responsibility Amount (352-NQ) amount where Other Payer-Patient Responsibility Amount Qualifier (351-NP) = 01 (Amount Applied to Periodic Deductible (517-FH) as reported by previous payer)
4. The Deductible amount = Other Payer-Patient Responsibility Amount (352-NQ) amount where Other Payer-Patient Responsibility Amount Qualifier (351-NP) = 05 (Amount of Copay (518-FI) as reported by previous payer)

Item 3 and 4 were incorrect. They have been corrected to

For MSP Calculations:
1. The Allowed amount = sum of Other Payer Amount Paid (431-DV) amounts (qualifiers applicable to MSP benefit) + sum of Other Payer-Patient Responsibility Amount (352-NQ) amounts
2. The Paid amount = sum of the Other Payer Amount Paid (431-DV) amounts (qualifiers applicable to the MSP benefit, e.g. 07 Drug Benefit)
3. The Co-insurance amount = Other Payer-Patient Responsibility Amount (352-NQ) amount where Other Payer-Patient Responsibility Amount Qualifier (351-NP) = “07” (Amount of Coinsurance (572-4U) as reported by previous payer)
4. The Deductible amount = Other Payer-Patient Responsibility Amount (352-NQ) amount where Other Payer-Patient Responsibility Amount Qualifier (351-NP) = “01” (Amount Applied to Periodic Deductible (517-FH) as reported by previous payer)

Section “Claim Segment” and “Response Claim Segment” were added to the “Typographical Errors” section.

Section “Route of Administration (995-E2) and SNOMED Codes” were added to the “Claim Segment (07)”.

18.9 Version 10.0

Section “Amount Attributed to Processor Fee (571-NZ)” was added to the “Response Pricing Segment (23)”.

Section “Vaccine Administration” was added to the “General Questions” section and the “Appendix D. Medicare Part D Topics” section.

Section “Product/Service ID/Qualifier in Compounds” and “Dispense As Written (408-D8) Value 9 During Transition” were added to section “Request Segment Discussion”, “Claim Segment (07)”.

Section “BIN and PCN from Response to Request” was added to the “Appendix D. Medicare Part D Topics” section.

A new question in section “Benefit Stage” has been added.

Section “Additional Message Information Continuity (131-UG)” has been added to “Response Status Segment (21)”.

Section “Coupon Segment”, “Prior Authorization Request And Billing Transaction” was added due to an error in Telecom D.0.

18.10 Version 11.0

Section “External Code List Notables” was added.

Question “CMS Place of Service Codes?” was added.

Additional information was added on the “Route of Administration (995-E2) and SNOMED Codes”.
Telecommunication Version D and Above Questions, Answers and Editorial Updates

Question “Other Amount Paid (565-J4) and COB” was added.

Question “Other Payer Coverage Type (338-SC) is Unknown” has been added.

“Example 14: $100 Medicare Secondary Payer claim for brand drug; initial coverage limit already met; $500 remaining to meet TrOOP. Other Payer Amount Paid is $75” has been added. All other examples in section “Benefit Stage Rules and Examples” were updated to show the Benefit Stage fields in the COB Segment.

Question “Amount Attributed to Processor Fee (571-NZ)” has added an additional clarification paragraph (“The enrollment fee must be received.....”).

Section “Response Patient Segment (29)” has been added.

Question “Medicaid ID Number (115-NS) and Cardholder ID (302-C2)” has been added.

A typographical error was noted in section “Controlled Substance Reporting (General) Examples”.

Section “Dispensing Methodologies for LTC in PPACA” has been added.

Section “Benefit State Rules and Examples” incorrectly referenced Total Amount Paid as 509-FN. The field id is 509-F9.

18.11 VERSION 12.0

Section “Typographical Errors”, subsection “Telecommunication Standard Implementation Guide Examples” has added “Examples using Medigap ID (359-2A)”. Example “Billing – Transaction Code B1 – Coordination of Benefits Scenarios Pharmacy Bills To Insurance Designated By Patient” inadvertently listed Quantity Dispensed (442-E7) twice and in one subsection was missing Dispense As Written (408-D8).

Section “Benefit Stage Qualifier values to Identify Claims Covered under the Not Part D portion of the Medicare D Plan” has been added.

Section “Notice of Appeal Rights” has been renamed to “Notice of Appeal Rights – Rejected Claim”. A new section “Notice of Appeal Rights – Paid Claim” has been added.

A new question was added to section “Prescription Origin Code (419-DJ)”.

A new question “Total Amount Paid (509-F9) Negative?” was added.

A new question “Adjust the Ingredient Cost Paid and Dispensing Fee Paid” was added.

A new question “Other Payer Amount Paid Qualifier (342-HC) Value 99?” was added.

Section “NCPDP Important External Code List (ECL) Information” was added.

18.12 VERSION 13.0

Section “Medicaid Subrogation Editorial Document” has been added. Section “Medicaid Subrogation Claim Billing or Encounter” has been copied from this document into the NCPDP Medicaid Subrogation Standard Implementation Guide Version 3.0 Questions, Answers and Editorial Updates document.

The “CMS Place of Service Codes?” link has been updated.
Section “NCPDP Recommendations for 4Rx Usage in Medicare Part D Processing Documents” has been added. Question “Foreign Prescriber Identifier” and “Benefit Stage Required for Part D?” have been added to the Medicare Part D section.

Question “Total Amount Paid (509-F9) Negative?” includes additional guidance for two known business cases.

Section “Workers’ Compensation and COB” was added.

Question “Ingredient Cost Paid (506-F6) and Total Patient Responsibility Amount from Last Payer” was added.

Section “Other Payer Reject Code (472-6E)” was added.

Question “Other Payer-Patient Responsibility Amount (352-NQ) to each Payer?” was added.

Question “CMS’ Definition of Primary Insurer’s Payment” was added.

Question “Payable Components of Other Payer-Patient Responsibility Amounts” was added.

Section “Patient Paid Amount Submitted (433-DX)” with questions has been added.

Section “Use of Additional Message Information for Next Available Fill Date” was added.

18.13  Version 14.0
A 10/2011 Update has been added to “Route of Administration (995-E2) and SNOMED Codes”.

18.14  Version 15.0
Question “Medicaid Pay only Applicable Components” and “Transition of Versions and COB” have been added to section “Coordination of Benefits Information”.

Question “Government COB?” was added to section “Other Coverage Code (308-C8)”.

Question “Component Pieces Not Sum to Patient Pay Amount?” has been added to section “Multiple COB Options Per BIN/PCN?”

Question “Valid Prescriber ID?” was added to the Medicare Topic section.

The section “Prescription Origin Code (419-DJ)” was modified to remove the bullet “if” statements regarding transfers because they were written before the value 5 (Pharmacy - This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional 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.) was added. This section also added new questions.

Section “Reject Code “569” and Submission Clarification Code” has been added to the “Medicare Part D Topic”, “Notice of Appeal Rights – Rejected Claim” section.

Section “Facility Segment” has been added.

Section “Use Of This Document” includes information that when the Version D Editorial is published, it is effective for use. It was also added to the “General Questions” section.
This question was removed from the document at this time because the WG1 Telecommunication FAQ Task Group felt that more information needed to be discussed and brought forward.

**Question:**
Situation: There is a standard written authorization/protocol from a medical director to give flu shots, and when they have a patient that wants a flu shot they write it up on a telephone blank. Is Prescription Origin Code 1 (Written) because the protocol is written – and the pharmacy then “writes the order”, or 2 (Telephone) because the pharmacy transcribes the information on a telephone Rx pad just as they would if a prescriber called in the order?

**Response:**
Use 1 (Written).

**18.15 VERSION 16.0**
Section “Response Status Segment (21)”, subsection “Additional Message Information Continuity (131-UG)” the Comment in the table for the correct example had a typographical error for the Additional Message Information Qualifier (132-UH). For each value 01, 02, 03, etc., the comment should reflect the correct use statement “Used for first line of free form text with no pre-defined structure.”, “Used for second line of free form text with no pre-defined structure.”, “Used for third line of free form text with no pre-defined structure.”, etc.

Section “Coordination of Benefits Information” added question “Like Amounts Submitted as Incentive Fee” and “Drug Benefit”. Subsection “Processor vs. Pharmacy Responsibility for Aggregating Other Payer Amounts” added a new question.

Section “Cost Share Calculation for Multi-Ingredient Compound Claims That Straddle the Coverage Gap and Catastrophic Phases” was added to “Appendix C. Medicare Part D and Multi-Ingredient Compound Processing”.

Section “Basis of Reimbursement (423-DN) and Multi-Ingredient Compounds” was added.

**Question** “Additional Message Information Qualifier (132-UH) Appear More Than Once?” was added.

**Question** “Other Coverage Code (308-C8) to Submit When One Other Payer Has Paid $0?” was added to section “Other Coverage Code (308-C8)”.

In section “Typographical Errors”, subsection “Other Coverage Code (308-C8)” was added.

**18.16 VERSION 17.0**
A correction for the SNOMED code for Mouth/Throat was added to “Route of Administration (995-E2) and SNOMED Codes”. An important chart showing all the corrections since 2007 was added. “Appendix E. Route of Administration Questions” has been added.

**Important:** The section “Prescription Origin Code (419-DJ)” was modified to include the data element and values in the beginning of the section. Responses to questions were modified in section “Use of Prescription Origin Code”.

**Question:**
If a prescriber sends an electronic prescription to a pharmacy, but the pharmacy is not “electronically prescribing-enabled yet” and the intermediary drops the prescription to fax, what Prescription Origin Code value would the pharmacy use on the claim submission? The Response was modified From:

Fax. If a prescriber sends an electronic prescription to a pharmacy, but the pharmacy is not “electronically prescribing-enabled yet” and the intermediary drops the prescription to fax, the Prescription Origin Code should represent how the prescription was received by the pharmacy.
To: Because the prescription was received at the pharmacy via fax the Prescription Origin Code is 4 and will remain a 4 throughout the life of the prescription number.

Question:
Relating to incentive or disincentive with regard to e-prescriptions for prescribers when a pharmacy must phone to clarify or change information on a prescription. Prescribers will be dis-incentivized if they transmit a prescription electronically and a pharmacy changes it to a telephone order as a result of calling to clarify or change something. Also, if a plan sponsor audits a pharmacy that has a telephone order, then contacts the prescriber only to learn that the prescriber electronically sent the order, pharmacies may have the entire payment retracted and deemed an “improper payment”. The Response was modified
From:
The prescriber sends an electronic prescription that the pharmacy cannot fill due to issues with the information received. If the pharmacy contacts the prescriber by telephone and as a result gets the information necessary to dispense, the Prescription Origin Code is 2 (Telephone) because the e-prescribing process did not provide a valid prescription.

If, as a result of the telephone call, the Prescriber cancels the original electronic prescription and sends a corrected electronic prescription that the pharmacy is able to dispense, then the Prescription Origin Code is 3 (Electronic - Prescription obtained via SCRIPT or HL7 Standard transactions.) because the e-prescribing process did result in a fillable prescription.

To: Because the prescription was received via e-prescribing the Prescription Origin Code is 3 and will remain a 3 throughout the life of the prescription number.

New questions were added for Controlled Substance, Intermediate Care Facility, a tube, DAW clarification, and written authorization prescriptions to this section.

Section “Duplicate Transaction” was added to “Response Status Segment (21)”.

Section “Benefit Stage Implementation for 01/01/2013” was added.

Sections “Impact on Downstream Payer for Alternative/Formulary”, “Other Impacts to Benefit Stage?”, “Part D Sponsor Transition Notice or Denial Letter”, “Coverage Gap and Amount Attributed to Coverage Gap [137-UP]”, and “Non-Formulary Penalty and Coverage Gap” were added.

18.17 VERSION 18.0
Section ”Hardcoded Values” was added to “Appendix D. Medicare Part D Topics”.
Section “Dual Eligibility” was added to “Appendix D. Medicare Part D Topics”.
Section “Prescriber Identification” was added to “Appendix D. Medicare Part D Topics”. Other questions in this section dealing with prescriber identification were moved into this section. Subsection “Processing with Prescriber ID” was added.

Section “Foreign Prescriber Identifier” was updated.
From
It is appropriate to use the value 08 State License qualifier for a foreign prescriber.
To
Prior to July 1, 2012, it is appropriate to use the value 08 State License qualifier for a foreign prescriber. The new value of 17 (Foreign Prescriber Identifier = a value used to identify a prescriber who practices outside of the United States and does not have a prescriber identifier issued from within the United States) was approved January 2012 and is available for use July 1, 2012. Please see the Emergency ECL document at http://www.ncpdp.org/Members/Standards-Lookup.
Section “Days Supply (405-D5)” and “Unit of Measure (600-28) and Multi-Ingredient Compounds” were added to “Claim Segment (07)”. Section “Compound Ingredient Quantity (448-ED) Smaller than 3 Digits of Precision to the Right of the Decimal” was added to “Compound Segment (10)”. 

**18.18**  
**VERSION 19.0**  
**Important:** Based on industry request, an enhancement was made to Telecommunication Standard Implementation Guide Version D.0 for Quantity Prescribed (460-ET). See section “Enhancement of Telecommunication Standard Implementation Guide Version D.0 November 2012”. 

Added references to the “NCPDP Emergency Preparedness Resource” information. 

In section “Route of Administration (995-E2) and SNOMED Codes” the original mapping suggested the use of Intradermal. On the SNOMED file now, there is a Transdermal. 

<table>
<thead>
<tr>
<th>Route of Administration</th>
<th>SNOMED Code 1</th>
<th>SNOMED Code 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transdermal</td>
<td>572464004</td>
<td>45890007</td>
</tr>
</tbody>
</table>

Question “Like Amounts Submitted as Incentive Fee” was updated with August DERF approval information. 

Question “Medicare Part D Claim Without Benefit Stage Fields?” was added. Question “Medicare Part D/Medicaid Benzodiazepine and Barbiturate Claims Processing Risks” was added. A reference was also added to this section in “Coordination of Benefits and Prior Authorization”. 

Question “If a provider is on the OIG sanction list, disbarred from a government health care program, will this be reflected within NPI status on the NPI Registry?” was added to “Prescriber Identification” section. Question “Must the Part D Sponsor reject the Part D claim submitted with a foreign prescriber ID?” was added to section “Foreign Prescriber Identifier”. 

Question “How can the NCPDP Telecommunication Standard be leveraged to comply with the valid prescriber communication process required by CMS?” was modified in section “Processing with Prescriber ID”, as well as updates made to the matrix. 

Section “Prescriber ID and PDE Questions” and “Other Prescriber ID Questions” were added. 

Section “Medicaid Allowed Amount and Prescription Response Formula” was added. 

In section “Long-Term Care (LTC) Pharmacy Claims Submission Recommendations for Version D.0” was updated to add more recent Special Packaging Indicator (429-DT) values, and section “Dispensing Methodologies for LTC in PPACA” was updated and is part of “Appropriate Dispensing (Short Cycle) for LTC “. Subsection “Submission Clarification Code Combinations and Rejections” and “Appropriate Dispensing and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFID) and Institute of Mental Disease (IMD)” were added. 

Sections “Notice of Appeal Rights – Rejected Claim” and “Notice of Appeal Rights – Paid Claim” were designated with the following statement: 

This applies to D.0 claims submitted on or after January 1, 2012. Modifications are denoted below in a new section stating “This applies to D.0 claims submitted on or after July 1, 2013”. 

Two new sections were created “Notice of Medicare Drug Coverage Rights – Rejected Claim” and “Notice of Medicare Drug Coverage Rights – Paid Claim” for the statement: “This applies to D.0 claims submitted on or after July 1, 2013”. 

Section “Benefit Stage Implementation for 07/01/2013” was added.
18.19  **VERSION 20.0**

Section “Medigap ID (359-2A) Use” was added to “Insurance Segment (04)”. 

Question “Other Carrier Payment Meets or Exceeds Payable” was added to “Appendix D. Medicare Part D Topics”. 

Question “Total Amount Paid (509-F9) Negative?” subsection “Transaction Click Fees” was updated to include bullets marked “(Added Version 20)”. 

Questions were added to section “Prescriber Identification”, subsection “Prescriber ID and PDE Questions”. A question was added to “Valid Prescriber ID?” section. 

Questions “Correct Telecom Version?” and “Leave Off Ingredients that are Identifiable by the Pharmacy and the Payer” were added to section “Compound Segment (10)”. 

References to IDM were changed to IMD - Institute of Mental Disease. 

Section “Pricing Segment (11)”, subsection “340B Processing”, an editorial note was added showing the complete definition of the values cited in the response. 

18.20  **VERSION 21.0**

**Important:** Based on industry request, an enhancement was made to Telecommunication Standard Implementation Guide Version D.0 for Quantity Prescribed (460-ET). See section “Enhancement of Telecommunication Standard Implementation Guide Version D.0 November 2012”. This section was updated with information 03/2013. 

18.21  **VERSION 22.0**

Section “Reversals and COB” was added. 

Section “Recommendations on the Submission of Identifiable Ingredients that are Not Recognized by the Payer” was added to “Compound Segment (10)”. 

The response to question “Does CMS expect Part D Sponsors to validate the DEA Schedule down to the Narcotic/Non-Narcotic level?” was modified in section “Prescriber Identification” to include information on the CFR and validation rules to assist implementers. Question “Can CMS Assist with Industry Outreach for Entities that need Type 1 NPIs?” was added to section “Prescriber Identification”. 

Question “How should the Medicare Part D prescription claim and PDE be processed in the situation where the prescriber is not a HIPAA covered entity and refuses to obtain a Type 1 NPI? “ and “How should the Medicare Part D prescription claim and PDE be processed in the situation with a deceased prescriber who did not obtain an NPI (where state law allows subsequent fills to process after a prescriber’s death)?” were added to section “Prescriber ID and PDE Questions”. Question “How should plan sponsors handle a controlled substance prescription claim where the prescriber’s individual Type 1 NPI is submitted, however the prescriber is acting under the DEA registration of the hospital, to which the prescriber DEA registration ID field will be blank on the plan’s prescriber data base?” was added to section “Valid Prescriber ID?”. 

Section “Long-Term Care (LTC) Pharmacy Claims Submission Recommendations For Version D.0” was updated to clarify 
- Two Patient Residence codes be used for qualifying LTC and only one code be used for Assisted Living. 
- Paragraph “Prior to the CMS requirements for Appropriate Dispensing...” was added.
Recommendations were clarified. Pharmacy Service Type (147-U7) now recommends to see the External Code List.

Subsection “Date of Service for LTC Billing Claim” was added.

The statement “Note, the regulatory requirement to dispense in 14 day or less increments is not directly linked to billing in equivalent increments” was added.

“Note, although the CMS mandate applies to Brand Oral Solid Drugs....” was added.

The bullet “All other SCC values are acceptable...” was added.

The statement “The above are the old valid SCC values...” was added under the table of Submission Clarification Code values appropriate for LTC Short Cycle.

The statement “The payers must accept the Patient Residence (384-4X) value for ICFMR/IMD...” was clarified.

18.22 **VERSION 23.0**

Important updates were added to section “Quantity Prescribed (460-ET)”. From the Data Dictionary, section “Appendix C – Telecommunication Phases with Flow Charts” was moved into this document into section “General Questions”, “Reject Code Guidance”, “Telecommunication Phases with Flow Chart”.

Question “A prescriber’s DEA registration is expired and can only write scripts for schedules III – V in the plan’s database. The claim is for a schedule II medication....” was added to section “Valid Prescriber ID?”

Subsection “Pricing Segment Contains Values ‘as if’ the Claim was Primary” has been added to “Pricing Segment (11)”. A reference to this same section was added in “Coordination of Benefits Segment (05)”.

Subsection “Brand Medically Necessary” has been added to “Response Pricing Segment (23)”.

Subsection “Military Treatment Facilities – Government Billing the Government” has been added to “Appendix D. Medicare Part D Topics”.

Eligibility Verification examples from the Telecommunication Standard Implementation Guide that were specific to Medicare Part D processing were moved into this document so as program changes occur, the implementation guide would not need to be modified. The examples were updated for more current dates and more concise scenarios. See section “Eligibility Verification Examples”.

18.23 **VERSION 24.0**

For clarity when Reject Code (511-FB) values are referenced, the values in quotes show the 2 digit or 3 digit length as appropriate. The field is 3 digits so a trailing space is allowed, but can be truncated.

Section “Improving the Value of the Claim Response with Additional Messaging” was added with important guidance for the industry.

Reject Code value “43” was modified to remove “or expired”. This is found in section “Valid Prescriber ID?” and the “Definition” matrix. Background:

Effective in May 2013, the Drug Enforcement Administration (DEA) changed the record layout for the DEA CSA database by adding a field for Activity - Active/Inactive. A value of “Active” indicates that the registrant is authorized for handling of controlled substances in the schedules and “Inactive” indicates the registrant is not authorized for handling of controlled substances in any schedule. With this new field, it becomes possible for an expired DEA registration to continue to be Active and authorized to prescribe for controlled substances (this scenario would indicate that the DEA number is still within the renewal process).
Question “How should plan sponsors handle a controlled substance prescription claim where the prescriber’s individual Type 1 NPI is submitted, however the prescriber is acting under the DEA registration of the hospital, to which the prescriber DEA registration ID field will be blank on the plan’s prescriber data base?” in section “Valid Prescriber ID?” was updated to include clarification from CMS following the May 2013 HPMS memo.

In order to accurately reflect the data currently available from the DEA, the description of Reject Code (field 511- FB) “43” should be changed from Plan’s Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive or expired to Plan’s Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive.

Section “ICD-9 Versus ICD-10 Information” was added to “General Questions”.
Section “Veterinarian Identifiers” was added to “Valid Prescriber ID?”
Section “Long-Term Care (LTC) Pharmacy Claims Submission Recommendations for Version D.0” subsection “Qualifying the Pharmacy Service” under “Home Infusion Therapy”

Pharmacy Service Type (147-U7) was updated

From

Please refer to the most current implemented version of the External Code List for all valid values. Plans should be aware that they may receive Assisted Living Facility claims from any available “Pharmacy Service Type”.

To

For a Home Infusion Therapy Provider Service use value = “3”.

18.24 VERSION 25.0

Section “Billing Transaction For Free Fills” was added under “Pricing Segment (11)”.
Section “Use of This Document”, subsection “How Soon Support This Document?” was updated. The same question was updated in section “General Questions”, “How Soon Support This Document?”

Question:
Once the Version D Editorial is published, how soon do implementers need to support?
Response:
When the Version D Editorial is published, it is effective for use.

Was modified to:

Question:
Once the Version D Editorial is published, how soon do implementers need to support?
Response:
When the Version D Editorial is published, it is effective for use immediately unless the specific section or response lists an effective date.

Section “Appendix G. Support of This Document” was added.

Section “Benefit Stage Implementation for 10/01/2014” was added with value “63”.

18.25 VERSION 26.0

Section “Quantity Prescribed (460-ET)” was updated with information received 03/2014.

Section “Multi-Ingredient Compound Processing” was added. Questions from the “Compound Segment” section were moved into this section. Question “Correlate Complexity in Compounding and DUR/PPS Level of Effort (474-8E)” was added. Subsection “Compound Ingredient Product Identifier and Qualifier Use” was added.

Section “Definition of a Valid Prescriber Matrix” has added two rows (Medicare D claim: prescriber NPI is not listed on the Medicare D prescriber active enrollment file and Medicare D claim: prescriber NPI is listed on the
Medicare D prescriber enrollment file as terminated.) and added a note to other rows (designated May 2014). Clarification was made in the document and the matrix:

From:
“PDEs will not reject if the Date of Service on the PDE is greater than or equal to the NPI deactivation date plus one year. This is true regardless of the reason for deactivation.”

To:
“PDEs will not reject if the Date of Service on the PDE is \( < \) or = (NPI deactivation date + 1 year), regardless of the reason for deactivation.”

A note was added after the chart in section “Other Payer Reject Code (472-6E)” to call out for the future that this chart was updated in Telecommunication version E6.

### 18.26 Version 27.0

Section “Quantity Prescribed (460-ET)” was updated with 08/2014 information.

Section “Prescription Origin Code (419-DJ)” and “Important Note” was updated to include information about the modification to the External Code List description for Prescription Origin Code value 3 (Electronic) “, or electronically within closed systems” which was approved 08/2014. Per the Emergency ECL implementation recommendations, the modification is available to be used 04/01/2015.

Section “Definition of a Valid Prescriber Matrix” added one row (No active state license with prescriptive authority associated to submitted prescriber ID).

Question “Part D Sponsors Applying Medicare Secondary Payer (MSP) Requirements” was added.

Section “Recommendations for Claim Reversal Processing for Telecommunication Version D.0” was added.

### 18.27 Version 28.0

Section “Prescription/Service Reference Number (455-EM) Value “3”” was added to document the change.

Section “Vaccine Services – Pharmacy Benefit Billing & Processing” was added, with Effective Date: August 2015 in preparation for the flu season.

Subsection “Dollar Field Not Received” has been added to section “Coordination of Benefits Information”.

### 18.28 Version 29.0

Section “Inactive State License” was added

The first question in Section” Processing with Prescriber ID” was modified.

Question “Does the 24 hour follow up requirement outlined under CMS 4157 (highlighted below) apply in any manner to Medicare Part D prescription claims submitted as of the enforcement date of CMS 4149 (§ 423.120(c)(5) and (6))?” was added to Section “Other Prescriber ID Questions”.

### 18.29 Version 30.0

Sections “When should Reject Code B4 be used?”, “Prescriber ID Rejections” and “State License Questions” were added.

Section “Specific Data Field Use Recommendations” and its’ subsections were modified.

### 18.30 Version 31.0

Version 48
November 2019
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Page: 212
Sections “Negative Patient Pay Values” and “Date of Service (401-D1)” were added. An additional note was added to Section “Notice of Medicare Drug Coverage Rights – Rejected Claim”.

18.31 VERSION 32.0
Sections “ICD-10 Submission”, “Level of Service”, “Prescriber Segment (03)”, “Provider Fees” and “Provisional Fill” were added.

18.32 VERSION 33.0
Section “Processing with Prescriber ID” was modified. Sections “Information Reporting Transactions”, “How can the payers and providers leverage the NCPDP standard to comply with Section 507 of the MACRA legislation?” and “Appendix F. Point of Service Prescriber Validation Guidance Applicable to CMS 4159 and IFC 6107” were added.

18.33 VERSION 34.0
An additional question was added to Section “340B Processing” Sections “Processing with Prescriber ID” and “Appendix F. Point of Service Prescriber Validation Guidance Applicable to CMS 4159 and IFC 6107” were modified.

18.34 VERSION 35.0
The response to “Provisional Fill” was updated. An additional “Question and Answer” was added to Appendix F. Many sections were modified by replacing the terms fill and refill with dispense/dispensing/dispensed.

18.35 VERSION 36.0
The following additional questions and responses were added: 3.1.10, 6.3.5, 6.3.6, 6.9 and 15.10.

18.36 VERSION 37.0
DERF 1482 changed the following terms in this document:
- Intermediate Care Facility /Mentally Retarded to Intermediate Care Facility/Individuals with Intellectual Disabilities
- ICFMR to ICFIID
- Mentally Retarded to Intellectually Disabled

DERF 1469 – a new question and response was added to Section 6.3.3 – Prescriber ID Rejections
Definition of a Valid Prescriber TG modified a response in Section 6.3.3 – Prescriber ID Rejections
Added Section 6.10 – UDI Conversion

18.37 VERSION 38.0
The COB TG added questions 10.12 and 10.13
The Compound TG revised the response to question 15.8
The FAQ TG added question 6.9

18.38 VERSION 39.0
Section 9 was replaced.
The FAQ TG added question 6.1

18.39 VERSION 40.0

The COB TG added question 3.1.3.2

A new Section, Guidance for Opioid Limits, was added.

Sections 9.3.6, 9.3.8, and 9.5.2 were updated as a result of the WG14 LTPAC Billing Issues. Also refer to DERF 001581/ECL 000257.

18.40 VERSION 41.0

Corrected the values and descriptions in Guidance for Opioid Limits - Claim Rejections, Recommended DUR Result of Service Codes (441-E6). In the same section, Long Term Care Exemptions to Opioid Policy was added.

Added Section – Response Insurance Segment to address a question around the use of Network Reimbursement ID (545-2F).

18.41 VERSION 42.0

Section 7 – Guidance for Opioid Limits was replaced.

18.42 VERSION 43.0

Section 7 – Guidance for Opioid Limits was replaced.

Section 20.27 – Updated the eligibility timeframe for a Medicare Part D Eligibility Verification Transaction. This information is an update to what is published in the Implementation Guide.

Section 22 – Update added due to CMS rule.

Section 6.13 was added to provide guidance on drug recalls.

18.43 VERSION 44.0

Added question 10.12 - OPPRA (352-NQ) Field Length Greater Than $999,999.99

Section 7 – Guidance for Opioid Limits was replaced.

18.44 VERSION 45.0

Section 14.2.1.4 – Corrected typographical error.

Section 14.2.1.1 – Removed duplicates from the table.

Section 3.5.1 – Patient Residence (384-4X): Updated code description for Value 6 and updated name and code description for Value 15.
18.45  Version 46.0

Updated the Quantity Prescribed Section.

Updated the CMS Place of Service Codes URL.

Added a Service Provider ID question and answer.

Updated the answer for question - Which NCPDP ECL Values (Reject Code, SCC, Approved message Code) should be used for Medicaid Ordering Referring Provider Requirements?

Added a Preferred Product Cost Share Incentive question and answer.

Added a new section – Universal Claim Form

Updated the Member Opioid/Benzodiazepine Lock-In Scenario – removed reject code 569

18.46  Version 47.0

Revised Date of Service for LTPAC Billing Claim Section

Modified MME Hard Stop; POS Override Not Allowed; Prescriber to Call Plan (potentially >200) Scenario Description of B9 and B11

Modified MME Prescriber Care Coordination Required (90-200, or >90) Scenario Description of C9 and C11

Modified Duplicative Therapy Soft Edit - Long Acting Opioids Scenario Description of D9 and D11

Modified Concurrent Use of Opioids & Benzodiazepines Scenario Description of E9 and E11

Modified Member Opioid/Benzodiazepine Lock-In by renumbering the scenario descriptions and adding two additional reject codes to Scenarios F1 and F2.

18.47  Version 48

Added new question and response to Section 10.13 Government COB

Revised 6.4.6 RPh Prescriptive Authority Validation

Modified Guidance for Opioid Limits.

Added Section 3.1.10.1 - Shortened Days Supply SCC Values

Added Section 3.1.10.2 - Approved Message Code and Shortened Days Supply SCC

Added Section 6.14 - Claim Adjudication Process for Opioid Utilization Rules

Added Section 3.5.2 - Species
19 APPENDIX B. WHERE DO I FIND

19.1 ANSWERS MAY BE FOUND IN THE FOLLOWING DOCUMENTS

- NCPDP Telecommunication Standard Implementation Guide Version D.0
- NCPDP Data Dictionary
- NCPDP External Code List
- NCPDP Telecommunication Version D Questions, Answers, and Editorial Updates (the “Editorial” document – this document)
- Future versions of the NCPDP Telecommunication Standard Implementation Guide

Other resources:

- NCPDP HIPAA page http://www.ncpdp.org/Resources/HIPAA
- Non-member to obtain standards http://www.ncpdp.org/Membership
- Member to obtain standards http://www.ncpdp.org/Members/Standards-Lookup

19.2 ADDITIONAL INFORMATION MAY BE FOUND IN THE FOLLOWING DOCUMENTS

Telecommunication Standard Implementation Guide Version D.1 and above
Although the usage of new fields or field changes in Version D.1 and above is not allowed in the implementation of Version D.0, the Version D.1 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 D Editorial document.

19.3 PARTICULAR TOPICS MAY BE FOUND IN THE FOLLOWING DOCUMENTS

19.3.1 WHAT TRANSACTIONS ARE SUPPORTED FOR WHAT BUSINESS PURPOSES?

NCPDP Telecommunication Standard Implementation Guide
- section “Business Environment”
- section “Business Functions”
- each transaction section such as “Information Reporting Information”

19.3.2 WHAT FIELDS CHANGED?

NCPDP Data Dictionary
- section “Appendix K. Publication Modifications”

NCPDP Telecommunication Standard Implementation Guide contains matrices which have legends that denote fields added and modified.
- section “Transmission Structure”

19.3.3 WHICH FIELDS ARE ALLOWED IN WHICH SEGMENTS?

NCPDP Telecommunication Standard Implementation Guide
- section “Structure Quick Reference”
- each transaction section such as “Claim Billing or Encounter information”

19.3.4 WHERE DO THE SEGMENTS BELONG?

NCPDP Telecommunication Standard Implementation Guide
- section “Transmission Structure”
- each transaction section such as “Claim Billing or Encounter information”
- section “General Structural Overview”
19.3.5 **What Are the Valid Responses for Each Transmission?**

NCPDP Telecommunication Standard Implementation Guide
- section “Transmission Structure”
- each transaction section such as “Claim Billing or Encounter Information”
- section “Response Overview”
- section “Response Processing Guidelines”

19.3.6 **Recommended Use of Dollar Fields and Calculated Amounts?**

NCPDP Telecommunication Standard Implementation Guide
- section “Standard Conventions”
- section “Response Processing Guidelines”
- section “Specific Segment Discussion”

19.3.7 **Explain the Syntax Rules for Version D**

NCPDP Telecommunication Standard Implementation Guide
- section “Standard Conventions”
- section “Framework”
- section “General Structural Overview”

19.3.8 **Documentation Dates**

**Question:** Where do I obtain publication date information of the various version/releases of the Telecommunication Standard?

**Response:** The Standards Matrix document should be referenced. The document can be found at [http://www.ncpdp.org/Members/Standards-Lookup](http://www.ncpdp.org/Members/Standards-Lookup) (lower left)

This document lists all of the NCPDP standard implementation guides, their status, and the appropriate Data Dictionary and External Code Lists to use.

19.3.9 **What If I Have a New Question?**

Send the question to NCPDP Council Office at ncpdp@ncpdp.org

19.3.10 **CMS Place of Service Codes?**

CMS has updated the website. The Place of Service Codes section is now visible to the public at [https://www.cms.gov/medicare/coding/place-of-service-codes/place_of_service_code_set.html](https://www.cms.gov/medicare/coding/place-of-service-codes/place_of_service_code_set.html). There is a “Printer–Friendly Version” of the POS Code Set available as a download at the bottom of the Place of Service Code Set.
APPENDIX C. MEDICARE PART D AND MULTI-INGREDIENT COMPOUND PROCESSING

Proposed Multi-Ingredient Processing Rules for Medicare Part D for Telecom D.0
Guidance Only

The reader should be aware that this information is presented as guidance only. During NCPDP’s Work Group 1 Telecommunication FAQ Task Group questions on multi-ingredient compounds and Medicare Part D processing were discussed. Pharmacies, vendors, payers, plans, and CMS representatives were involved in the discussion. This document was created from that effort. Once this document was “finalized”, CMS reviewed to provide further input to questions. The following unofficial guidance was received from CMS and constitutes the best available information until CMS can issue formal guidance in future rulemaking.

From CMS:
I have reviewed the NCPDP “Proposed Multi-Ingredient Processing Rules for Medicare Part D for Telecom D.0” document (attached) and believe that most of it is generally consistent with CMS policy regarding coverage of compounds under Part D. However, while they are not inconsistent with existing CMS policy and are in line with current CMS thinking, I believe some of the proposed business rules go beyond existing CMS policy and will require future rule-making by CMS to establish such requirements. Specifically, I do not believe our current policy addresses the following proposals:

- Page 1, proposed business rule 2a: If a compound is On-formulary, then all Part D ingredients are considered On-Formulary (even if the drug would be non-formulary as a single drug claim)
- Page 2, proposed business rule 3: Compounds can only be covered under one Medicare benefit
- Page 3, proposed business rule h (i): LICS/Catastrophic Copay/Coinsurance

(I should note that my comments are limited to the proposed business rules outlined in the 1st three pages of the document and do not encompass the specific examples that are also provided in the document.)

Since we have been asked, I would add that CMS also would need to establish new policy through rulemaking with respect to determine whether we would permit Part D enrollee financial responsibility for any non-covered ingredients of a covered Part D compound.

Finally, to the extent that this document does reflect current CMS policy, our expectation is that the rules will be followed with respect to processing claims for Part D compounds using D.0, and reporting PDEs for such claims, if D.0 is being used to process claims both before and after the 2012 mandatory implementation of D.0 as the new HIPAA standard.

In general we would not consider sponsors adopting those approaches (rule 2a, rule 3 or proposed business rule h (i): LICS/Catastrophic Copay/Coinsurance listed above) to be noncompliant with Part D rules.

Tracey A. McCutcheon
20.1 Key terms used in General Assumptions

**Part D drug in compound:** An ingredient within a compound that independently meets the definition of a Part D drug.

**Part D drug cost:** The sum of the ingredient costs paid for Part D drugs in the compound plus the dispensing fee paid and sales tax paid for the entire compound.

**Enhanced drug in compound:** An excluded drug within a compound covered under a Part D plan’s enhanced benefit that would otherwise meet the definition of a Part D drug but for the fact that it is specifically excluded as a Part D drug under 42 CFR 423.100.

**OTC drug in compound:** An excluded over-the-counter drug within a compound covered under a Part D plan’s formulary.

**CMS excluded drug in compound:** An excluded drug within a compound that is non-enhanced and non-OTC (such as bulk drugs and DESI drugs).

20.2 General Assumptions

Subject to appeal, it is up to the Part D sponsors to determine if any drug, including a compound drug, is not a Part D drug. If the plan determines compound(s) is/are not Part D, then the following rules do not apply unless an appeal forces the plan to pay as Part D. If the plan determines that compound(s) is/are a Part D drug, then the following scenarios and rules apply:

Three scenarios:

1. Part D sponsor covers compounds (considers them Part D) and compounds that contain any Part D drug is considered formulary.
2. Part D sponsor covers compounds (considers them Part D) and compounds that contain any Part D drug is considered non-formulary.
3. Part D sponsor covers compounds (considers them Part D) and some compounds are formulary and some are not (based on plan benefit design).

Claims submission recommendations:

To determine if any drugs are not covered by Part D, the Pharmacy should initially bill without Submission Clarification Code (SCC) of 8. (From Telecom Imp Guide: A value 8 is resubmitted on a rejected compound prescription when the pharmacist decides to accept payment for all other ingredients, except those not covered by the plan.) If no drugs are covered by Part D, follow Part D Plan guidance (i.e. PA required) or follow normal process downstream. If the Pharmacy chooses to accept reimbursement for covered ingredients, resubmit with SCC of 8.

The reject should include the ingredients not covered in the message as well as the Reject Code Occurrence Indicator to point to the ingredients not covered. (See section 28.1.12.6 of imp guide for guidance.)

The following business rules apply to processing of Multi-Ingredient Compound claims for Medicare Part D when using the Telecom D.0 Standard.

1. Only compounds that contain at least one ingredient that independently meets the definition of a Part D drug may be covered under Part D.
2. If sponsor accepts compounds under the benefit, sponsor can determine if all compounds are on or off formulary, or make a determination at an individual claim level.
   a. If a compound is On-formulary, then all Part D ingredients are considered On-Formulary (even if the drug would be non-formulary as a single drug claim).
   b. If a compound is Off-formulary, transition rules apply. Under transition all Part D ingredients in the compound must become payable as a result of that transition supply. If an exception is approved for an Off-Formulary compound, all Part D ingredients, but only Part D ingredients, are covered under the exception. Plans may contract to pay other components but may not charge cost sharing for non-Part D ingredients (per CMS policy).

3. Compounds can only be covered under one Medicare benefit:
   a. If a Compound contains a covered Part B ingredient:
      A claim that contains at least one ingredient confirmed to be covered under Part B is considered a Part B compound and will be rejected with “A5” (Not Covered Under Part D Law) and “A6” (This Medication May Be Covered Under Part B). It doesn’t matter if other ingredients in the compound are not Part B ingredients. Refer to example #1.
   b. Else if a Compound contains an ingredient that might be covered under Part B but needs further analysis (e.g. prior authorization, place of residence, diagnosis):
      Compounds that contain at least one ingredient that is considered B vs. D, whether or not any other ingredient is a Part D drug, must be rejected for coverage determination purposes. Use Reject Code “A6” (This Medication May Be Covered Under Part B).
   c. Else if a Compound contains at least one Part D ingredient and no ingredients covered by Part B
      Compounds that contain at least one Part D ingredient will be covered under Part D. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the Part D drug cost (see definition above). Plans may contract to pay the pharmacy the additional ingredients that are not Part D but may only report the Part D covered components cost on their PDEs and in reconciliation. NOTE: Plans may determine if they will/will not cover an enhanced drug or an OTC as part of a compound that are normally covered as a single drug claim.
      i. Compounds that contain a Part D drug, but non-Part D drugs are not covered by the plan:
         1. If the compound contains at least one Part D drug and the pharmacy accepts reimbursement for only the covered Part D ingredients, the compound should be covered under Part D. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the Part D drug cost (see definition above). Refer to example 2.
      ii. Compounds that contain a Part D Drug and an Enhanced drug that is covered by the plan:
         1. If the compound contains at least one Part D drug and at least one excluded drug (e.g., diazepam) that is covered under an enhanced Part D benefit, the compound should be covered under Part D and the enhanced drug CANNOT be covered under the enhanced benefit. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the Part D drug cost (see definition above). Plans may not charge cost share for the enhanced ingredients. Plans may contract to pay the pharmacy the additional ingredients that are not Part D but may only report the Part D covered components cost as identified above. Refer to Example 3a.
      iii. Compounds that contain a Part D Drug and a non-covered non-Part D drug (OTC) that is covered by the plan.
1. If the compound contains at least one Part D drug and at least one excluded drug that is NOT covered under an enhanced Part D benefit (think OTC), the compound should be covered under Part D. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the Part D drug cost (see definition above). As with single drug claims for OTCs, Plans may not charge cost share for the OTC ingredients. Plans may contract to pay the pharmacy the additional ingredients that are not Part D but may only report the Part D covered components cost as identified above. Refer to Example 3b.

iv. Compounds that contain a Part D covered drug and contain a CMS excluded drug that is covered by the plan

1. If the compound contains at least one ingredient that is a Part D drug and at least one excluded drug that is NOT covered under an enhanced Part D benefit and is not OTC, the compound should be covered under Part D. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the Part D drug cost (see definition above). Plans may not charge cost share for the non-Part D ingredients. Plans may contract to pay the pharmacy the additional ingredients that are not Part D but may only report the Part D covered components cost as identified above. Refer to example 3c.

f. Compounds that do not contain a Part D Drug but do contain Enhanced drugs that the plan reported as covered on their formulary.

i. If a Plan reported an enhanced drug as covered on their formulary, the Plan may choose to cover it in compounds, as well as in a single drug claim. Compounds that do not contain a Part D drug, but contain at least one Enhanced drug should be covered under the enhanced benefit. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the enhanced drug cost (defined as the sum of ingredient costs paid for the covered enhanced drugs in the compound plus dispensing fee paid and sales tax paid for the entire compound). Plans may not charge cost share for any other ingredients. Plans may contract to pay the pharmacy the additional ingredients that are not enhanced but may only report the enhanced components cost as identified above. Refer to example 4.

g. Compounds that do not contain a Part D drug, and do not contain an enhanced drug, but contain at least one OTC drug that the plan reported as covered on their formulary.

i. If a Plan reported an OTC drug as covered on their formulary, the plan may choose to cover it in compounds, as well as in a single drug claim. Compounds that do not contain a Part D drug or an enhanced drug, but contain at least one OTC drug should be reported as OTC. Calculations for PDE are based only on the OTC drug cost (defined as ingredient costs paid for the covered OTCs in the compound plus dispensing fee paid and sales tax paid for the entire compound). Plans may not charge cost share for any ingredients within the OTC compound. Plans may contract to pay the pharmacy the additional ingredients that are not OTC but may only report the OTC components cost as identified above. Refer to example 5.

h. Copay/Coinsurance: Part D sponsors determine which benefit copay or coinsurance applies to compounds.

i. In addition, for LICS/Catastrophic Copay/Coinsurance: Part D sponsors must determine cost-sharing for copays defined by statute (i.e., brand or generic cost-sharing for LIS and catastrophic) the Part D sponsor should apply the cost-sharing that is applicable to the Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity).
i. On the 835, the individual ingredients of the compound are not reported. The first valid Product/Service ID which is an NDC number is submitted (the individual ingredient in the Compound Segment, not the zeroes required of Product/Service ID of the Claim Segment for a compound). – **THIS NEEDS further discussion with WG45 and the work they are doing on the 835 to determine if the 835 and the PDE population logic should be the same.**

### 20.3 PDE Reporting

- For ALL Multi-Ingredient Compounds regardless of benefit category – Submit the NDC of the ingredient for the determined category with the highest line item computed ingredient cost (unit cost x quantity).

- Quantity – Submit the total quantity of the compound in its final form (as the pharmacy submitted) – using Quantity Dispensed (442-E7).
  - **Total quantity reported on the PDE must match the value of Quantity Dispensed (442-E7) in the Claim Segment.**

- Drug Costs – Report total “paid” drug costs for ingredients in the compound that independently meet the definition of a Part D drug. All Part D beneficiary cost-sharing amounts must be based upon only the costs associated with Part D ingredients. Part D “paid” drug costs = The sum of Part D ingredient costs paid plus the dispensing fee paid and sales tax paid for the entire compound.

- If no Part D drugs exist in the compound and the compound includes covered enhanced drugs, report total Enhanced “paid” drug costs for all enhanced ingredients. Enhanced “paid” drug costs = The sum of Enhanced drug ingredient costs paid plus the dispensing fee paid and sales tax paid for the entire compound. Beneficiary cost-sharing amounts must be based upon only the costs related to the enhanced drugs.

- If only OTC drugs are covered in the compound report total paid for covered OTC drugs. OTC “paid” drug costs = The sum of OTC drug ingredient costs paid plus the dispensing fee paid and sales tax paid for the entire compound. No beneficiary cost sharing applies to an OTC compound.

### 20.4 Cost Share Calculation for Multi-Ingredient Compound Claims That Straddle the Coverage Gap and Catastrophic Phases

**Question:**

Per NCPDP Editorial Update (version 11.0, published February, 2011):

- Section 13.2, paragraph 3.e indicates that compounds with at least one Part D ingredient use a ‘sum of Part D ingredients’ rules for adjudication.

- Section 13.2, paragraph 3.h.i indicates that compounds that fall in the Catastrophic benefit phase must calculate copay/coinsurance by applying brand or generic cost sharing applicable to the “Part D ingredient with the highest line item computed ingredient cost”.

If a processor receives a Part D compound claim (for example, 2 Part D ingredients ... non LIS member) and the claim crosses the TrOOP Threshold into CAT, do we apply ‘sum the Part D ingredients’ rule or do we apply the ‘highest cost D ingredient’ rule?

*This question was discussed with Craig Miner (CMS), and he approved the following response:*

**Response:**
CMS will likely clarify specific rules for determining catastrophic copay for multi-ingredient compounds in future guidance. Until such time as that guidance is issued, Part D sponsors are not prohibited from implementing catastrophic copays for multi-ingredient Part D compounds based on how compounds are treated in other benefit levels. However, Part D sponsors may also determine the applicable catastrophic copays based on whether the most expensive Part D ingredient is a generic or a brand name drug. The latter approach would be most consistent with the CMS general policy goal of ensuring consistent application of statutory copays across the Part D program.

Examples have not been created for claims straddling the Coverage Gap and Catastrophic benefit phases to avoid any confusion that may occur if Part D plans are using different methods for determining Gross Drug Cost Before Out-of-Pocket Threshold for claims that have a percentage coinsurance less than 100% in Gap. However, examples are provided below for variations in cost share allowed for claims that fall fully in the Catastrophic phase.

Example 1: Defined Standard Benefit; multi-ingredient compound dispensed; most expensive ingredient is ANDA drug. Full claim cost falls in catastrophic. Part D sponsor determines cost share for compounds based on most expensive ingredient; therefore, $2.50 catastrophic copay applies.

<table>
<thead>
<tr>
<th>Benefit Level Drug Cost</th>
<th>Patient Pay</th>
<th>Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Coverage – 25% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage Gap – 100% coinsurance</td>
<td>$40.00</td>
<td>$2.50</td>
</tr>
<tr>
<td>Catastrophic - Greater of 5% or $2.50/$6.30</td>
<td>$40.00</td>
<td>$2.50</td>
</tr>
<tr>
<td>Total</td>
<td>$40.00</td>
<td>$2.50</td>
</tr>
</tbody>
</table>

Example 2: Enhanced Benefit; multi-ingredient compound dispensed; most expensive ingredient is ANDA drug. Full claim cost falls in catastrophic. Part D sponsor applies brand cost share to all compounds; therefore, $6.30 catastrophic copay applies.

<table>
<thead>
<tr>
<th>Benefit Level Drug Cost</th>
<th>Patient Pay</th>
<th>Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Coverage – $40 copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage Gap – 100% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catastrophic - Greater of 5% or $2.50/$6.30</td>
<td>$40.00</td>
<td>$6.30</td>
</tr>
<tr>
<td>Total</td>
<td>$40.00</td>
<td>$6.30</td>
</tr>
</tbody>
</table>

20.5 Example 1: MAPD Plan covers the Part D Ingredients and some of the Non-Part D Ingredients of the Compound

Because one of the covered ingredients is a “B” drug, the compound is treated like “B” and is rejected by the Part D plan. Label for B1 response column consistent on all examples.
### Assumptions for Example 1:

- Because there is one covered Part B drug in this compound, it must be billed under Part B. Compounds that contain at least one non-Part D drug ingredient that is covered under Medicare Part B (as prescribed and dispensed or administered) CANNOT be covered under Part D.
  - If this is a PDP plan, the claim will be rejected, as illustrated above, and must be submitted to the Part B payer.
  - If any ingredients in the above compound were not covered, the claim would be rejected to identify to the pharmacy the non-covered ingredients. Reject Code combination “A5”/”A6” denotes the drug is Part B.
- If ingredient 5 above was a B vs. D drug, the claim would be rejected for a coverage determination.
20.5.1 **EXAMPLE 2: PDP ALTERNATE BASIC PLAN COVERS ONLY THE PART D INGREDIENTS OF THE COMPOUND**

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Drug</th>
<th>Substitution Indicator</th>
<th>Drug Type</th>
<th>Qty</th>
<th>Submitted IC</th>
<th>Contracted Rate</th>
<th>Part D Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>S$ Brand</td>
<td>Part D</td>
<td>90.00</td>
<td>$30.24</td>
<td>$18.31</td>
<td>$18.31</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>Generic</td>
<td>Part D</td>
<td>1.375</td>
<td>$0.90</td>
<td>$0.68</td>
<td>$0.68</td>
</tr>
<tr>
<td>3</td>
<td>C</td>
<td>MS Brand</td>
<td>Not B or D</td>
<td>0.220</td>
<td>$2.81</td>
<td>$2.09</td>
<td>$2.00</td>
</tr>
<tr>
<td>4</td>
<td>D</td>
<td>Generic</td>
<td>Part D</td>
<td>0.110</td>
<td>$2.84</td>
<td>$2.12</td>
<td>$2.12</td>
</tr>
<tr>
<td>5</td>
<td>E</td>
<td>S$ Brand</td>
<td>Not B or D</td>
<td>108.290</td>
<td>$20.62</td>
<td>$12.37</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**Ingredient Total A, B, D**

<table>
<thead>
<tr>
<th>Dispensing Fee</th>
<th>Sales Tax</th>
<th>Total Cost 20% Coinsurance</th>
<th>Plan Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>$57.41</td>
<td>$35.57</td>
<td>$24.11</td>
<td>$24.11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D.0 Response D</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$21.11</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PDE Cost Fields</th>
<th>PDE Payment Fields</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ingredient Cost</td>
<td>$21.11 Patient Pay</td>
</tr>
<tr>
<td>Dispensing Fee</td>
<td>$2.00 LICS Subsidy Amount</td>
</tr>
<tr>
<td>Sales Tax</td>
<td>$1.00 Other TrOOP</td>
</tr>
<tr>
<td>Vaccine Admin Fee</td>
<td>PLRO</td>
</tr>
<tr>
<td>CPP</td>
<td>$19.29</td>
</tr>
<tr>
<td>GDCB</td>
<td>$24.11 NPP</td>
</tr>
<tr>
<td>GDCA</td>
<td>Drug Coverage Status Code C</td>
</tr>
</tbody>
</table>

<p>| EOB Summary of Prescription Claims Processed from &lt;mm/dd/yyyy&gt; through &lt;mm/dd/yyyy&gt; |
|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|</p>
<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Prescription [Claim] Number</th>
<th>Name of Drug</th>
<th>Quantity Dispensed</th>
<th>Amount &lt;Plan Name&gt; Paid</th>
<th>Amount You Paid</th>
<th>[Amount Paid by Secondary Coverage/Other Sources]</th>
<th>[Extra Help from Medicare]</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2012</td>
<td>1234567</td>
<td>Compound</td>
<td>199.995</td>
<td>$19.29</td>
<td>$4.82</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**Assumptions for Example 2:**

- Pharmacy should bill without SCC to determine if any drugs are covered by Part D. If no drugs are covered by Part D, follow Part D Plan guidance (i.e. PA required) or follow normal process downstream. If any one of the ingredients in the rejected claim does not have a reject code associated with it (at least one drug is Part D payable), resubmit with SCC of 8.
- Compound is treated as Part D because there is at least one ingredient that independently meets the definition of a Part D drug and there are no Part B ingredients.
Dispensing fee and sales tax for the entire compound should be included on the PDE and reported with the NDC of the Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity).

- Total cost of Part D ingredients + dispensing fee + tax for the entire compound applies to Drug Spend and is used to calculate Patient Pay, LICS, TrOOP.
- TrOOP would be:
  - $4.82 if in initial coverage and 20% coinsurance for non-LICS members.
- LICS copay (generic vs. brand) is based on the Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity), which in this example is Drug A (brand).
  - $4.82 if in initial coverage of which $3.30 is LICS 2 copay and $1.52 is LICS Subsidy.
- PDE would report NDC for Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity), with cost and payment fields applicable only to the covered Part D ingredients.
- Model EOB would report “Compound” as the drug name for all multi-ingredient compound claims.
  - The Part D EOB will not reflect the member’s actual out of pocket if the pharmacy is allowed to bill the member for the cost of non-covered drugs in addition to Part D cost sharing.
20.5.2 EXAMPLE 3A: MAPD PLAN COVERS THE PART D INGREDIENTS AND ONE NON-PART D INGREDIENT (#3) IN THE COMPOUND

Because none of the covered ingredients is "B" and at least one of the covered ingredients is Part D, the compound is treated like Part D. Plan may choose to pay for non-Part D drugs; however, assumption is that no cost sharing may be charged for the non-Part D ingredients.

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Drug</th>
<th>Substitution Indicator</th>
<th>Drug Type</th>
<th>Qty</th>
<th>Submitted IC</th>
<th>Contracted Rate</th>
<th>Payable Part D</th>
<th>Payable Non-Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>SS Brand</td>
<td>Part D</td>
<td>90.00</td>
<td>$30.24</td>
<td>$18.31</td>
<td>$18.31</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>Generic</td>
<td>Part D</td>
<td>1.375</td>
<td>$0.90</td>
<td>$0.68</td>
<td>$0.68</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>C</td>
<td>MS Brand Enhanced</td>
<td>Part D</td>
<td>0.220</td>
<td>$2.81</td>
<td>$2.09</td>
<td>$2.09</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>D</td>
<td>Generic</td>
<td>OTC</td>
<td>0.110</td>
<td>$2.84</td>
<td>$2.12</td>
<td>$2.12</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>E</td>
<td>SS Brand</td>
<td>Part D</td>
<td>108.290</td>
<td>$20.62</td>
<td>$12.37</td>
<td>$12.37</td>
<td></td>
</tr>
<tr>
<td>Ingredient Total</td>
<td>All</td>
<td>SS Brand</td>
<td>Part D</td>
<td>108.290</td>
<td>$57.41</td>
<td>$35.57</td>
<td>$31.36</td>
<td>$33.45</td>
</tr>
</tbody>
</table>

Dispensing Fee  $2.00
8% Sales Tax  $2.84
Total Cost  $36.20
25% Coinsurance  $9.05
Plan Paid  $27.15

** PDE Cost Fields: **
- Ingredient Cost  $31.36
- Dispensing Fee  $2.00
- Sales Tax  $2.84
- Vaccine Admin Fee  PLRO
- GDCB  $36.20
- GDCA  Drug Coverage Status Code  C

** PDE Payment Fields: **
- Patient Pay  $9.05
- LICS Subsidy Amount  PLRO
- CPP  $27.15
- NPP  $0.00

EOB Summary of Prescription Claims Processed from <mm/dd/yyyy> through <mm/dd/yyyy>-

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Prescription [Claim Number]</th>
<th>Name of Drug</th>
<th>Quantity Dispensed</th>
<th>Amount &lt;Plan Name&gt; Paid</th>
<th>Amount You Paid</th>
<th>[Amount Paid by Secondary Coverage/Other Sources]</th>
<th>[Extra Help from Medicare]</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2012</td>
<td>1234567</td>
<td>Compound</td>
<td>199.995</td>
<td>$27.15</td>
<td>$9.05</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Assumptions for Example 3a:
Telecommunication Version D and Above Questions, Answers and Editorial Updates

- Pharmacy should bill without SCC to determine if any drugs are covered by Part D. If no drugs are covered by Part D, follow Part D Plan guidance (i.e. PA required) or follow normal process downstream. If any one of the ingredients in the rejected claim does not have a reject code associated with it (at least one drug is Part D payable), resubmit with SCC of 8. The pharmacy may bill the member or other payer, as appropriate, for drugs not covered per reject code on previous claim.
- Compound is treated as Part D because there is at least one ingredient that independently meets the definition of a Part D drug and there are no Part B ingredients.
- Med D accumulations of Drug Spend and TrOOP are based on the sum of the covered Part D ingredients + dispensing fee + sales tax for the entire compound. The ingredient cost for the covered enhanced drug is excluded from Med D accumulations.
- PDE would report NDC for Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity), with cost and payment fields applicable only to the covered Part D ingredients. The ingredient cost associated with the enhanced drug is not reported on the PDE.
- Model EOB would report “Compound” as the drug name for all multi-ingredient compounds.
- The EOB will not match with the patient receipt from the pharmacy. The Part D Plan paid the pharmacy $29.24; however, the EOB will show a plan paid amount of $27.15 (excludes enhanced drug cost). The patient pay of $9.05 is the same on the receipt and EOB since no cost sharing was assessed on the non-Part D drug.
20.5.3 **EXAMPLE 3b:** MAPD PLAN COVERS THE PART D INGREDIENTS AND ONE NON-PART D INGREDIENT (#4) IN THE COMPOUND

Because none of the covered ingredients is “B” and at least one of the covered ingredients is Part D, the compound is treated like Part D. Plan may choose to pay for non-Part D drugs; however, assumption is that no cost sharing may be charged for the non-Part D ingredients.

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Drug</th>
<th>Substitution Indicator</th>
<th>Drug Type</th>
<th>Qty</th>
<th>Submitted IC</th>
<th>Contracted Rate</th>
<th>Payable Part D</th>
<th>Payable Non-Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>SS Brand</td>
<td>Part D</td>
<td>90.00</td>
<td>$30.24</td>
<td>$18.31</td>
<td>$18.31</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>Generic</td>
<td>Part D</td>
<td>1.375</td>
<td>$0.90</td>
<td>$0.68</td>
<td>$0.68</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>C</td>
<td>MS Brand</td>
<td>Enhanced but not covered by plan</td>
<td>0.220</td>
<td>$2.81</td>
<td>$2.09</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>D</td>
<td>Generic</td>
<td>OTC</td>
<td>0.110</td>
<td>$2.84</td>
<td>$2.12</td>
<td>$0.00</td>
<td>$2.12</td>
</tr>
<tr>
<td>5</td>
<td>E</td>
<td>SS Brand</td>
<td>Part D</td>
<td>108.290</td>
<td>$20.62</td>
<td>$12.37</td>
<td>$12.37</td>
<td></td>
</tr>
</tbody>
</table>

Ingredient Total: All

Dispensing Fee: $2.00
Sales Tax: $1.00
Total Cost: $34.36
25% Coinsurance: $8.59
Plan Paid: $25.77

25% Coinsurance: $8.59
Total Cost: $34.36
Plan Paid: $25.77

Assumptions for Example 3b:
- Pharmacy should bill without SCC to determine if any drugs are covered by Part D. If no drugs are covered by Part D, follow Part D Plan guidance (i.e. PA required) or follow normal process downstream. If any one of the ingredients in the rejected claim does not have a reject code associated with it (at least one drug is Part D payable), resubmit with SCC of 8. The pharmacy may bill the member or other payer, as appropriate, for drugs not covered per reject code on previous claim.
- Compound is treated as Part D because there is at least one ingredient that independently meets the definition of a Part D drug and there are no Part B ingredients.
- Med D accumulations of Drug Spend and TrOOP are based on the sum of the covered Part D ingredients + dispensing fee + sales tax for the entire compound. The ingredient cost for the covered OTC drug is excluded from Med D accumulations.
- PDE would report NDC for Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity), with cost and payment fields applicable only to the covered Part D ingredients. The ingredient cost associated with the OTC drug is not reported on the PDE.
- Model EOB would report “Compound” as the drug name for all multi-ingredient compounds.
- The EOB will not match with the patient receipt from the pharmacy. The Part D Plan paid the pharmacy $27.89; however, the EOB will show a plan paid amount of $25.77 (excludes OTC drug cost). The patient pay of $8.59 is the same as no cost sharing was assessed on the non-Part D drug.
20.5.4 Example 3c: MAPD Plan covers the Part D ingredients and both excluded non-Part D ingredients (#3 & #4) in the compound

Because none of the covered ingredients is "B" and at least one of the covered ingredients is Part D, the compound is treated like Part D. Plan may choose to pay for non-Part D drugs; however, no cost sharing may be charged for the non-Part D ingredients.

### Ingredient Costs

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Drug Type</th>
<th>Drug</th>
<th>Qty</th>
<th>Submitted IC</th>
<th>Contracted Rate</th>
<th>Payable Part D</th>
<th>Total Paid to Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>SS Brand</td>
<td>Part D</td>
<td>90,000</td>
<td>$30.24</td>
<td>$18.31</td>
<td>$18.31</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>Generic</td>
<td>Part D</td>
<td>1.375</td>
<td>$0.90</td>
<td>$0.68</td>
<td>$0.68</td>
</tr>
<tr>
<td>3</td>
<td>C</td>
<td>MS Brand</td>
<td>Excluded</td>
<td>0.220</td>
<td>$2.81</td>
<td>$2.09</td>
<td>$2.09</td>
</tr>
<tr>
<td>4</td>
<td>D</td>
<td>Generic</td>
<td>Excluded</td>
<td>0.110</td>
<td>$2.84</td>
<td>$2.12</td>
<td>$2.12</td>
</tr>
<tr>
<td>5</td>
<td>E</td>
<td>SS Brand</td>
<td>Part D</td>
<td>108.290</td>
<td>$20.62</td>
<td>$12.37</td>
<td>$12.37</td>
</tr>
</tbody>
</table>

### Total Costs

- **Ingredient Total**: $57.41
- **Dispensing Fee**: $2.00
- **Sales Tax**: $1.00
- **Total Cost**: $34.36
- **25% Coinsurance**: $8.59
- **Plan Paid**: $25.77

### PDE Cost Fields

<table>
<thead>
<tr>
<th>Field</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ingredient Cost</td>
<td>$31.36</td>
</tr>
<tr>
<td>Dispensing Fee</td>
<td>$2.00</td>
</tr>
<tr>
<td>Sales Tax</td>
<td>$1.00</td>
</tr>
<tr>
<td>Vaccine Admin Fee</td>
<td>PLRO</td>
</tr>
<tr>
<td>GDCB</td>
<td>$34.36</td>
</tr>
<tr>
<td>GDCA</td>
<td>$25.77</td>
</tr>
</tbody>
</table>

### EOB Summary

<table>
<thead>
<tr>
<th>Date Prescription Filled</th>
<th>Prescription [Claim] Number</th>
<th>Name of Drug</th>
<th>Quantity Filled</th>
<th>Amount &lt;Plan Name&gt; Paid</th>
<th>Amount You Paid</th>
<th>[Amount Paid by Secondary Coverage/Other Sources]</th>
<th>[Extra Help from Medicare]</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2012</td>
<td>1234567</td>
<td>Compound</td>
<td>199.995</td>
<td>$25.77</td>
<td>$8.59</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### Assumptions for Example 3c:

Version 48  
November 2019  
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Page: 232
• Pharmacy should bill without SCC to determine if any drugs are covered by Part D. If no drugs are covered by Part D, follow Part D Plan guidance (i.e. PA required) or follow normal process downstream. If any one of the ingredients in the rejected claim does not have a reject code associated with it (at least one drug is Part D payable), resubmit with SCC of 8. The pharmacy may bill the member or other payer, as appropriate, for drugs not covered per reject code on previous claim.

• Compound is treated as Part D because there is at least one ingredient that independently meets the definition of a Part D drug and there are no Part B ingredients.

• Med D accumulations of Drug Spend and TrOOP are based on the sum of the covered Part D ingredients + dispensing fee + sales tax for the entire compound. The ingredient cost amounts for the covered non-Part D drugs are excluded from Med D accumulations.

• PDE would report NDC for Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity), with cost and payment fields applicable only to the covered Part D ingredients. The ingredient cost amounts associated with the non-Part D drugs are not reported on the PDE.

• Model EOB would report “Compound” as the drug name for all multi-ingredient compounds. The EOB will not match with the patient receipt from the pharmacy. The Part D Plan paid the pharmacy $29.98; however, the EOB will show a plan paid amount of $25.77 (excludes enhanced & OTC drug costs). The patient pay of $8.59 is the same as no cost sharing was assessed on the non-Part D drugs.
20.5.5 **EXAMPLE 4:** MAPD Plan covers the enhanced ingredients and OTC ingredients of the compound (no Part D drugs included)

Because one of the covered ingredients is an enhanced drug and none of the covered ingredients is Part B or Part D, the compound is treated like enhanced. Submit NDC of most expensive enhanced drug to the PDE and report costs and copays only related to the enhanced drugs. Plan may choose to pay the pharmacy for OTC ingredients based on contract, but no cost sharing may be assessed on these OTC ingredients.

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Drug Type</th>
<th>Qty</th>
<th>Submitted IC</th>
<th>Contracted Rate</th>
<th>Payable Enhanced Part D</th>
<th>Payable Non-Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enhanced</td>
<td>90.000</td>
<td>$30.24</td>
<td>$18.31</td>
<td>$18.31</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>OTC</td>
<td>1.375</td>
<td>$0.90</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Enhanced</td>
<td>0.220</td>
<td>$2.81</td>
<td>$2.09</td>
<td>$2.09</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>OTC</td>
<td>0.110</td>
<td>$2.84</td>
<td>$2.12</td>
<td>$2.12</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Enhanced</td>
<td>108.290</td>
<td>$20.62</td>
<td>$12.37</td>
<td>$12.37</td>
<td></td>
</tr>
</tbody>
</table>

| Ingredient Total | All | $57.41 | $35.57 | $32.77 | $35.57 |
| Dispensing Fee   |     | $1.00  | $1.00 |
| Sales Tax        |     |        |        |        |        |
| Total Cost       |     | $35.77 | $38.57 |
| 20% Coinsurance  |     | $7.15  | $7.15 |
| Plan Paid        |     | $28.62 | $31.42 |

**PDE Cost Fields**
- Ingredient Cost: $32.77
- Dispensing Fee: $2.00
- Sales Tax: $1.00
- Vaccine Admin Fee: PLRO
- GDCB: $0.00
- GDCA: $0.00

**PDE Payment Fields**
- Patient Pay: $7.15
- LICS Subsidy Amount: $0.00
- Other TrOOP: $0.00
- CPP: $0.00
- NPP: $28.62

**EOB** Summary of Prescription Claims Processed from <mm/dd/yyyy> through <mm/dd/yyyy>_

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Prescription [Claim] Number</th>
<th>Name of Drug</th>
<th>Quantity Dispensed</th>
<th>Amount &lt;Plan Name&gt; Paid</th>
<th>Amount You Paid</th>
<th>[Amount Paid by Secondary Coverage/Other Sources]</th>
<th>[Extra Help from Medicare]</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2012</td>
<td>1234567</td>
<td>Compound</td>
<td>199.995</td>
<td>$28.62</td>
<td>$7.15</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

EOB Notes:
Some compound ingredients aren’t generally covered by Medicare drug coverage and don’t count toward your out-of-pocket or total drug costs or help you reach catastrophic coverage. See section [2] for more information.

Assumptions for Example 4:

- MAPD enhanced plan that covers enhanced drugs and OTC drugs in the compound.
- Compound is treated as enhanced because none of the covered ingredients is a Part B drug or a Part D drug and at least one of the ingredients is an “E” drug.
- The 20% coinsurance was computed only for the enhanced drugs. The cost for the OTC drugs was excluded since the assumption is that OTC drugs may be covered only with $0 cost share to the member.
- Med D accumulations of Drug Spend and TrOOP are bypassed.
- PDE would report the NDC for the enhanced ingredient with the highest line item computed ingredient cost (unit cost x quantity), with an ingredient cost amount equal to the sum of only the enhanced ingredients. Dispensing fee paid and sales tax paid are for the entire compound.
- Model EOB would report “Compound” for the drug name for all multi-ingredient compound claims.
- The EOB will not match with the patient receipt from the pharmacy. The Part D Plan paid the pharmacy $31.42; however, the EOB will show a plan paid amount of $28.62 (excludes OTC drug costs). The patient pay of $7.15 is the same as no cost sharing was assessed on the OTC drugs.
20.5.6 Example 5: MAPD Plan Covers the OTC Ingredients of the Compound (No Part D Drugs Included)

Because all of the covered ingredients are OTC drugs and none of the covered ingredients is Part B or Part D, the compound is treated like OTC. Submit NDC of most expensive OTC drug to the PDE and report costs for all covered OTC drugs. No cost sharing may be assessed on OTC ingredients.

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Drug</th>
<th>Substitution Indicator</th>
<th>Drug Type</th>
<th>Qty</th>
<th>Submitted IC</th>
<th>Contracted Rate</th>
<th>Payable Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>SS Brand</td>
<td>OTC</td>
<td>90.00</td>
<td>$30.24</td>
<td>$18.31</td>
<td>$18.31</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>Generic</td>
<td>OTC</td>
<td>1.375</td>
<td>$0.90</td>
<td>$0.68</td>
<td>$0.68</td>
</tr>
<tr>
<td>3</td>
<td>C</td>
<td>MS Brand</td>
<td>OTC</td>
<td>0.220</td>
<td>$2.81</td>
<td>$2.09</td>
<td>$2.09</td>
</tr>
<tr>
<td>4</td>
<td>D</td>
<td>Generic</td>
<td>OTC</td>
<td>0.110</td>
<td>$2.84</td>
<td>$2.12</td>
<td>$2.12</td>
</tr>
<tr>
<td>5</td>
<td>E</td>
<td>SS Brand</td>
<td>OTC</td>
<td>108.290</td>
<td>$20.62</td>
<td>$12.37</td>
<td>$12.37</td>
</tr>
</tbody>
</table>

Ingredient Total All | $57.41 | $35.57 | $35.57 | $35.57 | $35.57 |

Dispensing Fee | $2.00 | $2.00 |
Sales Tax | $1.00 | $1.00 |
Total Cost | $38.57 | $38.57 |
Patient Pay | $0.00 | $0.00 |
Plan Paid | $38.57 | $38.57 |

PDE Cost Fields | PDE Payment Fields
Ingredient Cost | $35.57 | Patient Pay | $0.00 |
Dispensing Fee | $2.00 | LCS Subsidy Amount |
Sales Tax | $1.00 | Other TrOOP |
Vaccine Admin Fee | PLRO |
CPP | $0.00 |
GDCB | $0.00 | NPP | $38.57 |
GDCA | Drug Coverage Status Code | O |

EOB Summary of Prescription Claims Processed from <mm/dd/yyyy> through <mm/dd/yyyy>

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Prescription [Claim] Number</th>
<th>Name of Drug</th>
<th>Quantity Dispensed</th>
<th>Amount &lt;Plan Name&gt; Paid</th>
<th>Amount You Paid</th>
<th>[Amount Paid by Secondary Coverage/Other Sources]</th>
<th>[Extra Help from Medicare]</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2012</td>
<td>1234567</td>
<td>Compound</td>
<td>199.995</td>
<td>$38.57</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

EOB Notes:
Some compound ingredients aren’t generally covered by Medicare drug coverage and don’t count toward your out-of-pocket or total drug costs or help you reach catastrophic coverage. See section [2] for more information.
Assumptions for Example 5:

- MAPD enhanced plan that covers OTC drugs in the compound.
- Compound is treated as OTC because none of the covered ingredients is a Part B drug, a Part D drug, or a covered enhanced drug and all of the ingredients are OTCs.
- The cost share for OTC drugs is always $0.
- Med D accumulations of Drug Spend and TrOOP are bypassed.
- PDE would report the NDC for the OTC ingredient with the highest line item computed ingredient cost (unit cost x quantity), and an ingredient cost amount equal to the sum of the covered OTC ingredients. Dispensing fee paid and sales tax paid are for the entire compound.
- Model EOB would report "Compound" for the drug name for all multi-ingredient compound claims.
21 APPENDIX D. MEDICARE PART D TOPICS

21.1 HARDCODED VALUES
If information changes with Medicare Part D contractors, this document will be need to be updated for hardcoded BiNs, PCN, telephone numbers, etc.

21.2 NOTICE OF APPEAL RIGHTS — REJECTED CLAIM
Effective Date: January 1, 2012
This applies to D.0 claims submitted on or after January 1, 2012. Modifications are denoted below in a new section stating “This applies to D.0 claims submitted on or after July 1, 2013”.

CMS Appeals and Grievance Notice Process Guidelines
This was developed in anticipation of potential future CMS guidance requiring Part D Plans to direct their contracted pharmacies to provide beneficiaries with a Notice of Appeal Rights. The Notice should be provided based on information below. This is to ensure beneficiaries understand their rights when a Part D drug is rejected by the Part D Plan.

PLAN/PROCESSOR ACTION
This applies to D.0 claims submitted on or after January 1, 2012.

Part D Plans should assume denied drugs that are subject to transition requirement coverage will also be subject to the Notice of Appeal Rights requirement outside of the transition period.

If the beneficiary is not currently eligible for transition and has been prescribed a drug that is subject to transition requirement coverage, the plan’s processor should return the following Reject Code in addition to all other applicable Reject Codes:

“569” (Provide Beneficiary with CMS Notice of Appeal Rights)

The Notice of Appeal Reject Code should not be returned in circumstances where transition coverage would not apply, such as:

- CMS Exclusion
- Medicare B vs. D Determination
- Drug not FDA Listed
- OTC
- Sanctioned Provider

These rejection reasons cannot effectively be appealed.

PHARMACY ACTION
If the pharmacy receives a **REJECT** on a Part D claim and the claim contains the “569” (Provide Beneficiary with CMS Notice of Appeal Rights) Reject Code or free form message the beneficiary needs to know he or she has the right to appeal the rejection.

As a result of receiving this error code, the pharmacy should provide the beneficiary with the CMS Notice of Appeal Rights. The Notice of Appeal Rights is a standardized “handout” with CMS model language. The Notice will direct the beneficiary to use the phone number on the back of his or her Part D Plan card if the beneficiary chooses to appeal the reject.

When multiple claims deny with the Notice of Appeal Rights Reject Code, only one notice should be provided per pharmacy encounter or mail order package.

Mail Order Pharmacies are expected to mail/email the notice to the beneficiary based on the method of communication the beneficiary has chosen.

LTC pharmacies, serving LTC members, are exempt from providing the Notice of Appeal Rights to the beneficiary. These pharmacies do not dispense drugs to the beneficiary; they are dispensed to the facility.

### 21.2.1 **REJECT CODE “569” AND SUBMISSION CLARIFICATION CODE**

This applies to D.0 claims submitted on or after January 1, 2012. Modifications are denoted below in a new section stating “This applies to D.0 claims submitted on or after July 1, 2013”.

**Question:** How should Reject Code “569” (Provide Appeals Grievance Notice) work in conjunction with bypassed rejects using Submission Clarification Code 8 (Process Compound for Approved Ingredients)?

**For example:**

Pharmacy submits a compound for a member with 5 drugs in it. The following information is sent back to the pharmacy.

- Drug 1 - Rejected for “569”
- Drug 2 - Rejected for “569”
- Drug 3 - Rejected for “569”
- Drug 4 - Payable
- Drug 5 - Payable

What should happen in the case where the pharmacy uses Submission Clarification Code of 8 (Process Compound for Approved Ingredients) in this example? The question is if a compound claim initially rejects for “569” and the pharmacy uses Submission Clarification Code 8 indicating that they want the processor to pay the payable ingredients in the compound what should happen in this case? Is the pharmacy allowed to use Submission Clarification Code 8 in the below example or are they not allowed to use it and we should reject the entire compound?

**Response:**

1. There are rules for compounds submitted under a Part D BIN/PCN that contain (either Part B versus D) or Part B drugs (actually what the industry calls Part C drugs). Those rules state that any compound that contains either of these cannot be considered a Part D compound. The processor should not return the “569” or “018” because they are not Part D drugs and do not meet the appeal criteria.
2. If the compound contains at least one ingredient that is considered a Part D ingredient (and does not fall in #1) and the claim is rejected under “569” “criteria”:
   a. Reject Code “569” (and any other applicable claim level rejects) should be returned.
   b. Reject Codes that are specific to the ingredient should be returned.
   c. The pharmacy:
      i. Cannot resolve the reject, and provides the appeal notice to the patient. The claim is not paid by Part D.
      ii. May resubmit the claim with an SCC 8 (agreeing to accept only for covered ingredients) if the “569” is caused because one/more ingredients are not approved.
         1. If the Part D plan pays (SCC 8 is successful), appeal notice does not apply (no “018” is sent).
         2. If paid by co-administered insurance (not Part D) (SCC 8 is successful) and appeal notice does apply (018 is sent).

If the claim would have paid with an SCC 8 submitted originally, then the “569” should be returned.
If the compound is paid by Part D, then an appeal notice should not be provided.

21.3 NOTICE OF APPEAL RIGHTS – PAID CLAIM

This applies to D.0 claims submitted on or after January 1, 2012. Modifications are denoted below in a new section stating “This applies to D.0 claims submitted on or after July 1, 2013”.

DERF 1006 (approved 05/2011) requested a new Approved Message Code (548-6F) to identify claims not covered under the Part D portion but is paid under the co-administered supplemental portion of the member’s benefit.

The situation is specific to when the beneficiary is enrolled in a plan to which the supplemental benefits are co-administered with the Part D benefit, and adjudication occurs within one transaction. A claim is submitted to a Part D BIN/PCN. The Part D plan does not cover the drug, however the drug is covered by a supplemental payer and that coverage is returned in the form of a paid response.

If the drug, not covered by the Part D Plan, meets the criteria for providing an appeal notice to the member, the paid claim response must contain an approval code so that the pharmacy can provide the member with the appeal notice. In the situation where the claim is covered by the supplemental payer the beneficiary will receive the notice that the drug was not covered by their Part D plan.

Approved Message Code (548-6F)

<table>
<thead>
<tr>
<th>“018”</th>
<th>“018”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Beneficiary With CMS Notice Of Appeal Rights</td>
<td>Claim for a Part D drug submitted to the plan’s Medicare D BIN/PCN is not covered by the Part D plan and is outside the Part D transitional fill coverage period, but is paid under the plan’s co-administered benefit or plan-sponsored negotiated price to the beneficiary. In this situation the member should be provided the Medicare Part D Appeal and Grievance Notice.</td>
</tr>
</tbody>
</table>

21.4 NOTICE OF MEDICARE DRUG COVERAGE RIGHTS – REJECTED CLAIM
Telecommunication Version D and Above Questions, Answers and Editorial Updates

This applies to D.0 claims submitted on or after July 1, 2013.

CMS Appeals and Grievance Notice Process Guidelines

This appendix was developed to comply with CMS guidance for situations when Part D Plans need to direct their contracted pharmacies to provide beneficiaries with the notice entitled “Medicare Prescription Drug Coverage and Your Rights.” The Notice should be provided based on information below. This is to ensure beneficiaries understand their coverage rights when a Part D prescription drug claim is rejected by the Part D Plan.

PLAN/PROCESSOR ACTION

This applies to D.0 claims submitted on or after July 1, 2013.

Based on CMS guidance, Part D Plans should provide the appropriate indicator to the participating pharmacy to provide the Notice to the patient for rejected claims that qualify for coverage determination.

The plan’s processor should return the following Reject Code in addition to all other applicable Reject Codes:

“569” (Provide Notice: Medicare Prescription Drug Coverage and Your Rights)

Note: If there are more rejects than the allotted five occurrences, the “569” must be in one of the occurrences.

The Notice must be provided to the enrollee if the pharmacy receives a transaction response indicating the claim (contains all necessary data elements for adjudication) is not covered by the beneficiary’s Part D benefit and the designated NCPDP Reject Code is returned.

The “569” Reject Code should not be returned in the following circumstances:

- Claim does not contain all necessary data elements for proper adjudication at POS
- Drug not listed on the participating CMS Manufacturer Labeler Code List (applicable for NDA and BLA)
- Drug not listed on the FDA Electronic List - NDC Structured Product Labeling Data Elements File (NSDE)
- Drug classified as Over The Counter (OTC)
- Submitted provider ID or prescriber ID is identified as a sanctioned provider
- Submitted prescriber ID is for a foreign prescriber with an identifier other than an NPI (this is not considered a clean claim)
- Claim is rejected only because of a “fill too soon/early fill” edit

Note: Claims that meet the definition of a compound should follow the rules, above, and have no different requirements.

Note: While it is applicable to return the 569 reject code for B vs. D determinations beginning July 1, 2013, it is not applicable to return the reject code if the drug is known to be a Part B drug.
PHARMACY ACTION

If the pharmacy is unable to resolve the Part D claim rejection which contains the “569” (Provide Notice: Medicare Prescription Drug Coverage and Your Rights) Reject Code the beneficiary needs to know he or she has the right to request a coverage determination.

As a result of receiving this Reject Code, the pharmacy should provide the beneficiary with the notice entitled “Medicare Prescription Drug Coverage and Your Rights.” The Notice is a “handout” with standardized language. The Notice will direct the beneficiary to use the phone number on the back of his or her Part D Plan card if the beneficiary chooses to request a coverage determination.

When multiple claims reject with Reject Code “569”, at minimum a single notice must be provided per patient pharmacy encounter or mail order package.

Non-retail network pharmacies (home infusion, LTC, mail order) are not exempt from the requirement to distribute the Notice. Refer to the CMS Prescription Drug Benefit Manual, Chapter 18, Section 40.3.1.

21.4.1 REJECT CODE “569” AND SUBMISSION CLARIFICATION CODE 8 (COMPOUND PROCESSING)

This applies to D.0 claims submitted on or after July 1, 2013.

Question:
How should Reject Code “569” (Provide Notice: Medicare Prescription Drug Coverage and Your Rights) work in conjunction with bypassed rejects using Submission Clarification Code 8 (Process Compound for Approved Ingredients)?

For example:
Pharmacy submits a compound for a member with 5 drugs in it and the claim is rejected. The following information is sent back to the pharmacy.

Drug 1 - Rejected for “569”
Drug 2 - Rejected for “569”
Drug 3 - Rejected for “569”
Drug 4 - Payable
Drug 5 – Payable

What should happen in the case where the pharmacy uses Submission Clarification Code of 8 (Process Compound for Approved Ingredients) in this example? The question is if a compound claim initially rejects for “569” and the pharmacy uses Submission Clarification Code 8 indicating that they want the processor to pay the payable ingredients in the compound what should happen in this case? Is the pharmacy allowed to use Submission Clarification Code 8 in the below example or are they not allowed to use it and we should reject the entire compound?

Response:
Compounds submitted under a Part D BIN/PCN that contain one or more Part B versus D ingredients are not considered Part D. The processor should return the Reject Code “569” based upon the rules bulleted in section “Notice of Medicare Drug Coverage Rights – Rejected Claim” or Approved Message Code “018”, when Benefit Stage Qualifier of 70 is applicable.

1. If the compound contains at least one ingredient that is considered a Part D ingredient (and does not fall in #1) and the claim is rejected under “569” “criteria”:
a. Reject Code “569” (and any other applicable claim level rejects) should be returned.
b. Reject Codes that are specific to the ingredient should be returned.
c. The pharmacy:
   i. Cannot resolve the reject, and provides the Notice to the patient. The claim is not paid by Part D.
   ii. May resubmit the claim with an SCC 8 (agreeing to accept only for covered ingredients) if the “569” is caused because one/more ingredients are not approved.
   1. If the Part D plan pays (SCC 8 is successful), the Notice does not apply.
   2. If not covered by the Part D plan but is paid under the plan-sponsored negotiated discounted price to the beneficiary and Benefit Stage Qualifier of “70” is applicable, the Notice does apply (“018” is sent).

**21.5 NOTICE OF MEDICARE DRUG COVERAGE RIGHTS – PAID CLAIM**

This applies to D.0 claims submitted on or after July 1, 2013.

Approved Message Code “018” should be returned when the Part D drug not paid by Part D plan benefit, is paid by the beneficiary under plan-sponsored negotiated pricing. Plan-sponsored negotiated pricing refers to drugs not covered under the insured benefit design but are offered to beneficiaries under a negotiated discounted price. In this scenario, the beneficiary’s out-of-pocket expense is 100% of the plan’s negotiated discounted pricing with the pharmacy.

Note: In this scenario, Benefit Stage Qualifier field (393-MV) value “70” will be returned and trigger the generation of the “018”.

If the drug, not covered by the Part D Plan, meets the criteria for providing the Notice to the member, the paid claim response must contain an Approved Message Code so that the pharmacy can provide the member with the Notice.

Approved Message Code (548-6F)

<table>
<thead>
<tr>
<th>“018”</th>
<th>Provide Notice: Medicare Prescription Drug Coverage and Your Rights</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Claim for a Part D drug submitted to the plan’s Medicare D BIN/PCN is not covered by the Part D plan but is paid by the beneficiary per a plan-sponsored negotiated price. In this situation the member should be provided the notice entitled “Medicare Prescription Drug Coverage and Your Rights”.</td>
</tr>
</tbody>
</table>

**21.6 BENEFIT STAGE RULES AND EXAMPLES**

**21.6.1 BENEFIT STAGE RULES**

1. The sum of the benefit stage amounts must equal Patient Pay Amount (505-F5) plus Total Amount Paid (509-FN).
   a. There is an exception to this. See “Republication of Telecommunication Standard Implementation Guide Version D.0 August 2010”, subsection “Benefit Stage Formula”.
2. All benefit stage qualifiers and amounts should be based on where the member would have been in the benefit if they had been in the non LIS benefit. This will ensure the beneficiary is not hindered from receiving a benefit that might be available to them from a supplemental payer.
3. When the LIS benefit does not have a deductible, if the member would have been in the deductible stage in the non LIS benefit, return the Deductible Benefit Stage Qualifier (01) and applicable benefit stage amount. Return the LIS patient pay amount as Amount of Copay (518-FI) or Amount of Coinsurance (572-4U).

4. If the LIS benefit does not have a coverage gap and the member would have been in the coverage gap stage in the non LIS benefit, return the Coverage Gap Benefit Stage Qualifier (03) and applicable benefit stage amount. Report the LIS patient pay amount as Amount of Copay (518-FI) or Amount of Coinsurance (572-4U).

5. The supplemental payer should use benefit stage qualifiers and amounts to determine if supplemental coverage applies. Use the Other Payer-Patient Responsibility Qualifier(s) and Amount(s) and/or the Other Payer Amount Paid Qualifier(s) and Amount(s) to determine the amount payable under the supplemental plan.

21.6.2 Cost Share Parameters Used in Examples 1 thru 6

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<th>LIS Category Code 4</th>
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<td>100% to $310 DED limit</td>
<td>$2.50 generics/$6.30 brands</td>
</tr>
<tr>
<td>Initial Coverage</td>
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<td>$2.50 generics/$6.30 brands</td>
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<td>Coverage Gap</td>
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<td>Catastrophic</td>
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<td></td>
<td>&gt; 5%/$6.30 for brands</td>
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21.6.2.1 Example 1: $50 Claim - Amount Remaining to Meet Deductible is $310

Response Pricing Segment

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<th>LIS 1 Amount</th>
<th>LIS 4 Amount</th>
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</thead>
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<td>Amount Attributed To Sales Tax</td>
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<tr>
<td>517-FH</td>
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<td>Amount Of Copay</td>
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<td>520-FK</td>
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<tr>
<td>571-NZ</td>
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<tr>
<td>572-4U</td>
<td>Amount Of Coinsurance</td>
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</tr>
<tr>
<td>133-UJ</td>
<td>Amount Attributed To Provider Network Selection</td>
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<td>Amount Attributed To Product Selection/Brand Drug</td>
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<tr>
<td>135-UM</td>
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<tr>
<td>136-UN</td>
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<td>137-UP</td>
<td>Amount Attributed To Coverage Gap</td>
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<td>129-UD</td>
<td>Health Plan-Funded Assistance Amount</td>
<td>09</td>
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<td>509-F9</td>
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<td>394-MW</td>
<td>Benefit Stage Amount</td>
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## COB/Other Payments Segment

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<th>Field</th>
<th>Field Name</th>
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<th>LIS 1</th>
<th>LIS 4</th>
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<td>337-4C</td>
<td>Coordination of Benefits/Other Payments Count</td>
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### 21.6.2.2 EXAMPLE 2: $50 CLAIM - AMOUNT REMAINING TO MEET NON-LIS DEDUCTIBLE IS $260. AMOUNT REMAINING TO MEET LIS 4 DEDUCTIBLE IS $13

<table>
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<th>Field</th>
<th>Field Name</th>
<th>Maps to OPPR Qualifier</th>
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<td>517-FH</td>
<td>Amount Applied To Periodic Deductible</td>
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<tr>
<td>571-NZ</td>
<td>Amount Attributed To Processor Fee</td>
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<td>135-UM</td>
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<td>129-UD</td>
<td>Health Plan-Funded Assistance Amount</td>
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**COB/Other Payments Segment**

<table>
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<tr>
<th>Field</th>
<th>Field Name</th>
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<th>LIS 4</th>
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### 21.6.2.3 EXAMPLE 3: $50 CLAIM - AMOUNT REMAINING TO MEET NON-LIS DEDUCTIBLE IS $10. LIS 4 DEDUCTIBLE ALREADY MET

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<td>517-FH</td>
<td>Amount Applied To Periodic Deductible</td>
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<td>$10.00</td>
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<tr>
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<td>129-UD</td>
<td>Health Plan-Funded Assistance Amount</td>
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<td>$10.00</td>
<td>$10.00</td>
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### COB/Other Payments Segment

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<th>Field Name</th>
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<th>LIS 4</th>
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<td>02 (INIT)</td>
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**Rule 1**

- **Non-LIS 1, LIS 1, LIS 4**
  - Non-LIS 1 = $30.00
  - LIS 1 = $43.70
  - LIS 4 = $42.50

**Rule 2**

- **Non-LIS 1, LIS 1, LIS 4**
  - Non-LIS 1 = $30.00
  - LIS 1 = $43.70
  - LIS 4 = $42.50

**Rule 3**

- **Non-LIS 1, LIS 1, LIS 4**
  - Non-LIS 1 = $30.00
  - LIS 1 = $43.70
  - LIS 4 = $42.50

```
Difference:
Non-LIS 1 = $30.00
LIS 1 = $43.70
LIS 4 = $42.50
```
### 21.6.2.4 EXAMPLE 4: $50 CLAIM - AMOUNT REMAINING TO MEET INITIAL COVERAGE LIMIT IS $10

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<th>Field</th>
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<td>518-FI</td>
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<td>520-FK</td>
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<tr>
<td>571-NZ</td>
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#### COB/Other Payments Segment

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**EXAMPLE 5: $50 CLAIM - INITIAL COVERAGE LIMIT OF $2830 ALREADY MET. AMOUNT REMAINING TO MEET TROOP IS $2000**

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**Rule 1**

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**Rule 2**

**Rule 4**
### Example 6: $50 Claim - Amount Remaining to Meet Troop is $20

#### Table: Field Name, Maps to OPPR Qualifier, Non-LIS Amount, LIS 1 Amount, LIS 4 Amount

<table>
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<th>Field Name</th>
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<th>Non-LIS Amount</th>
<th>LIS 1 Amount</th>
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</thead>
<tbody>
<tr>
<td>505-FS</td>
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<td>$6.30</td>
<td>$3.00</td>
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<td>523-FN</td>
<td>Amount Attributed To Sales Tax</td>
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</tr>
<tr>
<td>517-FH</td>
<td>Amount Applied To Periodic Deductible</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>518-FI</td>
<td>Amount Of Copay</td>
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<td>$6.30</td>
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<tr>
<td>520-FK</td>
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<tr>
<td>572-4U</td>
<td>Amount Of Coinsurance</td>
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<td>$3.00</td>
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</tr>
<tr>
<td>133-UJ</td>
<td>Amount Attributed To Provider Network Selection</td>
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#### COB/Other Payments Segment

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**Rules:**
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- Rule 2: 2
- Rule 3: 2
- Rule 4: 2
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21.6.3 Cost Share Parameters Used in Examples 7 Thru 9

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### 21.6.3.2 EXAMPLE 8: $50 CLAIM - INITIAL COVERAGE LIMIT OF $2830 ALREADY MET. AMOUNT REMAINING TO MEET TROOP IS $2000

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<td>505-F5</td>
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**Rule 1**: If the total amount paid exceeds $2830, the amount remaining to meet the troop is $2000.

**Rule 2**: The remaining amount to meet the troop is $2000.

**Rule 4**: The remaining amount to meet the troop is $2000.

### COB/Other Payments Segment

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### 21.6.3.3 EXAMPLE 9: $100 CLAIM - INITIAL COVERAGE LIMIT OF $2830 ALREADY MET. AMOUNT REMAINING TO MEET TROOP IS $20

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**Rule 1**

**Rule 2**

**Rule 4**

### COB/Other Payments Segment

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### 21.6.4 Cost Share Parameters Used in Example 10

#### 21.6.4.1 Example 10: $100 Claim for Brand Drug. Amount Remaining to Meet Initial Coverage Limit is $50

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<td>518-FI</td>
<td>Amount Of Copay</td>
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<td>10.00</td>
<td>6.30</td>
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<tr>
<td>520-FK</td>
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<tr>
<td>572-4U</td>
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<tr>
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<tr>
<td>129-UD</td>
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<tr>
<td>509-F9</td>
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Rule 1: 03 (GAP) = 03 (GAP) = 03 (GAP)

Rule 2: Benefit Stage Count

Rule 4: $50.00 for generics, $6.30 for brands
### COB/Other Payments Segment

<table>
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<tr>
<th>Field</th>
<th>Field Name</th>
<th>Non-LIS</th>
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<th>LIS 4</th>
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<td>1</td>
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<td>01</td>
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<td>340-7C</td>
<td>Other Payer ID</td>
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<td>123456</td>
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<td>443-E8</td>
<td>Other Payer Date</td>
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<td>20120101</td>
<td>20120101</td>
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<td>353-NR</td>
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<td>2</td>
<td>2</td>
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<td>02 (INIT)</td>
<td>02 (INIT)</td>
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<td>$50.00</td>
<td>$50.00</td>
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<td>03 (GAP)</td>
<td>03 (GAP)</td>
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#### 21.6.5 Cost Share Parameters Used in Examples 11

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<th>LIS Category Code 4</th>
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<tr>
<td>Deductible</td>
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<td>N/A</td>
</tr>
<tr>
<td>Initial Coverage</td>
<td>$20 to $4550 TrOOP limit</td>
<td>$2.50 generics/$6.30 brands</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>&gt; 5%/$2.50 for generics &gt; 5%/$6.30 for brands</td>
<td>$0</td>
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#### 21.6.5.1 Example 11: $100 Claim – No Coverage Gap; Amount Remaining to Meet Troop is $500

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<th>Field Name</th>
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<th>LIS 4 Amount</th>
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<tr>
<td>505-F5</td>
<td>Patient Pay Amount</td>
<td>06</td>
<td>$20.00</td>
<td>$6.30</td>
<td>$15.00</td>
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<tr>
<td>523-FN</td>
<td>Amount Attributed To Sales Tax</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>517-FH</td>
<td>Amount Applied To Periodic Deductible</td>
<td>01</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>518-FI</td>
<td>Amount Of Copay</td>
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<td>20.00</td>
<td>6.30</td>
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<tr>
<td>520-FK</td>
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<tr>
<td>571-NZ</td>
<td>Amount Attributed To Processor Fee</td>
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<td></td>
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</tr>
<tr>
<td>572-4U</td>
<td>Amount Of Coinsurance</td>
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<td></td>
<td></td>
<td>$15.00</td>
</tr>
<tr>
<td>133-UJ</td>
<td>Amount Attributed To Provider Network Selection</td>
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<td></td>
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</tr>
<tr>
<td>134-UK</td>
<td>Amount Attributed To Product Selection/Brand Drug</td>
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<td></td>
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</tr>
<tr>
<td>135-UM</td>
<td>Amount Attributed To Product Selection/Non-Preferred Formulary Selection</td>
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<td>136-UN</td>
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### Table 1: Brand Non-Preferred Formulary Selection

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<th>Field</th>
<th>Description</th>
<th>Non-LIS</th>
<th>LIS 1</th>
<th>LIS 4</th>
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<tbody>
<tr>
<td>137-UP</td>
<td>Amount Attributed To Coverage Gap</td>
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<td></td>
</tr>
<tr>
<td>129-UD</td>
<td>Health Plan-Funded Assistance Amount</td>
<td>09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>509-F9</td>
<td>Total Amount Paid</td>
<td>$80.00</td>
<td>$93.70</td>
<td>$85.00</td>
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<td>392-MU</td>
<td>Benefit Stage Count</td>
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<td>1</td>
<td>1</td>
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<tr>
<td>393-MV</td>
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<td>02 (INIT)</td>
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<td>Benefit Stage Amount</td>
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### Table 2: COB/Other Payments Segment

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<th>Non-LIS</th>
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<td>Coordination of Benefits/Other Payments Count</td>
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<td>Other Payer Coverage Type</td>
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<td>Other Payer ID</td>
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<td>443-E8</td>
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<td>353-NR</td>
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<td>1</td>
<td>1</td>
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### 21.6.6 Cost Share Parameters Used in Examples 12

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<tbody>
<tr>
<td>Deductible</td>
<td>100% to $310 limit; brands only</td>
<td>$2.50 generics/$6.30 brands</td>
</tr>
<tr>
<td>Initial Coverage</td>
<td>$10 generics/$50 brands to $4550 TrOOP limit</td>
<td>$2.50 generics/$6.30 brands</td>
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<tr>
<td>Catastrophic</td>
<td>&gt; 5%/$2.50 for generics</td>
<td>$0</td>
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<tr>
<td></td>
<td>&gt; 5%/$6.30 for brands</td>
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### 21.6.6.1 Example 12: $50 Claim for Generic Drug – No Deductible for Generics; Amount Remaining to Meet Brand Non-LIS Deductible is $100. LIS Deductible Already Met

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</tr>
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<td>517-FH</td>
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<td>520-FK</td>
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21.6.7 COST SHARE PARAMETERS USED IN EXAMPLES 13

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<td>Coverage Gap</td>
<td>$2.50 generics/$6.30 brands</td>
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<tr>
<td>Catastrophic</td>
<td>$2.50 for generics</td>
<td>$6.30 for brands</td>
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### 21.6.7.1 EXAMPLE 13: $20 CLAIM FOR GENERIC DRUG; INITIAL COVERAGE LIMIT ALREADY MET; $500 REMAINING TO MEET TROOP. NON-LIS GENERIC COPAY APPLIES BECAUSE IT IS LESS THAN LIS COPAY

<table>
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<td>572-4U</td>
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<td>$19.00</td>
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<td>03 (GAP)</td>
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<tr>
<td>394-MW</td>
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**COB/Other Payments Segment**

<table>
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<tr>
<th>Field</th>
<th>Field Name</th>
<th>Non-LIS</th>
<th>LIS 1</th>
<th>LIS 4</th>
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<tr>
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</tbody>
</table>
21.6.7.2 **EXAMPLE 14: $100 MEDICARE SECONDARY PAYER CLAIM FOR BRAND DRUG; INITIAL COVERAGE LIMIT ALREADY MET; $500 REMAINING TO MEET TROOP. OTHER PAYER AMOUNT PAID IS $75.**

**B1 Response from Primary Payer (not Med D plan)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Primary Payer Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>505-FS</td>
<td>Patient Pay Amount</td>
<td>$25.00</td>
</tr>
<tr>
<td>523-FN</td>
<td>Amount Attributed To Sales Tax</td>
<td></td>
</tr>
<tr>
<td>517-FH</td>
<td>Amount Applied To Periodic Deductible</td>
<td></td>
</tr>
<tr>
<td>518-Fi</td>
<td>Amount Of Copay</td>
<td>$25.00</td>
</tr>
<tr>
<td>520-FK</td>
<td>Amount Exceeding Periodic Benefit Maximum</td>
<td></td>
</tr>
<tr>
<td>571-NZ</td>
<td>Amount Attributed To Processor Fee</td>
<td></td>
</tr>
<tr>
<td>572-4U</td>
<td>Amount Of Coinsurance</td>
<td></td>
</tr>
<tr>
<td>133-UJ</td>
<td>Amount Attributed To Provider Network Selection</td>
<td></td>
</tr>
<tr>
<td>134-UK</td>
<td>Amount Attributed To Product Selection/Brand Drug</td>
<td></td>
</tr>
<tr>
<td>135-UM</td>
<td>Amount Attributed To Product Selection/Non-Preferred Formulary Selection</td>
<td></td>
</tr>
<tr>
<td>136-UN</td>
<td>Amount Attributed To Product Selection/Non-Preferred Formulary Selection</td>
<td></td>
</tr>
<tr>
<td>137-UP</td>
<td>Amount Attributed To Coverage Gap</td>
<td></td>
</tr>
<tr>
<td>129-UD</td>
<td>Amount Attributed To Health Plan-Funded Assistance Amount</td>
<td></td>
</tr>
<tr>
<td>566-JS</td>
<td>Other Payer Amount Recognized</td>
<td></td>
</tr>
<tr>
<td>509-F9</td>
<td>Total Amount Paid</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

**COB/Other Payments Segment sent to Med D plan – Other Payer Amount Paid Billing**

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Non-LIS</th>
<th>LIS 1</th>
<th>LIS 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>337-4C</td>
<td>Coordination of Benefits/Other Payments Count</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>338-5C</td>
<td>Other Payer Coverage Type</td>
<td>01</td>
<td>01</td>
<td>01</td>
</tr>
<tr>
<td>339-6C</td>
<td>Other Payer ID Qualifier</td>
<td>03</td>
<td>03</td>
<td>03</td>
</tr>
<tr>
<td>340-7C</td>
<td>Other Payer ID</td>
<td>123456</td>
<td>123456</td>
<td>123456</td>
</tr>
<tr>
<td>443-E8</td>
<td>Other Payer Date</td>
<td>20120101</td>
<td>20120101</td>
<td>20120101</td>
</tr>
<tr>
<td>341-HB</td>
<td>Other Payer Amount Paid Count</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>342-HC</td>
<td>Other Payer Amount Paid Qualifier</td>
<td>07</td>
<td>07</td>
<td>07</td>
</tr>
<tr>
<td>341-DV</td>
<td>Other Payer Amount Paid</td>
<td>$75.00</td>
<td>$75.00</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

**B1 Response from Medicare Part D plan (MSP claim)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Non-LIS Amount</th>
<th>LIS 1 Amount</th>
<th>LIS 4 Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>505-FS</td>
<td>Patient Pay Amount</td>
<td>$25.00</td>
<td>$2.50</td>
<td>$15.00</td>
</tr>
<tr>
<td>523-FN</td>
<td>Amount Attributed To Sales Tax</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>517-FH</td>
<td>Amount Applied To Periodic Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>518-Fi</td>
<td>Amount Of Copay</td>
<td>$2.50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Telecommunication Version D and Above Questions, Answers and Editorial Updates

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Non-LIS</th>
<th>LIS 1</th>
<th>LIS 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>520-FK</td>
<td>Amount Exceeding Periodic Benefit Maximum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>571-NZ</td>
<td>Amount Attributed To Processor Fee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>572-AU</td>
<td>Amount Of Coinsurance</td>
<td>$15.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>133-UJ</td>
<td>Amount Attributed To Provider Network Selection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>134-UK</td>
<td>Amount Attributed To Product Selection/Brand Drug</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>135-UM</td>
<td>Amount Attributed To Product Selection/Non-Preferred Formulary Selection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>136-UJ</td>
<td>Amount Attributed To Product Selection/Brand Non-Preferred Formulary Selection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>137-UP</td>
<td>Amount Attributed To Coverage Gap</td>
<td>$25.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>129-UD</td>
<td>Amount Attributed to Health Plan-Funded Assistance Amount</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>566-JS</td>
<td>Other Payer Amount Recognized</td>
<td>$75.00</td>
<td>$75.00</td>
<td>$75.00</td>
</tr>
<tr>
<td>509-F9</td>
<td>Total Amount Paid</td>
<td>$0.00</td>
<td>$22.50</td>
<td>$10.00</td>
</tr>
<tr>
<td>392-MU</td>
<td>Benefit Stage Count</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>393-MV</td>
<td>Benefit Stage Qualifier</td>
<td>03 (GAP)</td>
<td>03 (GAP)</td>
<td>03 (GAP)</td>
</tr>
<tr>
<td>394-MW</td>
<td>Benefit Stage Amount</td>
<td>$100.00</td>
<td>$100.00</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

#### COB/Other Payments Segment sent to tertiary plan (not Med D) – Other Payer Amount Paid Billing

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Non-LIS</th>
<th>LIS 1</th>
<th>LIS 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>337-4C</td>
<td>Coordination of Benefits/Other Payments Count</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>338-5C</td>
<td>Other Payer Coverage Type</td>
<td>01</td>
<td>01</td>
<td>01</td>
</tr>
<tr>
<td>339-6C</td>
<td>Other Payer ID Qualifier</td>
<td>03</td>
<td>03</td>
<td>03</td>
</tr>
<tr>
<td>340-7C</td>
<td>Other Payer ID</td>
<td>123456</td>
<td>123456</td>
<td>123456</td>
</tr>
<tr>
<td>443-E8</td>
<td>Other Payer Date</td>
<td>20120101</td>
<td>20120101</td>
<td>20120101</td>
</tr>
<tr>
<td>341-HB</td>
<td>Other Payer Amount Paid Count</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>342-HC</td>
<td>Other Payer Amount Paid Qualifier</td>
<td>07</td>
<td>07</td>
<td>07</td>
</tr>
<tr>
<td>341-DV</td>
<td>Other Payer Amount Paid</td>
<td>$75.00</td>
<td>$75.00</td>
<td>$75.00</td>
</tr>
<tr>
<td>338-5C</td>
<td>Other Payer Coverage Type</td>
<td>02</td>
<td>02</td>
<td>02</td>
</tr>
<tr>
<td>339-6C</td>
<td>Other Payer ID Qualifier</td>
<td>03</td>
<td>03</td>
<td>03</td>
</tr>
<tr>
<td>340-7C</td>
<td>Other Payer ID</td>
<td>987654</td>
<td>987654</td>
<td>987654</td>
</tr>
<tr>
<td>443-E8</td>
<td>Other Payer Date</td>
<td>20120101</td>
<td>20120101</td>
<td>20120101</td>
</tr>
<tr>
<td>341-HB</td>
<td>Other Payer Amount Paid Count</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>342-HC</td>
<td>Other Payer Amount Paid Qualifier</td>
<td>07</td>
<td>07</td>
<td>07</td>
</tr>
<tr>
<td>341-DV</td>
<td>Other Payer Amount</td>
<td>$22.50</td>
<td>$22.50</td>
<td>$10.00</td>
</tr>
<tr>
<td>392-MU</td>
<td>Benefit Stage Count</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>393-MV</td>
<td>Benefit Stage Qualifier</td>
<td>03 (GAP)</td>
<td>03 (GAP)</td>
<td>03 (GAP)</td>
</tr>
<tr>
<td>394-MW</td>
<td>Benefit Stage Amount</td>
<td>$100.00</td>
<td>$100.00</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

---

**Rule 1**

**Rule 2**
21.7 BENEFIT STAGE QUALIFIER VALUES TO IDENTIFY CLAIMS COVERED UNDER THE NOT PART D PORTION OF THE MEDICARE D PLAN

Benefit Stage Qualifier values to identify claims covered under the Not Part D portion of the Medicare D plan, and eliminate the need for separate BIN/PCN processing requirements. The distinct Benefit Stage qualifier values identify the claim as covered under the Part C, Enhanced EGWP or co-administered supplemental portion of the Medicare D plan benefit. The distinct Benefit Stage Qualifier value would also be transmitted to the downstream Medicare D supplemental or SPAP plan, allowing the payer to determine if the claim was covered under the Part D, Part C, etc. benefit.

Note: It is important to remember that Benefit Stage Qualifiers (BSQ) have changed since inception and effective dates for implementation should be reviewed as to which BSQ should be used when.

<table>
<thead>
<tr>
<th>Claim Submitted Under Part D BIN/PCN</th>
<th>Benefit Stage Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part D Deductible</td>
<td>01 - Deductible</td>
</tr>
<tr>
<td>Part D Initial Benefit</td>
<td>02 - Initial Benefit</td>
</tr>
<tr>
<td>Part D Coverage Gap</td>
<td>03 - Coverage Gap</td>
</tr>
<tr>
<td>Part D Catastrophic</td>
<td>04 - Catastrophic</td>
</tr>
<tr>
<td>Part D Enhanced or OTC (E and O drugs)</td>
<td>Benefit Stage Not Reported</td>
</tr>
<tr>
<td>Medicare Advantage portion of MA-PD (Part C)</td>
<td>50 - Not Paid Under Part D, Paid Under Part C</td>
</tr>
<tr>
<td>Supplemental portion of Primary claim or paid as a Co-administered benefit (e.g. EGWP, Commercial Wrap, SPAP)</td>
<td>60 - Not Paid Under Part D, Paid Under Supplemental Benefit Only</td>
</tr>
</tbody>
</table>

- **Rules for New values:**
  a) The new benefit stage qualifiers are intended to be used on a standalone basis. The Benefit Stage Count would always be 1, when the new qualifiers (50, 60, 70, 80) are used.
  b) Whenever either of these qualifiers is used, the corresponding benefit stage amount should be populated with the total amount of the claim.

- **Rules for value = 50:**
  a) The phase qualifier = 50 (Not paid under Part D, paid under Part C) should be used in the following situations only:
     - This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN
     - The claim is NOT paid by the Part D plan benefit.
     - The claim IS paid for by Part C benefit (MA portion of the MA-PD).
     - When the qualifier value of 50 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
     - The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.

- **Rules for value = 60:**
  a) The Phase qualifier = 60 (Not Paid under Part D, Paid under supplemental benefit only) should be used in the following situations only
     - This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided.
     - This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit).
     - The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.
• When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.

• **Rules for value = 70:**
  a) The Phase qualifier = 70 (Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing)
     - This qualifier applies to co-administered claims where claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.
     - The claim is for a Part D drug, but is NOT paid by the Part D plan benefit (e.g. drug is non-formulary, quantity limit or step therapy required). The beneficiary is provided access to a negotiated discount rate (e.g. discount card).
     - There is only beneficiary payment on these claims (505-F5 Patient Pay Amount).
     - When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
     - The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid (would be zero in this instance), and 566-J5 Other Payer Amount Recognized (would be zero instance)) of the claim.

• **Rules for value = 80:**
  a) The Phase qualifier = 80 (Non-Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing)
     - This qualifier applies to co-administered claims where claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.
     - The claim is for drug NOT covered by Part D that is NOT paid by the Part D plan benefit (e.g. drug is non-formulary, quantity limit or step therapy required). The beneficiary is provided access to a negotiated discount rate (e.g. discount card).
     - There is only beneficiary payment on these claims (505-F5 Patient Pay Amount).
     - When the qualifier value of 80 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
     - The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid (would be zero in this instance), and 566-J5 Other Payer Amount Recognized (would be zero instance)) of the claim.

**Business Cases Supporting Need for New Benefit Stage Qualifiers:**

1) Medicare D MA-PD Plan – Part D and Part C BIN/PCNs (addressed with Benefit Stage Qualifier = 50)
   a) Pharmacy cannot determine whether claim is covered under the Part D or Part C benefit, to be able to determine whether claim should be submitted under the Part D or Part C BIN/PCN.
      - If/When Part C BIN/PCN is known, this will result in multiple active plan codes for single Medicare D plan benefit in the patient’s profile, significantly increasing risks of rejects.
   b) Processor determines whether claim is covered under Part D or Part C.
      - If claim is submitted to Part B BIN/PCN, claim may be accepted under Part C and should have been accepted under Part D.
      - Multiple ID cards required, or both Part D and Part C BIN/PCNs must be printed on the same ID card, and require continued maintenance.
      - Part C BIN/PCN not returned on Medicare D E1 response.
      - Even if required BIN/PCN is returned on the rejected response, not all pharmacy systems would be automated to ensure the claim was processed to the applicable BIN/PCN. Relying on manual processes, to read and react to reject detail, will result in customer service issues.
   c) Medicare D Supplemental plans still lacking Part D or Part C identifier on COB claims.
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d) Medicaid plans lacking MA-PD identifier on COB claims to determine dual eligible beneficiary is enrolled in a Medicare Advantage plan versus Medicare B FFS. Since member is not enrolled in the Medicare FFS plan, the non-real-time auto-cross process would not occur.
   - An MA-PD (Part C) identifier would provide the necessary trigger for Medicaid processor to accept the NCPDP point of service COB claim, versus rejecting as Submit to Primary and inappropriately expecting the Part B copay to process via the Medicare FFS auto-cross.

2) **EGWP Medicare D Plan with Enhanced Benefits** *(addressed with Benefit Stage Qualifier = 60)*
   a) Pharmacy cannot determine whether claim is covered under the Part D or EGWP Enhanced benefit, to be able to determine whether claim should be submitted under the Part D or alternate BIN/PCN.
      - If/When alternate B BIN/PCN is known, this will result in multiple active plan codes for single Medicare D plan benefit in the patient’s profile, significantly increasing risks of rejects.
   b) Processor determines whether claim is covered under Part D or EGWP Enhanced benefit.
      - If claim is submitted to alternate BIN/PCN, claim may be accepted under EGWP Enhanced and should have been accepted under Part D.
      - Multiple ID cards required, or both Part D and Alternate (EGWP Enhanced) BIN/PCNs must be printed on the same ID card, and require continued maintenance.
      - Alternate BIN/PCN not returned on Medicare D E1 response.
      - Even if required BIN/PCN is returned on the rejected response, not all pharmacy systems would be automated to ensure the claim was processed to the applicable BIN/PCN. Relying on manual processes, to read and react to reject detail, will result in customer service issues.
   c) Medicare D Supplemental plans still lacking Part D or Not Part D identifier on COB claims.

3) **Medicare D Plan + co-administered supplemental payer** *(addressed with Benefit Stage Qualifier = 60)* *(Same processor administering both benefits where one pharmacy response is provided).*
   a) Claim submitted under the Medicare D BIN/PCN and is not covered under the Medicare D benefit, but is fully covered under the co-administered benefit that is supplemental to Part D.
      - Pharmacy cannot determine whether claim is covered under the Part D or co-administered benefit, to be able to determine whether claim should be submitted under the Part D or alternate BIN/PCN.
      - Processor may not be able to accept POS primary or OCC3 COB claim for co-administered benefit.
      - If/When alternate B BIN/PCN for co-administered benefit is available, this will result in multiple active plan codes for single Medicare D plan benefit in the patient’s profile, significantly increasing risks of rejects, or duplicate claims.
      - Claims paid under the co-administered benefit lacking a specific identifier to determine that claim did not pay under Part D even though it was submitted to Part D BIN/PCN.

**Additional Analysis:**

**D.0 Structure:** The Benefit Stage Qualifier Count Max is 4, however adding the 50 or 60 qualifiers would not present a risk of increasing the count, as these business cases are only used when the claim is not paid under Part D and therefore would not overlap stages and the Benefit Stage Count would be 1.

**Consistency with Current Approach:** The addition of these new values for Benefit Stage Qualifier is consistent with the rules currently in place for this field, as specified in the NCPDP Telecom Implementation Guide (section “Claim Billing or Encounter Information”), and copied below for reference. In other words, the Benefit Stage Qualifier and Benefit Stage Amount fields will continue to be blank if the member is not in a Medicare Part D program.

From NCPDP Telecommunication Implementation Guide:

<table>
<thead>
<tr>
<th>Code</th>
<th>Field Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>393-MV</td>
<td>BENEFIT STAGE QUALIFIER</td>
<td>Q<em><strong>R</strong></em> Claim Billing/Encounter: Required if Benefit Stage Amount (394-MW) is used. Must only have one value per iteration - value must not be repeated.</td>
</tr>
<tr>
<td>394-MW</td>
<td>BENEFIT STAGE AMOUNT</td>
<td>Q<em><strong>R</strong></em> Claim Billing/Encounter: Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a</td>
</tr>
</tbody>
</table>

Version 48
November 2019
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Page: 264
Excessive (orphan) Information Reporting (N) Transactions: There has been some discussion regarding excessive (orphan) N transactions. The proposed new Benefit Stage Qualifier values provide a mechanism to address some of these concerns. The Information Reporting Task Group will address how to use these new Benefit Stage Qualifier values to reduce excessive (orphan) N transactions.

Summary:
To eliminate the risks associated to the above business cases, DERF 1005 (approved 05/2011) requests new Benefit Stage Qualifiers to identify claims submitted to a Part D BIN/PCN covered by entities other than Part D.

- This eliminates the need for separate BIN/PCN processing requirements for the situations identified above. In addition, this proposal helps identify the payment source for claims paid under co-administered benefits.
- The distinct Benefit Stage Qualifier value would also be transmitted to the downstream Medicare D supplemental or Medicaid FFS plan, allowing the plan to determine if the claim was covered under the Part D, Part C, etc. benefit. The information currently provided in the Other Payer ID field would also remain consistent to the beneficiary, eliminating confusion by the downstream payer when validating against their TPL eligibility file, that the appropriate plan was billed as primary.

RISK – CMS has indicated that EGWP’s should be treated like Part D plans and only cover Part D allowable drugs. Since there is not clear guidance to refer to presently, the approach to allow these claims to be submitted through the Part D BIN/PCN is being allowed with the indication in the response that these are not Part D covered drugs. Guidance may be forthcoming which may no longer allow this approach and could be retroactive.

NOTE: These new values may not be utilized prior to 01/01/2012 due to potential negative impact to downstream payers.

NOTE: In 05/2012 enhancements were approved to the Benefit Stage Qualifier values and will be effective 01/01/2013. These are shown in section “Benefit Stage Implementation for 01/01/2013”.

21.8 BENEFIT STAGE IMPLEMENTATION FOR 01/01/2013
Effective Date: January 1, 2013
In 05/2012, DERF 001056/Emergency ECL 000111 was approved, with an effective date of 01/01/2013. Implementation Recommendations:
1. Benefit Stage Qualifier (393-MV) value 60 (Not paid under Part D, paid as or under a supplemental benefit only) and the use of Approved Message Code field (548-6F) value 018 (Provide Beneficiary With CMS Notice Of Appeal Rights) with value 60 will be sunset as of 01/01/2013.
   a. Benefit Stage Qualifier (393-MV) value 60 would only be available for use on claims with dates of service of 12/31/2012 and prior.
2. New Benefit Stage Qualifier (393-MV) values 61 or 62 to replace the value of 60 are available for use as of 01/01/2013.
3. New Benefit Stage Qualifier (393-MV) value 90 is available for use as of 01/01/2013.

Benefit Stage Qualifier (393-MW) values: (yellow marks revision or addition)

<table>
<thead>
<tr>
<th>Value</th>
<th>Description prior to 01/01/2013</th>
<th>Revised Description as of 05/2012 DERF 001056/Emergency ECL 000111. Effective 01/01/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Not paid under Part D, paid under Part C benefit (for MA-PD plan)</td>
<td>No change.</td>
</tr>
<tr>
<td></td>
<td>• This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The claim is NOT paid by the Part D plan benefit</td>
<td></td>
</tr>
</tbody>
</table>
**Telecommunication Version D and Above Questions, Answers and Editorial Updates**

- The claim IS paid for by Part C benefit (MA portion of the MA-PD)
- When the qualifier value of 50 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
- The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-FS Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim

<table>
<thead>
<tr>
<th>Qualifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>60</strong></td>
<td>Not paid under Part D, paid as or under a supplemental benefit only</td>
</tr>
<tr>
<td>-</td>
<td>This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided.</td>
</tr>
<tr>
<td>-</td>
<td>This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit)</td>
</tr>
<tr>
<td>-</td>
<td>The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.</td>
</tr>
<tr>
<td>-</td>
<td>When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</td>
</tr>
<tr>
<td>-</td>
<td>The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-FS Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim</td>
</tr>
<tr>
<td><strong>61</strong></td>
<td>Part D drug not paid by Part D plan benefit, paid as or under a co-administered benefit only</td>
</tr>
<tr>
<td>-</td>
<td>This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.</td>
</tr>
<tr>
<td>-</td>
<td>The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit.</td>
</tr>
<tr>
<td>-</td>
<td>When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</td>
</tr>
<tr>
<td>-</td>
<td>The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-FS Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim</td>
</tr>
<tr>
<td><strong>62</strong></td>
<td>Non-Part D/non-qualified drug not paid by Part D plan benefit, paid as or under a co-administered benefit only</td>
</tr>
<tr>
<td>-</td>
<td>This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided.</td>
</tr>
<tr>
<td>-</td>
<td>The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit.</td>
</tr>
<tr>
<td>-</td>
<td>When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.</td>
</tr>
<tr>
<td>-</td>
<td>The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-FS Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim</td>
</tr>
</tbody>
</table>

Not paid under Part D, paid as or under a supplemental benefit only

- This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided. |
- This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit) |
- The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. |
- When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. |
- The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-FS Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim |
- Since 60 is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur:
  1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value 018 – “Provide Beneficiary With CMS Notice Of Appeal Rights” |
  2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 60 will be returned without the Approved Message Code value of 018. |

Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug. Benefit Stage Qualifier (393-MV) value 60 would only be available for use on claims with dates of service of 12/31/2012 and prior.

**Benefit Stage Qualifier (393-MV) value 60 would only be available for use on claims with dates of service of 12/31/2012 and prior.**

**Benefit Stage Qualifier (393-MV) values 61 or 62 to replace the value of 60 are available for use as of 01/01/2013.**
| 70 | Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing  
  • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non-formulary, quantity limit, etc.)  
  • When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.  
  • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 509-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim. | Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing  
  • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non-formulary, quantity limit, etc.)  
  • When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.  
  • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 509-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim. |
| 80 | Non-Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing  
  • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered under Part D law (i.e. excluded drugs).  
  • When the qualifier value of 80 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.  
  • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 509-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim. | Non-Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing  
  • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered under Part D law (i.e. excluded drugs).  
  • When the qualifier value of 80 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.  
  • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 509-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim. |
| 90 | Enhanced or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan  
  • When the qualifier value of 90 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.  
  • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 509-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim. | Benefit Stage Qualifier (393-MV) value 90 is available for use as of 01/01/2013. |

**21.9 BENEFIT STAGE IMPLEMENTATION FOR 07/01/2013**

**Effective Date: July 1, 2013**

In 11/2012, DERF 001098/Emergency ECL 000132 was approved, with an effective date of 07/01/2013. This DERF/ECL modified Approved Message Code (548-6F) value “018” and associated changes to Benefit Stage Qualifier.

1. CMS has determined the notice, “Medicare Prescription Drug Coverage and Your Rights,” should only be returned in the following instance.
   a. When the Part D drug not paid by Part D plan benefit, is paid by the beneficiary under plan-sponsored negotiated pricing. Plan-sponsored negotiated pricing refers to drugs not covered under the insured benefit design but are offered to beneficiaries under a negotiated discounted price. In this scenario, the beneficiary’s out-of-pocket expense is 100% of the plan’s negotiated discounted pricing with the pharmacy.

2. Prescription Drug Benefit Manual, Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals will be updated by CMS.

3. Approved Message Code value “018” is only applicable for certain values of Benefit Stage Qualifier.

Approved Message Code (548-6F)
### Benefit Stage Qualifier (393-MW) values: *(yellow* marks revision or addition)*

<table>
<thead>
<tr>
<th>Value</th>
<th>Description prior to 07/01/2013</th>
<th>Revised Description as of 11/2012 DERF 001098/Emergency ECL 000132. Effective 07/01/2013</th>
</tr>
</thead>
</table>
| 50    | Not paid under Part D, paid under Part C benefit (for MA-PD plan)  
• This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN  
• The claim is NOT paid by the Part D plan benefit  
• The claim IS paid for by Part C benefit (MA portion of the MA-PD)  
• When the qualifier value of 50 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.  
• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim | No change.  
• This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.  
• This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit)  
• The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.  
• When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.  
• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim  
• Since 60 is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur:  
  1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value 018 – “Provide Beneficiary With CMS Notice Of Appeal Rights”  
  2. For non Part D/non-qualified drugs Benefit Stage Qualifier 60 will be returned without the Approved Message Code value of 018.  
Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.  
Benefit Stage Qualifier (393-MV) value 60 would only be available for use on claims with dates of service of 12/31/2012 and prior. |  
| 60    | Not paid under Part D, paid as or under a supplemental benefit only  
• This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.  
• This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit)  
• The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.  
• When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.  
• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim  
• Since 60 is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur:  
  1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value 018 – “Provide Beneficiary With CMS Notice Of Appeal Rights”  
  2. For non Part D/non-qualified drugs Benefit Stage Qualifier 60 will be returned without the Approved Message Code value of 018.  
Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.  
Benefit Stage Qualifier (393-MV) value 60 would only be available for use on claims with dates of service of 12/31/2012 and prior. | Part D drug not paid by Part D plan benefit, paid as or under a co-administered **insured** benefit only  
• This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.  
• The claim is **NOT** paid by the Part D plan benefit but is paid under the co-administered benefit.  
• When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.  
• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim |
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- The Approved Message Code field (548-6F) must be returned with a value 018 – “Provide Beneficiary With CMS Notice Of Appeal Rights”

Benefit Stage Qualifier (393-MV) values 61 or 62 to replace the value of 60 are available for use as of 01/01/2013.

62 Non-Part D/non-qualified drug not paid by Part D plan benefit, paid as or under a co-administered benefit only
- This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided.
- The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit.
- When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
- The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim.

Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.

Benefit Stage Qualifier (393-MV) values 61 or 62 to replace the value of 60 are available for use as of 01/01/2013.

60 No change.

70 Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing
- This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non-formulary, quantity limit, etc.)
- When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
- The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim.
- For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value 018 – “Provide Beneficiary With CMS Notice Of Appeal Rights”

Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing
- This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non-formulary, quantity limit, etc.)
- When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
- The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim.
- For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value 018 – “Provide Beneficiary With CMS Notice Of Appeal Rights”

No change.

80 Non-Part D drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing
- This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the drug is not covered under Part D law (i.e. excluded drugs).
- When the qualifier value of 80 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
- The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim.

No change.

90 Enhanced or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan
- When the qualifier value of 90 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
- The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-JS Other Payer Amount Recognized) of the claim.

Benefit Stage Qualifier (393-MV) value 90 is available for use as of 01/01/2013.

No change.

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### 21.11 Impact on Downstream Payer for Alternative/Formulary

**Question/Statement:**
NCPDP needs to consider the impact to the downstream payer due to the beneficiary not being steered towards a therapeutic alternative medication or a drug that is on the formulary.

**Response:**
Based on the 4Rx Guidance, and the Medicare D plan’s benefit design, the claim may be paid under the Medicare D unique BIN/PCN, but not paid under Part D. New Benefit Stage Qualifier (393-MW) values 50, 60, 70 and 80 were added the External Code List to address these situations. These values were approved through the Emergency ECL process and are effective January 01, 2012. Benefit Stage Qualifier values 70 and 80 are used when the claim is paid by the beneficiary under the plan-sponsored negotiated pricing. Supplemental payers who meet the situation as defined in the NCPDP Telecommunication vD.0 Implementation Guide, may request the Benefit Stage fields to be submitted on coordination of benefit claims. The supplemental payer may leverage the Benefit Stage Qualifiers (353-MW) to determine their coverage rules. **Note value 60 (to be replaced by two new values) is sunsetting as of 01/01/2013 and the clarifications to 70, 80, and the new values are to be used by 01/01/2013.**

### 21.12 Other Impacts to Benefit Stage?

**Question/Statement:**
NCPDP will also need to flow through the following examples

- B vs. D drugs to determine how this negotiated pricing would be NOT applied and still force the claim to be billable under B.
- Hospice drugs billable under Medicare Part A and make sure that these drugs are not sent through negotiated pricing and still billable under A.
- Claims using patient location code/patient residence and ensuring these rules apply before negotiated pricing.

**Response:**
If there is other coverage under other components of Medicare, these claims would not be appropriate for negotiated pricing or discount card. ECL descriptions for Benefit Stage Qualifier 80 will be modified to reflect this detail. See section “*Benefit Stage Implementation for 01/01/2013*”.

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[Table of values and descriptions before 10/1/2014 and revised descriptions as of 10/1/2014]

<table>
<thead>
<tr>
<th>Value</th>
<th>Description prior to 10/1/2014</th>
<th>Revised Description as of 10/1/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>No change.</td>
<td>No change.</td>
</tr>
<tr>
<td>60</td>
<td>No change.</td>
<td>No change.</td>
</tr>
<tr>
<td>61</td>
<td>No change.</td>
<td>No change.</td>
</tr>
<tr>
<td>62</td>
<td>No change.</td>
<td>No change.</td>
</tr>
</tbody>
</table>
| 63    | Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid under Medicaid benefit only of the Medicare/Medicaid (MMP) plan.  
  - This qualifier applies to Medicare/Medicaid (MMP) plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.  
  - The claim is NOT paid by the Part D plan benefit but is paid under the Medicaid benefit only of the Medicare/Medicaid (MMP) plan.  
  - When the qualifier of 63 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.  
  - The field 394-MW Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. **Note: Non-qualified drugs are defined as not meeting the definition of Part D drug.** | Added |
| 70    | No change.                      | No change.                          |
| 80    | No change.                      | No change.                          |
| 90    | No change.                      | No change.                          |
21.13 **PART D SPONSOR TRANSITION NOTICE OR DENIAL LETTER?**

**Question:** Beneficiary with medication not covered under Medicare Part D where the discounted price is provided to the beneficiary. An appeal notice goes to the beneficiary. Will the Part D sponsor still send their transition notices or their denial letters for the drug not on the formulary or limited by clinical criteria?

**Response:**
- **Within transition**
  1. Transition notices are only sent when the drug is paid.
  2. Benefit Stage Qualifiers 1-4 would be sent.
  3. Applies to TrOOP.
- **Outside transition**
  The beneficiary would receive the Standardized Pharmacy Notice (CMS -10147) for Appeal when the claim is paid under the Medicare D unique BIN/PCN for the specific situations outlined in the grid in section “Benefit Stage Implementation for 01/01/2013” where Approved Message Code 018 is referenced.
  1. Transition notice is not sent.
  2. Does not apply to TrOOP.

21.14 **BENEFIT STAGE REQUIRED FOR PART D?**

21.14.1 **CAN NON-GOVERNMENT PROCESSOR REQUIRE?**

**Question:** Can a non-government processor make the Benefit Stage fields required if patient has Medicare Part D? In other words, if a pharmacy submits to Medicare Part D, and then attempts a COB claim (based on Other Payer-Patient Responsibility Amounts and OCC=8) to us, will we know the patient has Medicare Part D? If we cannot receive the Benefit Stage fields, is there any other way to know that the patient is covered by Medicare Part D?

**Response:**
NCPDP Telecommunication Standard vD.0 defines the situations in which the Benefit Stage fields can be requested for COB claim billing as:
- When the plan is a participant in the Medicare D program that requires reporting of the benefit stage specific financial amounts or;
- Required if necessary for state/federal/regulatory agency programs

The sum of the Benefit Stage Amounts, reflect the allowed amount or contracted rate between the Medicare D plan and the provider. To comply with the defined situations and to prevent un-authorized disclosure of contractual financial information, a non-government program or a program that does not participate in the Medicare D patient financial reporting process (e.g. TrOOP) cannot require the Benefit Stage fields be submitted on COB claims.

Neither the NCPDP Telecommunication Standard vD.0 nor the most current ECL publication contain a field or value available to the B1 claim billing transaction that would identify the patient as Medicare D eligible. The COB claim billing transaction does support the Other Payer ID (340-7C) and the Other Payer ID Qualifier (339-6C). The values submitted in these fields, may assist in identifying the previous payer as a Medicare D plan.

Other Payer ID – ID assigned to the payer
Other Payer ID Qualifier – Code Qualifying the Other Payer ID
Other Payer ID Qualifier Values (07/2011 ECL Publication)
  - 01 - National Payer ID-Code indicating that the information to follow is the National Payer Identifier mandated under HIPAA. This identification system is currently under development; therefore this Code is not in use
02 - Health Industry Number (HIN)-A 9 digit alphanumeric number used to identify health care entities such as veterinarians, animal clinics, and health care provider facilities. The number is assigned by HIBCC.

03 - Bank Information Number (BIN) Card Issuer ID or Bank ID Number assigned by ANSI used for network routing. Now defined by ANSI as the Issuer Identification Number (IIN). This may also be the Processor ID, assigned by NCPDP.

04 - National Association of Insurance Commissioners (NAIC)-A unique number for each company that does business in the United States as assigned by NAIC. A company may have multiple NAIC Codes to represent subsidiary companies under a main company.

05 - Medicare Carrier Number—A number assigned by the carrier or intermediary which administers the Medicare health insurance program. NOTE: This value is associated to Medicare Part B carriers and is not returned on the B1 claim response.

99 - Other-Different from those implied or specified

In the situation where the COB payer is not eligible to receive the Benefit Stage information but needs to know if Part D coverage applied, the following Other Payer ID options may address the business need:

• Option 1: Use Qualifier “03” where the BIN of the previous payer would always be transmitted. Note: Effective January 1, 2012 Medicare Part D Plans must use a unique BIN or BIN/PCN combination.

• Option 2: Use Qualifier “99” where the COB payer identifies the Other Payer ID values. To promote consistency in the industry, NCPDP recommends that the values be “MEDD” and “OTHER”. The provider must transmit appropriate value based on classification of previous payer. Provider may choose to leverage the response Benefit Stage Qualifiers “01” – “04” to determine that Part D coverage applied. Note: Pharmacy systems may not be able to automate this process.

The implementation of the National Health Plan ID (HPID) may provide a future solution.

21.14.2 **MEDICARE PART D CLAIM WITHOUT BENEFIT STAGE FIELDS?**

**Question:**
If the claim is paid under the Medicare D unique BIN/PCN, why doesn’t it include a Benefit Stage Qualifier and associated Benefit Stage Amount?

**Response:**
Prior to January 1, 2013 there may be situations where a Benefit Stage Qualifier would not be returned on a Part D claim. These situations should be limited to:

• Prior to July 1, 2012: The discretionary enforcement of HIPAA standards where compliant use of the NCPDP Telecommunication Standard Version D.0 was not enforced and some Version 5.1 claims were submitted.

• Prior to July 1, 2012: Benefit Stage Qualifier logic for a paid response may have been based on the implementation of the unique BIN/PCN; however CMS Regulatory requirement for unique 4Rx was not enforced until July 1, 2012. For more information see [Recommendations for Effective 4Rx Usage in Medicare Part D Processing](#).

• Prior to January 1, 2013: There is no Benefit Stage Qualifier available for enhanced and OTC drugs which are covered by the Part D Plan and do not count towards TrOOP.

All claims with Dates of Service as of January 1, 2013 paid under a Medicare Part D BIN/PCN should contain the applicable Benefit Stage Qualifier(s) and the associated Benefit Stage Amount(s). As a result the benefit stage information will be available for COB claims as required by law. Refer to the Benefit Stage Qualifier values in the External Code List and “Benefit Stage Implementation for 01/01/13” section.

21.15 **COVERAGE GAP AND AMOUNT ATTRIBUTED TO COVERAGE GAP**
Question:
When the Medicare D claim falls within the Coverage Gap benefit stage, should the Amount Attributed to Coverage Gap (137-UP) always be returned?

Response:
Please see section “Benefit Stage Rules”. Other than the condition outlined in # 4 below, when the claim falls within the Coverage Gap benefit stage, the Amount Attributed To Coverage Gap must be returned.

1. The sum of the benefit stage amounts must equal Patient Pay Amount (505-F5) plus Total Amount Paid (509-FN). There is an exception to this. See “Republication of Telecommunication Standard Implementation Guide Version D.0 August 2010”, subsection “Benefit Stage Formula”.

2. All benefit stage qualifiers and amounts should be based on where the member would have been in the benefit if they had been in the non LIS benefit. This will ensure the beneficiary is not hindered from receiving a benefit that might be available to them from a supplemental payer.

3. When the LIS benefit does not have a deductible, if the member would have been in the deductible stage in the non LIS benefit, return the Deductible Benefit Stage Qualifier (01) and applicable benefit stage amount. Return the LIS patient pay amount as Amount of Copay (518-FI) or Amount of Coinsurance (572-4U).

4. If the LIS benefit does not have a coverage gap and the member would have been in the coverage gap stage in the non LIS benefit, return the Coverage Gap Benefit Stage Qualifier (03) and applicable benefit stage amount. Report the LIS patient pay amount as Amount of Copay (518-FI) or Amount of Coinsurance (572-4U).

Question:
Does the Amount Attributed to Coverage Gap (137-UP) reflect the patient liability amount before or after the coverage gap discount applies?

Response:

- The components of the Patient Pay Amount must sum to the value reported in Patient Pay Amount (505-F5); therefore the value returned in the Amount Attributed to Coverage Gap (137-UP) should reflect the patient’s coverage gap liability amount after the required discount applies.

- Payers supplemental to Medicare D, requiring the components of Patient Pay to be submitted on the COB claim, when applicable (non-duals) would receive:
  a. The Other Payer Patient Responsibility Amount Qualifier of 12 (Amount Attributed to Coverage Gap)
  b. The associated Other Payer Patient Responsibility Amount as the amount after the coverage gap discount applied
  c. The Benefit Stage Qualifier of 03 (Coverage Gap)
  d. The associated Benefit Stage Amount as the full coverage gap amount prior to the discount

- Please refer to example # 5 under section “$50 Claim – Initial Coverage Limit of $2830 Already Met. Amount Remaining to Meet TrOOP is $2000”.

21.16 Non-Formulary Penalty and Coverage Gap

Question:
If the claim incurs a non-formulary penalty and also falls within the coverage gap, how should the components of patient pay be returned?

Response:
Non-formulary penalties no longer apply to Part D.

21.17 Vaccine Administration

Question:
In the v5.1 editorial document we speak to Vaccine Administration Claims for Medicare Part D and Usual and Customary. I am looking for guidance on the Vaccine Administration Claims and Usual and Customary going
forward. Does the recommendation carry forward from v5.1 where for just Medicare Part D that the Usual and Customary field includes the Vaccine Administration Fee? What about for a Commercial Vaccine Administration Claim, does the same apply; the vaccine administration fee is included in Usual and Customary? Need clarification for vD.0.

Response:
Medicare Part D should be handled the same way in version 5.1 and D.0. For all other payers - if the vaccine administration fee is part of the drug benefit cost, the Medicare Part D-based claim billing method can be used. If the vaccine administration fee is not part of the drug benefit cost, the claim billing is used for the drug benefit cost, and the service billing is to be used to bill the administration fee.

It is also suggested that instruction be added to the payer sheet for which way the payer does it.

21.18  BIN and PCN from Response to Request

Question:
Processors are to use the Response COB Segment to report other payer information to pharmacies. Today this is done in parsed messages (with Medicare Part D). When we parsed, the guidance was that BIN should always be 6 characters and PCN 10 – no truncation. If no PCN, it should still be reported as 10 spaces. Or if PCN less than 10, it should be padded with spaces to make the value 10.

Are we to assume that carries over to populating these fields in this segment? BIN is pretty straightforward because all BINs are 6 so while the Other Payer ID field takes 10, as long as we use the BIN Qualifier, the field size should be okay to truncate to 6.

But normally we recommend truncation – yet I think in the case of Other Payer Processor Control Number we probably should not.

Response:
In Version 5.1, the Other Health Insurance (OHI) is forced into a fixed length area. So if the Other Payer PCN is not used in this OHI environment, 10 spaces are returned. In Version D.0, the Other Payer PCN if not used, should not be sent – this is the recommendation. The pharmacy would submit the PCN on the subsequent claim header with blanks.

While not recommended, the processor could return the Other Payer PCN with spaces. Either way the pharmacy would submit the subsequent claim with a PCN of 10 spaces.

The alphanumeric padding rules of left justified and right filled must be followed.

For example –
the Other Payer BIN is “600429”,
the payer does not use a PCN,
so the Other Payer PCN field would be sent on the response as “” or not sent. Either way is correct, although the recommendation is to not send.

When the pharmacy submits a subsequent claim,
the header BIN contains 600429,
the PCN contains “”.

21.19  CMS’ Definition of Primary Insurer’s Payment

Question:
In the CMS instructions for MSP pricing and calculation rules, CMS refers to Primary Insurer’s payment or Primary payment in many of the rules for pricing the MSP claim. We are looking for an Industry consensus on CMS’s definition of Primary Insurer’s payment. We believe the following to be true but wanted to get the COB Task Groups thoughts.
Telecommunication Version D and Above Questions, Answers and Editorial Updates

When determining the amount the other payer(s) paid (Primary Insurer’s Payment) on MSP claims (claim examples attached):

The current processor should only sum/recognize the “like” amounts (qualifiers) that would be paid if paying as primary.

If the sum of Other Payer “like” amounts (qualifiers) that are recognized exceed the negotiated price (calculated as if paying as primary):

- Other Payer Amount Recognized on the pharmacy response is reduced to equal the Negotiated Total Cost
- Apply Other Payer Amount Recognized from pharmacy response to Member’s Drug Spend
- Report the sum of all Other Payer “like” amounts (including amounts exceeding Negotiated Total Cost) on the PDE in PLRO

The CMS MSP instructions are dated April 26, 2006. Section (17.4.2) contains the pricing and calculation rules.

Response:
Yes, primary insurer’s payment is based on other payer “like” amounts. This is accomplished by summarizing “like” Other Payer Amount Paid dollars across all prior payers and then using these values against current payers “like” contractual amounts to reduce the liability for the current payer (Part D).

<table>
<thead>
<tr>
<th>OTHER PAYER AMOUNT PAID QUALIFIER</th>
<th>Qualifier Field ID</th>
<th>Qualifier Value</th>
<th>Qualifier Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>342-HC 06</td>
<td>Cognitive Services</td>
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<tr>
<td>342-HC 05</td>
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<td></td>
</tr>
<tr>
<td>342-HC 01</td>
<td>Delivery</td>
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</tr>
<tr>
<td>342-HC 02</td>
<td>Shipping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>342-HC 03</td>
<td>Postage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>342-HC 04</td>
<td>Administrative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>342-HC 09</td>
<td>Compound Prep Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>342-HC 10</td>
<td>Sales Tax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>342-HC 07</td>
<td>Drug Benefit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This means Drug Benefit dollars paid by prior payers should be used to reduce Drug Benefit dollars (negotiated) that would be part of Part D if Part D was primary. Delivery dollars paid by prior payers would reduce delivery dollars paid by the current payer (Part D). If delivery is not part of the agreement with the current payer, the dollars paid for delivery by prior payers cannot be used to reduce the current payer’s liability.

<table>
<thead>
<tr>
<th>Pharmacy to Primary</th>
<th>Pharmacy to Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field</td>
<td>Qualifier</td>
</tr>
<tr>
<td>Ingredient Cost</td>
<td></td>
</tr>
<tr>
<td>Dispensing Fee</td>
<td></td>
</tr>
<tr>
<td>Incentive Amount</td>
<td>$25.00</td>
</tr>
<tr>
<td>Flat Sales Tax</td>
<td>$6.00</td>
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<tr>
<td>Other Amount Claimed</td>
<td>$10.00</td>
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<tr>
<td>Other Amount Claimed</td>
<td>$1.25</td>
</tr>
<tr>
<td>Other Amount Claimed</td>
<td>$3.25</td>
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<tr>
<td>Gross Amount Due</td>
<td>$158.00</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>COB Loop #1</th>
<th>Other Payer Amount</th>
<th>Other Payer Amount</th>
<th>Other Payer Amount</th>
<th>Other Payer Amount</th>
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</thead>
<tbody>
<tr>
<td>01 - Delivery</td>
<td>Primary</td>
<td>$9.00</td>
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<td>02 - Shipping</td>
<td>Primary</td>
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<td>Primary</td>
<td>$0.00</td>
</tr>
<tr>
<td>03 - Postage</td>
<td>Primary</td>
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<td>Primary</td>
<td>$0.00</td>
</tr>
<tr>
<td>05 - Incentive</td>
<td>Primary</td>
<td>$20.00</td>
<td>Primary</td>
<td>$82.00</td>
</tr>
<tr>
<td>07 - Drug Benefit</td>
<td>Primary</td>
<td>$82.00</td>
<td>Primary</td>
<td>$5.00</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Response</th>
<th>Secondary Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field</td>
<td>Qualifier</td>
</tr>
<tr>
<td>Ingredient Cost</td>
<td></td>
</tr>
</tbody>
</table>
Dispensing Fee Paid $2.00
Dispensing Fee Paid $2.00
Flat Sales Tax Amount Paid $5.00
Flat Sales Tax Amount Paid $4.50
Incentive Amount Paid $20.00
Incentive Amount Paid $15.00
Other Amount Paid 01 - Delivery $9.00
Other Amount Paid 01 - Delivery $0.00
Other Amount Paid 02 - Shipping $0.00
Other Amount Paid 02 - Shipping $0.00
Patient Pay Amount $25.00
Other Amount Paid 03 - Postage $0.00
Other Amount Paid 03 - Postage $0.00
Other Amount Paid 03 - Postage $0.00
Other Amount Paid 03 - Postage $0.00
Other Payer Amount Recognized $101.50
Other Payer Amount Recognized $0.00
Patient Pay Amount $25.00
Patient Pay Amount $0.00
Total Amount Paid $116.00
Total Amount Paid $0.00
Benefit Stage 02 - Initial Coverage $101.50

PDE FIELDS

<table>
<thead>
<tr>
<th>Value Suggested</th>
<th>Value Definition (required)</th>
<th>Value Explanation (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>620</td>
<td>This Product/Service may be covered under Medicare Part D</td>
<td></td>
</tr>
<tr>
<td>621</td>
<td>This Medicaid Patient is Medicare Eligible</td>
<td>This patient is eligible for Medicare but may not yet be enrolled. If no enrollment found attempt to use Medicare's temporary prescription drug program.</td>
</tr>
<tr>
<td>A6</td>
<td>This Product/Service May Be Covered Under Medicare Part B</td>
<td>This Product/Service May Be Covered Under Medicare Part B and Therefore May Not Be Covered Under the Medicare Part D Basic Benefit for This Beneficiary</td>
</tr>
</tbody>
</table>

21.20 DUAL ELIGIBILITY

Question:
How does the NCPDP Telecommunication Standard support the communication of the primary Medicare D plan 4-RX data when a Medicaid beneficiary is flagged as a dual eligible?

Response:
Reject Code “41” (Submit to Primary Payer) and “AE” (QMB-Bill Medicare) are currently available to indicate patient has other coverage or is Medicare eligible. Since these Reject Codes do not uniquely identify a dual eligible beneficiary, DERF/ECL 001082/000126 was approved in August 2012 to provide the following Reject Code changes:

In the situation where Medicaid agencies/processors are aware that a patient also has Medicare eligibility (i.e. Dual Eligible), it is recommended that the processor return a more specific NCPDP Reject Code than “41” (Submit to primary payer). The above Reject Codes should be used as of the October 2013 annual ECL implementation.

Prior to the October 2013 annual ECL implementation, it is recommended that NCPDP Reject Code value of “41” (Submit to Primary Payer) or “AE” (QMB – bill Medicare) be returned.

If the Medicaid Program can distinguish between Part B and Part D drugs, the appropriate NCPDP Reject Code should be returned (A6-Part B or 620-Part D).
If the Medicaid Program cannot distinguish between Part B and Part D drugs, the Medicaid Processor should return the more generic NCPDP Reject Code of “621” (This Medicaid patient is Medicare eligible).

When Reject Codes “AE”, “41”, “A6”, “620” or “621” are used as referenced above, the following freeform message should also be returned in Additional Message Information (526-FQ) (with appropriate qualifiers): “SUBMIT MEDICARE ELIGIBILITY INQUIRY (E1); IF ENROLLMENT IS NOT FOUND, SUBMIT TO THE MEDICARE LIMITED INCOME NET PROGRAM – BIN 015599 PCN 05440000. HELP DESK: 800-783-1307”.

Note: The above text is specific to the 2012 Medicare Limited Income Newly Eligible Transition Program.

21.21 PART D SPONSORS APPLYING MEDICARE SECONDARY PAYER (MSP) REQUIREMENTS

Question:
How should Part D sponsors address the following CMS guidance found within Medicare Prescription Drug Manual, Chapter 14 revised 8/23/2013, in section 50.12 Applying Medicare Secondary Payer (MSP) Requirements?

…. absent information on the COB file that Part D is secondary for a Part D enrollee, should the sponsor receive a secondary claim, the claim cannot be paid. Instead, the sponsor should determine if the enrollee has coverage that is primary to Medicare and, if so, report this information to the COB contractor via ECRS to update CMS.

Response:
The following recommendations are based on review of current guidance and discussions with CMS.

1. When plan has established it should only pay primary and:
   a. Pharmacy submits a primary claim.
      i. The Medicare Part D processor would adjudicate based on plan coverage rules.
   b. Pharmacy submits a COB claim with Other Coverage Code value of “2” or “3” or “4”:
      i. The Medicare Part D Plan must reject the COB claim. Until a new Reject Code value is available, use Reject Code “7M” (Discrepancy Between Other Coverage Code And Other Coverage Information On File).
         1. August 2014 note: A DERF will be submitted for a new Reject Code (Plan enrollment file does not indicate other coverage primary to Medicare).
      ii. The plan should also return the additional message “Instruct patient to call Medicare at 1-800-MEDICARE to report changes in other coverage” unless the primary payer rejected for coverage termination reasons.
         a. If the plan is able to establish credible primary coverage other than Part D that is not Workers’ Compensation, Black Lung or liability, sponsors may report this information through the Electronic Correspondence Referral System (ECRS)
            i. To report drug coverage, use an ECRS Prescription Drug Inquiry.

2. When the plan has established it should only pay secondary (MSP) and:
   a. Pharmacy submits a primary claim.
      i. The plan must reject the claim with Reject Code “41” (Submit to Primary) and return available OHI information in the Response COB/Other Payers Segment and/or the Additional Message Field.
   b. Pharmacy submits COB claim with OCC “2” or “4”.
      i. The Medicare Part D processor would adjudicate based on plan coverage rules.
   c. Pharmacy submits COB claim with OCC “3”.
      i. For claims processing, the Medicare Part D processor would adjudicate based on plan coverage rules.
      ii. For eligibility maintenance the plan should follow their established process for determining whether MSP requirements continue to apply (e.g. claims where other payer reject code indicates other coverage has terminated).
When the plan sponsor has established that MSP no longer applies, as directed in CMS guidance the Part D plan should report this information to the COBC contractor via ECRS.

i. To report drug coverage, use an ECRS Prescription Drug Inquiry. (Refer to CMS guidance for the reporting of credible coverage other than Part D.)

ii. To update an existing drug record, use an ECRS Prescription Drug Assistance Request.


21.22 PRESCRIBER IDENTIFICATION

21.22.1 FOREIGN PRESCRIBER IDENTIFIER

Question:
For Medicare Part D pharmacy claims, where can I obtain information about the proper identifier qualifier value to use for a foreign prescriber?

Response:

Prior to July 1, 2012, it is appropriate to use the value “08” State License qualifier for a foreign prescriber. The new value of “17” (Foreign Prescriber Identifier = a value used to identify a prescriber who practices outside of the United States and does not have a prescriber identifier issued from within the United States) was approved January 2012 and is available for use July 1, 2012. Please see the Emergency ECL document at http://www.ncpdp.org/Members/Standards-Lookup

Question:
Must the Part D Sponsor reject the Part D claim submitted with a foreign prescriber ID?

Response:
Note the ability for a foreign prescriber to write a prescription that is valid under state law is only relevant in a couple of states.

1. If there isn’t an active and valid NPI for the foreign prescriber and the claim is submitted with a Prescriber ID Qualifier value of “17” (Foreign Prescriber), the Part D prescriber validation rule allows a different action by the sponsor than when a domestic prescriber is involved.

   The sponsor is not required to pay the claim and 24-hour follow up is not required per CMS guidance. The claim will be rejected (Reject Code: “543” (Prescriber ID Qualifier Value Not Supported)). The pharmacy should not try to resubmit using Submission Clarification Code as overrides. The patient can pay cash or see a prescriber who is covered under the plan benefit. Per CMS this is not considered a clean claim; therefore, the Notice of Medicare Drug Coverage Rights is not required.

2. If there is an active and valid NPI for the foreign prescriber and the claim is submitted with a Prescriber ID Qualifier value of 01 (NPI)
   • The sponsor must pay the claim if it is otherwise payable (i.e. treat as any other prescription claim with an active and valid prescriber NPI).

21.22.2 VALID PRESCRIBER ID?

Background
Telecommunication Version D and Above Questions, Answers and Editorial Updates

Effective 01/01/2012, Part D sponsors must ensure that the acceptable prescriber identifiers (NPI, DEA Number, UPIN, State License) are active and valid. Sponsors should not reject the claim solely on the basis of an invalid prescriber ID, unless the issue can be resolved at point of service. If retrospective review is conducted, the Part D sponsors are responsible for reporting a valid prescriber ID on the PDE. Part D sponsors will also be required to confirm the validity of DEA numbers on Schedule II-V drug claims or map NPIs on these claims to the prescriber's DEA numbers. In addition, sponsors will be required to confirm that the controlled substance is within the prescriber's scope of practice to prescribe.

There are multiple prescriber data base vendors available in the market, where data matching rules may vary. As a result, the prescriber detail within the provider's system may be different than the prescriber detail in the payer's system for the single prescriber ID submitted on the claim. The timing of file updates may result in a situation where the provider has access to the current information (newly licensed prescriber) however the payer system does not have a record for this prescriber. Additionally, the administrative processes currently used by the DEA to renew prescriber DEA licenses produces inaccurate results within the DEA source file (NTIS) available to the industry. For example, the source file will report the DEA license as EXPIRED, however the DEA renewal process is in progress, where the prescriber receives an authorization letter from the DEA office indicating the DEA license number can be used.

Question:
To facilitate a consistent claims adjudication process relative to prescriber ID validation, to prevent retrospective rejects based only on the prescriber data within the Part D sponsor's system, to eliminate the financial risk to the provider and the need to obtain new prescription orders from the physician due to conflicts in data files; can NCPDP guidance be developed to require the Part D sponsor to reject the claim at point of service when the prescriber ID submitted cannot be validated? In the event the reject is the result of the timing of data file updates, or a DEA renewal in process, can the provider resubmit the claim with a specific Submission Clarification code?

Response:
WG1 Telecommunication approved two methods after long discussion. There was no consensus on one versus the other, but the need was shown for supporting one or the other. If needed, the topic will be evaluated in the future.

1. Reject method with overrides or
2. A paid response with the method approved at August WG using Approved Message Code (548-6F) or
   a. Prior to April 2012, Approved Message Codes (“019”, “020”, “021”) and descriptions should be return in Additional Message Code (526-FQ)
   b. Note, in this option, there is no opportunity for the pharmacy to convey additional information to the plan.

Question:
Does CMS expect Part D Sponsors to validate the DEA Schedule down to the Narcotic/Non-Narcotic level?
Situation: A prescriber’s DEA license is associated to the applicable DEA schedules (2, 3, 4, 5). The DEA further delineates the schedules as Narcotic and Non-Narcotic, where Non-Narcotic is listed as 2N, or 3N. Not all drug compendia may provide a Narcotic or Non-Narcotic classification. Based on the lack of a narcotic identifier on the drug files, does CMS expect sponsors to be editing to that level?

CMS Response:
As noted in the CY 2012 Call Letter, the DEA Schedule policy does not supersede or alter pharmacy obligations relative to DEA registrants under the Controlled Substances Act and DEA rules.

Response:
CMS does not expect Part D Sponsors to validate the DEA Schedule down to the Narcotic/Non-Narcotic level.

However, systematic validation may be available based on data elements on the drug compendia files. (Note: The DEA schedule and a narcotic box will eventually be on the HDMA form used by the wholesalers to send info to the compendia. As an additional resource, WG2 Structured Product Label Task Group will ask FDA to generate an Index of Narcotics on the Dailymed website.)

Narcotic drug means any of the following whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

(1) Opium, opiates, derivatives of opium and opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers whenever the existence of such isomers, esters, ethers and

Version 48
November 2019
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salts is possible within the specific chemical designation. Such term does not include the isoquinoline alkaloids of opium.
(2) Poppy straw and concentrate of poppy straw.
(3) Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine and derivatives of ecgonine or their salts have been removed.
(4) Cocaine, its salts, optical and geometric isomers, and salts of isomers.
(5) Ecgonine, its derivatives, their salts, isomers and salts of isomers.
(6) Any compound, mixture, or preparation which contains any quantity of any of the substances referred to in paragraphs (1) through (5) of this definition.

See chart below.
Validation rules:

- If the Prescriber has DEA schedule of 2, 2N, 3, 3N it must be an exact match to the drug DEA schedule of 2, 2N, 3, 3N.
- If the Prescriber has DEA schedule of 4, the match to drug DEA schedule of 4 or 4N is valid.
- If the Prescriber has DEA schedule of 5, the match to drug DEA schedule of 5 or 5N is valid.

Gray square is not applicable

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<thead>
<tr>
<th>Drug DEA Schedule</th>
<th>2</th>
<th>2N</th>
<th>3</th>
<th>3N</th>
<th>4</th>
<th>4N</th>
<th>5</th>
<th>5N</th>
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<tbody>
<tr>
<td>Prescriber Schedule</td>
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<td></td>
</tr>
<tr>
<td>2</td>
<td>Exact Match Only Valid</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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<td>Exact Match Only Valid</td>
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<tr>
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<td>4 or 4N Valid</td>
<td>4 or 4N Valid</td>
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<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>S or 5N Valid</td>
<td>S or 5N Valid</td>
</tr>
</tbody>
</table>

Examples:

1. Prescriber has a DEA schedule of 2 and does not have 2N, and the drug DEA schedule is 2N
   a. Check is not valid since the match of 2N must be exact.
2. Prescriber has a DEA schedule of 3N and does not have 3, and the drug DEA schedule is 3.
   a. Check is not valid since the match of 3 must be exact.
3. Prescriber has a DEA schedule of 4 and the drug DEA schedule is 4N
   a. Check is valid since the match for 4 is 4 or 4N.
Question:
If a provider is on the OIG sanction list, disbarred from a government health care program, will this be reflected within NPI status on the NPI Registry?

Response:
A provider’s NPI which may be listed with the OIG LEIE may not necessarily be listed as deactivated on the NPPES. The NPPES deactivation code of Fraud is specific to a provider’s ID being compromised and not that this particular provider has committed fraud. NPPES only indicates whether the NPI is active, and does not track whether the ID is excluded from government programs.

“CMS and the Enumerator do not report fraudulent provider issues to enrolling health plans. Issues involving health care providers who are fraudulent are handled by the enrolling health plan. If a government agency detected fraud, they should alert the health plans who have enrolled the provider (if the information is pertinent to the other health plans). From a NPI perspective, the provider is eligible to obtain/retain the NPI as long as the provider continues to meet the definition of a health care provider as defined at 45 CFR 160.103. Please keep in mind that a health care provider who has committed fraud with one health plan may still be actively/legitimately enrolled with other health plans, which means the provider still has a need for the NPI to remain active.”

Question
We have encountered prescribers whose DEA Licenses do not list one or more schedules as being permitted, even though the prescribers may believe their DEA Licenses should have authority for the missing schedule(s). How can a prescriber update details of his/her current registration to include all appropriate schedules?

Response:
As outlined in the 2012 CMS Call Letter, “Effective January 1, 2012 Part D sponsors will be required to confirm the validity of DEA numbers on Schedule II-V drug claims or map NPIs on these claims to the prescriber’s DEA numbers. In addition, sponsors will be required to confirm that the controlled substance is within the prescriber’s scope of practice to prescribe.”

In the event the prescriber’s DEA registration incurs an administrative error, an individual with a CURRENT or NEW/Pending DEA License may follow the steps below to update DEA Schedules:

1) Access the DOJ DEA registration site at http://www.deadiversion.usdoj.gov/drugreg/change_requests/index.html
2) Select the Registration Changes link to access the online form
3) Log in and select Change under STEP - 2 BUSINESS ACTIVITY
4) Enter the appropriate changes (all appropriate checkboxes must be checked) and select Update
5) Enter the certifier name and select Submit Application. Note: For individual registrants, the registrant themselves MUST complete the E-Signature

A DEA registration schedule change can be processed and posted within 24 hours (Monday-Friday). For any additional assistance you may contact one of the following:

▪ DEA.Registration.Help@usdoj.gov
▪ DEA Call Center 1-800-882-9539
Your local DEA office (http://www.deadiversion.usdoj.gov/offices_n_dirs/fi eldiv/index.html)

Question:
How should plan sponsors handle a controlled substance prescription claim where the prescriber’s individual Type 1 NPI is submitted, however the prescriber is acting under the DEA registration of the hospital, to which the prescriber DEA registration ID field will be blank on the plan’s prescriber data base?

Response:
In the situation where the processor is not able to identify a DEA number to be associated to the submitted individual prescriber NPI, the claim would reject as Reject Code “44” (Plan’s Prescriber data base indicates the associated DEA
Clarification received from CMS following the May 2013 HPMS memo supports the above recommendations:

“CMS’ policy is that Medicare Part D claims should not be denied solely on the basis that sponsors do not find an individual DEA number for the prescriber and thus are unsure of the prescriber’s DEA status. We do not believe that sponsors have reasonable access to the information necessary to research the relationship of individual prescribers to group DEA numbers, and have not required this in our guidance.

However, Part D drugs must be dispensed pursuant to a valid prescription under all applicable state and federal laws in order to be covered. Therefore, CMS’ policy also does not supersede or alter pharmacy obligations relative to DEA registrants under the Controlled Substance Act and DEA rules. This means that CMS continues to expect sponsors to take reasonable steps to ensure that their network pharmacies are complying with these rules without unreasonably delaying a beneficiary’s access to medications.

If the Task Group agrees that the Reject Code 44 and subsequent Submission Clarification Code 45 demonstrates that the pharmacy has met its obligations, then CMS does not see a reason to eliminate them for Part D claims, nor to revise the referenced response.”

**Question:**
A prescriber’s DEA registration is expired and can only write scripts for schedules III – V in the plan’s data base. The claim is for a schedule II medication. The claim rejects for “43” (Plan’s Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive). After the pharmacy enters a Submission Clarification Code of 43 should the claim pay and allow the schedule II medication or should the claim also have rejected “46” Plan’s Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA class? This would mean the pharmacy would have to submit two Submission Clarification Codes on the claim 43 and 46 to get the claim to pay?

**Response:**
This example is a scenario of a timing issue. The plan’s database differs from what the pharmacy has actually validated with the prescriber. The prescriber has updated their DEA registration and Schedule II-V are now included. This information may take time to funnel through the industry.

The plan should return all applicable Reject Codes on the initial response (Reject Code “43” and “46”). The pharmacy will validate the active status and prescriptive authority of the prescriber. When validated, the claim can be resubmitted with the Submission Clarification Code 43 (Prescriber’s DEA is active with DEA Authorized Prescriptive Right.)

While not recommended, in the event the plan only returns a single Reject Code when multiple errors are evident, the pharmacy would have to resubmit the claim with the applicable Submission Clarification Code for the initial Reject Code and then respond to any subsequent rejects.

**21.22.3 PROCESSING WITH PRESCRIBER ID**
**Telecommunication Version D and Above Questions, Answers and Editorial Updates**

**05/2016 Editorial Note:**
The guidance within the January 2016 vD.0 Editorial Document under the Prescriber Information section was based on the prescriber validation requirements under CMS 4157. As a result of recent CMS requirements under CMS 4159 and IFC 6107, the prescriber validation guidance required updates to support the Medicare enrollment, provisional fill and Other Authorized Prescriber point of service communication processes. The below updates to the existing Editorial guidance reflects the distinction between CMS 4157 and references the appendix information for CMS 4159 and IFC 6107.

**Question:**
Based on the Medicare Part D prescriber validation rules effective January 1, 2013, can a Part D Sponsor accept the claim if the Type 1 NPI can be identified based on submitted non-NPI ID?

**Situation:** Pharmacy doesn't submit the Type 1 NPI, processor is able to cross walk from the submitted ID and find the Type 1 NPI; must the processor reject the claim?

**CMS Response:**
The final regulation states that sponsors must submit PDEs with active and valid individual prescriber NPIs beginning 1/1/13. It also states that sponsors must ensure that the lack of an active and valid individual prescriber NPI does not unreasonably delay a beneficiary’s access to a covered Part D drug by communicating at point-of-sale whether an NPI is active and valid. The preamble to the final rule recognized that such communication could be via claim rejection. If the sponsor communicates that the NPI is not active and valid, the final regulation states that the sponsor must permit the pharmacy to confirm that it is active and valid or correct it.

**Response:**
In the situation where the Part D sponsor can identify the prescriber’s Type 1 NPI based on the alternate prescriber ID submitted on the claim, per the CMS regulations effective January 1, 2013, the sponsor must engage in conversation with the pharmacy to ensure the prescriber ID is valid. There are two options available within the NCPDP Telecommunication Standard to support the required communication.

1. **Reject Response:** Using a Reject Code that indicates a Type 1 NPI exists and should be submitted and may also include the NPI determined by the sponsor within the Additional Message field (526-FQ).
   a. Reject Code: “619” (Prescriber Type 1 NPI Required) (Emergency DERF/ECL 001079/ECL 000125 approved at August 2012 Work Group meeting).
   b. When the Plan can find an NPI based on the prescriber ID submitted but rejects the claim the Plan may choose to provide this information in the Additional Message Information (526-FQ) as free text (using the qualifier values 1-9) to assist the pharmacy.
      i. Text to be returned as “PLAN’S PRESCRIBER NPI DATA: ##########”

2. **Paid Response (where an override Submission Clarification Code is not submitted):** Using an Approved Message Code (548-6F) “026” (Prescriber Type 1 NPI Required - Flagged for Retrospective Review) and should also include within the Additional Message field (526-FQ) as free text (using the qualifier values 1-9) the NPI determined by the sponsor that will be submitted on the PDE, and should be used on future claims. Processor will not require the claim to be reprocessed.
   a. Approved Message Code: “028” (Type 1 NPI Required, Claim Paid Based on Plan’s Prescriber NPI Data).
   b. When the plan pays and chooses to send a cross walked NPI on the PDE, they should also return the cross walked NPI in the Additional Message Information (526-FQ) as free text (using the qualifier values 1-9) to assist the pharmacy.
      i. Text to be returned as “PLAN’S PRESCRIBER NPI DATA: ##########”
   c. In the situation where the pharmacy has submitted a Submission Clarification Code override with a prescriber NPI the plan/payer cannot validate, the plan/payer would leverage the prescriber ID provided by the pharmacy and not any internal cross-walked NPI.

As of the **12/01/2015** enforcement date for CMS 4159-F (§ 423.120(c)(5) and (6)), the above situation would not apply to Medicare Part D claims as the prescriber’s Type 1 NPI must be submitted on claim.
Question:
Will CMS require an override process when the submitted Prescriber ID results in a Missing/Invalid (M/I) Prescriber ID (Reject Code = “25”) reject?

Situation: Should Part D sponsors interpret the below CMS regulation to also apply to prescription claims where the submitted prescriber ID does not meet the formatting rules for the associated prescriber ID qualifier? In these situations, the plan sponsor is unable to attempt to validate the submitted ID to a prescriber data source. For example:

- The Prescriber ID Qualifier is submitted as “12” (DEA), however the submitted prescriber ID fails the DEA algorithm.
- The Prescriber ID Qualifier is submitted as “01” (NPI), however the submitted prescriber ID does not meet the Luhn formula.

2013 Part D Regulation:
“For these reasons, and in response to comments, we are revising our policy and the regulation text to require a Part D sponsor to ensure that the lack of an active and valid individual prescriber NPI on a network pharmacy claim does not unreasonably delay a beneficiary’s access to a covered Part D drug. Sponsors will be required to so ensure in the following manner: (1) a sponsor must communicate at point-of-sale whether or not the prescriber NPI is active and valid; (2) if the sponsor communicates that the prescriber NPI is not active and valid, the sponsor must permit the pharmacy to confirm that the NPI is active and valid, or in the alternative, to correct it; (3) if the pharmacy confirms that the prescriber NPI is active and valid or corrects it, the sponsor must pay the claim if it is otherwise payable; and (4) if the pharmacy cannot or does not correct or confirm that the prescriber NPI is active and valid, the sponsor must require the pharmacy to resubmit the claim (when necessary), which the sponsor must pay, if it is otherwise payable, unless there is an indication of fraud or the claim involves a prescription written by a foreign prescriber (where permitted by State law).”

Response:
To meet CMS regulations of 24 hour outreach, in the situation where the submitted Prescriber ID is formatted incorrectly or may be blank, the expectation is the pharmacy is to correct the ID and resubmit. However in an emergency situation where the pharmacy is unable to obtain a correct ID, either the pharmacy is to contact the plan or the plan to contact the pharmacy to facilitate a corrected claim or an emergency process (such as prior authorization) until a valid ID can be obtained. Any claims paid under the invalid Prescriber ID may be subject to retrospective audit.

Question:
How can the NCPDP Telecommunication Standard be leveraged to comply with the Medicare Part D prescriber validation and point of service communication process?

- CMS 4157-F Effective 01/01/2013
  - “Sponsors will be required to so ensure in the following manner: (1) a sponsor must communicate at point-of-sale whether or not the prescriber NPI is active and valid; (2) if the sponsor communicates that the prescriber NPI is not active and valid, the sponsor must permit the pharmacy to confirm that the NPI is active and valid, or in the alternative, to correct it; (3) if the pharmacy confirms that the prescriber NPI is active and valid or corrects it, the sponsor must pay the claim if it is otherwise payable; and (4) if the pharmacy cannot or does not correct or confirm that the prescriber NPI is active and valid, the sponsor must require the pharmacy to resubmit the claim (when necessary), which the sponsor must pay, if it is otherwise payable, unless there is an indication of fraud or the claim involves a prescription written by a foreign prescriber (where permitted by State law).”

- CMS 4159-F § 423.120(c)(6)(i) Regulation Effective 06/01/2015, Enforcement Effective 12/01/2015
  - Under § 423.120(c)(6)(i), in order for a Part D sponsor to submit to CMS a prescription drug event (PDE) record, the PDE must pertain to a claim for a Part D drug that was dispensed in accordance with a prescription written by a physician or eligible professional who is either (1) enrolled in Medicare in an approved status, or (2) has a valid opt-out affidavit on file with an A/B MAC.
Telecommunication Version D and Above Questions, Answers and Editorial Updates

- Under § 423.120(c)(6)(iii), a Part D sponsor must deny or must require its PBM to deny a pharmacy claim for a drug (or a request for reimbursement from a Medicare beneficiary for a drug) if the claim does not meet the requirements of § 423.120(c)(6)(i) or (ii), respectively.

Response:
New values and updated descriptions to existing values have been designated for the following fields:

Reject Code (511-FB)
Submission Clarification Code (420-DK)
Approved Message Code (548-6F)

Appropriate use of these values as outlined within the CMS 4157 and CMS 4159 matrices will provide the necessary communication between the provider and payer for prescriber ID validation and any subsequent retrospective reviews.

- CMS 4157-F Matrix – Medicare Part D Prescriber ID Requirements Effective 01/01/2013
- CMS 4159-F and IFC 6107 Matrix - Medicare Part D Prescriber Enrollment Requirements Enforcement Date 02/01/2017 (based on 03/01/2016 CMS Notice)
  - Refer to Appendix F for the comprehensive overview of point of service prescriber validation guidance that applies to CMS 4159 and IFC 6107.

Please reference all information within the “PROCESSING WITH PRESCRIBER ID” sections of this document, as the clarification and recommendations may not be reflected within the below matrix but may apply to your business needs.

CMS 4157-F Matrix – Medicare Part D Prescriber ID Requirements Effective 01/01/2013

The INTERIM Reject Code, Submission Clarification Code and Approved Message Code columns were specifically created to address the gap in time between the January 01, 2013 Part D effective date and the April 01, 2013 Emergency ECL Implementation date for the new values required to support the point of service prescriber validation communication process. CMS recognized the effects of this gap, where the October 01, 2012 Part D Plan Notice provided the following direction:

To facilitate industry implementation of these new regulatory requirements, we will align our requirements for Type 1 NPIs on PDEs with the deadline for individual prescribers to obtain and disclose Type 1 NPIs. Therefore, we are announcing a two-step implementation process.

Effective January 1, 2013, CMS will require sponsors to submit an active and valid NPI on PDE records; however, the NPI reported may be a group identifier if the prescriber has not yet obtained an individual NPI. Beginning May 6, 2013, sponsors must report only a Type 1 (individual) NPI on the PDE record. This delay will also allow the industry to align implementation of the requirement for an individual NPI with the new NCPDP emergency external code list values related to the new NPI requirements approved at the August Work Group meetings.

Point of service rejects implemented for the 2013 benefit year, should adhere to the values as outlined in the CMS 4157-F Matrix, the CMS Part D guidance and the April 1, 2013 NCPDP Emergency ECL effective date.

The CMS 4157-F Prescriber Reject Matrix has been updated to reflect the following CMS Medicare Part D clarifications:

- 11/2012: De-activated NPIs and prescription refills
- 11/2012: 24 hour follow up for foreign prescriber rejections
- 11/2012: Notice of Medicare Drug Coverage Rights for foreign and sanctioned prescriber rejections
- 11/2012: Removal of interim values for NPI = Type 2 scenario row.
- 08/2014: Addition of new code values for state license validation
21.22.3.1 **DEFINITION OF A VALID PRESCRIBER CMS 4157 PRESCRIBER REJECT MATRIX**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Non-NPI submitted and payer determines valid Type 1 NPI based on plan's prescriber data base</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>6F: “028” (Type 1 NPI Required, Claim Paid Based on Plan’s Prescriber NPI Data.)</td>
<td>Use Message (526-FQ) PLAN’S PRESCRIBER NPI DATA: #FFFFFFF</td>
<td></td>
</tr>
<tr>
<td>Non-NPI ID, and not a Foreign Prescriber ID, Qualifier &lt;&gt; 01 or 17. Submitted ID may be active and Valid. Foreign Prescriber ID Qualifier = 17</td>
<td>FB: “619” (Prescriber Type 1 NPI Required)</td>
<td>FB: “EZ” (M/I Prescriber ID Qualifier)</td>
<td>DK: 49 (Prescriber does not currently have an Active Type 1 NPI)</td>
<td>DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>6F: “026” (Prescriber Type 1 NPI Required - Flagged for Retrospective Review)</td>
<td>6F: “019” (The submitted Prescriber ID is not found or is inactive flagged for Retrospective Review)</td>
<td></td>
</tr>
<tr>
<td>DEA Expired Drug DEA Schedule = C2-C5</td>
<td>FB: “42” (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is expired)</td>
<td>FB: “42” (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is not found)</td>
<td>DK: 42 (Prescriber ID Submitted is active and prescribing requirements have been validated.)</td>
<td>DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>6F: “019” (The submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review)</td>
<td>6F: “019” (The Submitted Prescriber ID is Not Found or is Inactive – Flagged for Retrospective Review)</td>
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</table>

**Notes**
- Due to the lack of an interim Approved Message Code, payers should communicate the NPI that will be submitted on the PDE within the Additional Message (526-FQ) field.
- See section “Foreign Prescriber Identifier”.

**Added November 2012:**
- CMS Medicare D 24 hour follow-up not required.
- Notice of Medicare D Drug Coverage Rights (Reject Code “569”) not required.
- Refer to “Processing with Prescriber ID” sections for additional information on Foreign Prescriber IDs.
## DEFINITION OF A VALID PRESCRIBER REJECT MATRIX WHEN PRESCRIBER TYPE 1 NPI IS REQUIRED and ALTERNATE ID MAY BE ACCEPTED

<table>
<thead>
<tr>
<th>Payer Determination of a Valid Prescriber based on the submitted Prescriber ID Qualifier and ID</th>
<th>Reject Code (511-FB)</th>
<th>Interim Reject Code (511-FB) (Prior to 04/2013)</th>
<th>Submission Clarification Code (420-DK) - Once a SCC is submitted and accepted, no further prescriber reject should apply for POS.</th>
<th>Interim Submission Clarification Code (420-DK) (Prior to 04/2013)</th>
<th>Approved Message Code (548-6F)</th>
<th>Interim Approved Message Code (548-6F) (Prior to 04/2013)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEA Inactive Drug DEA Schedule = C2-C5</strong></td>
<td>FB: “42” (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is expired)</td>
<td>FB: “42” (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is not found)</td>
<td>DK: 42 (Prescriber ID Submitted is active and prescribing requirements have been validated.)</td>
<td>DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>6F: “019” (The submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review)</td>
<td>6F: “019” (The Submitted Prescriber ID is Not Found or is Inactive – Flagged for Retrospective Review)</td>
<td></td>
</tr>
<tr>
<td><strong>DEA Non-Matched Meets DEA algorithm, but not on Plan’s current file Drug DEA Schedule = C2-C5</strong></td>
<td>FB: “56” (Non-Matched Prescriber ID)</td>
<td>FB: “56” (Non-Matched Prescriber ID or 42 - Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is not found)</td>
<td>DK: 42 (Prescriber ID Submitted is active and prescribing requirements have been validated.)</td>
<td>DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>6F: “019” (The submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review)</td>
<td>6F: “019” (The Submitted Prescriber ID is Not Found or is Inactive – Flagged for Retrospective Review)</td>
<td></td>
</tr>
<tr>
<td><strong>DEA Invalid Does not meet DEA Algorithm Drug DEA Schedule = C2-C5</strong></td>
<td>FB: “25” (M/I Prescriber ID)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>DEA Schedule Invalid Drug DEA Schedule = C2-C5</strong></td>
<td>FB: “618” (Plan’s Prescriber data base indicates the submitted Prescriber’s DEA does not allow this drug DEA class Schedule)</td>
<td>FB: “46” (Plan’s Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA class)</td>
<td>DK: 46 (Prescriber’s DEA, has prescriptive authority for this drug DEA Schedule)</td>
<td>DK: 46 (For prescriber ID submitted, and associated prescriber DEA, the DEA has authorized prescriptive right for this drug DEA Class)</td>
<td>6F: “027” (The submitted Prescriber does not allow this drug DEA Schedule – Flagged for Retrospective Review)</td>
<td>6F: “022” (For the submitted Prescriber ID, the associated DEA Number does not allow this drug DEA class – Flagged for Retrospective Review)</td>
<td>Added November 2012: Notice of Medicare D Drug Coverage Rights (Reject Code “569”) not required.</td>
</tr>
<tr>
<td>Any Prescriber ID - OIG/State Medicaid Sanctioned</td>
<td>FB: “A1” (ID Submitted is associated with a Sanctioned Prescriber)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>See question above “Will CMS require an override process when the submitted Prescriber ID results in a Missing/Invalid (M/I) Prescriber ID (Reject Code = “25”) reject?”</td>
</tr>
</tbody>
</table>
## Definition of a Valid Prescriber Reject Matrix When Prescriber Type 1 NPI is Required and Alternate ID May Be Accepted

<table>
<thead>
<tr>
<th>Payer Determination of a Valid Prescriber based on the submitted Prescriber ID Qualifier and ID</th>
<th>Reject Code (511-FB)</th>
<th>Interim Reject Code (511-FB) (Prior to 04/2013)</th>
<th>Submission Clarification Code (420-DK) - Once a SCC is submitted and accepted, no further prescriber reject should apply for POS.</th>
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<th>Interim Approved Message Code (548-6F) (Prior to 04/2013)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Prescriber ID - Deceased</td>
<td>FB: &quot;A2&quot; (ID Submitted is associated to a Deceased Prescriber)</td>
<td>N/A</td>
<td>DK: 42 (Prescriber ID Submitted is active and prescribing requirements have been validated.)</td>
<td>DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>6F: &quot;025&quot; (The submitted prescriber ID is associated to a Deceased Prescriber – Flagged for Retrospective Review)</td>
<td>6F: &quot;019&quot; (The Submitted Prescriber ID is Not Found or is Inactive – Flagged for Retrospective Review)</td>
<td>Added November 2012/Updated May 2014: Plan Sponsors must adhere to State laws which dictate whether or not a prescription can be refilled based on the status of a prescriber that may be reflected as an NPI deactivation reason. If the state law allows for a grace period to the date in which the prescriber’s license is inactivated (e.g. death date), the grace period should apply to the claim date of service. If the Plan Sponsor leverages the date written of the prescription, the date written should not be greater than the prescriber’s deactivation date (e.g. NPI deactivation date, death date, etc.). PDEs will not reject if the Date of Service on the PDE is &lt; or = (NPI deactivation date + 1 year), regardless of the reason for deactivation.</td>
</tr>
<tr>
<td>NPI Inactive (Deactivation code not available)</td>
<td>FB: &quot;42&quot; (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is expired)</td>
<td>FB: &quot;42&quot; (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is not found)</td>
<td>DK: 42 (Prescriber ID Submitted is active and prescribing requirements have been validated.)</td>
<td>DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>6F: &quot;019&quot; (The submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review)</td>
<td>6F: &quot;019&quot; (The Submitted Prescriber ID is Not Found or is Inactive – Flagged for Retrospective Review)</td>
<td>Added November 2012/Updated May 2014: Plan Sponsors must adhere to State laws which dictate whether or not a prescription can be refilled based on the status of a prescriber that may be reflected as an NPI deactivation reason. If the state law allows for a grace period to the date in which the prescriber’s license is inactivated (e.g. death date), the grace period should apply to the claim date of service. If the Plan Sponsor leverages the date written of the prescription, the date written should not be greater than the prescriber’s deactivation date (e.g. NPI deactivation date, death date, etc.). PDEs will not reject if the Date of Service on the PDE is &lt; or = (NPI deactivation date + 1 year), regardless of the reason for deactivation.</td>
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<td>Reject Code (511-FB)</td>
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<td>Submission Clarification Code (420-DK) - Once a SCC is submitted and accepted, no further prescriber reject should apply for POS.</td>
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**DEFINITION OF A VALID PRESCRIBER REJECT MATRIX WHEN PRESCRIBER TYPE 1 NPI IS REQUIRED and ALTERNATE ID MAY BE ACCEPTED**

- Dispensed based on the status of a prescriber that may be reflected as an NPI deactivation reason. If the state law allows for a grace period to the date in which the prescriber’s license is inactivated (e.g. death date), the grace period should apply to the claim date of service. If the Plan Sponsor leverages the date written of the prescription, the date written should not be greater than the prescriber’s deactivation date (e.g. NPI deactivation date, death date, etc.).

- PDEs will not reject if the Date of Service on the PDE is ≤ (NPI deactivation date + 1 year), regardless of the reason for deactivation.
## DEFINITION OF A VALID PRESCRIBER REJECT MATRIX WHEN PRESCRIBER TYPE 1 NPI IS REQUIRED and ALTERNATE ID MAY BE ACCEPTED

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</thead>
<tbody>
<tr>
<td>NPI Inactive (Deceased deactivation code available)</td>
<td>FB: &quot;42&quot; (Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or is expired)</td>
<td>FB: &quot;42&quot; (Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or is not found)</td>
<td>DK: 42 (Prescriber ID Submitted is active and prescribing requirements have been validated.)</td>
<td>DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>6F: &quot;019&quot; (The submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review)</td>
<td>6F: &quot;019&quot; (The Submitted Prescriber ID is Not Found or is Inactive – Flagged for Retrospective Review)</td>
<td>If payer validates death date prior to NPI status, Reject Code &quot;A2&quot; may be returned. <strong>Added November 2012/Updated May 2014</strong>: Plan Sponsors must adhere to State laws which dictate whether or not a prescription can be refilled based on the status of a prescriber that may be reflected as an NPI deactivation reason. If the state law allows for a grace period to the date in which the prescriber’s license is inactivated (e.g. death date), the grace period should apply to the claim date of service. If the Plan Sponsor leverages the date written of the prescription, the date written should not be greater than the prescriber’s deactivation date (e.g. NPI deactivation date, death date, etc.). PDEs will not reject if the Date of Service on the PDE is &lt; or = (NPI deactivation date + 1 year), regardless of the reason for deactivation.</td>
</tr>
</tbody>
</table>

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### DEFINITION OF A VALID PRESCRIBER REJECT MATRIX WHEN PRESCRIBER TYPE 1 NPI IS REQUIRED and ALTERNATE ID MAY BE ACCEPTED

<table>
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<tr>
<th>Payer Determination of a Valid Prescriber based on the submitted Prescriber ID Qualifier and ID</th>
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<th>Interim Submission Clarification Code (420-DK) (Prior to 04/2013)</th>
<th>Approved Message Code (548-6F)</th>
<th>Interim Approved Message Code (548-6F) (Prior to 04/2013)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI Inactive (Disbandment deactivation code available)</td>
<td>FB: “42” (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is expired)</td>
<td>FB: “42” (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is not found)</td>
<td>DK: 42 (Prescriber ID Submitted is active and prescribing requirements have been validated.)</td>
<td>DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>6F: “019” (The submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review)</td>
<td>6F: “019” (The Submitted Prescriber ID is Not Found or is Inactive – Flagged for Retrospective Review)</td>
<td>Added November 2012/Updated May 2014: Plan Sponsors must adhere to State laws which dictate whether or not a prescription can be refilled based on the status of a prescriber that may be reflected as an NPI deactivation reason. If the state law allows for a grace period to the date in which the prescriber’s license is inactivated (e.g. death date), the grace period should apply to the claim date of service. If the Plan Sponsor leverages the date written of the prescription, the date written should not be greater than the prescriber’s deactivation date (e.g. NPI deactivation date, death date, etc.). PDEs will not reject if the Date of Service on the PDE is &lt; or = (NPI deactivation date + 1 year), regardless of the reason for deactivation.</td>
</tr>
<tr>
<td>NPI Inactive (Other deactivation code available)</td>
<td>FB: “42” (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is expired)</td>
<td>FB: “42” (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is not found)</td>
<td>DK: 42 (Prescriber ID Submitted is active and prescribing requirements have been validated.)</td>
<td>DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>6F: “019” (The submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review)</td>
<td>6F: “019” (The Submitted Prescriber ID is Not Found or is Inactive – Flagged for Retrospective Review)</td>
<td>Added November 2012/Updated May 2014: Plan Sponsors must adhere to State laws which dictate whether or not a prescription can be refilled</td>
</tr>
</tbody>
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### Definition of a Valid Prescriber Reject Matrix When Prescriber Type 1 NPI Is Required and Alternate ID May Be Accepted

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<tr>
<th>Payer Determination of a Valid Prescriber based on the submitted Prescriber ID Qualifier and ID</th>
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<th>Interim Submission Clarification Code (420-DK) (Prior to 04/2013)</th>
<th>Approved Message Code (548-6F) (Prior to 04/2013)</th>
<th>Interim Approved Message Code (548-6F) (Prior to 04/2013)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI Non-Matched (Meets Luhn formula, but not on plan’s current file)</td>
<td>FB: “56” (Non-Matched Prescriber ID)</td>
<td>FB: “56” (Non-Matched Prescriber ID) or “42” (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is not found)</td>
<td>DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>6F: “024” (The Submitted Prescriber ID is Not Found - Flagged for Retrospective Review)</td>
<td>6F: “019” (The Submitted Prescriber ID is Not Found or is Inactive – Flagged for Retrospective Review)</td>
<td>based on the status of a prescriber that may be reflected as an NPI deactivation reason. If the state law allows for a grace period to the date in which the prescriber’s license is inactivated (e.g. death date), the grace period should apply to the claim date of service. If the Plan Sponsor leverages the date written of the prescription, the date written should not be greater than the prescriber’s deactivation date (e.g. NPI deactivation date, death date, etc.). PDEs will not reject if the Date of Service on the PDE is ≤ (NPI deactivation date + 1 year), regardless of the reason for deactivation.</td>
</tr>
<tr>
<td>NPI Invalid (does not meet Luhn formula)</td>
<td>FB: “25” (M/I Prescriber ID)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>See question above “Will CMS require an override process when the submitted Prescriber ID...”</td>
</tr>
</tbody>
</table>
### DEFINITION OF A VALID PRESCRIBER REJECT MATRIX WHEN PRESCRIBER TYPE 1 NPI IS REQUIRED and ALTERNATE ID MAY BE ACCEPTED

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<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NPI = Type 2</strong></td>
<td>FB: “619” (Prescriber Type 1 NPI Required)</td>
<td>Removed November 2012: FB: “55 ” (Non-Matched Prescriber ID)</td>
<td>DK: 49 (Prescriber does not currently have an Active Type 1 NPI)</td>
<td>Removed November 2012: DK: 42 (Prescriber ID Submitted has been validated, is active.)</td>
<td>6F: “026” (Prescriber Type 1 NPI Required - Flagged for Retrospective Review)</td>
<td>Removed November 2012: 6F: “19 ” (The Submitted Prescriber ID is Not Found or is Inactive – Flagged for Retrospective Review)</td>
<td>Added November 2012: For the interim period 01/01/2013 – 05/05/2013 CMS will accept the Type 2 NPI on the PDE when the prescriber does not yet have an NPI (Type 1). Long Term - If Payer can determine Type 1 versus Type 2, paid claim with override should be returned to pharmacy on retrospective audit before submitted on PDE.</td>
</tr>
<tr>
<td>Associated DEA Expired Drug DEA Schedule = C2-C5</td>
<td>FB: “43” (Plan’s Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive or expired)</td>
<td>FB: “43” (Plan’s Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive)</td>
<td>DK: 43 (Prescriber’s DEA is Active with DEA Authorized Prescriptive Right)</td>
<td>DK: 43 (For prescriber ID submitted, associated prescriber DEA Renewed, or In Progress, DEA Authorized Prescriptive Right)</td>
<td>6F: “021” (For the submitted Prescriber ID, the associated DEA Number is inactive or expired – Flagged for Retrospective Review)</td>
<td>6F: “021” (For the submitted Prescriber ID, the associated DEA Number is inactive – Flagged for Retrospective Review)</td>
<td></td>
</tr>
<tr>
<td>Associated DEA Inactive Drug DEA Schedule = C2-C5</td>
<td>FB: “43” (Plan’s Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive or expired)</td>
<td>FB: “43” (Plan’s Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive)</td>
<td>DK: 43 (Prescriber’s DEA is Active with DEA Authorized Prescriptive Right)</td>
<td>DK: 44 (For prescriber ID submitted, associated prescriber DEA recently licensed or re-activated)</td>
<td>6F: “021” (For the submitted Prescriber ID, the associated DEA Number is inactive or expired – Flagged for Retrospective Review)</td>
<td>6F: “021” (For the submitted Prescriber ID, the associated DEA Number is inactive – Flagged for Retrospective Review)</td>
<td></td>
</tr>
<tr>
<td>Associated DEA Not Found</td>
<td>FB: “44” (Plan’s Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive or expired)</td>
<td>FB: “44” (Plan’s Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive or expired)</td>
<td>DK: 43 (Prescriber’s DEA is Active with DEA Authorized Prescriptive Right)</td>
<td>DK: 43 (For prescriber ID submitted, associated prescriber DEA Renewed, or In Progress)</td>
<td>6F: “020” (For the submitted Prescriber ID, the associated DEA Number is not found – Flagged for Retrospective Review)</td>
<td>6F: “020” (For the submitted Prescriber ID, the associated DEA Number is not found – Flagged for Retrospective Review)</td>
<td></td>
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</tbody>
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### DEFINITION OF A VALID PRESCRIBER REJECT MATRIX WHEN PRESCRIBER TYPE 1 NPI IS REQUIRED and ALTERNATE ID MAY BE ACCEPTED

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<th>Interim Submission Clarification Code (420-DK) (Prior to 04/2013)</th>
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<th>Interim Approved Message Code (548-6F) (Prior to 04/2013)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitted Prescriber ID is not found)</td>
<td>submitted Prescriber ID is not found)</td>
<td>submitted Prescriber ID is not found)</td>
<td>&quot;45&quot; (Prescriber’s DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule)</td>
<td>Progress, DEA Authorized Prescriptive Right) or &quot;45&quot; (Prescriber’s DEA is a valid Hospital DEA with Suffix)</td>
<td>Flagged for Retrospective Review</td>
<td>Flagged for Retrospective Review</td>
<td></td>
</tr>
<tr>
<td>Associated DEA Schedule Invalid</td>
<td>FB: &quot;46&quot; (Plan’s Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule)</td>
<td>FB: &quot;46&quot; (Plan’s Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule)</td>
<td>DK: 46 (Prescriber’s DEA has prescriptive authority for this drug DEA Schedule)</td>
<td>DK: 46 (For prescriber ID submitted, and associated prescriber DEA, the DEA has authorized prescriptive right for this drug DEA class)</td>
<td>6F: &quot;022&quot; (For the submitted Prescriber ID, the associated DEA Number does not allow this drug DEA Schedule – Flagged for Retrospective Review)</td>
<td>6F: &quot;022&quot; (For the submitted Prescriber ID, the associated DEA Number does not allow this drug DEA class – Flagged for Retrospective Review)</td>
<td></td>
</tr>
<tr>
<td>Medicare D claim: prescriber NPI is not listed on the Medicare D prescriber active enrollment file</td>
<td>FB: &quot;773&quot; (Prescriber not listed within Medicare Fee for Service active enrollment file)</td>
<td>N/A</td>
<td>DK: 50 (Prescriber’s active Medicare Fee for Service enrollment status has been validated)</td>
<td>N/A</td>
<td>6F: &quot;030&quot; (Prescriber active enrollment with Medicare Fee for Service required. Flagged for retrospective review.)</td>
<td>N/A</td>
<td>Added May 2014. Active Medicare enrollment also includes practitioners with an active Medicare opt out affidavit on file.</td>
</tr>
<tr>
<td>Medicare D claim: prescriber NPI is listed on the Medicare D prescriber enrollment file as terminated.</td>
<td>FB: &quot;774&quot; (Prescriber enrollment with Medicare Fee for Service has terminated.)</td>
<td>N/A</td>
<td>DK: 50 (Prescriber’s active Medicare Fee for Service enrollment status has been validated)</td>
<td>N/A</td>
<td>6F: &quot;030&quot; (Prescriber active enrollment with Medicare Fee for Service required. Flagged for retrospective review.)</td>
<td>N/A</td>
<td>Added May 2014. Active Medicare enrollment also includes practitioners with an active Medicare opt out affidavit on file.</td>
</tr>
</tbody>
</table>
| No active state license with prescriptive authority associated to submitted prescriber ID | FB: "777" (Plan’s Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted) | FB: "42" (Plan’s Prescriber data base indicates the Prescriber ID Submitted is inactive or is not found) | DK: 42 (Prescriber ID Submitted is active and prescribing requirements have been validated) | N/A | 6F: "032" (For the submitted Prescriber ID, an associated active State License with prescriptive authority was not found – Flagged for Retrospective Review) | 6F: "019" (The submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review) | Added August 2014 for use 04/01/2015. This reject code, and approved message code would be used when verifying the state license active status, not the state license expiration date,
## DEFINITION OF A VALID PRESCRIBER REJECT MATRIX WHEN PRESCRIBER TYPE 1 NPI IS REQUIRED and ALTERNATE ID MAY BE ACCEPTED

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</table>

### Question:
Can CMS assist with industry outreach for entities that need Type 1 NPIs?

### Response:

NCPDP has also drafted a Prescriber NPI Outreach Letter Template that is available at [http://www.ncpdp.org/Resources/HIPAA](http://www.ncpdp.org/Resources/HIPAA) under NPI.
**21.22.3.2 INACTIVE STATE LICENSE**

Question:
If there is no active state license for a prescriber, can you confirm what standard reject codes should be used? SCC codes?

Response:

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<tr>
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<th>Interim Approved Message Code (548-6F) (Prior to 04/2013)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No active state license with prescriptive authority associated to submitted prescriber ID</td>
<td>“777” (Plan’s Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted)</td>
<td>N/A</td>
<td>52 (Prescriber’s State License with Prescriptive Authority has been validated)</td>
<td>N/A</td>
<td>“YYY” (Unable to verify prescriber’s active state license with prescriptive authority – Flagged for Retrospective Review)</td>
<td>“19” (The submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review)</td>
<td>Added 08/2014. Verification against the state active status, not the state license expiration date, and whether the prescriber has prescriptive authority as determined by the state. 24 hour follow up required. Reject Code 569 required</td>
</tr>
</tbody>
</table>

24 hour follow up required.
21.22.3.3 HOW CAN THE PAYERS AND PROVIDERS LEVERAGE THE NCPDP STANDARD TO COMPLY WITH SECTION 507 OF THE MACRA LEGISLATION?

**SEC. 507. REQUIRING VALID PREScribER NATIONAL PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.**

Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

“(4) REQUIRING VALID PRESCRIBER NATIONAL PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.—

“(A) IN GENERAL.—For plan year 2016 and subsequent plan years, the Secretary shall require a claim for a covered part D drug for a part D eligible individual enrolled in a prescription drug plan under this part or an MA–PD plan under part C to include a prescriber National Provider Identifier that is determined to be valid under the procedures established under subparagraph (B)(i).

“(B) PROCEDURES.—

“(i) VALIDITY OF PRESCRIBER NATIONAL PROVIDER IDENTIFIERS.—The Secretary, in consultation with appropriate stakeholders, shall establish procedures for determining the validity of prescriber National Provider Identifiers under subparagraph (A).

“(ii) INFORMING BENEFICIARIES OF REASON FOR DENIAL.—The Secretary shall establish procedures to ensure that, in the case that a claim for a covered part D drug of an individual described in subparagraph (A) is denied because the claim does not meet the requirements of this paragraph, the individual is properly informed at the point of service of the reason for the denial.

“(C) REPORT.—Not later than January 1, 2018, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the effectiveness of the procedures established under subparagraph (B)(i).”

**Response:**

In accordance with MACRA legislation section 507 effective 01/01/2016, prescriptions will no longer be covered under Medicare Part D if written by a prescriber who does not have a valid Type 1 NPI. The legislation also requires the pharmacy when the claim rejects as a result of the prescriber NPI requirement, to notify the beneficiary the reason the claim could not be covered under Medicare Part D. To support these requirements, the Part D claim response must include the appropriate information to indicate the claim does not meet MACRA requirements. This can be achieved through the use of a standardized Additional Information Message, and specific reject codes. Refer to the below chart for additional information as new reject codes will be available April and July 2016, through the Emergency ECL process. Once reject code 829 is available for use, it should be returned in addition to the specific reject code reflecting the prescriber validation error.

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<table>
<thead>
<tr>
<th>NCPDP Values and Standard Messaging</th>
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<th>04/01/2016</th>
<th>07/01/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>511-FB: Reject Code</td>
<td>– 25 – M/I PRESCRIBER ID</td>
<td>– 829 - Pharmacy Must Notify beneficiary: Claim not covered due to failure to meet Medicare Part D active, valid prescriber NPI requirements</td>
<td>– 829 - Pharmacy Must Notify beneficiary: Claim not covered due to failure to meet Medicare Part D active, valid prescriber NPI requirements</td>
</tr>
</tbody>
</table>

CMS is currently drafting an example of information expected to be communicated verbally to the beneficiary. The information will be published as soon as it is available.
Question: Does the Type 1 Prescriber NPI PDE requirement apply to claims with a date of service > 01/01/2013, or does it apply to all claims submitted on the PDE as of 01/01/2013, regardless of the claim date of service?
Response: Per CMS, the requirement will be based on date of service.

Question: How do NPI enumeration and deactivation dates, along with the claim date of service (DOS), determine whether or not an NPI can be considered “active” for inclusion on PDE?

(Question originally stated as: Are there any PDE rule sets which compare the NPI Enumeration Date, NPI De-activation Date, the claim Date of Service or Prescription Written date?)

Response: Effective January 1, 2013, all PDEs must be submitted with an active and valid NPI. Per CMS, the final regulation preamble stated the meaning of “active and valid” is that “the NPI number is in the expected format/sequencing for such numbers and is listed as an active identifier in the National Plan and Provider Enumeration System (NPPES).” The following are clarifications related to the timing for what will be treated as an active NPI:

1. The claim date of service may be prior to the NPI enumeration date; however the NPI must be active and valid at the time of PDE submission.
2. If the NPI is active as of the Date of Service, if otherwise payable, the Plan Sponsor should accept the claim regardless of the claim transmission date.
3. If an NPI is available on the NPPES registry at the time of the dispensing, but is not yet on the data dissemination file at the time of the PDE processing, the PDE may reject with PDE reject 834 (NPI is not active for the date of service). The sponsor will have to resubmit the PDE after the NPI has been included in the next full replacement or weekly incremental NPI file.

4. Per CMS, “NPIs which are active and valid on DOS and deactivated before PDE submission will be considered active and valid.” PDEs should not reject unless the deactivation date is retroactive to a date earlier than the DOS.

5. State prescribing laws dictate whether or not a prescription can be dispensed. Therefore after the NPI becomes deactivated it will be the sponsors’ responsibility to ensure that appropriate state laws are being followed. To accommodate different state laws, PDEs will not reject if the Date of Service on the PDE is < or = (NPI deactivation date + 1 year), regardless of the reason for deactivation. Detailed guidance announcing these edits will be released by CMS in February 2013.

6. For PDEs submitted for claims with dates of services on or after May 6, 2013, plans must submit an individual NPI in the Prescriber ID field. PDEs submitted for claims with dates of service prior to May 6, 2013, the Type 2 NPI will be accepted (refer to 10/02/2012 CMS Notice).

   ▪ In the event that Part D claims are subject to a declared emergency and the state has granted the pharmacist the authority to prescribe, for CY 2013 CMS will accept the pharmacy’s Type 2 NPI as the prescriber ID on the submitted PDE. The NCPDP Emergency Preparedness Information document v1.3, provides resource information for the pharmacy industry for a declared emergency. (http://www.ncpdp.org/Resources/Emergency-Preparedness)

   Note: refer to Definition of a Valid Prescriber ECL Matrix above for reject, submission clarification, and approved message codes that may be used when the NPI is not yet available.

   Question:
   The NCPDP Emergency Preparedness Information document v1.3, provides resource information for the pharmacy industry for a declared emergency. (http://www.ncpdp.org/Resources/Emergency-Preparedness) In the Prescriber Segment, guidance is given for submission of the pharmacy’s NPI in emergency situations when the pharmacist may prescribe.

   In the event that Part D claims are subject to a declared emergency, and the state has granted the pharmacist the authority to prescribe, will CMS accept the pharmacy’s Type 2 NPI as the prescriber ID on the submitted PDE?

   Response:
   CMS Response: “For CY 2013, the answer is yes.” The WG1 Definition of a Valid Prescriber Task Group will ask CMS on guidance after CY 2013.

   Question:
   What should be submitted on the PDE as the prescriber ID for Part D vaccines administered by the pharmacy/pharmacist or clinic/nurse?

   Response:
   ▪ CMS requires the PDE to be submitted with an active and valid type 1 NPI. For vaccines, this may be the NPI of one of the following prescribers:
     o a prescriber who has written a prescription for the product
     o a prescriber who has issued an established protocol for the product
     o a mid-level or alternate care provider (pharmacist, nurse practitioner, mid-wife, etc.) who is administering the vaccine who has prescriptive authority per state law
     ▪ In the event that the plan’s database does not include the NPIs of mid-level and/or alternate care providers, the point of service communication process may require the Submission Clarification Code (420-DK) override of 42 (Prescriber ID Submitted is active and prescribing requirements have been validated).
     ▪ Note, for emergency situations please see previous question.

   Question:
   How should the Medicare Part D prescription claim and PDE be processed in the situation where the prescriber is not a HIPAA covered entity and refuses to obtain a Type 1 NPI?
Response:
CMS response: The vast majority of prescribers are either HIPAA covered entities themselves, or even more commonly, have a member, employment, or contractual relationship with an organization covered health care provider. In both instances, the prescribers must obtain an NPI. For the very limited instances when a Part D sponsor has verified that a prescriber does not have an NPI and the sponsor has been unable to persuade the prescriber to obtain one, the sponsor may report this instance to HHS/CMS/OESS as a possible violation of HIPAA Administrative Simplification requirements by an organization covered health care provider or covered entity. Please see [http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Enforcement/index.html](http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Enforcement/index.html) to learn more about the HIPAA Enforcement process and how to file a complaint.

In the event that the prescriber does not obtain an individual Type 1 NPI, the Part D Sponsor will not be able to submit the PDE. There is not a PDE exception process for this situation. The sponsor must administer the benefit and update the accumulators correctly.

Question:
How should the Medicare Part D prescription claim and PDE be processed in the situation with a deceased prescriber who did not obtain an NPI (where state law allows subsequent dispensing to process after a prescriber’s death)?

Response:
CMS Response: In this situation, which we believe will be extremely rare; the Part D sponsor will not be able to submit the PDE. There is not a PDE exception process for this situation. The sponsor must administer the benefit and update the accumulators correctly. (It is understood that this situation will eventually resolve itself in time.)

21.22.5 VETERINARIAN IDENTIFIERS

Question:
Are veterinarian prescribers identified with an NPI?

Response:
No.
Per CMS: Veterinarians do not meet the regulatory definition of "health care provider" and are thus ineligible for NPI numbers (unless they meet the definition in some other capacity).


1. If pharmacies dispense medications for non-humans, the claims are not submitted with a NPI for the prescriber.
2. If a processor only supports NPI as the prescriber ID, all claims must be for humans. In other words, the processor would not support claims for non-humans.
3. If a processor supports a veterinary program or offers a discount program regardless of species (i.e. human and non-human), they should allow the State License (or DEA) on these claims.
4. Processors should clearly identify on their payer sheets how veterinarian prescribed claims are identified and submitted (non-human claim supports prescriber ID State License (or DEA)).

21.22.6 STATE LICENSE QUESTIONS

Question:
Which Reject Code (S11-FB) value should be returned when the payer/processor is unable to identify an active state license number with prescriptive authority for the submitted prescriber ID?

Response:
If the payer/processor determines based on the plan’s prescriber data that an active and valid state license with prescriptive authority cannot be found for the submitted prescriber ID, reject code 777 ([Plan’s Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted](http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Enforcement/index.html)) should be returned with the rejected response. Reject Code 777 was published in the October 2014 Emergency ECL Addendum for use as of April 1, 2015.
Question: Which Submission Clarification Code (420-DK) value should be used when a claim is resubmitted as a result of the payer/processor’s reject for no active state license with prescriptive authority on the plan’s prescriber data base, however the pharmacy has validated the prescriber’s license to be active and valid?

Response: Submission Clarification Code 52 (Prescriber’s state license with prescriptive authority has been validated—Indicates the prescriber ID submitted is associated to a healthcare provider with the applicable state license that grants prescriptive authority) would be used when the pharmacy determines the prescriber’s state license is active and with the applicable prescriptive authority.

- Submission Clarification Code 52 was published in the April 2015 Emergency ECL Addendum and is available for use as of October 15, 2015.
- For the period between April 01, 2015 and October 15, 2015, Submission Clarification Code 42 (Prescriber ID Submitted is active and prescribing requirements have been validated) should be used.

It was determined that a unique Submission Clarification Code (420-DK) value is needed to allow payer/processors and pharmacies to manage the hierarchical rule set that includes Medicare Part D prescriber validation. The unique value allows for distinct rule sets to apply based on the specific prescriber validation step. For example:

- Submission Clarification Code 42 would only be used for prescriber validation conflicts which occur prior to the Medicare prescriber enrollment check.

Distinct Submission Clarification Code values would be used for Medicare enrollment conflicts and each prescriber validation check thereafter (e.g. active and valid state license).

21.22.7 OTHER PRESCRIBER ID QUESTIONS

Question: Is the plan obligated to reimburse the patient for Direct Member Reimbursement (DMR) where the plan is unable to obtain a valid prescriber NPI?

Response: NCPDP received the following from CMS: “If the claim otherwise satisfies the criteria for a DMR, the plan cannot refuse to pay within the required timeframe because there is no active and valid NPI. Payment to the beneficiary cannot be made dependent upon the sponsor’s acquisition of the prescriber ID.”

Question: When does the Medicare Part D plan sponsor need to provide 24 hour follow up with the pharmacy due to a prescriber validation error?

Response: Refer to prescriber validation reject scenario matrix in Version D Editorial.

Medicare Part D plan sponsors should have policies in place consistent with CMS guidance for all prescriber validation reject scenarios identified within the matrix.

Question: Does the 24 hour follow up requirement outlined under CMS 4157 (highlighted below) apply in any manner to Medicare Part D prescription claims submitted as of the enforcement date of CMS 4149 (§ 423.120(c)(5) and (6))?

...effective January 1, 2013, that Part D sponsors must submit an active and valid individual prescriber NPI on any PDE record submitted to CMS. Revising our policy and the regulation text to require a Part D sponsor to ensure that the lack of an active and valid individual prescriber NPI on a network pharmacy claim does not unreasonably delay a beneficiary’s access to a covered Part D drug. Sponsors will be required to so ensure in the following manner: (1) a sponsor must communicate at point-of-sale whether or not the prescriber NPI is active and valid; (2) if the sponsor communicates that the prescriber NPI is not active and valid, the sponsor must permit the pharmacy to confirm that the NPI is active and valid, or in the alternative, to correct it; (3) if the pharmacy
confirms that the prescriber NPI is active and valid or corrects it, the sponsor must pay the claim if it is otherwise payable; and (4) if the pharmacy cannot or does not correct or confirm that the prescriber NPI is active and valid, the sponsor must require the pharmacy to resubmit the claim (when necessary), which the sponsor must pay, if it is otherwise payable, unless there is an indication of fraud or the claim involves a prescription written by a foreign prescriber (where permitted by State law). We would expect the back-and-forth between a sponsor and network pharmacy described previously to take no more than 24 hours, which means that sponsors will have to have controls in place to make sure network pharmacies resubmit claims where the sponsor has communicated an issue with the NPI and a pharmacy cannot or does not correct or confirm that the NPI is active and valid. If an active and valid prescriber ID is not included on the Part D claim, either the sponsor, or the pharmacy if in accordance with the contractual terms of the network pharmacy agreement, must follow up retrospectively to acquire an active and valid ID before the PDE may be submitted to CMS...

...further revising the regulation text to state that a Part D sponsor must not later recoup payment from a network pharmacy for a claim that does not contain an active and valid individual prescriber NPI on the basis that it does not contain one, unless the sponsor: (1) has complied with the POS requirements previously described; (2) has verified that a submitted NPI was not in fact active and valid; and (3) the agreement between the parties explicitly permits such recoupment.

Response:
The 24 hour period described above is CMS guidance that applies to 423.120(c)(5), which is the current regulation in effect. It is not applicable to 423.120(c)(6), which will be enforced beginning December 1, 2015 per CMS HPMS memo of December 2014.

21.23  **MEDICARE PART D/MEDICAID BENZODIAZEPINE AND BARBITURATE**

**CLAIMS PROCESSING RISKS**

Question: How should Medicare and Medicaid handle the processing of benzodiazepine and barbiturates?

Response:
Medicaid may be billed as primary due to barbiturates previously being excluded under Medicare Part D and the patient’s Medicaid plan being set as the primary payer for this prescription or drug. If Medicaid is billed as primary, per CMS guidance, the claim should be rejected as P/A required rather than code “41” (Submit to Primary) to avoid patient care disruptions.

While this specific question is relative to the conditional coverage of barbiturates in the 2013 benefit year there is an overall need to address prior authorization requirements with COB processing.

The claim denied by Medicare Part D will be represented in the COB Segment within the Other Payer Reject Code (472-6E) field. Other Payer Reject Codes may include:

- “75” (P/A Required)
- “3Y” (P/A Denied) Note: Reject Code is not commonly used today as payers P/A review process is not linked to the claims adjudication system.
- “70” (Product/Service Not Covered – Plan Benefit Exclusion)
- “MR” (Product Not on Formulary)
- “39” (M/I Diagnosis Code)
- “80” (Drug/Diagnosis Mismatch)

If the COB claim contains any of the above Other Payer Reject Code (472-6E) values, the Medicaid plan may choose to accept and pay the claim or deny using Reject Code (511-FB) values “75” (P/A Required) or “39” (M/I Diagnosis Code) confirming the patient’s disease state.

<table>
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<tr>
<th>Other Payer Reject Code</th>
<th>Medicaid COB Claim Response Recommendation</th>
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</thead>
<tbody>
<tr>
<td>“75” (P/A Required)*</td>
<td>Reject as P/A required or diagnosis required to validate Medicare Part D determination of drug not covered.</td>
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</tbody>
</table>
Other Payer Reject Code | Medicaid COB Claim Response Recommendation
---|---
“39” (M/I Diagnosis Code)* | Reject as P/A required or diagnosis required to validate Medicare Part D determination of drug not covered.
“70” (Product/Service Not Covered – Plan Benefit Exclusion)* | Reject as P/A required or diagnosis required to validate Medicare Part D determination of drug not covered.
“MR” (Product Not on Formulary)* | Reject as P/A required or diagnosis required to validate Medicare Part D determination of drug not covered.
“80” (Drug/Diagnosis Mismatch)* | Reject as P/A required or diagnosis required to validate Medicare Part D determination of drug not covered.
“3Y” (P/A Denied)** | Options are to accept or reject the claim as P/A required or diagnosis required if additional information is needed for documentation.
Any other Reject Codes not listed above | Reject using standard processes

*Unable to determine if Reject Codes are from initial reject or subsequent to a P/A request being denied where processor returns the same reject code.

**Intent was to be used with the P/A Request And Billing Transaction (P1) and P/A Request Only (P4) therefore not commonly used with the Billing Transaction (B1).

This business case is not limited to Medicare Part D/Medicaid claims for benzodiazepine and barbiturates. The effort to obtain a prior authorization approval cannot be effectively communicated by the pharmacy to the downstream payer unless the rejected claim response includes reject code “3Y” (P/A Denied) when the prior authorization request has been denied. Currently most processor systems do not link prior authorization denials to the claims processing. The following short and long term Industry recommendations should address this business case.

**Short Term Recommendation:** Downstream payers should not automatically assume that the P/A has not been requested. (This assumes that the pharmacy software is reporting all prior payers reject code values on the claim.) Until such time as the industry links the P/A process to indicate the pending status or rejection of a P/A request within the payers adjudication system, downstream payers need to develop processes to evaluate the actual status of Other Payer Reject Code “75” (P/A Required). For example, Patient is a Part D beneficiary, drug is a barbiturate and prior payer has rejected the claim for “P/A Required” and by verbal or other communication provider has determined the P/A has been denied.

**Long Term Recommendation:** Payers need to refine the P/A process to log the status of the request; approved, pending or denied in order to provide the information back on a claim so that downstream payers may react accordingly. This minimizes additional pharmacy provider intervention downstream.

### 21.24 Other Carrier Payment Meets or Exceeds Payable

**Question:**
When Medicare D Plan is paying second (MSP) and the 1st payer met or exceeded the payable, CMS guidance is to not reject the claim with a “74” (Other Carrier Payment Meets Or Exceeds Payable) but rather return a $0 claim (patient and net check are both $0). What would the pharmacy collect from the patient in these situations? Using the example below would the pharmacy collect nothing ($0) because the patient pay is $0 from the secondary payer or would the pharmacy realize that the secondary payer Medicare Part D plan paid nothing and collect the patient pay from the 1st payer of $50?

For example:

Payer #1 (commercial plan)
- Ingredient cost $200
- Dispensing fee $5
- Incentive/Admin $0
- Sales tax $10

Response from Payer #1
- Ingredient cost $190
- Dispensing fee $2
- Incentive/Admin $0
- Sales tax $9

**Net check $151**
Patient pay $50
Payer #2 (Medicare D plan)
Ingredient cost $200
Dispensing fee $5
Incentive/Admin $0
Sales tax $10
**Other payer paid $151**

Response from Payer #2

Ingredient cost $100
Dispensing fee $2
Incentive/Admin $0
**Other Payer Amount Recognized $102**
Sales tax $0
Net check $0
Patient pay $0

Response:

In general when processing COB claims:

- If secondary payer does not have COB benefit, then claim could reject
- If secondary does have COB benefit and their allowed amount is less than primary paid amount then:
  - A paid response may be returned as Patient Pay Amount (505-F5) equal to $0 and Total Amount Paid (509-F9) equal to $0
  - Or
  - A rejected response may be returned using Reject Code (511-FB) value of “74” (Other Carrier Payment Meets Or Exceeds Payable)
- When a COB paid response is based on Other Payer Amount Paid (431-DV) it must include the Ingredient Cost Paid (506-F6), Dispensing Fee Paid (507-F7), etc. as if paying primary and represent within Other Payer Amount Recognized (566-J5) the like Other Payer Amount Paid values (431-DV) recognized in the reimbursement calculation.
- For a COB claim where Patient Pay Amount and Total Amount Paid are returned as $0, the Patient Pay Amount collected by the pharmacy would be based on the contractual agreement between the pharmacy and the COB payer.

Per CMS MSP guidance dated April 26, 2006 “If the primary payment is greater than or equal to the negotiated price, no other payments are made.” Per NCPDP standards, primary payment as referenced in the statement above would be the recognized Other Payer Amount Paid values using like value comparison. From the CMS MSP guidance:

“17.4.2 Pricing and calculation rules”

In the logic for pricing and adjudicating an MSP claim under Part D, the provider/pharmacy receives at least the Part D plan’s negotiated price for the drug. Payments are applied to this price in the following order: primary insurer’s payment, beneficiary cost sharing liability under the Part D PBP, and finally the Part D plan picks up any remaining balance. In other words, the primary payment reduces plan-paid amounts first, then beneficiary liabilities. If the primary payment is greater than or equal to the negotiated price, no other payments are made. In particular, plans shall use the following steps to price an MSP claim and populate a PDE record:

1.1.1 Price or re-price the claim according to the Part D plan’s negotiated price for the drug. In the GDCB or GDCA field, report the negotiated price if the drug is covered or $0 if the drug is non-covered.
1.1.2 Report the primary payment amount in the PLRO field. Note that if PLRO ≥ gross drug cost (negotiated price), all other payment amounts on the PDE record are $0.”

<p>| Example 1: Secondary Submission for Other Payer Amount Paid where COB payer pays a remaining amount. |
|---|---|
| 101-A1 | BIN NUMBER |
| 102-A2 | VERSION RELEASE NUMBER |
| 103-A3 | TRANSACTION CODE |
| 104-A4 | PROCESSOR CONTROL NUMBER |
| 109-A9 | TRANSACTION COUNT |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER |</p>
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### EXAMPLE #2

Secondary Submission for Other Payer Amount Paid where that amount is greater than COB Payer’s rate.

*Submission criteria the same, payment response is different.*

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The pricing of the COB claim is likely to be different from the amount paid by the first payer. The net pay may be more or less (and could be the same). Depending on payment parameters of the COB payer, the patient may or may not have a copay (COB does not automatically mean the patient copay results in zero).
### Telecommunication Version D and Above Questions, Answers and Editorial Updates

| 338-SC | OTHER PAYER COVERAGE TYPE | 01 (Primary) |
| 339-6C | OTHER PAYER ID QUALIFIER | 03 |
| 340-7C | OTHER PAYER ID | 789123 |
| 443-E8 | OTHER PAYER DATE | 20100409 |
| 341-HB | OTHER PAYER AMOUNT PAID COUNT | 1 |
| 342-HC | OTHER PAYER AMOUNT PAID QUALIFIER | 07 Drug Benefit |
| 431-DV | OTHER PAYER AMOUNT PAID | $90.00 |

**TRANSACTION RESPONSE**

| 102-A2 | VERSION/RELEASE NUMBER | D0 |
| 103-A3 | TRANSACTION CODE | B1 |
| 109-A9 | TRANSACTION COUNT | 1 |
| 501-F1 | HEADER RESPONSE STATUS | A |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | 01 |
| 201-B1 | SERVICE PROVIDER ID | 123456789 |
| 401-D1 | DATE OF SERVICE | 20100409 |

**RESPONSE STATUS SEGMENT**

| 111-AM | SEGMENT IDENTIFICATION | 21 |
| 112-AN | TRANSACTION RESPONSE STATUS | P |
| 503-F3 | AUTHORIZATION NUMBER | 123654987322 |

**RESPONSE CLAIM SEGMENT**

| 111-AM | SEGMENT IDENTIFICATION | 22 |
| 455-EM | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER | 1 |
| 402-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER | 200345 |

**RESPONSE PRICING SEGMENT**

| 111-AM | SEGMENT IDENTIFICATION | 23 |
| 506-F6 | INGREDIENT COST PAID | $86.00 |
| 507-F7 | DISPENSING FEE PAID | $3.00 |
| 566-JS | OTHER PAYER AMOUNT RECOGNIZED* | $89.00 |
| 505-F5 | PATIENT PAY AMOUNT | $0.00 |
| 509-F9 | TOTAL AMOUNT PAID | $0.00 |
| 572-4U | AMOUNT OF COINSURANCE | $0.00 |
| 522-FM | BASIS OF REIMBURSEMENT DETERMINATION | 01 (AWP) |

*Since $90.00 was already paid and the net due pharmacy per this payer contract is $89.00, Other Payer Amount Recognized is the amount of dollars from Other Payer Amount Paid ‘used’ in order for Total Amount Paid to balance.

**17.4.2 Pricing and calculation rules**

In the logic for pricing and adjudicating an MSP claim under Part D, the provider/pharmacy receives at least the Part D plan’s negotiated price for the drug. Payments are applied to this price in the following order: primary insurer’s payment, beneficiary cost sharing liability under the Part D PBP, and finally the Part D plan picks up any remaining balance. In other words, the primary payment reduces plan-paid amounts first, then beneficiary liabilities. If the primary payment is greater than or equal to the negotiated price, no other payments are made.

**EXAMPLE #3**

Secondary Submission for Other Payer Amount Paid where that amount is greater than COB Payer’s rate.

*Submission criteria the same, Response is Denied*

For non-Part D claims, Trading Partner Agreement determines whether COB Payer Pays Zero or Rejects.
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Reject "74" (Other Carrier Payment Meets Or Exceeds Payable)
21.25  MILITARY TREATMENT FACILITIES – GOVERNMENT BILLING THE GOVERNMENT

Question:
A Part D member who has commercial coverage as secondary was visiting someone at a military base. For some reason this person went to the base for a prescription.

The military base pharmacy is telling us that they cannot bill Medicare Part D as ‘government’ doesn’t bill ‘government’. So military base pharmacy is billing the commercial coverage who is rejecting for 41 – Bill Other Payer since the commercial coverage is a secondary benefit and the claim submitted is for a primary benefit.

Processor for commercial coverage expects a COB claim as they ‘need to see’ that billing to the other payer, who is primary, was attempted. But military base pharmacy says they can’t do this and are unable to submit a COB claim.

Typical thought would be that pharmacy would require member to pay 100% since the pharmacy is out of network and then member would submit the claim for reimbursement. But that did not seem to happen in this case. The military base pharmacy wants the commercial coverage to have override capability to allow non-COB claim to process under the commercial secondary benefit. How should this situation be addressed?

Response (Based on information provided by CMS):
If the claim is submitted to the supplemental payer, the supplemental payer is under no obligation to pay as primary to accommodate the pharmacy or member.

Per CMS information: The VA and Military Treatment Facility (MTF), by law, cannot bill Medicare. The VA or MTF pharmacy should direct the member to an in-network pharmacy or require the member to pay cash.

If the member is unable to reasonably access a network pharmacy and elects to pay cash, the claim could be submitted by the member for reimbursement and the Medicare Part D plan would determine if the member met the plan’s out-of-network access requirements. The Medicare Part D sponsor may deny the direct member reimbursement (DMR) claim because it’s not a covered Medicare Part D drug unless it’s accessed from a network pharmacy or meets the out-of-network access requirements.

21.26  PROVISIONAL FILL

Question:
How can claims paid under the provisional supply be identified? Is there a way to notify the pharmacy prior to the applicability date of CMS 4159 that the prescriber associated with the Medicare Part D prescription claim is not actively enrolled in Medicare?

Response:
Yes, until a specific Approved Message Code (548-6F) is available, the recommendation is to return the following standardized message within the Additional Information Message Field (526-FQ) - “CMS 4159 Notify Prescriber: Prescriber must enroll in or opt-out of Medicare by 06/01/2016 for continued Part D coverage”. Note: In the event the applicability date changes, processors should adjust the message accordingly.

Response (updated August 2016):
An Approved Message Code was not created because it would not be available until after the applicability date of CMS 4159. Because the effective date was delayed to 2/1/17, the specific date in the message is removed. The recommended standardized message within the Additional Information Message Field (526-FQ) is: “CMS 4159 Notify Prescriber: Prescriber must enroll in or opt-out of Medicare by 06/01/2016 for continued Part D coverage”. The new message may be used prior to effective date as a notification on a paid claim (soft message) and in conjunction with reject code or approved message code after the effective date.

21.27 **Eligibility Verification**

**Question:**
In Section 6.1.1 of the Implementation Guide, the timeframe used by the Facilitator to determine eligibility is up to 90 days prior to or later than the current date. Is this timeframe still accurate?

**Answer:**
No. Pharmacies may submit eligibility transactions with the Date of Service (401-D1) up to 9 months prior to or 4 months in the future from the current date. The effective date of this change was May 23, 2013.

*Added November 2018*

21.27.1 **Eligibility Medicare Part D to Facilitator – Request – Could Not Find This Member**

Member never had Medicare Part D coverage in the past, does not have current Part D coverage, and has no future Part D Coverage based upon the date of service submitted. (Could not find this member. Cardholder ID not found.)

**Date of Request:** 10-01-2012
**Date of Service:** 08-01-2012
**Response:** Rejected Response

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**21.27.1.1 Eligibility Medicare Part D to Facilitator – Reject Response - Could Not Find This Member**

Eligibility Rejected Response – Patient could not be found
**Telecommunication Version D and Above Questions, Answers and Editorial Updates**

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**21.27.2 ELIGIBILITY MEDICARE PART D TO FACILITATOR – REQUEST – FOUND MEMBER BUT NO COVERAGE**

Member had Medicare Part D Coverage in the past but does not have current Part D coverage.

(Found member but no coverage for the date of service submitted.)

Date of Request: 10/01/2012

Date of Service: 08/01/2012

Response: Rejected Response- Member has no Medicare Part D coverage as of date of service submitted.

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**Insurance Segment**

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**21.27.2.1 ELIGIBILITY MEDICARE PART D TO FACILITATOR – REJECT RESPONSE – FOUND MEMBER BUT NO COVERAGE**

Eligibility Rejected Response – Patient found but no Part D Coverage for Date of Service submitted.
Telecommunication Version D and Above Questions, Answers and Editorial Updates

21.27.3   ELIGIBILITY MEDICARE PART D TO FACILITATOR – REQUEST - MEMBER HAS CURRENT MEDICARE PART D COVERAGE AND NO OTHER COVERAGE

Date of Request: 10/01/2012
Date of Service: 08/01/2012
Response: Approved

Note: This Patient data is from the Facilitator’s system. It is not echoed back from the submission information.
### 21.27.3.1 Eligibility Medicare Part D to Facilitator — Approved Response - Member Has Current Medicare Part D Coverage and No Other Coverage

Eligibility Approved Response

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**Note:** This Patient data is from the Facilitator’s system. It is not echoed back from the submission information.

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### 21.27.4 Eligibility Medicare Part D to Facilitator — Request — Member Has Current Medicare Part D Coverage (Primary) and Current Other Coverage

314
Eligibility Approved Response With More Than Two Payers

Loops of Coordination of Benefits/Other Payments Segment show three Other Coverages in the order shown above.

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### INSURANCE SEGMENT

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### 21.27.4.1 ELIGIBILITY MEDICARE PART D TO FACILITATOR – APPROVED RESPONSE – MEMBER HAS CURRENT MEDICARE PART D COVERAGE (PRIMARY) AND CURRENT OTHER COVERAGE

Eligibility Approved Response With More Than Two Payers

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21.27.5 **ELIGIBILITY MEDICARE PART D TO FACILITATOR – REQUEST – MEMBER HAS CURRENT MEDICARE PART D COVERAGE AND NO OTHER COVERAGE (DATE OF SERVICE IS BASED UPON ALLOWED FUTURE DATE RANGE)**

Note: This Patient data is from the Facilitator’s system. It is not echoed back from the submission information.

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<td>BIN</td>
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<td>OTHER PAYER GROUP ID</td>
<td>Q</td>
<td>789123</td>
<td></td>
</tr>
<tr>
<td>142-UV</td>
<td>OTHER PAYER PERSON CODE</td>
<td>Q</td>
<td>010</td>
<td>01 = Other Payer assigned person code.</td>
</tr>
<tr>
<td>143-UW</td>
<td>OTHER PAYER PATIENT RELATIONSHIP CODE</td>
<td>Q</td>
<td>1</td>
<td>Cardholder</td>
</tr>
<tr>
<td>127-U8</td>
<td>OTHER PAYER HELP DESK NUMBER</td>
<td>Q</td>
<td>5556861111</td>
<td>Primary Payer listed Help Desk Telephone Number – in this instance is the Part D help desk</td>
</tr>
<tr>
<td>144-U8</td>
<td>OTHER PAYER BENEFIT EFFECTIVE DATE</td>
<td>Q</td>
<td>20120101</td>
<td>January 1, 2012</td>
</tr>
<tr>
<td>145-U8</td>
<td>OTHER PAYER BENEFIT TERMINATION DATE</td>
<td>Q</td>
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<td>September 30, 2012</td>
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<tr>
<td>338-SC</td>
<td>OTHER PAYER COVERAGE TYPE</td>
<td>M</td>
<td>02</td>
<td>Secondary</td>
</tr>
<tr>
<td>339-6C</td>
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<td>R</td>
<td>03</td>
<td>BIN</td>
</tr>
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<td>00 = Other Payer assigned person code</td>
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<td>127-U8</td>
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</tr>
<tr>
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<td>Q</td>
<td>20120201</td>
<td>February 1, 2012</td>
</tr>
<tr>
<td>145-U8</td>
<td>OTHER PAYER BENEFIT TERMINATION DATE</td>
<td>Q</td>
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</tr>
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<td>Other Payer B</td>
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<td>142-UV</td>
<td>OTHER PAYER PERSON CODE</td>
<td>Q</td>
<td>00</td>
<td>00 = Other Payer assigned person code</td>
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<tr>
<td>143-UW</td>
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<td>1</td>
<td>Cardholder</td>
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<tr>
<td>127-U8</td>
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<td>Other Payer B Help Desk Telephone Number</td>
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<tr>
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<td>Q</td>
<td>20120801</td>
<td>August 1, 2012</td>
</tr>
<tr>
<td>145-U8</td>
<td>OTHER PAYER BENEFIT TERMINATION DATE</td>
<td>Q</td>
<td>20121231</td>
<td>December 31, 2012</td>
</tr>
</tbody>
</table>
Date of Request: **10/01/2011**
Date of Service: **01/01/2012** note this is a future date
Member is effective as of date of service with Medicare Part D as primary (01/01/2012 through 09/30/2012)
Response: Approved

### TRANSACTION HEADER SEGMENT

<table>
<thead>
<tr>
<th>FIELD</th>
<th>FIELD NAME</th>
<th>CAT</th>
<th>VALUE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>101-A1</td>
<td>BIN NUMBER</td>
<td>M</td>
<td>011727</td>
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</tr>
<tr>
<td>102-A2</td>
<td>VERSION/RELEASE NUMBER</td>
<td>M</td>
<td>D0</td>
<td>Transaction Format</td>
</tr>
<tr>
<td>103-A3</td>
<td>TRANSACTION CODE</td>
<td>M</td>
<td>E1</td>
<td>Eligibility verification</td>
</tr>
<tr>
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<td>109-A9</td>
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<td>National Provider ID</td>
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<tr>
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<td>SERVICE PROVIDER ID</td>
<td>M</td>
<td>4563663111bbbbb</td>
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</tr>
<tr>
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<td>DATE OF SERVICE</td>
<td>M</td>
<td>20120101</td>
<td>January 1, 2012</td>
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<tr>
<td>110-AK</td>
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<td>M</td>
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### PATIENT SEGMENT

<table>
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<tr>
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<th>CAT</th>
<th>VALUE</th>
<th>COMMENTS</th>
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<tr>
<td>111-AM</td>
<td>SEGMENT IDENTIFICATION</td>
<td>M</td>
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<td>PATIENT SEGMENT</td>
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<tr>
<td>304-C4</td>
<td>DATE OF BIRTH</td>
<td>Q</td>
<td>19620615</td>
<td>Born June 15, 1962</td>
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<tr>
<td>305-CS</td>
<td>PATIENT GENDER CODE</td>
<td>Q</td>
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<td>Male</td>
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<tr>
<td>310-CA</td>
<td>PATIENT FIRST NAME</td>
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<td>SAMUEL</td>
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</tr>
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<td>311-CB</td>
<td>PATIENT LAST NAME</td>
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<td>JONES</td>
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<tr>
<td>322-CM</td>
<td>PATIENT STREET ADDRESS</td>
<td>Q</td>
<td>123 MAIN STREET</td>
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</tr>
<tr>
<td>323-CN</td>
<td>PATIENT CITY ADDRESS</td>
<td>Q</td>
<td>MY TOWN</td>
<td></td>
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<tr>
<td>324-CD</td>
<td>PATIENT STATE/PROVINCE ADDRESS</td>
<td>Q</td>
<td>CO</td>
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<td>325-CP</td>
<td>PATIENT ZIP/POSTAL ZONE</td>
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### INSURANCE SEGMENT

<table>
<thead>
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<th>FIELD NAME</th>
<th>CAT</th>
<th>VALUE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
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<td>SEGMENT IDENTIFICATION</td>
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<td>302-C2</td>
<td>CARDHOLDER ID</td>
<td>M</td>
<td>123456789</td>
<td>The HICN (Health Insurance Claim Number, Part A, B, or C), SSN, or RRB.</td>
</tr>
</tbody>
</table>

### 21.27.5.1 ELIGIBILITY MEDICARE PART D TO FACILITATOR – APPROVED RESPONSE – MEMBER HAS CURRENT MEDICARE PART D COVERAGE AND NO OTHER COVERAGE

Eligibility Approved Response

### RESPONSE HEADER SEGMENT

<table>
<thead>
<tr>
<th>FIELD</th>
<th>FIELD NAME</th>
<th>CAT</th>
<th>VALUE</th>
<th>COMMENTS</th>
</tr>
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<td>D0</td>
<td>Transaction Format</td>
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<td>E1</td>
<td>Eligibility Verification</td>
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<tr>
<td>109-A9</td>
<td>TRANSACTION COUNT</td>
<td>M</td>
<td>1</td>
<td>One occurrence</td>
</tr>
<tr>
<td>501-F1</td>
<td>HEADER RESPONSE STATUS</td>
<td>M</td>
<td>A</td>
<td>Accepted</td>
</tr>
<tr>
<td>202-B2</td>
<td>SERVICE PROVIDER ID QUALIFIER</td>
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<td>01</td>
<td>National Provider ID</td>
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<tr>
<td>201-B1</td>
<td>SERVICE PROVIDER ID</td>
<td>M</td>
<td>4563663111bbbbb</td>
<td></td>
</tr>
<tr>
<td>401-D1</td>
<td>DATE OF SERVICE</td>
<td>M</td>
<td>20120101</td>
<td>January 1, 2012</td>
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### RESPONSE INSURANCE ADDITIONAL INFORMATION SEGMENT

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<th>VALUE</th>
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</tr>
</thead>
<tbody>
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<td>RESPONSE INSURANCE ADDITIONAL INFORMATION SEGMENT</td>
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<td>139-UR</td>
<td>MEDICARE PART D COVERAGE CODE</td>
<td>M</td>
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<td>Primary</td>
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### RESPONSE INSURANCE ADDITIONAL INFORMATION SEGMENT

<table>
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<tr>
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<th>FIELD NAME</th>
<th>CAT</th>
<th>VALUE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>138-UQ</td>
<td>CMS LOW INCOME COST SHARING (LICS) LEVEL</td>
<td>Q</td>
<td>Y</td>
<td>Yes</td>
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<tr>
<td>240-U1</td>
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<td>Q</td>
<td>ABCXUX333</td>
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<tr>
<td>926-FF</td>
<td>FORMULARY ID</td>
<td>Q</td>
<td>F33H12XU</td>
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<tr>
<td>757-U6</td>
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### RESPONSE PATIENT SEGMENT
**Telecommunication Version D and Above Questions, Answers and Editorial Updates**

<table>
<thead>
<tr>
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<th>FIELD NAME</th>
<th>CAT</th>
<th>VALUE</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>111-AM</td>
<td>SEGMENT IDENTIFICATION</td>
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<td>29</td>
<td>RESPONSE PATIENT SEGMENT</td>
</tr>
<tr>
<td>310-CA</td>
<td>PATIENT FIRST NAME</td>
<td>M</td>
<td>SAM</td>
<td></td>
</tr>
<tr>
<td>311-CB</td>
<td>PATIENT LAST NAME</td>
<td>Q</td>
<td>JONES</td>
<td></td>
</tr>
<tr>
<td>304-C4</td>
<td>DATE OF BIRTH</td>
<td>Q</td>
<td>19620615</td>
<td>Born June 15, 1962</td>
</tr>
</tbody>
</table>

Note: This Patient data is from the Facilitator’s system. It is not echoed back from the submission information.

<table>
<thead>
<tr>
<th>FIELD</th>
<th>FIELD NAME</th>
<th>CAT</th>
<th>VALUE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
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<td>A</td>
<td>Approved</td>
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<tr>
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<tr>
<td>130-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION COUNT</td>
<td>R</td>
<td>1</td>
<td>1 occurrence</td>
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<tr>
<td>132-UH</td>
<td>ADDITIONAL MESSAGE INFORMATION QUALIFIER</td>
<td>R</td>
<td>01</td>
<td>Used for first line of free form text with no pre-defined structure.</td>
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<tr>
<td>526-FQ</td>
<td>ADDITIONAL MESSAGE INFORMATION</td>
<td>Q</td>
<td>TRANSACTION MESSAGE TEXT</td>
<td>For illustrative purposes only. Up to 40 Bytes</td>
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**RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT**

<table>
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<th>CAT</th>
<th>VALUE</th>
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<tbody>
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<td>Primary</td>
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<tr>
<td>339-SC</td>
<td>OTHER PAYER ID QUALIFIER</td>
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<td>03</td>
<td>BIN</td>
</tr>
<tr>
<td>340-7C</td>
<td>OTHER PAYER ID</td>
<td>Q</td>
<td>123456</td>
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</tr>
<tr>
<td>991-MH</td>
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<tr>
<td>992-MI</td>
<td>OTHER PAYER GROUP ID</td>
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<td>789123</td>
<td></td>
</tr>
<tr>
<td>142-UV</td>
<td>OTHER PAYER PERSON CODE</td>
<td>Q</td>
<td>01</td>
<td>01 = Other Payer assigned person code</td>
</tr>
<tr>
<td>143-UW</td>
<td>OTHER PAYER PATIENT RELATIONSHIP CODE</td>
<td>Q</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>127-UB</td>
<td>OTHER PAYER HELP DESK NUMBER</td>
<td>Q</td>
<td>5556861111</td>
<td>Primary Payer listed Help Desk Phone Number - in this instance is the Part D help desk</td>
</tr>
<tr>
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<td>January 1, 2012</td>
</tr>
<tr>
<td>145-UY</td>
<td>OTHER PAYER BENEFIT TERMINATION DATE</td>
<td>Q</td>
<td>20120930</td>
<td>September 30, 2012</td>
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</table>
22 APPENDIX E. ROUTE OF ADMINISTRATION QUESTIONS

22.1 Route of Administration Used in NCPDP Telecommunication Standard

1. **Question:** What is the purpose of “Appendix H. Route of Administration Transition” in the Telecommunication Standard Implementation Guide?

   **Response:** This appendix was only presented for transition purposes to Telecommunication Standard Version C.4 and above. If you were an entity that used the original two-digit Compound Route of Administration (452-EH) values in versions prior to Telecommunication Standard Version C.4, this appendix was added to assist in transition from the NCPDP code values formerly found in Compound Route of Administration (452-EH) in the Compound Segment to the Route of Administration (995-E2) in the Claim Segment, which only uses Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT).

   Prior to Telecommunication Standard Version C.4, Compound Route of Administration (452-EH) was used. In Version C.4, Compound Route of Administration (452-EH) was sunsetted. Route of Administration (995-E2) supported in Version C.4 and above, uses the SNOMED values.

   If you did not use the original two-digit Compound Route of Administration (452-EH) values in Telecommunication Standard Version C.3 and below, “Appendix H. Route of Administration Transition” was not intended to be used. The valid Route of Administration codes found in SNOMED are to be used for Telecommunication Standard Version C.4 and above.

   It is important that you read the updated information on “Route of Administration (995-E2) and SNOMED Codes” for corrections and other information.

2. **Question:** Are the values in “Appendix H. Route of Administration Transition” in the Telecommunication Standard Implementation Guide the only values to use?

   **Response:** No. The SNOMED codes listed were only given to assist if an entity was using the original two-digit Compound Route of Administration (452-EH) values. If you did not use the original two-digit Compound Route of Administration (452-EH) values, “Appendix H. Route of Administration Transition” should not be used.

   It is important that you read the updated information on “Route of Administration (995-E2) and SNOMED Codes” for corrections and other information.

3. **Question:** Is Route of Administration (995-E2) required in NCPDP transactions?

   **Response:** No. The Route of Administration (995-E2) is not mandatory or required in NCPDP transactions. The field is situational (Required if specified in trading partner agreement). Entities that wish to receive the field are to denote the situation when the field should be sent. It is recognized that the submission of Route of Administration (995-E2) in transactions helps to further clarify the compound being submitted.

4. **Question:** Where is the SNOMED code list?

   **Response:** The Route of Administration subset is now available publically from the NLM SNOMED CT web site at [http://www.nlm.nih.gov/research/umls/licensedcontent/snomedctfiles.html](http://www.nlm.nih.gov/research/umls/licensedcontent/snomedctfiles.html). As before, it was derived from the SNOMED CT route of administration values hierarchy in the latest international release of SNOMED CT.

   NLM has a website which addresses some frequently asked questions: [http://www.nlm.nih.gov/research/umls/Snomed/snomed_faq.html](http://www.nlm.nih.gov/research/umls/Snomed/snomed_faq.html)
5. **Question:** How often is a version of SNOMED released?
   **Response:** A new version of SNOMED CT is released every 6 months. If there have been accepted requests during that time, then that would be the release cycle. The release dates are approximately January 31 and July 31.

   Trading partners are strongly encouraged not to use retired and/or ambiguous codes that are not valid Route of Administration codes per SNOMED guidance.

6. **Question:** Can a payer choose to limit which SNOMED codes they will accept and reject a code that is a valid SNOMED code?
   **Response:** If the payer accepts Route of Administration, they must accept valid SNOMED codes. NCPDP does not dictate business requirements. If the Route of Administration field contains a valid SNOMED code the value cannot be rejected with a Reject Code of “E2” (Missing/Invalid (M/I) Route of Administration). The payer may reject if their business warrants (not covered, not supported, e.g. perhaps they do not pay for injectables or such) with Reject Codes such as “552” (Route of Administration Value Not Supported), “9Q” (Route Of Administration Submitted Not Covered) or other applicable rejects.

7. **Question:** Can the old Compound Route of Administration (452-EH) codes be used in Telecom D.0 if they are sufficient for the client’s needs?
   **Response:** No. For Telecommunication Standard Version D.0 and above, on the SNOMED codes are to be used.

8. **Question:** Can both be used for Compound Route of Administration (452-EH) - the old NCPDP codes where they work and the SNOMED codes used for the missing situations not covered by NCPDP codes?
   **Response:** No. In one version of the Telecommunication Standard multiple code lists cannot be used for the Compound Route of Administration (452-EH). For Telecommunication Standard Version C.4 and above, the SNOMED codes are to be used.

9. How should the industry support the changes within the SNOMED vocabulary which occurs outside the NCPDP ECL timelines?
   **Response:** The NCPDP External Code List timelines were developed and approved by the NCPDP membership for values that occur **within** the NCPDP External Code List publications. The vocabulary owners (FDA for NDC, HHS for ICD, NLM for SNOMED, NCI for FMT DoseForm, etc) are based on the schedule established by these entities for their products. As the industry implements for example NDC or ICD-9 updates outside of the NCPDP External Code List timeline, so implementation of SNOMED is based on NLM’s publication dates.

10. **Note,** “Appendix H. Route of Administration Transition” will be sunsetted in Telecommunication Standard Version E.0.
APPENDIX F. POINT OF SERVICE PRESCRIBER VALIDATION GUIDANCE APPLICABLE TO CMS 4159 AND IFC 6107

23.1 INTRODUCTION

Update October 2018:
CMS rule 4182-F replaces the Medicare Prescriber Enrollment requirement under CMS 4159 and IFC 6107 with the Medicare Precluded Provider requirement. While the effective date of this provision is January 1, 2019, refer to CMS FAQ’s which indicates point-of-service (POS) edits will apply as of April 1, 2019. Information below will be updated as additional guidance is provided by CMS.

CMS final rule 4157, provision 423.120(c)(5) effective January 01, 2013 required an active an valid prescriber NPI to be submitted on the PDE and validation of controlled substance prescriptive authority. As a result of these requirements, new NCPDP Reject Codes (511-FB), Submission Clarification Codes (420-DK) and Approved Message Codes (548-6F) were added to the External Code List to support the necessary point of service telecommunication process. Guidance in the form of a reject code matrix was also published within Version D Editorial Document under section “PROCESSING WITH PRESCRIBER ID.” CMS final rule 4159, provision 423.120(c)(6) and IFC 6107 which as of the publication of this document are applicable as of June 01, 2016, require prescriber Medicare enrollment/opt-out validation in coordination with an Other Authorized Prescriber (OAP) and provisional supply exception process. This appendix outlines these regulations, associated CMS guidance and provides implementation guidance through the use of new and updated NCPDP reject codes, submission clarification codes and approved message codes.

23.2 BACKGROUND:

- CMS 4157-F Effective 01/01/2013
  - “Sponsors will be required to so ensure in the following manner: (1) a sponsor must communicate at point-of-sale whether or not the prescriber NPI is active and valid; (2) if the sponsor communicates that the prescriber NPI is not active and valid, the sponsor must permit the pharmacy to confirm that the NPI is active and valid, or in the alternative, to correct it; (3) if the pharmacy confirms that the prescriber NPI is active and valid or corrects it, the sponsor must pay the claim if it is otherwise payable; and (4) if the pharmacy cannot or does not correct or confirm that the prescriber NPI is active and valid, the sponsor must require the pharmacy to resubmit the claim [when necessary], which the sponsor must pay, if it is otherwise payable, unless there is an indication of fraud or the claim involves a prescription written by a foreign prescriber (where permitted by State law).”

- CMS 4159-F § 423.120(c)(6)(i) Regulation Effective 06/01/2015, Enforcement Effective 02/01/2017
  - Under § 423.120(c)(6)(i), in order for a Part D sponsor to submit to CMS a prescription drug event (PDE) record, the PDE must pertain to a claim for a Part D drug that was dispensed in accordance with a prescription written by a physician or eligible professional who is either (1) enrolled in Medicare in an approved status, or (2) has a valid opt-out affidavit on file with an A/B MAC.
  - Under § 423.120(c)(6)(iii), a Part D sponsor must deny or must require its PBM to deny a pharmacy claim for a drug (or a request for reimbursement from a Medicare beneficiary for a drug) if the claim does not meet the requirements of § 423.120(c)(6)(i) or (ii), respectively.

- IFC 6107 Regulation Effective 06/01/2015, Enforcement Effective 06/01/2016
  - Under these revised requirements, pharmacy claims and beneficiary requests for reimbursement for Medicare Part D prescriptions, written by prescribers other than physicians and eligible professionals who are permitted by state or other applicable law to prescribe medications, will not be rejected at the point of sale or denied by the plan if all other requirements are met.
In addition, a plan sponsor will not reject a claim or deny a beneficiary request for reimbursement for a drug when prescribed by a prescriber who does not meet the applicable enrollment or opt out requirement without first providing provisional coverage of the drug and individualized written notice to the beneficiary. This interim final rule with comment period also revises certain terminology to be consistent with existing policy and to improve clarity.
23.3 Timeline (As of 03/01/2016)

- **Soft Roll Out**
  - POS Reject Will Not Apply
  - Prescriber Outreach

- **MACRA:**
  - Active Valid NPI
  - No SCC 49
  - Pharmacy Must Notify Beneficiary of Reject

- **NCPDP ECL**
  - Reject Code 829: MACRA Notice

- **NCPDP ECL**
  - Approved Message Code 41: Provisional Fill
  - SCC 54: OAP
  - Reject Code 832, SCC 53, AMC 42: Super Set
  - Update Value Limitations for existing code values

- **CMS 4159: 423.120(c)(6)**
  - CMS 6107 IFC Enforcement Date
    - OAP By-Pass Enrollment Check
      - SCC to Confirm OAP
    - Provisional Fill 90 Days or 3 month supply
      - Not Enrolled
      - Enrollment Termed
      - Enrollment Future
      - NPI must be active in NPPES
    - Plan Must Notify Beneficiary and Prescriber
    - Not OAP - Active Enrollment Required
      - SCC 50
### 23.4 CMS Documentation References

<table>
<thead>
<tr>
<th>REGULATION GUIDANCE</th>
<th>OVERVIEW</th>
<th>PUBLISHED DATE</th>
<th>EFFECTIVE DATE</th>
<th>ENFORCEMENT DATE</th>
</tr>
</thead>
</table>
| **1** CMS-4159 Final Rule 423.120(c)(6) | • POS claim must contain an active and valid NPI  
• Prescriber NPI must be on the Medicare Individual Provider Enrollment File with an enrolled or Opt Out status and claim date of service within the enrollment period.  
  o Claim DOS must be ≥ Enrollment Effective date and less than Enrollment End Date  
  o Through 12/2015, CMS will update the file bi-monthly. Post 12/2015, the file should be updated weekly. | 05/19/2014 | 01/01/2015 | 06/01/2015 |
| **2** CMS Memo 4159 | • Effective date for prescriber enrollment requirements changed from 06/01/2015 to 12/01/2015.  
• See # 5 below for updated HPMS memo – enforcement date moved to 06/01/2016 | 12/03/2015 | 01/01/2015 | 12/01/2015 |
| **3** CMS 6107 IFC | • Applicability date changed from 12/1/2015 to 1/1/2016. See # 5 for updated HPMS memo and new enforcement date of 06/01/2016.  
• OAP: Part D prescriptions written by prescribers other than physicians and eligible professionals who are permitted by state or other applicable law to prescribe medications, not be | 05/06/2015 | 01/01/2015 | 01/01/2016 |
<table>
<thead>
<tr>
<th>REGULATION GUIDANCE</th>
<th>OVERVIEW</th>
<th>PUBLISHED DATE</th>
<th>EFFECTIVE DATE</th>
<th>ENFORCEMENT DATE</th>
</tr>
</thead>
</table>
| reject at the POS by the plan if all other requirements are met. These prescribers are defined in this IFC as “other authorized prescribers” (OAP).  
▪ Provisional Fills: Plans must first allow a provisional supply of 3 months (as prescribed by the prescriber and that would otherwise be covered by the plan) when the prescription is written by a prescriber who is eligible to enroll but who is not enrolled in or opted out of Medicare.  
▪ Beneficiary Notification: The plan must provide individualized written notice to the beneficiary that the supply is being provided on a provisional basis.  
▪ Prescriber Notification: The plan must ensure reasonable efforts are made to notify the prescriber that a provisional fill notice was provided to the beneficiary. | 04/29/2015 | 01/01/2016 | 01/01/2016 |
| MACRA Legislation Section 507 | Effective 01/01/2016. Part D claim must be submitted with an active and valid Type 1 NPI.  
▪ Part D plan must reject if:  
  o Non-NPI ID  
  o Type 1 NPI is inactive  
  o Invalid NPI is submitted (e.g. Type 2 NPI) | 04/29/2015 | 01/01/2016 | 01/01/2016 |
<table>
<thead>
<tr>
<th>REGULATION GUIDANCE</th>
<th>OVERVIEW</th>
<th>PUBLISHED DATE</th>
<th>EFFECTIVE DATE</th>
<th>ENFORCEMENT DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Pharmacy MUST notify the beneficiary the reason for the reject if the active and valid NPI reject cannot be resolved.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 5 HPMS Memo – Enforcement Date | ▪ 423.120(c)(6) enforcement date pushed from 01/01/2016 to 06/01/2016.  
▪ Part D plans to begin POS validation of OAP status, provisional fills and prescriber enrollment.  
▪ CMS determined that current practices to validate the NPI is active and valid will meet the objectives of MACRA legislation section 507  
▪ Starting no later than 01/01/2016, Part D plans may conduct prescriber outreach to request Medicare enrollment.  
▪ Starting no earlier than 04/01/2016 and ending 05/31/2016, Part D plans may notify beneficiaries. Additional guidance expected Q4 2015. | 06/01/2015 | 01/01/2015 | 06/01/2016 |
| 6 HPMS Memo – PDE Changes | ▪ Two changes to the PDE to support prescriber enrolment requirements  
▪ Type of Fill  
  o Provisional  
  o Regular  
  o Edit (DMR) – Retrospective enrollment date  
▪ Re-use field #53 to identify claims where prescriber is determined to be an OAP | 06/09/2015 |                | 06/01/2016 |
<table>
<thead>
<tr>
<th>REGULATION GUIDANCE</th>
<th>OVERVIEW</th>
<th>PUBLISHED DATE</th>
<th>EFFECTIVE DATE</th>
<th>ENFORCEMENT DATE</th>
</tr>
</thead>
</table>
| HPMS Memo – MAPDs Network Providers | ▪ MAPDs to confirm their contracting providers are eligible to furnish Part D prescriptions when CMS-4159-F, as modified by CMS 6107-IFC (80 FR 25958), is enforced.  
▪ Prescriber must meet 423.120(c)(6) requirements regardless of their network enrollment status | 06/10/2015 | 06/01/2016 | 06/01/2016 |
| Final Technical Guidance | ▪ Provisional Supply - 90 day time period has passed or a 3-month supply has been dispensed, whichever comes first  
▪ OAP taxonomy codes defined  
▪ “Drug” is defined by the generic name, dosage form, and route of administration (not strength). Examples for concurrent and overlapping therapy  
▪ Compound- any ingredient of the compound is the same “drug” as another compound for the patient/prescriber, then a single provisional supply applies.  
▪ Transition Supply and Provisional Fill overlap  
▪ Beneficiary Notice  
▪ Data Files – download within 3 business days, coordinate use with PDE timing  
▪ Deceased prescribers – 1 year grace period eliminated | 12/29/2015 | 06/01/2016 | 06/01/2016 |
| 9 | CMS Memo 03/01/2016 Enforcement Date Delay | ▪ Enforcement Date Delayed to 02/01/2017  
▪ Prescribers to enroll by August 1, 2016  
▪ CMS Templates (e.g. Beneficiary Provisional Fill Notice) pending  
▪ Attachment A – Prescriber Outreach: January 1, 2016 – January 31, 2017 | 03/01/2016 | 02/01/2017 |
|---|---|---|---|
| 10 | CMS Memo 04/07/2016 Revised PDE Guidance | ▪ Edit 843 will trigger if OAP Indicator field is populated  
▪ Edit 842 will trigger if Type of Fill field is populated  
▪ New message for edit 833 – NPI not found  
▪ Edit 834 changed from information to reject  
▪ Schedule of CMS use of NPPES files | 04/07/2016 | 05/08/2016 |

### 23.5 CMS Clarification

Post the 12/29/2015 release of the Final Technical Guidance, CMS provided further clarification to several enrollment file data inquiries.

1. **Timing of the Medicare Individual Provider Enrollment file data file updates:**
   a. The final technical guidance states “Sponsors should not use a new file until midnight on the 3rd business day after its posting in order to synchronize with PDE editing. Additionally, it is noted that the PDE Type of Fill must set as “E” to be used as a trigger for CMS to leverage the most current enrollment file versus the file as of the claim date of service.
      o Which time zone should CMS and plan sponsors leverage to identify 12:00 am midnight?
CMS Response 01/06/2016: Eastern Time Zone

- If the Medicare Enrollment file and weekly NPPES file are posted on Mondays, should these files be available for claim adjudication use as of Friday 12:00am, or Thursday 12:00am?

CMS Response 01/06/2016: Example 1:
- File 2 released 7/25. That’s day 1.
- Day 2 is 7/26,
- Day 3 is 7/27. The end of that day 7/27 11:59 PM they are using File 1.
- Midnight 7/28 they have to use File 2.

CMS Response 01/06/2016: Example 2:
- File 3 is released 8/1.
- Day 2 is 8/2.
- Day 3 is 8/3. The end of that day, 8/3 11:59 PM they are using File 2.
- Midnight 8/4 they have to use File 3.

CMS Response 01/06/2016: Example 3:
- File 3 is released 8/1.
- Day 2 is 8/2.
- Day 3 is 8/3. The end of that day, 8/3 11:59 PM they are using File 2.
- Midnight 8/4 they have to use File 3.

CMS Response 01/06/2016: Example 4:
- File 3 is released 8/1.
- Day 2 is 8/2.
- Day 3 is 8/3. The end of that day, 8/3 11:59 PM they are using File 2.
- Midnight 8/4 they have to use File 3.

CMS Response 01/06/2016: Example 5:
- File 3 is released 8/1.
- Day 2 is 8/2.
- Day 3 is 8/3. The end of that day, 8/3 11:59 PM they are using File 2.
- Midnight 8/4 they have to use File 3.

CMS Response 01/06/2016: Example 6:
- File 3 is released 8/1.
- Day 2 is 8/2.
- Day 3 is 8/3. The end of that day, 8/3 11:59 PM they are using File 2.
- Midnight 8/4 they have to use File 3.

2. Deceased prescribers and NPPES NPI De-activation Schedule:
   a. Can CMS provide access to the NPI de-activation reason code so that it can be used to support potential beneficiary outreach prior to the estimated next fill date. This will mitigate patient access to care concerns.
      CMS Response 01/11/2016: We can’t release the deactivation codes as there is potential fraud related information.
   b. Can CMS clarify what the estimated time period is between a prescriber’s death date and the date in which the NPI is de-activated in NPPES? Would CMS consider supporting at least a 30 day period before the NPI is de-activated, so as to mitigate patient access to care concerns?
      CMS Response 01/11/2016: The NPI customer service team always waits at least 30 days before taking any deactivation action due to death. The timer starts when the team learns of the death (through the SSA’s weekly file, or from the provider’s office staff), not when the actual death occurred. This alone can add more 5-10 days to that range.

23.6 OPEN AREAS OF CONCERN

As of April 19, 2016, there are several subject areas still pending CMS guidance. These items are being tracked under a separate document that is available under the WG1, Definition of a Valid Prescriber Task group folder within the NCPDP Collaborative Workspace (http://dms.ncpdp.org/index.php/ncpdp-workgroups?view=document&id=5468). Below is an overview of the specific topics still under review.

- Data File Conflicts – Duplicate Records
- Data File Conflicts - Missing Records, Inactive NPIs
- Data File Frequency
- Deceased dates – Patient Access to care Concerns with Elimination of 12 Month Grace Period
- Enrollment Records with Retrospective Effective and End Dates
- Definition of Drug for Purposes of Provisional Fill
- Number of Non-Enrolled Prescribers and Percent of Claims at Risk
- Beneficiary/Prescriber Provisional Fill Notice
- Provisional Supply Period and retroactive Patient Claims

23.7 FAQs

Question:
In coordination with existing prescriber validation requirements under CMS 4157 and the associated NCPDP guidance, how can the NCPDP Telecommunication Standard be leveraged to comply with Medicare Part D prescriber enrollment requirements under CMS 4159 and IFC 6107?

**Task Group Response:**

The § 423.120(c)(6)(i) provision within CMS 4159-F requires the prescriber to be (1) enrolled in Medicare in an approved status, or (2) has a valid opt-out affidavit on file with an A/B MAC. Prescriber enrollment validation must occur on the point of service claim. Additionally, IFC 6107 requires Part D Sponsors to allow other authorized prescribers (OAP) and support a provisional fill process for active and valid NPIs that are not on the enrollment file or not active on the claim date of service.

The Medicare provider enrollment file can be accessed from: [https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx](https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx). This file represents all Medicare enrolled individual providers and is not exclusive to providers with prescriptive authority.

Section 12 below outlines the hierarchy of prescriber validation rules that may be used to ensure the prescriber validation requirements are met, as outlined in provision 423.120(c)(5) of CMS 4157-F as well as the prescriber enrollment requirements within provision 423.120(c)(6) of CMS 4159-F and IFC 6107.

**Question (added August 2016):**

For OAP validation, CMS guidance states to use NPPES taxonomy. In the situation where a prescriber has multiple taxonomies which taxonomy (primary or any) will CMS and plan sponsors be validating?

**Response:**

A prescriber’s NPPES record may be associated to multiple taxonomy codes where at least one is an OAP based on CMS guidance.

For Example:

1. **Primary Taxonomy = 175F00000X (Naturopath)**
   - Secondary Taxonomy = 363LF0000X (Nurse Practitioner, Family Health)

2. **Primary Taxonomy = 363LF0000X (Nurse Practitioner, Family Health)**
   - **Secondary Taxonomy = 175F00000X (Naturopath)**

CMS guidance states to use the NPPES taxonomy to validate OAP status.

In the situation where a prescriber has multiple taxonomies, validation of OAP status should occur as follows:

1. Check enrollment first, if enrolled, follow enrollment process
2. If not enrolled, prioritize check for OAP taxonomy:
   a. Primary or secondary designation is not relevant as long as there is an active taxonomy.
   b. If at least one of the active taxonomy meets the definition of OAP, treat the prescriber as an OAP.
   c. Otherwise, if none of the taxonomy codes meets the definition of an OAP, determine provisional fill eligibility.

**23.8 HIGH LEVEL HIERARCHICAL RULES:**

Note, order of checks could vary slightly based on different keys used in processing.

- Step 1: Validate Prescriber ID submitted is an NPI
- Step 2: Validate NPI format
- Step 3: Validate Prescriber OIG Status
- Step 4: Validate NPI Medicare Enrollment Status
  - Determine OAP status
  - Determine Provisional Fill
- Step 5: Validate Deceased Date
- Step 6: Validate State Prescriptive Authority
- Step 7: Validate Controlled Substance Prescriptive Authority
# 23.9 Prescriber Related Reject Codes

<table>
<thead>
<tr>
<th>S11-FB Code</th>
<th>NCPDP Reject Code Description</th>
<th>New Dates</th>
<th>Emergency ECL Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>ID Submitted is associated with a Sanctioned Prescriber</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>ID Submitted is associated to a Deceased Prescriber</td>
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<td></td>
</tr>
<tr>
<td>E2</td>
<td>M/I Prescriber ID Qualifier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>M/I Prescriber ID</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Plan's Prescriber database indicates the Prescriber ID Submitted is inactive or expired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Plan's Prescriber database indicates the associated DEA to submitted Prescriber ID is inactive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>Plan's Prescriber database indicates the associated DEA to submitted Prescriber ID is not found</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Plan's Prescriber database indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>543</td>
<td>Prescriber ID Qualifier Value Not Supported</td>
<td></td>
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<tr>
<td>56</td>
<td>Non-Matched Prescriber ID</td>
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</tr>
<tr>
<td>569</td>
<td>Provide Notice: Medicare Prescription Drug Coverage and Your Rights</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>07/01/2016 Value Limitation: Reject Code 569 must not be sent with Reject Code 829 as Reject Code 829 is a reject that cannot be appealed. Telecom Emergency Implementation Date for restricted use of the value 569 is July 01, 2016.</td>
<td>07/01/2016</td>
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<tr>
<td>619</td>
<td>Prescriber Type 1 NPI Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>773</td>
<td>Prescriber Is Not Listed On Medicare Enrollment File</td>
<td></td>
<td></td>
</tr>
<tr>
<td>774</td>
<td>Prescriber Medicare Enrollment Period Is Outside Of Claim Date Of Service</td>
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</tr>
<tr>
<td>777</td>
<td>Plan's Prescriber database not able to verify active state license with prescriptive authority for Prescriber ID Submitted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>826</td>
<td>Prescriber NPI Submitted Not Found Within Processor's NPI File</td>
<td></td>
<td></td>
</tr>
<tr>
<td>829</td>
<td>Pharmacy Must Notify beneficiary: Claim not covered due to failure to meet Medicare Part D active, valid prescriber NPI requirements.</td>
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<td>04/01/2016 – Reject Code available for use</td>
</tr>
<tr>
<td></td>
<td>07/01/2016 Value Limitation: Reject Code 829 must not be sent with Reject Code 569 as Reject Code 829 is a reject that cannot be appealed. Telecom Emergency Implementation Date for restricted use of the value 829 is July 01, 2016.</td>
<td>07/01/2016 – Value Limitation added</td>
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<td>S11-FB Code</td>
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<td>New Emergency ECL Dates</td>
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<tr>
<td>-------------</td>
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<td>-------------------------</td>
<td></td>
</tr>
<tr>
<td>832</td>
<td>Prescriber NPI not found, NPI active status, Medicare enrollment and prescriptive authority could not be validated.</td>
<td>07/01/2016</td>
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</tr>
</tbody>
</table>

### 23.10 Prescriber Related Submission Clarification Codes

<table>
<thead>
<tr>
<th>420-DK Code</th>
<th>NCPDP SCC Description</th>
<th>New Emergency ECL Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>Prescriber ID Submitted is valid and prescribing requirements have been validated. 07/01/2016 Value of 42 does not apply to prescriber Medicare enrollment validation. Telecom Emergency Implementation Date for restricted use of the value 42 is July 01, 2016. Prescriber’s DEA is active with DEA Authorized Prescriptive Right.</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>43</td>
<td>Prescriber’s DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Prescriber’s DEA has prescriptive authority for this drug DEA Schedule</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Prescriber’s DEA has prescriptive authority for this drug DEA Schedule</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Prescriber’s active Medicare Fee For Service enrollment status has been validated</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Prescriber’s state license with prescriptive authority has been validated- Indicates the prescriber ID submitted is associated to a healthcare provider with the applicable state license that grants prescriptive authority.</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Prescriber NPI active and valid, prescriber active Medicare enrollment and prescriptive authority has been validated.</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>54</td>
<td>CMS Other Authorized Prescriber-OAP: e.g. Naturopath or Pharmacist, with prescriptive authority, ineligible to enroll with Medicare.</td>
<td>07/01/2016</td>
</tr>
</tbody>
</table>

### 23.11 Prescriber Related Approved Message Codes 548-6F

<table>
<thead>
<tr>
<th>548-6F CODE</th>
<th>DESCRIPTION</th>
<th>New Emergency ECL Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>019</td>
<td>The Submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review - The claim paid, however, the combination of Prescriber ID qualifier (466-EZ) and Prescriber ID (411-DB) provided on the transaction was inactive or expired in the processor’s system.</td>
<td></td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
<td>New Emergency ECL Dates</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>020</td>
<td>For the Submitted Prescriber ID, the associated DEA Number is Not Found – Flagged for Retrospective Review - The claim paid for a controlled substance, however, a valid DEA number could not be found (within the processor’s system) using the combination of Prescriber ID qualifier (466-EZ) and Prescriber ID (411-DB) provided on the transaction.</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>021</td>
<td>For the Submitted Prescriber ID, the associated DEA Number is Inactive or Expired – Flagged for Retrospective Review - The claim paid for a controlled substance, however, an active DEA number could not be found (within the processor’s system) using the combination of Prescriber ID qualifier (466-EZ) and Prescriber ID (411-DB) provided on the transaction.</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>022</td>
<td>For the submitted Prescriber ID, the associated DEA Number does not allow this drug DEA Schedule – Flagged for Retrospective Review</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>024</td>
<td>The submitted Prescriber ID is Not Found - Flagged for Retrospective Review</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>025</td>
<td>The submitted Prescriber ID is associated to a Deceased Prescriber – Flagged for Retrospective Review</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>026</td>
<td>Prescriber Type 1 NPI Required - Flagged for Retrospective Review</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>027</td>
<td>The submitted Prescriber DEA does not allow this drug DEA Schedule – Flagged for Retrospective Review</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
<td></td>
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<tr>
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<td></td>
</tr>
<tr>
<td>548-6F</td>
<td>As of the 01/01/2016 effective date of MACRA legislation section 507 and the applicability date of CMS 4159-F (423.120 (c)(6)), Approved Message Code 027 will no longer be valid for Medicare Part D claims. Telecom Emergency Implementation Date for restricted use of the value 027 is July 01, 2016.</td>
<td></td>
</tr>
<tr>
<td>028</td>
<td>Type 1 NPI Required, Claim Paid Based on Plan's Prescriber NPI Data - When the plan pays and chooses to send a cross walked NPI on the PDE. 07/01/2016 Value Limitation: As of the 01/01/2016 effective date of MACRA legislation section 507 and the applicability date of CMS 4159-F (423.120 (c)(6)), Approved Message Code 028 will no longer be valid for Medicare Part D claims. Telecom Emergency Implementation Date for restricted use of the value 028 is July 01, 2016.</td>
<td></td>
</tr>
<tr>
<td>030</td>
<td>Prescriber active enrollment with Medicare Fee For Service required. Flagged for retrospective review. Value returned only if Submission Clarification Code 50 (Prescriber’s active Medicare Fee For Service enrollment status has been validated) was submitted and accepted.</td>
<td></td>
</tr>
<tr>
<td>032</td>
<td>Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted, flagged for retrospective review.</td>
<td></td>
</tr>
<tr>
<td>041</td>
<td>Filled Under Provisional Benefit - Active prescriber Medicare enrollment or Other Authorized Prescriber status not found. Once the provisional supply is exhausted, additional claims for this drug from this prescriber will not be covered under Medicare Part D. 07/01/2016</td>
<td></td>
</tr>
<tr>
<td>042</td>
<td>The submitted prescriber NPI not found, NPI active status, Medicare enrollment and prescriptive authority could not be validated. Flagged for retrospective review. 07/01/2016</td>
<td></td>
</tr>
<tr>
<td>043</td>
<td>The submitted Prescriber ID could not be validated as an Other Authorized prescriber-OAP and is not found on the Medicare Enrollment file. Flagged for retrospective review. 07/01/2016</td>
<td></td>
</tr>
</tbody>
</table>
The following reject matrix incorporates new ECL values to support section 507 of the MACRA legislation, section 423.120(c)6 of CMS 4159 and IFC 6107. Please refer to the regulatory documents for the associated effective dates.

<table>
<thead>
<tr>
<th>Edit Order</th>
<th>Step Description</th>
<th>Reject Code</th>
<th>Reject Code Description</th>
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<th>SCC Description</th>
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<th>AMC Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>NPI Required</td>
<td>543</td>
<td>Prescriber ID Qualifier Value Not Supported</td>
<td>829</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>829 may not be returned with 569 because not appealable</td>
</tr>
<tr>
<td>1.1</td>
<td>NPI Required</td>
<td>619</td>
<td>Prescriber Type 1 NPI Required</td>
<td>829</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>829 may not be returned with 569 because not appealable 619 would be returned in this step when the Prescriber ID Qualifier does not equal “01” - NPI. No SCC would be allowed at this step. See also step 4.1</td>
</tr>
<tr>
<td>1.2</td>
<td>NPI Required</td>
<td>EZ</td>
<td>M/I Prescriber ID Qualifier</td>
<td>829</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>829 may not be returned with 569 because not appealable</td>
</tr>
<tr>
<td>2.0</td>
<td>Invalid Prescriber ID format</td>
<td>25</td>
<td>M/I Prescriber ID</td>
<td>829</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>829 may not be returned with 569 because not appealable</td>
</tr>
</tbody>
</table>
# Telecommunication Version D and Above Questions, Answers and Editorial Updates

<table>
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<th>Notes</th>
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<tbody>
<tr>
<td>3.0</td>
<td>OIG Check</td>
<td>A1</td>
<td>ID Submitted is associated with a Sanctioned Prescriber</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4.0</td>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions.</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>041</td>
<td>Filled Under Provisional Benefit</td>
<td>Paid response with new AMC for Provisional Fill.</td>
</tr>
<tr>
<td>4.1</td>
<td>If Prescriber ID qualifier = 01 (NPI) and Medicare enrollment check failed, check NPPES for provisional fill or OAP. NPI check determines it is not a Type 1 NPI.</td>
<td>619</td>
<td>Prescriber Type 1 NPI Required</td>
<td>829</td>
<td>42</td>
<td>Prescriber ID submitted is valid and prescribing requirements have been validated.</td>
<td>026</td>
<td>041</td>
<td>Prescriber Type 1 NPI Required - Flagged for Retrospective Review Filled Under Provisional Benefit</td>
</tr>
</tbody>
</table>

619 would be returned in this step when the Prescriber ID Qualifier does equals “01” - NPI. SCC 42 would be allowed at this step, when the submitted NPI is validated to be a Type 1 NPI. SCC 42 would trigger provisional fill logic. Both 26 and 41 would
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<td></td>
<td></td>
<td>511</td>
<td>FB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>be returned as AMCs.</td>
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<td></td>
<td>See also step 1.1</td>
</tr>
<tr>
<td>4.2</td>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions. Plan determines NPI to be inactive.</td>
<td>42</td>
<td>Plan’s prescriber database indicates prescriber ID submitted is inactive or expired.</td>
<td>829</td>
<td>42</td>
<td>Prescriber ID submitted is valid and prescribing requirements have been validated.</td>
<td>019</td>
<td>041</td>
<td>Processor able to match NPI is able to determine NPI not an OAP and is not active in NPPES. SCC 42 would trigger provisional fill logic. Both 19 and 41 would be returned as AMCs.</td>
</tr>
<tr>
<td>4.3</td>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions. Day supply exceeds Provisional Fill supply remaining.</td>
<td>7X</td>
<td>Day supply exceeds plan limitations</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>If claim meets provisional fill criteria however the accumulated day supply exceeds the 90 day provisional fill limit, reject claim as 7X and provide messaging as to the claim day supply allowed</td>
</tr>
<tr>
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</tr>
<tr>
<td>4.4</td>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions.</td>
<td>773</td>
<td>Prescriber Is Not Listed On Medicare Enrollment File</td>
<td>N/A</td>
<td>50</td>
<td>Prescriber’s active Medicare Fee For Service enrollment status has been validated</td>
<td>030</td>
<td></td>
<td>Provisional Fill exhausted and non-OAP per plan’s data base. Pharmacy submits SCC 50 validating prescriber Medicare enrollment status.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>777 (optional)</td>
<td>Plan’s Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted (RC 777 may also be returned when OAP status could not be confirmed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.4.1</td>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions.</td>
<td>773</td>
<td>Prescriber Is Not Listed On Medicare Enrollment File</td>
<td>N/A</td>
<td>54</td>
<td>CMS Other Authorized Prescriber-OAP: e.g. Naturopath or Pharmacist, with prescriptive authority, ineligible to enroll with Medicare.</td>
<td>043</td>
<td></td>
<td>Provisional Fill exhausted and non-OAP per plan’s data base. Pharmacy submits SCC 54 validating prescriber is an OAP.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>777 (optional)</td>
<td>Plan’s Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID</td>
<td></td>
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<td></td>
<td></td>
<td>511-FB</td>
<td>Submitted (RC 777 may also be returned when OAP status could not be confirmed)</td>
<td></td>
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</tr>
<tr>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions.</td>
<td>774</td>
<td>Prescriber Medicare Enrollment Period Is Outside Of Claim Date Of Service</td>
<td>N/A</td>
<td>50</td>
<td>Prescriber’s active Medicare Fee For Service enrollment status has been validated</td>
<td>030</td>
<td>Prescription Medicare enrollment with Medicare Fee For Service required. Flagged for retrospective review.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional</td>
<td>774</td>
<td>Prescriber Medicare Enrollment Period Is Outside Of Claim Date Of Service</td>
<td>N/A</td>
<td>54</td>
<td>CMS Other Authorized Prescriber-OAP: e.g. Naturopath or Pharmacist, with prescriptive authority,</td>
<td></td>
<td>Pharmacy validates prescriber Medicare enrollment status. This could occur post provisional day supply period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edit Order</td>
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<tr>
<td></td>
<td>fill or OAP conditions.</td>
<td>511 FB</td>
<td>Plan's Prescriber database not able to verify active state license with prescriptive authority for Prescriber ID Submitted (RC 777 may also be returned when OAP status could not be confirmed)</td>
<td></td>
<td></td>
<td>ineligible to enroll with Medicare.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NPI cannot be found in processor’s database, no further checks can apply.</td>
<td>56</td>
<td>Non-Matched Prescriber ID</td>
<td>829</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Refer to reject code 832.</td>
</tr>
<tr>
<td>See 4.6</td>
<td>NPI cannot be found in processor’s database, no further checks can apply.</td>
<td>826</td>
<td>Prescriber NPI Submitted Not Found Within Processor’s NPI File</td>
<td>829</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Refer to reject code 832</td>
</tr>
<tr>
<td>4.6</td>
<td>NPI cannot be found in processor’s database, no further checks can apply.</td>
<td>832</td>
<td>Prescriber NPI not found, NPI active status, Medicare enrollment and prescriptive authority could not be validated.</td>
<td>829</td>
<td>53</td>
<td>Prescriber NPI active and valid, prescriber active Medicare enrollment and prescriptive authority has been validated.</td>
<td>042</td>
<td></td>
<td>Plan is unable to match submitted NPI therefore prescriber validation, OAP or provisional fill do not apply.</td>
</tr>
<tr>
<td>Edit Order</td>
<td>Step Description</td>
<td>Reject Code</td>
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</tr>
<tr>
<td>4.6.1</td>
<td>NPI cannot be found in processor’s database, no further checks can apply.</td>
<td>832</td>
<td>Prescriber NPI not found, NPI active status, Medicare enrollment and prescriptive authority could not be validated. Prescriber NPI, Medicare Enrollment, Prescriptive Authority</td>
<td>829</td>
<td>54</td>
<td>CMS Other Authorized Prescriber (OAP): Provider with prescriptive authority, ineligible to enroll with Medicare, e.g.: Pharmacist, Naturopath.</td>
<td>042</td>
<td>043</td>
<td>The submitted NPI cannot be validated. Pharmacy may submit super SCC 53 to validate NPI is active and valid with prescriptive authority and is enrolled with Medicare. Pharmacy may submit SCC 54 to validate the non-matched NPI is an OAP.</td>
</tr>
<tr>
<td>Edit Order</td>
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<td>Reject Code</td>
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</tr>
<tr>
<td>4.6.2</td>
<td>NPI cannot be found in processor’s database, no further checks can apply.</td>
<td>832</td>
<td>Prescriber NPI not found, NPI active status, Medicare enrollment and prescriptive authority could not be validated. Prescriber NPI, Medicare Enrollment, Prescriptive Authority</td>
<td>829</td>
<td>42</td>
<td>Prescriber ID Submitted is valid and prescribing requirements have been validated.</td>
<td>042</td>
<td>041</td>
<td>Pharmacy may submit SCC 42 to validate the non-matched NPI is an active and valid NPI with prescriptive authority. This would trigger a provisional fill. There is a time when the SCC 042 will not work because the provisional fills have been exhausted and processor does not have the NPI in their system to be able to return any other reject code besides 832.</td>
</tr>
</tbody>
</table>
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<th>AMC</th>
<th>AMC Description</th>
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</thead>
<tbody>
<tr>
<td>5.0</td>
<td>Deceased date check. Note, CMS will no longer apply the 12 month grace period to PDEs, either enrollment is active or NPI is active in NPPES.</td>
<td>A2</td>
<td>ID Submitted is associated to a Deceased Prescriber</td>
<td>N/A</td>
<td>42</td>
<td>Prescriber ID Submitted is valid and prescribing requirements have been validated.</td>
<td>025</td>
<td>The submitted Prescriber ID is associated to a Deceased Prescriber – Flagged for Retrospective Review</td>
<td>CMS Guidance: If NPI is enrolled, PDE accepted. If NPI not enrolled and NPI active in NPPES, provisional fill or OAP applies. As soon as NPI is listed as inactive, PDE will be rejected. Effective 06/01/2016 PDE processing will no longer support 12 month grace period.</td>
</tr>
<tr>
<td>6.0</td>
<td>State prescriptive authority rules</td>
<td>777</td>
<td>Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted</td>
<td>N/A</td>
<td>52</td>
<td>Prescriber’s state license with prescriptive authority has been validated- Indicates the prescriber ID submitted is associated to a healthcare provider with the applicable state license that grants prescriptive authority.</td>
<td>032</td>
<td>Plan’s Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted, flagged for retrospective review.</td>
<td></td>
</tr>
<tr>
<td>Edit Order</td>
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</tr>
<tr>
<td>7.0</td>
<td>DEA, controlled substance rules (active DEA registration)</td>
<td>43</td>
<td>Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive</td>
<td>N/A</td>
<td>43</td>
<td>Prescriber's DEA is active with DEA Authorized Prescriptive Right. Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule</td>
<td>021</td>
<td></td>
<td>For the Submitted Prescriber ID, the associated DEA Number is Inactive or Expired – Flagged for Retrospective Review</td>
</tr>
<tr>
<td>7.1</td>
<td>DEA, controlled substance rules (DEA not found)</td>
<td>44</td>
<td>Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found</td>
<td>N/A</td>
<td>43, 45</td>
<td>Prescriber's DEA is active with DEA Authorized Prescriptive Right. Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule</td>
<td>020</td>
<td></td>
<td>For the Submitted Prescriber ID, the associated DEA Number is Not Found – Flagged for Retrospective Review</td>
</tr>
<tr>
<td>7.2</td>
<td>DEA, controlled substance rules (Drug DEA schedule)</td>
<td>46</td>
<td>Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow</td>
<td>N/A</td>
<td>46</td>
<td>Prescriber's DEA has prescriptive authority for this drug DEA Schedule</td>
<td>022</td>
<td></td>
<td>The submitted Prescriber DEA does not allow this drug DEA Schedule – Flagged for Retrospective Review</td>
</tr>
<tr>
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<tr>
<td></td>
<td></td>
<td>511-FB</td>
<td>this drug DEA Schedule</td>
<td></td>
<td>420-DK</td>
<td></td>
<td>548-6F</td>
<td></td>
<td>Retrospective Review</td>
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## 23.13 Quick Reference Matrix

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<tr>
<td>NPI Required</td>
<td>543</td>
<td>829</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>NPI Required. NPI Qualifier &lt;&gt; NPI</td>
<td>619</td>
<td>829</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>NPI Required</td>
<td>6Z</td>
<td>829</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Invalid Prescriber ID format</td>
<td>25</td>
<td>829</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>OIG Check</td>
<td>A1</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>041</td>
</tr>
<tr>
<td>If Prescriber ID qualifier = 01 (NPI) and Medicare enrollment check failed, check NPPES for provisional fill or OAP. NPI check determines it is not a Type 1 NPI.</td>
<td>619</td>
<td>829</td>
<td>42</td>
<td>026 041</td>
</tr>
<tr>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions. Plan determines NPI to be inactive. If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions. Day supply exceeds Provisional Fill supply remaining</td>
<td>42</td>
<td>829</td>
<td>42</td>
<td>019 041</td>
</tr>
<tr>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions.</td>
<td>7X</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions.</td>
<td>773 777 (optional)</td>
<td>N/A</td>
<td>50</td>
<td>030</td>
</tr>
<tr>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions.</td>
<td>773 777 (optional)</td>
<td>N/A</td>
<td>54</td>
<td>043</td>
</tr>
<tr>
<td>Edit Order</td>
<td>Step Description</td>
<td>Reject Code</td>
<td>Appeal or MACRA</td>
<td>SCC 420-DK</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-----------------</td>
<td>------------</td>
</tr>
<tr>
<td>4.5</td>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions.</td>
<td>774 777 (optional)</td>
<td>N/A</td>
<td>50</td>
</tr>
<tr>
<td>4.5.1</td>
<td>If NPI found and Medicare Enrollment check failed, Check NPPES for provider type and provisional fill or OAP conditions.</td>
<td>774 777 (optional)</td>
<td>N/A</td>
<td>54</td>
</tr>
<tr>
<td>See 4.6</td>
<td>NPI cannot be found in processor’s database, no further checks can apply.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See 4.6</td>
<td>NPI cannot be found in processor’s database, no further checks can apply.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td>NPI cannot be found in processor’s database, no further checks can apply.</td>
<td></td>
<td></td>
<td>53</td>
</tr>
<tr>
<td>4.6.1</td>
<td>NPI cannot be found in processor’s database, no further checks can apply.</td>
<td></td>
<td></td>
<td>54</td>
</tr>
<tr>
<td>4.6.2</td>
<td>NPI cannot be found in processor’s database, no further checks can apply.</td>
<td></td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>5.0</td>
<td>Deceased date check. Note, CMS will no longer apply the 12 month grace period to PDEs, either enrollment is active or NPI is active in NPPES.</td>
<td>A2</td>
<td>N/A</td>
<td>42</td>
</tr>
<tr>
<td>6.0</td>
<td>State prescriptive authority rules</td>
<td>777</td>
<td>N/A</td>
<td>52</td>
</tr>
<tr>
<td>7.0</td>
<td>DEA, controlled substance rules (active DEA registration)</td>
<td>43</td>
<td>N/A</td>
<td>43 45</td>
</tr>
<tr>
<td>7.1</td>
<td>DEA, controlled substance rules (DEA not found)</td>
<td>44</td>
<td>N/A</td>
<td>43 45</td>
</tr>
<tr>
<td>Edit Order</td>
<td>Step Description</td>
<td>Reject Code</td>
<td>Appeal or MACRA</td>
<td>SCC 420-DK</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------</td>
<td>-------------</td>
<td>-----------------</td>
<td>------------</td>
</tr>
<tr>
<td>7.2</td>
<td>DEA, controlled substance rules (Drug DEA schedule)</td>
<td>46</td>
<td>N/A</td>
<td>46</td>
</tr>
</tbody>
</table>
24 APPENDIX G. SUPPORT OF THIS DOCUMENT

As of February 2014, when the Version D Editorial is published, it is effective for use immediately unless the specific section or response lists an effective date.

For NCPDP task groups that bring forward recommendations to this document, the task group is asked to determine if there is a specific effective date for implementation of the question or guidance. If there is no specific effective date, the next publication date of the Version D Editorial is the effective date. (This has been the default.) On occasion there has been an effective date included (e.g. regulation requirements, Medicare Part D implementation timing, etc.).

The submitter of the question may supply a possible effective date. An effective date might be determined if entities might have to change existing processing and need some lead time. The task group(s) or the work group(s) reviewing the question may override the submitter to modify the date, suggest a date is none is given, or remove the date. For items that are just general questions, clarifications, effective date can be not applicable. We don’t want the effective date discussion to be cumbersome for each question.

Section “Appendix A. Modifications to This Document” beginning with version 25 will include a table to designate any items in that publication that were approved with an effective date. For example only:

| Section/Topic | Effective Date: January 1, 2015 |