NCPDP Implementation of Telecommunication Standard vD.0 Service Billing Transactions for Pharmacist Professional Services

VERSION 10

October 2024

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NCPDP
Version 10

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1. PURPOSE

This guidance document is intended to outline how to use the NCPDP Telecommunication Standard Version D.0 (vD.0) Service Billing transactions to support the immediate growing need to bill for pharmacist professional services.

The healthcare industry is rapidly changing, specifically in the areas of healthcare delivery methods that make patient care services more accessible within community settings. Interdisciplinary, team-based approaches have been acknowledged as a key strategy to meet primary care provider shortages. Community pharmacists under various program policies and credentialing requirements can provide professional services distinct from the traditional prescription dispensing function. A limiting factor to reaching these goals has been the fractured claim adjudication process to bill for these services.

The COVID-19 Public Health Emergency (PHE) marked a critical turning point, emphasizing the immeasurable value of pharmacist professional services within the community setting, particularly for our most vulnerable patients. Under the 118th Congress, HR1770– *Equitable Community Access to Pharmacist Services Act*, promoting pharmacist provider status under Medicare was introduced.

In the absence of federal adoption of a policy or law naming pharmacists as providers, states have taken action by passing provider status legislation and modernizing the scope of practice to include activities previously allowed only under the COVID-19 PHE. These state-level legislations, executive orders and federal-level initiatives acknowledge the expanded scope-of-practice of pharmacists, including their ability to order and administer vaccines and lab tests, prescribe medications and provide a range of other patient care services. Many of these policies highlight the necessity for adequate reimbursement structures for pharmacists, emphasizing their role as essential healthcare providers. This aligns with NCPDP's objective to standardize billing processes and efforts to provide guidance on using the NCPDP Telecommunication Standard vD.0 for billing pharmacist services, ensuring there are processes in place for pharmacists to be compensated for the crucial services they provide to patients.

For these clinical services to be sustainable, pharmacists must be able to bill and receive payment from health plans in a routine manner for the resources and time dedicated to improving patient care and outcomes. These business needs have become increasingly evident within the pharmacy industry as more and more plan benefits and Medicaid programs rely on solutions available within NCPDP standards to move forward with care coordination directives and achieve health data interoperability.

It is also important to note how various NCPDP standards support interoperability of professional service transactions. The *NCPDP SCRIPT Standard Implementation Guide Version 2023011* (January 2028 compliance date) contains five distinct Patient Care Service Referral transactions allowing for service referral request, service referral response, request for a service referral and service documentation. These service referral messages are typically exchanged between the patient's physician or the patient's plan and the pharmacy/pharmacist. This provides systems leveraging NCPDP standards to conduct electronic communications from the point of requesting a service, to billing for the professional service and standardizing the service documentation. Refer to Diagram 1 below for a visual of pharmacist professional services data interoperability process which leverages NCPDP standards for several critical steps.

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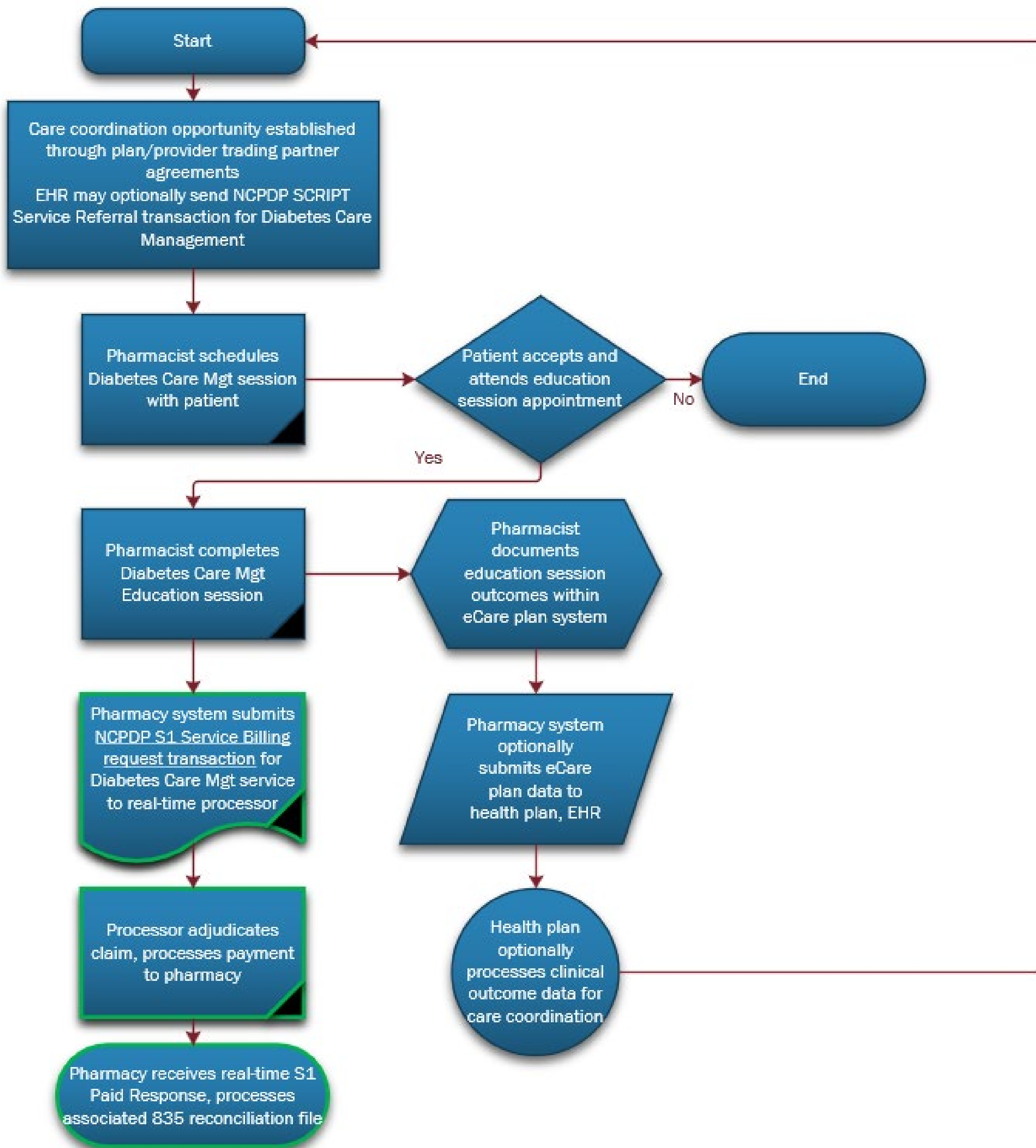
Integrating legislative advancements with NCPDP standards and professional service billing guidance, the industry can support a cohesive and streamlined approach to recognizing and reimbursing pharmacist-led services across the healthcare continuum.

Diagram 1: Example Pharmacist Professional Service Process Flow Using NCPDP Standards



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2. SCOPE

The content of this document is intended to provide guidance to supplement the *NCPDP Telecommunication Standard Implementation Guide vD.0*, Data Dictionary and External Code List (ECL) to expedite the immediate implementation and use of the Service Billing transactions (S1 – Bill, S2 - Reverse, S3 - Reverse/Rebill). Industry adoption of NCPDP Service Billing transactions is critical to address current gaps with pharmacist professional service claim adjudication processes and, more importantly, join forces with payer objectives to meet the growing needs of patient access to care.

2.1 TELECOMMUNICATION STANDARD VERSION

This guidance document will provide S1, S2 and S3 transaction guidance based on NCPDP Telecommunication Standard Version D.0.

As the pharmacy industry is preparing for the implementation of the next Health Insurance Portability and Accountability Act (HIPAA) named version of the Telecommunication Standard, industry familiarity with Version D.0 will ease the implementation of the Service Billing transactions now. Implementers will need to update all transactions when the next Telecommunication Standard is named under HIPAA. It is important to call out while there were no specific changes related to the Service Billing transactions in Versions F6, the modifications in these new versions of the standard apply to all Telecommunication Standard transactions (e.g., B1, B2, B3, S1, S2, S3, N1, N2, N3, P1, P2, P3, P4). Refer to the NCPDP SNIP Committee Telecommunication Standard Version F6 Transition Guidance document.

2.2 SERVICE BILLING BUSINESS CASES

Recommendations outlined within this document are based on current business needs for pharmacist professional services that may or may not be concurrent with the dispensing of a therapeutic medication or device.

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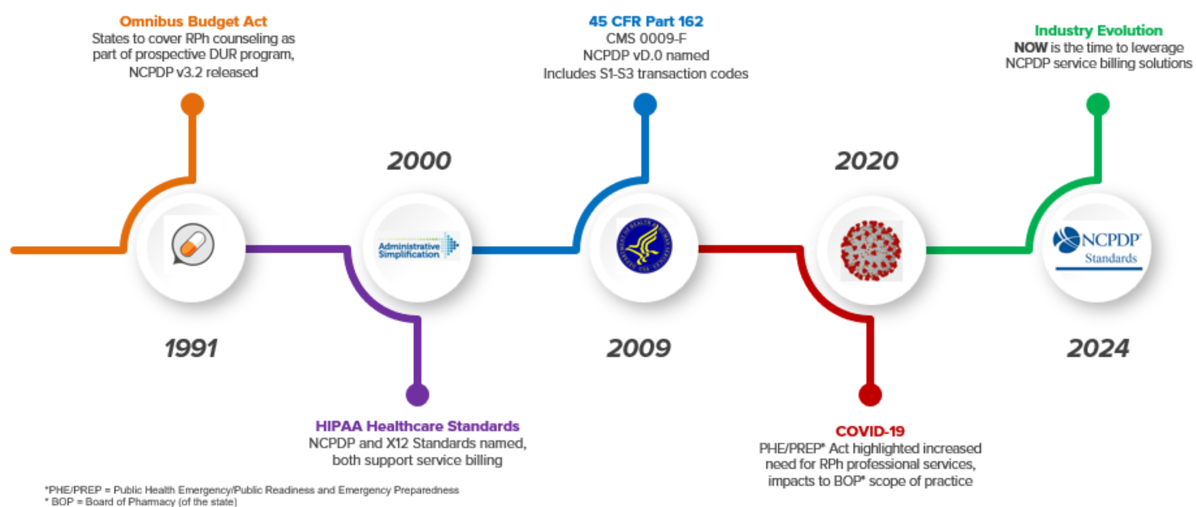
3. NCPDP SERVICE BILLING HISTORY, GUIDING PRINCIPLES AND TIMELINES

3.1 History

The concept of billing for services was incorporated into the NCPDP Telecommunication Standard dating back to version 3.2 – Medicaid Claim Format. The "Medicaid Claim Format" was specifically developed to encourage implementation of a Telecommunication Standard within numerous state Medicaid programs. It was specifically designed to handle the Drug Utilization Review (DUR) and consultation/cognitive service requirements created by the OBRA-1990 Medicaid drug program provisions.

Consultation and cognitive service billing capabilities carried through to the first pharmacy claim billing standard named under HIPAA, NCPDP Telecommunication Standard v5.1. Within this version, specific DUR/PPS[1] code set values were created to identify services rendered. This version supported prescription drug/product Claim Billing and Service Billing transactions. The Transaction Code (103-A3) value was always submitted as B1 (Billing) regardless if the claim was for a drug/product or professional service. Values submitted in specific fields within the Claim and Pricing Segments made the distinction between claim and service billings.

Telecommunication Standard vD.0 included updates (DERF 776) to further streamline service billing by creating the new Transaction Code (103-A3) values of S1 (Service Billing), S2 (Service Reversal) and S3 (Service Rebill). This change allowed processors to identify whether the request was for a product or service within the header section of the transaction to direct the claim to the applicable processing system or coverage rules. This version also clarified the use of Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) (level 1) Product Service ID Qualifiers (436-E1) within the ECL and the implementation guide. NCPDP Telecommunication Standard vD.0 was named under HIPAA as the required electronic standard for pharmacy claims transactions, with covered entity compliance by January 2012.



[1] PPS = Professional Pharmacy Services

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3.2 Guiding Principles for Pharmacist Professional Service Claim Billing

In 2021, the Pharmacy Health Information Technology (HIT) Collaborative published guiding principles[2] on the use of billing codes for pharmacist professional services. These principles are supported within this NCPDP Service Billing transaction implementation guidance to promote standardization of processes, interoperability of health care data and improved patient outcomes.

- *Pharmacists should be able to bill as eligible providers for all covered services within their scope of practice.*
- *Payment for pharmacist's patient care services should be independent from payment for medication dispensing activities. Pharmacists may bill as providers to medical benefits or, when permitted, through the pharmacy benefits.*
- *Established processes and codes should be utilized by pharmacists for billing for patient care services. Proprietary systems, "dummy" codes and manual processes should be avoided.*
- *Documentation and billing codes should accurately attribute the time, complexity and value of the pharmacists' work in providing care to a patient.*
- *The pharmacy profession must advocate with a unified voice for consistent approaches to the documentation and billing of pharmacist patient care services.*
- *The pharmacy profession should align with other providers to advocate for updated medical billing systems that permit real-time eligibility checkers, adjudication of claims and electronic billing.*
- *The pharmacy profession should monitor the environment and advocate for the development and use of standardized documentation and codes that are relevant to the needs of pharmacists providing patient care services (e.g., value-based care).*

It is important to note, while traditionally services covered under a medical benefit have leveraged the X12 837-Health Care Claims: Professional (837P) billing format, pharmacist professional services may be billed using NCPDP S1-S3 transactions, regardless of the service being covered under a pharmacy or medical benefit. Payer requirements, trading partner agreements, implementation priorities and healthcare needs within the industry (e.g., pandemic) may designate the applicable billing format.

3.3 Timeline Recommendations for NCPDP Service Billing Transaction Adoption

Another important detail that surfaced during the COVID-19 PHE was the increased need for the pharmacies, pharmacists and payers to support NCPDP Service Billing transactions to allow for the billing of patient evaluation, medication administration, medication counseling and other services. However, due to system capabilities and the urgent need for pharmacists to perform these services, temporary workaround claim billing solutions for these services using NCPDP Telecommunication

[2] Pharmacy HIT Collaborative: https://pharmacyhit.org/workgroups-and-committees/
Guiding Principles: https://pharmacyhit.org/wp-content/uploads/PHIT_WG1_GUIDANCE-_FOR_BILLING_3-8-21.pdf

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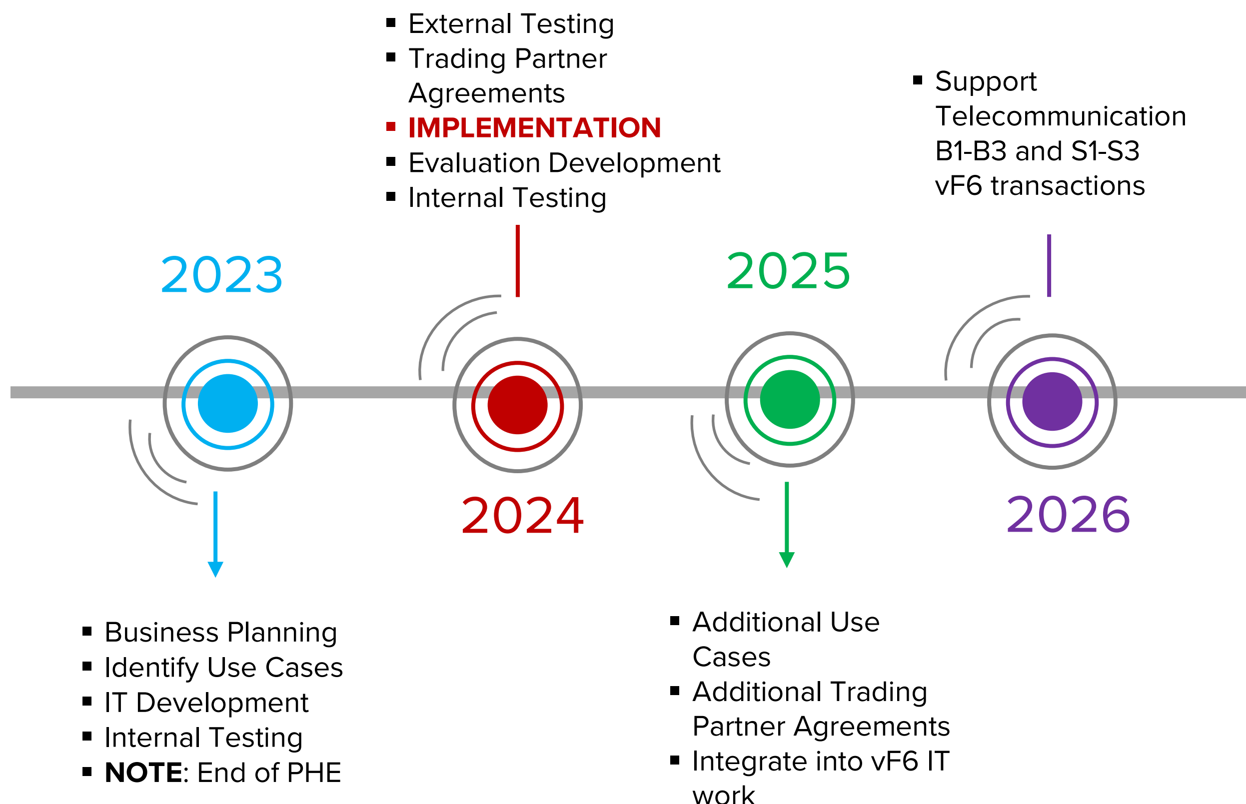
Standard B1-B3 transactions were developed. These temporary solutions (e.g., Oral Anti-Viral Patient Assessment) are not sustainable but are still being used because the S1 is not widely adopted.

The pharmacy industry has also recognized an increasing number of states expanding scope of practice by legislation or regulation to support the growing need for pharmacist professional services. Scope of practice is typically tailored to meet state, jurisdiction or institution-specific public health needs related to specific diseases, conditions, epidemics, drugs or drug classes.

Additionally, Medicaid regulations and policies allow coverage of clinical services furnished by a pharmacist. The Centers for Medicare & Medicaid Services (CMS) encourages states to use the flexibility inherent in federal law to create innovative payment methodologies for services. CMS has provided tools and authorities to state Medicaid programs to, if they choose, enroll and reimburse pharmacist practitioners as Medicaid providers under the "other licensed practitioner" (OLP) provision. State Medicaid programs are adding services provided by pharmacist practitioners as an optional benefit using the Medicaid state plan amendment (SPA) process. Once developed, proposed Medicaid SPAs are submitted to CMS to review and approve or deny, a process that can take up to 90 days or longer in more complex situations.

These turning points within the pharmacy industry support the immediate need for the adoption of the NCPDP Service Billing transactions. NCPDP recommends stakeholders leverage NCPDP Telecommunication Standard vD.0 and begin this effort in 2024, with at least an initial implementation in 2025. This timeline offers trading partners and NCPDP an opportunity to evaluate the results, coordinate the necessary adjustments to trading partner agreements and for NCPDP to publish applicable guidance needed for the next HIPAA named version of the Telecommunication Standard.



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4. PROFESSIONAL SERVICE CLAIM BILLING OPTIONS

The Administrative Simplification provisions of the 1996 HIPAA created electronic transactions and code sets standards requirements. The HIPAA transactions and code set standards are rules to standardize the electronic exchange of patient-identifiable, health-related information. They are based on electronic data interchange (EDI) standards which allow the electronic exchange of information from computer to computer.

The HIPAA Standards for Electronic Transactions and Code Sets rule, published August 17, 2000, adopted the below standards for pharmacy and healthcare claim transactions:

- Pharmacy Claims:
    - *NCPDP Telecommunication Standard Implementation Guide* and equivalent *NCPDP Batch Standard Batch Implementation Guide Version 5.1*
- Professional Claims:
    - ASC X12N 837—Health Care Claim, Professional, Version 4010

This HIPAA rule[3] was modified on March 17, 2009, to name the below standards for pharmacy and healthcare transactions. This modification allowed either named standard to be used for professional service claims, to which the choice would be between trading partners.

- Pharmacy Claims and Retail Pharmacy Supplies and Professional Service Claims:
    - *NCPDP Telecommunication Standard Implementation Guide vD.0*
- Professional Claims:
    - ASC X12N 837—Health Care Claim, Professional Version 5010

4.1 NCPDP TELECOMMUNICATION STANDARD

The *NCPDP Telecommunication Standard Implementation Guide* defines the record layout for real-time claim transactions between providers and adjudicators. Since the communication between these parties is bidirectional, the record layout for both the transmitted claim and the real-time response are defined by the *NCPDP Telecommunication Standard Implementation Guide*. Subsequent payment and remittance advice information used for claim reconciliation processes use the X12 Health Care Claim Payment/Advice Set (835) standard.

The processor must relay, in real-time, complete information regarding the disposition of a transaction, including status, reason(s) for rejection and basis of determination for payment, as applicable. A "Paid" response is returned to the provider when all Telecommunication Standard and plan requirements have been met.

[3] CMS 0009-F: https://www.govinfo.gov/content/pkg/FR-2009-01-16/pdf/E9-740.pdf

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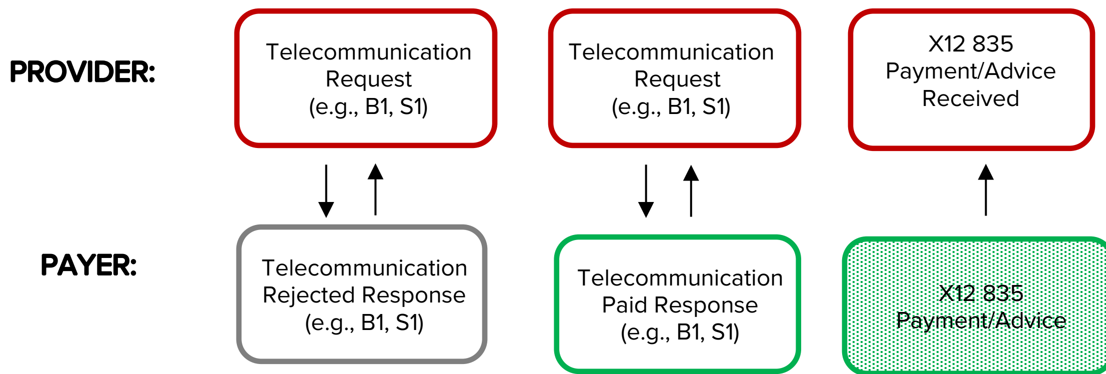
Diagram 2: Transaction Flow Example:



NCPDP Telecommunication Standard vD.0 streamlined service billing by creating the new Transaction Code (103-A3) values: S1 (Service Request), S2 (Service Reversal) and S3 (Service Rebill). This change allowed processors to identify whether the request was for a product or service within the header section of the transaction to direct claims to the applicable processing system or coverage rules. This version also clarified the use of CPT® and HCPCS (level 1) Product Service ID Qualifiers (465-EY) within the ECL and the implementation guide. NCPDP Telecommunication Standard vD.0 was named under HIPAA as the required electronic standard for pharmacy claims transactions, with covered entity compliance by January 2012.

NCPDP vD.0 Field	Service Billing (DUR/PPS)	Service Billing (CPT®)	Service Billing (HCPCS)
Transaction Code (103-A3)	S1	S1	S1
Rx/Service Reference Number Qualifier (455-EM)	02 (Service)	02 (Service)	02 (Service)
Product Service ID Qualifier (436-E1)	06 (DUR/PPS)	07 (CPT4)	09 (HCPCS)
Product Service ID (402-D7)	"0"	CPT® Code	HCPCS
Procedure Modifier Code (459-ER)	As Needed	As Needed	As Needed
Diagnosis Code (424-DO)	As Needed	As Needed	As Needed
Reason for Service Code (439-E4)	Required	As Needed	As Needed
Professional Service Code (440-E5)	Required	As Needed	As Needed
Result of Service Code (441-E6)	Required	As Needed	As Needed
DUR/PPS Level of Effort (474-8E)	As Needed	As Needed	As Needed
Professional Service Fee Submitted (477-BE)	Required	Required	Required

The NCPDP Telecommunication Standard Implementation Guide vD.0 also includes:

- Professional Pharmacy Services guidance, "Billing With DUR Segment"
- Guidance on the use of the Incentive Amount Submitted and Paid fields for B1 claim billing with associated professional service(s) (e.g., vaccine dispensing and administration)

Service Billing request and response transaction diagrams are outlined within Section 9 of *the NCPDP Telecommunication Standard Implementation Guide vD.0*. The implementation guide states, "Services may be correlated with a dispensing event or may be separate and unrelated to any particular prescription. Professional pharmacy services may include but are not limited to blood pressure monitoring, taking a patient history for a new disease or diagnosis, referring patients to

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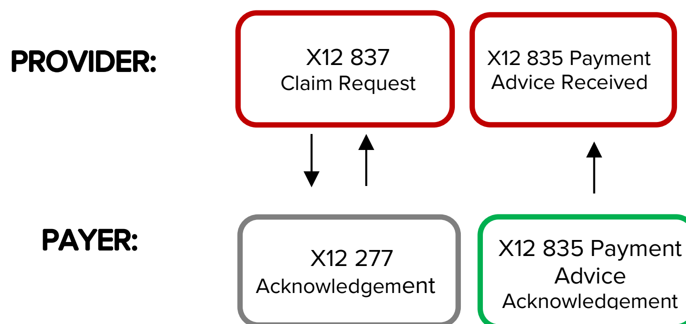
other health care providers and counseling and education beyond the simple act of describing a medication's use and side effects."[4]

4.2 X12 837-Health Care Claim: Professional Transaction Standard

The Health Care Claim Implementation Guides describe the use of the X12 Health Care Claim (837) transaction set to submit and transfer claims and encounters to primary, secondary and subsequent payers. The X12 Health Care Claim: Professional (837P) transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. The 837P transaction is a billing request format, and unlike the Telecommunication Standard, does not have an 837 response format. Instead, the X12 standard uses the Health Care Claim Status Response (277) transaction set for the real-time response and the associated claim payment or denial information is returned in the subsequent 835 transaction set. Timing of the 835 electronic remittance advice is based on trading partner agreement and is generally not real-time.

Diagram 3: Transaction Flow Example:



4.3 Opportunities For Payers, Processors, Providers and Patients with Real-Time Billing

In a report[5] released by the Association of American Medical Colleges (AAMC) in June 2021, the U.S. faces a projected shortage between 37,800 and 124,000 physicians by the year 2034. Pharmacists can help fill that void, and in many areas across the country, pharmacists are the only accessible health care provider. The challenge for the health care industry is how to pay the pharmacists and pharmacies for these services separately and above any drug dispensing. A major feature that sets the NCPDP Telecommunication Standard billing transactions apart from the X12 837 Professional transaction is that it supports real-time adjudication. The pharmacy provider sends the claim and receives a response from the payer/processor within seconds. This is not possible with the X12 837 Professional claim format because it lacks a response format. Using the 837, the pharmacy provider might not receive a rejected claim until days or weeks after submission. This extends the time required to correct and resubmit the claim. The use of NCPDP Service Billing transactions can overcome non-real-time billing barriers, facilitating the adoption of pharmacist professional services to better support current patient care needs.

[4] NCPDP Telecommunication Standard vD.0, August 2010. p127.

[5] https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage

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The table below highlights specific features of real-time pharmacy service claims processing and the benefits they produce for patients, providers and payers.

Features of Real-time Claims Processing	Benefit Results
Pharmacy providers are already familiar with and their systems already support real-time claims processing features. This will increase and expedite the adoption rate of the NCPDP Service Billing transaction to bill for patient care services.	• Expands patient access to professional services and care options • Improves member satisfaction
Plan benefit coverage restrictions and more precise patient out-of-pocket costs can be determined at/prior to point of care.	• Enables patient to make an informed decision regarding their care options • Mitigates surprise billing situations • Improves member satisfaction
Plan eligibility, benefit, prior authorization, financial and other information is made available at/prior to point of care enabling real-time resolution of claim rejections and care coordination.	• Reduces provider, payer and processor call center volume • Reduces claim administrative costs • Enables payer to communicate member care coordination opportunities in real-time • Enables provider to make an informed decision at/prior to point of care and identify alternative care options • Aligns with provider cash flow timelines to coordinate all business processes
Coordination of benefits, third-party liability and alternative payer liability information can be communicated in real-time, allowing for proper billing of professional service claims at point of care.	• Expands member access to professional services and care options • Enables patient to make an informed decision on their care options • Mitigates surprise billing situations • Improves member satisfaction • Reduces provider, payer and processor call center volume
Outcomes of claim billing transactions and their associated services can be incorporated into downstream systems and processes in a timely manner.	• Expedites clinical care data interoperability • Enhances additional care coordination • Reduces administrative costs

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5. NCPDP SERVICE BILLING REFERENCE DOCUMENTS

Payers and providers should access all NCPDP Telecommunication Standard resources to prepare for the submission and receipt of Telecommunication Standard Service Billing transactions.

The below resources are only available to NCPDP members under the MYNCPDP section of the NCPDP web-site (Standards, Data Dictionary & External Code Lists Lookup Tools).

It is important to note these documents may reference the use of the DUR/PPS segment and the Product/Service ID Qualifier (436-E1) value 06 (DUR/PPS). While this guidance is valid, it creates variability in processing methods and differs from the medical services billing practices. As noted within this Telecommunication Standard vD.0 implementation guidance document, the use of the DUR/PPS segment and the Product/Service ID Qualifier (436-E1) value 06 (DUR/PPS) is not recommended.

5.1 Telecommunication Standard Implementation Guide Version D.0

The *NCPDP Telecommunication Standard Implementation Guide vD.0* provides the transaction detail for each defined Transaction Code (103-A3). This includes request and response transactions. Below are specific sections of this document that are critical for Service Billing transaction implementation.

Section 5: TERMINOLOGY USED THROUGHOUT
This section provides description of terms used throughout the document, and most importantly, the Table Designations defining the segment and field situations of use values (e.g., M-Mandatory, S-Situational, I-Informational Only, etc.).

Section 9: Service Billing (Professional Pharmacy Service) Information
This section outlines the transaction diagrams, transaction detail, segment and field situations of use for S1/S3 requests and responses. The *NCPDP Telecommunication Standard Implementation Guide* is the only document that contains the situation of use detail. This information is critical to ensure standardization of implementation and compliance with the HIPAA-named standard.

Section 10: REVERSAL INFORMATION
This section provides the reversal transaction information for all transaction types.

Section 24: Transmission Structure
This section provides the matrices of the segment and field level situations of use by transaction code.
It offers an abbreviated view of the detail in transaction diagram sections. It only includes the segment and field designation (e.g., M, S, R, N) and does not provide the situation of use text.

Field Level Matrices Example:

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.		Eligibility	Claim Billing/Claim Rebill/Encounter	Predetermination Of Benefits (Claim)	Service Billing/Service Rebill	Claim Reversal	Service Reversal
	TRANSACTION HEADER SEGMENT						
1Ø1-A1	BIN Number	**M**	**M**	**M**	**M**	**M**	**M**
1Ø2-A2	Version Release Number	**M**	**M**	**M**	**M**	**M**	**M**
1Ø3-A3	Transaction Code	**M**	**M**	**M**	**M**	**M**	**M**
1Ø4-A4	Processor Control Number	**M**	**M**	**M**	**M**	**M**	**M**
1Ø9-A9	Transaction Count	**M**	**M**	**M**	**M**	**M**	**M**
2Ø2-B2	Service Provider ID Qualifier	**M**	**M**	**M**	**M**	**M**	**M**
2Ø1-B1	Service Provider ID	**M**	**M**	**M**	**M**	**M**	**M**
4Ø1-D1	Date of Service	**M**	**M**	**M**	**M**	**M**	**M**
11Ø-AK	Software Vendor/Certification ID	**M**	**M**	**M**	**M**	**M**	**M**

Segment Level Matrices Example:

VERSION D AND ABOVE REQUEST SEGMENT USAGE MATRIX								
SEGMENT	**Eligibility**	**Billing (Claim) or Encounter**	**Rebill (Claim)**	**Predetermination Of Benefits (Claim)**	**Billing (Service)**	**Rebill (Service)**	**Reversal (Claim)**	**Reversal (Service)**
Header	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**M**
Patient	S	S	S	S	S	S	N	N
Insurance	**M**	**M**	**M**	**M**	**M**	**M**	S	S
Claim	N	**M**	**M**	**M**	**M**	**M**	**M**	**M**
Pharmacy Provider	S	S	S	S	S	S	N	N
Prescriber	S	S	S	S	S	S	N	N
Coordination of Benefits/Other Payments	N	S	S	N	S	S	S	S
Workers' Compensation	N	S	S	N	S	S	N	N
DUR/PPS	N	S	S	S	S	S	S	N
Pricing	N	**M**	**M**	**M**	**M**	**M**	S	N
Coupon	N	S	S	N	N	N	N	N
Compound	N	S	S	S	N	N	N	N
Prior Authorization	N	N	N	N	N	N	N	N
Clinical	N	S	S	S	S	S	N	N
Additional Documentation	S	S	S	N	S	S	N	N
Facility	N	S	S	S	S	S	N	N
Narrative	N	S	S	N	S	S	N	N

The field and segment level matrices are also available in excel format, under the Standards Look-Up tool section (D.0 Matrices).

Section 28: SPECIFIC SEGMENT DISCUSSION

This section provides additional detail to further clarify the use of specific segments. The following sub-sections provide information related to Service Billing transactions.

- Section 28.1.8.3: *Specific Discussion-Professional Pharmacy Services*
  - This section provides an overview of Reason for Service (439-E4), Professional Service (440-E5) and Result of Service (441-E6) values that may be used to communicate administrative or patient care professional services. These code values are often used in B1 Claim Billing transactions.
  - As noted within this vD.0 implementation guidance document, the use of the DUR/PPS segment and the Product/Service ID Qualifier (436-E1) value 06 (DUR/PPS) is not recommended.
- Section 28.1.9: *Claim Segment*
  - This section describes the use of specific fields within the Claim Segment for Service Billing transactions. Several optional fields are listed as available for use. Please refer to section *6.1 Service Billing Request Segments* above for recommended use for the vD.0 implementation of Service Billing transactions.

Section 34: Transmission Examples

Refer to section 34.64 *Service Billing* for S1 transaction examples using a CPT® code as the Product Service ID (442-E7) with a Product Service ID Qualifier (436-E1) value of 07 (Current Procedural Terminology (CPT4)). Note, the CPT® code values used in these examples may have been inactivated by the AMA, post the publication of the *NCPDP Telecommunication Standard vD.0 Implementation Guide*.

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5.2 Telecommunication Version D and Above Questions, Answers and Editorial Updates (aka Version D Editorial Document or FAQ Document)

The *Telecommunication Version D and Above Questions, Answers and Editorial Updates* (FAQs) houses additional guidance on various topics related to the use of the Telecommunication Standard vD.0. Refer to Section 6.23 *Pharmacist Services Billing* and Section 16 *Vaccine Services – Pharmacy Benefit Billing & Processing* for additional guidance specific to the Service Billing transaction.

5.3 Data Dictionary (July 2007)

NCPDP produces a single comprehensive Data Dictionary for all published NCPDP standards. The NCPDP Data Dictionary provides the following information for all data elements across all NCPDP standards.

- FIELD NUMBER
- NAME OF FIELD
- DEFINITION OF FIELD
- FIELD FORMAT
- STANDARD FORMATS
- FIELD LENGTH
- VALUES (Reference to ECL)
- COMMENTS/EXAMPLES

While multiple, and more current, publications of the Data Dictionary are available, only the July 2007 Data Dictionary applies to *NCPDP Telecommunication Standard Implementation Guide vD.0*. This is available as a pdf document under the Standards Lookup Tools section on MyNCPDP. The Data Dictionary identifies the standards format(s) to which a data element applies, such as (T) Telecommunication. It does not specify the use of the field within specific transaction codes for that standard. Field usage information is available within the *NCPDP Telecommunication Standard Implementation Guide vD.0*.

5.4 Web-Enabled External Code List (ECL)

NCPDP supports an ECL of approved code list values for associated data elements within the NCPDP approved standards. Each data element contains a list of the codes and a description in effect for the publication period.

For Example:
Product/Service ID Qualifier (436-E1) field is defined as a "Code qualifying the value in Product/Service ID (407-D7)." This data element includes multiple ECL values, as various code sets can be used to identify the specific Product Service ID (407-D7) value. For service billing, the following ECL values would commonly be used.

07: Current Procedural Terminology (CPT4)
09: Healthcare Common Procedure Coding System (HCPCS)

The ECL used within the NCPDP Telecommunication Standard allows industry support of new, updated or replaced values for existing data elements, within an existing named version of the standard. An annual ECL implementation schedule is in place where all changes approved in the previous time period are made available for use as of October 15th. The Telecommunication Standard ECL implementation process also supports an Emergency ECL implementation schedule for time-sensitive regulatory changes.

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6. PROFESSIONAL SERVICE BILLING CODES

NCPDP supports the Pharmacy HIT Collaborative Guiding Principles for the Development and Use of Documentation and Billing Codes for Pharmacists' Patient Care Services[6]. The guidelines listed below are
inherent in the development of NCPDP standards, using distinct transaction codes, standardized code sets and data element/value definitions that support business needs.

- *Pharmacists should be able to bill as eligible providers for all covered services within their scope of practice.*
- *Payment for pharmacist's patient care services should be independent from payment for medication dispensing activities. Pharmacists may bill as providers to a medical benefit or when permitted, through the pharmacy benefit.*
- *Established processes and codes should be utilized by pharmacists for billing for patient care services. Proprietary systems, "dummy" codes and manual processes should be avoided.*
- *Documentation and billing codes should accurately attribute the time, complexity and value of the pharmacist's work in providing care to a patient.*

The code used to identify the specific product or service billed is one of the most critical components of the billing transaction. Plan coverage, payment rules, patient out of pocket costs and access to care rules begin based on the specific billing code submitted. The *NCPDP Telecommunication Standard Implementation Guide vD.0* uses the Product Service ID (407-D7) to communicate the billing code for the specific claim request. There are multiple types of Product Service IDs, where the Product Service ID Qualifier (436-E1) defines the type of identifier submitted. The NCPDP ECL includes various Product/Service ID Qualifier values such as 03 (National Drug Code (NDC)), 12 (Global Trade Identification Number (GTIN)), 07 (Current Procedural Terminology (CPT4)), 09 (Healthcare Common Procedure Coding System (HCPCS)), etc.

6.1 NCPDP Recommendation on Which Service Billing Code Set to Use

NCPDP recommends the use of the CPT® code set and, where applicable, CMS HCPCS codes as these will support standardization in the implementation of NCPDP Service Billing Transactions and align with existing medical billing practices.

6.1.1 Current Procedure Terminology (CPT®) Code Set

- **NCPDP External Code List:**
  - **Product Service ID Qualifier (436-E1) value 07 (Current Procedural Terminology (CPT4))**
    - 07: CPT4 code set is used for reporting medical services and procedures and is available via the American Medical Association (AMA) at https://www.ama-assn.org/amaone/cpt-current-procedural-terminology.

- **CPT® Code Set Information**[7]:

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[6] Pharmacy HIT Collaborative: https://pharmacyhit.org/workgroups-and-committees/
Guiding Principles: https://pharmacyhit.org/wp-content/uploads/PHIT_WG1_GUIDANCE-_FOR_BILLING_3-8-21.pdf

[7] AMA: Use of CPT® Code Set: https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

- Designated by the U.S. Department of Health and Human Services (HHS) under HIPAA as a national coding set for physician and other health care professional services and procedures, CPT® evidence-based codes accurately encompass the full range of health care services.
- CPT® Code Types:
  - Category I: These codes have descriptors that correspond to a procedure or service. Codes range from 00100–99499 and are generally ordered into sub-categories based on procedure/service type and anatomy.
    - Subcategories:
      - Evaluation and Management (E/M)*: 99201 – 99499

(Refer to Section 6.1.1.1 *Evaluation and Management (E/M) Code Management* below for additional E/M code information)

      - Anesthesia: 00100 – 01999; 99100 - 99140
      - Surgery: 10021 - 69990
      - Radiology: 70010 - 79999
      - Pathology and Laboratory*: 80047 - 89398
      - Medicine*: 90281 – 99199; 99500 - 99607

*These CPT® code values are generally applicable to pharmacist professional services

  - Category II: These alphanumeric tracking codes are supplemental codes used for performance measurement.
  - Category III: These are temporary alphanumeric codes for new and developing technology, procedures and services. They were created for data collection, assessment and, in some instances, payment of new services and procedures that currently do not meet the criteria for a Category I code.
- All CPT® codes are five-digits and can be either numeric or alphanumeric, depending on the category.
- The CPT® Editorial Panel, appointed by the AMA Board of Trustees, is responsible for maintaining and updating the CPT® code set.
- The CPT® Editorial Panel meets three times a year to review the applications for either new codes or revisions to existing codes.
- Any individual or entity using CPT® content needs permission or a license (i.e., a written agreement authorizing use of CPT® codes) from the AMA or an authorized distributor.
- CPT® Category 1 CPT® Code Updates – Effective Dates of Use[8]
  - General Category 1 New/Updated CPT® Codes
    - Published annually, (i.e., usually in the fall)
      - Effective January 1 (following year)
  - Vaccine Category 1 New/Updated CPT® Codes
    - Published January 1
      - Effective July 1 (same year)
    - Published July 1
      - Effective January 1 (following year)

6.1.1.1 EVALUATION AND MANAGEMENT (E/M) CODE MANAGEMENT

In 2021, the AMA implemented revised guidelines and code descriptors for office and other outpatient services E/M codes 99202-99215. The coding guidelines were overhauled to change the code selection requirements to be based on medical decision making (MDM) or total time of the E/M

[8] AMA: CPT® Code Set Process: https://www.ama-assn.org/about/cpt-editorial-panel/cpt-code-process

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service. The revisions eliminated the requirement to meet a certain level of history and exam, instead requiring a medically appropriate history and/or physical exam.[9]

- E/M is divided into broad categories, such as office visits, hospital inpatient or observation care visits and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits: new patient and established patient.[10]
    - A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.
    - An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.
- Billing for E/M services may be based on MDM or be time based.
    - MDM includes establishing diagnoses, assessing the status of a condition and/or selecting a management option.
    - Time-based coding is the total time on the date of the encounter. It includes both the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter.
    - Refer to industry references for additional information, e.g.,
        - AMA: CPT® Evaluation and Management (E/M) Code and Guideline Changes
        - AMA: CPT® Code Process
        - American Academy of Professional Coders (AAPC): AAPC E/M Calculator
        - AAPC: E/M 2023 Coding Changes

6.1.2 Healthcare Common Procedure Coding System (HCPCS) Code Sets

- **NCPDP External Code List:**
    - **Product Service ID Qualifier (436-E1) value 09 (Healthcare Common Procedure Coding System (HCPCS))**
        - 09: The Healthcare Common Procedure Coding System (HCPCS) is a uniform method for health care providers and medical suppliers to report professional services, procedures and supplies. Used specifically it applies to the Level II Alpha codes (a letter followed by 4 numerals) and modifiers. Used generically HCPCS includes the Level I CPT® procedure codes and modifiers. HCPCS Level II codes are maintained and published by the Centers for Medicare and Medicaid Services (CMS).
- **HCPCS Code Set Information:**
    - The Secretary of HHS delegated authority under the HIPAA legislation to CMS to maintain and distribute HCPCS Level II Codes. As stated in 42 CFR Sec. 414.40 (a), CMS establishes uniform national definitions of services, codes to represent services and payment modifiers to the codes.
    - **HCPCS Level I** is comprised of CPT®, a numeric coding system maintained by the AMA.
    - **HCPCS Level II** is a standardized coding system that is used primarily to identify drugs, biologicals and non-drug and non-biological items, supplies and **services not included in the CPT® code set jurisdiction**, such as ambulance services and durable

[9] AAPC 2023 E/M Code Changes: Evaluation and Management (E/M) Code Changes 2023 - AAPC
[10] AMA New/Established Patient: https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

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medical equipment, prosthetics, orthotics and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies and equipment that are not identified by CPT® codes, HCPCS Level II codes were established for submitting claims for these items.[11]

    - Level II codes are five characters, beginning with a letter (A–V) and followed by four numeric digits.
    - The G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT®4 (the current version of CPT® codes) but for which there are no CPT®4 codes.
        - Refer to CMS HCPCS Codes for Stand-alone Vaccine Counseling[12] for recent examples of G codes.
- CMS maintains HCPCS Level II codes, including decisions about additions, revisions and deletions to the codes.
    - The application and instructions for requesting CMS to add, revise or discontinue a HCPCS Level II code can be accessed at: https://mearis.cms.gov/public/home.
    - HCPCS Level II application submission deadlines for non-drug and non-biologicals is the first business day of January and July.
- CMS Level II Updates – Effective Dates of Use
    - Quarterly Cycle 2 Drug and Biological Code Applications and for Biannual Cycle 1 Non-Drug and Non-Biological Code Applications:
        - Published April
        - Effective October (same year)
    - Quarterly Cycle 4 Drug and Biological Code Applications and for Biannual Cycle 2 Non-Drug and Non-Biological Code Applications:
        - Published October
        - Effective April (following year)
- Refer to the CMS HCPCS Quarterly Update[13] for Level II modifications.

6.2 Product Service IDs Not Recommended for Service Billing

While the NCPDP Telecommunication Standard supports the use of Product Service ID Qualifier (436-E1) value "06 – DUR/PPS," this results in "0" being submitted in the mandatory Product Service ID (407-E7) field, which most claim adjudication systems are dependent on a valid value in this field to initiate coverage and pricing rules. Based on current interconnected system infrastructure, the use of Product Service ID Qualifier (436-E1) value 06 – DUR/PPS for Service Billing (S1 – S3) transactions is NOT RECOMMENDED.

[11] CMS HCPCS Level II Coding: https://www.cms.gov/medicare/coding/medhcpcsgeninfo/downloads/2018-11-30-hcpcs-level2-coding-procedure.pdf
[12] CMS Vaccine Counseling G Codes: https://www.aafp.org/pubs/fpm/blogs/gettingpaid/entry/vaccine_counseling_codes.html
[13] CMS HCPCS Quarterly Updates: https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update

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7. SEGMENTS FOR S1 IMPLEMENTATION

The following segment sections are meant to provide guidance on specific fields that differentiate the Service Billing (S1, S2, S3) from Claim Billing (B1, B2, B3) transactions. Please refer to Section 5 *NCPDP Service Billing Reference Documents* above for additional NCPDP resource documents.

Segments and fields not outlined in this section were intentionally eliminated due to the lack of known business cases that require S1 implementation guidance.

7.1 Service Billing Request Segments

The table below lists the segments available for an S1 Request transaction. The situational segments highlighted in gray are not recommended for the Telecommunication Standard vD.0 implementation.

Mandatory
Transaction Header Segment *Segment Separator* **Insurance Segment**
Situational
Segment Separator **Patient Segment**
Mandatory
Group Separator *Segment Separator* **Claim Segment** *Segment Separator* **Pricing Segment**
Situational
Segment Separator **Pharmacy Provider Segment** *Segment Separator* **Prescriber Segment** *Segment Separator* **DUR Segment**
Segment Separator **Coordination of Benefits/Other Payments Segment** *Segment Separator* **Workers' Compensation Segment** *Segment Separator* **Clinical Segment** *Segment Separator* **Additional Documentation Segment** *Segment Separator* **Facility Segment** *Segment Separator*

The following request segments are NOT used within the Service Billing request transaction:

- Coupon
- Compound
- Prior Authorization

7.1.1 Transaction Header Segment

BIN NUMBER (101-A1) and PROCESSOR CONTROL NUMBER (104-A4)

- *BIN: Card Issuer ID or Bank ID Number used for network routing/Number assigned by the processor*
- *Processor Control Number (PCN): Number assigned by the processor*
- The BIN and Processor Control Number fields in the Request Header segment are used to route the transaction to the applicable payer processing system.
    - Refer to Section 9 *Transaction Routing* below for additional information.

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- Providers should be mindful that professional service claims may or may not be covered under the same BIN/PCN as a payer's pharmacy benefit BIN/PCN.
- In the event a professional service claim requires a BIN/PCN that is different than the BIN/PCN required for B1 transactions, the payer should reject the claim with Reject Code (511-FB) values 01 – M/I BIN and 04 – M/I PCN and provide the BIN/PCN required for the S1 claim within the Additional Message Information (526-FQ) field.

TRANSACTION CODE (103-A3)

- *Code identifying the type of transaction*
- Providers will send the following values in the Transaction Code (103-A3) field when submitting a service transaction:
    - S1 – Service Billing
    - S2 – Service Reversal
    - S3 – Service Rebill

TRANSACTION COUNT (109-A9)

- *Count of transactions in the transmission*
- To mitigate version transition issues, it is recommended for the implementation of Service Billing transactions under NCPDP Telecommunication Standard vD.0 a separate claim be submitted for each service performed in a single patient encounter (i.e., Transaction Count = 1).

Note: Telecommunication Standard Version D.0 indicates, "Each service submission request may contain up to four occurrences of claim/service data." This is based on the value submitted in the Transaction Count (109-A9) field in the header segment where the applicable claim transaction segments for each service would repeat up to four times. Under Telecommunication Standard vD.0, a single transmission could contain up to 4 different services to be billed where the applicable segments repeat for each service. However, the Transaction Count will change from 4 to 1 as of Telecommunication Standard vF6.

SERVICE PROVIDER ID (201-B1)

- *ID assigned to a pharmacy or provider*
- The Service Provider ID (201-B1) field is used to identify the Type 2 National Provider Identifier (NPI) of the pharmacy/provider submitting the S1 claim request to which any associated claim reimbursement would be remitted.
    - The Service Provider ID (201-B1) field is not used to communicate the ID of the individual provider rendering the services.
    - Providers should continue to send their pharmacy ID in the Service Provider ID (201-B1) field.
- The Service Provider ID (201-B1) field is mandatory on all Service Billing transaction requests (S1, S2, S3).

7.1.2 INSURANCE SEGMENT

GROUP ID (301-C1)

- *ID assigned to the cardholder group or employer group*
- Similar to the BIN/PCN, providers should be mindful that professional service claims may be covered under a distinct Group ID, different than the Group ID required for a B1 claim request for that payer.
- In the event a professional service claim is not covered under the submitted Group ID, the reject response should provide messaging directing the provider to the required Group ID for S1 claim requests.

7.1.3 PATIENT SEGMENT

PLACE OF SERVICE (307-C7)

- *Code identifying the place where a drug or service is dispensed or administered.*
    - The above is the field definition within the vD.0 Data Dictionary.
    - The definition was updated for future versions to align with the CMS use of this field.
        - Code identifying the place where a product or service is administered.
- This field is required if a specific Place of Service (307-C7) value could result in different coverage, pricing or patient financial responsibility.
- The ECL for this field is a CMS code set.
    - CMS maintains this code set. Place of Service codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.
    -
- Place of Service (307-C7) is not to be used as a replacement to the Patient Residence Code (384-4X). While the values differ, the value descriptions for these fields will remain synchronized. For Example:
    - Place of Service (307-C7) value 12: HOME – Location, other than a hospital or other facility, where the patient receives care in a private residence
    - Patient Residence Code (384-RX) value 01: HOME – Location, other than a hospital or other facility, where the patient receives drugs or services in a private residence.
- The values used to identify the Place of Service (307-C7) are specific to where the service occurred, versus the location of the service provider. As a result, the Place of Service (307-C7) values used in an S1 transaction may vary from those used in a B1 transaction. For example:
    - Service Billing (S1):
        - The Place of Service (307-C7) value will represent the location where the service was rendered, including telehealth. Pharmacist professional services can take place within the pharmacy location (e.g., patient education, blood pressure monitoring). For example, if the Place of Service results in different coverage or pricing rules, the S1 claim would be submitted with the value 01 Pharmacy, "a facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients."
        - However, there may be specific services which take place outside the pharmacy, such as medication therapy management (MTM) services at an Assisted Living Facility or patient's home. When the Place of Service results in different coverage or pricing rules, the corresponding Place of Service (307-C7) value (13 – Assisted Living Facility or 12 - Home) would be used.
    - Claim Billing (B1):
        - The Place of Service (307-C7) value will represent the location where the medication was dispensed, which will generally be the pharmacy, CMS Place of Service value "01."
        - There may be situations where the service (i.e., drug dispensing) associated to the B1 claim takes place outside the pharmacy location. For example, a vaccine may be dispensed and administered to the patient within the patient's home. In this instance, the B1 claim is used to bill for the vaccine product plus the administration and the specific Place of Service (307-C7) value (12-Home) is submitted as it impacts coverage or pricing rules.
- The following fields work in tandem to identify and qualify various combinations of pharmacy service, service location and patient residence:
    - Place of Service (307-C7)

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  - Patient Residence (384-4X)
  - Pharmacy Service Type (147-U7)
- Payers and providers may consider implementing the use of the Place of Service (307-C7), Patient Residence (384-4X) and Pharmacy Service Type (147-U7) fields for S1 Service Billing requests in a similar manner to how they use these fields within B1 claim billing requests to apply the applicable coverage rules and expected reimbursement based on the specific contract terms.
- The payer's S1 payer sheet should represent their use of the Place of Service (307-C7) field when the place of service results in different coverage or pricing rules.

PATIENT RESIDENCE CODE (384-4X)

- *Code identifying the patient's place of residence*
- Required if this field could result in different coverage, pricing or patient financial responsibility.
- As noted above, the Place of Service (307-C7) is not to be used as a replacement to the Patient Residence Code (384-4X). While the values differ, the value descriptions for these fields will remain synchronized. For Example:
  - Place of Service (307-C7) value 12: HOME – Location, other than a hospital or other facility, where the patient <u>receives care</u> in a private residence
  - Patient Residence Code (384-4X) value 01: HOME - Location, other than a hospital or other facility, where the patient <u>receives drugs or services</u> in a private residence.
- Historical Background:
  - Prior to Telecommunication Standard vD.0, field 307-C7 was defined as Patient Location.
  - As of vD.0, field 307-C7 was defined as the Place of Service, pointing to the CMS Code list.
  - Patient Residence Code (384-4X) was created as a new field, to account for the former Patient Location values and to synchronize with the CMS Place of Service values.
  - Clarification was added to several Patient Residence Code (384-4X) values, where only Medicare Part A or B benefits would apply and traditional pharmacy benefits would not. For Example:
    - Patient Residence Code (384-4X) value 2: 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.
    - Patient Residence Code (384-4X) value 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 intellectually disabled individuals.
- Patient Residence (384-4X) field is often used by government funded programs where covered services, provider networks and pricing differ based on the where the patient resides.
- The following fields work in tandem to identify and qualify various combinations of pharmacy service, service location and patient residence:
  - Patient Residence (384-4X)
  - Place of Service (307-C7)
  - Pharmacy Service Type (147-U7)
- Payers and providers may consider implementing the use of the Patient Residence (384-4X), Place of Service (307-C7) and Pharmacy Service Type (147-U7) fields for S1 Service Billing

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requests in a similar manner to how they use these fields within B1 claim billing requests to apply the applicable coverage rules and expected reimbursement based on the specific contract terms.

- The payer's S1 payer sheet should represent their use of the Patient Residence (384-4X) field when the patient's residence results in different coverage or pricing rules.

PHARMACY SERVICE TYPE (147-U7)
Refer to Section 7.1.4 *Claim Segment* for information on the Pharmacy Service Type (147-U7) field.

7.1.4 Claim Segment

PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER (455-EM)

- *Indicates the type of billing submitted*
- Providers will send a value of 2 (Service Billing) in the Prescription/Service Reference Number Qualifier (455-EM) field when submitting a service billing transaction.

PRODUCT/SERVICE ID QUALIFIER (436-E1)/PRODUCT/SERVICE ID (407-D7)

- *ID of the product dispensed or service provided*
- As part of an S1 transaction for a professional service claim, the following Product/Service ID Qualifier (436-E1) and Product/Service ID (407-D7) values are preferred:
  - 07 – Current Procedural Terminology (CPT®4)
    - If the Product/Service ID Qualifier = 07, the Product/Service ID is a five-character CPT® value.
  - 09 – Healthcare Common Procedure Coding System (HCPCS)
    - If the Product/Service ID Qualifier = 09, the Product/Service ID is a five-character HCPCS value.

PROCEDURE MODIFIER CODE (459-ER)

- *Identifies special circumstances related to the performance of the service*
- The Procedure Modifier Code (459-ER) field can be used to define a further level of specificity to the submitted Product/Service ID (407-D7) value, (i.e., CPT®4, HCPCS).
- NCPDP recommends limiting the use of a Procedure Modifier Code (459-ER) for initial service billing implementation to defined uses cases where point of service billing is dependent on this level of detail (See Scenario 3 under Fill Number section below).

DATE PRESCRIPTION WRITTEN (414-DE)

- *Date prescription was written*
- The Date Prescription Written (414-DE) field should be used to communicate the date the billed service was ordered.
  - This date may be the same as submitted in the Date of Service (401-D1) field.

QUANTITY DISPENSED (442-E7)

- *Quantity dispensed expressed in metric decimal units*
- The value in the Quantity Dispensed (442-E7) field correlates to the reimbursement per service unit.
- The Quantity Dispensed (442-E7) value will generally be "1" but should not be less than "1."
- In an S1 transaction, the Quantity Dispensed (442-E7) field contains the number of units of the service provided and should be a whole number, not a decimal quantity.
- This is a situational field where the situation is "Required if value is greater than zero."
  - Recommended best practice is to always submit the field with a value corresponding to the number of service units provided for that service on the same date of service.

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FILL NUMBER (403-D3)

- *The code indicating whether the prescription is an original or a refill*
- Fill Number (403-D3) is a situational field.
    - Recommended best practice for the pharmacy is to always submit the Fill Number (403-D3) field with an appropriate value, (including "00"), as it is an integral component of the transaction key in most payer processing systems.
    - Service Provider ID (201-B1), Date of Service (401-D1), Prescription/Service Reference Number (402-D2) and Fill Number (403-D3) are necessary to identify distinct transactions and prevent rejections for duplicate claims.
    - The Product/Service ID (407-D7) field may also be included within duplicate claim or utilization management edits. It is important to note, that the same Product/Service ID (407-D7) value may be used to bill for multiple services performed on the same date of service. In this situation, the use of distinct Prescription/Service Reference Number (402-D2) values for each service should be considered to prevent duplicate claim rejects. (See Scenario 2).

Scenario 1: Patient receives blood pressure readings at regular intervals, where each service is represented as a different Fill Number (403-D3) and distinct Date of Service (401-D1).

Pharmacy ID	Patient ID	DOS	Service Reference #	Fill Number	Product Service ID	Other Payer Coverage Type
1234567890	ABC123	6/8/2023	1234567	00	99999	
1234567890	ABC123	6/15/2023	1234567	01	99999	

Scenario 2: Multiple services are rendered for the same patient to occur as separate encounters on the same date of service leveraging the same Product/Service ID (different services using the same time-based billing codes).

Pharmacy ID	Patient ID	DOS	Service Reference #	Fill Number	Product Service ID	Other Payer Coverage Type
1234567890	ABC123	6/8/2023	1234567	00	99999	
1234567890	ABC123	6/8/2023	7654321	00	99999	

Scenario 3: Patient receives multiple blood pressure readings on the same DOS, where multiple claims are billed using the same Prescription/Service Reference Number (402-D2) and Product/Service ID (407-D7). The second claim is distinguished by the incremented Fill Number (403-D3) value and a Procedure Modifier Code that indicates the patient required separate identifiable evaluation and management (E/M) services on the same day.

Pharmacy ID	Patient ID	DOS	Service Reference #	Fill Number	Product Service ID	Other Payer Coverage Type	Procedure Modifier Code
1234567890	ABC123	6/8/2023	1234567	00	99999		
1234567890	ABC123	6/8/2023	1234567	01	99999		25

DAYS SUPPLY (405-D5)

- *Estimated number of days the prescription will last*
- Days Supply (405-D5) is a situational field.
    - If submitted, the value in the Days Supply field (405-D5) should be "1."

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PHARMACY SERVICE TYPE (147-U7)

- *The type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy, or when benefits are based upon the type of service performed*
- ECL value examples: (See ECL for current, complete list)
  - 1: Community/Retail Pharmacy Services
  - 5: Long Term Care Pharmacy Services
  - 6: Mail Order Pharmacy Service
  - 8: Specialty Care Pharmacy Services
- Situation of use: This field is required in an S1 claim request when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer.
- The following fields work in tandem to identify and qualify various combinations of pharmacy service, service location and patient residence:
  - Pharmacy Service Type (147-U7)
  - Patient Residence (384-4X)
  - Place of Service (307-C7)
- Payers and providers may consider implementing the use of the Pharmacy Service Type (147-U7), Patient Residence (384-4X) and Place of Service (307-C7) fields for service billing requests in a similar manner to how they use these fields within claim billing requests to apply the applicable coverage rules and expected reimbursement based on the specific contract terms.
- The payer's S1 payer sheet should represent their use of the Pharmacy Service Type (147-U7) field when the pharmacy service type results in different coverage or pricing rules.

NOT USED FIELDS

- The following fields, commonly used in a claim billing (B1/B3) transaction, are **not used** in a service (S1/S3) transaction.
  - Dispense as Written/Product Selection Code (408-D8)
  - Prescription Origin Code (419-DJ)
  - Submission Clarification Code (420-DK)

7.1.5 PRICING SEGMENT

As outlined in the *NCPDP Telecommunication Standard Implementation Guide vD.0*, for pricing, the Service Claim Request Formula is as follows:
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).

PROFESSIONAL SERVICE FEE SUBMITTED (477-BE)

- *Amount submitted by the provider for professional services rendered*

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- This field is required when submitting a Service Billing transaction.

USUAL AND CUSTOMARY CHARGE (426-DQ)

- *Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed*
  - For purposes of service billing, the "prescription" is defined as the service being billed.

NOT USED FIELDS

- The following fields, commonly used in a claim billing (B1/B3) transaction, are **not used** in a service (S1/S3) transaction:
  - Ingredient Cost Submitted (409-D9)
  - Dispensing Fee Submitted (412-DC)
  - Incentive Amount Submitted (438-E3)
  - Percentage Sales Tax Basis Submitted (484-JE) – Please note this field will be used in NCPDP Telecommunication Standard Version F6 Service Billing Transactions.
  - Basis of Cost Determination (423-DN)

7.1.6 PHARMACY PROVIDER SEGMENT

The Pharmacy Provider Segment is situational for a service billing request if required under provider payer contract or situational on service billings where this information is necessary for adjudication of the service. The Pharmacy Provider Segment refers to the pharmacist dispensing the medication or performing the professional service, not the prescriber writing the prescription. It provides information about the specific pharmacist involved in the transaction.

PROVIDER ID (444-E9)

- *Unique ID assigned to the person responsible for the provision of the service*
- This field should be populated with the ID of the pharmacist performing the specified service submitted for reimbursement.
- Refer to Section 7.1.8 *Provider_Prescriber Scenario Matrix* for additional information.

7.1.7 PRESCRIBER SEGMENT

PRESCRIBER ID (411-DB)

- *ID assigned to the prescriber*
- For purposes of an S1 transaction, the Prescriber ID (411-DB) field should only be sent to identify a prescriber who ordered/referred the specific professional service(s) to be performed by the pharmacist. If the pharmacist and patient coordinate scheduling a professional service, the Prescriber ID field would not be sent.
- Refer to Section 7.1.8 *Provider_Prescriber Scenario Matrix* for additional information.
- Note: the NCPDP SCRIPT Standard supports referral messages, allowing the ordering referring provider to send a request for specific services to the provider intended to provide the service(s), as well as other referral type messages. The individual Type 1 NPI of the provider sending the ServiceReferralRequest to the pharmacy could be submitted as the Prescriber ID (411-DB) in the pharmacy's S1 Service Billing request transaction.

NCPDP SCRIPT Referral Message Types: (NCPDP SCRIPT Standard Versions 20200101 and above)

ServiceReferralRequest	**This transaction is a referral for a patient care service.** This transaction requests the service provider (receiver) perform the requested service and should be considered an order by the service provider. It may be initiated by the payer, clinician or

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	other healthcare entity (e.g., hospital, pharmacy or other healthcare facility) upon clinical necessity and/or at the request of the patient or designated representative.
ServiceReferralResponse	This transaction allows the service provider (receiver) to respond with an <Approved> or <Denied> response when responding to the ServiceReferralRequest transaction. It does not allow the service provider to send back a request for service modification or documentation of services provided as part of the response.
RequestForServiceReferral	This transaction provides a mechanism for the clinician or other healthcare entity to request a referral from a payer, clinician or other healthcare entity for a specific patient care service (including services requested by the patient or designated representative).
ResponseToServiceReferralDenied	This transaction is a denied response to a previously sent RequestForServiceReferral transaction. (If approved, a ServiceReferralRequest transaction would be sent.)
ServiceDocumentation	This transaction supplies clinical or service information related to the patient care service encounter. This is not a billing transaction but the information in the transaction or attachment may be required by the payer for payment. It is sent to the originator of the referral after a patient service has been provided.

7.1.8 PROVIDER_PRESCRIBER SCENARIO MATRIX

The NCPDP Telecommunication Standard contains multiple fields used to identify the billing provider, prescriber and the individual pharmacy provider (e.g., pharmacist) performing the service. Each of the below fields are used to identify a specific person/entity associated to the billing transaction.

It is important to note the unique differences of how/when the Prescriber ID (411-DB) and Provider ID (444-EY) fields are used within B1 and S1 transactions. Refer to the below matrices of example scenarios intended to display these differences.

- SERVICE/PROVIDER ID (201-B1)
  - *ID assigned to a pharmacy or provider*
  - This Header Segment field is used to identify the Type 2 NPI of the pharmacy submitting the B1 or S1 claim request, to which any associated claim reimbursement would be remitted.
  - This field is mandatory on all service billing transaction requests (S1, S2, S3).
- PROVIDER ID (444-E9)
  - *Unique ID assigned to the person responsible for the dispensing of the prescription or provision of the service*
  - This Pharmacy Provider Segment field is used to identify the applicable ID (e.g., Type 1 NPI) associated to the individual performing the service(s) associated to the claim.

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- This is an optional field for both claim billing (B1, B3) and Service Billing (S1) transaction requests.
  - It is generally required for S1 Service Billing requests as validation of the servicing provider may be necessary.
  - It is rarely used for B1 claim billing only requests, generally limited to B1 claims for a product and associated service.

- PRESCRIBER ID (411-DB)
  - *ID assigned to the prescriber*
  - This Prescriber Segment field is used to identify the individual provider who prescribed the medication or who ordered/referred the request for professional service.
  - This is an optional field for both claim billing (B1, B3) and Service Billing (S1) transaction requests.
    - It may rarely be used for S1 Service Billing requests to identify/validate the provider ordering/referring the request for professional services.
    - It is generally required for B1 claim billing requests as validation of the prescribing provider may be necessary.

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The following table offers a high-level overview of the use of provider identifier fields within service and claim billing transactions.

		S1 Request Transaction			B1 Request Transaction		
Scenario ID	Billing Scenario	201-B1: Service Provider ID	411-DB: Prescriber ID	444-E9: Provider ID	201-B1: Service Provider ID	411-DB: Prescriber ID	444-E9 Provider ID
A	B1: Product Only				Required	Required	N/A
B	B1: Product + Service				Required	Required	Situational
C	S1: Service No Referral	Required	N/A	Required			
D	S1: Service Referral	Required	Situational	Required			
E	B1: (Product + Service) + S1: Service (No Referral)	Required	N/A	Required	Required	Required	Situational
F	B1: Product + S1: Service (No Referral)	Required	N/A	Required	Required	Required	N/A

The following two tables apply descriptive examples to the above billing scenarios (A-F).
Table 1:

- Gray cells indicate the transaction code does not apply to the specific example
- "N/A" indicates the specific field is not used for the transaction example

			B1 Product Only: (A)	B1 Product + Service: (B)	S1 Service, No Referral: (C)
Txn Code	Request Segment	Impacted Fields	*eRX received for drug *Pharmacy submits B1 *Pharmacy dispenses drug	* eRX received for vaccine * Pharmacy submits B1 for drug + vaccine admin * RPh administers vaccine	* Patient requests RPh to provide vaccine information * RPh provides vaccine counseling
S1	Header	201-B1 Service Provider ID			PHARMACY NPI
S1	Pharmacy Provider	444-E9 Provider ID			PHARMACIST NPI
S1	Prescriber	411-DB Prescriber ID			N/A

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Txn Code	Request Segment	Impacted Fields	B1 Product Only: (A)	B1 Product + Service: (B)	S1 Service, No Referral: (C)
			*eRX received for drug *Pharmacy submits B1 *Pharmacy dispenses drug	* eRX received for vaccine * Pharmacy submits B1 for drug + vaccine admin * RPh administers vaccine	* Patient requests RPh to provide vaccine information * RPh provides vaccine counseling
S1	Claim	436-E1 Product/Service ID Qualifier			CPT®/HCPCS QUALIFIER
S1	Claim	407-D7 Product/Service ID			CPT®/HCPC CODE for Patient Education
S1	DUR/PPS *	440-E5 Professional Service Code			N/A
B1	Header	201-B1 Service Provider ID	PHARMACY NPI	PHARMACY NPI	
B1	Pharmacy Provider	444-E9 Provider ID	N/A	PHARMACIST NPI (as required by plan)	
B1	Prescriber	411-DB Prescriber ID	PRESCRIBER NPI	PRESCRIBER NPI	
B1	Claim	436-E1 Product/Service ID Qualifier	03- NDC	03- NDC	
B1	Claim	407-D7 Product/Service ID	PRODUCT NDC	PRODUCT NDC	
B1	DUR/PPS *	440-E5 Professional Service Code	N/A	(MA) MEDICATION ADMIN	

* DUR/PPS segment is being used to communicate professional services, to which the pricing segment may also include charges for those services

Table 2:

- Gray cells indicate the transaction code does not apply to the specific example
- "N/A" indicates the specific field is not used for the transaction example

Txn Code	Request Segment	Impacted Fields	S1 Service Referral: (D)	S1 Service + B1 Product: (E)	S1 Service + B1 Product: (F)
			* Patient's Primary Care Physician refers patient to pharmacy for RPh diabetes care education * RPh performs patient education services	* Patient requests vaccine appointment w/pharmacy * RPh completes: - Patient eval/management - Dispenses vaccine drug - Administers vaccine	* Patient asks RPh for oral contraceptive drug * RPh performs patient evaluation/management and prescribes drug * RPh dispenses prescribed drug
S1	Header	201-B1 Service Provider ID	PHARMACY NPI	PHARMACY NPI	PHARMACY NPI
S1	Pharmacy Provider	444-E9 Provider ID	PHARMACIST NPI	PHARMACIST NPI	PHARMACIST NPI
S1	Prescriber	411-DB Prescriber ID	REFERRING PROVIDER (as required by plan)	N/A	N/A
S1	Claim	436-E1 Product/Service ID Qualifier	CPT®/HCPCS QUALIFIER	CPT®/HCPCS QUALIFIER	CPT®/HCPCS QUALIFIER
S1	Claim	407-D7 Product/Service ID	CPT®/HCPC CODE for Patient Education	CPT®/HCPC CODE for Evaluation/Management	CPT®/HCPC CODE for Evaluation/Management
S1	DUR/PPS *	440-E5 Professional Service Code	N/A	N/A	N/A
B1	Header	201-B1 Service Provider ID		PHARMACY NPI	PHARMACY NPI
B1	Pharmacy Provider	444-E9 Provider ID		PHARMACIST NPI (as required by plan)	N/A
B1	Prescriber	411-DB Prescriber ID		PRESCRIBER NPI (RPh)	PRESCRIBER NPI (RPh)
B1	Claim	436-E1 Product/Service ID Qualifier		03- NDC	03- NDC
B1	Claim	407-D7 Product/Service ID		PRODUCT NDC	PRODUCT NDC
B1	DUR/PPS *	440-E5 Professional Service Code		(MA) MEDICATION ADMIN	N/A

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Txn Code	Request Segment	Impacted Fields	S1 Service Referral: (D)	S1 Service + B1 Product: (E)	S1 Service + B1 Product: (F)
			* Patient's Primary Care Physician refers patient to pharmacy for RPh diabetes care education * RPh performs patient education services	* Patient requests vaccine appointment w/pharmacy * RPh completes: - Patient eval/management - Dispenses vaccine drug - Administers vaccine	* Patient asks RPh for oral contraceptive drug * RPh performs patient evaluation/management and prescribes drug * RPh dispenses prescribed drug

* DUR/PPS segment is being used to communicate professional services, to which the pricing segment may also include charges for those services

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7.1.9 DUR/PPS SEGMENT

As outlined in Section 6 *Professional Service Billing Codes* above, the Telecommunication Standard and ECL currently support the billing of pharmacist professional services using various Product/Service ID Qualifier (436-E1) values (e.g., CPT®, HCPCS, DUR/PPS). When CPT® or HCPCS qualifiers are used, the specific CPT® or HCPCS code submitted in the Product/Service ID (407-D7) field identifies the specific professional service performed. However, when the DUR/PPS qualifier is used, "0" is sent in the Product/Service ID (407-D7) field and systems must leverage the fields submitted in the DUR/PPS segment to identify the specific professional service being billed. The request DUR/PPS segment includes the following fields:

- DUR/PPS Code Counter (473-7E)
- Reason for Service Code (439-E4)
- Professional Service Code (440-E5)
- Result of Service Code (441-E6)
- DUR/PPS Level of Effort (474-8E)
- DUR Co-Agent ID Qualifier (475-J9)
- DUR Co-Agent ID (476-H6)

The use of "06 – DUR/PPS" as the Product/Service ID Qualifier (436-E1) requires claim adjudication systems to leverage the code values submitted in the DUR/PPS segment to determine plan coverage, payment and patient out of pocket cost rules. Current pharmacy and payer claim adjudication, product/service identification validation and payment processes are generally triggered off the mandatory Product Service ID (407-D7) field. Alternate use of the DUR segment to perform these steps may result in service billing implementation delays and risks.

Recommendation:

- Do not require the use of Product/Service ID Qualifier value 06 – DUR/PPS.
  - Use industry standard service billing codes within the Product Service ID Qualifier (436-E1) (e.g., CPT®, HCPCS).
- Limit the use of the DUR/PPS Segment for communication of additional professional service information where applicable. For example, the DUR/PPS segment may be used to provide additional information to the specific Product/Service ID (407-D7) value submitted.

7.1.10 CLINICAL SEGMENT

The Clinical Segment is situational for a Service Billing request. It is used to specify diagnosis information and/or clinical measurements associated with the Service Billing transaction.

DIAGNOSIS CODE (424-DO)

- *Code identifying the diagnosis of the patient*
- Service Billing Situation of Use:
  - The value for this field is obtained from the prescriber or authorized representative.
  - Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.
  - Required if this field affects payment for professional pharmacy service.
  - Required if this information can be used in place of prior authorization.
  - Required if necessary for state/federal/regulatory agency programs.
- Patient diagnosis code information (e.g., ICD-10) can offer the documentation necessary for real-time coverage determination rules and eliminate care delays with prior authorization processes.

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MEASUREMENT FIELDS
The below measurement fields are available for use in Service Billing transactions. The situation of use is defined as, “Required, if necessary, when this field could result in different coverage and/or drug utilization review outcome.”

It is recommended to limit the use of these fields to trading partner agreements, where systems are able to support the submission and receipt of this detail to produce the expected real-time claim adjudication results.

- MEASUREMENT DATE (494-ZE) – *Date clinical information was collected or measured*
- MEASUREMENT TIME (495-H1) – *Time clinical information was collected or measured*
- MEASUREMENT DIMENSION (496-H2) – *Code indicating the clinical domain of the observed value in Measurement Value (499-H4)*
- MEASUREMENT UNIT (497-H3) – *Code indicating the metric or English units used with the clinical information*
- MEASUREMENT VALUE (499-H4) – *Actual value of clinical information*

7.1.11 SEGMENTS NOT PRIORITIZED

The following segments are used to support complicated business cases that require specific, extraneous detail not addressed in Version 10 of this guidance document. These business cases are low in volume under the claim billing (B1) situation and even less frequent, if at all, with billing for professional services (S1). To expedite the initial implementation and use of NCPDP Telecommunication Service Billing Transactions necessary to support known business cases, guidance on the use of the below segments has been intentionally eliminated from guidance document.

- Coordination of Benefits
- Worker’s Compensation
- Additional Documentation
- Facility
- Narrative

7.2 SERVICE BILLING RESPONSE DIAGRAMS AND SEGMENTS

7.2.1 TRANSMISSION ACCEPTED/TRANSACTION PAID

The table below lists the segments available for a Transmission Accepted/Transaction Paid S1 response. The situational segments highlighted in gray are not recommended for initial implementation.

Mandatory
Response Header Segment
Situational
Segment Separator **Response Message Segment** *Segment Separator* **Response Insurance Segment** *Segment Separator* **Response Patient Segment**
Mandatory first response
Group Separator *Segment Separator* **Response Status Segment** *Segment Separator* **Response Claim Segment** *Segment Separator* **Response Pricing Segment** *Segment Separator*

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Response DUR/PPS Segment
Situational
Segment Separator **Response Coordination of Benefits/Other Payers Segment**

The following response segments are NOT Used in the Service Billing Accepted/Paid, Duplicate Paid Response:

- Response Insurance Additional Information Segment
- Response Prior Authorization Segment

7.2.1.1 Response Header Segment (Transmission Accepted/Transaction Paid)

TRANSACTION CODE (103-A3)

- Mirror back the transaction code value submitted in the request which should be 'S1'.

HEADER RESPONSE STATUS (501-F1)

- Valid value for an accepted transmission:
  - A: Accepted. Code indicating the receipt and approval of the transmission.

VERSION RELEASE NUMBER (102-A2)

- No specific S1 implementation instructions identified. Mirror request field values.

TRANSACTION COUNT (109-A9)

- No specific S1 implementation instructions identified. Mirror request field values.

SERVICE PROVIDER ID QUALIFIER (202-B2)

- No specific S1 implementation instructions identified. Mirror request field values.

SERVICE PROVIDER ID (201-B1)

- No specific S1 implementation instructions identified. Mirror request field values.

DATE OF SERVICE (401-D1)

- No specific S1 implementation instructions identified. Mirror request field values.

7.2.1.2 Response Message Segment (Transmission Accepted/Transaction Paid)

MESSAGE (504-F4)

- Only transmission level messages should be included in the Message (504-F4) field.

7.2.1.3 Response Insurance Segment (Transmission Accepted/Transaction Paid)

- No specific S1 implementation instructions identified.

7.2.1.4 Response Patient Segment (Transmission

ACCEPTED/TRANSACTION PAID)

- No specific S1 implementation instructions identified.

7.2.1.5 RESPONSE STATUS SEGMENT (TRANSMISSION ACCEPTED/TRANSACTION PAID)

TRANSACTION RESPONSE STATUS (112-AN)

- This is a mandatory response field, making the Response Status Segment mandatory.
- Valid values for Transaction Response Status (112-AN) field for Transmission Accepted/Transaction Paid response include:
  - P: Paid. Code indicating that the transaction has been adjudicated using plan rules and was paid.
  - D: Duplicate Paid. Code indicating that the transaction was paid in a previously submitted transaction.
    - Refer to Section 26.3 *Duplicate Transactions* of the *NCPDP Telecommunication Standard Implementation Guide Version D.0* for additional information on Duplicate responses.

7.2.1.6 RESPONSE CLAIM SEGMENT (TRANSMISSION ACCEPTED/TRANSACTION PAID)

The only fields used on the Response Claim Segment for an S1 transaction are Prescription/Service Reference Number Qualifier (455-EM) and the Prescription Service Reference Number (402-D2).

PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER (455-EM)

- Prescription/Service Reference Number Qualifier (455-EM) should be '2' – Service Billing.

PRESCRIPTION/SERVICE REFERENCE NUMBER (402-D2)

- Mirror back the value from request.

7.2.1.7 RESPONSE PRICING SEGMENT (TRANSMISSION ACCEPTED/TRANSACTION PAID)

As outlined in the *NCPDP Telecommunication Standard Implementation Guide Version D.0*, the Service Claim Response Pricing Formula is as follows:

Professional Service Fee Paid (562-J1)
+ Flat Sales Tax Amount Paid (558-AW)
+ Percentage Sales Tax Amount Paid (559-AX)
+ Other Amount Paid (565-J4)
- Patient Pay Amount (505-F5)
- Other Payer Amount Recognized (566-J5)

= Total Amount Paid (509-F9)

PROFESSIONAL SERVICE FEE PAID (562-J1)

- The Professional Service Fee Paid (562-J1) is the amount paid to the provider for professional services rendered.
- This field is required when responding to a Service Billing transaction.

PERCENTAGE SALES TAX AMOUNT PAID (559-AX)

- This is based on professional service fee.

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PERCENTAGE SALES TAX RATE PAID (560-AY)

- This is the percentage rate applied to the Professional Service Fee Amount (562-JI).

PATIENT PAY AMOUNT (505-F5)

The Patient Pay Amount (505-F5) is determined by the plan benefit design, where there may be various components that make up the final patient out of pocket cost returned in field 505-F5. Telecommunication Standard vD.0 includes 11 distinct response pricing fields that must sum to the value returned in 505-F5. However, several of these fields are NOT used in S1 response transactions as they are specific to drug benefit amounts.

The following component fields to Patient Pay (505-F5) are AVAILABLE for use in the S1 response.

- Amount of Coinsurance (572-4U)
- Amount of Copay (518-FI)
- Amount Attributed to Processor Fee (571-NZ)
- Amount Attributed to Coverage Gap (137-UP)
- Amount Attributed to Sales Tax (523-FN)
- Amount Applied to Periodic Deductible (517-FH)

The following component fields to Patient Pay (505-F5) are NOT AVAILABLE for use in the S1 response.

- Amount Exceeding Periodic Benefit Maximum (520-FK)
- Health Plan-Funded Assistance Amount (129-UD)
- Amount Attributed to Provider Network Selection (133-UJ)
- Amount Attributed to Product Selection/Brand Drug (134-UK)
- Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM)
- Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN)

OTHER RESPONSE PRICING FIELDS NOT USED IN THE S1 RESPONSE

The following fields, commonly used in a claim billing (B1/B3) Paid/Duplicate Paid response are **not used** in a service (S1/S3) transaction:

- Ingredient Cost Paid (506-F6)
- Dispensing Fee Paid (507-F7)
- Percentage Sales Tax Basis Paid (561-AZ)
  - Please note this field will be used in Telecommunication Standard Version F6 Service Billing Response transactions.
- Incentive Amount Paid (521-FL)
- Basis of Reimbursement Determination (522-FM)

7.2.1.8 Response DUR/PPS Segment (Transmission Accepted/Transaction Paid)

The Response DUR/PPS Segment is situational for an S1 Accepted/Paid Response. While generally this segment is used to communicate drug utilization warnings that impact patient safety, a payer could use this segment to communicate additional pharmacy professional service opportunities within the response Reason for Service Code (439-E4) field. This may not be a common use case for the initial implementation of service billing transactions but can be supported based on trading partner agreement.

REASON FOR SERVICE CODE (439-E4)

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- *Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.*
    - Reason for Service Code (439-E4) is a required field if the professional service opportunity reason is detected by the receiver that is different from the professional service submitted.

7.2.1.9 Response Coordination of Benefits/Other Payers Segment (Transmission Accepted/Transaction Paid)

- The Response Coordination of Benefits/Other Payers Segment is not addressed in Version 10 of this guidance document.

7.2.1.10 Transmission Accepted/Transaction Captured

- Captured responses are not addressed in Version 10 of this guidance document.

7.2.2 Transmission Accepted/Transaction Rejected

The below table lists the segments available for a Transmission Accepted/Transaction Rejected S1 response. The situational segments highlighted in gray are not recommended for initial implementation.

Mandatory
Response Header Segment
Situational
Segment Separator **Response Message Segment** *Segment Separator* **Response Insurance Segment** *Segment Separator* **Response Patient Segment**
Mandatory first response
Group Separator *Segment Separator* **Response Status Segment** *Segment Separator* **Response Claim Segment**
Situational
Segment Separator **Response Prior Authorization Segment** *Segment Separator* **Response Coordination of Benefits/Other Payers Segment**

The following Segments are **not used** in the Service Billing Accepted/Rejected Response:

- Response Insurance Additional Information Segment
- Response Pricing Segment
- Response DUR/PPS Segment

7.2.2.1 Response Header Segment (Transmission Accepted/Transaction Rejected)

TRANSACTION CODE (103-A3)

- Mirror back the transaction code value submitted in the request which should be 'S1'.

HEADER RESPONSE STATUS (501-F1)

- Valid value for an accepted transmission:
    - A: Accepted. *Code indicating the receipt and approval of the transmission.*

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VERSION RELEASE NUMBER (102-A2)

- No specific S1 implementation instructions identified. Mirror request field values.

TRANSACTION COUNT (109-A9)

- No specific S1 implementation instructions identified. Mirror request field values.

SERVICE PROVIDER ID QUALIFIER (202-B2)

- No specific S1 implementation instructions identified. Mirror request field values.

SERVICE PROVIDER ID (201-B1)

- No specific S1 implementation instructions identified. Mirror request field values.

DATE OF SERVICE (401-D1)

- No specific S1 implementation instructions identified. Mirror request field values.

7.2.2.2 *Response Message Segment (Transmission Accepted/Transaction Rejected)*

MESSAGE (504-F4)

- Only transmission level messages should be included in the Message (504-F4) field.

7.2.2.3 *Response Insurance Segment (Transmission Accepted/Transaction Rejected)*

- No specific S1 implementation instructions identified.

7.2.2.4 *Response Patient Segment (Transmission Accepted/Transaction Rejected)*

- No specific S1 implementation instructions identified.

7.2.2.5 *Response Status Segment (Transmission Accepted/Transaction Rejected)*

TRANSACTION RESPONSE STATUS (112-AN)

- This is a mandatory response field making the Response Status Segment mandatory.
- Valid value for field 112-AN for Transmission Accepted/Transaction Rejected response:
  - R: Rejected. *Code indicating that the transaction has been denied/rejected.*
- S1 Reject Use Case Guidance:
  - If Product/Service ID Qualifier (436-E1) is not equal to ‘07’ or ‘09’, then ‘8Z’ *(Product/Service ID Qualifier Value Not Supported)* should be returned in Reject Code (511-FB) with ‘Use CPT® or HCPCS’ in Additional Message Information (526-FQ).

7.2.2.6 *Response Claim Segment (Transmission Accepted/Transaction Rejected)*

PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER (455-EM)

- Mirror back the request which should be value ‘2’ – Service Billing in the Prescription/Service Reference Number Qualifier (455-EM) field.

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7.2.2.7 *Response Prior Authorization Segment (Transmission Accepted/Transaction Rejected)*

PRIOR AUTHORIZATION NUMBER – ASSIGNED (498-PY)
- This is the only field in this response segment available for use in the S1 Accepted/Rejected response.
- Recommend not implementing this segment for initial service billing implementation.

7.2.2.8 *Response Coordination of Benefits/Other Payers Segment (Transmission Accepted/Transaction Rejected)*

- Specific guidance for S1 Coordination of Benefits (COB) transactions was not prioritized for Version 10 of this guidance document.
- If COB is required, trading partners may support real-time electronic billing or paper claim processing.

7.2.3 Transmission Rejected/Transaction Rejected

The below table lists the segments available for a Transmission Rejected/Transaction Rejected S1 response.

Mandatory
Response Header Segment
Situational
Segment Separator **Response Message Segment**
Mandatory first response
Group Separator *Segment Separator* **Response Status Segment**

The following Segments are NOT USED in the Service Billing Rejected/Rejected Response:
- Response Insurance Segment
- Response Insurance Additional Information Segment
- Response Patient Segment
- Response Claim Segment
- Response Pricing Segment
- Response DUR/PPS Segment
- Response Prior Authorization Segment
- Response Coordination of Benefits/Other Payers Segment

7.2.3.1 *Response Header Segment (Transmission Rejected/Transaction Rejected)*

TRANSACTION CODE (103-A3)
- Mirror back the transaction code value submitted in the request which should be 'S1'

HEADER RESPONSE STATUS (501-F1)
- Valid value for a rejected transmission:
  - R: Rejected. Code indicating the rejection or refusal to accept the transmission.

VERSION RELEASE NUMBER (102-A2)

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- No specific S1 implementation instructions identified. Mirror request field values.

TRANSACTION COUNT (109-A9)
- No specific S1 implementation instructions identified. Mirror request field values.

SERVICE PROVIDER ID QUALIFIER (202-B2)
- No specific S1 implementation instructions identified. Mirror request field values.

SERVICE PROVIDER ID (201-B1)
- No specific S1 implementation instructions identified. Mirror request field values.

DATE OF SERVICE (401-D1)
- No specific S1 implementation instructions identified. Mirror request field values.

7.2.3.2 Response Message Segment (Transmission Rejected /Transaction Rejected)

MESSAGE (504-F4)
- Only transmission level messages should be included in the Message (504-F4) field.

7.2.3.3 Response Status Segment (Transmission Rejected /Transaction Rejected)

- No specific S1 implementation instructions identified.

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8. CLAIM BILLING USE CASE EXAMPLES

As outlined in Section 6 *Professional Service Billing Code Options and Recommendations* above, the NCPDP Telecommunication Standard supports multiple code set values that can be used as the Product Service ID for S1 transactions. This implementation guidance recommends the use of the CPT® code set and, where applicable, CMS HCPCS codes to promote standardization in implementation and align with existing medical billing practices. It is also important to note trading partner agreements will define the CPT® codes to use for reportable/payable services. This means Payer A could require code 12345 and Payer B could require code 67890 for the same professional service. The below use case examples highlight common CPT® and HCPCS codes that may be used between trading partners.

8.1 USE CASE DESCRIPTIONS

This section outlines ten different uses cases of pharmacist professional and dispensing services, where the associated claim billing requests may use the NCPDP Telecommunication B1 and/or S1 transactions. These uses cases are unique, to display the variation in Product/Service IDs (407-D7) that may be used.

Use Case Summary Table

Billing Scenario	Use Case #	Use Case Description	Use Case Service Billing Code Example
B1: PRODUCT + SERVICE (VACCINE & ADMINISTRATION)	1	Pharmacist dispenses and administers prescribed vaccine	Vaccine NDC
S1: SERVICE * (VACCINE COUNSELING)	2	Pharmacist counsels Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible patient on preventative vaccines, vaccine not administered on same date of service	G0310
S1: SERVICE (NICOTINE REPLACEMENT THERAPY (NRT) COUNSELING)	3	Medical provider referral for pharmacist tobacco cessation patient education/counseling	99406
S1: SERVICE (LAB SERVICE)	4	Pharmacist performs clinical test as allowed by the pharmacy's Clinical Laboratory Improvement Amendments (CLIA) waiver	87880
B1: PRODUCT + S1: SERVICE (DIABETES CARE MANAGEMENT (DCM) EDUCATION)	5	Medical Provider referral for pharmacist diabetes care management counseling with associated prescription for new drug	98960
B1: PRODUCT + S1: SERVICE * (E/M PLAN OF CARE)	6	Patient evaluation/management for associated pharmacist prescribed oral contraceptive	99211
B1: PRODUCT + S1: SERVICE (E/M 25 MINUTES)	7	Patient evaluation/management service arrangement associated to medical provider prescriptions for GLP-1 therapy	99213
B1: (PRODUCT + SERVICE) + S1: SERVICE (E/M 35 MINUTES)	8	Pharmacist dispenses and administers vaccine. Review of patient history results in care plan for blood pressure monitoring and referral to physician	99214

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S1: MTM SERVICE (15 MINUTES)	9	Pharmacist provides face to face MTM service with an established patient with no known drug therapy problems (15 mins)	99606
S1: MTM SERVICE (35 MINUTES, TWO CLAIMS)	10	Pharmacist provides face to face MTM service with an established patient, two known drug therapy problems (45 mins) result in care plan modifications	99606 (x1) 99607 (x2)

* Also refer to S1 transaction diagram examples below for Use Cases 2 and 6.

USE CASE 1:
B1: PRODUCT + SERVICE (VACCINE & ADMINISTRATION)
Pharmacist dispenses and administers prescribed vaccine

- Patient schedules vaccine administration appointment with pharmacy.
- Pharmacist completes the vaccine administration service.
- Pharmacy submits single B1 claim for vaccine drug and the vaccine administration service.
    - Product Service ID (407-D7) value is the NDC of the vaccine product.
    - Professional Service Code (440-E5) value of "MA" indicates the vaccine administration service.
    - Quantity Dispensed (442-E7) value is based on the vaccine quantity unit of measure (e.g., 0.5ml).
- Refer to the Section 16 *Vaccine Services – Pharmacy Benefit Billing & Processing* guidance in the *Telecommunication Version D and Above Questions, Answers and Editorial Updates.*
    - "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."
    - This does not prohibit the pharmacist from submitting an S1 claim for only the administration of a vaccine (e.g., product is procured, dispensed and recorded by a different entity).

For professional services other than vaccine administration, NCPDP recommends using the S1 transaction as outlined in the below use case examples.

Return to Use Case Summary Table

USE CASE 2:
S1: SERVICE (VACCINE COUNSELING)
Pharmacist counsels Medicaid EPSDT eligible patient on preventative vaccines, vaccine not administered on same date of service

- Pharmacist schedules preventative vaccine counseling appointment for qualified patient and guardian.
- Patient/guardian acknowledge understanding of information and schedule future appointment for vaccine administration.
- Pharmacy submits single S1 claim for the EPSDT vaccine counseling.
    - Applicable CPT®/HCPCS code based on trading partner agreement would be submitted as the Product/Service ID (407-D7) (e.g., HCPCS G0310: Immunization

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counseling by a qualified health care professional when the vaccine(s) is not administered on the same date of service, 5-15 minutes).
    - Quantity Dispensed (442-E7) value is based on the specific service billing code used and the number of service increments provided for the date of service. In this example, the quantity is one (1).
    - See Section 8.2 *Example S1 Transaction Diagram.*

Return to Use Case Summary Table

USE CASE 3:
S1: SERVICE (NRT COUNSELING)

Medical provider referral for pharmacist tobacco cessation patient education/counseling

- Patient's medical provider refers them to the pharmacist tobacco cessation counselor.
- Pharmacist provides counseling to patient and feedback to the prescriber.
- Patient purchases an over-the-counter nicotine replacement product.
- Pharmacy submits single S1 claim for the patient education/counseling service.
    - Applicable CPT® code based on trading partner agreement would be submitted as the Product/Service ID (407-D7) (e.g., 99406: Smoking and Tobacco Use Cessation Counseling Visits).
    - Quantity Dispensed (442-E7) value is based on the specific service billing code used and the number of service increments provided for the date of service. In this example, the quantity is one (1).

Return to Use Case Summary Table

Use Case 4:
S1: SERVICE (LAB SERVICE)

Pharmacist performs a clinical test as allowed by the pharmacy's CLIA waiver

- Patient schedules an appointment with their local pharmacy for a strep test.
- Pharmacist collects the specimen and interprets the results.
- Pharmacist advises patient on symptoms and applicable next steps.
- Pharmacy submits S1 claim for the specimen collection and interpretation service.
    - Applicable CPT® code based on trading partner agreement would be submitted as the Product/Service ID (407-D7) (e.g., CPT® 87880: Infectious Agent Antigen Detection).
    - Quantity Dispensed (442-E7) value is based on the specific service billing code used and the number of service increments provided for the date of service. In this example, the quantity is one (1).

Return to Use Case Summary Table

USE CASE 5:
B1: Product + S1: Service (DCM EDUCATION)

Medical Provider referral for pharmacist DCM counseling with associated prescription for new drug

- Primary care provider refers patient to the pharmacist certified diabetes education specialist for diabetes education and sends a new prescription medication for uncontrolled diabetes.
- Pharmacist provides diabetes management counseling to patient.
- Pharmacy dispenses prescribed medication.
- Pharmacy submits single S1 claim for the patient education service.
    - Applicable CPT® code based on trading partner agreement would be submitted as the Product/Service ID (407-D7) (e.g., CPT® 98960: Education and Training for Patient Self-Management).

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    - Quantity Dispensed (442-E7) value is based on the specific service billing code used and the number of service increments provided for the date of service. In this example, the quantity is one (1).
- Pharmacy submits single B1 claim for the dispensed product.

Return to Use Case Summary Table

USE CASE 6:

B1: Product + S1: Service (E/M Plan of Care)

Patient evaluation/management for associated pharmacist prescribed oral contraceptive

- Patient consults with the pharmacist regarding the use of prescribed oral contraceptive.
- Pharmacist obtains consent from patient to provide a patient evaluation service, where an applicable product could be prescribed.
- Pharmacist:
    - Completes a single 15-minute patient evaluation service
    - Records the prescribing of the federal legend oral contraceptive product within the applicable health record
    - Refers the patient to their primary care provider for additional care
    - Provides patient with a visit summary
- Pharmacy submits single S1 claim for the E/M professional service.
    - Applicable CPT® code based on trading partner agreement would be submitted as the Product/Service ID (407-D7) (e.g., CPT® 99211: Evaluation and Management for Established Patient).
    - Quantity Dispensed (442-E7) value is based on the specific service billing code used and the number of service increments provided for the date of service. In this example, the quantity is one (1), for an established plan of care.
    - NDC of prescribed hormonal contraceptive is submitted within the DUR Co-Agent ID (476-H6) field with applicable Reason for Service (439-E4), Professional Service (440-E5) and Result of Service (441-E6) values as additional optional information.
        - Pharmacy completes Pharmacist eCare Plan documentation and shares with applicable trading partners, providers and patient.
    - See Section 8.2 *Example S1 transaction diagram.*
- Pharmacy submits single B1 claim for the federal legend oral contraceptive product.
    - Pharmacy benefit accepts claim with pharmacist NPI as the Prescriber ID (411-DB).

Return to Use Case Summary Table

USE CASE 7:

B1: PRODUCT + S1: SERVICE (E/M 25 MINUTES)

Patient evaluation/management service arrangement associated to medical provider prescriptions for GLP-1 therapy

- Patient's medical provider sends a new prescription for a GLP-1 medication.
- Pharmacy/payer trading partner agreement includes collection and reporting of patient weight and A1C level.
- Pharmacist completes E/M service, obtains current weight and A1C and documents clinical evaluation.
- Pharmacy dispenses prescribed GLP-1 medication.
- Pharmacy submits single S1 claim for the E/M professional service.
    - Applicable CPT® code based on trading partner agreement would be submitted as the Product/Service ID (407-D7) (e.g., CPT® 99213: Evaluation and Management for Established Patient, 20-29 minutes).
    - Quantity Dispensed (442-E7) value is based on the specific service billing code used and the number of service increments provided for the date of service. In this

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example, the quantity is one (1) to represent 20-29 minutes or low level of E/M decision making.
    - Pharmacy completes Pharmacist eCare Plan documentation and shares with applicable trading partners, providers and patient.
- Pharmacy submits single B1 claim for the dispensed product.

Return to Use Case Summary Table

USE CASE 8:

B1: (Product + Service) + S1: Service (E/M 35 minutes)

Pharmacist dispenses and administers vaccine; patient encounter results in care plan for blood pressure monitoring

- Patient schedules vaccine administration appointment with pharmacy.
- Pharmacist completes the vaccine administration service.
- During the post vaccine administration evaluation period, a student pharmacist offers a blood pressure screening which the patient accepted.
- Student pharmacist:
    - Administers blood pressure readings for the patient
    - Documents results in patient record
    - Identifies increase from past readings
    - Collects additional symptoms of concern, reviews antihypertensive fill history and consults the pharmacist on a care plan
- Pharmacist refers the patient to their cardiologist.
- Pharmacist advises patient on vaccine side effects common in the 72 hours after a vaccination and actions to take should side effects occur.
- Pharmacy submits an S1 claim for the symptomatic patient evaluation and management service.
    - Applicable CPT® code based on trading partner agreement would be submitted as the Product/Service ID (407-D7) (e.g., CPT® 99214: Evaluation and Management for Established Patient, 30 – 39 minutes).
    - Quantity Dispensed (442-E7) value is based on the specific service billing code used and the number of service increments provided for the date of service. In this example, the quantity is one (1) to represent 35 minutes or moderate level of E/M decision making.
    - Pharmacy completes Pharmacist eCare Plan documentation and shares with applicable trading partners, providers and patient.
- Pharmacy submits a B1 claim for vaccine drug and the vaccine administration service.

Return to Use Case Summary Table

USE CASE 9:

S1: MTM SERVICE (15 MINUTES)

Pharmacist provides face to face MTM service with established patient with no known drug therapy problems

- Pharmacist schedules MTM session with patient having a simple medication condition; taking two medications.
- MTM session takes 15 minutes to complete.
- Pharmacy submits an S1 claim for the single unit, 15-minute MTM session.
    - Applicable CPT® code based on trading partner agreement would be submitted as the Product/Service ID (407-D7) (e.g., CPT® 99606: Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient with assessment and intervention if provided; initial 15 minutes, established patient).

    - Quantity Dispensed (442-E7) value is based on the specific service billing code used and the number of service increments provided for the date of service. In this example, the quantity is one (1) to represent a single 15-minute MTM session.
- Pharmacy completes Pharmacist eCare Plan documentation and shares with applicable trading partners, providers and patient.

Return to Use Case Summary Table

USE CASE 10:
S1: MTM SERVICE (TWO CLAIMS – ONE 15 MIN SESSION, TWO 15 MIN SESSIONS)
Pharmacist provides face to face MTM service with an established patient with two known drug therapy problems

- Pharmacist schedules MTM session with patient having two low complexity medical conditions, taking four medications.
- MTM session takes 45 minutes to complete.
- Pharmacy submits an S1 claim for a single 15-minute unit of MTM service.
    - Applicable CPT® code based on trading partner agreement would be submitted as the Product/Service ID (407-D7) (e.g., CPT® 99606: Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient with assessment and intervention if provided; initial 15 minutes, established patient).
    - Quantity Dispensed (442-E7) value is based on the specific service billing code used and the number of service increments provided for the date of service. In this example, the quantity is one (1) to represent a single 15-minute MTM session.
- Pharmacy submits another S1 claim with a Quantity Dispensed (442-E7) value of two (2) for the two additional 15-minute MTM service periods.
    - Applicable CPT® code based on trading partner agreement would be submitted as the Product/Service ID (407-D7) (e.g., CPT® 99607: Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (list separately in addition to code for primary service).
    - Quantity Dispensed (442-E7) value is based on the specific service billing code used and the number of service increments provided for the date of service. **In this example, the quantity is two (2) to represent the two additional 15-minute MTM sessions**.
- Pharmacy completes Pharmacist eCare Plan documentation and shares with applicable trading partners, providers and patient.

Return to Use Case Summary Table

8.2 Use Case Example S1 Transaction Diagrams

Use Case # 2 SI: Service (Vaccine Counseling)

- Pharmacist counsels Medicaid EPSDT eligible patient on preventative vaccines, vaccine not administered on same date of service.
- Service billing claim is submitted to patient's pharmacy benefit plan, using same BIN), PCN, Group and Cardholder ID as B1 claims.
    - Prescriber Segment (03) is not submitted, as the counseling service was not ordered by a different medical provider.
- Plan confirms patient eligibility, coverage of billed service and returns Paid response.

Claim Request

	TRANSACTION HEADER SEGMENT	Use Case 2 Example Value
101-A1	BIN Number	654321

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102-A2	Version Release Number	D0
103-A3	Transaction Code	S1
104-A4	Processor Control Number	MEDICAIDMCO
109-A9	Transaction Count	1
202-B2	Service Provider ID Qualifier	01
201-B1	Service Provider ID	1234512345
401-D1	Date of Service	20240501
110-AK	Software Vendor/Certification ID	PROVIDERABC
Field ID	INSURANCE SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	04
302-C2	Cardholder ID	ABC45600D123
301-C1	Group ID	TITLE19
Field ID	PATIENT SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	01
304-C4	Date of Birth	20100501
305-C5	Patient Gender Code	M
310-CA	Patient First Name	JAMES
311-CB	Patient Last Name	BEARD
Field ID	PHARMACY PROVIDER SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	02
465-EY	Provider ID Qualifier	01
444-E9	Provider ID	1112223335 (RPH NPI)
Field ID	CLAIM SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	07
455-EM	Prescription/Service Reference Number Qualifier	02
402-D2	Prescription/Service Reference Number	1234567
436-E1	Product/Service ID Qualifier	09 (HCPCS)
407-D7	Product/Service ID	G0310
442-E7	Quantity Dispensed	1
403-D3	Fill Number	0
405-D5	Days Supply	1
Field ID	PRICING SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	11
477-BE	Professional Service Fee Submitted	$25.00
426-DQ	Usual and Customary Charge	$25.00
430-DU	Gross Amount Due	$25.00

Claim Response

Field ID	RESPONSE HEADER SEGMENT	Use Case 2 Example Value
102-A2	Version Release Number	D0
103-A3	Transaction Code	S1
109-A9	Transaction Count	1

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501-FI	Header Response Status	A
202-B2	Service Provider ID Qualifier	01
201-B1	Service Provider ID	1234512345
401-D1	Date of Service	20240501
Field ID	RESPONSE MESSAGE SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	20
504-F4	Message	TRANSMISSION ACCEPTED
Field ID	RESPONSE INSURANCE SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	25
301-C1	Group ID	TITLE19
545-2F	Network Reimbursement ID	RPHSERVICE15
Field ID	RESPONSE STATUS SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	21
112-AN	Transaction Response Status	P
503-F3	Authorization Number	2024897854321
130-UF	Additional Message Information Count	1
132-UH	Additional Message Information Qualifier	01
526-FQ	Additional Message Information	USE B1 TO BILL VACCINE/Admin
550-7F	Help Desk Phone Number Qualifier	03 – PBM
550-8F	Help Desk Phone Number	888-555-7777
Field ID	RESPONSE CLAIM SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	22
455-EM	Prescription/Service Reference Number Qualifier	2
402-D2	Prescription/Service Reference Number	1234567
Field ID	RESPONSE PRICING SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	23
505-F5	Patient Pay Amount	$0.00
562-J1	Professional Service Fee Paid	$25.00
509-F9	Total Amount Paid	$25.00
518-FI	Amount of Copay	$0.00

Use Case # 6 B1: Product + S1: Service (E/M Plan of Care)

- Pharmacist completes face-to-face 15-minute patient evaluation service for oral contraceptive medication and completes applicable documentation.
- S1 claim is submitted to patient's pharmacy benefit plan,
  - S1 claim submitted to the same BIN, PCN, Group and Cardholder ID as B1 claims
  - S1 claim includes NDC of prescribed oral contraceptive within the DUR Co-Agent ID (476-H6) field, with applicable Reason for Service (439-E4), Professional Service (440-E5) and Result of Service (441-E6) values as additional optional information.
- Plan confirms patient eligibility, coverage of billed service and returns an S1 Paid response.

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	TRANSACTION HEADER SEGMENT	Use Case 6 Example Value
101-A1	BIN Number	654321
102-A2	Version Release Number	D0
103-A3	Transaction Code	S1
	Processor Control Number	COMMERCIAL
109-A9	Transaction Count	1
202-B2	Service Provider ID Qualifier	01
201-B1	Service Provider ID	1234512345
401-D1	Date of Service	202400715
110-AK	Software Vendor/Certification ID	PHARMACYABC
Field ID	INSURANCE SEGMENT	Use Case 6 Example Value
111-AM	Segment Identification	04
302-C2	Cardholder ID	6352AC45321
301-C1	Group ID	DONUTSDINER
Field ID	PATIENT SEGMENT	Use Case 6 Example Value
111-AM	Segment Identification	01
304-C4	Date of Birth	19920328
305-C5	Patient Gender Code	F
310-CA	Patient First Name	MARIA
311-CB	Patient Last Name	WEST
Field ID	PHARMACY PROVIDER SEGMENT	Use Case 6 Example Value
111-AM	Segment Identification	02
465-EY	Provider ID Qualifier	01
444-E9	Provider ID	1112223335 (RPH NPI)
Field ID	CLAIM SEGMENT	Use Case 6 Example Value
111-AM	Segment Identification	07
455-EM	Prescription/Service Reference Number Qualifier	2
402-D2	Prescription/Service Reference Number	1965467
436-E1	Product/Service ID Qualifier	07 (CPT4)
407-D7	Product/Service ID	99211
442-E7	Quantity Dispensed	1
403-D3	Fill Number	0
405-D5	Days Supply	1
	DUR/PPS SEGMENT	
111-AM	Segment Identification	08
473-7E	DUR/PPS Code Counter	1
439-E4	Reason for Service Code	AD – ADDITIONAL DRUG NEEDED
440-E5	Professional Service Code	AS- PATIENT ASSESSMENT
441-E6	Result of Service Code	3A – RECOMMENDATION ACCEPTED
475-J9	DUR Co-Agent ID Qualifier	03 – NDC

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476-H6	DUR Co-Agent ID	11111-5555-01 HORMONAL CONTRACEPTIVE
Field ID	PRICING SEGMENT	Use Case 6 Example Value
111-AM	Segment Identification	11
477-BE	Professional Service Fee Submitted	$45.00
426-DQ	Usual and Customary Charge	$45.00
430-DU	Gross Amount Due	$45.00

Claim Response

Field ID	RESPONSE HEADER SEGMENT	Use Case 2 Example Value
102-A2	Version Release Number	D0
103-A3	Transaction Code	S1
109-A9	Transaction Count	1
501-FI	Header Response Status	A
202-B2	Service Provider ID Qualifier	01
201-B1	Service Provider ID	1234512345
401-D1	Date of Service	20240715
Field ID	RESPONSE MESSAGE SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	20
504-F4	Message	TRANSMISSION ACCEPTED
Field ID	RESPONSE INSURANCE SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	25
301-C1	Group ID	TITLE19
545-2F	Network Reimbursement ID	RPHSERVICE15
Field ID	RESPONSE STATUS SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	21
112-AN	Transaction Response Status	P
503-F3	Authorization Number	2024071559876
130-UF	Additional Message Information Count	1
132-UH	Additional Message Information Qualifier	01
526-FQ	Additional Message Information	USE B1 TO BILL DRUG CLAIM
550-7F	Help Desk Phone Number Qualifier	03 – PBM
550-8F	Help Desk Phone Number	888-555-7777
Field ID	RESPONSE CLAIM SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	22
455-EM	Prescription/Service Reference Number Qualifier	2
402-D2	Prescription/Service Reference Number	1965467
Field ID	RESPONSE PRICING SEGMENT	Use Case 2 Example Value
111-AM	Segment Identification	23
505-F5	Patient Pay Amount	$0.00
562-J1	Professional Service Fee Paid	$45.00

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509-F9	Total Amount Paid	$45.00
518-FI	Amount of Copay	$0.00

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9. TRANSACTION ROUTING

9.1 S1/B1 PLAN BENEFIT CLAIM TRANSACTION ROUTING

NCPDP S1 Transaction Routing
With real-time claim billing, the service provider manages the billing process at point of service versus a retrospective billing vendor. While the real-time processing capability of the NCPDP Telecommunication Standard S1 transaction reduces the transaction routing risks, the benefit of it is contingent upon payers:

- Publishing an NCPDP Payer Sheet for their S1 transaction processing that includes:
    - BIN Identification Number (BIN)
    - PCN
- Distributing member ID cards that contain the four main claim transaction routing identifiers required for the S1 transaction request:
    - BIN Identification Number (BIN)
    - PCN
    - Group ID
    - Cardholder ID

B1 and S1 Transaction Routing for the Same Patient, Same Health Plan
A single pharmacy system that supports both B1 Claim Billing and S1 Service Billing transactions would generally create a single patient third-party profile for all services provided and apply the applicable billing format based on the selected Product/Service ID Qualifier (436-E1) and Product/Service ID (402-D7). This would, in turn, determine the Prescription/Service Reference Number Qualifier (455-EM) value, where the value of “01” (Rx Billing) is used for B1 transactions and the value of “02” (Service Billing) is used for S1 transactions. It is recommended payers apply similar patient/member set-up rules and use the same 4Rx (i.e., BIN Number (101-A1), Processor Control Number (104-A4), Group ID (301-C1) and Cardholder ID (302-C2)) for both B1 and S1 transactions. This approach would assist in streamlining pharmacy system patient profiles and plan eligibility files. An exception to this approach would be when the payer separates the eligibility and enrollment process, where one of the benefits could terminate and the other remains active.

B1 and S1 Transaction Routing for the Same Patient, Different Health Plans or Payer/Processors
When B1 claims for products and S1 claims for professional services are managed by two different health plans or payer/processors, the pharmacy system will need to maintain two different patient third-party profiles. The B1 claims would be associated to that payer/processor’s specific 4Rx identifiers (i.e., BIN Number (101-A1), Processor Control Number (104-A4), Group ID (301-C1) and Cardholder ID (302-C2)). Similarly, S1 claims would be associated to that payer/processor’s specific 4Rx identifiers (i.e., -BIN Number (101-A1), Processor Control Number (104-A4), Group ID (301-C1) and Cardholder ID (302-C2)). When the B1 and S1 benefits are managed by different processors, this increases the need to make available real-time eligibility verification for professional service benefits.

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10. PAYER SHEET

Refer to the *NCPDP vD.0 Payer Sheet Template Implementation Guide*, located on the Documents, Guides and Templates section of the NCPDP public Resource page (https://ncpdp.org/NCPDP/media/pdf/Payer_Sheet_Template_1.pdf).

Section 9 of the *NCPDP vD.0 Payer Sheet Template Implementation Guide* includes a payer sheet example for the S1 Billing Request, S1 Accepted/Paid, Accepted/Rejected and Rejected/Rejected response transactions for a specific health plan. This example service billing/response payer sheet reflects the segments and fields outlined within Version 10 of this guidance document.

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11. BEST PRACTICES/FAQS

11.1 Pharmacy Systems and Workflows

Question:
How does professional service billing impact traditional pharmacy workflow and patient profile recordkeeping?

Response:
Service billing implementation may vary across pharmacy systems. Some may establish a unique professional service documentation, workflow and billing solution, separate from existing claim billing processes for products dispensed. Others may integrate professional service billing processes into existing NCPDP Telecommunication Standard system solutions. In either approach, it generally requires a third-party insurance plan code to be associated to the patient, within the pharmacy system's patient third-party profile. Active third-party profiles would be leveraged during the claim billing process, and where applicable, plans would be sequenced within a defined billing order.

Keeping the patient's third-party profile up to date will be critical to reduce point-of-service or retrospective eligibility rejects. One of the major benefits of the NCPDP S1 Service Billing transaction is the availability of point-of-service responses to confirm patient eligibility and coverage of the service to be performed. As patient healthcare coverage can change frequently, pharmacy access to a real-time eligibility check specific to professional services will become a necessary component as NCPDP Telecommunication Standard S1 transaction billing expands.

11.2 X12 837 Transaction Routing

Question:
How does a provider determine where to submit the claim to bill the patient's medical benefit?

Response:
Historically, pharmacist professional services have been billed to the patient's medical benefit plan using the X12 Health Care Claim (837) Standard. These transactions are routed to the applicable payer via the contracted clearinghouse. It is the Payer ID associated to the plan to which the claim must be routed. Payer IDs may or may not be human readable on the member's ID card and may only be in the bar code/magnetic strip or may not be present at all. Additionally, for the same payer, the Payer IDs may vary by clearinghouse. These barriers create retrospective claim billing risks managed by the provider's claim billing vendor.

11.3 Prescription and Services Billings in One Transaction

(Copied from Section 35.11 of the NCPDP Telecommunication Standard Version D.0 Implementation Guide)

Question: Can I Submit DUR/PPS Codes and Service Billings with A Claim For Product?

Response: No, in Version D.0 and above, the Service Billings have their own Transaction Code (S1, S2, S3). The Transaction Code is at the transmission level. Claim and service billings are associated (using the Associated Prescription/Service Reference Number (456-EN) and Associated Prescription/Service Date (457-EP), but they must appear in separate transmissions. Drug product billings are designated by
Transaction Code = "B1" (Billing) and Prescription/Service Reference Number Qualifier = "1" (Rx Billing). Service billings are designated by Transaction Code = "S1" (Service Billing) and Prescription/Service Reference Number Qualifier = "2" (Service Billing).

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11.4 MULTIPLE SERVICES FOR SAME PATIENT SAME DATE OF SERVICE

Question:
Can a single NCPDP Telecommunication Standard Service Billing transaction support the billing of multiple services for the same patient on the same date of service?

Response:
The Transaction Count (109-A9) field within NCPDP Telecommunication Standard vD.0 can support values 1 through 4. While vD.0 can support multi-claim transactions, this changes with the next HIPAA-named version where the Transaction Count (109-A9) is limited to one (1) (single claim per transmission). To mitigate version transition issues when implementing NCPDP Telecommunication Standard Service Billing transactions (S1-S3), it is recommended that each service is submitted on a separate transmission. Refer to Section 7.1.1 *Transaction Header Segment* above.

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12. ACKNOWLEDGMENTS

The impact of NCPDP's work is felt throughout the broader healthcare community as the organization collaborates with other organizations and individual stakeholders to realize the clinical and economic benefits of a connected system. NCPDP is grateful for the ongoing and dedicated work by its members, the industry and the community to improve patient's healthcare outcomes. NCPDP would like to take this opportunity to especially thank the following representatives who generously provided their expertise, support and passion to advance the direct billing of pharmacist professional services.

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Executive Director at Pharmacy HIT Collaborative

Pamela Schweitzer
Assistant Surgeon General (retired), US Public Health Service Commissioned Corps

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13. APPENDIX A – HISTORY OF CHANGES

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