

MEDICAID SUBROGATION STANDARD IMPLEMENTATION GUIDE VERSION 3.0 QUESTIONS, ANSWERS AND EDITORIAL UPDATES

DOCUMENTATION

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National Council for Prescription Drug Programs
9240 East Raintree Drive
Scottsdale, AZ 85260

Phone: (480) 477-1000
Fax: (480) 767-1042
E-mail: ncdp@ncdp.org
http: www.ncdp.org



Medicaid Subrogation Version 3.0 Questions, Answers and Editorial Updates

Version 2.0

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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 **Medicaid Subrogation Standard Implementation Guide Version 3.0**, and the Data Dictionary and External Code List only as they apply to Medication Subrogation. This document also addresses an editorial change made to the implementation guide in October 2010.

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 9 Government Programs meetings.

NCPDP Medicaid Subrogation Standard Implementation Guide Version 3.0 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.

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

1.1 REPUBLICATION OF MEDICAID SUBROGATION STANDARD IMPLEMENTATION GUIDE VERSION 3.0 DATED OCTOBER 2010

1.1.1 TYPOGRAPHICAL ERROR

Transaction Example 6.3 "[Compounded Rx Claim and Response](#)" contained an error. Product/Service ID Qualifier (436-E1) contained 03 instead of 00. It has been corrected in the October 2010 republication.

1.2 USE OF THIS DOCUMENT

This document should be used as a reference for the Medicaid Subrogation Implementation Guide Version 3.0. References to the Telecommunication Standard Version D.0 and above and the Batch Standard Version 1.2 will only appear in this document if they directly affect Medicaid Subrogation usage. 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.

1.2.1 TELECOMMUNICATION VERSION D AND ABOVE QUESTIONS, ANSWERS AND EDITORIAL UPDATES

The NCPDP **Telecommunication Version D and Above Questions, Answers and Editorial Updates** 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.

This document must be referenced for important updates, questions to segments, fields, etc that may affect implementers of Medicaid Subrogation.

1.3 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.

Please review the **NCPDP Process Overview for External Code List** document at http://www.ncpdp.org/members/members_wg_info.aspx?wgid=wgmc

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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/members_download.aspx 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.

2. FREQUENTLY ASKED QUESTIONS

2.1 CLOSING THE LOOP ON OUTSTANDING SUBROGATION CLAIMS

Question:

After submitting a Medicaid Subrogation batch to a Third Party Payer, we want to be sure to close the loop on any outstanding subrogation claims. So after a certain number of days without receiving any response (either paid or denied) for a particular transaction/claim, we (on behalf of the State) would want to send out a reminder or second request transaction. At first I was thinking this could be sent as a B3 – rebill, but that is not the appropriate use of a B3 transaction. But if we just re-send the transaction as a B1 (duplicate of one sent XX days ago) there is no way to flag it as a second request transaction. Do we need a new transaction code (maybe B4?) to identify these as already requested but not responded to?

Response:

The receiver of the Medicaid Subrogation (Request) batch must include a response status for all transactions in the Response file. Please refer to the NCPDP **Batch Standard Implementation Guide v1.2**, Section 4.1 Introduction which states, “The processor will build a response file containing an NCPDP response for each detail data record received in the claim file from the pharmacy.”

2.2 USE OF TRANSACTION REFERENCE NUMBER (880-K5)

Question:

How should Field 880-K5 Transaction Reference Number be used in a batch Medicaid Subrogation file submission?

Background: While researching the Batch Transaction Standard for use in Medicaid Subrogation, I ran across a potential problem with the definition and/or appropriate use of field 880 -K5 Transaction Reference Number. The (current) definition from the Data Dictionary is: “A reference number assigned **by the provider** to each of the data records in the batch or real-time transactions. The purpose of this number is to facilitate the process of matching the transaction response to the transaction. The transaction reference number assigned should be returned in the response.”

In the Functional Flow section of the Batch Standard Implementation Guides for versions 1.0, 1.1 and 1.2 this field is addressed as follows:

“The Transaction Reference Number field **is assigned by the pharmacy** to uniquely identify each claim within the file. The numbering scheme is at the pharmacy’s discretion; the number only needs to be unique within the file. As the processor builds the response file, the original Transaction Reference Number from the claim is attached to each detail data record response to allow the pharmacy to match the response with the claim originally submitted.

When the processor returns a response file to the pharmacy, the file will contain one Transaction Header, a Transaction Detail Data response record for every claim, and one Transaction Trailer. Each Transaction Detail Data response record will contain a valid formatted NCPDP response* with the Transaction Reference Number from the original request.”

*The phrase “-- paid, rejected, captured, etc...” appears in the version 1.0 Implementation guide, but not in version 1.1 or version 1.2.

7.1.3 TRANSACTION DETAIL DEFINITION

FIELD	FIELD NAME	TYPE	LENGTH	START	END	VALUE
880-K4	Text Indicator	A/N	1	1	1	Start of Text (STX) = X'02'
701	Segment Identifier	A/N	2	2	3	G1=Detail Data Record
880-K5	Transaction Reference Number	A/N	10	4	13	To be determined by Provider
	NCPDP Data Record		Varies	14	Varies	
880-K4	Text Indicator	A/N	1	Varies	Varies	End of Text(ETX) = X'03'

As displayed above, this field precedes the actual NCPDP Data Record within each Batch Detail record and its described value is “To be determined by Provider.”

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Transaction Detail Notes in Batch v1.2 Implementation Guide also refer to this field as follows: “The Transaction Reference Number (880-K5) is assigned by the Pharmacy. When the processor receives the file and begins processing the claims, the Transaction Reference Number (880-K5) **must** be returned with the response. The Transaction Reference Number (880-K5) is used to explicitly tie a response back to the original claim.”

This is the only instance of the word “must” that I could find in any of the Implementation Guides but because of its inclusion in the Transaction Detail Definition it appears that this field is supposed to be included in the Batch Detail record. But because of its definition as being “Provider assigned” I believe that this field is not really applicable for Medicaid Subrogation. Also, 880 -K5 has been added to the Telecommunication Standard in Version D.0 in the Request Claim and Response Status Segments, so technically this field could appear in the Detail “envelope” and then also in the NCPDP Data Record.

Response:

Field 880-K5 Transaction Reference Number should always be implemented as a simple sequential record counter within the Batch file and that same sequence should be used in the response file.

2.3 USE OF FIELD 114-N4 MEDICAID SUBROGATION INTERNAL CONTROL NUMBER/TRANSACTION CONTROL NUMBER (ICN/TCN)

Question:

Is Field 114-N4 Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN) returned on a rejected response?

Response:

Field 114-N4 Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN) is to be returned on a Paid or a Rejected response. The examples in *Section 6.1.1.3 Billing Transaction Rejected Response For Duplicate Claim* and *6.2.1.1 Rebill Accepted Response – Paid* will be revised to include Field 114-N4. Notes will be added to the guide to state Field 114-N4 Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN) is not used in a Reversal transaction or a Capture response.

2.4 CO-INSURANCE

Question:

What field in the Medicaid Subrogation Implementation Guide can be used when a member actually pays a co-insurance to Medicaid? Is the field to be used 433-DX, Patient Paid Amount Submitted?

Response:

Field 433-DX can be used to reflect the amount that was paid as either coinsurance or copay to Medicaid. Note: Appropriate use of 433-DX is being addressed by the WG1 COB Task Group.

2.5 COORDINATION OF BENEFITS AND MEDICAID SUBROGATION

Question:

How does Coordination of Benefits fit into subrogation? We do not have the information on file which is the reason for subrogation.

Response:

Coordination of Benefits and Medicaid Subrogation are mutually exclusive processes used by State Medicaid agencies to either cost avoid or recover (respectively) Medicaid funds. Medicaid Subrogation, also known as cost recovery, occurs when the Medicaid agency was not aware that there was a primary payer at the time the product was dispensed or the service was delivered.

Note: The Medicaid agency may elect to adjust the original paid claim in their internal system using the subrogation response amount paid and reflect this as a coordination of benefits claim.

2.6 FIELD 307-C7 PLACE OF SERVICE

Question:

We are looking at the Medicaid Subrogation Implementation Guide and on page 15, 16 Section 6.1.1, there is Nursing Home Billing Transaction. In the Patient Segment, the field 307-C7 Place of Service is populated with the value of "32" rather than value of "1" Pharmacy. I know before we had the Telecommunication FAQ information provided on the appropriate values for LTC billing, entities were looking at the use of the "31", "32" value, etc. I am trying to determine if per the implementation guides we are really supposed to use the value "32" for billing of Medicaid Subrogation claims or if this maybe requires a change in the example?

Response:

In the example in the Medicaid Subrogation Implementation Guide v3.0, the value of 32 Nursing Facility in Field 307-C7 Place of Service indicates an in-house pharmacy at the nursing facility. We will revise the example in the next version of the Medicaid Subrogation Implementation Guide to reflect the value of "1" Pharmacy in field 307-C7 Place of Service to be consistent with Long Term Care (LTC) Pharmacy Claims Submission Recommendations for Version D.0 (in the Version D Editorial Document). The current recommendation is the use of value "1" Pharmacy in field 307-C7 Place of Service in conjunction with field 384-4X Patient Residence values "03" or "09" to reflect a long term care transaction.

3. EDITORIAL CORRECTIONS

3.1 REPUBLICATION OF MEDICAID SUBROGATION STANDARD IMPLEMENTATION GUIDE VERSION 3.0 DATED OCTOBER 2010

3.1.1 TYPOGRAPHICAL ERROR

Transaction Example 6.3 "[Compounded Rx Claim and Response](#)" contained an error. Product/Service ID Qualifier (436-E1) contained 03 instead of 00. It has been corrected in the October 2010 republication.

3.1.2 RESPONSE CLAIM SEGMENT

3.1.2.1 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.

4. APPENDIX A. HISTORY OF CHANGES TO THE MEDICAID SUBROGATION VERSION 3.0 QUESTIONS, ANSWERS AND EDITORIAL UPDATES

4.1 VERSION 2.0

New question: "Is Field 114-N4 Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN) returned on a rejected response?"

New question: "What field in the Medicaid Subrogation Implementation Guide can be used when a member actually pays a co-insurance to Medicaid? Is the field to be used 433-DX, Patient Paid Amount Submitted?"

New question: "How does Coordination of Benefits fit into subrogation? We do not have the information on file which is the reason for subrogation."

New question: "We are looking at the Medicaid Subrogation Implementation Guide and on page 15, 16 Section 6.1.1, there is Nursing Home Billing Transaction. In the Patient Segment, the field 307-C7 Place of Service is populated with the value of "32" rather than value of "1" Pharmacy. I know before we had the Telecommunication FAQ information provided on the appropriate values for LTC billing, entities were looking at the use of the "31", "32" value, etc. I am trying to determine if per the implementation guides we are really supposed to use the value "32" for billing of Medicaid Subrogation claims or if this maybe requires a change in the example?"