# TELECOMMUNICATION VERSION D© AND ABOVE QUESTIONS, ANSWERS AND EDITORIAL UPDATES

## *DOCUMENTATION*

See important update in section "*Quantity Prescribed (460-ET)*"

September 2026

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

Phone: (480) 477-1000
Fax: (480) 767-1042
Email: ncpdp@ncpdp.org
http: www.ncpdp.org


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# Telecommunication Version D© and Above Questions, Answers and Editorial Updates

**Version 74**

**COPYRIGHT (©) National Council for Prescription Drug Programs, Inc. 2026**

National Council for Prescription Drugs Programs, Inc. (NCPDP) publications are owned by NCPDP, 9240 East Raintree Drive Scottsdale, AZ 85260, and protected by the copyright laws of the United States and other countries. 17 U.S.C. §101, et. seq.

Subject to the restrictions described below, NCPDP grants permission to NCPDP members to copy and use NCPDP publications in connection with the business purposes of the Council members solely in support of healthcare transactions conducted wholly within the United States. The NCPDP publications may not be changed or altered. The NCPDP publications may be shared with employees within the member company with a reasonable need to know but may not be (1) disclosed or distributed to any unauthorized party; (2) used without NCPDP's express written permission outside the United States; and (3) placed into any artificial intelligence ("AI") technology including but not limited to statistical learning algorithms, models (including large language models), neural networks, and other AI tools or methodologies, software implementations of such AI technology, related hardware or equipment which generates content based on user-supplied prompts. The NCPDP publications may not be disclosed, copied, modified, compiled, sold, used, published, or exploited for commercial purposes except as expressly authorized herein. This permission may be revoked by NCPDP at any time. NCPDP is not responsible for any errors or damage in any way associated with the use of NCPDP publications. Except as expressly permitted herein, NCPDP publications may not be provided to third parties without NCPDP's express written authorization, and members and other recipients of NCPDP publications must not, directly or indirectly, (1) publish or participate in the publication, sharing, or disclosure of any NCPDP publication to any third party, or (2) authorize, permit, or encourage any third party to do so. Any such member or other recipient of an NCPDP publication waives all rights to share NCPDP publications, including any right based on "fair use," and will be responsible for any and all such disclosures, including but not limited to disclosures by employees, agents, contractors, affiliates, or other third parties acting on behalf of or with the knowledge or consent of such member or other recipient.

All NCPDP publications and other material are provided "as is", without warranty of any kind, express or implied, including but not limited to warranties of merchantability, fitness for a particular purpose, accuracy, completeness, and non-infringement of third-party rights. In no event shall NCPDP, its members, or its contributors be liable for any claim, or any direct, special, indirect, or consequential damages, or any damages whatsoever resulting from loss of use, data, or profits, whether in an action of contract, negligence, or other tortious action, arising out of or in connection with the use or performance of NCPDP publications or other NCPDP material.

NCPDP recognizes the confidentiality of certain information exchanged electronically through the use of its standards. It is the responsibility of users to be familiar with the federal, state, and local laws, regulations, and codes requiring confidentiality of this information and should utilize the standards accordingly. NCPDP standards must not be used outside the United States without the express written permission of NCPDP.

**NOTICE:** In addition, certain NCPDP standards contain certain data fields and elements that may be completed by users with the proprietary information of third parties. The use and distribution of third parties' proprietary information without such third parties' consent, or the execution of a license or other agreement with such third party, could subject the user to numerous legal claims. **All users are encouraged to contact such third parties to determine whether such information is proprietary and, if necessary, to consult with legal counsel to make arrangements for the use and distribution of such proprietary information**.

**Published by:**
**National Council for Prescription Drug Programs**

**Publication History:**

| | | | | |
|---|---|---|---|---|
| Version 1.0, Version 2.0 June 2009 | Version 19.0 December 2012 | Version 35.0 August 2016 | Version 51 November 2020 | Version 67 November 2024 |
| Version 3.0 July 2009 | Version 20.0 February 2013 | Version 36.0 December 2016 | Version 52 February 2021 | Version 68 February 2025 |
| Version 4.0 September 2009 | Version 21.0 April 2013 | Version 37.0 May 2017 | Version 53 May 2021 | Version 69 May 2025 |
| Version 5.0 November 2009 | Version 22.0 May 2013 | Version 38.0 August 2017 | Version 54 August 2021 | Version 70 August 2025 |
| Version 6.0 January 2010 | Version 23.0 August 2013 | Version 39.0 December 2017 | Version 55 November 2021 | Version 71 December 2025 |
| Version 7.0 February 2010 | Version 24.0 November 2013 | Version 40.0 March 2018 | Version 56 February 2022 | Version 72 March 2026 |
| Version 8.0 May 2010 | Version 25.0 February 2014 | Version 41.0 May 2018 | Version 57 May 2022 | Version 73 June 2026 |

| | | | | |
|---|---|---|---|---|
| Version 9.0 August 2010 | Version 26.0 May 2014 | Version 42.0 August 2018 | Version 58 August 2022 | Version 74 September 2026 |
| Version 11.0 February 2011 | Version 27.0 August 2014 | Version 43.0 November 2018 | Version 59 December 2022 | |
| Version 12.0 June 2011 | Version 28.0 December 2014 | Version 44.0 February 2019 | Version 60 February 2023 | |
| Version 13.0 August 2011 | Version 29.0 February 2015 | Version 45.0 April 2019 | Version 61 May 2023 | |
| Version 14.0 October 2011 | Version 30.0 May 2015 | Version 46.0 May 2019 | Version 62 October 2023 | |
| Version 15.0 November 2011 | Version 31.0 August 2015 | Version 47.0 September 2019 | Version 63 November 2023 | |
| Version 16.0 February 2012 | Version 32.0 January 2016 | Version 48 November 2019 | Version 64 February 2024 | |
| Version 17.0 May 2012 | Version 33.0 March 2016 | Version 49 February 2020 | Version 65 May 2024 | |
| Version 18.0 August 2012 | Version 34.0 May 2016 | Version 50 August 2020 | Version 66 August 2024 | |

# Table of Contents

**1 PURPOSE OF THIS DOCUMENT ..... 14**

1.1 REPUBLICATION OF TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE VERSION D.0© JULY 2009 ..... 14
*1.1.1 Scheduled Prescription ID Number (454-EK) ..... 14*
1.2 REPUBLICATION OF TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE VERSION D.0© AUGUST 2010 ..... 15
*1.2.1 Benefit Stage Formula ..... 15*
*1.2.2 Denote Individual Amounts of Patient Financial Responsibility as Reported from a Previous Payer ..... 15*
1.3 QUANTITY PRESCRIBED (460-ET) ..... 16
*1.3.1 Quantity Prescribed (460-ET) ..... 16*
1.4 USE OF THIS DOCUMENT ..... 16
*1.4.1 How Soon Support This Document? ..... 16*
*1.4.2 Medicaid Subrogation Editorial Document ..... 17*
1.5 NCPDP IMPORTANT EXTERNAL CODE LIST© (ECL) INFORMATION ..... 17
1.6 NCPDP RECOMMENDATIONS FOR 4RX USAGE IN MEDICARE PART D PROCESSING DOCUMENTS ..... 17
1.7 NCPDP EMERGENCY PREPAREDNESS RESOURCE ..... 18

**2 EDITORIAL CORRECTIONS CITED IN TELECOM D.0 ..... 19**

**3 REQUEST SEGMENT DISCUSSION ..... 20**

3.1 CLAIM SEGMENT (07) ..... 20
*3.1.1 Days Supply (405-D5) ..... 20*
*3.1.2 Dispense As Written (408-D8) Value 9 During Transition ..... 21*
*3.1.3 DAW Codes – Use of Value 9 and Status of A ..... 22*
*3.1.4 Interchangeable Biosimilar Products and DAW ..... 24*
*3.1.5 Other Coverage Code (308-C8) ..... 26*
*3.1.6 Prescription Origin Code (419-DJ) ..... 31*
*3.1.7 Product/Service ID/Qualifier in Compounds ..... 35*
*3.1.8 Route of Administration (995-E2) and SNOMED CT Codes ..... 35*
*3.1.9 Date of Service (401-D1) ..... 35*
*3.1.10 Unit of Measure (600-28) and Multi-Ingredient Compounds ..... 36*
*3.1.11 Level of Service ..... 36*
*3.1.12 Submission Clarification Code (SCC) ..... 36*
3.2 COMPOUND SEGMENT (10) ..... 38
3.3 COORDINATION OF BENEFITS SEGMENT (05) ..... 38
3.4 INSURANCE SEGMENT (04) ..... 39
*3.4.1 Medicaid Indicator (360-2B) ..... 39*
*3.4.2 Medicaid ID Number (115-N5) and Cardholder ID (302-C2) ..... 39*
*3.4.3 Medigap ID (359-2A) Use ..... 39*
3.5 PATIENT SEGMENT (01) ..... 40
*3.5.1 Species ..... 40*
*3.5.2 Patient Gender ..... 41*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

3.6 PRICING SEGMENT (11) ..... 42
*3.6.1 340B Processing* ..... *42*
*3.6.2 Pricing Segment Contains Values 'as if' the Claim was Primary* ..... *44*
*3.6.3 Billing Transaction For Free Fills* ..... *44*
3.7 FACILITY SEGMENT (14) ..... 45
3.8 PRESCRIBER SEGMENT (03) ..... 45
3.9 DUR/PPS SEGMENT (08) ..... 45

**4 RESPONSE SEGMENT DISCUSSION ..... 47**

4.1 RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT (28) ..... 47
4.2 RESPONSE PATIENT SEGMENT (29) ..... 47
4.3 RESPONSE PRICING SEGMENT (23) ..... 47
*4.3.1 Amount Attributed to Processor Fee (571-NZ)* ..... *47*
*4.3.2 Basis of Reimbursement Determination (522-FM)* ..... *49*
*4.3.3 Benefit Stage* ..... *50*
*4.3.4 Health Plan-Funded Assistance Amount (129-UD)* ..... *50*
*4.3.5 Total Amount Paid (509-F9) Negative?* ..... *51*
*4.3.6 Response Processing Guidelines* ..... *52*
*4.3.7 Negative Patient Pay Values* ..... *53*
*4.3.8 Brand Medically Necessary* ..... *54*
4.4 RESPONSE STATUS SEGMENT (21) ..... 54
*4.4.1 Additional Message Information* ..... *54*
*4.4.2 Duplicate Transaction* ..... *58*
*4.4.3 Reject Code (511-FB) "70"and "MR"* ..... *59*
4.5 RESPONSE INSURANCE SEGMENT (25) ..... 59
*4.5.1 Network Reimbursement ID (545-2F)* ..... *59*
4.6 RESPONSE CLAIM SEGMENT (22) ..... 59
*4.6.1 Preferred Product Cost Share Incentive (555-AT)* ..... *59*
4.7 RESPONSE DUR/PPS SEGMENT (24) ..... 60
*4.7.1 DUR Free Text Message (544-FY)* ..... *60*

**5 TYPOGRAPHICAL ERRORS ..... 61**

5.1 TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE© FIELDS ..... 61
*5.1.1 Additional Message Information Examples* ..... *61*
*5.1.2 Date of Service (401-D1)* ..... *61*
*5.1.3 Help Desk Phone Number Qualifier (549-7F)* ..... *61*
*5.1.4 Internal Control Number (993-A7)* ..... *61*
*5.1.5 Other Coverage Code (308-C8)* ..... *62*
*5.1.6 Other Payer Coverage Type (338-5C)* ..... *62*
*5.1.7 Repeating Designation* ..... *62*
*5.1.8 Route of Administration (995-E2)* ..... *62*
5.2 TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE© SEGMENTS ..... 63
*5.2.1 General* ..... *63*
*5.2.2 Claim Segment* ..... *63*
*5.2.3 Coupon Segment* ..... *63*
*5.2.4 Clinical Segment* ..... *63*
*5.2.5 Patient Segment* ..... *63*
*5.2.6 Purchaser Segment* ..... *64*
*5.2.7 Response Claim Segment* ..... *64*
*5.2.8 Response Coordination of Benefits/Other Payers Segment* ..... *64*
5.3 TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE© EXAMPLES ..... 64


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

*5.3.1 Billing – Transaction Code B1 – Coordination of Benefits Scenario Pharmacy Bills To Secondary Which Meets Designation As Government Payer , Patient Requests Brand ..... 64*
*5.3.2 Billing – Transaction Code B1 – Coordination of Benefits Scenarios Pharmacy Bills To Insurance Designated By Patient ..... 65*
*5.3.3 Billing - Transaction Code B1 - COB Scenario - Pharmacy Bills Reporting Amount Paid by Previous Payer Only ..... 65*
*5.3.4 Controlled Substance Reporting (General) Examples ..... 65*
*5.3.5 Examples using Medigap ID (359-2A) ..... 65*
5.4 APPENDIX A. HISTORY OF DOCUMENT CHANGES CORRECTIONS ..... 65
5.5 EXTERNAL CODE LIST© NOTABLES ..... 66
*5.5.1 Reject Code (511-FB) List ..... 66*
*5.5.2 Prescription/Service Reference Number (455-EM) Value "3" ..... 66*

**6 GENERAL QUESTIONS ..... 67**

6.1 BIN AND IIN ..... 67
6.2 CLAIMS IN EXCESS OF $999,999.99 ..... 67
6.3 HOW SOON SUPPORT THIS DOCUMENT? ..... 67
6.4 PRINTABLE CHARACTERS ..... 67
6.5 REJECT CODE GUIDANCE ..... 67
*6.5.1 Telecommunication Phases with Flow Chart ..... 68*
*6.5.2 When should Reject Code 84 be used? ..... 70*
*6.5.3 Prescriber ID Rejections ..... 70*
*6.5.4 Information Reporting Transactions ..... 75*
*6.5.5 Which NCPDP ECL Values (Reject Code, SCC, Approved message Code) should be used for Medicaid Ordering Referring Provider Requirements ..... 76*
*6.5.6 RPh Prescriptive Authority Validation ..... 76*
*6.5.7 Service Provider ID ..... 77*
*6.5.8 Reject Code 71: Prescriber ID Is Not Covered ..... 77*
6.6 SYNTAX ERROR ..... 78
6.7 NOT USED DATA ELEMENT ..... 78
6.8 VACCINE ADMINISTRATION ..... 78
6.9 ICD-9 VERSUS ICD-10 INFORMATION ..... 78
6.10 ICD-10 SUBMISSION ..... 78
6.11 NUMBER OF DIAGNOSIS CODE FIELDS ..... 79
6.12 MINIMUM AND MAXIMUM FIELD LENGTH ..... 79
6.13 UNIQUE DEVICE IDENTIFIER CONVERSION ..... 79
6.14 DRUG RECALLS ..... 79
6.15 CLAIM ADJUDICATION PROCESS FOR OPIOID UTILIZATION RULES ..... 80
6.16 EMERGENCY FILL ..... 81
6.17 QUANTITY PRESCRIBED/QUANTITY DISPENSED AND APPROVED MESSAGE CODE ..... 81
6.18 QUANTITY PRESCRIBED AND QUANTITY DISPENSED ..... 82
6.19 QUANTITY PRESCRIBED 30-DAY REFERENCE ..... 82
6.20 INSULIN PEN PACKAGING CLAIM ADJUDICATION GUIDANCE ..... 84
6.21 PHARMACIST ASSESSMENT BILLING ..... 88
6.22 LOWER CASE DATA ..... 88
6.23 PHARMACIST SERVICES BILLING ..... 89
6.24 PHARMACIST MEDICATION ADMINISTRATION ..... 89
6.25 TRANSITION TO COMMERCIAL COVID ANTI-VIRALS ..... 90
6.26 COVERAGE OF A DUPLICATE THERAPY INTERACTION ..... 91
6.27 INSULIN ADMINISTRATION – DELIVERY DEVICE ..... 95
6.28 CLAIM SUBMISSION ENTITIES ..... 100
6.29 PHARMACOGENOMIC (PGX) TESTING ..... 100


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**7 GUIDANCE FOR OPIOID LIMITS ..... 103**

7.1 OVERVIEW ..... 103
7.2 BACKGROUND INFORMATION ..... 103
*7.2.1 Medicare Part D Background ..... 103*
*7.2.2 State and Plan Background ..... 104*
*7.2.3 Medicaid and CHIP Background ..... 104*
7.3 SPECIFIC NCPDP CLAIM RESPONSE FIELDS AND VALUES USED FOR OPIOID UTILIZATION EDITS GUIDANCE ..... 104
*7.3.1 Reject Codes (511-FB) ..... 104*
*7.3.2 Reason for Service Code (439-E4) ..... 106*
*7.3.3 Other Pharmacy Indicator (529-FT), Other Prescriber Indicator (533-FX) ..... 106*
*7.3.4 Approved Message Code (548-6F) ..... 107*
*7.3.5 Additional Message Information Qualifier (132-UH) ..... 107*
*7.3.6 Additional Message Information (526-FQ) ..... 108*
*7.3.7 Help Desk Telephone Number (550-AF) ..... 109*
*7.3.8 DUR Free Text Message (544-FY) & DUR Additional Text (570-NS) ..... 109*
7.4 CLAIM BILLING REQUEST FIELDS AND VALUES USED TO SUPPORT OPIOID UTILIZATION EDIT OVERRIDES ..... 109
*7.4.1 Diagnosis Code (424-DO) ..... 109*
*7.4.2 Long Term Care Exemptions to Opioid Policy – Patient Residence Code (384-4X) ..... 109*
*7.4.3 DUR/PPS Segment (111-AM) ..... 109*
7.5 CLAIM BILLING REQUEST FIELDS NOT RECOMMENDED FOR OPIOID UTILIZATION EDIT OVERRIDES ..... 110
*7.5.1 Submission Clarification Code (420-DK) ..... 110*
*7.5.2 Prior Authorization Number Submitted (462-EV) ..... 110*
7.6 OPIOID UTILIZATION SCENARIOS MATRIX ..... 112
*7.6.1 Opioid Naïve Day Supply Limitation ..... 113*
*7.6.2 MME Hard Stop; POS Override Not Allowed; Prescriber to Call Plan (potentially >200) ..... 115*
*7.6.3 MME Prescriber Care Coordination Required (90-200, or >90) ..... 118*
*7.6.4 Duplicative Therapy Soft Edit - Long Acting Opioids ..... 120*
*7.6.5 Soft Stop for Concurrent Use of Conflicting Drug Categories (e.g.; Opioids & Benzodiazepines, Opioids & Buprenorphine, Opioids & Antipsychotics) ..... 123*
*7.6.6 Member Lock-In (e.g. opioid, benzodiazepine or other targeted drug) ..... 125*

**8 NCPDP BATCH STANDARD© ..... 127**

8.1 DELIMITER ..... 127
8.2 RESPONSE FORMAT ..... 127
8.3 SEGMENT DEFINITION ..... 127
*8.3.1 Batch Standard© Segment Usage Different than Telecommunication Standard©? ..... 127*
8.4 TRANSACTION PROCESSING ..... 127
*8.4.1 Batch Processing – Reject ..... 127*

**9 LONG-TERM AND POST-ACUTE CARE (LTPAC) PHARMACY CLAIMS SUBMISSION RECOMMENDATIONS FOR VERSION D.0 ..... 129**

9.1 INTRODUCTION (PURPOSE) ..... 129
9.2 BACKGROUND ..... 129
9.3 ISSUES AND RECOMMENDATIONS ..... 129
*9.3.1 Provider Contracts ..... 129*
*9.3.2 How do we know we have a LTPAC transaction? ..... 130*
*9.3.3 Special Packaging ..... 132*
*9.3.4 Leave of Absence Medications ..... 132*
*9.3.5 Medication Lost, Dropped, or Patient "Spits out" ..... 133*
*9.3.6 Emergency Box / Kit Dispensing Operations ..... 133*
*9.3.7 LTPAC Admissions and Readmissions ..... 134*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

*9.3.8 Coverage Ends for Medicare Part A Resident Before Medication Supply is Used ..... 135*
*9.3.9 On-Line Window for Submission of New and Rejected Claims ..... 135*
*9.3.10 Predetermination of Benefits ..... 136*
*9.3.11 Date of Service for LTPAC Billing Claim ..... 136*
*9.3.12 Cycle Fills ..... 136*
*9.3.13 Back Up Pharmacies ..... 137*
9.4 Implementation of Changes Requested ..... 137
9.5 Appropriate Dispensing (Short Cycle) for LTC ..... 137
*9.5.1 Dispensing Methodologies for LTC in PPACA ..... 137*
*9.5.2 Submission Clarification Code Combinations and Rejections ..... 138*
*9.5.3 Appropriate Dispensing and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFIID) and Institute of Mental Disease (IMD) ..... 141*
9.6 LTC Service Outside of an LTC Setting ..... 141
9.7 Patient Residence Value ..... 142

**10 COORDINATION OF BENEFITS INFORMATION ..... 143**

10.1 Clarification of Net Amount Due in Coordination of Benefits ..... 143
*10.1.1 Payable Components of Other Payer-Patient Responsibility Amounts ..... 146*
10.2 Three Options for Coordination of Benefits ..... 147
*10.2.1 Only Three Options Allowed? ..... 147*
*10.2.2 Multiple COB Options Per BIN/PCN? ..... 147*
*10.2.3 Can a BIN/PCN combination contain groups that use multiple COB methods? ..... 148*
10.3 Other Payer Amount Paid Qualifier (342-HC) Value for Sales Tax ..... 148
10.4 Other Payer Coverage Type (338-5C) is Unknown ..... 157
10.5 Other Payer Amount Paid Qualifiers (342-HC) For B1 COB ..... 157
10.6 Other Payer Amount Paid Qualifier (342-HC) Values Sunsetted ..... 169
*10.6.1 Medicaid Allowed Amount and Prescription Response Formula ..... 171*
10.7 Other Payer Amount Paid Qualifier (342-HC) Value 99? ..... 172
10.8 Like Amounts Submitted as Incentive Fee ..... 173
10.9 Drug Benefit ..... 174
10.10 Other Payer Reject Code (472-6E) ..... 175
10.11 Other Payer-Patient Responsibility Amount (352-NQ) to each Payer? ..... 177
10.12 OPPRA (352-NQ) Field Length Greater Than $999,999.99 is received ..... 178
10.13 Government COB ..... 178
10.14 OPPRA and Other Coverage Code Value 3 ..... 179
10.15 Processor vs. Pharmacy Responsibility for Aggregating Other Payer Amounts ..... 179
10.16 Patient Paid Amount Submitted (433-DX) ..... 181
*10.16.1 Accounting for Monies Paid to the Patient? ..... 181*
*10.16.2 Receiving Patient Paid Amount Submitted (433-DX) when Previous Payer Paid the Claim? ..... 181*
*10.16.3 Receiving Patient Paid Amount Submitted (433-DX) when Previous Payer Rejected the Claim? ..... 181*
10.17 Coordination of Benefits Segment (05) vs. Pricing Segment (11) ..... 182
10.18 Coordination of Benefits and Prior Authorization ..... 182
*10.18.1 How should Medicare and Medicaid handle the processing of benzodiazepine and barbiturates? 182*
10.19 Medicaid Pay only Applicable Components? ..... 182
10.20 Response Coordination of Benefits/Other Payers Segment (28) ..... 183
*10.20.1 Other Payer Coverage Type (338-5C) and Processing for Mid-Stream Payers ..... 183*
*10.20.2 Ingredient Cost Paid (506-F6) and Total Patient Responsibility Amount from Last Payer ..... 183*
10.21 Transition of Versions and COB ..... 184
10.22 Workers' Compensation and COB ..... 185
*10.22.1 Provide Guidance for Handling Workers' Compensation Payer as Primary, that is not Required to Send Telecom D.0 ..... 185*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

10.23 Reversals and COB ..... 186
10.24 Dollar Field Not Received ..... 186
10.25 Medicare/Medicaid Part B COB ..... 186
10.26 Communication of the Medicaid Benefit responsible for QMB Program Medicare Part B Coordination ..... 188
10.27 Identification and Override To Plan Sponsored Drug Discount Pricing Program Benefit To Support COB With Supplemental Payers ..... 191
10.28 Reject Code Use When Other Payer Loop Contains Both Paid Amount(s) and Reject Code(s) ..... 192
10.29 OPAP Qualifiers and Sales Tax ..... 195
10.30 Other Payer Amount Paid Qualifiers (342-HC) For S1 (Service Billing) COB ..... 196
10.31 Payer-to-Payer COB ..... 197

**11 RECOMMENDATIONS FOR CLAIM REVERSAL PROCESSING FOR TELECOMMUNICATION VERSION D.0© . 199**

11.1 Current info on Claim Reversal Processing for Telecommunication Version D.0© ..... 199
11.2 Why is Guidance Needed? ..... 199

**12 NCPDP MEDICAID SUBROGATION STANDARD© ..... 202**

12.1 Typographical Errors ..... 202

**13 WORKERS' COMPENSATION-SPECIFIC INFORMATION ..... 203**

13.1 Workers' Compensation and Repackaged NDCs ..... 203

**14 IMPROVING THE VALUE OF THE CLAIM RESPONSE WITH ADDITIONAL MESSAGING ..... 204**

14.1 Background ..... 204
14.2 Specific Data Field Use Recommendations ..... 204
*14.2.1 Benefit- or Plan-Generated Rejections ..... 205*
*14.2.2 Other Notable Reject Codes ..... 210*
14.3 DUR/PPS-Generated Rejections ..... 212
14.4 Participating Organizations ..... 213
14.5 Long Term Care Transition, Emergency Supply and Change in level of Care Messaging for Rejected and Paid Claims 214
*14.5.1 Background ..... 214*
*14.5.2 Claims Paid Due To CMS Initial Eligibility Transition Period ..... 216*
*14.5.3 Claims Paid Due To CMS Emergency Supply Requirement ..... 217*
*14.5.4 Claims Paid Due To CMS Change In Level Of Care Requirement ..... 217*

**15 MULTI-INGREDIENT COMPOUND PROCESSING ..... 219**

15.1 Correct Telecom Version? ..... 219
15.2 Leave Off Ingredients that are Identifiable by the Pharmacy and the Payer? ..... 219
15.3 Compound Ingredient Quantity (448-ED) Smaller than 3 Digits of Precision to the Right of the Decimal ..... 219
15.4 Compound Ingredient Modifier Code (363-2H) ..... 221
15.5 Basis of Reimbursement (423-DN) and Multi-ingredient Compounds ..... 221
15.6 Unit of Measure (600-28) and Multi-Ingredient Compounds ..... 221
15.7 Recommendations on the Submission of Identifiable Ingredients that are Not Recognized by the Payer ..... 221
15.8 Correlate Complexity in Compounding and DUR/PPS Level of Effort (474-8E) ..... 222
15.9 Compound Ingredient Product Identifier and Qualifier Use ..... 224
15.10 Use of the Compound Segment for the billing of 2 commercially available products ..... 227

**16 VACCINE SERVICES – PHARMACY BENEFIT BILLING & PROCESSING ..... 229**

16.1 Overview ..... 229
16.2 New/Modified Code Values ..... 229
*16.2.1 Reject Codes ..... 229*
*16.2.2 New Basis Values ..... 229*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

16.3 PHARMACY BENEFIT BILLING – PRIMARY VACCINE CLAIMS ..... 230
*16.3.1 Question: When Billing a Vaccine Claim to a Pharmacy Benefit Using the NCPDP Telecommunication Standard©, What are the Responsibilities of the Pharmacy? ..... 230*
*16.3.2 Question: How Do I Determine the Submitted Value in the Usual & Customary Charge for Vaccine Product and Administration Claim Billing? ..... 231*
*16.3.3 Question: Should the Usual & Customary Charge on the Billing Request Resubmission Remain Unchanged? Alternatively, Should the Administration Fee be Removed? ..... 231*
*16.3.4 Question: What Actions are Expected of the Pharmacy in the Scenario in Which a Billing Request for a Vaccine Product and Administration was Rejected by the Pharmacy Benefit Processor to Indicate that the Product is Reimbursable and the Administration Fee is Not Reimbursable? ..... 231*
*16.3.5 Question: Should the Submitted "Date of Service" Reflect the Date of the Billing Request or the Date in Which the Vaccine is Administered? ..... 232*
*16.3.6 Question: Can NCPDP Provide Inbound Billing Request Examples (Header, Claim, DUR/PPS, and Pricing Segments) for the following three vaccine claim billing examples? ..... 232*
*16.3.7 Question: When Submitting a Prescription Billing Request for a Vaccine, What Value Should a Pharmacy Submit in the Days Supply? ..... 236*
*16.3.8 Question: Which NDC Should be Submitted in a Vaccine Billing Request when a Vaccine has an Outer Package NDC and an Inner Package NDC? ..... 236*
16.4 PHARMACY BENEFIT PROCESSING – PRIMARY CLAIMS ..... 236
*16.4.1 Question: When Processing a Vaccine Billing Request using the NCPDP Telecommunication Standard©, What are the Responsibilities of the Pharmacy Benefit Processor? ..... 236*
*16.4.2 Question: When Processing a Billing Request for a Vaccine, What Value is Received in the Days Supply? 239*
*16.4.3 Question: When Processing a Claim for a Vaccine Product and Administration, What is Meant by the Terms "Bundled Reimbursement" or "Separate Reimbursement"? ..... 239*
*16.4.4 Question: Can NCPDP Provide Response Examples (Claim, DUR/PPS, and Pricing Segments) for the Following Scenarios? ..... 239*
*16.4.5 Question: When Processing a Bundled Payment Claim, Can the Incentive Amount Paid be $0.00 or a Negative Dollar Amount? ..... 241*
*16.4.6 Question: When Processing a Pharmacy Billing Request for a Vaccine when the Pharmacy Benefit Processor Knows the Patient's Medical Benefit Covers the Vaccine Product, what Information is Returned by in the Claim? ..... 241*
*16.4.7 Question: Does the Telecommunication Standard© Support the Billing from a Single Provider the Vaccine Product and the Administration Via Separate Transaction Types? ..... 242*
16.5 COORDINATION OF BENEFIT CLAIMS PROCESSING ..... 242
*16.5.1 Question: What Value does the Pharmacy Assign to the Other Payer Amount Paid Qualifier (342-HC) to Report the Vaccine Administration Fee (Incentive Amount Paid) Paid by the Previous Payer? ..... 242*
*16.5.2 Question: Can NCPDP Provide Other Payer Amount Paid COB Claim examples (COB Method 1) for the Following Two Scenarios? ..... 242*
*16.5.3 Question: What Value Should the Pharmacy Benefit Processor Recognize in the Other Payer Amount Paid Qualifier (342-HC) when Processing a COB Billing Request for a Vaccine Product and Administration? ..249*
*16.5.4 Question: How should the PBM/processor respond to an NCPDP Telecommunication Standard Version D.0© Coordination of Benefits (COB) claim that contains the individual Other Payer-Patient Responsibility Amount (OPPRA) components and the aggregated patient pay amount? ..... 249*
16.6 USE OF SUBMISSION CLARIFICATION CODES AND COVID VACCINES ..... 252

**17 UNIVERSAL CLAIM FORM (UCF) ..... 254**

17.1 EXPANDED DOLLAR AMOUNTS ..... 254

**18 SAFE DISPOSAL OF MEDICATION ..... 255**

**19 APPENDIX A. MODIFICATIONS TO THIS DOCUMENT ..... 263**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

19.1 VERSION 2.0 ..... 263
19.2 VERSION 3.0 ..... 263
19.3 VERSION 4.0 ..... 263
19.4 VERSION 5.0 ..... 263
19.5 VERSION 6.0 ..... 263
19.6 VERSION 7.0 ..... 263
19.7 VERSION 8.0 ..... 264
19.8 VERSION 9.0 ..... 264
19.9 VERSION 10.0 ..... 265
19.10 VERSION 11.0 ..... 265
19.11 VERSION 12.0 ..... 266
19.12 VERSION 13.0 ..... 266
19.13 VERSION 14.0 ..... 267
19.14 VERSION 15.0 ..... 267
19.15 VERSION 16.0 ..... 268
19.16 VERSION 17.0 ..... 268
19.17 VERSION 18.0 ..... 269
19.18 VERSION 19.0 ..... 270
19.19 VERSION 20.0 ..... 271
19.20 VERSION 21.0 ..... 271
19.21 VERSION 22.0 ..... 271
19.22 VERSION 23.0 ..... 272
19.23 VERSION 24.0 ..... 272
19.24 VERSION 25.0 ..... 273
19.25 VERSION 26.0 ..... 273
19.26 VERSION 27.0 ..... 274
19.27 VERSION 28.0 ..... 274
19.28 VERSION 29.0 ..... 274
19.29 VERSION 30.0 ..... 274
19.30 VERSION 31.0 ..... 274
19.31 VERSION 32.0 ..... 275
19.32 VERSION 33.0 ..... 275
19.33 VERSION 34.0 ..... 275
19.34 VERSION 35.0 ..... 275
19.35 VERSION 36.0 ..... 275
19.36 VERSION 37.0 ..... 275
19.37 VERSION 38.0 ..... 275
19.38 VERSION 39.0 ..... 275
19.39 VERSION 40.0 ..... 276
19.40 VERSION 41.0 ..... 276
19.41 VERSION 42.0 ..... 276
19.42 VERSION 43.0 ..... 276
19.43 VERSION 44.0 ..... 276
19.44 VERSION 45.0 ..... 276
19.45 VERSION 46.0 ..... 277
19.46 VERSION 47.0 ..... 277
19.47 VERSION 48 ..... 277
19.48 VERSION 49 ..... 278
19.49 VERSION 50 ..... 278
19.50 VERSION 51 ..... 278
19.51 VERSION 52 ..... 278
19.52 VERSION 53 ..... 278


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

19.53 VERSION 54 ..... 279
19.54 VERSION 55 ..... 279
19.55 VERSION 56 ..... 279
19.56 VERSION 57 ..... 279
19.57 VERSION 58 ..... 279
19.58 VERSION 59 ..... 279
19.59 VERSION 60 ..... 280
19.60 VERSION 61 ..... 280
19.61 VERSION 62 ..... 280
19.62 VERSION 63 ..... 280
19.63 VERSION 64 ..... 280
19.64 VERSION 65 ..... 280
19.65 VERSION 66 ..... 280
19.66 VERSION 67 ..... 281
19.67 VERSION 68 ..... 281
19.68 VERSION 69 ..... 283
19.69 VERSION 70 ..... 286
19.70 VERSION 71 ..... 289
19.71 VERSION 72 ..... 290
19.72 VERSION 73 ..... 291
19.73 VERSION 74 ..... 291

**20 APPENDIX B. WHERE DO I FIND ..... 292**

20.1 ANSWERS MAY BE FOUND IN THE FOLLOWING DOCUMENTS ..... 292
20.2 ADDITIONAL INFORMATION MAY BE FOUND IN THE FOLLOWING DOCUMENTS ..... 292
20.3 PARTICULAR TOPICS MAY BE FOUND IN THE FOLLOWING DOCUMENTS ..... 292
*20.3.1 What Transactions Are Supported For What Business Purposes? ..... 292*
*20.3.2 What Fields Changed? ..... 292*
*20.3.3 Which Fields Are Allowed In Which Segments? ..... 292*
*20.3.4 Where Do The Segments Belong? ..... 292*
*20.3.5 What Are The Valid Responses For Each Transmission? ..... 293*
*20.3.6 Recommended Use Of Dollar Fields And Calculated Amounts? ..... 293*
*20.3.7 Explain The Syntax Rules For Version D ..... 293*
*20.3.8 Documentation Dates ..... 293*
*20.3.9 What If I Have A New Question? ..... 293*
*20.3.10 CMS Place of Service Codes? ..... 293*

**21 APPENDIX C. MEDICARE PART D AND MULTI-INGREDIENT COMPOUND PROCESSING ..... 294**

21.1 KEY TERMS USED IN GENERAL ASSUMPTIONS ..... 295
21.2 GENERAL ASSUMPTIONS ..... 295
21.3 PDE REPORTING ..... 298
21.4 COST SHARE CALCULATION FOR MULTI-INGREDIENT COMPOUND CLAIMS THAT STRADDLE THE COVERAGE GAP AND CATASTROPHIC PHASES ..... 298
21.5 EXAMPLE 1: MAPD PLAN COVERS THE PART D INGREDIENTS AND SOME OF THE NON-PART D INGREDIENTS OF THE COMPOUND ..... 299
*21.5.1 Example 2: PDP Alternate Basic Plan covers only the Part D ingredients of the compound ..... 301*
*21.5.2 Example 3a: MAPD Plan covers the Part D ingredients and one non-Part D ingredient (#3) in the compound ..... 303*
*21.5.3 Example 3b: MAPD Plan covers the Part D ingredients and one non-Part D ingredient (#4) in the compound ..... 305*
*21.5.4 Example 3c: MAPD Plan covers the Part D ingredients and both excluded non-Part D ingredients (#3 & #4) in the compound ..... 307*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

*21.5.5 Example 4: MAPD Plan covers the enhanced ingredients and OTC ingredients of the compound (no Part D drugs included) ....309*
*21.5.6 Example 5: MAPD Plan covers the OTC ingredients of the compound (no Part D drugs included) ...311*

**22 APPENDIX D. MEDICARE PART D TOPICS ....313**

22.1 HARDCODED VALUES....313
22.2 NOTICE OF APPEAL RIGHTS – REJECTED CLAIM....313
*22.2.1 Reject Code "569" and Submission Clarification Code....314*
22.3 NOTICE OF APPEAL RIGHTS – PAID CLAIM....315
22.4 NOTICE OF MEDICARE DRUG COVERAGE RIGHTS – REJECTED CLAIM....315
*22.4.1 Reject Code "569" and Submission Clarification Code 8 (Compound Processing) ....317*
22.5 NOTICE OF MEDICARE DRUG COVERAGE RIGHTS – PAID CLAIM....318
22.6 BENEFIT STAGE RULES AND EXAMPLES....318
*22.6.1 Benefit Stage Rules....318*
*22.6.2 Cost Share Parameters Used in Examples 1 thru 6....319*
*22.6.3 Cost Share Parameters Used in Examples 7 thru 9....327*
*22.6.4 Cost Share Parameters Used in Example 10....330*
*22.6.5 Cost Share Parameters Used in Examples 11....331*
*22.6.6 Cost Share Parameters Used in Examples 12....332*
*22.6.7 Cost Share Parameters Used in Examples 13....333*
22.7 BENEFIT STAGE QUALIFIER VALUES TO IDENTIFY CLAIMS COVERED UNDER THE NOT PART D PORTION OF THE MEDICARE D PLAN 337
22.8 BENEFIT STAGE IMPLEMENTATION FOR 01/01/2013....340
22.9 BENEFIT STAGE IMPLEMENTATION FOR 07/01/2013....342
22.10 BENEFIT STAGE IMPLEMENTATION FOR 10/01/2014....344
22.11 IMPACT ON DOWNSTREAM PAYER FOR ALTERNATIVE/FORMULARY....345
22.12 OTHER IMPACTS TO BENEFIT STAGE?....345
22.13 PART D SPONSOR TRANSITION NOTICE OR DENIAL LETTER?....346
22.14 BENEFIT STAGE REQUIRED FOR PART D?....346
*22.14.1 Can Non-Government Processor Require?....346*
*22.14.2 Medicare Part D Claim Without Benefit Stage Fields?....347*
22.15 COVERAGE GAP AND AMOUNT ATTRIBUTED TO COVERAGE GAP (137-UP)....348
22.16 NON-FORMULARY PENALTY AND COVERAGE GAP....348
22.17 VACCINE ADMINISTRATION....348
22.18 BIN AND PCN FROM RESPONSE TO REQUEST....349
22.19 CMS' DEFINITION OF PRIMARY INSURER'S PAYMENT....349
22.20 DUAL ELIGIBILITY....351
22.21 PART D SPONSORS APPLYING MEDICARE SECONDARY PAYER (MSP) REQUIREMENTS....352
22.22 PRESCRIBER IDENTIFICATION....353
*22.22.1 Foreign Prescriber Identifier....353*
*22.22.2 Valid Prescriber ID?....353*
*22.22.3 Processing with Prescriber ID....357*
*22.22.4 Prescriber ID and PDE Questions....360*
*22.22.5 Veterinarian Identifiers....361*
*22.22.6 State License Questions....362*
*22.22.7 Other Prescriber ID Questions....362*
*22.22.8 Deceased Prescribers and NPPES NPI Deactivation Schedule....363*
22.23 MEDICARE PART D/MEDICAID BENZODIAZEPINE AND BARBITURATE CLAIMS PROCESSING RISKS....363
22.24 OTHER CARRIER PAYMENT MEETS OR EXCEEDS PAYABLE....364
22.25 MILITARY TREATMENT FACILITIES – GOVERNMENT BILLING THE GOVERNMENT....370
22.26 ELIGIBILITY VERIFICATION....370
*22.26.1 Eligibility Medicare Part D to Facilitator – Request – Could not find this member....371*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

*22.26.2 Eligibility Medicare Part D to Facilitator – Request – Found Member But No Coverage ..... 372*
*22.26.3 Eligibility Medicare Part D to Facilitator – Request- Member Has Current Medicare Part D Coverage and No Other Coverage ..... 373*
*22.26.4 Eligibility Medicare Part D to Facilitator – Request – Member Has Current Medicare Part D Coverage (Primary) and Current Other Coverage ..... 374*
*22.26.5 Eligibility Medicare Part D to Facilitator – Request – Member Has Current Medicare Part D Coverage and No Other Coverage (Date of Service is Based upon Allowed Future Date Range) ..... 376*
22.27 Medicare Prescription Payment Plan Program Frequently Asked Questions ..... 378
22.28 Hepatitis B Vaccine Billing ..... 378
22.29 Medicare Part B vs Medicare Part D Vaccine Billing ..... 381

**23 APPENDIX E. ROUTE OF ADMINISTRATION QUESTIONS ..... 384**

23.1 Best Practices for Use of SNOMED CT Route of Administration Values ..... 384
23.2 Timing Considerations ..... 384
23.3 Route of Administration in the NCPDP Telecommunication Standard© ..... 385

**24 APPENDIX F. POINT OF SERVICE PRESCRIBER VALIDATION GUIDANCE APPLICABLE TO CMS 4159 AND IFC 6107 387**

24.1 Introduction ..... 387
24.2 Background: ..... 387
24.3 High Level Hierarchical Rules ..... 388
24.4 Prescriber Related Reject Codes ..... 388
24.5 Prescriber Related Submission Clarification Codes ..... 389
24.6 Prescriber Related Approved Message Codes 548-6F ..... 390
24.7 Medicare Part D Prescriber Validation Flow ..... 393
24.8 Medicare Part D Prescriber Validation Reject Matrix ..... 395
24.9 Medicaid Prescriber Validation Flow ..... 404
24.10 Medicaid Prescriber Validation Reject Matrix ..... 407

**25 APPENDIX G. SUPPORT OF THIS DOCUMENT ..... 413**


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 1 PURPOSE OF THIS DOCUMENT

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

As members reviewed the documents, questions arose which were not specifically addressed in the guides or could be clarified further. These questions were addressed in the Work Group 1 Telecommunication meetings.

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

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

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

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

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

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

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

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

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

### 1.1.1 SCHEDULED PRESCRIPTION ID NUMBER (454-EK)

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | |
|---|---|---|---|
| 454-EK | SCHEDULED PRESCRIPTION ID NUMBER | Q | Claim Billing/Encounter:<br>Required if necessary for state/federal/regulatory agency programs. |

Note that Telecom D.1 and above were also updated, with the inclusion of the Controlled Substance Reporting transaction specifications.

## 1.2 REPUBLICATION OF TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE VERSION D.0© AUGUST 2010

### 1.2.1 BENEFIT STAGE FORMULA

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

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

Telecommunication Implementation guide clarification:

Benefit Stage Amount (394-MW) –

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

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

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

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

### 1.2.2 DENOTE INDIVIDUAL AMOUNTS OF PATIENT FINANCIAL RESPONSIBILITY AS REPORTED FROM A PREVIOUS PAYER

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

For example, in an original claim ~~or service billing~~, the primary payer returns amounts in the Amount Attributed to Product Selection/Brand Drug (134-UK) and ~~Amount Attributed to Sales Tax (523-FN)~~ Amount


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

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

## 1.3 Quantity Prescribed (460-ET)

### 1.3.1 Quantity Prescribed (460-ET)

**CMS-0055-F: Administrative Simplification: Modification of the Requirements for the Use of Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Council for Prescription Drug Programs (NCPDP) D.0 Standard**

**SUMMARY:** The final rule published on January 24, 2020, adopts a modification of the requirements for the use of the Telecommunication Standard Implementation Guide, Version D, Release 0© (Version D.0), August 2007, National Council for Prescription Drug Programs, by requiring covered entities to use the Quantity Prescribed (460-ET) field for retail pharmacy transactions for Schedule II drugs. This change constitutes a modification to the *use* of the adopted standard, not a modification to the standard itself.

**EFFECTIVE DATE:** March 24, 2020

**COMPLIANCE DATE**: September 21, 2020

These dates indicate that covered entities can begin using the Quantity Prescribed field for Schedule II prescriptions as of March 24,2020, and all covered entities must require and submit this field for all Schedule II prescriptions as of September 21, 2020.

**CHANGE OF USE**:

- Quantity Prescribed (460-ET) must be treated as **required** when the transmission is for a Schedule II drug as defined in 21 CFR 1308.12.
- This modification is applicable for a claim or equivalent encounter, referral certification and authorization and coordination of benefits transactions.

The Final Rule is located at https://www.govinfo.gov/content/pkg/FR-2020-01-24/pdf/2020-00551.pdf
The CMS Information Bulletin is located at https://www.cms.gov/files/document/d0-final-rule-information-bulletin.pdf

## 1.4 Use Of This Document

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

### 1.4.1 How Soon Support This Document?

**Question:**

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

**Response:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

See *"Appendix G. Support of This Document".*

### 1.4.2 MEDICAID SUBROGATION EDITORIAL DOCUMENT

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

## 1.5 NCPDP IMPORTANT EXTERNAL CODE LIST© (ECL) INFORMATION

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

Please review the **NCPDP *Process Overview for External Code List©*** document at http://www.ncpdp.org/Members/Standards-Lookup - lower left side.

> This document provides the process to request additions, modifications, and deletions to the data element values existing in the External Code List© (ECL). It provides the rules governing the procedures and steps for this process and maintenance of the ECL as approved by the NCPDP Board of Trustees. In addition, this document outlines the Telecommunication ECL implementation time table used to facilitate consistency across the industry.
>
> This document contains an ECL Publication and Implementation Chart to provide key dates in which full ECL Publications and ECL Emergency Values should be implemented across all industry participants supporting the NCPDP Telecommunication Standard©.

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

## 1.6 NCPDP RECOMMENDATIONS FOR 4RX USAGE IN MEDICARE PART D PROCESSING DOCUMENTS

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

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

[1] Document is included in this packet of information.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

The intent of these provisions is to ensure that:

1. Pharmacies can routinely identify situations in which they are billing a Medicare Part D claim and
2. Payers supplemental to Medicare Part D can properly coordinate benefits on Part D claims.

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

The term "4Rx" refers to

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

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

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

## 1.7 NCPDP Emergency Preparedness Resource

The *NCPDP Emergency Preparedness Guidance* document provides guidance for the pharmacy industry for resources available during a declared emergency. The intended audience is healthcare industry providers who would need resource information for eligibility and claims processing affecting displaced individuals. It is available at https://ncpdp.org/Resources under Topic. Other guidance on patient demographic information during displacement is given. References to the Prior Authorization Number Submitted (462-EV) are available in the *NCPDP External Code List*©.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 2 EDITORIAL CORRECTIONS CITED IN TELECOM D.0

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

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

Field DUR Additional Text (570-NS) was inadvertently left off the Response DUR/PPS Segment in sections

- *"Response DUR/PPS Segment (Claim Billing or Encounter) (Transmission Accepted/Transaction Paid)"*
- *"Response DUR/PPS Segment (Claim Rebill) (Transmission Accepted/Transaction Paid)"*

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

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

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

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

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

Response Prior Authorization Segment inadvertently was listed in the table heading as Mandatory even though all other references were for a situational segment. The table heading has been changed in

- *Response Prior Authorization Segment (Claim Billing or Encounter) (Transmission Accepted/Transaction Rejected)*
- *Response Prior Authorization Segment (Service Billing) (Transmission Accepted/Transaction Rejected)*
- *Response Prior Authorization Segment (Claim Rebill) (Transmission Accepted/Transaction Rejected)*
- *Response Prior Authorization Segment (Service Rebill) (Transmission Accepted/Transaction Rejected)*

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

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

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 3 REQUEST SEGMENT DISCUSSION

## 3.1 CLAIM SEGMENT (07)

### 3.1.1 DAYS SUPPLY (405-D5)

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

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

**Question:**
Does the definition of Days Supply (405-D5) (Estimated number of days the prescription will last), represent a single dispensing of the prescription or the initial dispensing plus refills?

**Response:**
Within the Version D.0 Telecommunication Standard© Billing Transaction, Days Supply (405-D5) represents a single dispensing. Note, however, in the LTC environment, pre- or post-consumption billing may apply when a single claim billing transaction is used to bill for a consolidation of multiple dispensings over a given time period (e.g., 7 days x 4 weeks = 28 total days).

Added November 2021

**Question:**
How should the number of days a prescription fill will last be estimated in order to populate the Days Supply (405-D5) field?

**Response:**
The estimated days supply for a single prescription fill may be determined by dividing the quantity supplied by the number of units used per time period, expressed in days.
***Formula: Days supply = dispense quantity / (quantity/time).***

The following chart provides examples to illustrate this formula for calculating days supply.

**Examples:**

| Type of Product | Sig | Dispense Quantity | Number of Units Per Day | Calculation | Days Supply |
|---|---|---|---|---|---|
| Acute/Maintenance medication | 1 tablet per day | 30 tablets | 1 tab/1 day | 30 tabs / (1 tab / 1 day) = 30 DS | 30 |
| | 2 tablets per day | 30 tablets | 2 tabs/1 day | 30 tabs / (2 tab / 1 day) = 15 DS | 15 |
| | 1 tab every 7 days | 4 tablets | 1 tab/7 days | 4 tabs / (1 tablet / 7 days) = 28 DS | 28 |
| | 1-2 actuations every 6 hours (Not more than 8 | 200 actuations (in an 8.5 GM inhaler) | 8 actuations / 1 day | 200 actuations / (8 actuations/1 day) = 25 DS | 25 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Type of Product | Sig | Dispense Quantity | Number of Units Per Day | Calculation | Days Supply |
|---|---|---|---|---|---|
| | actuations per day) | | | | |
| | 40 mg every 14 days | 2 pens (40 mg per pen) | 1 pen/14 days | 2 pens / (1 pen / 14 days) = 28 DS | 28 |
| | 5 mL every 8 hours | 120 mL | 15mL/1 day | 120 mL / (15 mL / 1 day) = 8 DS | 8 |
| Recurring medication that has a long period between dosing or administering (such as once every 90 days, 180 days, etc.) that is dispensed as a single dose* | Inject 1 mL (150 mg) Intramuscularly and repeat in 90 days | 1 mL | 1 mL/ 90 days | 1 mL / (1 mL / 90 days) = 90 DS | 90 |
| | Take 4 tablets every 120 days | 4 tablets | 4 tabs/120 days | 4 tablets / (4 tablets / 120 days) = 120 DS | 120 |
| Medical Supply: Test Strips | Test 2 times a day | 50 test strips | 2 strips/1 day | 50 strips / (2 strips / 1 day) = 25 DS | 25 |

*Vaccines: the recommended days supply is one based on Sections 16.3.7 and 16.4.2 in this guide and industry standard practice.

**Exceptions:**
Examples of exceptions to the calculation of days supply as described above, include, but are not limited to, the following:

1. Products where day supply is based on payer requirements. For example, blood glucose meters.
2. Products where day supply is dependent upon surface area to which they are being applied. For example, creams/ointments.
3. Digital therapeutics where the dispensed item is the activation code, not the software application. The day supply may be derived from the Sig which provides instructions for frequency of use of the software application over a time period.
4. Eye or ear products as the day supply is dependent upon one or two eye(s) or ear(s), number of drops in package quantity and/or allowance for spillage.
5. Contraceptive tablets used continuously (e.g., Sig of take one tablet daily, do not take placebo) may need to have the quantity used in the days supply calculation formula adjusted.
   21 Day Supply = (28 dispense quantity – 7 placebo = 21 active tablets) / (1 tablet/1 day).

**Other Consideration:**
If the number resulting from the calculation is not a whole number, rounding rules should be at the discretion of the pharmacy and its system. Please note rounding up can result in a plan DUR rejection (e.g., exceeds maximum allowed per day) but rounding down could place the pharmacy at risk for an audit or the patient may not have enough medication for the number of days (partial fill on last day).

Added November 2021

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

**Question:**
XYZ Medicaid and a commercial plan have requested to begin utilizing DAW 9 for plan mandated brand medications. (This is in line with D.0 implementation.) The current option of DAW codes does not agree with


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

the reasoning for using a brand over the generic. Utilizing the DAW 9 will give pharmacies a way to differentiate these plan mandated brands for purposes of calculating their generic compliance rates in addition, it will allow pharmacies to receive proper pricing without having to get the brand name drug prior approved therefore the patient's and the pharmacies services will go uninterrupted.

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

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

| | |
|---|---|
| 9 | Other -This value is reserved and currently not in use. NCPDP does not recommend use of this value at the present time. Please contact NCPDP if you intend to use this value and document how it will be utilized by your organization. |

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

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

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

### 3.1.3 DAW CODES – USE OF VALUE 9 AND STATUS OF A

**Question – DAW 9 Use:**
When should DAW CODE (408-D8) value 9 - Substitution Allowed By Prescriber but Plan Requests Brand or Reference Product be accepted on claim billing requests? When should value 9 be rejected and which Reject Code (511-FB) value should be returned?

**Response:**
**DAW 9 is accepted when**:

DAW Code 9 is specifically used when the plan formulary requests the brand or reference product be dispensed, when the prescriber has not written the prescription as brand or reference product as medically necessary. Note, when the prescriber requests the brand/reference product, DAW Code 1 would be used. Plans requesting the multi-source brand/reference product should support the use of DAW Code 9 on these claims, as no other DAW Code value applies.

**DAW 9 is rejected when**:

As published under the DAW 9 value description, plans must reject claims submitted for the multi-source brand/reference product and DAW 9, when the submitted product is not a plan requested brand/reference product.

DAW 9 Description as of the 04/2024 ECL Publication:
Substitution Allowed By Prescriber but Plan Requests Brand or Reference Product

This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic or interchangeable biosimilar substitution is permitted, but the plan's formulary requests the brand or reference product. This situation can occur when the prescriber writes the prescription using either the brand, reference product, generic or interchangeable biosimilar name and the product is available from multiple sources. The use of DAW 9 for brand/reference products not requested or no longer required by the plan should result in a point of service rejection to indicate the brand/reference product is not required by the plan to allow for substitution where applicable.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

These claims should reject with the applicable reject code as noted below, allowing the pharmacy to dispense the product with the appropriate DAW as allowed by the prescriber, requested by the patient, or determined by the pharmacy.

| **Timeframe** | **Reject Code** |
|---|---|
| Current – 10/2026 | 22: M/I Dispense as Written (DAW)/Product Selection Code |
| 10/2026 – onward | DO9: Plan Does Not Request Brand or Reference Product |

Added 02/2024; Updated 05/2025

**Question – DAW 9 Multi-payer:**
Which DAW Code (408-D8) value should be used on multi-payer claims (same prescription processed by at least two payers) where at least one payer requests the brand product be dispensed with DAW 9 (Substitution Allowed By Prescriber but Plan Requests Brand or Reference Product), but the other payer does not request the Brand or Reference Product?

**Response:**
If the brand product must be dispensed due to payer coverage rules, DAW Code (408-D8) 9 should be submitted on each payer claim request transaction. As outlined in the above FAQ, when DAW 9 with the multi-source brand/reference product is submitted to a payer who is not requesting the multi-source brand/reference product, the claim should reject.
The following recommendations could be used by the COB payer to avoid patient access to care risks:

- Align to coverage provided by primary payer and bypass COB plan benefit restrictions (e.g., brand required) when the COB claim indicates the primary payer returned a paid response (e.g., contains either Other Payer Patient Responsibility Amount (352-NQ) and/or Other Payer Amount Paid (431-DV)).
- If the COB payer enforces their plan benefit restrictions and the COB claim indicates the primary payer returned a rejected response (e.g., contains Other Payer Reject Code (472-6E)), the COB payer should support the applicable Other Payer Reject Code values that indicate a conflict in plan benefits as the reason for the primary reject (e.g., 22- M/I Dispense as Written (DAW)/Product Selection Code, XXX - Plan Does Not Request Brand or Reference Product).

**Example:** Primary requires generic, COB requires brand drug and COB payer is Medicaid to which the patient cannot pay any more than the Medicaid copay
Approach that Creates Conflict:

| **Claim Submission Attempt** | **Pharmacy submission** | **Primary response** | **COB response** |
|---|---|---|---|
| 1 | Generic Product DAW 0 | Paid | Reject 606 (Brand Required) |
| 2 | Brand Product DAW 9 | Reject 22 (M/I DAW) | Reject 6E (M/I Other Payer Reject Code) |

The only option is for the patient to pay the primary Patient Pay Amount or pay the cash price, both creating risks for the patient and the pharmacy.
Recommended Approaches:

1. COB payer aligns to primary payer benefits, bypasses COB plan benefit restrictions on COB claim.

This approach eliminates the POS reject conflict and reduces the transaction attempts.

| **Claim Submission Attempt** | **Pharmacy submission** | **Primary response** | **COB response** |
|---|---|---|---|
| 1 | Generic Product DAW 0 | Paid | Paid (relaxed restrictions on COB claim) |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

2. COB payer enforces COB plan benefits, supports reject returned by primary payer.

This approach still results in a POS reject and requires a second transaction attempt by the pharmacy.

| Claim Submission Attempt | Pharmacy submission | Primary response | COB Request | COB response |
|---|---|---|---|---|
| 1 | Generic Product DAW 0 | Paid | | Reject 606 (Brand Required) |
| 2 | Brand Product DAW 9 | Reject 22: M/I Dispense as Written (DAW)/Product Selection Code, or Reject DO9 (Plan Does Not Request Brand or Reference Product) | Submit with Other Coverage Code (308-C8) = 3 *Other Coverage Billed – Claim Rejected* | Paid (plan recognizes reject code as acceptable) |

Added 02/2024; Updated 05/2025

**Question – DAW A use (limited time period):**
When should DAW CODE (408-D8) value A - Multi-payer Brand/Reference Product Formulary Conflict be accepted on claim billing requests? When should value A be rejected and which Reject Code (511-FB) value should be returned?

**Response:**
DAW CODE (408-D8) value A - Multi-payer Brand/Reference Product Formulary Conflict should not be used on claim billing requests.

DERF 1966 added DAW CODE (408-D8) value A - Multi-payer Brand/Reference Product Formulary Conflict to the April 2024 publication of the ECL. DAW value A is available within the April 2024 – April 2025 ECL publications and was incorporated into the October 2025 Annual ECL.

However, it has since been determined that the use of DAW A may create barriers, such as:

- Pharmacy systems ability to support multiple DAW codes for a single prescription fill,
- Payer systems determining payer coverage, reimbursement, and variation in reject codes when receiving the value of "A"
- COB payer systems not recognizing the reject codes or payment amount from the primary payer responding to DAW A.

As the benefits of DAW "A" do not outweigh the risks and complexities, DERF 2060/456 sunset the value of A as of July 2025. Payers should reject all claims where value A is submitted with Reject Code (511-FB) value 8K: DAW Code Value Not Supported or value 22: M/I DAW Code.

Added: 05/2025

### 3.1.4 INTERCHANGEABLE BIOSIMILAR PRODUCTS AND DAW

**Question**:
When claims are submitted for reference product or interchangeable biosimilars, which DAW code (408-D8) should be submitted? Refer to the FDA Article entitled "*FDA Approves First Interchangeable Biosimilar Insulin Product for Treatment of Diabetes*".

**Response:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

The below FDA Definitions of Biosimilar, Interchangeable Product (interchangeable biosimilar) and Reference Product indicate interchangeable biosimilars can be substituted for the reference biologic product. The Dispense As Written (DAW)/Product Selection Code (408-D8) field is used to indicate whether or not the prescriber's instructions regarding generic or interchangeable biosimilar substitution were followed.

- **Biosimilar Product**: A biosimilar product is a biological product that is highly similar to and has no clinically meaningful differences in terms of safety or effectiveness from an existing FDA-licensed (approved) reference product.
- **Interchangeable Product**: An interchangeable product is a biological product that meets the requirements for a biosimilar product and is approved based on information that is sufficient to show that it can be expected to produce the same clinical result as the reference product in any given patient; and for a biological product that is administered more than once to an individual, there is not a greater safety risk or risk of reduced efficacy from alternating or switching between use of the interchangeable product and its reference product. An interchangeable product can be substituted for the reference product without the intervention of the prescribing health care provider.
- **Reference Product**: A reference product is the single biological product, already licensed (approved) by FDA under section 351(a) of the Public Health Service Act, against which a proposed biosimilar or interchangeable product is compared. A reference product is approved based on, among other things, a full complement of safety and effectiveness data. A biosimilar or interchangeable product is licensed (approved) by FDA under section 351(k) of the Public Health Service Act. A proposed biosimilar or interchangeable product is compared to and evaluated against a reference product to ensure that the proposed product is highly similar to, and has no clinically meaningful differences from, its reference product.

DAW 1 is used when the prescriber indicates substitution for the product as written is not allowed. The DAW code may vary between 0 and 2-9, when the prescriber indicates substitution is allowed.

The following table provides examples of a reference product biosimilar with interchangeable biosimilars, the prescription's substitution allowed or not allowed instructions, the resulting dispensed product and DAW code submitted on the claim.

| Prescribed Drug | Substitution Allowed Substitution Not Allowed | Dispensed/Billed Drug | DAW Code (408-D8) |
|---|---|---|---|
| Reference Product | Allowed | Interchangeable Biosimilar | 0 |
| Reference Product | Not Allowed | Reference Product | 1 |
| Reference Product | Allowed | Reference Product | 2 - 9 |
| Interchangeable Biosimilar | Allowed | Interchangeable Biosimilar | 0 |
| Interchangeable Biosimilar | Not Allowed | Interchangeable Biosimilar | 1 |
| Interchangeable Biosimilar | Allowed | Reference Product | 2 - 9 |

Dispense As Written (DAW)/Product Selection Code (408-D8) value definitions may be found in the NCPDP External Code List©.

**Related DERF 001881** - Based on the usage of interchangeable biosimilars on claims submissions, the Dispense As Written (DAW)/Product Selection Code (408-D8) and value descriptions need to be updated to include "interchangeable biosimilar."


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Related DERF 001893/ECL 000368**- Request to update the definitions of the values for Dispense As Written (DAW)/Product Selection Code (408-D8) based on the usage of interchangeable biosimilars on claims submissions. Refer to DERF 001881 for the change to the definition of the field.

*Added May 2022*

## 3.1.5 OTHER COVERAGE CODE (308-C8)

### *3.1.5.1 SUBMITTING TO MULTIPLE PAYERS?*

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

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

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

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

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

### *3.1.5.2 NON-COB CLAIMS*

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

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

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

As per the Telecommunication Standard Implementation Guide©, a value of 1 (No Other Coverage) must not be used as a default value. The value of 1 may be used:

- On a claim to a payer who requires pharmacy providers to validate the presence of other coverage for every prescription filled. By sending a value of 1 the pharmacy is indicating they have exhausted all means of determining pharmacy benefit coverage and no other coverage is identified.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- On a claim when the payer denies with reject code 41 (Submit Bill to Other Processor or Primary Payer) and the payer provides no or insufficient other coverage information to the pharmacy and the pharmacy has exhausted all means of identifying the other coverage information necessary to bill another processor.

Added: March 2018

#### *3.1.5.3 GOVERNMENT COB?*

**Question:**

Can all of the Other Coverage Codes (308-C8) be used by the SPAP? Or should it be restricted to 0 – 4 as it is for the Medicaid payers using government COB processing? My company provides adjudication services for payers that wrap around patient responsibilities (e.g. payer of last resort, SPAPs, state funded programs). The programs are "government programs" in that they are made available through local, state and Federal funds. Currently, we use OCC 8, copayment only billing; we also require the COB segment of other payer information. The D.0 guidance is recommending use of OCC 2. My specific question was "what is the definition of "government programs"? And, given the above clarification, can we still mandate (and use) OCC 8 for COB billing?

**Response:**

The allowed Other Coverage Code (308-C8) values are specific to the COB method required by the payer. The payer sheet must indicate only one COB processing method and cannot request the provider to alter the COB method based on the previous payer's response. Once established in the Payer Sheet, it is not an option to change the COB processing method unless the current Payer Sheet is replaced.

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

The COB processing methods include:

1. Other Payer Amount Paid only
    - Other Coverage Code (308-C8) values of '2' (Other coverage exists-payment collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received) and '4' (Other coverage exists-payment not collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received)
2. Other Payer Patient Responsibility Amounts only
    - Other Coverage Code (308-C8) value of '8' (Claim is billing for patient financial responsibility only - Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection or network selection)
3. Other Payer Amount Paid and Other Payer Patient Responsibility Amount (Government COB - Full Disclosure)
    - Other Coverage Code (308-C8) values of '2' (Other coverage exists-payment collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received) and '4' (Other coverage exists-payment not collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received)
    - As outlined within the NCPDP v5.1 Editorial document sections 7.4 *PATIENT PAID AMOUNT SUBMITTED (433-DX)* and 20.9 *SCENARIO 1E REQUEST: PHARMACY BILLS SECONDARY INSURANCE AFTER PRIMARY PAID*, full disclosure COB can only be used when state or federal statute or regulation requires knowledge of full reimbursement by previous payer(s). The request for documentation of government regulation or policy for full disclosure is for the protection of the provider's obligation to not disclose contractual rates to others. It is not NCPDP's place to determine whether a regulation or policy language meets full disclosure, but


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

is instead a trading partner issue.

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

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

#### *3.1.5.4 HOW DOES A PLAN QUALIFY TO USE GOVERNMENT COB?*

**Question**:
How does a Plan qualify to use Government COB which requires full disclosure of reimbursement information from the previous payer(s)? Is there any special documentation required?
**Response**:
Government related plans do not automatically qualify to use Government COB. As indicated in Section 3.1.3.3, "full disclosure COB can only be used when state or federal statute or regulation requires knowledge of full reimbursement by previous payer(s)".

Some considerations for determining if Government COB will be allowed include the assessment of the funding source and existence of state/federal/regulatory authorization. Trading Partner Agreements may specify documentation requirements to support Government COB. Once the Government COB method has been confirmed, the use of a distinct payer sheet is necessary to identify the claim routing and the Government COB methodology.

Added May 2021

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

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

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

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

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

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

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

This was added to Telecommunication Standard Version E.0©.

### *3.1.5.6 OTHER COVERAGE CODE WHEN DRUG BENEFIT AMOUNT IS ZERO*

**Question:**

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

| Bill to Primary Submitting Tax Amounts | | | |
|---|---|---|---|
| **PRIMARY REQUEST Pricing Segment** | | Primary Pays 6% Tax and Flat Tax | PRIMARY - CLAIM & RESPONSE |
| 409-D9 | Ingredient Cost Submitted | $95.00 | |
| 412-DC | Dispensing Fee Submitted | $5.00 | |
| 482-GE | Percentage Tax Amount Submitted | $6.00 | |
| 483-HE | Percentage Sales Tax Rate Submitted | 6.00% | |
| 484-JE | Percentage Sales Tax Basis Submitted | 3 – IC + Fee | |
| 481-HA | Flat Sales Tax Amount Submitted | $0.20 | |
| 426-DQ | Usual and Customary Charge | $101.99 | |
| 430-DU | Gross Amount Due | $106.20 | |
| 423-DN | Basis of Cost Determination | 01 - AWP | |
| **PRIMARY RESPONSE Pricing Segment** | | Primary Pays 6% Tax and Flat Tax | |
| 512-FC | Amount Attributed to Periodic Deductible | $82.30 | |
| 523-FN | Amount Attributed to Sales Tax | $0.00 | |
| 505-F5 | Patient Pay Amount | $82.30 | |
| 509-F9 | Total Amount Paid | $5.14 | |
| 506-F6 | Ingredient Cost Paid | $79.80 | |
| 507-F7 | Dispensing Fee Paid | $2.50 | |
| 559-AX | Percent Sales Amount Paid | $4.94 | |
| 560-AY | Percent Sales Tax Rate Paid | 6.00% | |
| 561-AZ | Percent Sales Tax Basis Paid | 3 – IC + Fee | |
| 558-AW | Flat Sales Tax Amount Paid | $0.20 | |
| 574-2Y | Plan Sales Tax Amount | $5.14 | |
| 575-EQ | Patient Sales Tax Amount | $0.00 | |
| 522-FM | Basis of Reimbursement Determination | 8 – Contract Pricing | |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Bill to Secondary Submitting Tax Amounts | | | |
|---|---|---|---|
| **SECONDARY Claim Segment** | | Secondary is Tax Exempt | |
| 308-C8 | Other Coverage Code | ? | |
| **SECONDARY Pricing Segment** | | Secondary is Tax Exempt | |
| 409-D9 | Ingredient Cost Submitted | $95.00 | |
| 412-DC | Dispensing Fee Submitted | $5.00 | |
| 426-DQ | Usual and Customary Charge | $101.99 | |
| 430-DU | Gross Amount Due | $100.00 | |
| 423-DN | Basis of Cost Determination | 01 - AWP | |
| **SECONDARY COB Segment** | | Secondary is Tax Exempt | |
| 337-4C | Coordination Of Benefits/Other Payments Count | 1 | |
| 338-5C | Other Payer Coverage Type | 1 | |
| 339-6C | Other Payer Id Qualifier | 3 | |
| 340-7C | Other Payer Id | 123456 | |
| 443-E8 | Other Payer Date | 20090201 | |
| 341-HB | Other Payer Amt Paid Count | 2 | |
| 342-HC | Other Payer Amt Paid Qualifier | 7 | |
| 431-DV | Other Payer Amt Paid | $0.00 | |
| 342-HC | Other Payer Amt Paid Qualifier | 10 | |
| 431-DV | Other Payer Amt Paid | $5.14 | |
| **SECONDARY RESPONSE Pricing Segment** | | Secondary is Tax Exempt | |
| 518-FI | Amount of Copay | $1.00 | |
| 523-FN | Amount Attributed to Sales Tax | $0.00 | |
| 505-F5 | Patient Pay Amount | $1.00 | |
| 509-F9 | Total Amount Paid | $80.35 | |
| 506-F6 | Ingredient Cost Paid | $78.85 | |
| 507-F7 | Dispensing Fee Paid | $2.50 | |
| 566-J5 | Other Payer Amt Recognized | $0.00 | |
| 522-FM | Basis of Reimbursement Determination | 8 – Contract Pricing | |

SECONDARY - CLAIM & RESPONSE

**Response:**
Other Coverage Code (308-C8) value of "2" (Other coverage exists-payment collected) must be submitted. In the example above, even though drug benefit paid was 0 there were other amounts paid by the previous payer.

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

### 3.1.6 PRESCRIPTION ORIGIN CODE (419-DJ)

For reference, this is the definition and valid values of the field.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

419-DJ – Prescription Origin Code

| Definition of Field | Field Format |
|---|---|
| Code indicating the origin of the prescription. | 9(1) |

Values:

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

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

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

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

#### *3.1.6.1 IMPORTANT NOTE*

**Effective Date: June 6, 2012**

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

**Effective Date: October 15, 2013**

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

**Effective Date: April 1, 2015**

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

#### *3.1.6.2 TRANSFERS*

**Question:**

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

For example, if ABC Pharmacy dispenses a prescription that was coded with an origin of "Fax", and the Rx was subsequently transferred to a different pharmacy, would the new Rx transmitted at the new pharmacy code the Rx as "Fax" also, since this was the original designation?


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Response:**
As of January 1, 2012 all transfers of prescriptions between pharmacies including traditional transfers, intrachain transfers, and file-buys should use a Prescription Origin Code of 5 (Pharmacy - This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, intrachain transfers, file buys, software upgrades/migrations, and any reason necessary to "give it a new number." This value is also the appropriate value for “Pharmacy dispensing” when applicable such as BTC (behind the counter), Plan B, etc.). Use this value as soon as practical for the Prescription Origin Code when the prescription being billed has been transferred from another pharmacy, irrespective of the method used for such a transfer.

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

**Response:**
As of January 1, 2012 all transfers of prescriptions between pharmacies including traditional transfers, intrachain transfers, and file-buys should use a Prescription Origin Code of 5 (Pharmacy - This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, intrachain transfers, file buys, software upgrades/migrations, and any reason necessary to "give it a new number." This value is also the appropriate value for “Pharmacy dispensing” when applicable such as BTC (behind the counter), Plan B, etc.). Use this value as soon as practical for the Prescription Origin Code when the prescription being billed has been transferred from another pharmacy, irrespective of the method used for such a transfer.

#### *3.1.6.3 USE OF PRESCRIPTION ORIGIN CODE*

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

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

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

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

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

If a pharmacy phones the prescriber to clarify an order or must make a change if allowed by state and federal


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

law, the resulting origin by current recommendations is "2" telephone. Since telephone orders for C II's are not allowed, the pharmacy is transmitting information that is not a legal representation of the prescription order.

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

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

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

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

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

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

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

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

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

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

**Response:**
As we understand this it appears to be pharmacist protocol which should have a Prescription Origin Code of "5"


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Pharmacy and will remain a '5' throughout the life of the prescription number.

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

**Question:**

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

From the implementation guide:

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

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

**Response:**

This is correct. When billing for multiple ingredients, Claim Segment fields:

Product/Service ID (407-D7) – defaults to zero. (Zero means "0".) – **This means a single 0 is the only acceptable content.**
Product/Service ID Qualifier (436-E1) – defaults to "00" – T**his means two zeroes – 00 is the only acceptable content.**

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

| | | |
|---|---|---|
| 8G | Product/Service ID (407-D7) Must Be A Single Zero "0" For Compounds | 407-D7 |

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

Telecommunication Standard Version D.0© and above uses the Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) terminology for the Route of Administration (995-E2). NCPDP's External Code List© (ECL) entry for Route of Administration (995-E2) points to National Library of Medicine (NLM)'s Value Set Authority Center (VSAC) for the list of values and includes a link with download instructions, which can be found here. To ensure consistent values and processes across trading partners, NCPDP recommends using the downloadable list of codes published biannually by NLM.

Please see "*Appendix E. Route of Administration Questions*" for specific FAQs on Route of Administration (995-E2) and SNOMED CT values.

*Updated June 2026*

### 3.1.9 DATE OF SERVICE (401-D1)

**Question:**

It has become evident that some in the industry are interpreting the definition of the date the "prescription was dispensed" inconsistently. Based on reports and discussions, several parties are populating the date of service based on when they are actually submitting the billing transaction. One of the main issues seems to be on some COB claims where the primary and secondary claims have a different date of service. We are wondering if clarification can be added to the editorial guide. It seems that the date of service should either be


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

when the prescription is determined to be ready to be picked up, or when it's actually dispensed (initially in the case of LTC or partial fill situations). At a minimum, the date of service should not change between a primary and supplemental claim billings for the same fill and should not represent the date of billing. The example in the data dictionary© indicates that date of service is tied to the act of dispensing.

From the July 2007 Data Dictionary©:
Date of Service (401-D1) Identifies date the prescription was dispensed or professional service rendered or subsequent payer began coverage following Part A expiration in a long-term care setting only. Examples: If the prescription was dispensed on April 22, 2000, this field would reflect 20000422.

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

### 3.1.10 Unit of Measure (600-28) and Multi-Ingredient Compounds

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

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

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

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

### 3.1.11 Level of Service

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

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

### 3.1.12 Submission Clarification Code (SCC)

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

Added 12/2016


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### *3.1.12.1 SHORTENED DAYS SUPPLY SCC VALUES*

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

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

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

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

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

Added November 2019


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

#### *3.1.12.2 APPROVED MESSAGE CODE AND SHORTENED DAYS SUPPLY SCC*

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

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

Added November 2019

#### *3.1.12.3 PRESCRIBER DOES NOT CURRENTLY HAVE AN ACTIVE TYPE 1 NPI*

**Question:**
Does Submission Clarification Code (420-DK) value 49 – Prescriber does not currently have an active Type 1 NPI – imply that the prescriber's Medicare Part D or Medicaid prescriber enrollment status has been validated?

**Response:**
No, SCC value of 49 does not imply Medicare Part D or Medicaid prescriber enrollment has been validated. SCC value of 49 is used to indicate the prescriber does not have an Active Type 1 NPI.

> ***Sub-question 1****: Which SCC value is used to communicate the prescriber is enrolled with a specific Medicaid plan, when the payer/processor rejects the claim indicating the prescriber is not enrolled?*
>
> ***Sub-answer 1:*** *SCC 55 - Prescriber Enrollment in State Medicaid Program has been validated – is the appropriate SCC to use to communicate the prescriber is enrolled with the specific Medicaid plan, as may occur with rare data file timing issues. SCC 55 is not used as an emergency override for unenrolled prescribers.*
>
> ***Sub-question 2****: Which SCC value is used to communicate the prescriber is enrolled with the Medicare Part D program?*
>
> ***Sub-answer 2****: No SCC value is appropriate because there is currently no prescriber enrollment requirement for Medicare Part D. CMS Rule 4182-F replaced the Medicare Prescriber Enrollment requirement under CMS 4159 and IFC 6107 with the Medicare Precluded Provider requirement.*

Added May 2023

## 3.2 COMPOUND SEGMENT (10)

See section "*Multi-Ingredient Compound Processing*".

## 3.3 COORDINATION OF BENEFITS SEGMENT (05)

See section "*Coordination of Benefits Information*".

See section "*Pricing Segment Contains Values 'as if' the Claim was Primary*" for clarifying information.

**Question:**
Does the Other Payer Date (443-E8) have to match the Date of Service (401-D1)?

**Response:**
No, the Other Payer Date (443-E8) does not have to match the Date of Service (401-D1).


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

The definition of Other Payer Date (443-E8) is, "Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits."

The definition of Date of Service (401-D1) is, "Identifies date the prescription was filled or professional service rendered or subsequent payer began coverage following Part A expiration in a long-term care setting only." In the retail pharmacy setting, the Date of Service (401-D1) represents the date the prescription was filled or administered in the case of vaccines.

When additional coverage is known at the time the prescription is filled, the Other Payer Date (443-E8) will typically match the Date of Service (401-D1) as the COB claim will process immediately after the primary is billed. When additional coverage is identified after the prescription is picked up (or administered), the pharmacy protocol may require the reversal and resubmission of the original claim in order to process the COB claim.

For example, the claim was filled on 9/2/2025 and the COB coverage was identified on 9/4/2025. The two fields in the COB transaction would be populated as follows:

| | | |
|---|---|---|
| Date of Service | 401-D1 | 20250902 |
| Other Payer Date | 443-E8 | 20250904 |

The Other Payer Date (443-E8) is based on the last adjudication for this fill to the previous payer. Because this was billed to the primary payer again on 9/4/2025, the Other Payer Date (443-E8) is 9/4/2025, which is different from the Date of Service (401-D1).

*Added November 2025*

## 3.4 INSURANCE SEGMENT (04)

### 3.4.1 MEDICAID INDICATOR (360-2B)

**Question:**

Do I use the 2 digit alphabetic "State Code" or the numeric "NCPDP State Code" column for the values for the Medicaid Indicator field?

**Response:**

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

### 3.4.2 MEDICAID ID NUMBER (115-N5) AND CARDHOLDER ID (302-C2)

**Question:**

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

**Response:**

The first situation has been clarified in Telecom Imp Guide version D.7 and above:

> Required, if known, when patient has Medicaid coverage and Medicaid ID has not been provided in Cardholder ID (302-C2).
> *(The second situation does not change.)*

### 3.4.3 MEDIGAP ID (359-2A) USE


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

**Answer:**
Field 359-2A Medigap ID was added to the NCPDP Telecommunication Standard Version D.0© to enable pharmacy providers to communicate information regarding a Medicare Part B recipient's supplemental coverage as part of the pharmacy claim billing (B1) transaction. Medigap policies do not work with Medicare Parts C or D, therefore this field is basically limited to use for the submission of Part B drug claims.

Pharmacy claims for Part B DME drugs and supplies can be submitted to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) using the NCPDP Telecommunication Standard©. If the pharmacy is aware that the patient has Medicaid or other Medicare Supplemental (i.e. Medigap) coverage, the following fields should be populated when using the NCPDP D.0 transaction for billing the DME MAC to allow them to crossover bill the supplemental payer:

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

Field usage and examples:

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

## 3.5 PATIENT SEGMENT (01)

### 3.5.1 SPECIES

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

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

SNOMED Reference: Refer to the SNOMED CT® code list for the most current values. Date:10/15/2019

| Species | SNOMED | SCTID | Recommended Text |
|---|---|---|---|
| Birds | Class Aves | 387972009 | Bird |
| Cat | Felis catus | 448169003 | Cat |
| Chicken | Gallus gallus | 47290002 | Chicken |
| crabs | Infraorder Brachyura | 420975000 | Crab |
| Dog | Canis lupus subspecies familiaris | 448771007 | Dog |
| Ferrets | Mustela putorius subspecies furo | 449310008 | Ferret |
| Fish | Fish | 90580008 | Fish |
| Gerbils | Subfamily Gerbillinae | 384659000 | Gerbil |
| Goats | Capra hircus | 125097000 | Domestic Goat |
| Guinea Pigs | Cavia porcellus | 125076001 | Guinea Pig |
| Hamsters | Subfamily Cricetinae | 392390005 | Hamster |
| Horses | Equus caballus | 35354009 | Horse |
| Lizard | Lizard | 2773008 | Lizard |
| Mice | Mouse | 82968002 | Mouse |
| Monkeys | Order Primates | 388073004 | Primate |
| Pig | Sus scrofa | 78678003 | Pig |
| Rabbits | Rabbit | 88818001 | Rabbit |
| Rat | Rattus norvegicus | 371565004 | Rat |
| Sheep | Ovis aries | 125099002 | Sheep |
| Snakes | Suborder Serpentes | 107280007 | Snake |
| Spiders | Order Araneae | 420814007 | Spider |
| Toads/Frogs | Order Salientia | 107226004 | Toad or Frog |
| Turtles | Turtle | 87243000 | Turtle |
| Other | Kingdom Animalia | 387961004 | use the type of species |

Added November 2019

### 3.5.2 PATIENT GENDER

**Question**:

How should the Patient Gender Code (305-C5) value of Non-Binary be used in Telecommunication Standard© versions that do not yet support the Sex Assigned at Birth (F32-W8) field, when Patient Gender Code is used to support multiple business processes (e.g., eligibility verification, patient matching algorithms, formulary coverage rules, DUR patient safety checks, etc.) and also requires harmonization with other standards?

**Response:**

Telecommunication Standards© vD.0 and F6 supports the single field, Patient Gender Code (305-C5), to represent gender and sex assigned at birth code values. The value of Non-Binary was added to the ECL, with annual ECL implementation date of October 2020. The Sex Assigned at Birth (F32-W8) field was added to the NCPDP Telecommunication Standard vF7©. Until both the Patient Gender Code (305-C5) and Sex Assigned at Birth (F32-W8) fields are implemented, providers, payers and eligibility verification software vendors including EHRs need to be able to support the Male and Female values when internal records may have Patient Gender listed as Non-Binary and vice versa.

The below table outlines gender code value mapping options when gender code edits are in place. For example, if the payer's enrollment file has the member listed with a gender code of non-binary, then the claim adjudication process would support Patient Gender Code (305-C5) values of 0 – Not Specified, 1–Male, 2–


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Female, or 3–Non-Binary. Alternately, the pharmacy submitted value of 3-Non-Binary would be accepted if the payer file lists the patient gender as 1-Male, or 2-Female. A one to many solution will support the variations that can occur in the multitude of patient record keeping processes.

| Specific Entity's Patient/Member Record Patient Gender Code (305-C5) Value | Acceptable Patient Gender Code (305-C5) Values |
|---|---|
| 0 – Not Specified | 0 – Not Specified*<br>1 – Male<br>2 – Female<br>3 – Non-Binary |
| 1 – Male | 1 – Male<br>3 – Non-Binary |
| 2 – Female | 2 – Female<br>3 – Non-Binary |
| 3 – Non-Binary | 0 – Not Specified*<br>1 – Male<br>2 – Female<br>3 – Non-Binary |

* Acceptance of Not Specified is based on trading partner agreement.

**Note**: DUR edits may require greater specificity when the Non-Binary value is used. This can be accomplished using POS DUR edits and the associated override codes. Refer to Section 14.3 in this document for additional information.

Added August 2022

# 3.6 PRICING SEGMENT (11)

## 3.6.1 340B PROCESSING

**Question:**

How do I designate 340B claims?

**Response:**

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

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

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

**03/2013 Editorial Note:**

Basis of Cost Determination (423-DN) value "08" definition prior to October 2011:

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

After October 2011:

340B /Disproportionate Share Pricing/Public Health Service - Price available under Section 340B of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 340B (a)(10)


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

and those made through the Prime Vendor Program (Section 340B(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation.

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

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

After October 2011:

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

**Question:**

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

**Response:**

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

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

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

By definition, the Basis of Cost Determination field describes the Ingredient Cost Submitted in the pricing segment of the claim. Therefore, utilization of the Basis of Cost Determination value 08 requires submission of the 340B price in the Ingredient Cost Submitted field.

In general, the Submission Clarification Code (Field 420-DK) value of 20 would be submitted on the point of service real time claim when required by trading partner agreement to indicate whether the claim submitted is for a drug within the provider's physical inventory that was purchased pursuant to rights under the 340B Drug Pricing Program. This code, which is independent of claim pricing, can also be used within the post-dispensing Information Reporting transaction to convey the drug dispensed was purchased through the 340B Drug Pricing Program. However, implementation of NCPDP's methods, particularly the retrospective method via the


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Information Reporting transaction has not been widely adopted for a variety of reasons. Some of these reasons include the prohibitive development cost for lack of scalability, state budget constraints to updating MMIS processes, Medicaid Drug Rebate Program invoicing timing does not align with retrospective/virtual inventory processes, inconsistent usage of NCPDP standards by applicable stakeholders, and the storage of necessary data across disparate systems. NCPDP has called upon HRSA to encourage all stakeholders to work with NCPDP and its proven process to continuously improve our framework.

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

### 3.6.2 PRICING SEGMENT CONTAINS VALUES 'AS IF' THE CLAIM WAS PRIMARY

Section "*Clarification of Net Amount Due in Coordination of Benefits*" of this document states:

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

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

### 3.6.3 BILLING TRANSACTION FOR FREE FILLS

**Question:**

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

**Response:**

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

Example Scenarios:

- Usual and Customary (426-DQ) = $0
  - Pharmacy initiated free product program and elected to charge $0 as their usual and customary price for the specific product and dispensed quantity.
  - Other fees may apply based on contractual agreements
- Gross Amount Due (430-DU) = $0
  - Pharmacy price matched or applied special patient pricing, where their usual and customary price is not $0
  - Basis of Cost Determination (423-DN) should be submitted as 13 – Special Patient Pricing
- Ingredient Cost (409-D9) = $0
  - Pharmacy is dispensing free product, where their usual and customary price is not $0
  - Other fees may apply based on contractual agreements

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 3.7 FACILITY SEGMENT (14)

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

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

## 3.8 PRESCRIBER SEGMENT (03)

**Question:**
What should be submitted on a Version D.0 claim to indicate the claim is not associated with a patient specific prescription/standing order (i.e., there is no prescriber)? What should be submitted on a Version F6 claim?

**Response:**
To support recent regulatory changes that support coverage for products without a prescription, updates were made to the External Code List© (ECL) to distinctly identify a claim is not associated with a patient specific prescription/standing order. The ECL changes were effective in the October 2025 Annual ECL implementation.

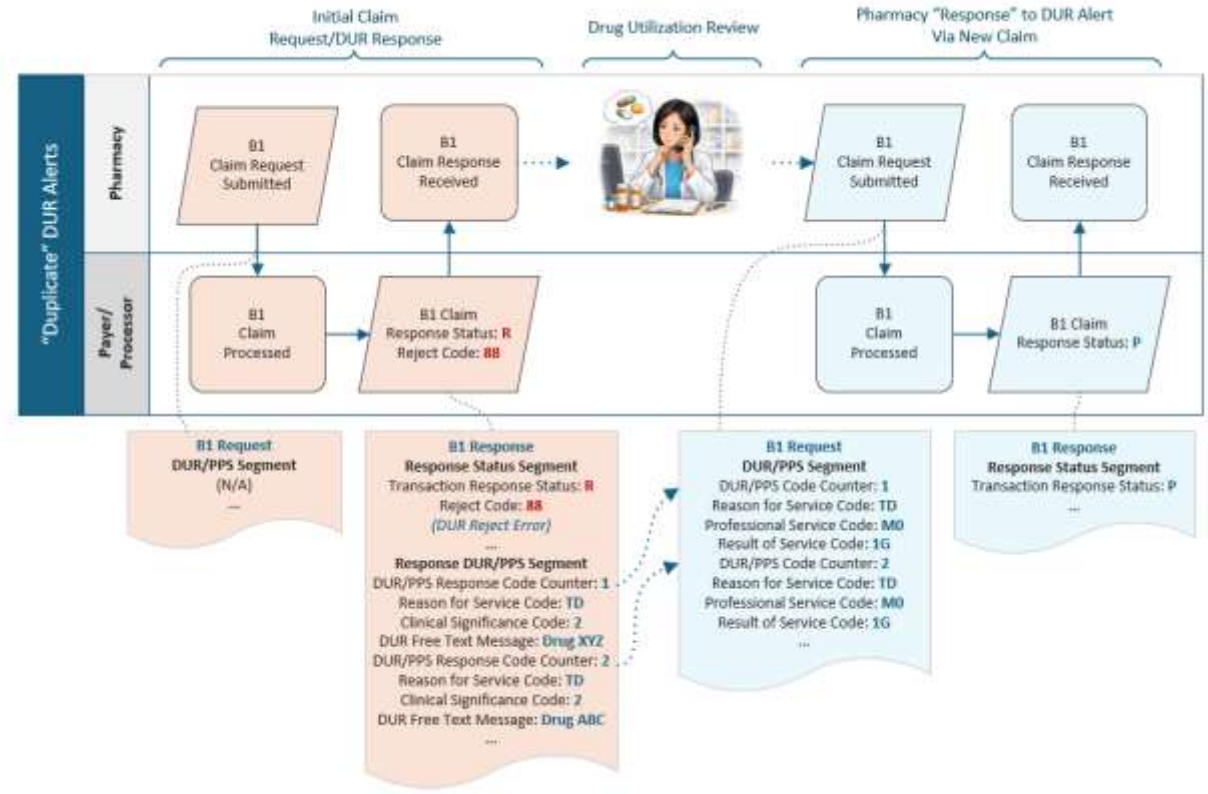
- As of October 2025:
    - Prescriber ID Qualifier (466-EZ) value 18 (No Prescriber ID, No Prescription Associated to the transaction.) will be available for use within Version D.0 and Version F6 transactions (if applicable).
    - Prescriber ID (411-DB) = 0 (as directed by the Prescriber ID Qualifier (466-EZ) value 18 limitation).
    - Prescription Origin Code (419-DJ) value 6 (No Associated Prescription) will be available for use within Version D.0 and Version F6 transactions (if applicable).
    - When the above values are submitted and the payer determines a prescription is required, the claim should reject with new Reject Code (511-FB) DO6 - Prescription Required. Claim without an associated prescription is not covered.

Replaced – June 2026

## 3.9 DUR/PPS SEGMENT (08)

**Question:**
Does the NCPDP *Telecommunication Standard©* support transmitting two occurrences within the DUR/PPS Segment in a B1 Claim Request with the same Reason for Service Code (439-E4), Professional Service Code (440-E5) and Result of Service Code (441-E6)? For example, there are instances when a Payer/Processor will return multiple occurrences within the Response DUR/PPS Segment of the Claim Response with the same Reason for Service Code, expecting the pharmacy to respond to each independently. This would result in the pharmacy needing to submit a new B1 Claim Request with two or more occurrences in the DUR/PPS Segment with identical Reason for Service Code, Professional Service Code and Result of Service Code values (see example below).


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use




**Response**:
Yes. The NCPDP *Telecommunication Standard©* does support transmitting multiple occurrences within the DUR Segment within a single B1 Claim Request—even when those occurrences contain the same Reason for Service Code (e.g., *TD – Therapeutic Duplication*), Professional Service Code and Result of Service Code.

The Standard does not prohibit sending two or more occurrences within the DUR/PPS Segment with identical Reason for Service Code, Professional Service Code and Result of Service Code values when a processor or payer has generated multiple DUR alerts that require individual responses. In such cases, each DUR alert represents a distinct interaction that the pharmacy must address, even if the interaction types are the same.

Pharmacy systems should allow multiple occurrences within the DUR/PPS Segment to be transmitted and should not automatically suppress an occurrence simply because it appears duplicative. Removing an occurrence may prevent the payer/processor from recognizing that all required DUR alerts have been addressed, resulting in continued claim rejection.

When multiple DUR alerts are returned, the pharmacy should respond to them in the same order in which they were received.

Payers and processors are encouraged to review the *Telecommunication Implementation Guide©* section titled "*The Problem of Noise*" and should consolidate alerting where appropriate. Duplicate alerts for the same interaction within a member's claim history should be avoided to reduce unnecessary burden on pharmacies and prevent redundant DUR responses.

*Added June 2026*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 4 RESPONSE SEGMENT DISCUSSION

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

See section "*Coordination of Benefits Information*".

## 4.2 RESPONSE PATIENT SEGMENT (29)

**Question:**

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

> **28.2.2 RESPONSE PATIENT SEGMENT**
> This segment is used for Medicare Part D Eligibility transactions to provide patient name and date of birth in order to provide additional patient information. This information could assist in the verification that the eligibility information returned is indeed the patient for which the eligibility request was intended.
> **This segment is returned only when the patient has had Medicare Part D eligibility at some point within the Facilitator's files and within the search parameters established. The data returned is based on information within the Facilitator's files and not on information sent on the Eligibility Request.**
> Patient First Name (310-CA) – will contain the first name of the patient as known on the Facilitator's files.

**Response:**

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

Rewritten:

### 28.2.2 RESPONSE PATIENT SEGMENT

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

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

**For Medicare Part D eligibility transactions:**

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

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

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

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

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

## 4.3 RESPONSE PRICING SEGMENT (23)

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

**Question:**

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

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

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

Examples:
**BILLING - TRANSACTION CODE B1**

| TRANSACTION HEADER SEGMENT | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 101-A1 | BIN NUMBER | *610066* | |
| 102-A2 | VERSION/RELEASE NUMBER | *D0* | D.0 Transaction Format |
| 103-A3 | TRANSACTION CODE | *B1* | Rx billing |
| 104-A4 | PROCESSOR CONTROL NUMBER | *1234567890* | |
| 109-A9 | TRANSACTION COUNT | *1* | One occurrence |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | *01* | National Provider Identifier (NPI) |
| 201-B1 | SERVICE PROVIDER ID | *1112223330bbbbb* | *Store A* |
| 401-D1 | DATE OF SERVICE | *20100122* | January 22, 2010 |
| 110-AK | SOFTWARE VENDOR/CERTIFICATION ID | *98765bbbbb* | |

| PATIENT SEGMENT | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 111-AM | SEGMENT IDENTIFICATION | *01* | PATIENT SEGMENT |
| 304-C4 | DATE OF BIRTH | *19620615* | Born June 15, 1962 |
| 305-C5 | PATIENT GENDER CODE | *1* | Male |
| 310-CA | PATIENT FIRST NAME | *MICKEY* | Mickey is patient's first name |
| 311-CB | PATIENT LAST NAME | *MOUSE* | Mouse is patient's last name |

| INSURANCE SEGMENT | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 111-AM | SEGMENT IDENTIFICATION | *04* | INSURANCE SEGMENT |
| 302-C2 | CARDHOLDER ID | *987654321* | Cardholder Id |

| CLAIM SEGMENT | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 111-AM | SEGMENT IDENTIFICATION | *07* | CLAIM SEGMENT |
| 455-EM | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER | *1* | Rx billing |
| 402-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER | *123456789128* | |
| 436-E1 | PRODUCT/SERVICE ID QUALIFIER | *03* | NDC |
| 407-D7 | PRODUCT/SERVICE ID | *00006094228* | Clinoril 200mg |
| 442-E7 | QUANTITY DISPENSED | *30000* | 30.000 tablets |
| 403-D3 | FILL NUMBER | *0* | Original dispensing for RX# |
| 405-D5 | DAYS SUPPLY | *30* | 30 Days supply |
| 406-D6 | COMPOUND CODE | *1* | Not a compound – required D.0 |
| 408-D8 | DISPENSE AS WRITTEN | *0* | Required D.0 – No Product Selection Indicated |
| 414-DE | DATE PRESCRIPTION WRITTEN | *20100122* | January 22, 2010 |

| PRESCRIBER SEGMENT | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 111-AM | SEGMENT IDENTIFICATION | *03* | PRESCRIBER SEGMENT |
| 466-EZ | PRESCRIBER ID QUALIFIER | *01* | National Provider Identifier (NPI) |
| 411-DB | PRESCRIBER ID | *5556667772* | |

| PRICING SEGMENT | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 111-AM | SEGMENT IDENTIFICATION | *11* | PRICING SEGMENT |
| 409-D9 | INGREDIENT COST SUBMITTED | 657{ | $65.70 |
| 412-DC | DISPENSING FEE SUBMITTED | 30{ | $3.00 |
| 426-DQ | USUAL AND CUSTOMARY CHARGE | 707{ | $70.70 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | |
|---|---|---|---|
| 430-DU | GROSS AMOUNT DUE | 687{ | $68.70 |
| 423-DN | BASIS OF COST DETERMINATION | 1 | AWP |

**BILLING ACCEPTED RESPONSE— PAID**

| RESPONSE HEADER SEGMENT | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 102-A2 | VERSION/RELEASE NUMBER | *D0* | D.0 Transaction Format |
| 103-A3 | TRANSACTION CODE | *B1* | Rx Billing |
| 109-A9 | TRANSACTION COUNT | *1* | One occurrence |
| 501-F1 | HEADER RESPONSE STATUS | *A* | Accepted |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | *01* | National Provider Identifier (NPI) |
| 201-B1 | SERVICE PROVIDER ID | *1112223330bbbbb* | *Store A* |
| 401-D1 | DATE OF SERVICE | *20100122* | January 22, 2010 |

| RESPONSE STATUS SEGMENT | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 111-AM | SEGMENT IDENTIFICATION | *21* | RESPONSE STATUS SEGMENT |
| 112-AN | TRANSACTION RESPONSE STATUS | *P* | Paid |
| 503-F3 | AUTHORIZATION NUMBER | *ABC12345* | |

| RESPONSE CLAIM SEGMENT | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 111-AM | SEGMENT IDENTIFICATION | *22* | CLAIM SEGMENT |
| 455-EM | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER | *1* | Rx Billing |
| 402-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER | *123456789128* | |

| RESPONSE PRICING SEGMENT | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 111-AM | SEGMENT IDENTIFICATION | *23* | RESPONSE PRICING SEGMENT |
| 505-F5 | PATIENT PAY AMOUNT | *697{* | $69.70 |
| 506-F6 | INGREDIENT COST PAID | *657{* | $65.70 |
| 507-F7 | DISPENSING FEE PAID | *30{* | $3.00 |
| 509-F9 | TOTAL AMOUNT PAID | *10}* | $1.00- |
| 522-FM | BASIS OF REIMBURSEMENT DETERMINATION | *1* | Ingredient cost paid as submitted |
| 518-FI | AMOUNT ATTRIBUTED TO COPAY | *687{* | $68.70 |
| 571-NZ | AMOUNT ATTRIBUTED TO PROCESSOR FEE | *10{* | $1.00 |

Here is another example where a one-time membership fee of $30 was assessed in addition to a $1 processor fee.

| RESPONSE PRICING SEGMENT | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 111-AM | SEGMENT IDENTIFICATION | *23* | RESPONSE PRICING SEGMENT |
| 505-F5 | PATIENT PAY AMOUNT | *997{* | $99.70 |
| 506-F6 | INGREDIENT COST PAID | *657{* | $65.70 |
| 507-F7 | DISPENSING FEE PAID | *30{* | $3.00 |
| 509-F9 | TOTAL AMOUNT PAID | *310}* | $31.00- |
| 522-FM | BASIS OF REIMBURSEMENT DETERMINATION | *1* | Ingredient cost paid as submitted |
| 518-FI | AMOUNT ATTRIBUTED TO COPAY | *68.7{* | $68.70 |
| 571-NZ | AMOUNT ATTRIBUTED TO PROCESSOR FEE | *310{* | $31.00 |

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

**Question:**

How should the Basis of Reimbursement Determination (522-FM) value be populated?

**Response:**

The Basis of Reimbursement Determination (522-FM) should be populated by assigning the value that most accurately reflects the reimbursement methodology used to determine the pricing for the prescription claim. See examples below:

- Reimbursement based on AWP minus a percentage
    - The Basis of Reimbursement Determination (522-FM) value would be 3 (Ingredient Cost Reduced to AWP Less X% Pricing)
- Reimbursement based on a processor's Maximum Allowable Cost (MAC)


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

  - The Basis of Reimbursement Determination (522-FM) value would be 7 (MAC Pricing Ingredient Cost Reduced to MAC)
- Reimbursement at a mutually agreed upon price between trading partners where reimbursement is not based on any currently available Basis of Reimbursement Determination (522-FM) value
  - The Basis of Reimbursement Determination (522-FM) value would be 8 (Contract Pricing)

*Added November 2025*

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

**Response:**
For D.0, if "Direct" pricing is to be returned, for Basis of Reimbursement Determination, a value of 8 (Contract Pricing) could be used if the other more specific values do not apply. A DERF for version D.0 will be submitted to add a value for "Direct" in the Basis of Reimbursement Determination. If approved, if the External Code List© dated after this value is added is used, the new value for "Direct" would be used.

#### *4.3.2.1 ADJUST THE INGREDIENT COST PAID AND DISPENSING FEE PAID?*

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

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

### 4.3.3 BENEFIT STAGE

See section "*Appendix D. Medicare Part D Topics*", subsection "*Benefit Stage Rules and Examples*".

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

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

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

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

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

**Question:**
(Payer) has the ability to apply FSA amounts (where/when applicable) to reduce patient's responsibility from an adjudicated claim real time and without a separate transaction (i.e. secondary and separate debit card transaction). It appears that none of the dollar fields currently support including those dollar amounts. As such,


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

if (Payer) were to apply the FSA dollars to reduce the patient responsibility at POS then the patient pay formula will not balance out. Can Health Plan-Funded Assistance Amount (129-UD) be used?

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

### 4.3.5 TOTAL AMOUNT PAID (509-F9) NEGATIVE?

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

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

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

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

- Cash Discount programs are not insurance and may not be properly coordinated by payers as other insurance. CMS does not consider discount plans as other coverage. From D.0 Implementation Guide section 28.2.6.4.1.1 Example 1 Brand Selection:
  - "When the Amount Attributed to Processor Fee (571-NZ) is greater than zero resulting in a negative payment to the provider, the claim is reversed and billed to the next payer as Primary using the appropriate Other Coverage Code (308-C8) value."
- In order to clearly identify a cash discount claim so coordination does not occur with other insurance, it is recommended that processors return 'ZR5' in the Payer ID (569-J8) and a Payer ID Qualifier (568-J7) value of "99" - Other. The Payer ID of ZR5 should be returned on all Cash Discount claim responses, regardless of the Total Amount Paid value.
  - *The value of ZR5 was derived from the new field Adjudicated Payment Type (A28-ZR) available with NCPDP Telecommunication Standard vD.3©.*
    - *ZR = field ID*
    - *Value of 5 = Cash Discount*
  - Claims submitted with the Medicare D BIN/PCN and paid under the cash discount/negotiated price program will be further identified with one of the following Benefit Stage Qualifiers
    - 70 = Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing
    - 80 = Non-Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing.

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

**Transaction Click Fees**
**Question:**
Looking for clarification on how to process a COB Scenario 1(OPAP) claim when the previous payer is charging "click fees" on 100% Patient Pay claims, resulting in a negative Total Amount Paid (509-59). We are seeing several Third Parties are rejecting when we send a negative in the Other Payer Amount Paid field


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

(431-DV). They cover the drug, the only reason they are rejecting is due to the negative amount being sent in OPAP field (431-DV).

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

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

- The transaction fee would appear as a negative Total Amount Paid (509-F9) value only in the situation where the fee is passed onto the patient and patient liability is 100%.
    - In this situation, the processor would return the fee in the Amount Attributed to Processor Fee field (571-NZ) and balance Total Amount Paid (509-F9) accordingly.
- If the transaction fee is passed onto the provider, and returned on the B1 claim response, the response must balance and financials identified appropriately.
- To promote consistency and mitigate COB claims processing issues, it is recommended that processors not return the click fee in the Total Amount Paid but to use the PLB segment in the 835 to report click fees. (Added Version 20)
    - To promote consistency and mitigate COB claims processing issues, it is recommended that processors use the PLB segment in the 835 to report click fees.
    - If trading partner agreement allows for click fee to be returned on the response, a negative Other Payer Amount Paid value may result in the member not being able to have coordinated benefits.
    - Supplemental payers should accept a negative Other Payer Amount Paid and process accordingly. Please recognize the COB claim may be processed using their primary claim processing logic which may result in the pharmacy not being reimbursed for the click fee. (Added Version 20)
    - If multiple payers have been billed and none have returned Total Amount Paid (509-F9) > 0 and at least one has returned Total Amount Paid <=0, Other Coverage Code will be 4 regardless of any additional payer rejections. (Added Version 20)
    - If multiple payers have been billed and at least one has returned Total Amount Paid (509-F9) > 0 and at least one has returned Total Amount Paid <=0, then Other Coverage Code will be 2 regardless of additional payer responses. (Added Version 20)

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

(Added Version 20)

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

## 4.3.6 RESPONSE PROCESSING GUIDELINES


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

**26.2.4 Patient Financial Responsibility (Claim)**

Patient Pay Amount (505-F5) must always be returned as well as any non-zero component fields. Return of zero value component fields is situational as defined in the implementation guide.

*In the examples, zero suppression has been applied. In other examples, the zero value fields may be included when necessary for clarification of the calculation.*

Section *"Response Pricing Segment", "Patient Pay Amount (505-F5) Formula"* has also been clarified.

Patient Pay Amount (505-F5) must always be returned as well as any non-zero component fields. When the patient pay amount is 100%, the response must contain Patient Pay Amount (505-F5) plus any of the ~~applicable~~ non-zero component Patient Responsibility fields included in this amount. Otherwise, return of zero value component fields is situational as defined in the implementation guide.

And

*(Note, the fields are not shown in the actual signed format. Total Amount Paid (509-F9) and Patient Pay Amount (505-F5) are required. Other component fields containing zero amounts are situational as defined in the implementation guide.)*

And in Example #2, Patient Pay Amount should be 20.00 instead of 49.88.

### 4.3.7 NEGATIVE PATIENT PAY VALUES

**Background:**

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

For example:

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

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

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

**Question:**

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

**Response:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

### 4.3.8 BRAND MEDICALLY NECESSARY

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

**Response:**
Plan benefit designs, while they allow a Dispense As Written (DAW)/Product Selection Code (408-D8) value of "1" (Substitution Not Allowed by Prescriber), may still pass on the cost difference between the brand and generic to the patient. This cost differential would be represented in the appropriate field:

- Amount Attributed to Product Selection/Brand Drug (134-UK), or
- Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) or
- Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN).

This allows the pharmacy to dispense the prescription as written per regulatory agency requirements.

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

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

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

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

## 4.4 RESPONSE STATUS SEGMENT (21)

### 4.4.1 ADDITIONAL MESSAGE INFORMATION

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

I have questions regarding the new free text message approach in Version D.0. Basically, I'm curious about the use of the qualifier in field 132-UH, Additional Message Information Qualifier. Based on the qualifier definitions that I found, each value represents "the XXX line of free form text with no pre-defined structure" where XXX is first, second, third, etc. The data dictionary© states that each value can only occur once per transaction and must be ordered sequentially. The Implementation Guide states that there is a maximum of nine occurrences within a transaction. I guess my concern is with the interpretation of "line" within the context of the message. The reason I'm asking questions is because we had a couple different developers read the NCPDP information


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

and they both came up with different interpretations. My concern now is that some processors may interpret the "line" concept of the qualifier differently without more guidance.

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

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

If a processor wanted to return two statements that were longer than the 40 characters provided by a single message field with the intended "readable" output to be displayed as:

Mary had a little Lamb, whose fleece was white as snow. And everywhere that Mary went, the lamb was sure to go.

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

**Option A -**
I'm wondering if the processor might properly return a response with the following sequence of fields?
**NCPDP: Option A is incorrect.**

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | |
|---|---|---|---|
| 131-UG | ADDITIONAL MESSAGE INFORMATION CONTINUITY | *Space* | (Optional denotes end of sentence) |

**NCPDP: Option A is incorrect.**

This potential implementation fails to consistently follow two situational requirements defined in the Implementation Guide for each repetition:

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

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

**Option B -**

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

**NCPDP: Option B is incorrect.**

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


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | |
|---|---|---|---|
| 131-UG | ADDITIONAL MESSAGE INFORMATION CONTINUITY | *Space* | (Optional denotes end of sentence) |

**NCPDP: Option B is incorrect.**

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

**Option C -**

From my understanding of the standard, I would actually expect a different response. Is this correct?

**NCPDP: Option C is correct.**

| **RESPONSE STATUS SEGMENT - CORRECT** | | | |
|---|---|---|---|
| **Field** | **Field Name** | **Value** | **Comments** |
| 111-AM | SEGMENT IDENTIFICATION | *21* | RESPONSE STATUS SEGMENT |
| …… | *Other fields* | | |
| 130-UF | ADDITIONAL MESSAGE INFORMATION COUNT | *6* | (Number of 526-FQ fields that are returned) |
| 132- UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER | *"01"* | (Line 1)<br>Used for first line of free form text with no pre-defined structure. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | *MARY HAD A LITTLE LAMB,* | Up to 40 Bytes |
| 131-UG | ADDITIONAL MESSAGE INFORMATION CONTINUITY | *+* | Continuation character |
| 132- UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER | *02* | Used for second line of free form text with no pre-defined structure. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | *WHOSE FLEECE WAS WHITE AS SNOW.* | Up to 40 Bytes<br>(Note presence of a leading space.) |
| 131-UG | ADDITIONAL MESSAGE INFORMATION CONTINUITY | *+* | Continuation character |
| 132- UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER | *03* | Used for third line of free form text with no pre-defined structure. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | *AND EVERYWHERE THAT MARY WENT,* | Up to 40 Bytes<br>(Note presence of a leading space.) |
| 131-UG | ADDITIONAL MESSAGE INFORMATION CONTINUITY | *+* | Continuation character |
| 132- UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER | *04* | Used for fourth line of free form text with no pre-defined structure. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | *THE LAMB WAS SURE TO GO.* | Up to 40 Bytes<br>(Note presence of a leading space.) |
| 132-UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER | *05* | Used for fifth line of free form text with no pre-defined structure. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | *FOR ADDITIONAL INFORMATION PLEASE CALL T* | Up to 40 Bytes |
| 131-UG | ADDITIONAL MESSAGE INFORMATION CONTINUITY | *+* | Continuation character |
| 132-UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER | *06* | Used for sixth line of free form text with no pre-defined structure. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | *HE HELPDESK AT 1-800-333-4444.* | Up to 40 Bytes |

**NCPDP: Option C is correct.**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

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

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

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

See also section "*Additional Message Information Examples*".

#### *4.4.1.2 USE OF ADDITIONAL MESSAGE INFORMATION FOR NEXT AVAILABLE DATE OF SERVICE*

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

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

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

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

### 4.4.2 DUPLICATE TRANSACTION

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

provided on the direct claim, the second claim will process as all the criteria is not identical; meanwhile, there doesn't seem to be another edit in place to stop the second claim from paying.

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

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

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

### 4.4.3 REJECT CODE (511-FB) "70" AND "MR"

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

## 4.5 RESPONSE INSURANCE SEGMENT (25)

### 4.5.1 NETWORK REIMBURSEMENT ID (545-2F)

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

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

*Added May 2018*

## 4.6 RESPONSE CLAIM SEGMENT (22)

### 4.6.1 PREFERRED PRODUCT COST SHARE INCENTIVE (555-AT)

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

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

*Added May 2019 – Telecommunication FAQ TG*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 4.7 RESPONSE DUR/PPS SEGMENT (24)

## 4.7.1 DUR FREE TEXT MESSAGE (544-FY)

**Question**:
For the Response DUR/PPS Segment on a Claim Billing or Encounter transaction (B1), is the field DUR Free Text Message (544-FY) allowed to be sent without a Reason For Service Code (439-E4) or any other associated fields in the initial loop of a DUR/PPS Response?"

**Response**:
No, the DUR Free Text Message (544-FY) must be sent with a Reason for Service Code (439-E4). Refer to the NCPDP Telecommunication Standard Implementation Guide© which lists the Reason for Service Code (439-E4) as a required field in the Response DUR/PPS Segment if a utilization conflict is detected.

*Added August 2025*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 5 TYPOGRAPHICAL ERRORS

## 5.1 TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE© FIELDS

### 5.1.1 ADDITIONAL MESSAGE INFORMATION EXAMPLES

In section "*Additional Message Information Fields*":

The raw data free text message for Example 2
"HELP DESK TO ASSIST WITH QUESTIONS. ASK FOR SHELLY SMITH." was changed to
"HELP DESK TO ASSIST WITH QUESTIONS."
"ASK FOR SHELLY SMITH."

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

The raw data free text message for Example 3
"PRIOR AUTHORIZATION EXPIRATION 12/31/200+7. FOR CONTINUATION OF SERVICE, CONTACT+ PRESCRIBER." was changed to
"PRIOR AUTHORIZATION EXPIRATION 12/31/200" + "7. FOR CONTINUATION OF SERVICE, CONTACT " + "PRESCRIBER."

The raw data free text message for Example 5
"NEXT AVAILABLE DATE OF SERVICE = 12/31/2007 WIT+H PRIOR AUTHORIZATION EXPIRING" was changed to
"NEXT AVAILABLE DATE OF SERVICE = 12/31/2007 WI" + "TH PRIOR AUTHORIZATION EXPIRING"

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

### 5.1.2 DATE OF SERVICE (401-D1)

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

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

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

In some of the transaction charts, Help Desk Phone Number Qualifier (549-7F) situation had a typo that referred to the Number as (550-F8) instead of (550-8F) – "Required if Help Desk Phone Number (550-8F) is used." This has been corrected in version D.5.

### 5.1.4 INTERNAL CONTROL NUMBER (993-A7)

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

| | COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT |
|---|---|
| **Field** | **Field Name** |
| 111-AM | SEGMENT IDENTIFICATION |
| 337-4C | COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT |
|---|---|
| **Field** | **Field Name** |
| 338-5C | OTHER PAYER COVERAGE TYPE |
| 339-6C | OTHER PAYER ID QUALIFIER |
| 340-7C | OTHER PAYER ID |
| 993-A7 | INTERNAL CONTROL NUMBER |
| 443-E8 | OTHER PAYER DATE |

This has been corrected in Version D.4.

| | COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT |
|---|---|
| **Field** | **Field Name** |
| 111-AM | SEGMENT IDENTIFICATION |
| 337-4C | COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT |
| 338-5C | OTHER PAYER COVERAGE TYPE |
| 339-6C | OTHER PAYER ID QUALIFIER |
| 340-7C | OTHER PAYER ID |
| 443-E8 | OTHER PAYER DATE |
| **993-A7** | **INTERNAL CONTROL NUMBER** |

### 5.1.5 OTHER COVERAGE CODE (308-C8)

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

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

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

### 5.1.6 OTHER PAYER COVERAGE TYPE (338-5C)

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

### 5.1.7 REPEATING DESIGNATION

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

### 5.1.8 ROUTE OF ADMINISTRATION (995-E2)

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

| | | | | |
|---|---|---|---|---|
| 995-E2 | ROUTE OF ADMINISTRATION | Q | *11* | Oral |

Should be

| | | | | |
|---|---|---|---|---|
| 995-E2 | ROUTE OF ADMINISTRATION | Q | *26643006* | Oral |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 5.2 TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE© SEGMENTS

### 5.2.1 GENERAL

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

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

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

### 5.2.2 CLAIM SEGMENT

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

### 5.2.3 COUPON SEGMENT

#### *5.2.3.1 PRIOR AUTHORIZATION REQUEST AND BILLING TRANSACTION*

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

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

### 5.2.4 CLINICAL SEGMENT

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

| Field | Field Name |
|---|---|
| 491-VE | Diagnosis Code Count |
| 492-WE | Diagnosis Code Qualifier |
| 424-DO | Diagnosis Code |
| 493-XE | Clinical Information Counter |
| 494-ZE | Measurement Date |
| 495-H1 | Measurement Time |
| 496-H2 | Measurement Dimension |
| 497-H3 | Measurement Unit |
| 499-H4 | Measurement Value |

### 5.2.5 PATIENT SEGMENT

In the Controlled Substance Reporting Reversal transaction, the Patient Segment chart was omitted. It has been added (version D.3).

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### 5.2.6 PURCHASER SEGMENT

In the Controlled Substance Reporting transaction, a "Note" on the Purchaser Segment inadvertently referenced the Patient Segment. It has been corrected to Purchaser Segment.

### 5.2.7 RESPONSE CLAIM SEGMENT

#### *5.2.7.1 MEDICAID SUBROGATION CLAIM BILLING OR ENCOUNTER*

A typo was corrected. Response Claim Segment (Medicaid Subrogation Claim Billing or Encounter) (Transmission Accepted/Transaction Paid) table had "Response Insurance Segment" in the table heading. It has been changed to "Response Claim Segment". This was corrected in Telecom version D.6 and above.

#### *5.2.7.2 PRIOR AUTHORIZATION REQUEST AND BILLING RESPONSE*

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

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

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

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

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

In addition, if any of the following three fields are sent:
- Other Payer Processor Control Number (991-MH),
- Other Payer Cardholder ID (356-NU),
- Other Payer Group ID (992-MJ),

then the Other Payer ID (340-7C) and Other Payer ID Qualifier (339-6C) must be sent.

### 5.2.8 RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT

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

## 5.3 TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE© EXAMPLES

### 5.3.1 BILLING – TRANSACTION CODE B1 – COORDINATION OF BENEFITS SCENARIO PHARMACY BILLS TO


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

#### SECONDARY WHICH MEETS DESIGNATION AS GOVERNMENT PAYER , PATIENT REQUESTS BRAND

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

| | | | | |
|---|---|---|---|---|
| 351-NP | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER | R | ~~*01*~~*05* | ~~Amount Applied to Periodic Deductible (517-FH) as reported by previous payer~~<br>Amount of Copay (518-FI) as reported by previous payer. |
| 351-NP | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER | R | ~~*07*~~*11* | ~~Amount of Coinsurance (572-4U) as reported by previous payer.~~<br>Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer |

And the Note was added:

| | | | | |
|---|---|---|---|---|
| 136-UN | AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION | Q | *250{* | $25.00<br>Note: Product Selection cost is NOT being paid by the secondary payer, but they are returning this for patient to pay. |

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

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

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

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

### 5.3.4 CONTROLLED SUBSTANCE REPORTING (GENERAL) EXAMPLES

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

### 5.3.5 EXAMPLES USING MEDIGAP ID (359-2A)

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

- *"Billing – Transaction Code B1 with Additional Documentation Segment"*
- *"Billing – Transaction Code B1 with Facility Information"*
- *"Billing – Transaction Code B1 with Additional Documentation and Facility Information"*
- *"Billing – Transaction Code B1 with Narrative Information"*
- *"Billing – Transaction Code B1 with Facility Information and Narrative Information"*
- *"Billing – Transaction Code B1 with Additional Documentation and Narrative Information"*

## 5.4 APPENDIX A. HISTORY OF DOCUMENT CHANGES CORRECTIONS

In the Telecommunication Standard Implementation Guide©, in this appendix in subsection Version C.4 changes, Submission Clarification Code (420-DK) was noted with new values. The list was incorrect. The External Code


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

List© is correct; just this list in the appendix was incorrect. This has been noted in version D.3 appendix. The corrected statement is:

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

## 5.5 External Code List© Notables

### 5.5.1 Reject Code (511-FB) List

This list inadvertently listed "7F" and "7G" with similar descriptions. Value "7F" will be removed

"7F" – Future date not allowed for Date of Birth

"7G" – Future Date not Allowed for DOB

### 5.5.2 Prescription/Service Reference Number (455-EM) Value "3"

455-EM Prescription/Service Reference Number Qualifier added value "3" (Non-Prescription Product) in version D.1. It was inadvertently left out of the External Code List©. It was added in the 201410 External Code List© version.

Updated February 2024


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 6 GENERAL QUESTIONS

## 6.1 BIN AND IIN

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

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

## 6.2 CLAIMS IN EXCESS OF $999,999.99

**Question:**
Can electronic submission of a claim in excess of $999,999.99 be supported utilizing the existing HIPAA-named Telecommunication Standard Version D.0©?

**Response:**
No, the current HIPAA named Telecommunication Standard Version D.0© does not support dollar amounts above $999,999.99. As such, the current recommendation is that trading partners come to an agreement on how to utilize the Universal Claim Form for manual claim submission. (Refer to Section 17.1 – Expanded Dollar Amounts)

While neither of these options are recommended, two alternative electronic methods of submission were evaluated. Each of these methods would divide the claim into multiple transmissions of smaller dollar and/or quantity values as described below. If trading partners choose to implement one of these methods, they should account for the various impacts outlined in *Electronic Billing of Million Dollar Claims Using Telecommunication Standard Version D.0© Guidance Document*.

- **Method 1**: Each claim submission should include the total quantity dispensed, regardless of how many claims are used to obtain the total quantity dispensed.
- **Method 2**: The Quantity Dispensed (442-E7) should be divided evenly across all claims, where possible. The sum of the Quantity Dispensed (442-E7) should equal the total quantity dispensed.

Added 02/2024 - Expanded Dollar Fields TG

## 6.3 HOW SOON SUPPORT THIS DOCUMENT?

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

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

## 6.4 PRINTABLE CHARACTERS

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

## 6.5 REJECT CODE GUIDANCE

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

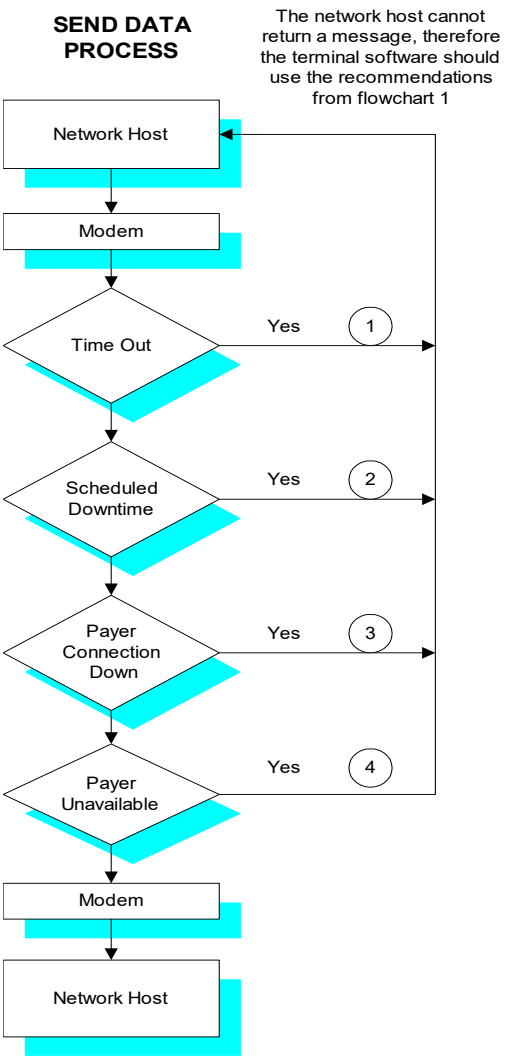

© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### 6.5.1 TELECOMMUNICATION PHASES WITH FLOW CHART

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

| LIST OF CONDITIONS AND RECOMMENDED RESPONSES PRESENTED TO OPERATORS | | |
|---|---|---|
| Ref # | Description | Reject Code |
| 1 | No Dial Tone. Call Telephone Company | 91 |
| 2 | Ring No Answer, Check Phone Number, And Call Network | 92 |
| 3 | Busy, Try Again | 93 |
| 4 | No Carrier From Network. Try Again | 94 |
| 5 | Logon Unsuccessful. Try Again | 95 |
| 6 | No ENQ. Try Again | 96 |
| 7 | No Response From Network. Call Network | 97 |
| 8 | Bad Response From Network. Try Again | 98 |
| 9 | NCPDP Standard Response | |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use




| LIST OF CONDITIONS AND RECOMMENDED REJECT CODES | | |
|---|---|---|
| Ref # | Description | Reject Code |
| 1 | Time Out | 95 |
| 2 | Scheduled Downtime | 96 |
| 3 | Connection to payer is down | 98 |
| 4 | Payer Unavailable | 97 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### 6.5.2 WHEN SHOULD REJECT CODE 84 BE USED?

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

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

| | | |
|---|---|---|
| 84 | Claim Has Not Been Paid/Captured | 201-B1, 401-D1, 402-D2 |

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

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

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

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

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

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

### 6.5.3 PRESCRIBER ID REJECTIONS

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

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

*Updated November 2025*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

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

- Prescriber Last Name (427-DR)
- Prescriber First Name (364-2J)
- Prescriber Phone Number (498-PM)
- Prescriber Street Address (365-2K)
- Prescriber City Address (366-2M)
- Prescriber State/Provence Address (367-2N)
- Prescriber Zip/Postal Code (368-2P)

As a result of a POS denial for prescriber enrollment, a new prescription may be required from a covered prescriber. This would also apply to other prescriber types where a supervising physician or a Collaborative Practice Agreement applies per state law. The Prescriber ID (411-DB) would be represented as defined below.

- The practitioner with prescriptive authority per state regulations not requiring a supervising physician is prescribing and signing the prescription for the medication/service for which they are authorized.
    - Prescriber ID (411-DB) – contains the *practitioner with prescriptive authority* who is prescribing and signing the prescription for the medication/service
- The resident where state law may require a supervising physician is prescribing and signing the prescription for the medication/service for which they are authorized.
    - Prescriber ID (411-DB) – contains the *resident* who is prescribing and signing the prescription for the medication/service
- The nurse practitioner/physician assistant is prescribing and signing the prescription for the medication/service for which they are authorized.
    - Prescriber ID (411-DB) – contains the *nurse practitioner/physician assistant* who is prescribing and signing the prescription for the medication/service
- The physician and nurse practitioner/physician assistant have a Collaborative Practice Agreement. The nurse practitioner/physician assistant is prescribing and signing the prescription for the medication/service for which they are authorized. A physician is supervising the nurse practitioner/physician assistant (direct or indirect).
    - Prescriber ID (411-DB) – contains the *nurse practitioner/physician assistant* who is prescribing and signing the prescription for the medication/service
- The pharmacist is allowed to prescribe without a Collaborative Practice Agreement. The pharmacist is prescribing and signing the prescription for the medication/service for which they are authorized.
    - Prescriber ID (411-DB) – contains the *pharmacist* who is prescribing and signing the prescription for the medication/service
- The physician and pharmacist have a Collaborative Practice Agreement. The pharmacist is prescribing and signing the prescription for a medication/service for which they are authorized.
    - Prescriber ID (411-DB) – contains the *pharmacist* who is prescribing and signing the prescription for the medication/service
- When a pharmacist administers the medication/service which requires a prescription/prescription order/protocol per state law (such as vaccines)


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Prescriber ID (411-DB) – contains the ID of the clinician who signed the prescription/prescription order/protocol for the medication/service. See 1-6 above.
- Provider ID (444-E9) - could contain the pharmacist who is *administering* a vaccine/service.

- When a pharmacist dispenses a federal legend, OTC or Additional Condition for Non-Prescription Use (ACNU) product under a Standing Order[2]
  - Prescriber ID (411-DB) contains the ID of the clinician who signed the Standing Order for the specified product/product category

*Replaced June 2026*

**Question:**
When should Reject Code 56 "Non-Matched Prescriber ID" be used?

**Response:**
Reject code 56 should only be used when the ID submitted is not found within the processor's prescriber data file given:

- The submitted ID meets the applicable formatting/check digit for the submitted Prescriber ID qualifier (466-EZ) **and**
- A distinct reject code is not available to describe the unmatched or non-covered situation.

When reject code 56 is returned, the processor should reference within the Additional Message field (526- FQ) the specific non-matched condition.

Reject Code 56 should not be used when the submitted ID is found; however, additional prescriber validation rules are not able to locate associated prescriber IDs. For example, when the submitted NPI is found and the processor is not able to locate the prescriber's DEA number, the processor should return the applicable prescriber DEA reject code (values 43-46).

See also Reject Code 71 FAQ - In which scenarios would Reject Code (511-FB) value 71 – Prescriber ID is Not Covered be returned?

*Replaced question – May 2024*

**Question:**
There are various provider exclusion files maintained by government entities, such as OIG excluded providers, Medicaid exclusions, CMS preclusions. Can Reject Code A1 be used regardless of which exclusion file contains the submitted Provider/Prescriber ID, and can the data source that triggered a prescriber validation reject be identified in the response?

**Response:**
Reject code A1 (ID Submitted Is Associated With An Excluded Prescriber) should be used when a provider is found to be excluded as listed on any of the government-maintained files (see below), except when the provider is found to be a CMS Precluded Provider. In a CMS Precluded Provider situation (provider is listed on the Precluded Provider file), reject code 929 (ID Submitted is Associated to a Precluded Prescriber) should be returned.

For prescription claims billed to a government program, the following files maintained by government entities, are used to validate provider exclusion status. When the provider is determined to be excluded as of the claim

[2] In this section the term "standing order" means a document prepared by a person authorized to prescribe medication that permits another person to acquire, dispense or administer medication without a person-specific prescription. (https://www.law.cornell.edu/uscode/text/42/290ee#g)


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

date of service, then either reject code A1 and/or 929 would be returned. If a provider is listed on any of the files as an active exclusion, treat the provider as excluded and return the following reject code:

- Use Reject Code (511-FB) value A1 (ID Submitted Is Associated With An Excluded Prescriber)
  - OIG List of Excluded Individuals and Entities (LEIE)
  - GSA (General Service Administration)/SAM (System for Award Management)
  - Medicaid State Exclusion File
- Use Reject code (511-FB) value 929 (ID Submitted is Associated to a Precluded Prescriber)

Depending on the processor's rules, one or both reject codes may be returned when the provider appears on the CMS Precluded Provider file as well as one of the other files.

To provide additional information regarding the exclusion, it is recommended the specific file in which the exclusion was determined be referenced in the appropriate claim response field. For the Telecommunication Standard Version D.0©, the Additional Message Information field (526-FQ) can be used to identify the data source that triggered the prescriber validation conflict.

The information should be returned with the below Additional Message Information Qualifiers (132-UH):

- 26 – INVALID PROVIDER DATA SOURCE
- 27 – INVALID PROVIDER DATA SOURCE STATE CODE

The information will be available as distinct response fields in the Telecommunication Standard Version F6© (E87-ZV: Data Source of Invalid Provider Determination and E88-ZZ: State Code for Data Source of Invalid Provider Determination).

Please refer to the below chart for guidance on the specific values to return in the Additional Message Information field (526-FQ) for each of these qualifiers and the associated reject codes for the specific prescriber validation error.

| **Prescriber Validation Error** | **Reject Code** | **Additional Message Information Qualifier(s) (132-UH)** | **Additional Message Information (526-FQ)** | **Description of Invalid Provider Data Source** |
|---|---|---|---|---|
| Prescriber has been identified as an Excluded Prescriber via the OIG LEIE file | A1<br>ID Submitted is associated with an Excluded Prescriber | 26 - INVALID PROVIDER DATA SOURCE | **"OIG LEIE"** | "Office of Inspector General List of Excluded Individuals/Entities": List of all currently excluded individuals and entities as determined by OIG authority to exclude individuals and entities from Federally funded health care programs pursuant to section 1128 of the Social Security Act (Act) (and from Medicare and State health care programs under section 1156 of the Act). |
| Prescriber has been identified as an Excluded Prescriber via the SAM file | A1<br>ID Submitted is associated with an Excluded Prescriber | 26 - INVALID PROVIDER DATA SOURCE | **"SAM"** | "System for Award Management": The SAM Exclusions extract contains a list of all currently active exclusions in SAM. These include exclusions for Individuals, Firms, Special Entity Designations and Vessels. https://www.sam.gov/SAM/pages/public/index.jsf |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Prescriber Validation Error | Reject Code | Additional Message Information Qualifier(s) (132-UH) | Additional Message Information (526-FQ) | Description of Invalid Provider Data Source |
|---|---|---|---|---|
| | | | | Note: SAM replaces General Services Administration (GSA) data source. |
| Prescriber has been identified as a Terminated/Excluded Medicaid Prescriber | A1<br>ID Submitted is associated with an Excluded Prescriber | 26 - INVALID PROVIDER DATA SOURCE<br>&<br>27 – INVALID PROVIDER DATA SOURCE STATE CODE | **"STATE MEDICAID EXCLUSION/TERMINATION"<br>&<br>2-character State Code of the applicable State Medicaid Exclusion file. Refer to state abbreviations within the ECL SHARED CODE LIST: State/Province Address** | State issued list of providers excluded/terminated from participation in the State Medicaid program. |
| Prescriber/Provider has been identified as not enrolled with the State Medicaid program | 889<br>Prescriber Not Enrolled in State Medicaid Program<br><br>890<br>Pharmacy Not Enrolled in State Medicaid Program | 26 - INVALID PROVIDER DATA SOURCE<br>&<br>27 – INVALID PROVIDER DATA SOURCE STATE CODE | **"STATE MEDICAID ENROLLMENT"<br>&<br>2-character State Code of the applicable State Medicaid Enrollment file. Refer to state abbreviations within the ECL SHARED CODE LIST: State/Province Address** | State issued list of providers' enrollment status within the State Medicaid program. State Medicaid provider enrollment data aligns to CMS Medicaid and other federal provider screening requirements |
| Prescriber has been identified as a Precluded Prescriber | 929<br>ID Submitted Is Associated With A Precluded Prescriber<br><br>930<br>ID Submitted Is Associated To A Precluded Pharmacy | 26 - INVALID PROVIDER DATA SOURCE | **"CMS PRECLUSION LIST"** | "Centers for Medicare and Medicaid Services" Preclusion List: A list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. |
| Prescriber's NPI has been identified as inactive or not found | 42<br>Plan's Prescriber database indicates the Prescriber ID Submitted is inactive or expired. | 26 - INVALID PROVIDER DATA SOURCE | **"NPPES NPI"** | "National Plan and Provider Enumeration System - National Provider Identifier": NPPES assigns standard unique identifiers (NPI) for health care providers and health plans. All information produced by the |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Prescriber Validation Error | Reject Code | Additional Message Information Qualifier(s) (132-UH) | Additional Message Information (526-FQ) | Description of Invalid Provider Data Source |
|---|---|---|---|---|
| | 826<br>Prescriber NPI Submitted Not Found Within Processor's NPI File | | | NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. |
| Prescriber's DEA has been identified as inactive, not found, or not registered with the applicable drug schedule | 43<br>Plan's Prescriber database indicates the Prescriber DEA Number is inactive or expired<br><br>44<br>Plan's Prescriber data base indicates the Prescriber DEA Number Is not found<br><br>46<br>Plan's Prescriber database indicates Prescriber DEA Number does not allow this drug DEA class | 26 - INVALID PROVIDER DATA SOURCE | **"NTIS DEA"** | "National Technical Information Service - Drug Enforcement Administration": DEA Active Controlled Substances Act (CSA) Registrants Database. Registration under the Act enables physicians, related practitioners, other established health organizations, pharmaceutical companies, and others to prescribe and handle controlled substances |
| Prescriber's state license has been identified as not active/valid | 777<br>Plan's Prescriber database not able to verify active state license with prescriptive authority for Prescriber ID Submitted | 26 - INVALID PROVIDER DATA SOURCE<br>&<br>27 – INVALID PROVIDER DATA SOURCE STATE CODE | **"STATE LICENSE"<br>&<br>2-character State Code of the applicable State Licensing Board file. Refer to state abbreviations within the ECL SHARED CODE LIST: State/Province Address** | Data from a state board or other state regulatory agency identifying individuals' and entities' license status to practice within a designated discipline and locality. |

Modified 08/2025 – Definition of a Valid Prescriber TG

### 6.5.4 INFORMATION REPORTING TRANSACTIONS

**Question:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

What reject code should be used for an N transaction submitted to the Part D Plan where the 'SOFTWARE VENDOR' field (110-AK) is not TROOP or TROOPBATCH?

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

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

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

**Response:**
NCPDP recommends the use of the following reject codes:

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

| Reject Code (511-FB) | Submission Clarification Code (420-DK) | Approved Message Code (548-6F) | Comment |
|---|---|---|---|
| 889 | 55 - Prescriber Enrollment in State Medicaid Program has been validated.<br>Value Limitation:<br>Used when overriding rejection for Prescriber Not Enrolled in State Medicaid Program. | 045 - Prescriber active enrollment with Medicaid Fee For Service/MCO required. Flagged for retrospective review.<br>Value Limitation:<br>Value returned only if Submission Clarification Code 55 (Prescriber Enrollment in State Medicaid Program has been validated) was accepted. | Reject Code (511-FB) value 8R – Submission Clarification Code Value Not Supported (This reject code would be returned if the payer does not support point of service overrides for this business case.) |
| 890 | 56 - Pharmacy Enrollment in State Medicaid Program has been validated.<br>Value Limitation:<br>Used when overriding rejection for Pharmacy Not Enrolled in State Medicaid Program. | 046 - Pharmacy active enrollment with Medicaid Fee For Service/MCO required. Flagged for retrospective review.<br>Value Limitation:<br>Value returned only if Submission Clarification Code 56 (Pharmacy Enrollment in State Medicaid Program has been validated) was accepted. | Reject Code (511-FB) value 8R – Submission Clarification Code Value Not Supported (This reject code would be returned if the payer does not support point of service overrides for this business case.) |

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

Added 12/2016 – BP
Updated 5/2019 – Definition of a Valid Prescriber TG
Updated 8/2025

### 6.5.6 RPH PRESCRIPTIVE AUTHORITY VALIDATION


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

**Response:**
*Reject Code:*
In the situation where prescriptive authority criteria have not been met, it is recommended to return reject code *876 - Prescriptive Authority Restrictions Apply, Criteria Not Met*. Additionally, the specific criteria which is not met should be referenced in the Additional Message Information field (526-FQ). For example, *"Rx Auth criteria not met for patient age*" or "*Prescriber can only prescribe X QTY per state reg*".

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

*Approved Message Code (AMC):*
A plan should return 44 (Plan's Prescriber data base determined prescriptive authority criteria not met, flagged for retrospective review) when SCC 42 is accepted for reject code 876. This approved message code allows the pharmacy to identify claims at audit risk.

Added December 2016; Updated November 2019; Updated August 2025

### 6.5.7 SERVICE PROVIDER ID

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

**Response:**
The below information is based on information outlined within the 2020 CMS rule, CMS FAQs and the availability of NCPDP reject codes:

- If the claim is processed under the Part C benefit (Part A/B), the claim must reject.
  - Reject Code 930 - ID Submitted Is Associated To A Precluded Pharmacy, should be returned.
- If the claim is processed under the Part D benefit, the claim will not reject based on the pharmacy's precluded provider status. However, the plan may choose to remove the pharmacy from its network resulting in Reject Code 40.
  - Reject Code 40 - Pharmacy Not Contracted With Plan/Processor On Date Of Service' or other applicable pharmacy network specific reject code, should be returned.

Added 5/2019 – Definition of a Valid Prescriber TG; Modified 8/2025

### 6.5.8 REJECT CODE 71: PRESCRIBER ID IS NOT COVERED

**Question**:
In which scenarios would Reject Code (511-FB) value 71 – *Prescriber ID is Not Covered* be returned?

**Response**:
Reject Code (511-FB) value 71 – *Prescriber ID is Not Covered* would be returned when the payer has applied specific edits or rules regarding eligibility to prescribe for the product/service and program combination. For example, the submitted NPI has been flagged by a plan or payer/processor for potential fraud, waste and abuse, and the payer has chosen not to cover submitted prescriber's claims. Another example, the plan has prescriber network restrictions outside of state prescriptive authority restrictions, such as only psychiatrists can prescribe antipsychotic drugs.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Reject Code 71 should not be used in the following scenarios:

- **Prescriptive Authority**: Use reject code 876 – *Prescriptive Authority Restrictions Apply, Criteria Not Met* as it is the more specific value.
- **Medicaid Enrollment:** Use reject code 889 – *Prescriber not Enrolled in State Medicaid Program* as it is the more specific value.
- **State and/or Federal Sanctions:** Use reject code A1 - *ID Submitted Is Associated With An Excluded Prescriber* as it is the more specific value.

Added 2/2024 – Definition of a Valid Prescriber TG

## 6.6 Syntax Error

**Question:**
What constitutes a syntax error?

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

## 6.7 Not Used Data Element

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

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

## 6.8 Vaccine Administration

See section "*Vaccine Administration*".

## 6.9 ICD-9 Versus ICD-10 Information

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

For information on ICD-9 and ICD-10 implementation, see FAQs on CMS website at https://questions.cms.gov/ Click on FAQs link at the top of the page. Use the "Browse by Group" and choose "Coding" "ICD-10". (As of version 24 of this document, FAQs 7579, 8246, 8248, 8252 were of interest for timing.)

## 6.10 ICD-10 Submission

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

The guidance from the External Code List© is below:


*** OFFICIAL RELEASE ***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

"From the code set maintainer: The ICD codes do have a decimal; however, for transaction/submission of the codes the decimal is **not** included in the code.
The reporting of the decimal between the third and fourth characters is unnecessary because it is implied. (Field is alphanumeric; count from left to right for the third and fourth characters.)
Preciseness is designated with the number of digits to the right of the implied decimal point.
Example:

O26851 Spotting complicating pregnancy, first trimester
O26852 Spotting complicating pregnancy, second trimester
O26853 Spotting complicating pregnancy, third trimester
O26859 Spotting complicating pregnancy, unspecified trimester
The above may be displayed with a decimal point (e.g. O26.851) but are transmitted without the decimal point.)"

## 6.11 Number of Diagnosis Code Fields

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

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

Added 08/2017 (BP)

## 6.12 Minimum and Maximum Field Length

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

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

Added 12/2016 (BP)

## 6.13 Unique Device Identifier Conversion

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

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

Added 05/2017 – MC UDI TG

## 6.14 Drug Recalls

**Partial Lot Recall – DUR Reason for Service Code (439-E4)**

Manufacturers specifically recall a lot/lot number. Within the processor system, the product (NDC) will be flagged as being recalled. A specific DUR Reason for Service code was created to notify pharmacies when the drug/product being dispensed is part of a partial lot recall and there is


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

additional information provided in the Response DUR/PPS Segment to communicate the potential safety concern associated with the product.

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

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

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

- (511-FB) Reject Code: '944' – All Lots of Drug/Product Recalled

Information on the recall, if available, is returned in the 526-FQ Additional Message Information field.

Added November 2018

## 6.15 CLAIM ADJUDICATION PROCESS FOR OPIOID UTILIZATION RULES

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

> *Safety edits (as specified by the State) for subsequent fills for opioids and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the State plan (or under a waiver of the State plan) is prescribed a subsequent fill of opioids in excess of any limitation that may be identified by the State.*
> *Safety edits (as specified by the State) on the maximum daily morphine equivalent that can be prescribed to an individual enrolled under the State plan (or under a waiver of the State plan) for treatment of chronic pain and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the plan (or waiver) is prescribed the morphine equivalent for such treatment in excess of any limitation that may be identified by the State; and A claims review automated process (as designed and implemented by the State) that monitors when an individual enrolled under the State plan (or under a waiver of the State plan) is concurrently prescribed opioids and – benzodiazepines; or antipsychotics.*

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

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

> 7.6.2 MME HARD STOP; POS OVERRIDE NOT ALLOWED; PRESCRIBER TO CALL PLAN (POTENTIALLY >200)
> 7.6.3 MME PRESCRIBER CARE COORDINATION REQUIRED (90-200, OR >90)
> 7.6.4 DUPLICATIVE THERAPY SOFT EDIT - LONG ACTING OPIOIDS
> 7.6.5 SOFT STOP FOR CONCURRENT USE OF CONFLICTING DRUG CATEGORIES *(E.G.; OPIOIDS & BENZODIAZEPINES, OPIOIDS & BUPRENORPHINE, OPIOIDS & ANTIPSYCHOTICS)*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Additionally, it should be noted that CMS released a memo on August 5, 2019, providing guidance for state Medicaid programs on the implementation of the required Drug Utilization Review (DUR) provisions included in the SUPPORT Act. Plans should also refer to this bulletin for additional information regarding the required safety edits, including comments on interpretation.
https://www.medicaid.gov/federal-policy-guidance/downloads/cib080519-1004.pdf

Added November 2019

## 6.16 EMERGENCY FILL

**Question:**
What information is needed within the claim request for payers to apply the applicable claim adjudication rules to support the COVID-19 urgency associated to state emergency declarations that allow for a pharmacist to extend a prescription refill for specified products (e.g. maintenance medications/products) when the original prescriber is not available to authorize a renewal?

**Response:**
Based on each entity's interpretation of the Board of Pharmacy rules, the emergency Rx could be an extension of the original prescription where the original prescriber ID would be associated to the claim, or the pharmacist Type 1 or pharmacy Type 2 NPI could be submitted as the prescriber ID. In both situations, this would be a new prescription number, where Prescription Origin Code (419-DJ) would be submitted with a value of '5'.

- Prescription Origin Code (419-DJ) value of '5'– Pharmacy
    - Pharmacy - This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, intrachain transfers, file buys, software upgrades/migrations, and any reason necessary to "give it a new number." This value is also the appropriate value for "Pharmacy dispensing" when applicable such as BTC (behind the counter), Plan B, established protocols, pharmacists authority to prescribe, etc.

When the pharmacist or pharmacy NPI is submitted, Type 1 NPI and prescriptive authority validation rules may apply. While various methods may be employed by payers to override these system rules, adhering to the following recommendations will promote standardization of processes and expedite patient access to care. Also refer to CMS HPMS Memo published April 3, 2020 (Notification of PDE Prescriber ID Editing and States of Emergencies) and trading partner agreements to validate specific claims processing expectations. When Prescriber Validation results in a POS reject, one or both of the below Submission Clarification Codes may be necessary to override prescriber validation rules as a result of the emergency Rx situation.

- Submission Clarification Code (420-DK)
    - 13: Payer-Recognized Emergency/Disaster Assistance Request - The pharmacist is indicating that an override is needed based on an emergency/disaster situation recognized by the payer
    - 42: Prescriber ID Submitted is valid and prescribing requirements have been validated

If plan benefit rules apply after the prescriber validation step, multiple Submission Clarification Codes may be needed. For example, the emergency Rx could initially reject with a prescriber validation error, to which SCC 42 would be accepted by the payer, then the claim rejects as refill too soon, requiring both SCC 42 and 13.

Added August 2020

## 6.17 QUANTITY PRESCRIBED/QUANTITY DISPENSED AND APPROVED


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### MESSAGE CODE

**Question:**
What Approved Message Code (548-6F) value should be returned if the copay is prorated based on Quantity Dispensed/Quantity Prescribed?

**Response:**
We recommend the use of Approved Message Code value 023 for proration of copay based on either quantity or days supply. If proration is based on quantity, processors may return the following text in Additional Message Information (526-FQ): "Prorated copayment based on quantity". Because the Approved Message Code value of 023 as originally approved does not address proration of copay based on quantity, DERF 001768/ECL 000326 to address copayment proration based on quantity was approved and the updated definition will be available October 2021.

Added August 2020

## 6.18 QUANTITY PRESCRIBED AND QUANTITY DISPENSED

**Question:**
Is the Quantity Prescribed (460-ET) always equal to Quantity Dispensed (442-E7) for Schedule II drugs?

**Response:**
Not always. The Quantity Prescribed (460-ET) and Quantity Dispensed (442-E7) will not be equal when a Schedule II prescription is dispensed incrementally. The field values will be equal when the Schedule II prescription is dispensed for the full quantity prescribed.

Added August 2020

## 6.19 QUANTITY PRESCRIBED 30-DAY REFERENCE

**Question:**
Should all Schedule II prescription claims always be filled within 30 days of the date the prescription was written, where if not within 30 days reject code 981 (Date of Service for Incremental Fill Exceeds Regulatory Timeframe for Dispensing) would apply?

**Response:**
No, as there are variations in federal and state regulations that make a distinction between a Schedule II fill that is for the full prescribed quantity and fills for the remaining prescribed quantity for incremental (partial) fills.

- As outlined under CARA Title 7 Section 702, Controlled Substance Act Title 21 Section 829, the 30 day restriction is specific to remaining quantities of Schedule II incremental fills, therefore does not apply to the original fill (Fill Number = 00) of an incremental quantity or to a Schedule II fill for the full quantity prescribed. In the context of CARA, Reject Code 981 should only apply to remaining quantities for Schedule II incremental fills, allowing for initial fills and prescriptions written with a Do Not Dispense Before date to be dispensed based on state regulations.
    - Reject Code 981 is applicable to Schedule II prescription claims where the Fill Number (403-D3) is greater than 00, the Quantity Dispensed (442-E7) is less than the Quantity Prescribed (460-ET), the Date of Service (401-D1) is more than 30 days past the Date Prescription Written (414-DE) date, and the prescription is not applicable to a LTC or terminally ill patient.
    - Reject Code 981 is not applicable to Schedule II prescription claims where the Fill Number (403-D3) = 00, and the Date of Service (401-D1) is more than 30 days past the Date Prescription Written (414-DE) date.
- As outlined under Controlled Substance Act, Title 21 CFR Part 1306.13, there is a 60 day restriction between the prescription issue date and the date of service, applied to Schedule II incremental fills


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

for LTC/terminally ill patients. Reject code 650 (Date Of Service Greater Than 60 Days From CII Date Prescription Written For LTC/Terminally Ill Patient), would apply in the following situation:

- Reject Code 650 is applicable to Schedule II prescription claims where the patient is determined to be LTC or terminally ill, the Quantity Dispensed (442-E7) is less than the Quantity Prescribed (460-ET) and the Date of Service (401-D1) is more than 60 days past the Date Prescription Written (414-DE) date, irrespective of the Fill Number (403-D3).

Schedule II Claim Examples:

| DEA/CARA Condition | Qty Dispensed (442-E7) | Qty Prescribed (460-ET) | Fill Number (403-D3) | Date RX Written (414-DE) | Do Not Dispense Before Date (D18-K9, post vD0) | Date of Service (401-D1) | Reject Code (511-FB) |
|---|---|---|---|---|---|---|---|
| LTC/Terminally Ill | 100 | 100 | 00 | 10/01/2020 | N/A | Any valid DOS | N/A (not an incremental fill) |
| LTC/Terminally Ill | 60 | 100 | 00 | 10/01/2020 | N/A | 10/01/2020 | N/A (Original incremental fill, within 60 days of RX Issue date) |
| LTC/Terminally Ill | 60 | 100 | 00 | 10/01/2020 | N/A | 12/05/2020 | 650 – Date Of Service Greater Than 60 Days From CII Date Prescription Written For LTC/Terminally Ill Patient |
| LTC/Terminally Ill | 40 | 100 | 01 | 10/01/2020 | N/A | 10/20/2020 | N/A (Incremental fill within 60 days of RX Issue date) |
| LTC/Terminally Ill | 40 | 100 | 01 | 10/01/2020 | N/A | 12/05/2020 | 650 – Date Of Service Greater Than 60 Days From CII Date Prescription Written For LTC/Terminally Ill Patient |
| Non-LTC/Terminally Ill | 100 | 100 | 00 | 10/01/2020 | N/A | Any valid DOS | N/A (not an incremental Fill) |
| Non-LTC/Terminally Ill | 100 | 100 | 00 | 10/01/2020 | 11/01/2020 | 11/01/2020 | N/A (not an incremental Fill) |
| Non-LTC/Terminally Ill | 100 | 100 | 00 | 10/01/2020 | 12/01/2020 | 12/01/2020 | N/A (not an incremental Fill) |
| Non-LTC/Terminally Ill | 30 | 100 | 00 | 10/01/2020 | 12/01/2020 | 12/01/2020 | N/A (not an incremental Fill of a Remaining portion) |
| Non-LTC/Terminally Ill | 50 | 100 | 01 | 10/01/2020 | 12/01/2020 | 12/15/2020 | 981 - Date of Service for Remaining Portion |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| DEA/CARA Condition | Qty Dispensed (442-E7) | Qty Prescribed (460-ET) | Fill Number (403-D3) | Date RX Written (414-DE) | Do Not Dispense Before Date (D18-K9, post vD0) | Date of Service (401-D1) | Reject Code (511-FB) |
|---|---|---|---|---|---|---|---|
| | | | | | | | of Incremental Fill Exceeds Regulatory Timeframe for Dispensing |
| Non-LTC/Terminally Ill | 60 | 100 | 00 | 10/01/2020 | N/A | 10/01/2020 | N/A (not an incremental Fill of a Remaining portion) |
| Non-LTC/Terminally Ill | 60 | 100 | 00 | 10/01/2020 | N/A | 12/05/2020 | N/A (not an incremental Fill of a Remaining portion) |
| Non-LTC/Terminally Ill | 40 | 100 | 01 | 10/01/2020 | N/A | 11/15/2020 | 981 - Date of Service for Remaining Portion of Incremental Fill Exceeds Regulatory Timeframe for Dispensing |

Updated February 2024

## 6.20 Insulin Pen Packaging Claim Adjudication Guidance

**Question:**
What, if any, claim adjudication requirements apply to insulin pen claims when a full box conflicts with the plan days supply limit or when less than a full box or full box plus additional syringes is necessary?

**Background:**
Updated FDA packaging and labeling requirements for insulin pens requires product to be dispensed in its sealed package, where package contains multiple insulin pens. Insulin dosing varies across patients, to which a full box dispensed as packaged today may exceed plan benefit days supply limits, conflict with care setting dispensing frequency (e.g., long-term care (LTC)), and/or create patient adherence risks as a result of increased out-of-pocket costs. Additionally, many states have regulations capping the patient copay for a defined day supply of insulin.

With these revised packaging guidelines there are concerns that pharmacies are unable to adjust the dispensed quantity or days supply to meet plan benefit day supply limits, patient needs or maximum copay regulations. The October 13, 2020 FDA notification, clarified the intent of the November 2019 revisions to labeling for insulin pens.

> *There is an increased risk of dispensing errors and patients using the wrong product if individual insulin pens are stored or dispensed outside of their carton. Insulin pens dispensed individually outside of their cartons may have contributed to medication errors including wrong-drug and wrong-dose errors resulting in hyper- or hypoglycemia, missed doses, complaints of possible tampering, and dispensing without the instructions for use.*
> *In November 2019, FDA approved revisions to the labeling for insulin pens to emphasize the agency's recommendation for dispensing insulin pens to a single patient in their original sealed carton. ……*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

*FDA understands that there are situations where health care professionals may choose to dispense individual pens (outside of the carton), not in accordance with FDA-approved labeling, based on their professional judgment. In these situations, health care professionals should consider the known risks of dispensing individual pens and incorporate additional safety measures (e.g., adding tamper-indicator tape; providing a copy of the instructions for use to the patient; labeling individual pens for individual patient use) to mitigate those risks. FDA will continue to monitor the safety risks associated with dispensing individual insulin pens outside of the original sealed carton and will consider further steps as warranted. FDA has also strongly encouraged the manufacturers of insulin pens to consider developing smaller carton sizes to better accommodate variable insulin doses and needs.*

**Problem Statement:**
The FDA insulin pen packaging guidance to dispense in sealed cartons may inhibit the claim adjudication process in the below scenarios, creating access to care delays, compromise expected healthcare outcomes and increase healthcare administrative costs. Claim adjudication guidance is necessary to facilitate standardization in claims processing when less than a full box is necessary, or a full box exceeds plan days supply limits. Standardization may include the determination if/when a specific override code is necessary on the claim request or product specific claim adjudication rules apply without the need for an override.

The following potential reject scenarios need to be considered:

- Scenario 1: Dispensing a full box exceeds the plan days supply limit and,
  - Plan claim adjudication rules do not support days supply exception for associated products; or
  - Plan requires claim submission override value or prior authorization process to override days supply limitation
- Scenario 2: Dispensing less than a full box when necessary (e.g.: patient request, LTC dispensing safety protocol*, regulated days supply copay maximum, etc.,) and,
  - Plan claim adjudication rules require full box to be dispensed (package size edits)

* Pharmacies servicing LTC and hospice care settings dispense based on the length of the patient's expected care.

For the below business case examples:

- Full box = 5 insulin pens
- Plan cost for the full box of insulin = $300

| Scenario | Full Box Days Supply | Plan Days Supply Limit | Full Box Patient Pay Type & Amount | Max Copay Regulation | Exception Override Type | Adjusted Quantity/Days Supply | Adjusted Patient Pay Amount |
|---|---|---|---|---|---|---|---|
| **1. Full box exceeds 30 day limit, days supply exception at NDC level**<br>Medicaid plan with max 30 day supply and $0 copay<br>Pharmacy submits claim for 5 pens/65 days supply<br>Plan supports days supply exception based on NDC | 5/65 | 30 | $ 0.00 Copay/Days Supply | N/A | N/A | 5/65 | $0 |
| **2. Full box exceeds 30 day limit, override required**<br>Plan with max 30 days supply, and $40 copay<br>Full box exceeds 30 day limit | 5/65 | 30 | $ 40.00/30 Copay/Days Supply | N/A | Prior Authorization ***(not recommended)*** | 5/65 | $120 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Scenario | Full Box Days Supply | Plan Days Supply Limit | Full Box Patient Pay Type & Amount | Max Copay Regulation | Exception Override Type | Adjusted Quantity/Days Supply | Adjusted Patient Pay Amount |
|---|---|---|---|---|---|---|---|
| Pharmacy submits claim for 5/65, claim rejects<br>Plan requires PA to override days supply limit | | | | | | | |
| **3. Patient requests less than full box, no override required**<br>Plan allows up to 100 days supply, with 25% co-insurance<br>Pharmacy resubmits claim with reduced qty/days supply<br>Plan accepts less than full box w/o override | 5/65 | 100 | $ 75.00<br>25% Co-Insurance | N/A | N/A | 2/26 | $30 |
| **4. Patient requests less than full box, override code required**<br>Plan allows up to 100 days supply, $40 copay per 30 days supply (Retail)<br>Pharmacy resubmits claim with reduced qty/days supply<br>Plan requires override to full box package size edit | 5/65 | 100 | $120.00<br>Copay/Days Supply = 3 copays | N/A | SCC 10<br>Meets Plan Limitations<br>The pharmacy certifies that the transaction is in compliance with the program's policies and rules that are specific to the particular product being billed. | 2/26 | $40 |
| **5. LTC setting requires reduced days supply, no override required**<br>Plan allows up to 100 days supply, $40 copay per 30 days supply<br>Pharmacy submits claim with reduced qty/days supply<br>Plan accepts less than full box w/o override | 5/65 | 100 | $120.00<br>Copay/Days Supply = 3 copays | N/A | N/A | 2/26 | $40 |
| **6. Patient requests less than full box, state max copay**<br>Plan allows up to 100 days supply, state max copay set at $35<br>Pharmacy resubmits claim with reduced qty/days supply<br>Plan accepts less than full box w/o override | 5/65 | 100 | $120.00<br>• Copay/Days Supply = 3 copays<br>$105<br>Max Copay/30 days supply | $35 for 30 Days Supply | N/A | 2/26 | $35 |
| **7. Patient requests full box + for 60 days supply, state max copay**<br>Plan allows up to 100 days supply, state max copay set at $35<br>Based on sig, 5 pens = 35 day supply<br>Patient pay amt = $70 ($35 x 2)<br>Pharmacy resubmits claim for 8 pens/56 days supply<br>Plan accepts full box + w/o override | 5/35 | 100 | $ 75.00<br>• 25% Co-Insurance<br>$ 70.00<br>Max copay/30 days supply | $35 for 30 Days Supply | N/A | 8/56 | $70.00 |
| **8. LTC Emergency Box replacement less than full box, no additional override** | 5/65 | 100 | $ 75.00<br>25% Co-Insurance | N/A | SCC 16: Long Term Care Emergency box | 1/13 | $15 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Scenario | Full Box Days Supply | Plan Days Supply Limit | Full Box Patient Pay Type & Amount | Max Copay Regulation | Exception Override Type | Adjusted Quantity/Days Supply | Adjusted Patient Pay Amount |
|---|---|---|---|---|---|---|---|
| Plan allows up to 100 days supply, 25% co-insurance<br>Pharmacy dispenses 1 pen to replace emergency box supply, bills patient's insurance with SCC 16<br>Plan accepts less than full box w/o additional override | | | | | (kit) or automated dispensing machine Indicates the transaction is a replacement supply for doses previously dispensed to the patient. | | |
| **9. Full Box: Plan requires extended day supply (e.g., 84, 90, 100), $100 copay**<br>2 full boxes = 70 days supply, falls below min day supply<br>3 full boxes = 105 days supply, falls above max days supply<br>Pharmacy dispenses 2 full boxes<br>Plan requires override for min days supply and full box package size edit | 5/35 | 100 | $ 80.00 | N/A | SCC 10 | 10/70<br>Or<br>15/105 | Prorated |
| **10. Box +: Plan requires extended day supply (e.g., 84, 90, 100), $100 copay**<br>Pharmacy dispenses 14 pens for 92 days supply<br>Plan accepts full box + w/o override | 5/65 | 100 | $ 80.00 | N/A | N/A | 14/92 | $100.00 |

**Response:**
Claim adjudication processes should align to FDA guidance, where insulin pen packages are intended for single patient use to be dispensed in its sealed package. However, based on professional judgment, individual insulin pens may be dispensed outside of the sealed carton. Professional judgment for breaking a package may include patient's setting of care, plan benefit rules and specific patient needs, while ensuring patient safety. This aligns to the following NCPDP description of an unbreakable package:

> *"A product in which the manufacturer package is not conducive to being broken based on package type or with FDA approved labeling which states products must be dispensed in their original container. Breaking certain package types must ensure patient safety risks are not compromised, where the sterility, quality and stability of the drug product and appropriate product identification are maintained. The provider may elect to break the package based on the setting of care; however, the provider cannot be forced to break a product identified as unbreakable."**

Below are recommendations to the most common dispensing scenarios for insulin pen packages:

- SCENARIO 1: PHARMACY IS ATTEMPTING TO SUBMIT A FULL PACKAGE:
  Therapeutic days supply for the dispensed quantity of a full package size may conflict with a plan's days supply requirements.
  - Days supply restrictions should not hinder the pharmacy's ability to dispense a full package


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Payer should not reject the claim and should leverage the NDC and associated package size to bypass plan limitations
- If payer system requires some type of override action by the pharmacy, the override process must be clearly identified
    - If an override is necessary, the recommendation is to use a Submission Clarification Code value 10 = "Meets Plan Limitations. The pharmacy certifies that the transaction is in compliance with the program's policies and rules that are specific to the particular product being billed"

❖ SCENARIO 2: PROFESSIONAL JUDGMENT AND/OR CARE SETTING REQUIRES THE PACKAGE TO BE BROKEN: The determination of most appropriate economic value for the patient and specific care settings are common conditions for dispensing individual pens. Payers' expectations to dispense full package size should not hinder the pharmacy's ability to dispense less than a full package or a full package plus additional individual pens.

- Payers should not reject the claim for full package size edits and should leverage the NDC to allow less than a full box.
- Payers should continue to recognize the use of SCC 16 to identify LTC emergency box use.

*September 10, 2015 NCPDP letter to CMS regarding unbreakable/smallest package size

Added May 2021

## 6.21 Pharmacist Assessment Billing

**Question**:
Some states are now allowing or mandating enhanced dispensing and incentive fees when pharmacists assess and prescribe certain medications (e.g., HIV PrEP medication) other than vaccines. What is the most appropriate method by which a pharmacy can indicate that an assessment occurred in an NCPDP Telecommunication Standard Version D.0© claim?

**Response**:

It is recommended the value of AS-Patient Assessment be submitted in the DUR segment Professional Service Code (440-E5) field. The amount requested for the assessment should be submitted in the Incentive Amount Submitted (438-E3) field.

The response should reflect the appropriate fields of the submission. The Incentive Amount Paid (521-FL) should reflect the payment amount for the assessment.

Added May 2021

## 6.22 Lower Case Data

**Question**:
If a pharmacy sends lower case data, for example a Patient First Name with lower case characters, and the PBM/Processor rejects the claim because the standard does not support lower case in that field, would it be appropriate for the rejected claim response to include the data as it was sent from the pharmacy in corresponding response fields or should the values be converted to upper case?

**Response:**
No, it is not appropriate for the response to echo back the invalid characters. The Reject code of 614 (Uppercase Character(s) Required) must be used and the M/I Reject Code(s) identifying the field(s) containing lower case character(s) in error must be returned per the ECL Value Limitation or Explanation.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

For example, on a Claim Request if the Patient First Name (310-CA) is submitted as John and the Patient Last Name (311-CB) is submitted as smith, the Response Status Segment would contain the three reject codes 614, CB and CA
AM21<1C>ANR<1C>FA03<1C>FB614<1C>FBCB<1C>FBCA

Reference: Reject Code 614 – Uppercase Character(s) Required
Value Limitation or Explanation: Used when lower case alphanumeric data is encountered. MUST send the M/I Reject code appropriate for the field containing lower case character(s) in error.
Reject Code CB – M/I Patient Last Name
Reject Code CA - M/I Patient First Name

Added November 2021

## 6.23 PHARMACIST SERVICES BILLING

**Question**:
How can claims for pharmacist professional services such as patient evaluation and management necessary to prescribe medication, be processed using the NCPDP Telecommunication Standard©?

**Response:**
The NCPDP Telecommunication Standard© Service Billing transaction codes (S1/S3, S2) can be used to process real-time, or batch service billing claims. While the use of NCPDP service billing transactions has been available since vD.0 was named under HIPAA in 2009, recent changes in state scope of practice laws and payer coverage policies have escalated the opportunities with this billing method.

Refer to below sections of the NCPDP Telecommunication Standard vD.0© for details on the use of S1/S3 and S2 transactions.

- SECTION 9: SERVICE BILLING (PROFESSIONAL PHARMACY SERVICE) INFORMATION
- SECTION 28.1.8.3: SPECIFIC DISCUSSION-PROFESSIONAL PHARMACY SERVICES
- SECTION 34.9: S1 CLAIM EXAMPLES USING DUR/PPS CODES
- SECTION 34.64: SERVICE BILLING – TRANSACTION CODE S1 WITH CPT CODES
- SECTION 35.11: PRESCRIPTION AND SERVICE BILLING IN ONE TRANSACTION

*The NCPDP Implementation of Telecommunication Standard vD.0© Service Billing Transactions for Pharmacist Professional Services* is available to provide additional guidance as entities implement the use of Telecommunications vD.0 service billing transactions.

Replaced November 2024

## 6.24 PHARMACIST MEDICATION ADMINISTRATION

**Question**:
Which Professional Service Code (440-E5) value(s) should be used for a B1 claim request for a non-vaccine product dispensed and administered at the pharmacy?

**Response:**
This document outlines vaccine administration billing guidance under Section 16 - VACCINE SERVICES – PHARMACY BENEFIT BILLING & PROCESSING. While this guidance is specific to vaccine products as this was the initial focus of pharmacist professional services, the same guidance can apply to other medications where scope of practice supports pharmacist administration.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

When trading partners support the use of a single B1 claim billing request for drug dispensing and administration, the Professional Service Code (440-E5) value of "MA" Medication Administration should be used to communicate the administration service. The MA value is further defined as "Code indicating an action of supplying a medication to a patient through any of several routes--oral, topical, intravenous, intramuscular, intranasal, etc." The Incentive Amount Submitted (438-E3) and Incentive Amount Paid (531-FL) fields would be used to communicate the financials associated to the administration service.

Added November 2024

## 6.25 TRANSITION TO COMMERCIAL COVID ANTI-VIRALS

**Question:**

As of March 9th, the Paxlovid oral anti-virals procured by the US Government (USG) will no longer be available for dispensing. How should payers/processors respond to claims submitted with the below USG-procured NDCs?

***US Government (USG) NDCs***

| *NDC* | *Drug Name* |
|---|---|
| *00069034506* | *PAXLOVID 300-100 MG PACK (EUA)* |
| *00069034530* | *PAXLOVID 150(X2)-100MGPK (EUA)* |
| *00069108506* | *PAXLOVID 300-100 MG PACK (EUA)* |
| *00069108530* | *PAXLOVID 150(X2)-100MG PK(EUA)* |
| *00069110104* | *PAXLOVID 150-100 MG PACK (EUA)* |
| *00069110120* | *PAXLOVID 150-100 MG PACK (EUA)* |

**Response:**

In the event a pharmacy submits a claim with a Date of Service on or after March 9, 2024, for USG- procured COVID anti-viral products, payer/processors should return reject code **77 - Discontinued Product/Service ID Number**. The use of any other reject code for this specific use case may impact pharmacy workflow processes and potentially impact or delay access to care. Pharmacies should be submitting claims with the commercial NDCs.

***Commercial NDCs***

| *NDC* | *Drug Name* |
|---|---|
| *00069531702* | *PAXLOVID 150-100 MG DOSE PACK* |
| *00069531720* | *PAXLOVID 150-100 MG DOSE PACK* |
| *00069532103* | *PAXLOVID 300-100 MG DOSE PACK* |
| *00069532130* | *PAXLOVID 300-100 MG DOSE PACK* |

*For additional information regarding the commercialization of Covid anti-virals, refer to:*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- *February 1, 2024 ASPR memo: COVID-19 Therapeutics Transition to Commercial Distribution: Frequently Asked Questions | HHS/ASPR*

- *January 29, 2024 FDA memo: https://www.fda.gov/drugs/drug-safety-and-availability/fda-revises-letter-authorization-emergency-use-authorization-paxlovid*

Added 02/2024

## 6.26 COVERAGE OF A DUPLICATE THERAPY INTERACTION

**Question:**
What Reject Code, Reason for Service code(s) and DUR Messaging should be returned when coverage of a duplicate therapy interaction may be allowed at point-of-sale under the following circumstances?

1. Coverage is allowed at point of sale with submission of appropriate DUR codes from the pharmacy.
2. Coverage is allowed at point of sale, short term or for limited fills (for example, to support dose adjustments).
3. Coverage is not allowed at point of sale and must follow the PA process.

**Response:**
Using a DUR Reason for Service Code or alert such as a Therapeutic Duplication as an example, the following values would be returned in the response:

| No | Scenario | Date Available | Reject Code 511-FB | Reason for Service Code 439-E4 | Approved Message Code* 548-6F |
|---|---|---|---|---|---|
| 1 | POS Override Allowed | Current | 88 | TD | N/A |
| 2a | POS Override Limited | Prior to 10/2025 | 88 | TD | N/A |
| 2b | POS Override Limited | 10/2025 | DO5 | TD | 060* |
| 3 | POS Override Not Allowed | Current | 943 | TD | N/A |

**Approved Message Code would only be returned in the scenario where the DUR reject has been clinically evaluated and the claim is approved due to submitted point of sale override codes from the pharmacy.*

Reject Code (511-FB)
The following reject codes should be used in the following scenarios:

Scenario 1: POS Override Allowed: 88 – *DUR Reject Error*
Scenario 2a: POS Override Limited: 88- *DUR Reject Error* until new reject code available October 2025
Scenario 2b: POS Override Limited: DO5 - *DUR Conflict. Limited override allowed at pharmacy. Thereafter, a prior authorization may be required.*
Scenario 3: POS Override Not Allowed: 943 - *DUR Reject - Pharmacy Override Using DUR/PPS Not Allowed*

- Returning reject code '75' (*Prior Authorization Required*) alongside the '943' is optional.

Reason for Service Code (439-E4)
The Reason for Service Code (439-E4) should identify the type of utilization conflict detected while the Reject Code (511-FB) indicates the action the pharmacy may take. This FAQ refers to several scenarios related to Therapeutic Duplication (TD) only.

DUR Additional Text (570-NS) & DUR Free Text Message (544-FY)
The DUR Additional Text (570-NS) and DUR Free Text Message (544-FY) fields should be used to expand on the reason for service identified and what steps may be taken to indicate the alert was reviewed and is appropriate. Note:


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- DUR Free Text Message (544-FY) may be used but is limited to 30 characters in Telecommunication Standard Version D.0©. As of Telecommunication Standard Version F6©, the field name was changed to DUR/DUE Free Text Message and field size was increased to 360 characters.
- DUR Additional Text (570-NS) allows for up to 100 characters but is sunset in Telecommunication Standard Version F6© and greater.

Approved Message Code (548-6F)
Additionally, returning the Approved Message Code (548-6F) of 060, Temporary Coverage Allowed Under a Limited DUR Override, for those scenarios where a limited override is allowed and has been applied may help the pharmacy to identify claims where a PA may be required in the near future.

The examples below show how these codes might be used, from initially rejected claims to subsequent claim attempts, including approvals and rejections.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Scenario 1: POS Override Allowed**

The following example shows a series of claims submitted for a member/beneficiary where point of sale DUR overrides are not limited. Note: the 2nd and 3rd examples below are identical to compare against scenarios 2 and 3 where point of sale overrides may be limited or not allowed/supported.

| | | Claim Request | | | | Claim Response | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 403-D3 | 439-E4 | 440-E5 | 441-E6 | 112-AN | 511-FB | 548-6F | 439-E4 | 570-NS / 544-FY | |
| Txn Attempt | Scenario | Fill Number | Reason for Service Code | Professional Service Code | Result of Service | Transaction Response Status | Reject Code(s) | Approved Message Code | Reason for Service Code(s) | DUR Additional Text / DUR Free Text Message | Suggested Pharmacy Action |
| 1 | Initial Therapeutic Duplication Rejection; no POS override codes submitted | 0 | N/A | N/A | N/A | R(eject) | 88 | N/A | TD | The message would provide additional detail about the alert. | Evaluate the alert and determine if POS override is appropriate |
| 2 | Therapeutic Duplication Rejection overridden by DUR codes; no limit. Initial Fill | 0 | TD | M0* | 1G* | P(aid) | N/A | N/A | TD | The message would provide additional detail about the alert. | |
| 3 | Therapeutic Duplication Rejection overridden by DUR codes; no limit. Refill #1 | 1 | TD | M0* | 1G* | P(aid) | N/A | N/A | TD | The message would provide additional detail about the alert. | |

**Professional Service Code and Result of Service Code shown as examples and would depend on actual actions from pharmacy and accepted codes from payer/processor*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Scenario 2: POS Override Limited**

The following example shows a series of claims submitted for a member/beneficiary where point of sale DUR overrides are limited to 3 fills total, after which a PA would be required.

| | | Claim Request | | | | Claim Response | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 403-D3 | 439-E4 | 440-E5 | 441-E6 | 112-AN | 511-FB | 548-6F | 439-E4 | 570-NS / 544-FY | |
| Txn Attempt | Scenario | Fill Number | Reason for Service Code | Professional Service Code | Result of Service | Transaction Response Status | Reject Code(s) | Approved Message Code | Reason for Service Code(s) | DUR Additional Text / DUR Free Text Message | Suggested Pharmacy Action |
| 1 | Initial Therapeutic Duplication Rejection; no POS override codes submitted. Override limited to 3 fills | 0 | N/A | N/A | N/A | R(eject) | DO5 | N/A | TD | POS Override limited to three overrides before PA required | Evaluate the alert, determine if POS override is appropriate and initiate PA process through prescriber if therapy and/or alert are expected to continue |
| 2 | Therapeutic Duplication Rejection overridden by DUR codes. Fill 1 of 3. | 0 | TD | M0* | 1G* | P(aid) | N/A | 060 | TD | POS Override limited; 1 of 3 overrides applied; PA Required | Review clinical conflict for future fills |
| 3 | Therapeutic Duplication Rejection overridden by DUR codes. Fill 2 of 3. | 1 | TD | M0* | 1G* | P(aid) | N/A | 060 | TD | POS Override limited; 2 of 3 overrides applied; PA Required | Review clinical conflict for future fills |
| 4 | Therapeutic Duplication Rejection overridden by DUR codes. Fill 3 of 3. | 2 | TD | M0* | 1G* | P(aid) | N/A | 060 | TD | POS Override limited; 3 of 3 overrides applied; PA Required | Review clinical conflict for future fills |
| 5 | Not overridden by DUR code. Overrides exhausted. | 3 | TD | M0* | 1G* | R(eject) | 943** | N/A | TD | POS Overrides exhausted PA Required for continued therapy… | Follow standard process for rejected claim |

**Professional Service Code and Result of Service Code shown as examples and would depend on actual actions from pharmacy and accepted codes from payer/processor.*

***Reject Code '943' indicates "DUR Reject - Pharmacy Override Using DUR/PPS Not Allowed"; Returning reject code '75' (Prior Authorization Required) alongside the '943' is optional.*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Scenario 3: POS Override Not Allowed; PA Required**

The following example shows a series of claims submitted for a member/beneficiary where point of sale DUR overrides are not allowed, and a PA must be obtained.

| | | Claim Request | | | | Claim Response | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 403-D3 | 439-E4 | 440-E5 | 441-E6 | 112-AN | 511-FB | 548-6F | 439-E4 | 570-NS / 544-FY | |
| Txn Attempt | Scenario | Fill Number | Reason for Service Code | Professional Service Code | Result of Service | Transaction Response Status | Reject Code(s) | Approved Message Code | Reason for Service Code(s) | DUR Additional Text / DUR Free Text Message | Suggested Pharmacy Action |
| 1 | Therapeutic Duplication Rejection; no POS override codes allowed. | 0 | N/A | N/A | N/A | R(eject) | 943* | N/A | TD | Message to explain the alert that cannot be overridden. | Initiate prescriber outreach |
| 2 | Therapeutic Duplication Rejection; no POS override codes allowed. Additional claim attempts continue to reject without PA. | 0 | TD | M0* | 1G* | R(eject) | 943* | N/A | TD | Message to explain the alert that cannot be overridden. | Initiate prescriber outreach |

**Reject Code '943' indicates "DUR Reject - Pharmacy Override Using DUR/PPS Not Allowed"; Returning reject code '75' (Prior Authorization Required) alongside the '943' is optional.*

Added May 2024

## 6.27 INSULIN ADMINISTRATION – DELIVERY DEVICE

**Question**:

What claim billing data elements can be used to communicate the delivery device method for rapid-acting insulin claims and assist in determining the appropriate Medicare benefit under which the claim should adjudicate?

**Response:**

The External Code List© (ECL) values below have been created for use with existing ECL values to support a standardized point of service process to communicate insulin delivery device method information when necessary.

**Reason for Service Code (439-E4):**

One new Reason for Service Code (439-E4) has been created for the payer to return on a rejected response, indicating the insulin delivery device method is needed.

- MD - Medication Delivery Device Method Required
  *Code indicating that a payer/processor requested information related to the delivery device method of the dispensed drug*
  Value Limitation: Not Used in Real Time Prescription Benefit Standard

**Professional Service Code (440-E5):**

One new Professional Service Code (440-E5) value has been created to support emergency situations when the insulin delivery device method cannot be confirmed.

- UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access
  *Code indicating the delay to confirm the medication delivery device method would compromise patient therapy.*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Note, there are other existing Professional Service Code (440-E5) values that can be used for the pharmacy to indicate the source of the insulin delivery method information.

**Result of Service Code (441-E6):**
Three new Result of Service Code (441-E6) values have been created for the pharmacy to communicate the insulin delivery device method of the dispensed insulin product.

- 5A – DME Pump Delivery Device Method
  *Dispensed drug is being administered via durable medical equipment (DME) pump. DME is defined by Medicare as medically necessary, reusable medical equipment*
- 5B - Non-DME or Disposable Delivery Device Method
  *Dispensed drug is being administered via non-durable medical equipment (DME) pump or some other disposable mechanism. Examples of these products may include disposable pumps, pens, needles/syringes.*
- 5C – Unknown Delivery Device Method and Immediate Access Required
  *Medication delivery device method of dispensed drug is unknown, not defined on the prescription. Patient requires immediate access to medication.*

**Approved Message Code (548-6F):**
One new Approved Message Code (548-6F) value has been created for the payer to communicate on a Paid claim response when the Result of Service Code value for Unknown Delivery Device Method and Immediate Access Required has been accepted under an exception.

- 062 - Submitted claim indicates Unknown Delivery Device Method; may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills.

Pharmacies could pro-actively submit an applicable Result of Service Code (441-E6) value to identify the insulin delivery device method, as the information may be mapped from an e-prescription to the B1 claim request. Refer to the SCRIPT Implementation Recommendations document for more information about how prescribers can communicate the insulin delivery device method information on an eRX using the current and future versions of the SCRIPT Standard©.

If the information is not on the submitted claim and is necessary for the payer to complete the claim adjudication process, payers can initiate the point of service communication process using the specified ECL values as outlined below.

Refer to the Insulin Delivery Device Method DUR Code Set Sample Matrices at the end of this FAQ for a combination of Reason for Service (439-E4), Professional Service (440-E5) and Result of Service Code (441-E6) code values that could be submitted on the request.

**POINT OF SERVICE CLAIMS PROCESSING GUIDANCE BASED ON MEDICARE PLAN TYPE**
**PDP - Prescription Drug Plan (Part D Benefit ONLY, No Part B)**

1. Rapid-acting insulin claim submitted
2. If Patient Residence Code = 3 (Nursing Facility) or 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities), regardless of the insulin delivery device method, claim continues to adjudicate under the PDP benefit.
3. All other Patient Residence Codes, or Patient Residence Code not submitted, and the Result of Service Code (441-E6) field does not contain one of the new insulin delivery device method values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*
   ii. Reason For Service Code (439-E4): MD - *Medication Delivery Device Method Required*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

iii. Additional Message Information (526-FQ) indicating claim should be submitted with an appropriate Result of Service Code (441-E6) value to identify the insulin delivery device method

4. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of MD – *Medication Delivery Device Method Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
   i. 5A - *DME Pump Delivery Device Method*
      - Payer Response: Claim rejects with Reject Code (511-FB): A6 – *This Product/Service May Be Covered Under Medicare Part B*
   ii. 5B- *Non-DME or Disposable Delivery Device Method*
      - Payer Response: Claim continues to adjudicate under the PDP benefit
   iii. 5C - *Unknown Delivery Device Method and Immediate Access Required*
      - Payer Response: Claim continues to adjudicate under the PDP benefit
        - If final status is a Paid claim, plan to return Approved Message *Code* (548-6F) *062 - Submitted claim indicates Unknown Delivery Device Method; may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills*
5. If required, Pharmacy includes one of the below Professional Service Code (440-E5) values:
   *i.* M0 - Prescriber consulted
   *Communication with prescriber related to collection of information or clarification of a drug therapy concern*
   ii. P0 - Patient consulted
   *Consultation with the patient to clarify or collect additional information*
   iii. R0 - Pharmacist consulted other source
   *Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern*
   iv. UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access
   *Code indicating the delay to confirm the medication delivery device method would compromise patient therapy*

**MA Only - Medicare Advantage (Part B Benefit ONLY, No Part D)**

1. Rapid-acting insulin claim submitted
2. If Patient Residence Code = 3 (Nursing Facility) or 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities), regardless of the insulin delivery device method, claim rejects with Reject Code (511-FB) value 620 – *This Product/Service May Be Covered Under Medicare Part D*
3. All other Patient Residence Codes, or Patient Residence Code not submitted, and the Result of Service Code (441-E6) field does not contain one of the new insulin delivery device method values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*
   ii. Reason For Service Code (439-E4): MD - *Medication Delivery Device Method Required*
   iii. Additional Message Information (526-FQ) indicating claim should be submitted with an appropriate Result of Service Code (441-E6) value to identify the insulin delivery device method.
4. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of MD – *Medication Delivery Device Method Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

i. 5A - *DME Pump Delivery Device Method*
   - Payer Response: Claim continues to adjudicate under the MA Only benefit

ii. 5B - *Non-DME or Disposable Delivery Device Method*
   - Payer response: Claim rejects with Reject Code (511-FB): 620 – *This Product/Service May Be Covered Under Medicare Part D*

iii. 5C - *Unknown Delivery Device Method and Immediate Access Required*
   - Payer Response: Claim continues to adjudicate under the MA Only benefit
     - If final status is a Paid claim, plan to return Approved Message Code (548-6F): 062 - *Submitted claim indicates Unknown Delivery Device Method; may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills.*

5. If required, Pharmacy includes one of the below Professional Service Code (440-E5) values:
   i. M0 - Prescriber consulted
   *Communication with prescriber related to collection of information or clarification of a drug therapy concern*
   ii. P0 - Patient consulted
   *Consultation with the patient to clarify or collect additional information*
   iii. R0 - Pharmacist consulted other source
   *Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern*
   iv. UA- Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access.
   *Code indicating the delay to confirm the medication delivery device method would compromise patient therapy*

**MAPD – Medicare Advantage Prescription Drug (Part B+D BENEFITS)**

1. Rapid-acting insulin claim submitted
2. If Patient Residence Code = 3 (Nursing Facility) or 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities), the claim should continue to adjudicate under the Part D benefit regardless of the insulin delivery device method
3. All other Patient Residence Codes, or Patient Residence Code not submitted, and the Result of Service Code (441-E6) field does not contain one of the new insulin delivery device method values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*
   ii. Reason For Service Code (439-E4): MD - *Medication Delivery Device Method Required*
   iii. Additional Message Information (526-FQ) indicating claim should be submitted with an appropriate Result of Service Code (441-E6) value to identify the insulin delivery device method.
4. Pharmacy resubmits claim with one of the below Result of Service Code values:
   i. 5A - *DME Pump Delivery Device Method*
      - Payer Response: Claim continues to adjudicate under the MAPD Part B benefit

   ii. 5B - *Non-DME or Disposable Delivery Device Method*
      - Payer Response: Claim continues to adjudicate under the MAPD Part D benefit

   iii. 5C - *Unknown Delivery Device Method and Immediate Access Required*
      - Claim routed to applicable plan benefit based on plan setup
        - If final status is a Paid claim, plan to return Approved Message Code 062 - *Submitted claim indicates Unknown Delivery Device Method;*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

*may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills.*

5. If required, Pharmacy resubmits claim with one of the below Professional Service Code (440-E5) values:
   i. M0 - Prescriber consulted
   *Communication with prescriber related to collection of information or clarification of a drug therapy concern*
   ii. P0 - Patient consulted
   *Consultation with the patient to clarify or collect additional information*
   iii. R0 - Pharmacist consulted other source
   *Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern*
   iv. UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access
   *Code indicating the delay to confirm the medication delivery device method would compromise patient therapy*

**Insulin Delivery Device Method DUR Code Set Sample Claim Request Matrices**

| Scenario | Request: Reason for Service Code (439-E4) | Professional Service Code (440-E5) | Result of Service Code (441-E6) |
|---|---|---|---|
| Pharmacy Proactively Submits Medication Delivery Device Method | _ | M0 - Prescriber Consulted | 5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method |
| Pharmacy Proactively Submits Medication Delivery Device Method | _ | P0 - Patient Consulted | 5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method |
| Pharmacy Proactively Submits Medication Delivery Device Method | _ | R0 - Pharmacist Consulted Other Source | 5A - DME Pump Delivery Device Method, or 5B- Non-DME or Disposable Delivery Device Method |
| Pharmacy Proactively Submits Medication Delivery Device Method | _ | UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access | 5C - Unknown Delivery Device Method and Immediate Access Required |
| Pharmacy Proactively Submits Medication Delivery Device Method | MD - Medication Delivery Device Method Required | M0 - Prescriber Consulted | 5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method |
| Pharmacy Proactively Submits Medication Delivery Device Method | MD - Medication Delivery Device Method Required | P0 - Patient Consulted | 5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method |
| Pharmacy Proactively Submits Medication Delivery Device Method | MD- Medication Delivery Device Method Required | R0 - Pharmacist Consulted Other Source | 5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method |
| Pharmacy Proactively Submits Medication Delivery Device Method | MD - Medication Delivery Device Method Required | UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access | 5C - Unknown Delivery Device Method and Immediate Access Required |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | |
|---|---|---|---|
| Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required | MD - Medication Delivery Device Method Required | M0 - Prescriber Consulted | 5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method |
| Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required | MD - Medication Delivery Device Method Required | P0 - Patient Consulted | 5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method |
| Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required | MD - Medication Delivery Device Method Required | R0 - Pharmacist Consulted Other Source | 5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method |
| Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required | MD - Medication Delivery Device Method Required | UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access | 5C - Unknown Delivery Device Method and Immediate Access Required |

*Added August 2024*

## 6.28 CLAIM SUBMISSION ENTITIES

**Question:**
What types of entities may submit claims using NCPDP Telecommunication Standard© transactions? Must the submitter be a pharmacy?

**Response:**
The NCPDP Telecommunication Standard© does not restrict submission solely to pharmacies or pharmacists. Any entity acting as the service provider may submit transactions as long as*:*

i. The entity can be properly identified using the Service Provider ID Qualifier (202-B2) and Service Provider ID (201-B1) fields,
ii. The transaction is permitted under applicable laws, regulations, and contractual or payer requirements, and
iii. The payer accepts NCPDP Telecommunication Standard© transactions for that type of product/service.

This may include pharmacies, physicians, clinics, or other qualified providers when allowed by regulation and payer policy.

Added March 2026

## 6.29 PHARMACOGENOMIC (PGX) TESTING

**Question:**
How can a plan indicate that pharmacogenomic (PGx) testing is required before approving a medication or dose on a claim response?

**Response:**
Plans may communicate PGx testing requirements at the time of adjudication in several ways. When determining how to apply these requirements, payers should consider:


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Whether the pharmacy can resolve the rejection at the time of adjudication using an available override.
- Whether the requirement applies only to new starts or to all users of the therapy.
- Whether abrupt discontinuation of therapy may pose a clinical risk—particularly in cases where the member is already stabilized on the medication or dose.
- Whether abrupt discontinuation of therapy may pose unnecessary side effects or adverse reactions, particularly in cases where a taper of the drug is required before switching to a new therapy.
- Whether pharmacist or prescriber clinical judgment should be allowed to determine if therapy must continue temporarily while PGx testing is obtained.
- Whether applying the requirement would pose an access to care issue.

Based on these considerations, the following codes may be used:

**Communicating the Need for PGx Testing**
There are several options available for communicating that PGx testing is needed before a medication can be dispensed depending on whether the claim will be rejected and if so, whether an override is available:

1. **Hard Reject (No Pharmacy Override Permitted)**
   Use 511-FB Reject Code **DQ5 "Pharmacogenomic Test Required"**
   This communicates that PGx testing must occur before any dispensing can take place and no override is permitted at the pharmacy level.
2. **Soft Reject (Pharmacy Override Permitted)**
   Use 511-FB Reject Code **88 "DUR Reject Error"**, and 439-E4 Reason for Service Code **UH "Pharmacogenomic Test is Needed"**
   This approach allows the pharmacist to evaluate the clinical situation and submit an override when continuation of therapy is appropriate while testing is obtained.
   Result of Service Code **5J "Dispensed, Discontinuation Not Recommended"** may be used when it has been determined that discontinuation of a current drug therapy is not recommended.
3. **Soft Messaging Only (Pharmacy Override Not Needed)**
   Use 439-E4 Reason for Service Code **UH "Pharmacogenomic Test is Needed"**
   This approach allows the pharmacist to evaluate the clinical situation and work with the patient and or prescriber to initiate PGx testing, while allowing the current claim to continue to process. This may be considered where the clinical significance of the potential pharmacogenomic contraindication is low.

**Communicating that PGx Testing Indicates Contraindication for Patient**
When communicating that PGx testing has been completed and results indicate that the medication or dose is contraindicated for the member, plans may consider issuing a hard reject or a soft reject depending on whether pharmacist or prescriber judgment should be allowed to process the claim:

1. **Hard Reject (No Pharmacy Override Permitted)**
   Use 511-FB Reject Code **DN4 "PGx: Dispensing Not Authorized Due to PGx Lab Test Results"**
   This indicates that the medication should not be dispensed based on the completed PGx results.
2. **Soft Reject (Pharmacy Override Permitted)**
   Use 511-FB Reject Code **88 "DUR Reject Error"**, and 439-E4 Reason for Service Code **UG "Drug-Gene Interaction"**
   This option is appropriate when pharmacist review is needed and when abrupt discontinuation may not be clinically appropriate. In such cases, the pharmacist may determine whether temporary continuation is necessary while therapeutic changes are coordinated.

Whenever Drug Utilization Review (DUR) information is returned to the pharmacy, the DUR messaging should provide clear, comprehensive, and actionable details. Messaging must include enough information for the


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

pharmacist to understand why the alert was triggered, the clinical concern identified, and the required next steps—such as whether an override is permissible, additional documentation is needed, or follow-up testing or prescriber consultation is required. Providing complete and transparent DUR messaging supports patient safety, reduces delays in therapy, and ensures the pharmacist can make informed decisions.

*Added June 2026*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 7 GUIDANCE FOR OPIOID LIMITS

## 7.1 OVERVIEW

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

The guidance below is divided into several parts:

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

## 7.2 BACKGROUND INFORMATION

### 7.2.1 MEDICARE PART D BACKGROUND

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

Additional information can be found at:
https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Medicare-PartD-Overutilization-Control-HPMS-memos-October-2018.zip

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18016.pdf

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

- Opioid naïve patients:
  - Limit initial opioid prescription fills for the treatment of acute pain to no more than a 7 days supply
  - As the plan may not know of exemptions prior to this initial fill, pharmacies may submit these exemptions on the claim or by contacting the plan's help desk
- Opioid Cumulative MME & Care Coordination
  - Plan sponsors should implement an opioid care coordination edit at 90 MME per day as a formulary-level safety edit based on the beneficiary's cumulative MME per day across their opioid prescriptions
  - Pharmacists should consult with the prescriber, document the discussion, and if prescriber intent is confirmed, use the appropriate overrides to relay that information to the plan


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Additionally, plans have the option to invoke an edit at 200 MME or above that may only be overridden with a Prior Authorization unless the exemptions outlined in the 2019 guidance apply.

### 7.2.2 State and Plan Background

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

### 7.2.3 Medicaid and CHIP Background

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

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

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

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

### 7.3.1 Reject Codes (511-FB)

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

| ECL Effective Date | 511-FB | Description |
|---|---|---|
| Now | 76 | Plan Limitations Exceeded |
| Now | 7X | Days Supply Exceeds Plan Limitations |
| Now | AG | Days Supply Exceeded for Product/Service |
| 20190101 | 927 | Days Supply Limits Exceeded For Product/Service for Patient Age |
| Now | 9G | Quantity Dispensed Exceeds Maximum Allowed |
| Now | 75 | Prior Authorization Required (may be used when drug formulary status is set as prior authorization required) |
| 20190101 | 922 | Morphine Milligram Equivalent (MME) Exceeds Limits* |
| 20190101 | 923 | Morphine Milligram Equivalent (MME) Exceeds Limits for Patient Age* |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| ECL Effective Date | 511-FB | Description |
|---|---|---|
| 20190101 | 925 | Initial Fill Days Supply Exceeds Limits |
| 20190101 | 926 | Initial Fill Days Supply Exceeds Limits for Patient Age |
| 20190101 | 928 | Cumulative Fills exceed limits |
| Now | G4 | Prescriber must contact plan |
| Now | 88 | DUR Reject Error |
| Now | 80 | Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria |
| Now | 9C | Professional Service Code Value Not Supported |
| Now | 9D | Result of Service Code Value Not Supported |
| Now | 569 | Provide Notice: Medicare Prescription Drug Coverage and Your Rights |
| 20191015 | 943 | DUR may not be overridden at Point of Sale, prescriber to initiate coverage determination. |
| Now | 828 | Plan/Beneficiary Case Management Restriction In Place |
| Now | M2 | Recipient Locked In (Will be sunset 10-15-2020) |
| 20201015 | 979 | Patient Locked Into Specific Prescriber(s) |
| 20201015 | 980 | Patient Locked Into Specific Pharmacy(s) |

#### *7.3.1.1 SPECIFIC REJECT CODE DISCUSSION*

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

Reject code 88 may be used to alert the pharmacy that the reject requires pharmacist intervention and a drug utilization review:

- If the 88 has been returned for a hard stop edit where POS overrides are not allowed, the processor should
    - Return reject code G4 “Prescriber must contact Plan” to indicate the prescriber can initiate a request for an override.

Reject Code 943 may be used to indicate that the DUR information is for informational purposes only, and may not be overridden at POS. This code is not intended to be used for CMS Medicare Part D. Alternatively, the most specific hard stop reject can be returned with the appropriate opioid reject code, in which case the rejection will be identified at the pharmacy as a hard reject.

- When Reject Code 75 (Prior Authorization Required) is returned, Reject Code 88 (DUR Reject Error) would only be returned when alerting to a different DUR exception.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Reject Code 569 is for use only with Medicare Part D. Refer to the guidance listed in this document, "Notice of Medicare Drug Coverage Rights – Rejected Claim"

### 7.3.2 Reason for Service Code (439-E4)

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

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

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

| ECL Effective Date | 439-E4 | Description | Recommended Use |
|---|---|---|---|
| 20190101 | MP | Poly-Pharmacy Detected | See above |
| 20190101 | MR | Poly-Prescriber Detected | See above |

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

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

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

**Other Pharmacy Indicator (529-FT)**

| ECL Effective Date | 529-FT | Description |
|---|---|---|
| Now | 1 | Your Pharmacy |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| ECL Effective Date | 529-FT | Description |
|---|---|---|
| Now | 2 | Other Pharmacy in Same Chain |
| Now | 3 | Other Pharmacy |

**Other Prescriber Indicator (533-FX)**

| ECL Effective Date | 533-FX | Description |
|---|---|---|
| Now | 1 | Same Prescriber |
| Now | 2 | Other Prescriber |

### 7.3.4 APPROVED MESSAGE CODE (548-6F)

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

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

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

| ECL Effective Date | 548-6F | Value Description |
|---|---|---|
| Existing | 34 | Prior Authorization Approval On File |
| 20191015 | 47 | Result of Service Code Accepted |
| 20191015 | 48 | Diagnosis Code Accepted |

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

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

| ECL Effective Date | 132-UH | Additional Message Information Qualifier Description | Transaction Response P=Paid R=Rejected |
|---|---|---|---|
| 20110101 | 01- 09 | Used for free form text with no pre-defined structure | R,P |
| 20151015 | 10 | Next Available Fill Date | R |
| 20161015 | 11 | Date Prior Authorization Ends | P |
| 20161015 | 12 | Maximum qty allowed over the designated time period | P |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

### 7.3.6 ADDITIONAL MESSAGE INFORMATION (526-FQ)

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

type of information and specific limitations and values that can be returned in this field when used with Additional Message Information Qualifier (132-UH) values greater than 09.

### 7.3.7 HELP DESK TELEPHONE NUMBER (550-AF)

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

### 7.3.8 DUR FREE TEXT MESSAGE (544-FY) & DUR ADDITIONAL TEXT (570-NS)

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

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

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

### 7.4.1 DIAGNOSIS CODE (424-DO)

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

### 7.4.2 LONG TERM CARE EXEMPTIONS TO OPIOID POLICY – PATIENT RESIDENCE CODE (384-4X)

If an exemption for an opioid restriction is allowed based solely upon the member residing in a Long Term Care facility, then the payer can identify these members based upon the submitted Patient Residence Code (384-4X). For further clarification, please refer to "HOW DO WE KNOW WE HAVE A LTPAC TRANSACTION?" in this document.

### 7.4.3 DUR/PPS SEGMENT (111-AM)

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

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

#### *7.4.3.1 DUR PROFESSIONAL SERVICE CODE (440-E5)*

The following Professional Service Codes identify the type of pharmacist intervention that occurred to address the clinical conflict presented by the payer/processor. Based upon allowed plan or regulatory guidance, the following actions may be taken, and the codes may be submitted to request an override at point of service following an appropriate drug utilization review process


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| ECL Effective Date | 440-E5 | Description |
|---|---|---|
| Now | M0 | Prescriber Consulted |
| Now | DP | Dosage Evaluated |
| Now | DE | Dosage Evaluation/Determination |
| Now | MR | Medication Review |
| Now | R0 | Pharmacist Consulted Other Source |

#### *7.4.3.2 DUR RESULT OF SERVICE CODE (441-E5)*

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

| ECL Effective Date | 441-E6 | Description |
|---|---|---|
| Now | 1A | Dispensed As Is, False Positive |
| Now | 1B | Dispensed Prescription As Is |
| Now | 1G | Dispensed with Prescriber Approval |
| 20190101 | 4B | Dispensed, Palliative Care |
| 20190101 | 4C | Dispensed, Hospice |
| 20190101 | 4D | Dispensed, Cancer Treatment |
| 20190101 | 4E | Dispensed, Chronic Pain |
| 20190101 | 4F | Dispensed, Exempt Per Prescriber |
| 20190101 | 4G | Dispensed, Surgery/Trauma |
| 20190101 | 4H | Dispensed, Hospital Admission/Discharge |
| 20190101 | 4J | Dispensed, Patient Is Not Opioid Naive |
| 20191015 | 4K | Prescriber Specialty Exemption-Oncology or non-hospice Palliative Care |
| 20191015 | 4L | Prescriber Specialty Exemption-Hospice |
| 20230101 | 4R | Dispensed, Sickle Cell Disease |

Updated December 2022

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

### 7.5.1 SUBMISSION CLARIFICATION CODE (420-DK)

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

### 7.5.2 PRIOR AUTHORIZATION NUMBER SUBMITTED (462-EV)

Some payers allow the Prior Authorization Number Submitted to override a reject at point of service. There is no standard NCPDP set of external code values for this field. Therefore, the codes


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

being used in this field may vary from payer to payer. The use of the Prior Authorization Number Submitted field also does not support the pharmacy workflow and clinical objective necessary to ensure patient safety and access to care as it relates to these opioid safety edits.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 7.6 Opioid Utilization Scenarios Matrix

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

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

Additional References:

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

Important Medicare Part D Guidance

- It is critical to recognize that CMS has specified certain exemptions for Medicare Part D (e.g. cancer, palliative care). In the scenarios shown below, if a CMS specified exemption is submitted on a claim, the exemption must override any rejects or edits related to exceeding an MME threshold.
- In the case of the MME edit limitations, using the 'G4' reject code combined with the "569" reject code should indicate that the prescriber or the beneficiary must contact the plan. The absence of the G4 reject code indicates that Pharmacist Care Coordination is allowed.
- Per Payer Processor Discretion, claims submitted with a Hospice DUR/PPS code or with a Prescriber specialty exemption of hospice will most likely be rejected for a coverage determination for Part A/Hospice versus Part D.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### 7.6.1 OPIOID NAÏVE DAY SUPPLY LIMITATION

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| A1 | The claim exceeds the Opioid Naïve days supply with no exemption criteria submitted on the claim. | N/A | N/A | N/A | N/A | R(eject) | N/A | 88<br>569<br>925 | MX | N/A | N/A | N/A |
| A2 | The RPh reviews the patient's medication history or consults another source and determines that the patient is not opioid naïve. | MX | MR<br>or R0 | 4J | N/A | P(aid) | N/A | N/A | *MX* | N/A | N/A | N/A |
| A3 | The RPh consults with the prescriber and determines that the patient is not opioid naïve. | MX | M0 | 4J | N/A | P(aid) | N/A | N/A | *MX* | N/A | N/A | N/A |
| A4 | The RPh consults with the prescriber or other source and confirms the patient is under hospice care. | MX | M0<br>or R0 | 4C | N/A | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion |
| A5 | The RPh consults with the prescriber or other source and confirms the patient is under palliative care. | MX | M0<br>or R0 | 4B | N/A | P(aid) | 47 | N/A | *MX* | N/A | N/A | N/A |
| A6 | The RPh consults the prescriber, performs a medication review, or consults another source and confirms the patient has cancer. | MX | M0<br>or MR<br>or R0 | 4D | N/A | P(aid) | 47 | N/A | *MX* | N/A | N/A | N/A |
| A7 | The RPh consults the prescriber, performs a medication review, or consults another source and confirms the patient has sickle cell disease, and the specific diagnosis code is not available. | MX | M0<br>or MR<br>or R0 | 4R | N/A | P(aid) | 47 | N/A | *MX* | N/A | N/A | N/A |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| A8 | The RPh consults the prescriber, performs a medication review, or consults another source and determines that the drug is prescribed for chronic pain. | MX | M0 or MR or R0 | 4E | N/A | R(eject) | N/A | 88 569 9D 925 | MX | N/A | N/A | N/A |
| A9 | Submitted Result of Service code does not meet exception criteria. | MX | M0 or MR or R0 | Any other RSC except 4J, 4B, 4C or 4D | N/A | R(eject) | N/A | 88 569 9D 925 | MX | N/A | N/A | N/A |
| A10 | Submitted diagnosis code meets coverage criteria. | N/A | N/A | N/A | ICD-10 codes for accepted conditions | P(aid) | 48 | N/A | N/A | N/A | N/A | N/A |
| A11 | Submitted diagnosis code does not meet coverage criteria. | N/A | N/A | N/A | ICD-10 code(s) <> accepted conditions | R(eject) | N/A | 88 569 80 925 | MX | N/A | N/A | N/A |
| A12 | Submitted diagnosis code may meet coverage criteria, but field 424-D0 is not used by plan. | N/A | N/A | N/A | ICD-10 codes for accepted conditions | R(eject) | N/A | 88 569 521 925 | MX | N/A | N/A | N/A |
| A13 | Prescriber initiates Coverage Determination Request, which is approved. | N/A | N/A | N/A | N/A | P(aid) | 34 | N/A | N/A | N/A | N/A | N/A |

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

Updated December 2022


*** OFFICIAL RELEASE ***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| B1 | The claim exceeds the morphine equivalent dosing limitation with no exemption criteria submitted on the claim. If no known exemptions, the prescriber must contact the plan for a PA. | N/A | N/A | N/A | N/A | R(eject) | N/A | 88<br>G4<br>943**<br>569<br>922 | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | <Blank> = Fill Level<br>1,2,3 = Cumulative Level | <Blank> = Fill Level<br>1,2 = Cumulative Level | IF NO KNOWN EXEMPTIONS. PRESCRIBER TO CONTACT PLAN |
| B2 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for palliative care. | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | M0<br>or R0 | 4B | N/A | P(aid) | 47 | N/A | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | N/A | N/A | N/A |
| B3 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for cancer. | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | M0<br>or R0<br>or MR | 4D | N/A | P(aid) | 47 | N/A | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | N/A | N/A | N/A |
| B4 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of cancer or non-hospice palliative care. | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | M0<br>or R0 | 4K | N/A | P(aid) | 47 | N/A | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | N/A | N/A | N/A |
| B5 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for a patient with sickle cell disease and the specific diagnosis code is not available. | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | M0<br>or R0<br>or MR | 4R | N/A | P(aid) | 47 | N/A | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | N/A | N/A | N/A |
| B6 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of hospice. | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | M0<br>or R0 | 4L | N/A | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| B7 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber approval. | HD or HC *+/- MP* *+/- MR* | M0 | 1G | N/A | R(eject) | N/A | 88 G4 943** 569 9D 922 | HD or HC *+/- MP* *+/- MR* | <Blank> = Fill Level 1,2,3 = Cumulative Level | <Blank> = Fill Level 1,2 = Cumulative Level | IF NO KNOWN EXEMPTIONS. PRESCRIBER TO CONTACT PLAN |
| B8 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed per the pharmacist's review. | HD or HC *+/- MP* *+/- MR* | M0 or R0 | 1A or 1B | N/A | R(eject) | N/A | 88 G4 943** 569 9D 922 | HD or HC *+/- MP* *+/- MR* | <Blank> = Fill Level 1,2,3 = Cumulative Level | <Blank> = Fill Level 1,2 = Cumulative Level | IF NO KNOWN EXEMPTIONS. PRESCRIBER TO CONTACT PLAN |
| B9 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for hospice care. | HD or HC *+/- MP* *+/- MR* | M0 or R0 | 4C | N/A | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion |
| B10 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for cancer, sickle cell, or any other disease state identified as exempt by state and/or federal law. | N/A | N/A | N/A | ICD-10 code(s) for accepted conditions | P(aid) | 48 | N/A | N/A | N/A | N/A | N/A |
| B11 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for a non-exempt diagnosis. | N/A | N/A | N/A | ICD-10 code(s) <> accepted conditions | R(eject) | N/A | 88 G4 943** 569 80 922 | HD or HC *+/- MP* *+/- MR* | <Blank> = Fill Level 1,2,3 = Cumulative Level | <Blank> = Fill Level 1,2 = Cumulative Level | IF NO KNOWN EXEMPTIONS. PRESCRIBER TO CONTACT PLAN |
| B12 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for an exempt indication, but the plan does not use diagnosis codes. | N/A | N/A | N/A | Any ICD-10 | R(eject) | N/A | 88 G4 943** 569 | HD or HC *+/- MP* *+/- MR* | <Blank> = Fill Level 1,2,3 = Cumulative Level | <Blank> = Fill Level 1,2 = Cumulative Level | IF NO KNOWN EXEMPTIONS. PRESCRIBER TO CONTACT PLAN |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| | | | | | | | | 521<br>922 | | | | |
| B13 | The claim is submitted with an approved coverage determination on file. | N/A | N/A | N/A | N/A | P(aid) | 34 | N/A | N/A | N/A | N/A | N/A |

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

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

Updated December 2022


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| C1 | The claim exceeds the morphine equivalent dosing limitation with no exemption criteria submitted on the claim. Barring any exemptions, the pharmacy must coordinate care with the prescriber. | N/A | N/A | N/A | N/A | R(eject) | N/A | 88<br>569<br>922 | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | <Blank> = Fill Level<br>1,2,3 = Cumulative Level | <Blank> = Fill Level<br>1,2 = Cumulative Level | IF NO KNOWN EXEMPTIONS. PRESCRIBER CARE COORDINATION REQD |
| C2 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for palliative care. | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | M0<br>or R0 | 4B | N/A | P(aid) | 47 | N/A | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | N/A | N/A | N/A |
| C3 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for cancer. | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | M0<br>or R0<br>or MR | 4D | N/A | P(aid) | 47 | N/A | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | N/A | N/A | N/A |
| C4 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of cancer or non-hospice palliative care. | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | M0<br>or R0 | 4K | N/A | P(aid) | 47 | N/A | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | N/A | N/A | N/A |
| C5 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for a patient with sickle cell disease and the specific diagnosis code is not available. | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | M0<br>or R0<br>or MR | 4R | N/A | P(aid) | 47 | N/A | HD<br>or HC<br>*+/- MP*<br>*+/- MR* | N/A | N/A | N/A |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| C6 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of hospice. | HD or HC *+/- MP* *+/- MR* | M0 or R0 | 4L | N/A | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion |
| C7 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber approval. | HD or HC *+/- MP* *+/- MR* | M0 | 1G | N/A | P(aid) | 47 | N/A | HD or HC *+/- MP* *+/- MR* | N/A | N/A | N/A |
| C8 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed per the pharmacist's review. | HD or HC *+/- MP* *+/- MR* | M0 or R0 | 1A or 1B | N/A | R(eject) | N/A | 88 569 922 | HD or HC *+/- MP* *+/- MR* | <Blank> = Fill Level 1,2,3 = Cumulative Level | <Blank> = Fill Level 1,2 = Cumulative Level | IF NO KNOWN EXEMPTIONS. PRESCRIBER CARE COORDINATION REQD |
| C9 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for hospice care. | HD or HC *+/- MP* *+/- MR* | M0 or R0 | 4C | N/A | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion |
| C10 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for cancer, sickle cell, or any other disease state identified as exempt by state and/or federal law. | N/A | N/A | N/A | ICD-10 code(s) for accepted conditions | P(aid) | 48 | N/A | N/A | N/A | N/A | N/A |
| C11 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for a non-exempt diagnosis. | N/A | N/A | N/A | ICD-10 code(s) <> accepted conditions | R(eject) | N/A | 88 569 80 922 | HD or HC *+/- MP* *+/- MR* | <Blank> = Fill Level 1,2,3 = Cumulative Level | <Blank> = Fill Level 1,2 = Cumulative Level | IF NO KNOWN EXEMPTIONS. PRESCRIBER CARE COORDINATION REQD |
| C12 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for an exempt indication, | N/A | N/A | N/A | Any ICD-10 | R(eject) | N/A | 88 569 | HD or HC | <Blank> = Fill Level 1,2,3 = | <Blank> = Fill Level 1,2 = | IF NO KNOWN EXEMPTIONS. |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| | but the plan does not use diagnosis codes. | | | | | | | 521<br>922 | *+/- MP*<br>*+/- MR* | Cumulative Level | Cumulative Level | PRESCRIBER CARE COORDINATION REQD |
| C13 | The claim is submitted with an approved coverage determination on file. | N/A | N/A | N/A | N/A | P(aid) | 34 | N/A | N/A | N/A | N/A | N/A |

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

Updated December 2022

### 7.6.4 DUPLICATIVE THERAPY SOFT EDIT - LONG ACTING OPIOIDS

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| D1 | Concurrent use for a current claim for a long acting opioid is found with another long acting opioid in the patient's history. | N/A | N/A | N/A | N/A | R(eject) | N/A | 88<br>569 | TD | 1,2,or 3 | 1 or 2 | N/A |
| D2 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for palliative care. | TD | M0<br>or R0 | 4B | N/A | P(aid) | 47 | N/A | TD | N/A | N/A | N/A |
| D3 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for cancer. | TD | M0<br>or R0<br>or MR | 4D | N/A | P(aid) | 47 | N/A | TD | N/A | N/A | N/A |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| D4 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of cancer or non-hospice palliative care. | TD | M0 or R0 | 4K | N/A | P(aid) | 47 | N/A | TD | N/A | N/A | N/A |
| D5 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for a patient with sickle cell disease and the specific diagnosis code is not available. | TD | M0 or R0 or MR | 4R | N/A | P(aid) | 47 | N/A | TD | N/A | N/A | N/A |
| D6 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of hospice. | TD | M0 or R0 | 4L | N/A | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion |
| D7 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber approval. | TD | M0 | 1G | N/A | P(aid) | 47 | N/A | TD | N/A | N/A | N/A |
| D8 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed per payer/processor or CMS defined exception. | TD | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | N/A | P(aid) | 47 | N/A | TD | N/A | N/A | N/A |
| D9 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for hospice care. | TD | M0 or R0 | 4C | N/A | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion |
| D10 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for cancer, sickle cell, or any other disease state identified as exempt by state and/or federal law. | N/A | N/A | N/A | ICD-10 code(s) for accepted conditions | P(aid) | 48 | N/A | N/A | N/A | N/A | N/A |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| D11 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for a non-exempt diagnosis. | N/A | N/A | N/A | ICD-10 code(s) <> accepted conditions | R(eject) | N/A | 88<br>569<br>80 | TD | 1,2,or 3 | 1 or 2 | N/A |
| D12 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for an exempt indication, but the plan does not use diagnosis codes. | N/A | N/A | N/A | Any ICD-10 | R(eject) | N/A | 88<br>569<br>521 | TD | 1,2,or 3 | 1 or 2 | N/A |
| D13 | The claim is submitted with an approved coverage determination on file. | N/A | N/A | N/A | N/A | P(aid) | 34 | N/A | N/A | N/A | N/A | N/A |

Updated December 2022


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| E1 | Concurrent use between the incoming claim and a conflicting product(s) is found for the current claim. | N/A | N/A | N/A | N/A | R(eject) | N/A | 88<br>569 | DD | 1,2,or 3 | 1 or 2 | N/A |
| E2 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for palliative care. | DD | M0<br>or R0 | 4B | N/A | P(aid) | 47 | N/A | DD | N/A | N/A | N/A |
| E3 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for cancer. | DD | M0<br>or R0<br>or MR | 4D | N/A | P(aid) | 47 | N/A | DD | N/A | N/A | N/A |
| E4 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of cancer or non-hospice palliative care. | DD | M0<br>or R0 | 4K | N/A | P(aid) | 47 | N/A | DD | N/A | N/A | N/A |
| E5 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for a patient with sickle cell disease and the specific diagnosis code is not available. | DD | M0<br>or R0<br>or MR | 4R | N/A | P(aid) | 47 | N/A | DD | N/A | N/A | N/A |
| E6 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber specialty exemption of hospice. | DD | M0<br>or R0 | 4L | N/A | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| E7 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed with a prescriber approval. | DD | M0 | 1G | N/A | P(aid) | 47 | N/A | DD | N/A | N/A | N/A |
| E8 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed per payer/processor or CMS defined exception. | DD | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | N/A | P(aid) | 47 | N/A | DD | N/A | N/A | N/A |
| E9 | The claim is submitted with DUR/PPS codes indicating the claim is being dispensed for hospice care. | DD | M0 or R0 | 4C | N/A | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion | Per Payer/ Processor Discretion |
| E10 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for cancer, sickle cell, or any other disease state identified as exempt by state and/or federal law. | N/A | N/A | N/A | ICD-10 code(s) for accepted conditions | P(aid) | 48 | N/A | N/A | N/A | N/A | N/A |
| E11 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for a non-exempt diagnosis. | N/A | N/A | N/A | ICD-10 code(s) <> accepted conditions | R(eject) | N/A | 88<br>569<br>80 | DD | 1,2,or 3 | 1 or 2 | N/A |
| E12 | The claim is submitted with a diagnosis code indicating the claim is being dispensed for an exempt indication, but the plan does not use diagnosis codes. | N/A | N/A | N/A | Any ICD-10 | R(eject) | N/A | 88<br>569<br>521 | DD | 1,2,or 3 | 1 or 2 | N/A |
| E13 | The claim is submitted with an approved coverage determination on file. | N/A | N/A | N/A | N/A | P(aid) | 34 | N/A | N/A | N/A | N/A | N/A |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

| | | Claim Request | | | | Claim Response | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 439-E4 | 440-E5 | 441-E6 | 424-DO | 112-AN | 548-6F | 511-FB | 439-E4 | 529-FT | 533-FX | (Per Payer/ Processor) |
| No | Opioid Utilization Scenario | Reason for Service Code | Professional Service Code | Result of Service Code | Diagnosis Code (ICD10) | Transaction Response Status | Approved Message Code | Reject Code(s) | Reason for Service Code(s)* | Other Pharmacy Indicator | Other Prescriber Indicator | Suggested Free Text Messaging |
| F1 | The member is locked into a specific pharmacy and is attempting to fill an opioid, benzodiazepine or other targeted drug at a different pharmacy. | N/A | N/A | N/A | N/A | R(eject) | N/A | M2**<br>980** | N/A | N/A | N/A | *Patient locked into specific pharmacy.* |
| F2 | The member is locked into a specific prescriber and is attempting to fill an opioid, benzodiazepine or other targeted drug written by a different prescriber. | N/A | N/A | N/A | N/A | R(eject) | N/A | M2**<br>979** | N/A | N/A | N/A | *Patient locked into specific prescriber.* |
| F3 | The member is attempting to fill an opioid, benzodiazepine or other targeted drug that is not covered per a beneficiary case management restriction. | N/A | N/A | N/A | N/A | R(eject) | N/A | 828 | N/A | N/A | N/A | *Product not covered due to beneficiary case management restriction.* |
| F4 | The member has exceeded the daily dosage as set by a beneficiary case management restriction | N/A | N/A | N/A | N/A | R(eject) | N/A | 828<br>88<br>G4<br>943* | HD | N/A | N/A | *Indicate how much the limit was exceeded.* |
| F5 | The member has exceeded the MME limit for the claim as set by a beneficiary case management restriction | *N/A* | *N/A* | *N/A* | *N/A* | R(eject) | *N/A* | 828<br>88<br>G4<br>943* | HD/HC | *N/A* | *N/A* | *Indicate how much the limit was exceeded.* |

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

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

***Effective October 15, 2020, Reject Codes 980 (Patient Locked Into Specific Pharmacy(s)) and 979 (Patient Locked Into Specific Prescriber(s)) may be used in place of reject code M2 (Recipient Locked In. Contact Plan.). Reject code M2 will be sunset as of October 15, 2020.*

*Updated November 2019 – Clinical and Safety Edits TG*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 8 NCPDP BATCH STANDARD©

## 8.1 DELIMITER

**Question:** Can we require (as a processor in compliance with the standard) that the submitter delimit each record in the Batch Standard© by ASCII Carriage Return Line Feed (CRLF) in addition to the Start and End Text fields? We UNZIP and FTP the transmitted files to our mainframe system before processing and end up with a file of individual D.0 records. Without the CRLF, we will get continuous string of characters. These widely used utilities already handle the parsing of each record without touching the contents of it based on CRLF. Once in the mainframe file, no extra characters are present at the end of each record. In other words, is the standard to be interpreted in its purest way and no CRLF allowed? Or, does NCPDP allow using an extra character outside of the standard to delimit each batch claim record, similar to a text editor or other commonly used pieces of software?

**Response:** No, a payer must not require that a provider include delimiters other than those defined in the standard. The NCPDP Batch Standard Version 1.2© defines the delimiters to be used to separate records contained within a batch submission. The Start and End of Text characters are established to delimit the records within the file, as variable length Detail Records may be sent in the file. No additional delimiters must be required of a provider to fulfill this purpose.

## 8.2 RESPONSE FORMAT

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

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

## 8.3 SEGMENT DEFINITION

### 8.3.1 BATCH STANDARD© SEGMENT USAGE DIFFERENT THAN TELECOMMUNICATION STANDARD©?

**Question**: If a processor is using both the Telecommunication Standard Version D.0© and Batch Standard Version 1.2© can they define different segments and qualifiers to be used in each standard? How would that be communicated to their Trading Partners?

**Response:** Yes, via payer sheets, etc.

## 8.4 TRANSACTION PROCESSING

### 8.4.1 BATCH PROCESSING – REJECT

**Question**: Does the logic for transmission reject apply to Batch Standard Version 1.2©? Specifically if the transmission is rejected does it require that all transactions be marked as rejects as well?

**Response**: If a reject occurs at the Required Transaction Header Section level of the batch file, the entire batch is rejected (see Batch Implementation Guide©). If a reject occurs in the Detail Data Record within the Batch file, then the detail record is rejected. The Detail Data Record may be rejected due to the batch structure (Text Indicator, Segment Identifier, or Transaction Reference Number with some problem, or it may be rejected due to syntax or processing of the NCPDP Data Record.

Once the processing of the NCPDP Data Record occurs, the same structure and syntax rules apply as in the Telecommunication Standard Version D.0© (for example). As processing of the NCPDP Data Record occurs, the claim or service (for example) may be rejected for various reasons. Note that within the NCPDP Data Record,


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

the transmission level/transaction level applies where there may be one to four transactions within the transmission of one NCPDP Data Record within the Detail Data Record.

For example, the file may contain the following:
Required Transaction Header Section
Detail Data Record
Containing one NCPDP Data Record
Containing from one to four claim/service transactions

The NCPDP Data Record in the Batch Standard© is the same as the "transmission" level in the Telecommunication Standard©. The statement above "containing from one to four claim/service transactions" is the same as the discussion in the Telecommunication Standard© about multiple claims or services per transmission (using the Transaction Count field).


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 9 LONG-TERM AND POST-ACUTE CARE (LTPAC) PHARMACY CLAIMS SUBMISSION RECOMMENDATIONS FOR VERSION D.0

## 9.1 INTRODUCTION (PURPOSE)

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

## 9.2 BACKGROUND

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

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

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

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

Final Part D regulations from CMS (page 129) note: *"We have expanded the definition of the term ³long-term care facility² in §423.100 of our final rule to encompass not only skilled nursing facilities, as defined in section 1819(a) of the Act, but also any medical institution or nursing facility for which payment is made for institutionalized individuals under Medicaid, as defined in section 1902(q) (1) (B) of the Act.... Such an expansion would include ICFs/MR and inpatient psychiatric hospitals along with skilled nursing and nursing facilities in the definition of a long-term care facility, provided those facilities meet the requirements of a medical institution that receives Medicaid payments for institutionalized individuals under section1902(q)(1)(B) of the Act."*

## 9.3 ISSUES AND RECOMMENDATIONS

### 9.3.1 PROVIDER CONTRACTS


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

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

#### *9.3.2.1 QUALIFYING THE PATIENT*

CMS requires the Patient Residence Code be included on all Medicare Part D Prescription Drug Events (PDEs). The pharmacy must provide this information on all Part D claims. For consistency in claims adjudication, it is recommended that the Patient Residence be the field that all pharmacies and payers, including Medicare Part D, Medicaid and Commercial, use as the key designation of where the patient resides.
The "care" of long-term post-acute care (LTPAC) is specified by the setting in which the patient resides.
The setting that the patient resides in can be reasonably established using the field *Patient Residence (384-4X).*

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

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

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

#### *9.3.2.2 QUALIFYING THE PHARMACY SERVICE*

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

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

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

**Long Term Care Facility**

*Patient Residence (384-4X)*

For a LTC resident in an Intermediate Care Facility for the Individuals with Intellectual Disabilities (ICF/IID) or Institute for Mental Disease (IMD) use value 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities).


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

For a LTC resident (excluding those residents in ICF/IID or IMD) use value 3 (Nursing Facility). This value is broad enough to encompass all claims for patients who reside in LTPAC facilities, but should be used only for those LTC residents in LTC facilities other than ICF/IID or IMD (refer to CMS LTC definition).

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

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

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

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

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

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

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

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

*Patient Residence (384-4X)*

For a home based HIT patient use value 1 (Home).

For an ALF resident, use value 4 (Assisted Living Facility).

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

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

**Home and Community Based:**
From Medicaid.gov:


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

*Patient Residence (384-4X)*

For a home based patient use value 1 (Home).

*Place of Service (307-C7)*

For a pharmacy service dispensed from the pharmacy use value 1 (Pharmacy).

*Pharmacy Service Type (147-U7)*

Please refer to the most current implemented version of the External Code List© for all valid values.

*Level of Service (418-DI)*

Use value 7 (Medical at home with special pharmacy services identical to Long Term Care beneficiaries with the exception of emergency kits)

### 9.3.3 SPECIAL PACKAGING

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

LTPAC pharmacies commonly repackage pills purchased in bulk bottles into unit dose cards and containers to allow for storage in special patient drawers in medication carts at the facility for nurse administration.

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

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

**RECOMMENDATION:**

*Special Packaging Indicator (429-DT)*

Please refer to the most current implemented version of the External Code List© for all valid values.

### 9.3.4 LEAVE OF ABSENCE MEDICATIONS

Leave of Absence (LOA) medication refers to separate dispensing of small quantities of medications for take-home use allowing residents to leave the facility for weekend visits, holidays, etc. When filed for reimbursement, these LOA medications may need to be identified as such in order to avoid rejections for duplication, refill too soon or rejects with similar intent.

**RECOMMENDATION:**

*Submission Clarification Code (420-DK)*

For a LTPAC resident use value 14 (Long Term Care Leave of Absence) - The pharmacist is indicating the cardholder requires a short-fill of a prescription due to a leave of absence from the LTPAC facility.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Unless trading partner agreements indicate otherwise, for an ALF resident or other ambulatory patient circumstance use value 3 (Vacation Supply) - The pharmacist is indicating the cardholder requires a short-fill of a prescription due to a leave of absence from the ALF or other facility.

### 9.3.5 MEDICATION LOST, DROPPED, OR PATIENT "SPITS OUT"

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

**RECOMMENDATION:**

*Submission Clarification Code (420-DK)*

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

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

### 9.3.6 EMERGENCY BOX / KIT DISPENSING OPERATIONS

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

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

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

In order to ensure an efficient means of communicating the E-Kit dispensing and request for Refill Too Soon override, two submission clarification codes exist to clarify the situations. Due to the timing of communications between the LTPAC pharmacy and nursing home, often the first fill after the emergency dose may in fact be adjudicated before the pharmacy learns that the emergency dose has been withdrawn by the nurse. Therefore, we need separate clarification for the emergency dose itself and the first full or completion dispensing that occurs following the emergency dose. These fills may be adjudicated in any order beyond the pharmacy's control. While there are two Submission Clarification Codes related to E-Kit dispensing, there are additional variations as to when, how and if these SCCs are used.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Below are some E-Kit billing situations:

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

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

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

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

**RECOMMENDATION:**

*Submission Clarification Code (420-DK)*

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

Modified March 2018

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

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

**RECOMMENDATION:**

*Submission Clarification Code (420-DK)*

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

### 9.3.7 LTPAC ADMISSIONS AND READMISSIONS

To ensure patient safety, many states have regulations that result in Nursing Home requirements that medications be filled in a uniform manner of packaging for patients in their facilities. This ensures the pharmacy is packaging and labeling the medications in a manner that complies with the nursing home's policy and fits into the medication carts used in the nursing home. Due to prescriptions filled prior to admission or re-admission,


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

these dispensings may result in a "Refill Too Soon" reject or a reject with similar intent, if filled within plan RTS billing parameters. Pharmacies may opt to submit this override proactively for patients that meet the new admission / readmission criteria or may submit this value to override a related reject.

**RECOMMENDATION:**

*Submission Clarification Code (420-DK)*

Use value 18 (Long Term Care Patient Admit/Readmit Indicator) - Indicates the transaction is for a new dispensing of medication due to the patient's admission or readmission status.

### 9.3.8 COVERAGE ENDS FOR MEDICARE PART A RESIDENT BEFORE MEDICATION SUPPLY IS USED

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

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

**RECOMMENDATION:**

*Submission Clarification Code (420-DK)*

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

Updated March 2018

*Dispensing Fee Submitted (412-DC*)

The submitted amount of the dispensing fee for a split bill must = "$0.00". If a dispensing fee is submitted by the pharmacy and accepted by the payer, the payer should reduce the dispensing fee to $0.00.

CMS has corresponded with the following advice regarding the "Split Billing" practice when LTPAC residents move from the Part A to the Part D benefit:

*"There is no regulatory citation but this is not inconsistent with our guidance."*

### 9.3.9 ON-LINE WINDOW FOR SUBMISSION OF NEW AND REJECTED CLAIMS

A patient in a LTPAC setting may have claims that need to be adjudicated retroactive to an earlier date. The eligibility setting in LTPAC is different than in a regular retail environment. While there is no consensus on how long that period should be, most participants agreed that some minimum number of back days is required to accomplish acceptable business results.

**RECOMMENDATION:**

Federal regulations at §423.505 Contract provisions specify the window for LTPAC claims submission. The regulation states, **"**Effective contract year 2010, provide that pharmacies located in, or having a contract with, a long-term care facility (as defined in §423.100) must have not less than 30 days, nor more than 90 days, to submit to the Part D sponsor claims for reimbursement under the plan." Although the regulation allows as few as 30 days, it is recommended that the full 90 days for claims submission be observed by all payers.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### 9.3.10 PREDETERMINATION OF BENEFITS

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

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

1. Routine medications delivered in smaller days supplies:
   Certain care settings operate best when the pharmacy delivers medications to LTC residents in smaller and more frequent increments, such as 7-day or 14-day supplies of medications. Unfortunately, the common reimbursement model for prescription plans is a monthly supply with a single dispensing fee, and then a single monthly copay or coinsurance to the beneficiary. Pharmacies ideally would like to "predetermine" that a monthly supply is covered by the drug plan before the initial short supply is sent. Then later when a month's worth of medications have been dispensed, to formally and confidently adjudicate the prescription for a full month supply, with a date of service set to the date of the initial fill.
2. Preadmission activities, and mid-cycle coverage updates:
   Before dispensing medication for a recent admission, or after receiving coverage updates from the facility, a pharmacy can predetermine coverage on the medications before the next cycle of medication dispensing occurs.
3. Coordination of therapy change circumstances:
   Pharmacies often need to predetermine that a drug is non-formulary, requires prior authorization, or has quantity and/or days supply limitations before contacting the prescriber or family or LTPAC facility to confidently recommend and help coordinate any therapy change.

**RECOMMENDATION:**

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

### 9.3.11 DATE OF SERVICE FOR LTPAC BILLING CLAIM

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

### 9.3.12 CYCLE FILLS

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

**RECOMMENDATION:**

*Submission Clarification Code (420-DK)*

Use value 48 - Fill Subsequent to a Shortened Days Supply Fill - only used to request an override to plan limitations when a fill subsequent to a shortened days supply is being dispensed.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

### 9.3.13 BACK UP PHARMACIES

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

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

There are circumstances where a retail pharmacy is providing services to a LTPAC resident such as:
When the claim is submitted:

- The patient residence value is equal to LTPAC.
- The pharmacy service type submitted is not equal to LTPAC
- The non-LTPAC network pharmacy does not meet the LTPAC performance and service criteria.
- The pharmacy is contracted with the Part D plan sponsor/PBM to perform only non-LTPAC network pharmacy services.

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

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

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

## 9.4 IMPLEMENTATION OF CHANGES REQUESTED

The recommendations listed above are provided to enable automation of claims override; however, based on trading partner agreements they might not be utilized. Providers may need to refer to their trading partner agreements and/or provider communications for specific billing overrides.

## 9.5 APPROPRIATE DISPENSING (SHORT CYCLE) FOR LTC

### 9.5.1 DISPENSING METHODOLOGIES FOR LTC IN PPACA

**Effective Date: January 1, 2012**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

> **SEC. 3310. REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.**
> (a) IN GENERAL.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:
> ''(3) REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES.—The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA–PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.''.
>
> (b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2012.

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

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

### 9.5.2 SUBMISSION CLARIFICATION CODE COMBINATIONS AND REJECTIONS

CMS released guidance (4144-F) in 2011 regarding the appropriate dispensing of prescription drugs for Medicare Part D beneficiaries residing in LTC facilities. Pharmacies must dispense all brand oral solid drugs for Part D patients residing in LTC facilities in 14-day or less increments. NCPDP, CMS, and pharmacy providers developed a **Short Cycle Validity Matrix** (WG14 Members page - https://member.ncpdp.org/Member/media/pdf/WG14ValidityMatrix.xls) for valid Submission Clarification Code (SCC) and Special Packaging Indicator (SPI) combinations for use in the submission of these types of prescriptions.

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

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

Note, the regulatory requirement to dispense in 14 day or less increments is not directly linked to billing in equivalent increments.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Current Practice:**

NCPDP Telecommunication Standard© recommends the use of Submission Clarification Codes (SCC) (420-DK) to identify emergency fills, or other unique LTC Billing situations. The values are listed below:

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

**Modified March 2018**

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

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

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

**Claims submission recommendations:**

**Plans should continue to accept the usage of these codes (SCC 14-18) to identify unique dispensing situations**. When one of the above unique dispensing situations occurs for a short cycle medication, the following must be used in combination:

- SCC of 14, 15, 17 – Appropriate Brand Oral Solid Drugs must be sent with SCC 21 through 36
- SCC of 14, 15, 17 – Appropriate Brand Oral Solid Drugs not submitted with SCC 21 through 36 will reject with NCPDP Reject Code "613"
- SCC of 14, 15, 17 – Appropriate Brand Oral Solid Drugs submitted with SCC 16 will reject with NCPDP Reject Code "613"
- SCC 16 – Appropriate Brand Oral Solid Drugs are applicable for LTC Short Cycle
- SCC 16 – Appropriate Brand Oral Solid Drugs submitted with SCC 14, 15, or 17 will reject with NCPDP Reject Code "613"
- SCC 18 – Appropriate Brand Oral Solid Drugs must be sent with SCC 16, or 21 through 36
- SCC 18 - – Appropriate Brand Oral Solid Drugs not submitted with SCC 16, or 21 through 36 will reject with NCPDP Reject Code "613"
- SCC 21 or 36 – Appropriate Brand Oral Solid Drugs sent with SCC 22 through 35 will reject with NCPDP Reject Code "613"
- SCC 22 through 35 – Appropriate Brand Oral Solid Drugs are applicable for LTC Short Cycle
- SCC 22 through 35 – Appropriate Brand Oral Solid Drugs sent with SCC 21 or 36 will reject with NCPDP Reject Code "613"
- SCC 16 or 21-36 - Appropriate Brand Oral Solid submitted and an SCC of 16 or 21-36 is not submitted will Reject Code "613"
- SCC 16 or 22-35 - When multiple combinations of SCC 16 or 22-35 are received they **may** be rejected in 2013 with Reject Code "612" but **must** be rejected in 2014


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- All other SCC values are acceptable to be sent in conjunction with SCC 21-36 because they are intended to over-ride rejections or convey information unrelated to short cycle dispensing.

Submission Clarification Code values appropriate for LTC Short Cycle:

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

Modified March 2018

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

Reject Code values appropriate for LTC Short Cycle:

| **REJECT CODES FOR TELECOMMUNICATION STANDARD©** | | | |
|---|---|---|---|
| **Reject Code** | **Explanation** | Field # Possibly **In Error** | **Field Limitation or Explanation** |
| 597 | LTC Dispensing Type Does Not Support The Packaging Type | 420-DK, 429-DT | |
| 612 | LTC Appropriate Dispensing Invalid Submission Clarification Code (SCC) Combination | | Used when more than one Submission Clarification Code value of 16 or 22-35 are submitted. |
| 613 | The Packaging Methodology Or Dispensing Frequency Is Missing Or Inappropriate For LTC Short Cycle | | Used when the payer has determined this claim meets the definition of appropriate dispensing in Long Term Care and the packaging methodology or dispensing frequency is missing or inappropriate for LTC short cycle. |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

#### *9.5.2.1 PLAN SUPPORT OF SUBMISSION CLARIFICATION CODE*

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

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

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

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

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

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

## 9.6 LTC SERVICE OUTSIDE OF AN LTC SETTING

**Question:**
How do I communicate on a claim transaction that the patient is receiving LTC services when the patient does not reside in a LTC setting?

**Response:**
This would be communicated by using the appropriate Patient Residence Code (484-DX) and a Level of Service Code (418-DI) value of "7" (Medical at home with special pharmacy services identical to Long Term Care beneficiaries with the exception of emergency kits).

Added August 2020


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 9.7 PATIENT RESIDENCE VALUE

**Question:**
Which Patient Residence (384-4X) value is submitted when sending a claim for a patient being discharged from a LTC facility to home?

**Response:**
The patient residence value should be based upon where the medication is delivered. For example, if the medication is delivered to a SNF for the patient to take home with them, then the following values should be submitted:

- Patient Residence (384-4X) = 3 (Nursing Facility)
- Submission Clarification Code (420-DK) = 57 (Discharge Medication)
- Short-cycle applicable Submission Clarification Code (420-DK) = 16, 21-36
- Pharmacy Service Type (147-U7) = 5 (Long Term Care Pharmacy Services)

If the medication is delivered to the patient's home, then the following values should be submitted:

- Patient Residence (384-4X) = 1 (Home)
- Submission Clarification Code (420-DK) = 57 (Discharge Medication)
- Pharmacy Service Type (147-U7) = 5 (Long Term Care Pharmacy Services)

Added February 2023


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 10 COORDINATION OF BENEFITS INFORMATION

## 10.1 CLARIFICATION OF NET AMOUNT DUE IN COORDINATION OF BENEFITS

In Telecom D.4, the following was clarified

**FROM**:

*Prescription And Service Pricing Formulae*

**Question:** What Are The Prescription And Service Pricing Formulae?

**Response:**

**Prescription Formula Claim Request:**

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

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

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

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

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

**Prescription Formula Response:**

Ingredient Cost Paid (506-F6)
+ Dispensing Fee Paid (507-F7)
+ Incentive Amount Paid (521-FL)
+ Other Amount Paid (565-J4)
+ Flat Sales Tax Amount Paid (558-AW)
+ Percentage Sales Tax Amount Paid (559-AX)
- Patient Pay Amount (505-F5)
- Other Payer Amount Recognized (566-J5)
---
= Total Amount Paid (509-F9)

**Service Claim Request Formula:**

Professional Service Fee Submitted (477-BE)
+ Flat Sales Tax Amount Submitted (481-HA)
+ Percentage Sales Tax Amount Submitted (482-GE)
+ Other Amount Claimed Submitted (480-H9)
---
= Gross Amount Due (430-DU)
- Patient Paid Amount Submitted (433-DX)
- Other Payer Amount Paid (431-DV)
(Result is net amount due)


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

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

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

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

**Service Response Formula:**

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)

**TO**

*Prescription And Service Pricing Formulae*

**Question:** What Are The Prescription And Service Pricing Formulae?

**Response:**

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

**Prescription Formula Claim Request:**

Ingredient Cost Submitted (409-D9)
+ Dispensing Fee Submitted (412-DC)
+ Incentive Amount Submitted (438-E3)
+ Other Amount Claimed Submitted (480-H9)
+ Flat Sales Tax Amount Submitted (481-HA)
+ Percentage Sales Tax Amount Submitted (482-GE)

---

= 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/or COB claims in which Other Payer Amount Paid (431-DV) is submitted (further clarification below for COB).

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

- If COB processing is based on "Other Payer Amount Paid" the processor should determine what **has been paid** by prior payers. This is accomplished by summarizing 'like' Other


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Payer Amount Paid dollars across prior payers and then using these values against 'like' contractual amounts to reduce that liability for the current payer.

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

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

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

| | |
|---|---|
| 14 | Other Payer-Patient Responsibility Amount - Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ). |

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

**Prescription Formula Response:**

Ingredient Cost Paid (506-F6)
+ Dispensing Fee Paid (507-F7)
+ Incentive Amount Paid (521-FL)
+ Other Amount Paid (565-J4)
+ Flat Sales Tax Amount Paid (558-AW)
+ Percentage Sales Tax Amount Paid (559-AX)
- Patient Pay Amount (505-F5)
- Other Payer Amount Recognized (566-J5)

---

= Total Amount Paid (509-F9)

**Service Claim Request Formula:**

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

---

= Gross Amount Due (430-DU)
- Patient Paid Amount Submitted (433-DX)
- Other Payer Amount Paid (431-DV)
(Result is net amount due)

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

- If COB processing is based on "Other Payer Amount Paid" the processor should determine what **has been paid** by prior payers. This is accomplished by summarizing 'like' Other Payer Amount Paid dollars across prior payers and then using these values against 'like' contractual amounts to reduce that liability for the current payer.
  Once the applicable Other Payer Amount Paid dollars have been properly summarized, net amount due is the result of the calculation noted above.
- If COB processing is based on "Other Payer-Patient Responsibility Amounts", the net amount due is the ***sum of*** the payable components of the Other Payer-Patient Responsibility values from the **last** payer as determined by Other Payer Coverage Type (338-5C) (i.e. Primary, Secondary, etc.) that returned a **paid** response. When reimbursement is based on the Other Payer-Patient Responsibility Amount, Basis of Reimbursement Determination (522-FM) value 14 would be returned on the response.

| | |
|---|---|
| 14 | Other Payer-Patient Responsibility Amount - Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ). |

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

**Service Response Formula:**

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)

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

**Question:**

Above, it states

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

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

**Response:**

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 10.2 THREE OPTIONS FOR COORDINATION OF BENEFITS

## 10.2.1 ONLY THREE OPTIONS ALLOWED?

**Question:**

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

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

Question:

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

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

Example:

| Option | Primary Drug Cost | OPAP | Coinsurance | Secondary Drug Cost | Primary Plan Pay | Secondary Plan Pay |
|---|---|---|---|---|---|---|
| a) | 100 | 40 | 10% | n/a | 90 | Primary Plan Pay - OPAP = 50 |
| d) | 100 | 40 | 10% | 60 | n/a | Secondary Drug Cost - (Secondary Drug Cost * Coinsurance) = 54 |

Revised Question & Example – approved by submitter:

When the plan is non-primary, is the patient pay amount calculated or determined before or after the other payer amount paid is recognized?

Example:

| Option | Drug prior to other payer reduction | Member Liability | Other Payer Amount Paid (OPAP) | Patient Pay Calculation | Patient Pay Amount | Total Amount Paid Calculation | Total Amount Paid |
|---|---|---|---|---|---|---|---|
| a) Member liability applied to drug before to other payer reduction | $100.00 | 10% | $40.00 | $100.00 * 10% | $10.00 | $100.00 - $40.00 - $10.00 = $50.00 | $50.00 |
| d) Member liability applied to drug other payer reduction | $100.00 | 10% | $40.00 | ($100.00 - $40.00) * 10% | $6.00 | $100.00 - $40.00 - $6.00 = $54.00 | $54.00 |

**Response:**

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

## 10.2.2 MULTIPLE COB OPTIONS PER BIN/PCN?

**Question:**

We have a need to know as a secondary payer if the primary payer adjudicated the claim but paid nothing to the pharmacy or rather the patient paid all of it. We want to do one benefit if the patient has copay and another if the patient is paying the full amount. Under 5.1 we can't do this but under D.0 it appears we can. I was referred to section 33.6.5 of the imp guide. The example used the COB segment for Patient Responsibility Billing. The


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

example uses some of the "pieces" but not all of them. Are we allowed to require all of the pieces so that I can add them up and know the patients total out-of-pocket or is that not allowed? In the example provided (assuming it references the previous claim example to a primary payer) the 3 pieces included in the COB (deductible, copay and product selection) all add up the patients pay amount from the prior payer. My question is what if there are more pieces (e.g. portion attributable to the coverage gap or some other reason not related to part – d at all, there are after all 13 qualifiers for 351-NP). Can I require in my implementation those corresponding Other Payer-Patient Responsibility Amount values and their related qualifiers)?

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

#### *10.2.2.1 COMPONENT PIECES NOT SUM TO PATIENT PAY AMOUNT?*

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

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

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

### 10.2.3 CAN A BIN/PCN COMBINATION CONTAIN GROUPS THAT USE MULTIPLE COB METHODS?

**Question**:
Can a BIN/PCN combination contain groups that use multiple COB methods?

**Response**:
While there is nothing specific in Version D.0 guidance that precludes multiple COB methods within the same BIN/PCN combination, NCPDP recommends there only be one COB method used for any BIN/PCN combination. As new business is added, it is recommended PBM/payers assign them to a unique BIN/PCN combination that uses the desired COB method. Payers are encouraged to migrate existing groups to a BIN/PCN combination that solely supports the COB method, if possible.

Added May 2021

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

In order to appropriately bill sales tax amounts to a downstream payer, any tax amount paid by previous payers must also be reported. DERF 000953 was submitted and approved in the May 2010 Work Group meetings to


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

add a value to Other Payer Amount Paid Qualifier (342-HC). The value is available in the June 2010 NCPDP ***External Code List***.

| | |
|---|---|
| 10 | Sales Tax - An Indicator which signifies the dollar amount paid by the other payer which is related to Sales Tax. |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Price Attributes | Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient. | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary **Tax Exempt** (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |
|---|---|---|---|---|
| Drug AWP Cost | $95.00 | $95.00 | $95.00 | $95.00 |
| Tax Rate Submitted | 6.00% | 6.00% | 6.00% | 6.00% |
| | | | | |
| Primary Rate (AWP - X%) | -16.00% | -16.00% | -16.00% | -16.00% |
| Primary Fee | $2.50 | $2.50 | $2.50 | $2.50 |
| Primary Tax Rate Paid | 0.00% | 3.00% | 6.00% | 6.00% |
| Primary Tax Paid | $0.00 | $2.47 | $4.94 | $4.94 |
| Primary Receivable | $57.30 | $59.77 | $62.24 | $61.00 |
| | | | | |
| Drug AWP Cost | $95.00 | $95.00 | $95.00 | $95.00 |
| Secondary Rate (AWP - X%) | -17.00% | -17.00% | -17.00% | -17.00% |
| Secondary Fee ) | $2.50 | $2.50 | $2.50 | $2.50 |
| Secondary Tax Rate Paid | 6.00% | 6.00% | 6.00% | 6.00% |
| Secondary Tax Paid | $4.88 | $4.88 | $4.88 | |
| Secondary Receivable | $13.93 | $11.46 | $9.05 | |
| | | | | |
| Drug AWP Cost | $95.00 | $95.00 | $95.00 | $95.00 |
| Tertiary Rate (AWP - X%) | -15.00% | -15.00% | -15.00% | -15.00% |
| Tertiary Fee | $2.50 | $2.50 | $2.50 | $2.50 |
| Tertiary Tax Rate Paid | 6.00% | 6.00% | Tax Exempt | 7.00% |
| Tertiary Tax Paid | $5.00 | $5.00 | Tax Exempt | $5.83 |
| Tertiary Receivable | | | | |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Bill to Primary Submitting Tax Amounts | | | | | |
|---|---|---|---|---|---|
| **PRIMARY REQUEST Pricing Segment** | | Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient. | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary **Tax Exempt** (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |
| Ingredient Cost Submitted | 409-D9 | $95.00 | $95.00 | $95.00 | $95.00 |
| Dispensing Fee Submitted | 412-DC | $5.00 | $5.00 | $5.00 | $5.00 |
| Percentage Tax Amount Submitted | 482-GE | $6.00 | $6.00 | $6.00 | $6.00 |
| Percentage Sales Tax Rate Submitted | 483-HE | 6.00% | 6.00% | 6.00% | 6.00% |
| Percentage Sales Tax Basis Submitted | 484-JE | 3 – IC + Fee | 3 – IC + Fee | 3 – IC + Fee | 3 – IC + Fee |
| Usual and Customary Charge | 426-DQ | $101.99 | $101.99 | $101.99 | $101.99 |
| Gross Amount Due | 430-DU | $106.00 | $106.00 | $106.00 | $106.00 |
| Basis of Cost Determination | 423-DN | 01 - AWP | 01 - AWP | 01 - AWP | 01 - AWP |
| **PRIMARY RESPONSE Pricing Segment** | | Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient. | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary **Tax Exempt** (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |
| Amount of Copay | 518-FI | $25.00 | $25.00 | $25.00 | $25.00 |
| Amount Attributed to Sales Tax | 523-FN | $0.00 | $0.00 | $0.00 | $1.24 |
| Patient Pay Amount | 505-F5 | $25.00 | $25.00 | $25.00 | $26.24 |
| Total Amount Paid | 509-F9 | $57.30 | $59.77 | $62.24 | $61.00 |
| Ingredient Cost Paid | 506-F6 | $79.80 | $79.80 | $79.80 | $79.80 |
| Dispensing Fee Paid | 507-F7 | $2.50 | $2.50 | $2.50 | $2.50 |
| Percent Sales Amount Paid | 559-AX | $0.00 | $2.47 | $4.94 | $4.94 |
| Percent Sales Tax Rate Paid | 560-AY | 0.00% | 3.00% | 6.00% | 6.00% |
| Percent Sales Tax Basis Paid | 561-AZ | 3 – IC + Fee | 3 – IC + Fee | 3 – IC + Fee | 3 – IC + Fee |
| Plan Sales Tax Amount | 574-2Y | $0.00 | $2.47 | $4.94 | $3.70 |
| Patient Sales Tax Amount | 575-EQ | $0.00 | $0.00 | $0.00 | $1.24 |
| Basis of Reimbursement Determination | 522-FM | 8 – Contract Pricing | 8 – Contract Pricing | 8 – Contract Pricing | 8 – Contract Pricing |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Bill to Secondary Submitting Tax Amounts | | | | | |
|---|---|---|---|---|---|
| **SECONDARY Claim Segment** | | Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient. | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary **Tax Exempt** (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |
| Other Coverage Code | 308-C8 | 2 | 2 | 2 | 2 |
| **SECONDARY Pricing Segment** | | Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient. | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary **Tax Exempt** (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |
| Ingredient Cost Submitted | 409-D9 | $95.00 | $95.00 | $95.00 | $95.00 |
| Dispensing Fee Submitted | 412-DC | $5.00 | $5.00 | $5.00 | $5.00 |
| Percentage Tax Amount Submitted | 482-GE | $6.00 | $6.00 | $6.00 | $6.00 |
| Percentage Sales Tax Rate Submitted | 483-HE | 6.00% | 6.00% | 6.00% | 6.00% |
| Percentage Sales Tax Basis Submitted | 484-JE | 3 – IC + Fee | 3 – IC + Fee | 3 – IC + Fee | 3 – IC + Fee |
| Usual and Customary Charge | 426-DQ | $101.99 | $101.99 | $101.99 | $101.99 |
| Gross Amount Due | 430-DU | $106.00 | $106.00 | $106.00 | $106.00 |
| Basis of Cost Determination | 423-DN | 01 - AWP | 01 - AWP | 01 - AWP | 01 - AWP |
| **SECONDARY COB Segment** | | Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient. | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary **Tax Exempt** (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |
| Coordination Of Benefits/Other Payments Count | 337-4C | 1 | 1 | 1 | 1 |
| Other Payer Coverage Type | 338-5C | 1 | 1 | 1 | 1 |
| Other Payer Id Qualifier | 339-6C | 3 | 3 | 3 | 3 |
| Other Payer Id | 340-7C | 123456 | 123456 | 123456 | 123456 |
| Other Payer Date | 443-E8 | 20090201 | 20090201 | 20090201 | 20090201 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | | |
|---|---|---|---|---|---|
| Other Payer Amount Paid Count | 341-HB | 1 | 2 | 2 | 2 |
| Other Payer Amount Paid Qualifier | 342-HC | 07- drug benefit | 07 | 07 | 07 |
| Other Payer Amount Paid | 431-DV | $57.30 | $57.30 | $57.30 | $57.29 |
| Other Payer Amount Paid Qualifier | 342-HC | 10 | 10 | 10 | 10 |
| Other Payer Amount Paid | 431-DV | $0.00 | $2.47 | $4.94 | $3.70 |
| **SECONDARY RESPONSE Pricing Segment** | | Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient. | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary **Tax Exempt** (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |
| Amount of Copay | 518-FI | $15.00 | $15.00 | $15.00 | $15.00 |
| Amount Attributed to Sales Tax | 523-FN | $0.00 | $0.00 | $0.00 | $0.00 |
| Patient Pay Amount | 505-F5 | $15.00 | $15.00 | $15.00 | $15.00 |
| Total Amount Paid | 509-F9 | $13.93 | $11.46 | $9.05 | $10.23 |
| Ingredient Cost Paid | 506-F6 | $78.85 | $78.85 | $78.85 | $78.85 |
| Dispensing Fee Paid | 507-F7 | $2.50 | $2.50 | $2.50 | $2.50 |
| Percent Sales Amount Paid | 559-AX | $4.88 | $4.88 | $4.88 | $4.88 |
| Percent Sales Tax Rate Paid | 560-AY | 6.00% | 6.00% | 6.00% | 6.00% |
| Percent Sales Tax Basis Paid | 561-AZ | 3 – IC + Fee | 3 – IC + Fee | 3 – IC + Fee | 3 – IC + Fee |
| Other Payer Amount Recognized | 566-J5 | $57.30 | $59.77 | $62.18 | $61.00 |
| Plan Sales Tax Amount | 574-2Y | $4.88 | $4.88 | $4.88 | $4.88 |
| Patient Sales Tax Amount | 575-EQ | $0.00 | $0.00 | $0.00 | $0.00 |
| Basis of Reimbursement Determination | 522-FM | 8 – Contract Pricing | 8 – Contract Pricing | 8 – Contract Pricing | 8 – Contract Pricing |

| **Bill to Tertiary Submitting Tax Amounts** | | | | | |
|---|---|---|---|---|---|
| **TERTIARY Claim Segment** | | Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient. | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary **Tax Exempt** (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |
| Other Coverage Code | 308-C8 | 2 | 2 | 2 | 2 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| **TERTIARY Pricing Segment** | | Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient. | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary **Tax Exempt** (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |
|---|---|---|---|---|---|
| Ingredient Cost Submitted | 409-D9 | $95.00 | $95.00 | $95.00 | $95.00 |
| Dispensing Fee Submitted | 412-DC | $5.00 | $5.00 | $5.00 | $5.00 |
| Percentage Tax Amount Submitted | 482-GE | $6.00 | $6.00 | $6.00 | $6.00 |
| Percentage Sales Tax Rate Submitted | 483-HE | 6.00% | 6.00% | 6.00% | 6.00% |
| Percentage Sales Tax Basis Submitted | 484-JE | 3 – IC + Fee | 3 – IC + Fee | 3 – IC + Fee | 3 – IC + Fee |
| Usual and Customary Charge | 426-DQ | $101.99 | $101.99 | $101.99 | $101.99 |
| Gross Amount Due | 430-DU | $106.00 | $106.00 | $106.00 | $106.00 |
| Basis of Cost Determination | 423-DN | 01 - AWP | 01 - AWP | 01 - AWP | 01 - AWP |
| **TERTIARY COB Segment** | | Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient. | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary **Tax Exempt** (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |
| Coordination Of Benefits/Other Payments Count | 337-4C | 2 | 2 | 2 | 2 |
| Other Payer Coverage Type | 338-5C | 1 | 1 | 1 | 1 |
| Other Payer Id Qualifier | 339-6C | 3 | 3 | 3 | 3 |
| Other Payer Id | 340-7C | 123456 | 123456 | 123456 | 123456 |
| Other Payer Date | 443-E8 | 20090201 | 20090201 | 20090201 | 20090201 |
| Other Payer Amount Paid Count | 341-HB | 2 | 2 | 2 | 2 |
| Other Payer Amount Paid Qualifier | 342-HC | 07- drug benefit | 07 | 07 | 07 |
| Other Payer Amount Paid | 431-DV | $57.30 | $57.30 | $57.30 | $57.30 |
| Other Payer Amount Paid Qualifier | 342-HC | 10 | 10 | 10 | 10 |
| Other Payer Amount Paid | 431-DV | $0.00 | $2.47 | $4.94 | $3.70 |
| Other Payer Coverage Type | 338-5C | 2 | 2 | 2 | 2 |
| Other Payer Id Qualifier | 339-6C | 3 | 3 | 3 | 3 |
| Other Payer Id | 340-7C | 654321 | 654321 | 654321 | 654321 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | | |
|---|---|---|---|---|---|
| Other Payer Date | 443-E8 | 20090201 | 20090201 | 20090201 | 20090201 |
| Other Payer Amount Paid Count | 341-HB | 2 | 2 | 2 | 2 |
| Other Payer Amount Paid Qualifier | 342-HC | 07- drug benefit | 07 | 07 | 07 |
| Other Payer Amount Paid | 431-DV | $9.05 | $9.05 | $9.05 | $9.05 |
| Other Payer Amount Paid Qualifier | 342-HC | 10 | 10 | 10 | 10 |
| Other Payer Amount Paid | 431-DV | $4.88 | $2.41 | $0.00 | $1.18 |
| **TERTIARY RESPONSE Pricing Segment** | | Primary Does Not Pay Tax/Secondary Calculates 6% Tax/Tertiary Calculates 6% Tax | Primary Pays 3% Tax/Secondary Calculates 6% Tax /Tertiary Calculates 6% Tax, plan pays 50% and Passes 50% onto patient. | Primary Pays 6% Tax/Secondary Calculates 6% Tax/Tertiary **Tax Exempt** (431-DV Tax Amount Paid Not Considered) | Primary Plan Pays 75%, Patient Pays 25% of the 6% Tax/Secondary Calculates 6% Tax/Tertiary Calculates 7% Tax |
| Amount of Copay | 518-FI | $2.00 | $2.00 | $2.00 | $2.00 |
| Amount Attributed to Sales Tax | 523-FN | $0.00 | $0.06 | $0.00 | $0.00 |
| Patient Pay Amount | 505-F5 | $2.00 | $2.06 | $2.00 | $2.00 |
| Total Amount Paid | 509-F9 | $15.01 | $14.96 | $14.90 | $15.85 |
| Ingredient Cost Paid | 506-F6 | $80.75 | $80.75 | $80.75 | $80.75 |
| Dispensing Fee Paid | 507-F7 | $2.50 | $2.50 | $2.50 | $2.50 |
| Percent Sales Amount Paid | 559-AX | $5.00 | $5.00 | | $5.83 |
| Percent Sales Tax Rate Paid | 560-AY | 6.00% | 6.00% | | 7.00% |
| Percent Sales Tax Basis Paid | 561-AZ | 3 – IC + Fee | 3 – IC + Fee | | 3 – IC + Fee |
| Other Payer Amount Recognized | 566-J5 | $71.23 | $71.23 | $66.35 | $71.23 |
| Plan Sales Tax Amount | 574-2Y | $5.00 | $2.50 | | $5.83 |
| Patient Sales Tax Amount | 575-EQ | $0.00 | $2.50 | | $0.00 |
| Tax Exempt Indicator * | 557-AV | | | 1 | |
| Basis of Reimbursement Determination | 522-FM | 8 – Contract Pricing | 8 – Contract Pricing | 8 – Contract Pricing | 8 – Contract Pricing |
| **Net Amount Due** | | $88.25 | $88.25 | $88.19 | $89.08 |
| **Script Total Sales Tax** | | $5.00 | $5.00 | $4.94 | $5.83 |
| **Script Sell Price** | | $83.25 | $83.25 | $83.25 | $83.25 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

* If Percent tax Amount is submitted to the payer, unless a Tax Exempt Indicator applies, the payer must return a percent tax amount paid value, even if the value is $0, the percent sales tax rate and percent sales tax basis. If a Tax Exempt Indicator applies, the applicable tax exempt value must be returned, however the percent sales tax amount paid, basis and rate do not have to be returned.

| Tax Exempt Indicator Value | Definition |
|---|---|
| 1 | Payer/Plan is tax exempt |
| 3 | Patient is tax exempt |
| 4 | Plan/Payer and patient are tax exempt |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 10.4 OTHER PAYER COVERAGE TYPE (338-5C) IS UNKNOWN

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

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

Other Payer ID Count (355-NT) = the number of loops. This only is allowed in the Response COB/Other Payers Segment.
Other Payer Coverage Type (338-5C) – as the ***External Code List***© defines valid values of blank, 1, 2 or 3, occurrence 1, 2, and/or 3 could contain blank as a valid value. The pharmacy would then need to work with the patient and the plans to determine what the order really should be.

Response Coordination of Benefits/Other Payers Segment
*Other Payer ID Count*

| Field | Field Name |
|---|---|
| 355-NT | Other Payer ID Count |
| 338-5C | Other Payer Coverage Type |
| 339-6C | Other Payer ID Qualifier |
| 340-7C | Other Payer ID |
| 991-MH | Other Payer Processor Control Number |
| 356-NU | Other Payer Cardholder ID |
| 992-MJ | Other Payer Group ID |
| 142-UV | Other Payer Person Code |
| 127-UB | Other Payer Help Desk Phone Number |
| 143-UW | Other Payer Patient Relationship Code |
| 144-UX | Other Payer Benefit Effective Date |
| 145-UY | Other Payer Benefit Termination Date |

## 10.5 OTHER PAYER AMOUNT PAID QUALIFIERS (342-HC) FOR B1 COB

**Question**:
In a COB claim billing (B1) transaction, if a patient is in the deductible phase and Payer1 has agreed to pay for some Delivery Fee and the Sales Tax (or any 'Other Amount Paid'), what is the proper response data Payer1 should send back and what should the Pharmacy submit for the COB Segment in the request to Payer2?

| PRIMARY CLAIM REQUEST | | | SECONDARY CLAIM REQUEST | |
|---|---|---|---|---|
| Ingredient Cost Submitted | 94.00 | | Ingredient Cost Submitted | 94.00 |
| Dispensing Fee Submitted | 5.50 | | Dispensing Fee Submitted | 5.50 |
| Other Amount Claimed Submitted Count | 2 | | Other Amount Claimed Submitted Count | 2 |
| Other Amount Claimed Submitted Qualifier | 01 | | Other Amount Claimed Submitted Qualifier | 01 |
| Other Amount Claim Submitted (Delivery) | 12.00 | | Other Amount Claim Submitted (Delivery) | 12.00 |
| Other Amount Claimed Submitted Qualifier | 09 | | Other Amount Claimed Submitted Qualifier | 09 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| **Other Amount Claim Submitted (Compound)** | **9.00** | | **Other Amount Claim Submitted (Compound)** | **9.00** |
| **Incentive Amount Submitted** | **10.00** | | **Incentive Amount Submitted** | **10.00** |
| **Percent Sales Tax Amount** | **4.70** | | **Percent Sales Tax Amount** | **4.70** |
| **Percent Sales Tax Basis** | **02** | | **Percent Sales Tax Basis** | **02** |
| **Percent Sales Tax Rate** | **5%** | | **Percent Sales Tax Rate** | **0.05** |
| **Gross Amount Due** | **135.20** | | **Gross Amount Due** | **135.20** |
| **Usual and Customary** | **145.00** | | **Usual and Customary** | **145.00** |
| | | | **SECONDARY (COB) SEGMENT** | |
| **PRIMARY RESPONSE PRICING** | | | **Other Payer Coverage Type** | **01** |
| **Ingredient Cost Paid** | **90.00** | | **Other Payer Amount Paid Count** | **5** |
| **Dispensing Fee Paid** | **5.00** | | **Other Payer Amount Paid Qualifier** | **01** |
| **Other Amount Paid Count** | **2** | | **Other Payer Amount Paid – Delivery** | **10.00** |
| **Other Amount Paid Qualifier** | **01** | | **Other Payer Amount Paid Qualifier** | **09** |
| **Other Amount Paid (Delivery)** | **10.00** | | **Other Payer Amount Paid – Compound** | **0.00** |
| **Other Amount Paid Qualifier** | **09** | | **Other Payer Amount Paid Qualifier** | **05** |
| **Other Amount Paid (Compound)** | **0.00** | | **Other Payer Amount Paid – Incentive** | **0.00** |
| **Incentive Amount Paid** | **0.00** | | **Other Payer Amount Paid Qualifier** | **10** |
| **Percentage Sales Tax Amount Paid** | **4.50** | | **Other Payer Amount Paid – Sales Tax** | **4.50** |
| **Percentage Sales Tax Basis Paid** | **02** | | **Other Payer Amount Paid Qualifier** | **07** |
| **Percentage Sales Tax Rate Paid** | **5%** | | **Other Payer Amount Paid – Drug Benefit** | **0.00** |
| **Other Payer Amount Recognized** | | | | |
| **Patient Pay Amount** | **95.00** | | | |
| **Total Paid Amount** | **14.50** | | | |
| **Amount Applied to Periodic Deductible** | **95.00** | | | |

**Response**:
The Response Pricing Segment should be determined by the specific benefit and contractual agreement and must adhere to the NCPDP Pricing Formula. To accurately report the amounts paid in the Other Payer Amount Paid field (431-DV) in a COB Other Payer Coverage Type occurrence for B1 claim billing, a specific order of Other Payer Amount Paid Qualifiers (342-HC) must be followed.

- Order is based on the payment being associated to provider versus state revenue, the dispensing of a product, and any value-added services (e.g., delivery, postage, etc.).
- Drug Benefit (Other Payer Amount Paid Qualifier (342-HC) value 07) is the end result, after all Other Payer Amount Paid values are subtracted from Total Amount Paid (509-F9). Drug Benefit is always required in OPAP or Government COB.
- The financial fields within the COB Segment are considered pass through fields, where the provider is reporting what was received from the previous payers' responses, including zero-dollar amounts reported.

| COB CLAIM 342-HC REPORTING ORDER | 342-HC OTHER PAYER AMOUNT PAID QUALIFIER VALUE | DESCRIPTION | NOTES |
|---|---|---|---|
| 1 | 10 | **Sales Tax** - An Indicator which signifies the dollar amount paid by the other payer which is related to Sales Tax. | Neither Product nor Service, not part of Sales. Any tax amount paid by the previous plan(s) should be the 1st amount reported to downstream payer. If payer does not pay tax, then they cannot use taxes paid by prior payer(s) to reduce payment obligations |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| COB CLAIM 342-HC REPORTING ORDER | 342-HC OTHER PAYER AMOUNT PAID QUALIFIER VALUE | DESCRIPTION | NOTES |
|---|---|---|---|
| | | | or use towards other payer amount recognized amount reported. |
| 2 | 09 | **Compound Preparation Cost** – An indicator which signifies the dollar amount paid by the other payer which is related to the preparation of the compound. | The product cannot be dispensed without the compound prep. |
| 3 | 01 | **Delivery** – An indicator which signifies the dollar amount paid by the other payer which is related to the delivery of a product or service. | Value Added Service |
| 4 | 02 | **Shipping** – An indicator which signifies the dollar amount paid by the other payer which is related to the transportation of a product. | Value Added Service |
| 5 | 03 | **Postage** – An indicator which signifies the dollar amount paid by the other payer which is related to the mailing of a product. | Value Added Service |
| 6 | 04 | **Administrative** – An indicator which signifies the dollar amount paid by the other payer which is related to administrative activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance. | Value Added Service |
| 7 | 16 | **Medication Synchronization** – An indicator which signifies the amount paid by the other payer related to the process of coordinating a patient's prescription refills to be picked up on the same day each month. | |
| 8 | 17 | **Adherence (Compliance)** Packaging – An indicator which signifies the amount paid by the other payer related to the packaging of medications in a manner that helps patients take their medications correctly and on time. This packaging often includes features like labeled compartments for different times of the day or days of the week, making it easier to follow the prescribed medication schedule. | |
| 9 | 05 | **Incentive -** An indicator which signifies the dollar amount paid by the other payer which is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g. collection of survey data, counseling plan enrollees, vaccine administration). | Value Added Service |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| COB CLAIM 342-HC REPORTING ORDER | 342-HC OTHER PAYER AMOUNT PAID QUALIFIER VALUE | DESCRIPTION | NOTES |
|---|---|---|---|
| 10 | 07 | **Drug Benefit** – An indicator which signifies the dollar amount paid by the other payer which is related to the plan's drug benefit. | END RESULT of subtracting all Other Payer Amount Paid values from Total Amount Paid (509-F9) |

**Note:** The Other Payer Amount Paid Qualifier (342-HC) value 06 - Cognitive Service is not used in COB B1 Claim Billing transactions. This value is used for COB S1 – Service Billing transactions. Refer to FAQ titled "OTHER PAYER AMOUNT PAID QUALIFIERS (342-HC) FOR S1 (Service Billing) COB". Other Payer Amount Paid Qualifier (342-HC) values11 - 15 are not available for use in D.0 transactions.

- In the situation when the previous payer's Total Amount Paid (509-F9) is less than the sum of the Other Amounts Paid (565-J4) + Incentive Amount Paid (521-FL) + Tax Amount Paid (559-AX + 558-AW – 523-FN) values, the Other Payer Amount Paid (431-DV) values reported for that COB Other Payer Coverage Type (338-5C) occurrence should be subtracted from Total Amount Paid (509-F9) and reported in the COB claim in the specific order outlined above.
- The below steps outline a consistent process to report the Other Payer Amount Paid (431-DV) values in the Other Payer Coverage Type occurrences, regardless of the values returned in the payer's response pricing segment.
    - For each unique Other Payer Amount Paid (431-DV) value to be calculated, steps (1 – 6) should be performed before the Other Payer Amount Paid Drug Benefit (07) can be calculated (step 7).
    - The values listed under each step are associated to building the Other Payer Coverage Type 02 occurrence (i.e. when billing to the tertiary).
    - Note: NCPDP Telecommunication Standard limits the Other Amount Paid Count (563-J2) to 3. To illustrate detailed explanations for each Other Amount Paid Qualifier value listed in the January 2011 ECL, field 565-J4 is repeated 5 times in the below example.

| FIELD ID | PRIMARY RESPONSE PRICING | |
|---|---|---|
| 506-F6 | INGREDIENT COST PAID | $90.00 |
| 507-F7 | DISPENSING FEE PAID | $5.00 |
| 563-J2 | OTHER AMOUNT PAID COUNT | **2** |
| 564-J3 | OTHER AMOUNT PAID QUALIFIER | **01** |
| 565-J4 | OTHER AMOUNT PAID (Delivery) | **$10.00** |
| 564-J3 | OTHER AMOUNT PAID QUALIFIER | **09** |
| 565-J4 | OTHER AMOUNT PAID (Compound) | **$0.00** |
| 521-FL | INCENTIVE AMOUNT PAID | **$0.00** |
| 559-AX | PERCENTAGE SALES TAX AMOUNT PAID | **$4.50** |
| 561-AZ | PERCENTAGE SALES TAX BASIS PAID | 2 |
| 560-AY | PERCENTAGE SALES TAX RATE PAID | 5% |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | |
|---|---|---|
| 505-F5 | PATIENT PAY AMOUNT | $95.00 |
| 517-FH | AMOUNT APPLIED TO PERIODIC DEDUCTIBLE | $95.00 |
| 509-F9 | TOTAL PAID AMOUNT | **$14.50** |
| 574-2Y | PLAN SALES TAX AMOUNT | $4.50 |
| 575-EQ | PATIENT SALES TAX AMOUNT | $0. |
| FIELD ID | Secondary Claim COB Segment | |
| 338-5C | OTHER PAYER COVERAGE TYPE | 1 |
| | OTHER PAYER AMOUNT PAID COUNT | 5 |
| 431-DV | OTHER PAYER AMOUNT PAID - DELIVERY | **$10.00** |
| 431-DV | OTHER PAYER AMOUNT PAID - COMPOUND | **$0.00** |
| 431-DV | OTHER PAYER AMOUNT PAID - INCENTIVE | **$0.00** |
| 431-DV | OTHER PAYER AMOUNT PAID - SALES TAX | **$4.50** |
| 431-DV | OTHER PAYER AMOUNT PAID : DRUG BENEFIT | **$0.00** |
| FIELD ID | SECONDARY RESPONSE PRICING | |
| 506-F6 | INGREDIENT COST PAID | $89.00 |
| 507-F7 | DISPENSING FEE PAID | $3.50 |
| 565-J4 | OTHER AMOUNT PAID (Delivery) | **$0.00** |
| 565-J4 | OTHER AMOUNT PAID (Compound) | **$5.00** |
| 521-FL | INCENTIVE AMOUNT PAID | **$5.00** |
| 559-AX | PERCENTAGE SALES TAX AMOUNT PAID | **$1.03** |
| 561-AZ | PERCENTAGE SALES TAX BASIS PAID | 02 |
| 560-AY | PERCENTAGE SALES TAX RATE PAID | 5% |
| 566-J5 | OTHER PAYER AMOUNT RECOGNIZED | $14.50 |
| 505-F5 | PATIENT PAY AMOUNT | $20.00 |
| 518-FI | AMOUNT OF COPAY | $20.00 |
| 523-FN | AMOUNT ATTRIBUTED TO TAX | $0.00 |
| 517-FH | AMOUNT APPLIED TO PERIODIC DEDUCTIBLE | $0.00 |
| 509-F9 | TOTAL AMOUNT PAID | **$83.53** |
| 574-2Y | PLAN SALES TAX AMOUNT | $1.03 |
| 575-EQ | PATIENT SALES TAX AMOUNT | $0.00 |
| Filed ID | Tertiary Claim COB Segment | |
| 338-5C | OTHER PAYER COVERAGE TYPE | 1 |
| | OTHER PAYER AMOUNT PAID COUNT | 5 |
| 431-DV | OTHER PAYER AMOUNT PAID - DELIVERY | $10.00 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | |
|---|---|---|
| 431-DV | OTHER PAYER AMOUNT PAID - COMPOUND | $0.00 |
| 431-DV | OTHER PAYER AMOUNT PAID - INCENTIVE | $0.00 |
| 431-DV | OTHER PAYER AMOUNT PAID - SALES TAX | $4.45 |
| 431-DV | OTHER PAYER AMOUNT PAID: DRUG BENEFIT | $0.00 |
| **338-5C** | **OTHER PAYER COVERAGE TYPE** | **02** |
| | **OTHER PAYER AMOUNT PAID COUNT** | **5** |
| **431-DV** | **OTHER PAYER AMOUNT PAID - DELIVERY** | **$0.00** |
| **431-DV** | **OTHER PAYER AMOUNT PAID - COMPOUND** | **$5.00** |
| **431-DV** | **OTHER PAYER AMOUNT PAID - INCENTIVE** | **$5.00** |
| **431-DV** | **OTHER PAYER AMOUNT PAID - SALES TAX** | **$1.03** |
| **431-DV** | **OTHER PAYER AMOUNT PAID: DRUG BENEFIT** | **$72.50** |

| | | **Other Payer Amount Paid (431-DV) Reporting Order**<br>Example = Other Payer Coverage Type 02 Occurrence | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Step # | Action | 431-DV Tax [342-HC value 10] | 431-DV CMPD [342-HC value 09] | 431-DV Delivery [342-HC value 01] | 431-DV Shipping [342-HC value 02] | 431-DV Postage [342-HC value 03] | 431-DV Admin [342-HC value 04] | 431-DV Medication Synchronization [342-HC value 16] | 431-DV Adherence (Compliance) Packaging [342-HC value 17] | 431-DV Incentive [342-HC value 05] | 431-DV Drug Benefit [342-HC value 07] |
| 1 | Determine applicable "Response Amount Paid" values from current payer that the pharmacy will map to the COB segment in the request.<br>1. [10*] Tax Amount = 559-AX + 558-AW - 523-FN<br>2. [09*] Compound = 565-J4: [564-J3 = 09 Compound]<br>3. [01*] Delivery = 565-J4: [564- | $5.53 | $5.00 | $8.00 | | | | | | | N/A |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Other Payer Amount Paid (431-DV) Reporting Order<br>Example = Other Payer Coverage Type 02 Occurrence | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | J3 = 01 Delivery]<br><br>4. [02*] Shipping = 565-J4: [564-J3 = 02 Shipping]<br><br>5. [03*] Postage = 565-J4: [564-J3 = 03 Postage]<br><br>6. [04*] Administrative = 565-J4: [564-J3 = 04 Administrative]<br><br>7. [16*] Medication Synchronization = 565-J4: [564-J3 = 16 Medication Synchronization]<br><br>8. [17*] Adherence (Compliance) Packaging = 565-J4: [564-J3 = 17 Adherence (Compliance) Packaging]<br><br>9. [05*] Incentive = 521-FL [Incent Amount Paid]<br><br>*Other Payer Amount Paid Qualifier (342-HC) value the pharmacy will map to. | | | | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $5.00 | |
| 2 | Determine like "OPAP Values from ALL Prior Payers" | $4.50 | $5.00 | $10.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | N/A |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Other Payer Amount Paid (431-DV) Reporting Order<br>Example = Other Payer Coverage Type 02 Occurrence | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **3** | Determine "Actual Amount Paid" for current payer<br>• "Response Amount Paid" (step 1) minus "OPAP from ALL Prior Payers" (step 2)<br>• If results < = 0, set to 0 | $1.03 | $5.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $5.00 | N/A |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Other Payer Amount Paid (431-DV) Reporting Order<br>Example = Other Payer Coverage Type 02 Occurrence | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4 | Determine "Previously Reported OPAP Amount" for current payer.<br>1. ADD all Other Payer Amount Paid values previously uniquely reported (steps 1-6 completed), for current payer.<br>2. [10] Tax Amount = 0 (always)<br>3. [09] Compound = 431-DV [10 Tax]<br>4. [01] Delivery = 431-DV [10 Tax] + 431-DV [09 Compound]<br>5. [02] Shipping = 431-DV [10 Tax] + 431-DV [09 Compound] + 431-DV [01 Delivery]<br>6. [03] Postage = 431-DV [10 Tax] + 431-DV [09 Compound] + 431-DV [01 Delivery] + 431-DV [02 Shipping]<br>7. [04] Administrative = 431-DV [10 Tax] + 431-DV [09 Compound] + 431-DV [01 Delivery] + 431-DV [02 Shipping] + 431-DV [03 Postage]<br>8. [16*] Medication Synchronization = | $1.03 | $5.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | | | N/A |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Other Payer Amount Paid (431-DV) Reporting Order<br>Example = Other Payer Coverage Type 02 Occurrence | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | 9. [17*] Adherence (Compliance) Packaging =<br>10. [05] Incentive = 431-DV [10 Tax] + 431-DV [09 Compound] + 431-DV [01 Delivery] + 431-DV [02 Shipping] + 431-DV [03 Postage] + 431-DV [04 Administrative] | | | | | | | | $0.00 | $5.00 | |
| 5 | Determine "Total Amount Paid Remaining"<br>• Total Amount Paid (509-F9) from current payer minus "Previously Reported OPAP | $82.50 | $44.50 | $77.50 | $77.50 | $77.50 | $77.50 | $77.50 | $77.50 | $72.50 | $72.50 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | Other Payer Amount Paid (431-DV) Reporting Order<br>Example = Other Payer Coverage Type 02 Occurrence | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Amount" (step 4) | | | | | | | | | | |
| 6 | Set Other Payer Amount Paid value (431-DV). Compare "Total Amount Paid Remaining" (step 5) and "Actual Amount Paid" (step 3)<br>• When "Total Amount Paid Remaining" (step 5) > "Actual Amount Paid" (step 3), set OPAP amount (431-DV) = "Actual Amount Paid" (step 3)<br>• When "Total Amount Paid Remaining" (step 5) <= "Actual Amount paid" (step 3), set OPAP amount (431-DV) = "Total Amount Paid Remaining" (step 5) | $1.03 | $5.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $5.00<br>$2.50 | $72.50 |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | **Other Payer Amount Paid (431-DV) Reporting Order**<br>Example = Other Payer Coverage Type 02 Occurrence | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 7 | When there are additional OPAP amounts to calculate, continue to Step 1. Once all unique OPAP amounts have been calculated based on the reporting order, calculate Drug Benefit.<br><br>To report the Other Payer Amount Paid Drug Benefit (07), from that payer's Total Amount Paid (509-F9) value subtract all Other Payer Amount Paid values uniquely reported for that payer.<br><br>• OPAP Drug Benefit = Total Amount Paid (509-F9) – 431-DV [10 Tax] - 431-DV [09 Compound] - 431-DV [01 Delivery] - 431-DV [02 Shipping] - 431-DV [03 Postage] - 431-DV [04 Administrative] - 431-DV [05 Incentive] | → | → | → | → | → | → | → | → | → | **$0.00** |
| | | $12.50 | $12.50 | $4.50 | $4.50 | $0.00 | $0.00 | $2.50 | $2.50 | $0.00 | |

*Updated November 2025*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 10.6 OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) VALUES SUNSETTED

**Question:**

We're currently finalizing the requirements for our D.0 implementation, and we've come across a change between 5.1 and D.0 that is causing us some consternation. We're trying to figure out how to handle the elimination of values "08" and "99" in field Other Payer Amount Paid Qualifier (342-HC), which we're using in v5.1 to identify the Other Payer Amount Paid and the Other Payer Allowed Amount. We were using these codes for our MSP (Medicare Secondary Payer) claims, and we're considering submitting a DERF to have the code values added back in, but there must have been a reason these values were removed from D.0, in that there may be other fields that can be used to calculate these amount.

**Response:**

This is the process in place today:

1. The Allowed amount is submitted using qualifier 08
2. The Paid amount is submitted using qualifier 07
3. The Co-insurance amount is submitted using qualifier 99
4. The Deductible (when applicable) is submitted using qualifier 99

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

Other Payer-Patient Responsibility Amount (352-NQ) and

Other Payer-Patient Responsibility Amount Qualifier (351-NP)

Values:

| CODE | DESCRIPTION |
|---|---|
| Blank | Not Specified |
| 01 | Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. |
| 02 | Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. |
| 03 | Amount Attributed to Sales Tax (523-FN) as reported by previous payer. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. |
| 04 | Amount Exceeding Periodic Benefit Maximum (520-FK) as reported by previous payer. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. |
| 05 | Amount of Copay (518-FI) as reported by previous payer. Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. |
| 06 | Patient Pay Amount (505-F5) as reported by previous payer. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. |
| 07 | Amount of Coinsurance (572-4U) as reported by previous payer. Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. |
| 08 | Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer |
| 09 | Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer |
| 10 | Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. |
| 11 | Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer. |
| 12 | Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer. |
| 13 | Amount Attributed to Processor Fee (571-NZ) as reported by previous payer. |

Other Payer Amount Paid (431-DV) and

Other Payer Amount Paid Qualifier (342-HC)

Values:

| CODE | DESCRIPTION |
|---|---|
| 01 | Delivery – An indicator which signifies the amount paid for the costs related to the delivery of a product or service. |
| 02 | Shipping – The amount paid for transportation of an item. |
| 03 | Postage – The amount paid for the mailing of an item. |
| 04 | Administrative – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance. |
| 05 | Incentive-Used to indicate an additional fee or compensation paid to the provider by another payer as an inducement for an action taken by the provider; this might be a collection of survey data or counseling to plan enrollees. |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| CODE | DESCRIPTION |
|---|---|
| 06 | Cognitive Service – Used to indicate pharmacist interaction with patient or caregiver beyond the traditional dispensing/patient instruction activity. For example, therapeutic regimen review, recommendation for additional, fewer, or different therapeutic choices. |
| 07 | Drug Benefit – An indicator which signifies when the dollar amount paid by the other payer has been paid as part of the drug benefit plan. |
| 09 | Compound Preparation Cost – the amount paid for the preparation of the compound |

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

The response from the primary payer using the NCPDP Telecommunication version D.0 billing transaction is real-time and the amount received in the response is the actual amount of payment and the provider's contracted amount. The pharmacy provider then uses the primary response to send the claim to Medicare as the secondary payer. NCPDP understands that Medicare as the secondary payer is required by regulation to receive the amount that the other payer has paid, the amount allowed from the other payer and the amount that the provider is obligated to accept as payment in full. Since the primary claim's response was real-time the following should be used to determine the needed amounts:

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

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

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

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

For MSP Calculations:

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

4. The Deductible amount = Other Payer-Patient Responsibility Amount (352-NQ) amount where Other Payer-Patient Responsibility Amount Qualifier (351-NP) = "01" (Amount Applied to Periodic Deductible (517-FH) as reported by previous payer)

### 10.6.1 MEDICAID ALLOWED AMOUNT AND PRESCRIPTION RESPONSE FORMULA

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

Ingredient Cost Paid (506-F6)
+ Dispensing Fee Paid (507-F7)
+ Incentive Amount Paid (521-FL)
+ Other Amount Paid (565-J4)
+ Flat Sales Tax Amount Paid (558-AW)
+ Percentage Sales Tax Amount Paid (559-AX)
- Patient Pay Amount (505-F5)
- Other Payer Amount Recognized (566-J5)
---
= Total Amount Paid (509-F9)

Providers depend on consistent use of this formula to validate the B1 claim response balances. There are situations in which this balancing does not occur.

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

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

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

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

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

| | | | |
|---|---|---|---|
| **148-U8** | INGREDIENT COST CONTRACTED/REIMBURSABLE AMOUNT | I | Claim Billing/Encounter:<br>Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency.<br><br>This field is informational only. |
| **149-U9** | DISPENSING FEE CONTRACTED/REIMBURSABLE AMOUNT | I | Claim Billing/Encounter: |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | |
|---|---|---|---|
| | | | Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency.<br><br>This field is informational only. |

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

**Question:**

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

**479-H8 - Other Amount Claimed Submitted Qualifier**

| Definition of Field | Field Format | Standard/Version Formats | Field Limitations |
|---|---|---|---|
| Code identifying the additional incurred cost claimed in 'Other Amount Claimed Submitted' (480-H9). | x(2) | T | |

Values:

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

**564-J3 - Other Amount Paid Qualifier**

| Definition of Field | Field Format | Standard/Version Formats | Field Limitations |
|---|---|---|---|
| Code clarifying the value in the 'Other Amount Paid' (565-J4). | x(2) | T,A | |

Values:

| CODE | DESCRIPTION | Value Limitations |
|---|---|---|
| Blank | Not Specified | Used only in Telecommunication Standard© Versions 9.0 through C.4. and Post Adjudication Standard Version 1.0. Value was deleted and cannot be used in higher versions. |
| 01 | Delivery - An indicator which signifies the amount paid for the costs related to the delivery of a product or service. | |
| 02 | Shipping - The amount paid for transportation of an item. | |
| 03 | Postage - The amount paid for the mailing of an item. | |
| 04 | Administrative - An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance. | |
| 09 | Compound Preparation Cost Paid - The amount paid for the preparation of the compound. | |
| 99 | Other | |

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

| Definition of Field | Field Format | Standard/Version Formats | Field Limitations |
|---|---|---|---|
| Code qualifying the 'Other Payer Amount Paid' (431-DV). | x(2) | T | |

Values:


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

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

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

## 10.8 LIKE AMOUNTS SUBMITTED AS INCENTIVE FEE

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

**Response:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Submit a DERF to create a new value for Other Payer Amount Paid Qualifier (342-HC), Other Amount Paid Qualifier (564-J3) and Other Amount Claimed Submitted Qualifier (479-H8), for Medication Administration Fee. *(DERF 001084 was approved August 2012).*

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

A new qualifier specific to the Medication Administration Fee was added (value 11) for the following fields:

- Other Amount Claimed Submitted Qualifier (479-H8)
- Other Amount Paid Qualifier (564-J3)
- Other Payer Amount Paid Qualifier (342-HC)

To standardized the field in which a medication administration fee can be identified, and to mitigate COB claims processing risks, changes to support the new qualifiers are available in Telecommunication Standard Version E.1©.

## 10.9 DRUG BENEFIT

**Question:**

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

**Response:**

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

NCPDP Telecommunication Standard vD.0 Implementation Guide© section: 28.1.10.3

*"Note: Other Payer Amount Paid is in the Coordination of Benefits/Other Payments Segment, not the Pricing Segment.*

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

To clarify the above when processing COB claims:

The financial fields within the COB Segment are considered pass through fields, where the provider is reporting what was received from the previous payers' responses. Descriptive qualified values identify the other payers' patient responsibility amounts, amounts paid to the provider, and when applicable the Medicare D benefit stage amounts. These financial amounts are either a direct map from the previous


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

payer's response (Other Payer Patient Responsibility Amount, Benefit Stage Amount), or require specific mapping rules (Other Payer Amount Paid, see Question 1). The COB payer sheet may note that the benefit or trading partner agreement considers specific qualified values however; the payer sheet cannot restrict which qualified values can be submitted.

Other Payer-Patient Responsibility Amount COB billing may either be based on;

- Method 1 - Other Payer-Patient Responsibility Amount Qualifier (351-NP) value of 06 Patient Pay (505-F5) Amount as reported by previous payer or
- Method 2 -Other Payer-Patient Responsibility Amount Qualifiers (351-NP) not equal to 06

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

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

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

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

## 10.10 OTHER PAYER REJECT CODE (472-6E)

The situation on Other Payer Reject Code (472-6E) has been clarified from "Required when the payer in this occurrence has denied the payment for the billing, designated with Other Coverage Code (308-C8) = 3 (Other Coverage Billed – claim not covered)" to "Required when the payer in this occurrence has denied the payment for the billing." The reference to Other Coverage Code value of 3 caused an assumption that Other Coverage Code must be 3. This was modified in Telecom Version D.9. The Other Coverage Code chart in the Telecom Version D.9 was also updated and included here.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

This table lists the situations stated for the Claim Billing/Encounter environment. These rules also apply to other transactions that use the Other Coverage Code (308-C8) in similarly defined situations.

| | This is a code representing a **summation** of other coverage information that has been collected from other payers. The claim subsequent columns provide rules for which values to use in summation. | | **Claim Billing/Encounter:**<br>• Required if other payer has approved payment for some/all of the billing.<br>• Zero (0) is a valid value.<br>• Not used for patient financial responsibility only billing.<br>• Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. | **Claim Billing/Encounter:**<br>• Required if necessary for patient financial responsibility only billing.<br>• Required if necessary for state/federal /regulatory agency programs.<br>• Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted. | **Claim Billing/Encounter:**<br>• Required when the other payer has denied the payment for the billing.<br>• Note: This field must only contain the NCPDP Reject Code (511-FB) values. |
|---|---|---|---|---|---|
| **Value** | **Description** | **COB Segment** | **OPAP** | **OPPRA** | **Reject Codes** |
| 0 | Not specified by patient | No | n/a | n/a | n/a |
| 1 | No other coverage | No | n/a | n/a | n/a |
| 2 | Other coverage exists/billed-payment collected | Yes | **Governmental / Non-Governmental Receiver of Claim**<br>Required from at least one payer and at least one payer value must be other than zero.<br>In the case of multiple payers, OPAP (even if zero) must be submitted for all payers who paid. | **Non-Governmental Receiver of Claim**<br>No<br><br>**Governmental Receiver of Claim**<br>Required for all payers who paid | For OCC 2 one payer had to pay the claim with a receivable to pharmacy. OTHER payers may have rejected so Reject Codes are required for those billed who did reject. |
| 3 | Other Coverage Billed – claim not covered | Yes | No | No | ALL payers must have rejected so <u>each</u> payer should be represented by individual payer loops containing Reject codes |
| 4 | Other coverage exists-payment not collected | Yes | **Governmental / Non-Governmental Receiver of Claim**<br>Required from at least one payer however anyone who paid should have done so with OPAP of zero (100% copay).<br>When submitted with OCC 4, OPAP (as zero) must be submitted. | **Non-Governmental Receiver of Claim**<br>No<br><br>**Governmental Receiver of Claim**<br>Required for all payers who paid | For OCC 4 one payer had to pay the claim with a pharmacy receivable of zero. OTHER payers may have rejected so Reject Codes are required for those billed who did reject. |
| 8 | Claim is billing for patient financial responsibility only | Yes | No<br>Not used for patient financial responsibility only billing. | Required for all payers who paid | For OCC 8 one payer had to pay the claim. OTHER payers may have rejected so Reject Codes are required for those billed who did reject. |

*(05/2014: Editorial note this table has been updated in Telecommunication Standard Implementation Guide version E6© – this is for future use.)*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 10.11 OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT (352-NQ) TO EACH PAYER?

**Question:**

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

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

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

**Response:**

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

- For COB processing based on Other Payer-Patient Responsibility Amounts (352-NQ) the net amount due is the *sum of* the payable components of the Other Payer-Patient Responsibility values from
  - the LAST payer
  - as determined by the Other Coverage Type (338-5C) (i.e. Primary, Secondary, etc.)
  - that returned a PAID response
- When reimbursement is based on the Other Payer-Patient Responsibility Amount:
  - Basis of Reimbursement Code (522-FM) "14" is to be returned
- When the Patient has a responsibility amount from the prior payer that may not be included in the benefit structure of the COB plan, the COB payer must process via one of the following methods:
  - Pay the Patient Responsibility claim as submitted including all components of Other Payer-Patient Responsibility Amounts.
  - Pay the Patient Responsibility claim, reimburse for appropriate components of Patient Pay Amount and those NOT paid by the plan are passed back to the Patient as Patient Pay Amount (505-F5) and its component fields.
  - Reject the claim with the appropriate reject code.

Coordination of Benefit claim example:

- The secondary payer requires Other Payer Amount Paid (431-DV) and returns a Patient Pay Amount (505-F5) higher than the primary payer's Patient Pay Amount
- The tertiary payer requires Other Payer-Patient Responsibility Amount (352-NQ) and returns a Patient Pay Amount (505-F5) greater than $0

| Primary Submission | | | Secondary Submission for Other Payer Amount Paid | | | Tertiary Submission for Other Payer Patient Responsibility | | |
|---|---|---|---|---|---|---|---|---|
| | **Pricing Segment** | | | **Pricing Segment** | | | **Pricing Segment** | |
| 409-D9 | Ingredient Cost Submitted | 95.00 | 409-D9 | Ingredient Cost Submitted | 93.00 | 409-D9 | Ingredient Cost Submitted | 95.00 |
| 412-DC | Dispensing Fee Submitted | 5.00 | 412-DC | Dispensing Fee Submitted | 6.00 | 412-DC | Dispensing Fee Submitted | 4.00 |
| 430-DU | Gross Amount Due | 100.00 | 430-DU | Gross Amount Due | 99.00 | 430-DU | Gross Amount Due | 99.00 |
| 426-DQ | Usual and Customary | 105.00 | 426-DQ | Usual and Customary | 105.00 | 426-DQ | Usual and Customary | 105.00 |
| | | | | **Claim Segment** | | | **Claim Segment** | |
| | | | 308-C8 | Other Coverage Code | 2 | 308-C8 | Other Coverage Code | 8 |
| | | | | **COB Segment** | | | **COB Segment** | |
| | | | 337-4C | COB/Other Payments Count | 1 | 337-4C | COB/Other Payments Count | 2 |
| | | | 338-5C | Other Payer Coverage Type | 01 | 338-5C | Other Payer Coverage Type | 01 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 339-6C | Other Payer ID Qualifier | 03 | 339-6C | Other Payer ID Qualifier | 03 |
| | | | 340-7C | Other Payer ID | 789123 | 340-7C | Other Payer ID | 789123 |
| | | | 443-E8 | Other Payer Date | 20100409 | 443-E8 | Other Payer Date | 20100409 |
| | | | 341-HB | Other Payer Amount Paid Count | 1 | 353-NR | Other Payer-Patient Responsibility Amount Count | 1 |
| | | | 342-HC | Other Payer Amount Paid Qualifier | 7 | 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 05 |
| | | | 431-DV | Other Payer Amount Paid | 73.00 | 352-NQ | Other Payer-Patient Responsibility Amount | 20.00 |
| | | | | | | 358-5C | Other Payer Coverage Type | 2 |
| | | | | | | 339-6C | Other Payer ID Qualifier | 03 |
| | | | | | | 340-7C | Other Payer ID | 123456 |
| | | | | | | 443-E8 | Other Payer Date | 20100409 |
| | | | | | | 353-NR | Other Payer-Patient Responsibility Amount Count | 2 |
| | | | | | | 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 07 |
| | | | | | | 352-NQ | Other Payer-Patient Responsibility Amount | 11.25 |
| | | | | | | 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 08 |
| | | | | | | 352-NQ | Other Payer-Patient Responsibility Amount | 10.00 |
| | **Response Pricing Segment** | | | **Response Pricing Segment** | | | **Response Pricing Segment** | |
| 506-F6 | Ingredient Cost Paid | 90.00 | 506-F6 | Ingredient Cost Paid | 92.00 | 506-F6 | Ingredient Cost Paid | 21.25 |
| 507-F7 | Dispensing Fee Paid | 3.00 | 507-F7 | Dispensing Fee Paid | 3.50 | 507-F7 | Dispensing Fee Paid | 0.00 |
| | | | 566-J5 | Other Payer Amount Recognized | 73.00 | | | |
| 505-F5 | Patient Pay Amount | 20.00 | 505-F5 | Patient Pay Amount | 21.25 | 505-F5 | Patient Pay Amount | 2.00 |
| 509-F9 | Total Amount Paid | 73.00 | 509-F9 | Total Amount Paid | 1.25 | 509-F9 | Total Amount Paid | 19.25 |
| 518-F1 | Amount Of Copay | 20.00 | 572-4U | Amount of Coinsurance | 11.25 | 518-FI | Amount Of Copay | 2.00 |
| 522-FM | Basis of Reimbursement Determination | 1 | 135-UM | Amount Attributed to Product Selection/Non Preferred Formulary Selection | 10.00 | | | |
| | | | 522-FM | Basis of Reimbursement Determination | 1 | 522-FM | Basis of Reimbursement Determination | 14 |
| | | | | | | 148-U8 | Ingredient Cost Contracted/Reimbursable Amount | 91.00 |
| | | | | | | 149-U9 | Dispensing Fee Contracted/Reimbursable Amount | 4.00 |

## 10.12 OPPRA (352-NQ) FIELD LENGTH GREATER THAN $999,999.99 IS RECEIVED

**Question**:
What is the appropriate reject code a PBM should use when a claim with an Other Payer Patient Responsibility Amount (352-NQ) value greater than $999,999.99 is received?

**Answer:** Currently, NQ (M/I Other Payer-Patient Responsibility Amount) is the appropriate reject code for this situation. Additionally, the processor should return messaging for clarification regarding the reject. Effective 10/15/2020, a new reject code is available (945- High Dollar Amount Is Not Supported) and should be returned in conjunction with the NQ reject and additional messaging on D.0 claim transactions for this scenario.

*Updated August 2024*

## 10.13 GOVERNMENT COB

**Question**:


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

When a downstream payer uses Government COB, must the pharmacy send the Other Payer Amount Paid (OPAP) and Other Payer Patient Responsibility Amounts (OPPRA) from all previous payers or just the last payer?

**Response**:
The net amount due on an OPPRA COB claim is the sum of the Other Payer Patient Responsibility Amount (352-NQ) from the last payer who returned a paid response. For OPAP COB the downstream payer must sum the Other Payer Amount Paid (431-DV) from all previous payers. So in a government COB claim, it is not necessary to send the OPPRA amount(s) from all previous payers, as the OPPRA amount(s) from the last payer that returned a paid response is the only one necessary to calculate the net amount due. However, it is necessary to send the OPAP from all previous payers.

Added August 2017 (BP)

**Question:**
How should COB payers populate Basis of Reimbursement Determination (522-FM) when Government COB is used?

**Response:**
For Government COB, the recommendation is to populate the Basis of Reimbursement Determination based on the method used to determine COB pricing (patient responsibility and pharmacy reimbursement amounts). If reimbursement is based on OPPRA COB, use value '14 - Other Payer-Patient Responsibility Amount'. Any other values used for Basis of Reimbursement Determination would indicate reimbursement was calculated based on OPAP COB.

Added November 2019 (BP)

## 10.14 OPPRA AND OTHER COVERAGE CODE VALUE 3

**Question**:
When a COB claim is submitted using the Other Payer Patient Responsibility Amount (OPPRA) COB method with Other Coverage Code 3, what financial fields does the pharmacy submit and are there any special requirements for the payer's response?

**Response**:
OCC=3 is used when all previous payers reject a claim in all COB methods (OPAP, OPPRA and Govt). The COB segment in this case will not contain any financial information (i.e. OPAP or OPPRA fields) but must contain at least one reject code. The Payer will use the financial information from the Pricing Segment to adjudicate the claim. The financial information in the Pricing Segment is the pricing for the claim "as if" primary.

As far as guidance for how the downstream payer responds to an OCC=3 claim, they will use their own business rules to process. Some payers may use the reject codes from the primary claim to determine how/if they pay a claim. For example, if the primary payer rejected because the drug was not on formulary, the secondary may choose to reject as well to enforce the primary payer's formulary and keep their costs down. However if the primary rejected because the member was not covered, the secondary will likely adjudicate as if primary and use their own benefit rules to determine coverage and payment.

Added August 2017 (BP)

## 10.15 PROCESSOR VS. PHARMACY RESPONSIBILITY FOR AGGREGATING OTHER PAYER AMOUNTS

**Question:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

There are issues around the usage of, correlation of, aggregation of, and response of data submitted between payers and pharmacy involved in COB claims. There appears to be 2 ways to handle Other Payer-Patient Responsibility amounts when multiple payers are involved in claims processing.

**Response:**

1. When **Other Payer Amount Paid repetitions only** COB submission is required, the COB payer must SUMMARIZE like values in the Other Payer Amount Paid (431-DV) across all prior payers for processing. This means that Drug Benefit dollars paid will be summarized for all payers. Any other types of values (delivery dollars, incentives, administrative, etc.) are summarized with other like values, and applied based on third party agreements.
2. When **Other Payer-Patient Responsibility Amount repetitions only** COB is required, the COB payer must first identify the payer with the highest Other Payer Coverage Type (338-5C) value. If Other Payer-Patient Responsibility Amounts do not exist in this COB loop, the COB payer must determine whether to identify the next highest Other Payer Coverage Type (338-5C) value or reject the claim. Once the highest Other Payer Coverage Type (338-5C) value with Other Payer-Patient Responsibility Amounts is determined, ONLY these Other Payer-Patient Responsibility Amounts should be interrogated for payment. The COB payer may pay all of the components or some of the components and return the remaining dollars for the patient to pay; or reject the claim.
3. When **Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage repetitions (Government Programs)** is required for submission, COB payer should determine which method they wish to use for processing and then follow the appropriate calculation method noted in items 1 or 2 above.

**Question:**

For a government COB, the payer can pay either patient responsibility amount that was returned from the last prior payer that returned a paid response or pay based on other payer paid amount. Now if the last payer that did return a paid response, also did not return patient responsibility amount (No patient responsibility qualifier and amount was sent by the provider to the government COB payer to indicate patient responsibility amount returned from last payer that paid the claim). In this case, is a government COB payer safe to assume that $0 needs to be paid as allowed amount (there is no patient responsibility remaining on the claim) and any dispensing/incentive fee needs to be paid on top of that based on the contract between the provider and the government COB payer.

**Response:**

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

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

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

The transmission of the two data elements (Other Payer-Patient Responsibility Amount (352-NQ) and Other Payer Amount Paid (431-DV)) is the only way to identify the claim is intended for processing as a Government


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

COB claim. If the processor is expecting Government COB and Other Payer-Patient Responsibility Amount (352-NQ) is not present the processer should reject the claim with Reject Code (511-FB) value of "NQ" (M/I Other Payer-Patient Responsibility Amount).

This was added to Telecommunication Standard Version E.0©.

## 10.16 PATIENT PAID AMOUNT SUBMITTED (433-DX)

### 10.16.1 ACCOUNTING FOR MONIES PAID TO THE PATIENT?

**Question:**

In the March 2010 Data Dictionary©, the Patient Paid Amount Submitted (433-DX) has the following comment:

> This field is not used in coordination of benefit transactions to pass patent liability information to a downstream payer. See Other Payer-Patient Responsibility Amount (352-NQ).

Does this mean that any money paid by the patient to the pharmacy prior to submission of the claim would have to be accounted for by the primary payer?

**Response:**

While this field has rare usage, this could be used to reduce the contracted amount by what the patient has paid for the claim prior to adjudication (e.g. Spenddown). The amount paid by the patient is submitted in Patient Paid Amount Submitted (433-DX). The payer should respond with the Patient Paid Amount Submitted value in the Other Payer Amount Recognized (566-J5) field thus allowing Total Amount Paid (509-F9) to balance.

### 10.16.2 RECEIVING PATIENT PAID AMOUNT SUBMITTED (433-DX) WHEN PREVIOUS PAYER PAID THE CLAIM?

**Question:**

As a COB payer would we receive Patient Paid Amount Submitted (433-DX) when a previous payer has paid the claim using Patient Paid Amount Submitted (433-DX)?

**Response:**

No, NCPDP vD.0 does not support the use of Patient Paid Amount Submitted (433-DX) in COB processing. Based on the NCPDP definition and the defined situations Patient Paid Amount Submitted (433-DX) must only be used in single payer situations to report the monies actually paid to the pharmacy.

### 10.16.3 RECEIVING PATIENT PAID AMOUNT SUBMITTED (433-DX) WHEN PREVIOUS PAYER REJECTED THE CLAIM?

**Question:**

Similarly, if the previous payer(s) rejected the claim, would we (as a COB payer) then receive this field?

**Response:**

No, because the Patient Paid Amount Submitted (433-DX) is a requirement for the previous benefit, as a result of the rejection the patient would not have paid anything to the pharmacy.

The NCPDP Telecommunication Standard© provides an alternate method to support spend down or patient deductible requirements, eliminating the need for the provider to submit amounts paid by the patient in Patient Paid Amount Submitted (433-DX) prior to claim adjudication. The processor would maintain the patient financial responsibility accumulators and return the appropriate values in the following response fields; Amount Applied to Periodic Deductible (517-FH), Remaining Deductible Amount (513-FD) and Accumulated Deductible Amount (512-FC)). In order to support deductible/spend down in a COB situation and to avoid confusion, the WG1 COB Task Group recommends that Patient Paid Amount Submitted (433-DX) be sunsetted in a future version. WG1 Telecommunication approved the recommendation to sunset Patient Paid Amount Submitted (433-DX) in August 2011; the Task Group will to create the DERF.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 10.17 COORDINATION OF BENEFITS SEGMENT (05) VS. PRICING SEGMENT (11)

**Question:** XYZ Medicaid is looking for clarification on how new fields within the Coordination of Benefits Segment (05) are to be used. Currently, when pharmacies are billing Medicaid for Copay, and the Other Coverage Code indicator (308-C8) is equal to '02' (Other coverage exists-payment collected) or is equal to '08' (claim is billing for Copay), the pharmacies are directed to enter the 'Copay' in the Patient Paid Amount Submitted (433-DX) field. Our understanding is this has been an industry 'standard'. Additionally, XYZ business rules require that an other insurance payment (greater than zero) would accompany the copay (433-DX).

The Patient Paid Amount Submitted (433-DX) field still remains an active qualified field in the Pricing Segment (11) in the Telecommunication Standard Implementation Guide Version D.0©. However, with the definition of "Amount the pharmacy received from the patient for the prescription dispensed", it appears that the new Coordination Of Benefits fields "Other Payer-Patient Responsibility Amount Qualifier" (351-NP) and "Other Payer-Patient Responsibility Amount" (352-NQ) should be taking the place of 433-DX.

**Response:** In version 5.1, Patient Paid Amount Submitted (433-DX) was used in two different ways 1) for monies paid by the patient to the pharmacy prior to submission of the claim and 2) limited to government programs to report patient copay in some coordination of benefit situations. This caused confusion.

In version D.0, we added new fields in the COB Segment to support patient responsibility (Other Payer-Patient Responsibility Amount Qualifier"(351-NP) and Other Payer-Patient Responsibility Amount (352-NQ)) to report the amount of the cost share of the patient. Patient Paid Amount Submitted (433-DX) is only to be used to relay monies paid by the patient to the pharmacy prior to submission of the claim. This is different than patient responsibility dollars from the previous payer.

In version D.0 OCC function remains the same. Section 28.1.9.2 Other Coverage Code provides further clarification of the use of this field and segments.

## 10.18 COORDINATION OF BENEFITS AND PRIOR AUTHORIZATION

### 10.18.1 HOW SHOULD MEDICARE AND MEDICAID HANDLE THE PROCESSING OF BENZODIAZEPINE AND BARBITURATES?

See section "*Medicare Part D/Medicaid Benzodiazepine and Barbiturate Claims Processing Risks*".

## 10.19 MEDICAID PAY ONLY APPLICABLE COMPONENTS?

**Question:**
Can the XYZ Medicaid pay the components that are only applicable to them and disregard the rest of the components (instead of passing it to patient)?

**Response:**
No. The payer must always return a balanced response; therefore when the COB payer is paying based on Other Payer-Patient Responsibility Amount they must either:

- Pay the sum of the component pieces
- Reject the claim when specific components of Other Payer-Patient Responsibility Amounts are not supported
- Pass the unpaid other payer-patient responsibility amounts to the patient
- Or continue accepting the lump sum of patient pay as the Other Payer-Patient Responsibility Amount (352-NQ) with the Other Payer-Patient Responsibility Amount Qualifier (351-NP) value of '06' (Patient Pay Amount (505-F5) as reported by previous payer).

Refer to the following for supporting documentation:


*** OFFICIAL RELEASE ***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- The "*Specific Segment Discussion"* section 28.2.6.5.4.7 found on page 753 of the August 2010 NCPDP Telecommunication Implementation Guide vD.0.
- Section "*Clarification of Net Amount Due in Coordination of Benefits".*

## 10.20 RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT (28)

See section "*Coordination of Benefits Information*".

### 10.20.1 OTHER PAYER COVERAGE TYPE (338-5C) AND PROCESSING FOR MID-STREAM PAYERS

**Question:**

Scenario 1: Plan E is the 5th payer in a series of other payers. Plan E knows that 2 more payers exist after their processing (F & G). Several scenarios pose issues:

If, for some reason, the pharmacy doesn't process the 4 payers before E, and only processes A and C, is it safe to assume pharmacy will send to plan E using Other Payer Coverage Type (338-5C) values for the first 2 payers as 01 and 02 ? To the pharmacy, this implies that plan E is tertiary. When responding to the claim, what should plan E respond with when including Other Payer F and G? The Other Payer Coverage Type (338-5C) values can be sent based on either pharmacy knowledge of order, or based on plan data: Since plan E is processing 3rd instead of 5th, can send Other Payer Coverage Type (338-5C) of 04 and 05, or could send back 06 and 07. Which should it send back?

Scenario 2: Plan E is once again the 5th payer. Pharmacy submits a non-COB claim to plan E, which rejects and provides other health information (OHI) back to pharmacy. Since plan E can only send back 3 other payers (but there are 4), which 3 should it send back? A, B, and C, or the 3 immediately before it: B, C, D? Does industry have a preference? Our business owners think it should be the 3 immediately before plan E, and if plan B knows about plan A, they can in turn reject and provide their data (thus, if everyone knows about everyone else, eventually plan E will process correctly in position). If industry wants top-down reporting of OHI, then we'll have to change our course of action.

**Response:**

If payer is paying the claim, the payer should only send other health information (OHI) for the payers that follow them. If the payer is rejecting the claim, the payer should send OHI from the top down (what the payer has in their file as it pertains to OHI). If there are multiple claims in the transmission the payer is to send the same 3 OHI payers on all claims.

### 10.20.2 INGREDIENT COST PAID (506-F6) AND TOTAL PATIENT RESPONSIBILITY AMOUNT FROM LAST PAYER

**Question:**

Ingredient Cost Paid (506-F6) (Required if this value is used to arrive at the final reimbursement).

If the claim is being paid for patient responsibility only billing, is it mandatory that this field contains total patient responsibility amount from last payer?

There is a requirement that provider needs to be made whole (paid entirely) for patient responsibility only billing.

In that case, which of the 2 is true?

1. Allowed amount + dispensing fee should be equal to total patient responsibility amount from last payer
2. Allowed amount should be equal to total patient responsibility amount from last payer. The dispensing fee should be additional amount on top of that.

**Response:**

When COB processing is based on Other Payer-Patient Responsibility Amounts (352-NQ), the net amount due is the sum of the payable components of the Other Payer-Patient Responsibility values from


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- the LAST payer
- as determined by the Other Coverage Type (338-5C) (i.e. Primary, Secondary, etc.)
- that returned a PAID response

Basis of Reimbursement Determination (522-FM) is defined as "Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (506-F6)." Therefore when reimbursement is based on the Other Payer-Patient Responsibility Amount, the value of "14" (Other Payer-Patient Responsibility Amount) is to be returned. As a result, Ingredient Cost Paid (506-F6) becomes the sum of Other Payer-Patient Responsibility Amounts (352-NQ).

The contractual agreement between the COB payer and the provider determines whether a dispensing fee applies to Other Payer-Patient Responsibility Amount coordination of benefit claims. Any contracted dispensing fees should be returned in the Dispensing Fee Paid (507-F7) field. Based on the contractual agreement, other applicable payments (delivery, incentive, tax, etc.) would be returned in their respective response pricing fields.

## 10.21 TRANSITION OF VERSIONS AND COB

New vD.0 Reject Codes offer distinct messaging associated to specific reject scenarios. In the situation where the primary payer returns new vD.0 Reject Code values and the non-primary payer does not recognize/accept these new Reject Code values, coordination of benefit claims processing issues may occur. Situations may occur when the non-primary payer is still processing v5.1 transactions or, when processing vD.0 transactions but supporting an earlier version of the External Code List© (ECL).

**Recommendation:** A mapping of the vD.0 Reject Code values back to the comparable less descriptive v5.1 Reject Code values, allowing the COB claim to process as normal must be supported. This mapping can be implemented by either the processor or the provider. Please refer to the Reject Code Mapping table below.

**Reject Code Mapping**

**HIGH RISK: Most Commonly Used Reject Codes**

| D.0 Reject Code | Explanation | 5.1 Reject Code | 5.1 Reject Code Description |
|---|---|---|---|
| N1 | No patient match found | 52 | Non-Matched Cardholder ID |
| 569 | Provide Beneficiary with CMS Notice of Appeal Rights | 70 | Product/Service Not Covered |
| 7Y | Compounds Not Covered, | 70 | Product/Service Not Covered |
| A5 | Not Covered Under Part D Law | 70 | Product/Service Not Covered |
| A6 | This Medication May Be Covered Under Part B | 70 | Product/Service Not Covered |
| MR | Product Not On Formulary | 70 | Product/Service Not Covered |
| 7X | Days Supply Exceeds Plan Limitation | 76 | Plan Limitations Exceeded |

**MODERATE RISK:**

| D.0 Reject Code | Explanation | 5.1 Reject Code | 5.1 Reject Code Description |
|---|---|---|---|
| 582 | M/I Fill Number | 17 | M/I Fill Number |
| 585 | Fill Number Value Not Supported | 17 | M/I Fill Number |
| 7W | Number of Refills Authorized Exceed allowable Refills | 17 | M/I Fill Number |
| 512 | Compound Code Value Not Supported | 20 | M/I Compound Code |
| 8K | DAW Code Value Not Supported | 22 | M/I (DAW)/ Product Selection Code |
| 556 | Unit Of Measure Value Not Supported | 26 | M/I Unit Of Measure |
| 8R | Submission Clarification Code Value Not Supported | 34 | M/I Submission Clarification Code |
| 560 | Pharmacy Not Contracted in Retail Network | 40 | Pharmacy Not Contracted With Plan DOS |
| 561 | Pharmacy Not Contracted in Mail Order Network | 40 | Pharmacy Not Contracted With Plan DOS |
| 562 | Pharmacy Not Contracted in Hospice Network | 40 | Pharmacy Not Contracted With Plan DOS |
| 563 | Pharmacy Not Contracted in Veterans Administration Network | 40 | Pharmacy Not Contracted With Plan DOS |
| 564 | Pharmacy Not Contracted in Military Network | 40 | Pharmacy Not Contracted With Plan DOS |
| G6 | Pharmacy Not Contracted in Specialty Network | 40 | Pharmacy Not Contracted With Plan DOS |
| G7 | Pharmacy Not Contracted in Home Infusion Network | 40 | Pharmacy Not Contracted With Plan DOS |
| G8 | Pharmacy Not Contracted in Long Term Care Network | 40 | Pharmacy Not Contracted With Plan DOS |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | |
|---|---|---|---|
| G9 | Pharmacy Not Contracted in 90 Day Retail Network (this message would be used when the pharmacy is not contracted to provide a 90 days supply of drugs) | 40 | Pharmacy Not Contracted With Plan DOS |
| MS | More than 1 Cardholder Found – Narrow Search Criteria | 52 | Non-Matched Cardholder ID |
| 9G | Quantity Dispensed Exceeds Maximum Allowed | 76 | Plan Limitations Exceeded |
| 590 | Compound Dosage Form Not Covered | EG | M/I Compound Dispensing Unit Form Indicator |
| 547 | Prior Authorization Type Code Value Not Supported | EU | M/I Prior Authorization Type Code |
| 9T | Prior Authorization Type Code Submitted Not Covered | EU | M/I Prior Authorization Type Code |
| N9 | Use Prior Authorization Code Provided For Level of Care Change | EV | M/I Prior Authorization Number Submitted |
| 516 | Compound Type Value Not Supported | 70 | Product/Service Not Covered |
| 552 | Route of Administration Value Not Supported | 70 | Product/Service Not Covered |
| 9Q | Route Of Administration Submitted Not Covered | 70 | Product/Service Not Covered |

# 10.22 WORKERS' COMPENSATION AND COB

## 10.22.1 PROVIDE GUIDANCE FOR HANDLING WORKERS' COMPENSATION PAYER AS PRIMARY, THAT IS NOT REQUIRED TO SEND TELECOM D.0

**Question:**

Workers' Compensation payer is primary and does not require the claim transaction to be in the Telecom D.0 format and patient has additional coverage that is required to be HIPAA compliant and only accept D.0 claim transactions. Can the secondary payer accept a version 5.1 claim transaction from the pharmacy and still be in compliance with HIPAA? If not how should the claim be submitted to the secondary payer?

**Response:**

Prior to the January 1, 2012 NCPDP vD.0 compliance date, the provider can submit and the payer must accept NCPDP v5.1 claims. Until such time Workers' Compensation claims are covered under the HIPAA rules for electronic claims processing, when processed electronically, any version of the NCPDP Telecommunication Standard© may be used. To facilitate standardization of pharmacy claims processing and ensure proper coordination of benefits, NCPDP strongly recommends that Workers' Compensation claims processed electronically should adhere to the most current NCPDP Telecommunication Standard© version approved under HIPAA.

As of January 1, 2012, in the event that the Workers' Compensation claim is not processed as NCPDP vD.0 and a NCPDP vD.0 coordination of benefit claim to a HIPAA covered entity is required, when:

- The Other Payer-Patient Responsibility Amount (352-NQ) is required, the Other Payer-Patient Responsibility Qualifier (351-NP) value of "06" (Patient Pay Amount (505-F5) as reported by previous payer) should be used alone to report the patient pay on vD.0 coordination of benefit claims.
    - The qualifier of "06" is required in this situation as the response pricing components cannot be mapped to the detailed vD.0 Other Payer-Patient Responsibility Amount qualifiers, for example:
        - The provider cannot determine if the value returned in the Amount of Copay/Coinsurance (518-FI) field of a v5.1 claim response should be reported as the Other Payer-Patient Responsibility Amount Qualifier (351-NP) of "05" (Amount of Copay) or "07" (Amount of Coinsurance) on the vD.0 coordination of benefit claim.
- The Other Payer Amount Paid (431-DV) is required; the provider should calculate the Other Payer Amount Paid values in the order specified in section 9.5 of the NCPDP vD.0 Editorial Document. Drug Benefit is the end result, after all Other Payer Amount Paid values are subtracted from Total Amount Paid (509-F9).
    - Other Amount Claimed Submitted Qualifier (479-H8) and Other Amount Paid Qualifier (564-J3) the value of "99" (Other) is a valid value for v5.1 claims. The value of "99" however, cannot be used to report the Other Payer Amount Paid (431-DV) value on vD.0 coordination of benefit claims. If an appropriate Other Payer Amount Paid value is not reported in the claim, the categorization of the amount may be Drug Benefit "07" or Cognitive Service "06", which may


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

negatively impact the provider or patient. This may not reflect the original intent of the Other Payer Amount Paid dollar amount.

- To ensure any Other Amount Paid (565-J4) value(s) returned by the payer (e.g. Workers' Compensation) in a v5.1 response are reflected appropriately in the subsequent vD.0 coordination of benefit claim, the Other Amount Paid Qualifier (479-H8) value of "99" (Other) must not be used.

## 10.23 REVERSALS AND COB

**Question:**
Please clarify the "appropriate back-out order" for COB reversals.

**Response:**
Coordination of Benefit reversals: Reversal requests for COB claims should be submitted in the reverse order of the claim billing request (example: claim billing occurred as Primary, Secondary then Tertiary, reversal order should be Tertiary, Secondary, Primary). COB claim reversals must contain the Coordination Of Benefits/Other Payments Segment and include the Other Payer Coverage Type in order to facilitate the proper order especially in instances where one processor is the payer for multiple levels of coverage.

A rejected reversal for a COB claim may need to be addressed by alternative processes in order to maintain financial integrity for the claim associated to each payer (Tertiary, Secondary, Primary).

(Note the above applies to claims *and other Telecommunication transactions* that support reversal functionality.)

## 10.24 DOLLAR FIELD NOT RECEIVED

**Question:**
If a pharmacy does not receive a dollar field from a previous payer that is required by a downstream payer, does the pharmacy have to send the dollar field to the downstream payer?

**Response:**
No the pharmacy cannot send what they have not received from a previous payer.

**Question:**
If a pharmacy does not send a dollar field to a downstream payer because they did not receive it from an upstream payer, what assumptions can be made by the downstream payer?

**Response:**
The downstream payer will need to make their own business assumptions when these dollar fields are not provided.

## 10.25 MEDICARE/MEDICAID PART B COB

**QUESTION:**
If a Part B claim processes using the NCPDP Telecommunication real time transaction, how does the pharmacy know what type of benefit it was paid under, especially if the beneficiary is a Qualified Medicare Beneficiary (QMB) and the pharmacy is not allowed to collect the Part B copay/coinsurance from the beneficiary?

**RESPONSE:**
When a claim processes using the NCPDP Telecommunication real-time transaction and pays under Medicare Part B it is recommended that the Medicare Plan return the Benefit Stage Qualifier fields (when applicable) and populate the Additional Message Information (526-FQ) to identify the type of benefit the claim paid under. Refer to the WG9 Medicare Part D FAQ 2.83 Communicate Part B Claim Paid for a QMB Beneficiary


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

The following outlines recommendations for what information to return in the NCPDP Telecommunication Version D.0 response transaction depending on the Medicare Plan type and beneficiary status:

1. Medicare Advantage Prescription Drug (MAPD) where it was paid under Part C (assumption that it was submitted to Part D BIN)
    a. Qualified Medicare Beneficiary (QMB):
        i. Return Benefit Stage Qualifier (393-MV) value 51 "Not paid under Part D, paid under Part C benefit (for MA-PD plan). Beneficiary is a Qualified Medicare Beneficiary - pharmacy should not attempt to collect cost-share, but instead should attempt to bill COB to Medicaid coverage"
            Note: Value 50 should not be used when the beneficiary is QMB
        ii. If the claim is automatically crossed over, the Patient Pay Amount (505-F5) should be zero. The plan is expected to reimburse the pharmacy for the entire amount of the claim and coordination of benefits is not necessary.
        iii. If the claim is not automatically crossed over, the Patient Pay Amount (505-F5) is greater than zero. The pharmacy cannot collect the cost-share from the QMB patient and is expected to bill Medicaid for the patient pay.
            1. Return the Response Coordination of Benefits/Other Payers Segment and populate with Medicaid coverage information.
            2. Additional Message Information should be used to provide the pharmacy with additional information.
                a. Additional Message Information Qualifier (132-UH)
                    i. Until 10/15/2020, use standard qualifiers (01, 02, etc.)
                    ii. Effective 10/15/2020, use the new Qualifier value 32- CMS Dual Status
                b. Additional Message Information (526-FQ)
                    i. Until 10/15/2020, use free form text
                    ii. Effective 10/15/2020 use the following recommended verbiage along with the new qualifier values:
                        1. "CMS 01 Partial Dual"
                        2. "CMS 02 Full Dual"
                c. Other known information that would help the pharmacy facilitate COB should be returned using the Additional Message Information fields.
    b. Non-QMB
        i. Use Benefit Stage Qualifier (393-MV) value 50
        ii. The Additional Message Information should be used to provide the pharmacy with information regarding the benefit the claim paid under
            1. Sample Message: "Paid under Part B benefit for <Benefit Type>". Potential benefit types would be OTC's, Vaccines, DME, B vs D determination, etc.
            2. If payer is aware of downstream coverage:
                a. Additional messaging such as "COB coverage may be available"
                b. Populate the RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT with known other coverage
        iii. Pharmacy may be able to collect the patient responsibility unless the state has additional dual eligible requirements prohibiting collection from the beneficiary.
        iv. Pharmacy should bill COB when appropriate
2. Medicare Advantage (MA) Only where it was paid under Part B
    a. Benefit Stage Qualifiers **are not allowed**
    b. Qualified Medicare Beneficiary (QMB):
        i. Return the Response Coordination of Benefits/Other Payers Segment, and populate with known Medicaid coverage information
        ii. Additional Message Information should be used to provide the pharmacy with more


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

information about the benefit.

a. Additional Message Information Qualifier (132-UH)
    i. Until 10/15/2020, use standard qualifiers (01, 02, etc.)
    ii. Effective 10/15/2020, use the new Qualifier value 32- CMS Dual Status
b. Additional Message Information (526-FQ)
    i. Until 10/15/2020, use free form text
    ii. Effective 10/15/2020 use the following recommended verbiage along with the new qualifier values:
        1. "CMS 01 Partial Dual"
        2. "CMS 02 Full Dual"

c. Non-QMB:
    i. The Additional Message Information should be used to provide the pharmacy with information regarding the benefit the claim paid under
        1. Sample Message: "Paid under Part B benefit for <Benefit Type>". Potential benefit types would be OTC's, Vaccines, DME, etc.
        2. If payer is aware of downstream coverage:
            a. Additional messaging such as "COB coverage may be available"
            b. Populate the RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT with known other coverage
    ii. Pharmacy may be able to collect the patient responsibility unless the state has additional dual eligible requirements prohibiting collection from the beneficiary.
    iii. Pharmacy should bill COB when appropriate.

ADDED 02/2020 – COB TG

## 10.26 COMMUNICATION OF THE MEDICAID BENEFIT RESPONSIBLE FOR QMB PROGRAM MEDICARE PART B COORDINATION

**Question**:
How can the NCPDP Claim Response be used to communicate the Medicaid Benefit responsible for QMB Program Medicare Part B coordination?

- What information should the Medicaid Plan be leveraging to process real time COB when Medicare Part B is primary?
- If the COB claim is sent to the incorrect Medicaid plan, what reject codes and messaging should be returned in the response to assist in billing the correct Medicaid plan?

**Response**:

**Part 1:** What information should the Medicaid Plan be leveraging to process real time COB when Medicare Part B is primary?

Medicaid programs should leverage the information contained in the Request Coordination of Benefits/Other Payments Segment of the claim transaction. The segment contains data elements that help identify Medicare Part B as the primary payer.

The Other Payer ID (340-7C) and Benefit Stage Qualifier (393-MV) fields are the fields available in Version D.0 that identify the previous payer and benefit. Other Payer ID (340-7C) typically contains the previous payer's BIN and will identify the payer as a Medicare plan or Medicare Intermediary.

The Benefit Stage Qualifier (393-MV) field may be sent in the COB claim segment when the primary payer is a MA-PD plan and the Benefit Stage fields are populated in the primary response. The following Benefit


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Stage Qualifiers indicate the primary plan paid under the Medicare Part B benefit (under Part C for MA-PD):

- 50 - Not paid under Part D, paid under Part C benefit
- 51 - Not paid under Part D, paid under Part C benefit. Beneficiary is a Qualified Medicare Beneficiary - pharmacy should not attempt to collect cost-share, but instead should attempt to bill COB to Medicaid coverage

The COB/Other Payments Segment fields used along with the Product/Service ID (407-D7) should trigger the Medicaid system's rules to validate the submitted product's applicable benefit and the member's QMB status to adjudicate the claim in real time.

**Part 2:** What reject codes and messaging should be returned if an alternate Medicaid benefit (e.g. FFS vs MCO) should be billed for QMB Part B patient cost share?

When the NCPDP COB claim is submitted to a Medicaid benefit that is not responsible for managing the dual eligible Part B benefits, the rejected claim response should include the appropriate reject codes and the BIN, PCN, Group and Cardholder ID billing identifiers (4RX) for the pharmacy to redirect the claim to the appropriate Medicaid benefit.

Standardized use of specific reject codes will facilitate the billing of QMB Program Part B coordination of benefit claims to the appropriate Medicaid benefit.

The following describes the reject scenarios and recommended Reject Codes:

- COB claim submitted to the Medicaid FFS and the Medicaid MCO plan is responsible; or COB claim is submitted to the Medicaid MCO plan and the Medicaid FFS plan is responsible for QMB Program Part B claim coordination.
    - Return Reject Code 984 – "Bill Dual Eligible Medicaid Part B Patient Cost Share to Alternate Medicaid Benefit"

      Note: the new reject code 984 was approved (DERF 001770/ECL 000328) and will be available for use October 15, 2021.
    - Return 4RX of applicable Medicaid benefit within the below Response COB/Other Payers Segment fields:
        - Other Payer ID Count (355-NT)
        - Other Payer Coverage Type (338-5C)
        - Other Payer ID Qualifier (339-6C)
        - Other Payer ID (340-7C)
        - Other Payer Processor Control Number (991-MH)
        - Other Payer Cardholder ID (356-NU)
        - Other Payer Group ID (992-MJ)
        - Other Payer Person Code (142-UV)

  Until the new reject code 984 is available, reject code AF should be used and the 4RX billing identifiers for the applicable Medicaid benefit returned in the Response COB Other Payers Segment fields.
    - Interim scenario (until October 15, 2021): When pharmacy bills Medicaid FFS, FFS is NOT the responsible payer, and member is enrolled in a Medicaid MCO.

      If Medicaid Fee For Service knows the member is enrolled in Managed Medicaid, they should return the following reject code and 4RX, if known.
        - Return reject code: AF – "Patient Enrolled Under Managed Care"
        - Reject code AF indicates the pharmacy should bill the MCO which provides more specific information than reject code 41 – "Submit Bill to Other Processor or Primary Payer"


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Reject Code AF is only applicable when Medicaid FFS is billed and the Medicaid MCO is the correct payer
- Populate the Response COB/Other Payers Segment with the 4RX of the MCO if known

The following describes additional scenarios and reject codes recommended for use for the specific business cases outlined.

- Alternate scenario 1: When pharmacy bills Medicaid MCO and the member is not active. They may be enrolled in another MCO or FFS:
  - In this scenario, we would expect a member eligibility or plan termination reject.
  - It would be rare that the Medicaid MCO would have other plan information when they are not the plan of record. Therefore, they would not populate the Response COB/Other Payer Segment.

- Alternate scenario 2: When pharmacy bills Medicaid MCO, but the product or service is a carve-out benefit under Medicaid FFS:
  - Recommended reject codes to be returned are:
    - 831- "Product Service ID Carve-Out, Check Medicaid Fee For Service" and
    - 70 – "Product/Service Not Covered"
  - By returning the combination of these two reject codes, the MCO is indicating to the pharmacy to bill the Medicaid FFS for the specific product.
  - Return 4RX of Medicaid FFS in the Response COB/Other Payer Segment when known.

- Alternate scenario 3: If the claim is submitted under the pharmacy benefit (either FFS or MCO) and is not covered but may be covered under a different benefit:
  - When the product may be covered under the medical benefit, the recommended reject code to be returned is:
    - 816 – "Pharmacy Benefit Exclusion, May Be Covered Under Patient's Medical Benefit"
    - Return 4RX of applicable Medicaid benefit within the Response COB/Other Payers Segment fields
  - When the product is not covered because the PBM/processor's record indicates the member is institutionalized, the recommended reject code to be returned is:
    - 63 – "Product/Service ID Not Covered for institutionalized Patient"
    - Pharmacy would need to verify if member is institutionalized
      - If no, contact PBM/processor to update member status
      - If yes, follow pharmacy operational procedures

The following reject codes were identified as not recommended for use as they are being used incorrectly or may not convey the actual reason for the reject.

- Reject Code MV – M/I Benefit Stage Qualifier
  - This is currently being returned when Benefit Stage Qualifier 51 is in the COB claim request but the Medicaid payer does not recognize Benefit State Qualifier 51 in their logic.
  - It is recommended to use the more specific reject code to identify the plan benefit that the claim may be payable under.
- Reject Code 74 - Other Carrier Payment Meets or Exceeds Payable
  - For scenarios where the Medicaid reimbursement amount is determined to be $0, reject 74 should not be returned.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Rather than reject the claim, a Paid response should be returned with at least the following fields:
  - Patient Pay Amount (505-F5)
  - Ingredient Cost Paid (506-F6)
  - Dispensing Fee Paid (507-F7)
  - Total Amount Paid (509-F9) = $0

*Additional information regarding COB claims processing can be found in the Qualified Medicare Beneficiary Part B Coordination of Benefit Barriers and Recommendations White Paper.*

Added February 2021 – COB TG

## 10.27 IDENTIFICATION AND OVERRIDE TO PLAN SPONSORED DRUG DISCOUNT PRICING PROGRAM BENEFIT TO SUPPORT COB WITH SUPPLEMENTAL PAYERS

**Question**:
How should a payer/processor format a paid claim response when the expected prescription benefit claim response is diverted to a plan sponsored drug discount program response, such as:

- Prescription benefit response would have resulted in an unresolvable reject such as product/service is a plan benefit exclusion, to which the plan sponsored drug discount program pricing is made available.
- Prescription benefit response would have resulted in an unresolvable reject such as patient eligibility expired/terminated, to which the plan sponsored drug discount program pricing is made available.
- Prescription benefit response would have resulted in 100% patient liability, to which the plan sponsored drug discount pricing is applied to the plan benefit accumulators.

**Response:**
The payer/processor should return the following Approved Message Code (548-6F) values to alert pharmacies the claim submitted to the prescription benefit program was processed under a plan-sponsored drug discount program:

- 049 - Drug Discount Program Pricing Applied due to Plan Benefit Reject or Formulary Exclusion Reject
- 050 - Drug Discount Program Pricing Applied due to Plan Patient Eligibility Reject
- 059 - Drug Discount Program Pricing Applied to Plan Benefit

The payer/processor should also return the applicable Network Reimbursement ID (545-2F) based on trading partner agreement for the resulting plan sponsored drug discount program claim response.

As of future versions of the Telecommunication Standard©, the payer/processor should return the applicable values in the required claim response field Adjudicated Program Type (A28-ZR), based on the associated Approved Message Code (548-6F) value.

| Approved Message Code (548-6F) | Adjudicated Program Type (A28-ZR)* |
|---|---|
| 049 - Drug Discount Program Pricing Applied due to Plan Benefit Reject or Formulary Exclusion Reject | 36 - Integrated Discount Program: No Benefit Applied |
| 050 - Drug Discount Program Pricing Applied due to Plan Patient Eligibility Reject | 36 - Integrated Discount Program: No Benefit Applied |
| 059 - Drug Discount Program Pricing Applied to Plan Benefit | 37 - Integrated Discount Program: Benefit Applied |

*Available for use as of Telecommunication Standard Version F2© and greater


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Question**:
How should a pharmacy provider submit a claim request to override the plan sponsored drug discount response, so the expected plan benefit response is returned in order to appropriately coordinate benefits with supplemental payers (e.g., Medicaid, where COB with drug discount programs is not supported)?

**Response:**
Prescription benefit plans may offer members a plan-sponsored drug discount program price to reduce out of pocket cost for certain claims. This may occur when:

- The claim is not payable under the plan benefit, the claim denies for qualifying edits (e.g., drug was not covered due to benefit or formulary exclusions, member not active on date filled) and the prescription benefit plan adjudicates the submitted claim under the plan-sponsored drug discount program, resulting in a paid response with a discounted 100% patient pay amount. The claim response should contain the applicable Approved Message Code (548-6F) value:
  - 049: Drug Discount Program Pricing Applied due to Plan Benefit Reject or Formulary Exclusion Reject
  - 050: Drug Discount Program Pricing Applied due to Plan Patient Eligibility Reject
- The claim is payable under the plan benefit; however, the plan benefit accumulators result in 100% patient liability, and the prescription benefit plan adjudicates the submitted claim under the plan sponsored drug discount program and applies the discount 100% patient pay amount to the plan benefit accumulators. The claim response should include the applicable Approved Message Code (548-6F) value:
  - 059: Drug Discount Program Pricing Applied to Plan Benefit

When the pharmacy receives these paid responses, then submits a COB claim to the patient's supplemental benefit (e.g., Medicaid), the other payer pricing information that represents the plan-sponsored drug discount program may prevent the patient from accessing their downstream benefit, and/or may compromise the payment applied by the supplemental payer. For appropriate coordination of benefits to occur, the primary claim response should reflect the expected plan benefit response and not the plan-sponsored drug discount program price.

- When the pharmacy receives one of the above Approved Message Code values and/or the pharmacy knows the patient has a downstream federal/state funded benefit, the pharmacy can reverse the paid claim and resubmit or pro-actively submit:
  - Eligibility Clarification Code (309-C9) value: 8 – Third Party Liability: Patient also eligible with federal/state funded program, coordination of benefit restrictions apply. Value Limitation: Used to request the plan **benefit response** versus a coordinated drug discount program option.
- The payer should use the Eligibility Clarification Code value "8" to prevent the claim from reprocessing under the plan-sponsored drug discount program, and instead return the expected plan benefit rejected response with the appropriate Reject Code(s), or Paid response with the expected plan benefit pricing.
- The pharmacy is then able to submit a COB claim with the previous payer's plan benefit claim response information to the downstream federal/state funded payer allowing the downstream payer to appropriately adjudicate the COB claim.

*Added August 2021, WG1 FAQ TG – Original question retired and replaced November 2023, WG1 FAQ TG*

## 10.28 REJECT CODE USE WHEN OTHER PAYER LOOP CONTAINS BOTH PAID AMOUNT(S) AND REJECT CODE(S)

**Question**:
What Reject Code Should Be Used When A COB Claim Other Payer Loop Contains Both Paid Amount(s) and Reject Code(s)?


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Response:**
Scenario: The pharmacy submits the following COB Segment indicating the previous payer paid $20 for the submitted claim, but there is also a Product/Service Not Covered Reject Code:

| Field Number | Field Name | Field Value |
|---|---|---|
| 111-AM | Segment Identification | 05 |
| 337-4C | COB/Other Payment Count | 1 |
| 338-5C | Other Payer Coverage Type | 01 = Primary |
| 339-6C | Other Payer ID Qualifier | 03 = IIN |
| 340-7C | Other Payer ID | 123456 |
| 443-E8 | Other Payer Date | 20210520 |
| 341-HB | Other Payer Amount Paid Count | 1 |
| 342-HC | Other Payer Amount Paid Qualifier | 07 = Drug Benefit |
| 431-DV | Other Payer Amount Paid | **$20.00** |
| 471-5E | Other Payer Reject Count | 1 |
| 472-6E | Other Payer Reject Code | 70 = Product/Service Not Covered |

If the primary payer returned a rejected status (Transaction Response Status 112-AN = R), there should be no financial amounts in the COB loop. If the primary payer returned a paid status (Transaction Response Status 112-AN = P), there should be no reject code in the COB loop. Since there is a financial amount greater than 0 in the COB loop, the assumption is the previous payer returned a paid response.

The reject codes to be returned by the COB payer depend on the Other Coverage Code (308-C8) submitted.

**Other Coverage Code (308-C8) = 2**
If Other Coverage Code (308-C8) = 2 indicating the previous payer returned a paid response in the scenario above,

- In the paid response from the previous payer, both paid financial amounts and reject code(s) should not be returned.
    - The pharmacy cannot reject the response, so would likely pass through both paid amounts and reject code(s) in the COB transaction.
- In the COB transaction from the pharmacy, reject count and code(s) should not be submitted.
- When Other Payer Amount Paid (431-DV) is greater than $0.00 (zero), the assumption is the previous payer returned a paid response, therefore, it is recommended payers/processors not reject the claim and ignore the Other Payer Reject Count (471-5E) and Other Payer Reject Code (472-6E) values submitted. If the COB payer needs to reject, the other payer reject code fields would be in error and the following reject codes could be used:
    - 5E - M/I Other Payer Reject Count (471-5E)
    - 6E - M/I Other Payer Reject Code (472-6E)
- After 10/15/2022, use requested new reject code DE2 - <u>COB Data Conflict – Other Payer Information must contain either financial fields or reject codes, not both</u> If Government COB is used, the OPPRA fields would also be present on the submitted transaction.
    - OPPRA fields include:
        - Other Payer Patient Responsibility Amount Count (353-NR)
        - Other Payer Patient Responsibility Amount Qualifier (351-NP)
        - Other Payer Patient Responsibility Amount (352-NQ)
    - The recommended reject would be the same as above.

**Other Coverage Code (308-C8) = 3**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

If Other Coverage Code (308-C8) = 3 indicating the previous payer returned a reject response in the scenario above:

- In the rejected response from the previous payer, both paid financial amounts and reject code(s) should not be returned.
    - The pharmacy cannot reject the response, so would likely pass through both paid amounts and reject code(s) in the COB transaction.
- In the COB transaction from the pharmacy, Other Payer financial amounts should not be submitted.
- If the COB payer needs to reject, the other payer financial fields would be in error and the following reject codes could be used:
    - HB - M/I Other Payer Amount Paid Count (341-HB)
    - NR - M/I Other Payer-Patient Responsibility Amount Count (353-NR)
- After 10/15/2022, use requested new reject code DE2 - COB Data Conflict – Other Payer Information must contain either financial fields or reject codes, not both

**Other Coverage Code (308-C8) = 4 Scenario:** The pharmacy submits the following COB Segment indicating the previous payer paid $0 for the submitted claim, but there is also a Product/Service Not Covered Reject Code:

| Field Number | Field Name | Field Value |
|---|---|---|
| 111-AM | Segment Identification | 05 |
| 337-4C | COB/Other Payment Count | 1 |
| 338-5C | Other Payer Coverage Type | 01 = Primary |
| 339-6C | Other Payer ID Qualifier | 03 = IIN |
| 340-7C | Other Payer ID | 123456 |
| 443-E8 | Other Payer Date | 20210520 |
| 341-HB | Other Payer Amount Paid Count | 1 |
| 342-HC | Other Payer Amount Paid Qualifier | 07 = Drug Benefit |
| 431-DV | Other Payer Amount Paid | **$0.00** |
| 471-5E | Other Payer Reject Count | 1 |
| 472-6E | Other Payer Reject Code | 70 = Product/Service Not Covered |

When Other Coverage Code (308-C8) = 4 indicating the previous payer returned a paid response:

- In the paid response from the previous payer, both paid financial amounts and reject code(s) should not be returned.
    - The pharmacy cannot reject the response, so would likely pass through both paid amounts and reject code(s) in the COB transaction.
- In the COB transaction from the pharmacy, reject count and code(s) should not be submitted.
- If the COB payer needs to reject, the other payer reject code fields would be in error and the following reject codes could be used:
    - 5E - M/I Other Payer Reject Count (471-5E)
    - 6E - M/I Other Payer Reject Code (472-6E)
- After 10/15/2022, use requested new reject code DE2 - COB Data Conflict – Other Payer Information must contain either financial fields or reject codes, not both

**Other Coverage Code (308-C8) = 8 Scenario:** The pharmacy submits the following COB Segment indicating the patient responsibility from the previous payer is $25.00, but there is also a Product/Service Not Covered Reject Code:

| Field Number | Field Name | Field Value |
|---|---|---|
| 111-AM | Segment Identification | 05 |
| 337-4C | COB/Other Payment Count | 1 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | |
|---|---|---|
| 338-5C | Other Payer Coverage Type | 01 = Primary |
| 339-6C | Other Payer ID Qualifier | 03 = IIN |
| 340-7C | Other Payer ID | 123456 |
| 443-E8 | Other Payer Date | 20210520 |
| 353-NR | Other Payer Patient Responsibility Amount Count | 1 |
| 351-NP | Other Payer Patient Responsibility Amount Qualifier | 05 = Amount of Copay as reported by previous payer |
| 352-NQ | Other Payer Patient Responsibility Amount | **$25.00** |
| 471-5E | Other Payer Reject Count | 1 |
| 472-6E | Other Payer Reject Code | 70 = Product/Service Not Covered |

When Other Coverage Code (308-C8) = 8 indicating the previous payer returned a paid response:

- In the paid response from the previous payer, both patient responsibility amount(s) and reject code(s) should not be returned.
    - The pharmacy cannot reject the response, so would likely pass through both paid amount(s) and reject code(s) in the COB transaction.
- In the COB transaction from the pharmacy, reject count and code(s) should not be submitted.
- When Other Payer Patient Responsibility Amount (352-NQ) is greater than $0.00 (zero), the assumption is the previous payer returned a paid response, therefore, it is recommended payers/processors not reject the claim and ignore the Other Payer Reject Count (471-5E) and Other Payer Reject Code (472-6E) values submitted.
- If the COB payer needs to reject, the other payer reject code fields would be in error and the following reject codes could be used:
    - 5E - M/I Other Payer Reject Count (471-5E)
    - 6E - M/I Other Payer Reject Code (472-6E)
- After 10/15/2022, use requested new reject code DE2 - <u>COB Data Conflict – Other Payer Information must contain either financial fields or reject codes, not both</u>

*Added August 2021, WG1 COB TG*

## 10.29 OPAP QUALIFIERS AND SALES TAX

**Question**:
With the new ECL values available for Other Payer Amount Paid Qualifier (342-HC) for the Telecommunication Standard VF2©, how should tax amount paid by the previous payer be reported in the COB Segment of the Telecommunication Standard Version D.0©?

**Response**:
The pharmacy must follow the pricing formula and in the Telecommunication Standard VD.0© should populate the tax amount reported in Other Payer Amount Paid (431-DV) based on the fields returned in the Response Pricing Segment as follows.

558-AW Flat Sales Tax Amount Paid
+ 559-AX Percentage Sales Tax Amount Paid
<u>– 523-FN Amount Attributed to Sales Tax</u>
Other Payer Amount Paid (431-DV) with Other Payer Amount Paid Qualifier (342-HC) of 10 – Sales Tax

The following demonstrates the pricing formulas and how sales tax is incorporated:

**Total Amount Paid (509-F9) Formula**

| ID | Field | Amount |
|---|---|---|


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | |
|---|---|---|
| 506-F6 | Ingredient Cost Paid | 45.00 |
| 507-F7 | + Dispensing Fee Paid | 2.50 |
| 521-FL | + Incentive Amount Paid | 0.00 |
| 565-J4 | + Other Amount Paid | 0.00 |
| 558-AW | + Flat Sales Tax Amount Paid | 0.10 |
| 559-AX | + Percentage Sales Tax Amount Paid | 2.38 |
| 505-F5 | - Patient Pay Amount | 20.95 |
| 566-J5 | - Other Payer Amount Recognized | 0.00 |
| 509-F9 | = Total Amount Paid | 29.03 |

**Components of Patient Pay Amount (505-F5)**

| ID | Field | Amount |
|---|---|---|
| 517-FH | Amount Applied to Periodic Deductible | 0.00 |
| 520-FK | + Amount Exceeding Periodic Benefit Maximum | 0.00 |
| 518-FI | + Amount of Copay | 20.00 |
| 572-4U | + Amount of Coinsurance | 0.00 |
| 571-NZ | + Amount Attributed to Processor Fee | 0.00 |
| 523-FN | + Amount Attributed to Sales Tax | 0.95 |
| 505-F5 | = Patient Pay Amount | 20.95 |

**Other Payer Amount Paid (431-DV) Formula for Sales Tax (Other Payer Amount Paid Qualifier 342-HC = 10 – Sales Tax)**

| ID | Field | Amount |
|---|---|---|
| 558-AW | + Flat Sales Tax Amount Paid | 0.10 |
| 559-AX | + Percentage Sales Tax Amount Paid | 2.38 |
| 523-FN | - Amount Attributed to Sales Tax | 0.95 |
| 431-DV | = Other Payer Amount Paid | 1.53 |

*Added February 2022, WG1 COB TG*

## 10.30 Other Payer Amount Paid Qualifiers (342-HC) For S1 (Service Billing) COB

**Question:**
How should the pharmacy populate the Other Payer Amount Paid (431-DV) field for Other Payer Amount Paid Qualifier (342-HC) value = 06 – Cognitive/Professional Service for the S1 transaction?

**Response:**
There is no direct mapping from an S1 response pricing field to report the Other Payer Amount Paid Qualifier (342-HC) value of 06 - Cognitive/Professional Service. The Other Payer Amount Paid (431-DV) price for Cognitive/Professional Service is a calculated amount, similar to how Drug Benefit is calculated for a COB B1 claim request.

To accurately report the amounts paid in the Other Payer Amount Paid field (431-DV) in a COB Other Payer Coverage Type occurrence for S1 service billing, a specific order of Other Payer Amount Paid Qualifiers (342-HC) must be followed.

- Order is based on the payment being associated to provider versus state revenue, the professional service (e.g., cognitive service) and any value-added services (i.e., delivery, administrative).
- Cognitive/Professional Service (Other Payer Amount Paid Qualifier (342-HC) value 06) is the end result, after all Other Payer Amount Paid values are subtracted from Total Amount Paid (509-F9).


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Note: The following Other Payer Amount Paid Qualifier (342-HC) values are not applicable to S1 COB billing, as the associated response pricing fields are not used in the S1 transaction, and 07- Drug Benefit is a calculated amount specific to B1 claim billing transaction.
    - 02: Shipping
    - 03: Postage
    - 05: Incentive
    - 07: Drug Benefit

OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) VALUE 06 = COGNITIVE/PROFESSIONAL SERVICE CALCULATION
Total Amount Paid (509-F9)
- Percentage Sales Tax Amount Paid (559-AX)
- Flat Tax Amount Paid (558-AW)
- Other Amount Paid (565-J4), Other Amount Paid Qualifier (564-J3) value 01 = Delivery Cost
- Other Amount Paid (565-J4), Other Amount Paid Qualifier (564-J3) value 04 = Administrative Cost

= Cognitive Service

The following table reflects the specific vD.0 fields from the prior payer claim response that would be used to populate the applicable Other Payer Amount Paid Qualifier (342-HC) values in the vD.0 S1 COB service billing request transaction.

| **vD.0 S1 Response Field** | **vD.0 S1 Response Qualifier Field** | **vD.0 S1 COB Request Other Payer Amount Paid Qualifier (342-HC) value reported with the associated Other Payer Amount Paid (341-DV) dollar amount** |
|---|---|---|
| **509-F9 Total Amount Paid** | | |
| - (559-AX Percentage Sales Tax Amount Paid<br>+ 558-AW Flat Tax Amount Paid<br>– 523-FN Amount Attributed to Sales Tax) | | 342-HC OPAP Qualifier = (10) Tax<br>(Calculated as: 559-AX - 558-AW + 523-FN) |
| - 565-J4 Other Amount Paid | 564-J3 Other Amount Paid Qualifier<br>(01) Delivery Cost | 342-HC OPAP Qualifier = (01) Delivery Cost |
| - 565-J4 Other Amount Paid | 564-J3 Other Amount Paid Qualifier<br>(04) Administrative Cost | 342-HC OPAP Qualifier = (04) Administrative Cost |
| | | |
| = Cognitive Service | | 342-HC OPAP Qualifier = (06) Cognitive/Professional Service |

*Added August 2025*

## 10.31 PAYER-TO-PAYER COB

**Question**:
What is payer-to-payer coordination of benefits?

**Response**:


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

Payer-to-payer coordination of benefits is described in the NCPDP Telecommunication Standard© Section 3.2.2 as the two-way communication between adjudicators. There are two examples of payer-to-payer scenarios mentioned:

- Medicare Crossover – Medicare crossover process does not utilize NCPDP transactions to bill downstream payers.
- Information Reporting Transactions – Information Reporting is an NCPDP-defined transaction that may be payer-to-payer.

Other examples of payer-to-payer coordination of benefits include:

- Subrogation, a process with its own implementation guide using the NCPDP Telecommunication Standard© detail transaction and the NCPDP Batch Standard©
- Financial information reporting, a process with its own implementation guide, NCPDP Financial Information Reporting Standard©

*Added November 2025*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 11 RECOMMENDATIONS FOR CLAIM REVERSAL PROCESSING FOR TELECOMMUNICATION VERSION D.0©

The following chapter is intended to provide guidance for anticipated future industry requirements regarding reversal processing. This guidance will be added to a **future** Telecommunication Standard Implementation Guide© version. For processing using Telecommunication Standard Implementation Guide Version D.0©, these recommendations can currently be implemented but are not mandated until the use of the **future** Telecommunication Standard Implementation Guide© version is named in regulation.

## 11.1 CURRENT INFO ON CLAIM REVERSAL PROCESSING FOR TELECOMMUNICATION VERSION D.0©

The Telecommunication Standard Implementation Guide Version D.0© does not clearly state the criteria to match a Claim Reversal to a previously **paid** Claim Billing. What it does provide is:

- How to build a Claim Reversal – Section 10 "*Reversal Information*" in Telecommunication Standard Implementation Guide©
- How to build a multi-Reversal transmission - Section 10 "*Reversal Information*" in Telecommunication Standard Implementation Guide©
- Detail of Claim Reversal fields - Section 10.3 "*Claim Reversal Request Segments*" and 10.4 "*Claim Reversal Response Diagrams and Segments*" lists all D.0 fields with the majority noted as "not used".

Note: for the purposes of this discussion, the term "processor" may be seen as the plan, the payer, the Pharmacy Benefit Manager, etc. – the entity (or contracted entity) to perform the functions of claims adjudication. This may be one or more entities.

## 11.2 WHY IS GUIDANCE NEEDED?

In order to assist with current Claim Reversal processing issues reported by both processors and providers, we are providing 'best practice' recommendations for Telecommunication Standard Version D.0© Claim Reversal processing.

**1. List of the MAXIMUM fields allowed in a Claim Reversal**

- Other than Transaction Code "B2" (Claim Reversal), the fields sent on a Claim Reversal should mimic fields submitted on the original Claim Billing unless otherwise noted by processor due to a processing change since time of claim.
- The processor may on the Claim Billing response provide updated information for the pharmacy to use in future claim and reversal processing, such as Group ID, Cardholder ID.
- The Product/Service ID sent on the Claim Reversal should be the same value as what was submitted on the Claim Billing.

**2. Criteria for MATCHING a Claim Reversal transaction to its associated Claim Billing**
**Critical Match criteria that should always be used:**

- Service Provider ID (202-B2) (pharmacy identifier)
- Prescription/Service Reference Number (402-D2)
- Date of Service (401-D1)

**If more than one <u>paid</u> claim exists, further criteria that should be used as 'tie-break' criteria include:**

- Fill Number (403-D3) – can delineate two similar Pharmacy, Prescription, Date of Service approved Claim Billings where one was a regular dispensing fill and the other a subsequent dispensing such as a vacation supply or other special circumstance causing the Fill Number to be incremented by the pharmacy.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Other Coverage Code (308-C8) - only used to delineate claim paid as primary from similar one by Pharmacy, Prescription, Date of Service that was paid as coordination of benefits.
- Other Payer Coverage Type (338-5C) – only available on coordination of benefits Claim Billing and thus the Claim Reversal.
    - If two Approved Claim Billings are on file a primary claim will not contain this field. The secondary and beyond Claim Billings will contain this field.
    - When multiple Approved claims by Pharmacy, Prescription, Date of Service exist and identity different coverage levels, this field is used to match to the right coordination of benefits Claim Billing – Secondary or Tertiary, Secondary or Quaternary, etc.

**3. Fields on a Claim Reversal that are <u>not</u> recommended for matching the Claim Reversal to the Claim Billing and why.**

**CARDHOLDER ID**

If a processor wishes to use Cardholder ID, it should be done as a secondary level match. Since there is not a universal unique member ID, numerous members within various health plans can have the same member ID. Matching on Pharmacy ID, Prescription Number and Date of Service will generally narrow the search with noted fields already providing the means to identify the specific Claim Billing to be reversed.

- Cardholder ID may be a Family ID. The Claim Reversal transaction does not allow for Person Codes, Date Of Birth, Name fields etc. that are used to identify the specific member within a family. As such there could be multiple member profiles to check whereas Pharmacy ID, Prescription number and Date of Service with noted tie break fields should ultimately yield one Approved Claim Billing.
- Discount programs and some 'on the fly' eligibility result in numerous individuals with the same non-unique Cardholder ID since the field is mandatory on a Claim Billing. In these scenarios the Cardholder ID should **not** be used for matching.

**GROUP ID**

- There are instances where the Group ID is used to route a claim within a processing system to the appropriate platform to find the Approved Claim Billing.
- When Group ID is returned in a claim response, the value should be used in future claim and reversal processing by the pharmacy.
- The recommendation is to allow processors whose business needs require and use the field for internal routing however it is recommended to **not** use field in the match criteria to determine a specific Claim Billing that is to be reversed.

**PRODUCT/SERVICE ID**

- Although this field is mandatory on a Claim Reversal it is **not required as part of the match criteria** for the Claim Reversal to the Claim Billing.
- While the same Product/Service ID that was billed should be included on the reversal, it has been found that this is **not** always industry practice which causes a rejected reversal when the field is included in match criteria.

**4. Recommended time frame for Reversal processing**

- Medicare Part D requires a reversal window of a minimum of 90 days.
- Some programs allow up to a year or more.
- NCPDP recommends that processors **<u>allow a minimum</u>** of 30 days from the date the claim processed for a reversal to occur.

**Telecommunication Standard© <u>future</u> version considerations to be aware of:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

1. There has been a request for a new transaction identifier in a future version of the Telecommunication Standard© (on the submission and response) to facilitate the matching of a Claim Reversal to a Claim Billing.
    - There are various uses of existing transaction ID fields, so to not conflict with current usage, the WG1 Transaction ID Task Group is examining a new field with concise usage.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 12 NCPDP MEDICAID SUBROGATION STANDARD©

## 12.1 TYPOGRAPHICAL ERRORS

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


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 13 WORKERS' COMPENSATION-SPECIFIC INFORMATION

See also section "*Coordination of Benefits Information*", subsection "*Workers' Compensation and COB*".

## 13.1 WORKERS' COMPENSATION AND REPACKAGED NDCS

*The following applies to all state workers' compensation agencies that have a regulatory requirement (state fee schedule) that the billing provider is to submit the NDC of the original or underlying medication product that has been repackaged for distribution/dispensing.*

In an effort to establish correct pricing for repackaged drugs, various state workers' compensation agencies are adding a billing requirement for reporting of the original or underlying NDC of the repackaged drugs.

For paper submissions

NCPDP has approved an update to the NCPDP *Manual Claim Forms Reference Implementation Guide* (version 1.1 dated April 2012) providing a standardized method for reporting the original/underlying NDC on the NCPDP Workers' Compensation/Property and Casualty Universal Claim Form (WC-UCF).

Since reporting of the original or underlying NDC of the repackaged drugs is 1) a state regulatory issue and 2) appears to be proliferating across many states the Jurisdictional Field 5 (WC-UCF Field 61) is to be used for this purpose, when required by regulation.

Pharmacy Benefit Managers/Processors/Plans must reflect the use of these fields to pharmacies/providers when governed by the use of these state regulations for Workers' Compensation state fee schedules.

For electronic billing

NCPDP has approved the use of these existing fields in the NCPDP *Telecommunication Standard version D.0*©

- Originally Prescribed Product/Service ID Qualifier (453-EJ) value of "03" (National Drug Code (NDC))
- Originally/underlying Prescribed Product/Service Code (445-EA) contains the actual (original) NDC
- The Product/Service ID Qualifier (436-E1) contains the value of "03" (National Drug Code (NDC)) and Product/Service ID (407-D7) contains the actual dispensed (repackaged) NDC.

Pharmacy Benefit Managers/Processors/Plans who support Payer Sheets to pharmacies/providers must reflect the use of these fields when governed by state regulations for Workers' Compensation state fee schedules. Intermediaries/third party administrators that are involved in the processing of workers' compensation bills must provide this same support.

Note: The Basis of Reimbursement Determination (522-FM) will clarify which reimbursement method the processor used in adjudicating the bill.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 14 IMPROVING THE VALUE OF THE CLAIM RESPONSE WITH ADDITIONAL MESSAGING

## 14.1 BACKGROUND

Disclaimer: This replaces ***Appendix G Two Way Communication to Increase the Value of On-Line Messaging*** from the Telecommunication Standard Implementation Guide©.

For electronic messaging to be effective, pharmacists and coordination of benefit claims processing systems must be able to understand the reason the message was sent, be able to interpret the meaning of that message easily, and be able to perform some action based on that interpretation.

Instances of messages that are not clear and effective can occur at various points in the processing of prescription drug claims. For example, pharmacy systems do not always translate the NCPDP Reject Codes into the specified NCPDP reject messages. This can lead to confusion in interpreting the displayed reject message, because the message that is presented to the user may not be the same message expected by the processor. Additionally, downstream coordination of benefit payers only have access to the reject code returned by the previous payer where interpretation may be compromised if further clarification of the reject was returned as text within the Additional Information Message (526-FQ) field.

Claims processing systems sometimes populate free text fields with text that duplicates the reject code translations or DUR/PPS information, resulting in redundant information and message fatigue. Processors should leverage the specified reject code(s) for the conflict that occurs and use caution sending messages that are redundant, not specific, or are otherwise unrelated to the claim's payment or clinical status. Messages on every claim transaction can lead to a phenomenon called "Alert Fatigue" and could decrease the perceived importance of more "relevant" messages. That is, if every paid prescription claim gets four messages returned—or even just one--, the pharmacist may become desensitized to noticing and acting upon relevant messages.

Plan rejections and supplementary messages can often be incomplete, leaving the pharmacist without a recommended course of action. For example, an NCPDP Reject Code of "76" (Plan Limitations Exceeded) without an accompanying free text message explaining the limitation does not provide enough information for the pharmacist to take action. Likewise, "Fill Too Soon" rejects sometime do not inform the pharmacist of the next available dispensing date, while "Drug Not Covered" rejections do not always supply the names of the covered alternatives.

Reject codes caused by eligibility problems collectively have a high degree of occurrence. These errors are primarily due to incomplete or inaccurate eligibility data that the health plan/employer supplied to the claims processor. When a processor cannot find a match in their eligibility files using the submitted claim information, the exact data element that is causing the problem is not always known. Therefore, the processor will often send multiple reject codes to the pharmacy, even though there may be only one error on the claim. For example, if the Cardholder ID field was submitted with an error, the processor would be unable to identify the patient, but may also be unable to identify the specific cause of the error, because errors in any of several fields (i.e. Group Number, BIN number) can cause misidentified/unidentified cardholders. As a result, the processor should send an error message for each field that may have erroneous data. Some processors utilize other submitted data elements, like Date of Birth and Gender Code to find a "best two out of three" match. Transmittal of such information from pharmacy to processor is subject to covered entity interpretation under the HIPAA regulations and beyond the scope of this discussion.

## 14.2 SPECIFIC DATA FIELD USE RECOMMENDATIONS

Claims processors:

- Be more specific in the information relayed to the pharmacist. Pharmacists want messages to be relevant and actionable.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Use the most specific Reject Code(s) possible.
- Eliminate unnecessary free text messages.
- Populate the Help Desk Telephone Number field (550-8F) with the applicable phone number for the pharmacist to call for additional assistance. If multiple phone numbers exist for different issue types (technical claim support versus clinical prior authorization support), return the most appropriate phone number for the situation at hand. Do not put the Help Desk Phone number in the message field itself.
- Use only standard abbreviations in the Additional Message Information field (526-FQ). Keep the messages succinct. The NCPDP Reject Code translations must not be placed in this field.
- Target DUR/PPS inter-pharmacy conflicts (rather than intra-pharmacy conflicts) and all DUR/PPS messages should remain in the Response DUR/PPS Segment.
- Use the Additional Message Information field (526-FQ) to explain sudden changes in coverage issues, such as an increase in copayment for a non-preferred drug product.
- The URL field (987-MA) should be populated in the response transaction whenever possible to provide electronic address for additional prior authorization information.
- Do not send leading zeroes in front of alphanumeric values such as Reject Codes when they do not exist. A leading zero on a numeric field can be truncated, but a leading zero on an alphanumeric field is not (070 is equal to 70 but "070" is not equal to "70" or "70 ").

Software vendors:

- Display the entire Additional Message Information field (526-FQ). Show the standard definitions for the NCPDP Reject Codes.
- If the Help Desk Telephone Number (550-8F) is populated, present it to the pharmacist.

New fields and new values for old fields are introduced in the *NCPDP Telecommunication Standard Implementation Guide*©. The *NCPDP External Code List*© (ECL) will always contain a comprehensive listing of valid Reject Code values and definitions. Some specific use recommendations of these fields are highlighted in the table below, along with possible alternative Reject Codes and recommended supplemental messages that may be transmitted in the Additional Message Information field (526-FQ). In the table, the Reject Code in question is listed in the first row, but the definition is not repeated. Supplemental messages, if any, which should be used with the Reject Code, are listed in the last column. However, a supplemental message is not always needed, as the standard definition of the Reject Code may be self-explanatory.

These recommendations are intended as guidelines, not mandates, for use in pharmacy and claim processing systems to increase the value of messaging. Their use is highly recommended, but not required. Additional operational and system improvements are beyond the scope of this document, and are not discussed here.

### 14.2.1 BENEFIT- OR PLAN-GENERATED REJECTIONS

#### *14.2.1.1 REJECT CODE "76" (PLAN LIMITATIONS EXCEEDED)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "76" | Plan Limitations Exceeded | Define the specific limit that caused the rejection. |
| "7X" | Days Supply Exceeds Plan Limitation | "MAXIMUM DAYS SUPPLY = XXX DAYS." |
| "73" | Additional Fills Are Not Covered | "NEW PRESCRIPTION REQUIRED" or "NO FURTHER CLAIMS FOR THIS PRODUCT ARE ALLOWED" |
| "78" | Cost Exceeds Maximum | "MAXIMUM AMOUNT = $XXX" |
| "81" | Claim Too Old | "SUBMIT DATE > NN DAYS FROM DATE OF SERVICE" |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| | | "DATE OF SERVICE DATE > NNN DAYS FROM WRITTEN DATE" |
| "AG" | Days Supply Limitations for Product/Service | "MAXIMUM DAYS SUPPLY = XXX DAYS." |
| "M4" | Prescription/Service Reference Number/Time Limit Exceeded | Define the number of prescriptions allowed within a given time period |
| "RN" | Plan Limits Exceeded on Intended Partial Fill Values | "MAXIMUM DAYS SUPPLY = XXX DAYS" |
| "70" | Product/Service Not Covered – Plan/Benefit Exclusion | "SPECIFIC PLAN EXCLUSION" |
| "MR" | Product Not On Formulary | Formulary Alternatives/Preferred Products Available |
| "60" | Product/Service Not Covered for Patient Age | "MAXIMUM (or MINIMUM) AGE = NN YEARS" |
| "61" | Product/Service Not Covered for Patient Gender | |
| "66" | Patient Age Exceeds Maximum Age | "MAXIMUM PATIENT AGE = XX YEARS" |
| "9G" | Quantity Dispensed Exceeds Maximum Allowed | "MAXIMUM QUANTITY = XXX" |

#### *14.2.1.2 REJECT CODE "79" (FILL TOO SOON)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "79" | Fill Too Soon | "NEXT AVAILABLE DATE OF SERVICE = MM/DD/CCYY" |

#### *14.2.1.3 REJECT CODE "52" (NON-MATCHED CARDHOLDER ID)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "52" | Non-Matched Cardholder ID | Since this code is often transmitted with other Reject Codes, an example of a supplementary message is: "ONE OR MORE OF THESE REASONS MAY APPLY." |
| "ZZ" | Cardholder ID submitted is inactive. New Cardholder ID on file. | Indicates patient is covered, but claim requires the new Cardholder ID. This will keep the claim data clean and will assist in the TrOOP Facilitation N1 matching process. When claim rejects with this code, the processor must return the new Cardholder ID in field 302-C2 in the Response Insurance Segment. |

#### *14.2.1.4 REJECT CODE "69" (DATE OF SERVICE AFTER COVERAGE TERMINATED)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "69" | Date of Service After Coverage Terminated | "TERMINATED MM/DD/CCYY." |

#### *14.2.1.5 REJECT CODE "68 " (DATE OF SERVICE AFTER COVERAGE EXPIRED)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "68" | Date of Service After Coverage Expired | "COVERAGE EXPIRED MM/DD/CCYY." |
| "66" | Patient Age Exceeds Maximum Age | "MAXIMUM PATIENT AGE = XX YEARS." |

#### *14.2.1.6 REJECT CODE "70" (PRODUCT/SERVICE NOT COVERED – PLAN/BENEFIT*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

***EXCLUSION)***

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "70" | Product/Service Not Covered – Plan/Benefit Exclusion | "SPECIFIC PLAN EXCLUSION." |
| "MR" | Product Not On Formulary | Formulary Alternatives/Preferred Products Available |
| "60" | Product/Service Not Covered for Patient Age | "MAXIMUM (OR MINIMUM) AGE = NN YEARS" |
| "61" | Product/Service Not Covered for Patient Gender | |
| "63" | Institutionalized Patient Product/Service ID Not Covered | |
| "73" | Additional Fills Are Not Covered | "NEW PRESCRIPTION REQUIRED" or "NO FURTHER CLAIMS FOR THIS PRODUCT ARE ALLOWED" |
| "AC" | Product Not Covered Non-Participating Manufacturer | Identify the covered manufacturer(s). |
| "AH" | Unit Dose Packaging Only Payable For Nursing Home Recipients | |
| "AJ" | Generic Drug Required | |

* Use the Response Claim Segment to provide the Preferred Product ID (553-AR), its Qualifier (552-AP), Description (556-AU), Incentive (554-AS) and Copay/Coinsurance Incentive (555-AT) whenever applicable, with the Preferred Product Count (551-9F). If multiple preferred products are possible, use the Preferred Product Count (551-9F) field, populating it with the correct number of products and repeat the above fields as needed.

### *14.2.1.7 REJECT CODE "06" (M/I GROUP ID)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "06" | M/I Group ID | Since this code is often transmitted with other reject codes, an example of a supplementary message is: "ONE OR MORE OF THESE REASONS MAY APPLY." |
| "RD" | Mismatched Cardholder/Group ID-Partial to Completion | |

### *14.2.1.8 REJECT CODE "19" (M/I DAYS SUPPLY)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "19" | M/I Days Supply | Do not use this reject code for claims that exceed a days supply limitation – use Reject Code "76" and indicate the maximum days supply in the Message fields. |

### *14.2.1.9 REJECT CODE "88" (DUR REJECT ERROR)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "88" | DUR Reject Error | Note that the Response DUR/PPS Segment does not indicate which of the potentially multiple DUR/PPS alerts caused the rejection—one or more of the other alerts may just be informational warning messages. Consider indicating in the Additional Message Information field (526- |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| | | FQ) the DUR/PPS alert number(s) that caused the rejection, for example, "DUR/PPS ALERTS 1 AND 2 ARE REJECTION ALERTS." |

### *14.2.1.10 REJECT CODE "65" (PATIENT IS NOT COVERED)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "60" | Product/Service Not Covered for Patient Age | "MAXIMUM PATIENT AGE FOR THIS DRUG IS XX YEARS." |
| | | "MINIMUM PATIENT AGE FOR THIS DRUG IS XX YEARS." |
| "61" | Product/Service Not Covered for Patient Gender | |
| "63" | Institutionalized Patient Product/Service ID Not Covered | |
| "66" | Patient Age Exceeds Maximum Age | "MAXIMUM PATIENT AGE FOR THIS DRUG IS XX YEARS." |

### *14.2.1.11 REJECT CODE "07" (M/I CARDHOLDER ID)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "07" | M/I Cardholder ID | Since this code is often transmitted with other reject codes, an example of a supplementary message is: "ONE OR MORE OF THESE REASONS MAY APPLY." |
| "RD" | Mismatched Cardholder/Group ID-Partial to Completion | |
| "ZZX" | Cardholder ID submitted is inactive. New Cardholder ID on file. | Indicates patient is covered, but claim requires the new Cardholder ID. This will keep the claim data clean and will assist in the TrOOP Facilitation N1 matching process. When claim rejects with this code, the processor must return the new Cardholder ID in field 302-C2 in the Response Insurance Segment. |

### *14.2.1.12 REJECT CODE "54" (NON-MATCHED PRODUCT/SERVICE ID NUMBER)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "54" | Non-Matched Product/Service ID Number | Example "NO ACTIVE NDC NUMBER FOUND." |
| "55" | Non-Matched Product Package Size | |
| "77" | Discontinued Product/Service ID Number | If a replacement ID and date are known, "SUPERCEDED BY NNNNN-NNNN-NN ON MM/DD/YY." |

### *14.2.1.13 REJECT CODE "75" (PRIOR AUTHORIZATION REQUIRED)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "75" | Prior Authorization Required | Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| | | The URL field (987-MA) should be populated in the response transaction whenever possible. |
| "3W" | Prior Authorization in Process | "REQUESTED ON MM/DD/CCYY." Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. The URL field (987-MA) should be populated in the response transaction whenever possible. |
| "3X" | Authorization Number Not Found | Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. The URL field (987-MA) should be populated in the response transaction whenever possible. |
| "3Y" | Prior Authorization Denied | Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. The URL field (987-MA) should be populated in the response transaction whenever possible. |
| "G4" | Physician must contact plan | Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. The URL field (987-MA) should be populated in the response transaction whenever possible. |
| "G5" | Pharmacist must contact plan | Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. The URL field (987-MA) should be populated in the response transaction whenever possible. |

#### *14.2.1.14 REJECT CODE "09" (M/I DATE OF BIRTH)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "09" | M/I Date Of Birth | Since this code is often transmitted with other reject codes, an example of a supplementary message is: "ONE OR MORE OF THESE REASONS MAY APPLY." |

#### *14.2.1.15 REJECT CODE "51" (NON-MATCHED GROUP ID)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "51" | Non-Matched Group ID | Since this code is often transmitted with other reject codes, an example of a |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | |
|---|---|---|
| | | supplementary message is: "ONE OR MORE OF THESE REASONS MAY APPLY." |

#### *14.2.1.16 REJECT CODE "41" (SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYER)*

See also section "*Dual Eligibility*".

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "41" | Submit Bill to Other Processor or Primary Payer | If known, return the other payer routing instructions: BIN, Processor Control Number, Submitted Group, Member ID |
| "620" | This Product/Service may be covered under Medicare Part D | |
| "621" | This Medicaid Patient is Medicare Eligible | |
| "A6" | This Product/Service May Be Covered Under Medicare Part B | |
| "AE" | QMB Bill Medicare | |

### 14.2.2 OTHER NOTABLE REJECT CODES

#### *14.2.2.1 REJECT CODE "83" (DUPLICATE PAID/CAPTURED CLAIM)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "83" | Duplicate Paid/Captured Claim | "CHANGE FILL NUMBER IF MULTIPLE DISPENSINGS ARE REQUESTED ON SAME DAY." |

#### *14.2.2.2 REJECT CODE "92" (SYSTEM UNAVAILABLE/HOST UNAVAILABLE)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "92" | System Unavailable/Host Unavailable | |
| "90" | Host Hung Up | |
| "91" | Host Response Error | |
| "95" | Time Out | |
| "96" | Scheduled Downtime | "EXPECTED TO RESUME AT HH:MM EST" or CST, MST, PST, EDT, CDT, MDT, PDT as appropriate based on the processor's location. |
| "97" | Payer Unavailable | |
| "98" | Connection to Payer Is Down | "EXPECTED TO RESUME AT HH:MM EST" or CST, MST, PST, EDT, CDT, MDT, PDT as appropriate based on the processor's location. |
| "99" | Host Processing Error | |

#### *14.2.2.3 REJECT CODE "85" (CLAIM NOT PROCESSED)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "85" | Claim Not Processed | Whenever possible more specific Reject Codes should be used. If "85" is used, recommend including explanation as to why the claim is not processing. |

#### *14.2.2.4 REJECT CODE "87" (CLAIM NOT PROCESSED)*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "87" | Reversal Not Processed | Whenever possible more specific Reject Codes should be used. An additional Reject Code should be returned with "87" to identify the specific error. Alternately Reject Code "30" or "31" could be used as of 10/2015. |
| "84" | Claim Not Paid/Captured | This reject code was intended for use with B2 transactions, where the processor was not able to identify the matching B1 claim (referenced fields: 201-B1, 401-D1, 402-D2). Due to the non-distinct description associated to reject code 84 and the availability of reject code 31 as of 10/2015, reject code 84 will be sunset as of 10/2016. |
| "30" | Reversal outside processor reversal window. | Additional Message could include the allowed reversal window timeframe. |
| "31" | No matching paid claim found for reversal request. | Reversal within reversal window but corresponding paid claim not found. |

#### *14.2.2.5 REJECT CODE "53" (NON-MATCHED PERSON CODE)*

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "53" | Non-Matched Person Code | Since this code is often transmitted with other reject codes, an example of a supplementary message is: "ONE OR MORE OF THESE REASONS MAY APPLY." |

#### *14.2.2.6 REJECT CODE "40" (PHARMACY NOT CONTRACTED WITH PLAN)*

These additional Reject Codes would provide the type of pharmacy network through which the drug would be covered.

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "G6" | Pharmacy Not Contracted in Specialty Network | Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. |
| "G7" | Pharmacy Not Contracted in Home Infusion Network | Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. |
| "G8" | Pharmacy Not Contracted in Long Term Care Network | Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. |
| "G9" | Pharmacy Not Contracted in 90 Day Retail Network (this message would be used when the pharmacy is not contracted to provide a 90 days supply of drugs) | Processors should populate the Help Desk Telephone Number field (550-8F) and system vendors should display the contents of this field when this reject code appears. |

If a given processor's Payer Sheet indicates a specific field is required for the claim to process and that field is not submitted, the appropriate field "M/I" Reject Code must be returned in the Reject Response and its appropriate Explanation/Definition displayed for the pharmacist.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

***14.2.2.7 REJECT CODE "608" (STEP THERAPY)***

| Related Reject Codes | NCPDP Reject Code Definition | Supplementary Message/Notes |
|---|---|---|
| "608" | Step Therapy, alternate drug therapy required prior to use of submitted product service ID | In addition, the payer/plan must return the alternate drug therapy in Additional Message Information (526-FQ) and/or Preferred Product Description (556-AU). Example: "ALTERNATE DRUG THERAPY: (return generic drug name, specific therapeutic class description)." |

## 14.3 DUR/PPS-GENERATED REJECTIONS

Claims processing systems should develop methods to provide a different set of criteria for DUR/PPS Alerts detected when the claims for the interacting drugs originate from the same pharmacy versus DUR/PPS Alerts detected due to claims where the interacting drugs are dispensed at different pharmacies. In some instances, DUR/PPS Alerts are based on information on a claims processor's patient profile—data possibly collected from multiple sources. Responses for same-pharmacy DUR/PPS Alerts (that is, the information was obtained from the same pharmacy submitting the claim) should be significantly downgraded as compared to Alerts generated due to other pharmacy-submitted or other profiled data. One possible answer is the development of three-tier DUR/PPS responses:

- Tier 1 = Other Pharmacy
- Tier 2 = Same Pharmacy within the a chain DUR/PPS
- Tier 3 = Same Pharmacy DUR/PPS

Processors should consider utilizing a restrictive hierarchal approach to DUR/PPS Responses such as the following DUR/PPS:

- Hard Reject: This level should be used for a small subset of Alerts. Only a processor-assigned Prior Authorization can override "Hard Rejections". Recommendations from industry, database providers, Pharmacy and Therapeutics Committees, specialty providers and groups, and other sources should be followed to define this subset of Alerts, but the decision of which Alerts actually fall into this category should be left to the plan sponsors, due to processor liability concerns.
- Soft Reject: This level should be used for other severe or major DUR/PPS Alerts. Processor-assigned Prior Authorizations and pharmacist-submitted NCPDP DUR/PPS codes can override these rejections.
- Message Only Alerts: This level should be used for the remaining DUR/PPS Alerts that are deemed necessary to warn the pharmacist of potential patient harm. Claims are not rejected, but the processor provides information to make the pharmacist aware of potential problems and allow the pharmacist to make an informed decision whether or not to continue with the claim. Lack of any additional claim activity (i.e. Claim Reversal) assumes the pharmacist has judged that the warning(s) is/are of no significance for the patient. Message Only Alerts should be used cautiously to minimize alert fatigue situations due to message overload.
- No Alerts: At this level, DUR/PPS Alerts are generated by the processor, but not returned to the pharmacy. his allows retrospective analysis of DUR/PPS Alerts, where the processor has determined that the immediate patient risk is minimal (low severity Alerts). This level can also be used for those Alerts otherwise downgraded due to same pharmacy detection or the transmission of applicable DUR/PPS codes with the claim.

It is prudent to note that even a statistically insignificant drug-drug interaction can be significant in any given patient. Patients do experience low incidence and minor severity problems, and when this occurs, it is significant to them. There are always outliers in any study that attempts to categorize DUR/PPS Alerts based on statistical probabilities. There are degrees of occurrence for every drug-drug interaction, and a problem does not "always happen" or "never happens" in every patient. All stakeholders must recognize the need to balance the risk of


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

suppression of DUR/PPS messages in the interest of reducing noise to the risk of individual patient significance and harm of even low risk DUR/PPS Alerts.

Information fields in the Claim Submission should be used whenever possible when a pharmacist's in-house system detects a drug-drug interaction, but in the pharmacist's professional judgment, it is decided that the interaction is of minimal risk to the patient and the product should be dispensed. Some systems provide the capability for the pharmacist to document this decision internally. These documentations usually include the description of the problem, the identity of the person making the decision, and the result of the decision. The NCPDP *Telecommunication Standard Implementation Guide©* contains the following fields in its Response DUR/PPS Segment that should map to these documentations: Reason for Service Code (439-E4), Professional Service Code (440-E5), Result of Service Code (441-E6), and DUR Co-Agent ID (476-H6).

In situations in which the pharmacist decides to transmit a claim that he/she knows will trigger a DUR/PPS Alert, the DUR/PPS fields should be populated with the correct codes and transmitted to the processor with the claim. If the Claims Processing system has functionality built around these fields and codes, it then searches the claims and clinical databases, plus the patient demographic information on file to determine if DUR/PPS problems exist. Then the processor should compare these submitted codes to criteria on the claims processing system to determine if the defined DUR/PPS Alert response should be reduced or suppressed entirely.

The NCPDP *Telecommunication Standard Implementation Guide©* does not differentiate between a Hard Reject and a Soft Reject. Both situations simply generate a Reject Code of "88" (DUR Reject Error) and claims processors should populate the DUR/PPS Segment with the appropriate values. In the event that a DUR/PPS Reject is transmitted to the pharmacy and the pharmacist desires to override the rejection, the pharmacist should use the four PPS fields above and retransmit the claim. If the rejection was a "Soft Reject," then this action may override the rejection. If it will not override the rejection, the pharmacist can always call the phone number provided in the claim transaction's Help Desk Telephone Number field (550-8F) and request an authorization that will override the rejection. The pharmacist should first attempt a second transaction using the DUR/PPS codes—it may avert the need to call the Help Desk. Pharmacy systems can be built to facilitate the population of these DUR/PPS fields. All DUR/PPS Alerts have the Reason for Service Code (439-E4) populated for each Alert. The value from the processor automatically should be placed in this same field when building the claim re-submittal transaction. Then the pharmacist should be presented a list of values for the Professional Service Code (440-E5) and Result of Service Code (441-E6) fields to transmit. If the system programmer wants to further enhance the system, the available values in these latter two fields can be reduced to only those codes that apply for a given Reason for Service Code, thereby minimizing the long list of codes from which a pharmacist must choose.[3]

Implementation of these recommendations is voluntary. There is value in streamlining the on-line message functionality that exists within the NCPDP *Telecommunication Standard Implementation Guide©*. Selected benefits of more meaningful and actionable messages include improved patient quality of care and saved time by all parties in researching and interpreting such messages.

## 14.4 PARTICIPATING ORGANIZATIONS

NCPDP would like to thank the following organizations that provided input and comments in the original writing of this section. The organizations listed below should not be considered as endorsers for the content but rather contributors to information contained within this section.

America's Health Insurance Plans (AHIP)
Academy of Managed Care Pharmacy (AMCP)
American Pharmacists Association (APhA)
Blue Cross Blue Shield Association (BCBSA)

[3] See NCPDP *Data Dictionary©* and *External Code List©* for list of values.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Council for Affordable Quality Healthcare (CAQH)
National Association of Chain Drug Stores (NACDS)
National Community Pharmacists Association (NCPA)
National Council for Prescription Drug Programs (NCPDP)
Pharmaceutical Care Management Association (PCMA)

## 14.5 LONG TERM CARE TRANSITION, EMERGENCY SUPPLY AND CHANGE IN LEVEL OF CARE MESSAGING FOR REJECTED AND PAID CLAIMS

### 14.5.1 BACKGROUND

There is an ongoing need for an industry wide methodology for response messaging for claims that meet the transition period/emergency supply/change in level of care criteria.

CMS Transition Guidance in Summary

***CMS TRANSITION PERIOD REQUIREMENT***

***Non-LTC:*** "The minimum transition process standards described in Section I will apply to beneficiaries obtaining their drugs in a retail setting (or via home infusion, safety-net, or I/T/U pharmacies). However, we clarify that, in the retail setting, the one-time, temporary supply of non-formulary Part D drugs – including Part D drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules – must be for at least 30 days of medication, unless the prescription is written by a prescriber for less than 30 days. Plans should note that, outside the long term care setting, such a temporary fill may be a one-time fill only."

***LTC:*** "The minimum transition process standards described in Section I will apply to beneficiaries obtaining their drugs in a long-term care setting. The temporary supply of non-formulary Part D drugs – including Part D drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules – for a new enrollee in a LTC facility must be for at least 31 days (unless the prescription is written for less than 31 days). We are requiring a 31-day transition supply given that many LTC pharmacies and facilities dispense medications in 31-day increments. However, unlike in the retail setting, plans must honor multiple fills of non-formulary Part D drugs, including Part D drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules, as necessary during the entire length of the 90-day transition period."

***CMS EMERGENCY SUPPLY REQUIREMENT***

Non-LTC: No CMS requirement (however plans may choose to offer this for non-LTC claims)

LTC: "Since, as a matter of general practice, LTC facility residents must receive their medications as ordered without delay, Part D plans must cover an emergency supply of non-formulary Part D drugs for LTC facility residents as part of their transition process. During the first 90 days after a beneficiary's enrollment, he or she will receive a transition supply via the process described above. However, to the extent that an enrollee in a LTC setting is outside his or her 90-day transition period, the plan must still provide an emergency supply of non-formulary Part D drugs – including Part D drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules – while an exception is being processed. These emergency supplies of non-formulary Part D drugs – including Part D drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules – must be for at least 31 days of medication, unless the prescription is written by a prescriber for less than 31 days. We are requiring a 31-day emergency supply given that many LTC pharmacies and facilities dispense medications in 31-day increments."

***CMS CHANGE IN LEVEL OF CARE REQUIREMENT***


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

> "In addition to circumstances impacting new enrollees who may enter a plan with a medication list that contains non-formulary Part D drugs, other circumstances exist in which unplanned transitions for current enrollees could arise and in which prescribed drug regimens may not be on plan formularies. These circumstances usually involve level of care changes in which a beneficiary is changing from one treatment setting to another. For example, beneficiaries who enter LTC facilities from hospitals are sometimes accompanied by a discharge list of medications from the hospital formulary, with very short term planning taken into account (often under 8 hours). Similar situations may exist, for example, for beneficiaries who are discharged from a hospital to a home; for beneficiaries who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary; for beneficiaries who give up hospice status to revert to standard Medicare Part A and B benefits; for beneficiaries who end a long-term care facility stay and return to the community; and for beneficiaries who are discharged from psychiatric hospitals with medication regimens that are highly individualized. For these unplanned transitions, beneficiaries and providers must clearly avail themselves of plan exceptions and appeals processes. We have streamlined the grievance, coverage determination, and appeals process requirements in order to ensure that beneficiaries receive quick determinations regarding the medications they need. In all cases, we make it clear that a Part D plan sponsor is required to make coverage determinations and re-determinations as expeditiously as the enrollee's health condition requires. In addition, and as described above, current enrollees entering LTC settings from other care settings will be provided emergency supplies of non-formulary drugs – including Part D drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules".

In the 2007 guidance CMS states: "… we strongly encourage point-of-sale notification of enrollees about transition supplies by pharmacists".

Earlier versions of this document including version 5.1 guidance recommended multiple methodologies for handling transition claims that included rejecting the claim with a message indicating resubmission of a Prior Authorization Code or resubmitting the claim and paying with a structured (5.1) approved message or Approved Message Code (548-6F) related to transition supply D.0.

On August 27, 2010, CMS provided in the memo titled "***Part D Transition Policy Reminder***" stating that

> "… CMS has found that sponsors adopting the "hard edit" approach … are at the most risk for being found non-compliant because the sponsor's administration of the transition policy is reliant on the pharmacist effectuating the coverage of a transition supply by inputting an override code. When sponsors and/or their processors adopt the "hard edit" approach, sponsors must either ensure that their contracted pharmacies apply the override code or put in place other internal controls to ensure the beneficiary does not leave the pharmacy without the transition supply required under Medicare rules."

In order to be compliant with CMS intent that all members receive their transition supply, NCPDP recommends that plans should pay the claims with the appropriate Approved Message Code (548-6F) related to transition supply, instead of rejecting and providing a Prior Authorization Code and/or requiring the pharmacy to resubmit the claim. This ensures consistency between the Long Term Care (LTC) and retail community.

Medicare Part D plans are not prohibited from denying a drug claim that meets transition criteria during the transition period provided the plan clearly identifies the reason for the denial and return all appropriate Reject Codes.

It is expected that based on the appropriate Approved Message Code (548-6F) the member or in long term care settings, the pharmacy will initiate timely appropriate follow-up to ensure that the member will continue to receive the prescribed drug or an alternative therapy after the transition days supply has been exhausted.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Plans should ensure that the member receives a transition notice and all other communications related to transition supply as required by CMS.

#### *14.5.1.1 WHEN PRIOR AUTHORIZATION NUMBER (498-PY) REQUIRED*

In some situations of a Claim Billing, the payer requires the pharmacy to submit a Prior Authorization Number in order to receive payment for the claim if rejected outside the transition/emergency supply/level of care change. An example of a situation may include a Benefit Transition Period that allows for payment of claims, for a period of time that would normally reject.

When paying the claim, the processor must return the Approved Message Code (548-6F) field with the appropriate value listed below:

- "005" Dispensed During Transition Benefit/Prior Authorization Required
- "009" Emergency Supply Situation/Prior Authorization Required
- "013" Level of Care Change/Prior Authorization Required

#### *14.5.1.2 TRANSITION AND SAFETY-RELATED REJECTS*

From CMS:

> "We note that although Part D plans may implement quantity limits for safety purposes or drug utilization edits that are based upon approved product labeling during a beneficiary's transition period, to the extent that the prescription is dispensed for less than the written amount due to a plan edit, plans must provide refills for that transition supply (up to a 30-day supply in a retail setting and a 90-day supply in a long-term care setting). For example, if a beneficiary presents at a retail pharmacy with a prescription for one tablet per day for 30 days and a plan has a quantity limit edit in place that limits the days supply to 14 per prescription for safety purposes, the beneficiary would receive a 14-day supply (consistent with the safety edit). At the conclusion of the 14-day supply, the beneficiary should be entitled to another 14-day supply while he/she continues to pursue an exception with the Part D plan, or a switch to a therapeutic alternative that is on the plan's formulary."

In some situations of a Claim Billing, the payer may have rejected the claim due to safety related issues if outside the transition/emergency supply/level of care change. It is recommended that during the transition/emergency supply/level of care period that the claim is paid.

When paying the claim, the processor must return the Approved Message Code (548-6F) field with the appropriate value listed below:

- "007" Dispensed During Transition Benefit/Other Reject
- "011" Emergency Supply Situation/Other Rejection
- "015" Level of Care Change/Other Rejection

### 14.5.2 CLAIMS PAID DUE TO CMS INITIAL ELIGIBILITY TRANSITION PERIOD

It is recommended that plans use the most descriptive Approved Message Codes when utilizing soft edits for purposes of applying transition benefits.

#### *14.5.2.1 APPROVED MESSAGE CODE "004" (DISPENSED DURING TRANSITION BENEFIT)*

If during the transition period a claim is not rejected (claim is paid) and the processor paid the claim by setting edits to soft, the plan must notify the pharmacy using one of the following Approved Message Codes (548-6F). In addition, the plan must notify the pharmacy why the claim would have rejected using the appropriate mapped Reject Code in one of the response message fields to increase the value of the messaging.

| Approved Message Codes (548-6F) | NCPDP Approved Message Code Definition | Supplementary Message/Notes |
|---|---|---|


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | |
|---|---|---|
| "005" | Dispensed During Transition Benefit/Prior Authorization Required | Mapped when Reject Code "75" (Prior Authorization Required) is overridden |
| "006" | Dispensed During Transition Benefit /Non-Formulary | Mapped when Reject Code "61" (Product/Service Not Covered For Patient Gender), "60" (Product/Service Not Covered For Patient Age), "70" (Product/Service Not Covered – Plan/Benefit Exclusion) is overridden |
| "007" | Dispensed During Transition Benefit /Other Rejection (e.g. Step Therapy, Benefit Maximum, Generic First Requirement, and Non- safety related DUR) | Mapped when Reject Code "76" (Plan Limitations Exceeded), "78" (Cost Exceeds Maximum), "80" (Drug-Diagnosis Mismatch), "88" (DUR Reject Error) is overridden |

### 14.5.3 CLAIMS PAID DUE TO CMS EMERGENCY SUPPLY REQUIREMENT

#### *14.5.3.1 APPROVED MESSAGE CODE "008" (EMERGENCY SUPPLY SITUATION)*

If a claim that meets emergency supply criteria is not rejected (claim is paid) and the processor paid the claim by setting errors to soft, the plan must notify the pharmacy using one of the following Approved Message Codes (548-6F). In addition, the plan must notify the pharmacy why the claim would have rejected using the appropriate mapped Reject Code in one of the response message fields to increase the value of the messaging.
.

| Approved Message Codes (548-6F) | NCPDP Approved Message Code Definition | Supplementary Message/Notes |
|---|---|---|
| "009" | Emergency Supply Situation/ Prior Authorization Required | Mapped when Reject Code "75" (Prior Authorization Required) is overridden |
| "010" | Emergency Supply Situation/ /Non-Formulary | Mapped when Reject Code "61" (Product/Service Not Covered For Patient Gender), "60" (Product/Service Not Covered For Patient Age), "70" (Product/Service Not Covered – Plan/Benefit Exclusion) is overridden |
| "011" | Emergency Supply Situation/Other rejection (e.g. Step Therapy, Benefit Maximum, Generic First Requirement, and Non- safety related DUR) | Mapped when Reject Code "76" (Plan Limitations Exceeded), "78" (Cost Exceeds Maximum), "80" (Drug-Diagnosis Mismatch), "88" (DUR Reject Error) is overridden |

### 14.5.4 CLAIMS PAID DUE TO CMS CHANGE IN LEVEL OF CARE REQUIREMENT

#### *14.5.4.1 APPROVED MESSAGE CODE "012" (LEVEL OF CARE CHANGE)*

If a claim that meets level of care change criteria is not rejected (claim is paid) and the processor and the processor paid the claim by setting errors to soft, the plan must notify the pharmacy using one of the following Approved Message Codes (548-6F). In addition, the plan must notify the pharmacy why the claim would have rejected using the appropriate mapped Reject Code in one of the response message fields to increase the value of the messaging.

| Approved Message Codes (548-6F) | NCPDP Approved Message Code Definition | Supplementary Message/Notes |
|---|---|---|


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | |
|---|---|---|
| "013" | Level Of Care Change/ Prior Authorization Required | Mapped when Reject Code "75" (Prior Authorization Required) is overridden |
| "014" | Level Of Care Change/Non-Formulary | Mapped when Reject Code "61" (Product/Service Not Covered For Patient Gender), "60" (Product/Service Not Covered For Patient Age), "70" (Product/Service Not Covered – Plan/Benefit Exclusion) is overridden |
| "015" | Level Of Care Change/Other rejection (e.g. Step Therapy, Benefit Maximum, Generic First Requirement, and Non- safety related DUR) | Mapped when Reject Code "76" (Plan Limitations Exceeded), "78" (Cost Exceeds Maximum), "80" (Drug-Diagnosis Mismatch), "88" (DUR Reject Error) is overridden |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 15 MULTI-INGREDIENT COMPOUND PROCESSING

See also section "*Appendix C. Medicare Part D and Multi-Ingredient Compound Processing*".

## 15.1 CORRECT TELECOM VERSION?

**Question:**
What is the Telecom version for multi-ingredient claims?

**Response:**
HIPAA covered entities submitting electronic transactions are required to use the Telecommunication Standard Version D.0© using the Compound Segment and the submission of all ingredients (up to 25), and following the compound requirements.

Workers' Compensation multi-ingredient electronic claims are not covered under HIPAA and may use any version of Telecom since Version 3.3, however the industry recommends Version D.0 be used for consistency.

## 15.2 LEAVE OFF INGREDIENTS THAT ARE IDENTIFIABLE BY THE PHARMACY AND THE PAYER?

**Question:**
When using the Telecommunication Standard version D.0© multi-ingredient claim, should we leave off ingredients that are not paid for, like cream bases, empty capsules and fillers which are necessary to prepare the compounds, etc.? **NOTE:** This question assumes that all ingredients in the compound are identifiable by the pharmacy and the payer.

**Response:**
In general, it is best to report all ingredients so that DUR can be performed. If an ingredient product ID is identifiable but not covered by the payer, best practice is for the payer to reject the claim and identify at the ingredient level those ingredients that are not covered by using the Reject Code(s) and Reject Field Occurrence Indicator. This allows the pharmacy the option to resubmit the claim with the Submission Clarification Code of 8 (Process compound for approved ingredients).

## 15.3 COMPOUND INGREDIENT QUANTITY (448-ED) SMALLER THAN 3 DIGITS OF PRECISION TO THE RIGHT OF THE DECIMAL

**Question:**
I have a question about compound claims and the Reject Code value "ED" (M/I Compound Ingredient Quantity). When a compound is prepared where one of the ingredients is actually measured more in the microgram range, it is possible for the value in Compound Ingredient Quantity (448-ED) to amount to less than .0005 gram (or milliliter): while it is clearly outlined in the Imp Guide that it is allowed and actually required for a compound ingredient to be reported even if the cost of that ingredient rounds to $0.00, I cannot find any specific recommendations or guidelines on what to do if the quantity similarly would round to 0.000.

**Response:**
DERF 001073/ECL 000120 requesting new Reject Codes and new value for Compound Ingredient Basis of Cost Determination was approved in August 2012.

**Reject Codes:**

"615" = "Compound Ingredient Basis Of Cost Determination value "14" required when Compound Ingredient Quantity is 0 but cost is greater than $0".

"616" = "Submission Clarification Code 8 required when Compound Ingredient Quantity is 0".

**Compound Ingredient Basis of Cost Determination:**

"14" = "Cost basis on unreportable quantities".


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

The following scenarios are given for using the new values.

1. **Scenario 1: The pharmacy submits a claim with an ingredient Compound Ingredient Quantity (448-ED) of 0 and cost is $0 and new value of Compound Ingredient Basis Of Cost Determination is not sent.**
    a. *The processor does not know if the 0 in quantity was an intentional 0 (unreportable) quantity by the pharmacy.*
    b. The processor can:
        i. Accept the claim and pay $0 on this ingredient.
            1. *The processor is assuming the 0 quantity submission was intentional 0 (unreportable).*
        ii. Reject at the ingredient level (using Reject Code Occurrence Indicator and Reject Code new value of)
            1. "616" (Submission Clarification Code 8 required when Compound Ingredient Quantity is 0).
                a. Action is for pharmacy to resubmit claim with SCC 8.
                    i. *By sending the SCC 8 and the fact that the payer rejected previously for "616", the payer is to not reject the claim based on the 0 quantity but ignore the ingredient for compound pricing.*
2. **Scenario 2: The pharmacy submits a claim with an ingredient Compound Ingredient Quantity (448-ED) of 0 and cost submitted based on contractual relationship (cost is > $0) and new value of Compound Ingredient Basis Of Cost Determination is not sent.**
    a. *The processor does not know if the 0 in quantity was an intentional 0 (unreportable) quantity by the pharmacy.*
    b. The processor can:
        i. Accept the claim and pay cost submitted on this ingredient.
        ii. Reject at the ingredient level (using Reject Code Occurrence Indicator and Reject Code new value of)
            1. "615" (Compound Ingredient Basis Of Cost Determination value "14" required when Compound Ingredient Quantity is 0 but cost is greater than $0).
            2. Action is for the pharmacy to resubmit claim with new value of Compound Ingredient Basis Of Cost Determination.
                a. *By sending the new value, the pharmacy is noting intentional 0 (unreportable) quantity and providing the cost. The payer is to not reject the claim based on the 0 quantity and to price this ingredient based on contractual relationship.*
3. **Scenario 3: The pharmacy submits a claim with an ingredient Compound Ingredient Quantity (448-ED) of 0 and cost is $0 and new value of Compound Ingredient Basis Of Cost Determination is sent.**
    a. *By sending the new value, the pharmacy is noting an intentional 0 (unreportable) quantity and providing the cost of $0.*
        i. The payer is to not reject the claim based on the 0 quantity but ignore the ingredient for compound pricing.
4. **Scenario 4: The pharmacy submits a claim with an ingredient Compound Ingredient Quantity (448-ED) of 0 and cost submitted based on contractual relationship (cost is > $0) and new value of Compound Ingredient Basis Of Cost Determination is sent.**
    a. *By sending the new value, the pharmacy is noting an intentional 0 (unreportable) quantity and providing the cost.*
        i. The payer is to not reject the claim based on the 0 quantity and to price this ingredient based on contractual relationship.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

DERF 001074 requesting to increase the size of Compound Ingredient Quantity from 9(7)v999 (10 digits) to 9(7)v9999999 (14 digits) in a future version was approved in August 2012.

## 15.4 Compound Ingredient Modifier Code (363-2H)

**Question:**
Is there information about the Compound Ingredient Modifier Code (363-2H)?

**Response:**
The field was added for Medicare Part B needs. There is a counter (Compound Ingredient Modifier Code Count (362-2G)) so multiple codes per ingredient can be sent. The Compound Ingredient Modifier Code (363-2H) occurs per ingredient. See section 33.14.2.4.4 Compound Segment, subsection 33.14.2.4.4.1 Compound Ingredient Component Count of the Implementation Guide.

According to CMS:
The file available from CMS has both the modifiers and HCPCS codes in the same file. The modifiers are the two byte elements in the spreadsheet found in the first 409 rows. The HCPCS codes start at row 411 and are 5 bytes the first byte being alpha followed by 4 numerics. The link is:
2010 Alpha-Numeric HCPCS File:
http://www.cms.hhs.gov/apps/ama/license.asp?file=/HCPCSReleaseCodeSets/Downloads/10anweb.zip
2010 HCPCS Corrections:
http://www.cms.hhs.gov/apps/ama/license.asp?file=/HCPCSReleaseCodeSets/Downloads/2010_Corrections_alpha.zip

## 15.5 Basis of Reimbursement (423-DN) and Multi-Ingredient Compounds

**Question:**
Is the use of fields Basis of Cost Determination (423-DN) and Compound Ingredient Basis of Cost (490-UE) mutually exclusive? If so, should field Basis of Reimbursement Determination (522-FM) be returned on compound claim responses?

**Response:**

1. In a multi-ingredient compound request, Basis of Cost Determination (423-DN) may be irrelevant.
    a. If all Compound Ingredient Basis of Cost (490-UE) are the same, use the same value in Basis of Cost Determination (423-DN).
    b. If a plan requires Basis of Cost Determination (423-DN), recommend use value 9 (Other).
2. In a multi-ingredient compound response, Basis of Reimbursement (522-FM), recommend use value 8 (Contract Pricing) unless a more specific value applies.
3. It is recommended that the individual payer sheets designate the value for both these fields for multi-ingredient compounds.

## 15.6 Unit of Measure (600-28) and Multi-Ingredient Compounds

See section "*Unit of Measure (600-28) and Multi-Ingredient Compounds*".

## 15.7 Recommendations on the Submission of Identifiable Ingredients that are Not Recognized by the Payer

1. **It is recommended that the correct Product/Service ID Qualifier (436-E1) value be supported for the Product/Service ID (407-D7).**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

a. It has been identified that entities may not be supporting the valid qualifier values for the types of products exchanged in compounds. This may be a long term implementation modification. However the industry needs to move to use the correct ID and Qualifier pair.

**b. Recommendation if the processor does not support the code list (does not support the value for the Product/Service ID Qualifier):**

i. It is recommended the processor identify on the payer sheets which Product/Service ID Qualifiers are supported. If an ingredient has a qualifier value that is not supported by the processor, it is recommended that procedures for how the pharmacy is to be able to submit the claim and be reimbursed for ingredients that are covered be handled between trading partners.

**2. There is an NDC code for the product, but it is not in the pharmacy or the processor's drug file.**

a. Someone in the supply chain should insure that the identifier is loaded timely into the drug file.

b. May be payer-specific or drug compendia-specific and is time-consuming to update the drug file(s).

c. **Recommendation for identification of product:**

i. The processor may not know enough about the product to contact their compendia. The pharmacy has the product in hand to contact the manufacturer. *The pharmacy could provide information about the product to the processor so the processor could follow up with their compendia.*

ii. The pharmacy or the processor should contact the manufacturer and their compendium.

iii. The manufacturer should share their information with the compendia to update all drug file(s).

**3. There is a UPC code for the product; the product does not have an NDC. It is not in the drug file.**

a. Compendia list products that only have UPCs on their files.

b. Private label product identifiers have to be shared with entities in the entire supply chain. Whether private label or not, there is a distributor. The distributor (pharmacy chain, buying group) should have relationships with the compendia.

c. **Recommendation for identification of product:**

i. For this recommendation, manufacturer or distributor is the entity that applies for the UPC. Repackaged products are not included in this recommendation.

ii. The processor may not know enough about the product to contact their compendia. The pharmacy has the product in hand to contact the manufacturer or distributor. *The pharmacy could provide information about the product to the processor so the processor could follow up with their compendia.*

iii. The pharmacy or the processor should contact the manufacturer or distributor and their compendium.

iv. The manufacturer or distributor should share their information with the compendia to update all drug file(s).

## 15.8 Correlate Complexity in Compounding and DUR/PPS Level of Effort (474-8E)

**Question:**

What is the best way to correlate the complexity in compounding to the commonly used DUR/PPS Level of Effort (474-8E)?

**Response:**

For current Telecommunication Version D.0 usage: DUR/PPS Level of Effort (474-8E) values 16-22 are available for use by willing trading partners for compound prescription claims effective October 15, 2017. The usage of these values is described with examples below.

**Note: active pharmaceutical ingredients (APIs) also include commercial products.**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**ECL Value 16**

Low Level Complexity: Non-sterile compounding, non-hazardous compound active pharmaceutical ingredients (API), 2 or more active ingredients combined in a simple one step procedure. For example, two commercial creams being mixed together.

*Example:*

*The pharmacist receives a RX for a combination of Retin A and hydrocortisone cream. The dermatologist asks for the compound to be one tube of Retin A mixed evenly with one tube of hydrocortisone.*

**ECL Value 17**

Mid-Level Complexity Non-Hazardous: Non-sterile compounding, non-hazardous compound active pharmaceutical ingredients (API), whereby two or more API are mixed together with added complexity of melting, diluting, solubilizing, heating, two phase mixing, aliquot, with final form being something other than a simple cream. For example, suppository, troche, capsule, rapid dissolve tablet, inhaler, spray, etc.

*Example:*

*The pharmacist receives a RX for a suppository of diphenhydramine, metoclopramide, and lorazepam. The pharmacist would need to separately weigh the ingredients, solubilize the powders, mix them, melt suppository base, incorporate evenly the API into the base, pour the base into suppository molds, let cool, correct for air pockets, remove from mold, wrap or package appropriately, and dispense.*

**ECL Value 18**

Mid-Level Complexity Hazardous: Non-sterile but manipulating hazardous active pharmaceutical ingredients (API). When working with hazardous API, the pharmacist must follow State and Federal Regulations specific to compounding of hazardous API. Special training, documentation, and experience are required in order to compound hazardous API.

*Example:*

*The pharmacist receives a RX for a topical cancer medication such as fluorouracil, mixed with imiquimod. The API for the fluorouracil would have to be weighed in the appropriate laboratory environment as specified by State and Federal Regulations. The regulations could include a pressurized room, air flow hood, proper gowning, washing, body protection, and filter systems. The two API powders would be solubilized, and then mixed into a cream base in the proper percentages as specified by the RX. The final product would be tubed and capped in the appropriate pressured lab area, and then released to the dispensary for dispensing.*

**ECL Value 19**

High Level Non-Hazardous: Non-sterile to Sterile compounding with non-hazardous active pharmaceutical ingredients (API). Involves high complexity due to sterile compounding. The pharmacist must follow State and Federal Regulations and compound in the appropriate pressurized room. Appropriate testing as per State and Federal Regulations for sterile compounding must be implemented.

*Example:*

*Pharmacist receives a RX for a combination of dexamethasone and Marcaine, to be mixed into one single use vial.*

**ECL Value 20**

High Level Hazardous: Non-sterile to Sterile compounding with hazardous active pharmaceutical ingredients (API). Involves a high complexity due to sterile hazardous compounding. The pharmacist and facility must follow all State and Federal Regulations that pertain to compounding and testing of final product in a sterile environment with hazardous commercial products.

*Example:*

*Pharmacist receives a RX for a combination of testosterone and estradiol, to be mixed into one single use vial.*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**ECL Value 21**

High Level Non-Hazardous Sterile: Sterile to Sterile compounding with non-hazardous active pharmaceutical ingredients (API). All State and Federal Regulations pertaining to compounding a sterile product shall be followed including testing.

*Example:*

*The pharmacist would receive a RX for gentamicin sterile nasal irrigation solution. The pharmacist would need to take a vial of gentamicin injection solution and mix it with sterile water for irrigation. The entire procedure would be performed in the appropriate pressurized room, with proper safety precautions.*

**ECL Value 22**

High level Hazardous Sterile: Sterile to Sterile compounding with hazardous active pharmaceutical ingredients (API). This is the highest level of complexity. The pharmacist and facility must follow all State and Federal Regulations that pertain to compounding and testing of final product in a sterile environment with a sterile API.

*Example:*

*The pharmacist receives a RX for preparation of a chemotherapy treatment for intravenous infusion.*

Response Revised August 2017

## 15.9 COMPOUND INGREDIENT PRODUCT IDENTIFIER AND QUALIFIER USE

### Effective Date: October 15, 2015

As of the July 2014 publication of the External Code List© new Reject Code (511-FB) values are available. Annual implementation effective date is October 15, 2015.

"771" (Compound contains unidentifiable ingredient(s); Submission Clarification Code override not allowed)

"772" (Compound contains not covered ingredient(s); Submission Clarification Code override not allowed)

These new Reject Code values notify the pharmacy that the processor does not recognize or does not cover one or more ingredient(s) of the compound. The pharmacy cannot resubmit the claim with a Submission Clarification Code to override this edit. If one of these new Reject Code values is received, in order to service the patient, the pharmacy and the payer will need to collaborate according to trading partner agreement. This guidance is not indicating which value must be used, but if the processor will not process the claim with the ingredient(s) that to them are unidentifiable, the use of these Reject Code values lets the pharmacy know to not attempt to retry sending the compound claim by using the Submission Clarification Code 8 as an override.

Note that when Reject Code value "771" or "772" are sent, the corresponding Reject Field Occurrence Indicator (546-4F) should also be included to help identify the ingredient(s) in question.

**Example 1: Pharmacy submits the claim with industry-recognized valid product IDs and the corresponding qualifiers but the processor does not support a qualifier value**

A claim with 4 ingredients:

- 3 products are recognized that are covered and payable and
- 1 product and qualifier pair is not supported by the processor (ex: UPC, a device identified by HRI)

Process Options:

1. The pharmacy knows the valid product(s) being submitted.
2. The processor may choose to
    a. ignore the products for which they do not support the qualifier value
    b. OR allow Submission Clarification Code 8 and continue processing claim


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

i. The processor should use reject code 515 – Compound Product ID Qualifier Submitted Not Supported and corresponding Reject Field Occurrence Indicator (546-4F)

c. OR reject for the products for which they do not support the qualifier value

3. If the processor cannot pay the claim because the unsupported ingredient (e.g. concern of inability to perform DUR checking, safety, etc.. of the unidentified ingredient):
    a. The processor should use Reject Code "771" (Compound Contains Unidentifiable ingredient(s); Submission Clarification Code override Not Allowed),
        i. If desired, the processor should use any other reject codes to support this rejection (i.e. 8Z, 8J, 515). It is not recommended "21" (M/I Product/Service ID) because it is not specific enough.
        ii. The corresponding Reject Field Occurrence Indicator (546-4F) should also be sent.

Notes:

1. Although the pharmacist has the choice of removing an ingredient from the claim before adjudication processing occurs in order to service the patient, this practice is not recommended and these examples are not providing any guidance as to whether that should or should not happen. In order to service the patient, the pharmacy and the payer should collaborate according to their trading partner agreement.
2. Upon receipt of the claim with Submission Clarification Code 8, the processor should have logic to **ignore ingredients with valid qualifier values they do not support** to allow further processing of the claim. Note, the claim may still reject for other reasons, but not for the 1 product and qualifier pair that is not supported by the processor.

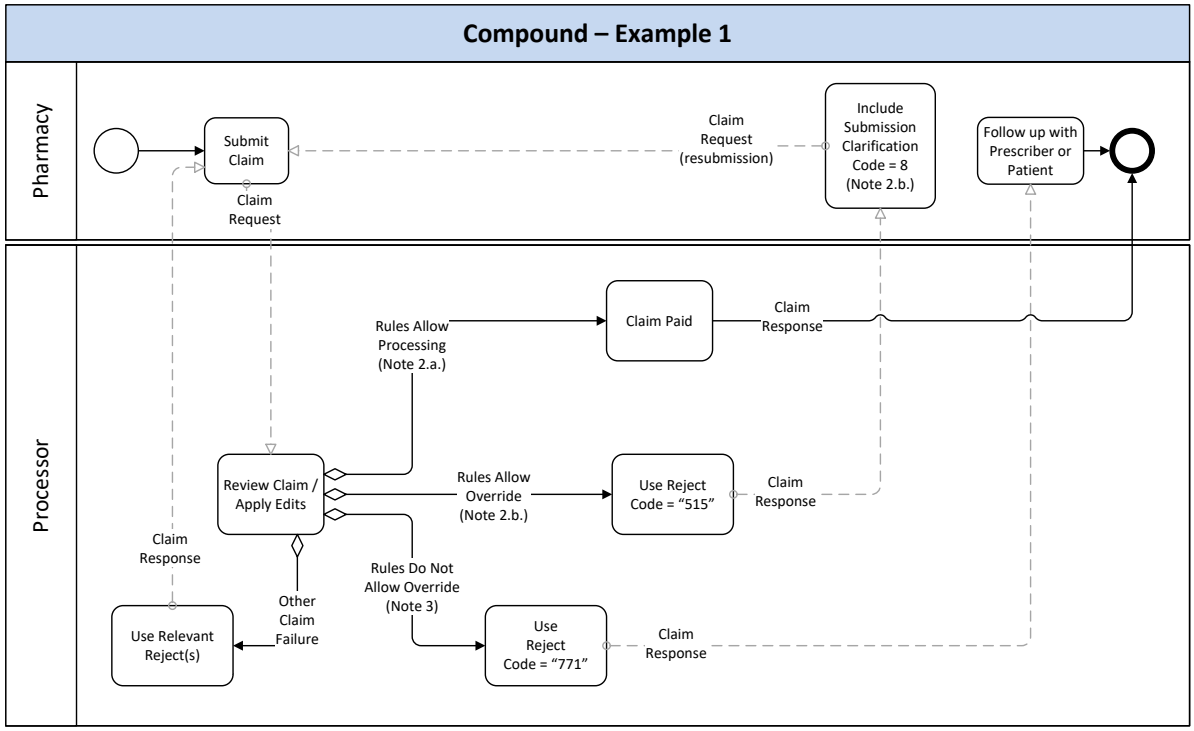



**Figure 1 for Example 1:** Pharmacy submits the claim with industry-recognized valid product IDs and the corresponding qualifiers but the processor does not support a qualifier value

**Example 2: Pharmacy submits the claim with industry-recognized valid product IDs and the corresponding qualifiers.**

A claim with 4 ingredients:


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- 3 products are recognized that are covered and payable and
- 1 product is recognized and not covered (ex: a non-formulary product, non-covered HRIs (non-covered qualifier))

Process Options:

1. The pharmacy knows the valid product(s) being submitted.
2. The processor may choose to
    a. ignore the products they do not cover
    b. OR allow Submission Clarification Code 8 and continue processing claim, ***or***
        i. The processor should use the appropriate Reject Codes for that ingredient (e.g. "MR" (Product Not on Formulary) or "70" (Product/Service Not Covered-Plan Benefit Exclusion), etc..) along with Reject Field Occurrence Indicator (546-4F) to identify the ingredient(s) rejected.
        ii. Or Reject Code "9Y" (Compound Product ID Qualifier Submitted Not Covered) could be used if appropriate to relay that product(s) with this qualifier value are not covered along with Reject Field Occurrence Indicator (546-4F) to identify the ingredient rejected.
    c. OR reject for the product(s) they recognize but do not cover
3. ***If and only if*** the Processor considers the recognized, but not covered ingredient(s) to render the entire claim unpayable
    a. The processor should return Reject Code "772" (Compound contains not covered ingredient(s); Submission Clarification Code override not allowed)
        i. If desired, the processor should use any other reject codes to support this rejection (i.e. "8Z", "8J", "515", etc.)
        ii. The corresponding Reject Field Occurrence Indicator (546-4F) should also be sent.

Notes:

1. Although the pharmacist has the choice of removing an ingredient from the claim before adjudication processing occurs in order to service the patient, this practice is not recommended and these examples are not providing any guidance as to whether that should or should not happen. In order to service the patient, the pharmacy and the payer should collaborate according to their trading partner agreement.
2. In this example, the term "unpayable" means the processor is unable to return a "Paid" response.
3. Upon receipt of the claim with Submission Clarification Code 8, the processor should have logic to **ignore ingredients with valid qualifier values they do not support** to allow further processing of the claim. Note, the claim may still reject for other reasons, but not for the 1 product and qualifier pair that is not supported by the processor.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

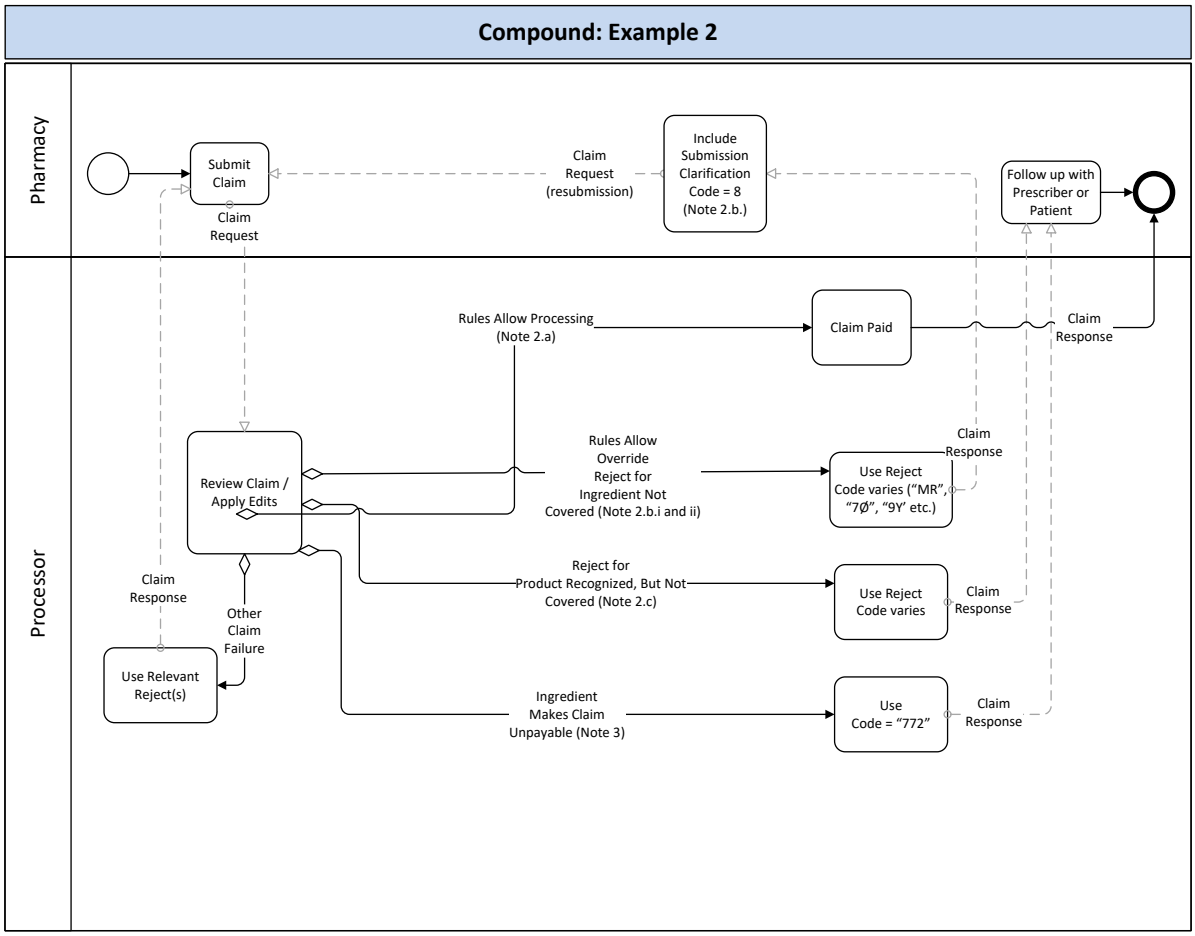



**Figure 2 for Example 2:** Pharmacy submits the claim with industry-recognized valid product IDs and the corresponding qualifiers.

## 15.10 USE OF THE COMPOUND SEGMENT FOR THE BILLING OF 2 COMMERCIALLY AVAILABLE PRODUCTS

**Business Case**: A payer is requiring the use of the Compound Segment for the billing of 2 commercially available products, commonly two different strengths of a drug (e.g. palivizumab, blood factors) that cannot be compounded to a single product. The purpose of using the compound segment is for the payer to manage prescription claim limits per time period and patient copays on a single claim versus a separate claim for each product dispensed.

**Question**: What is the definition of a Compound or Compounding?

**Response**: Refer to the definition of a Compound in the ECL – "Customized medication prepared in a pharmacy by combining, mixing, or altering of ingredients (but not reconstituting) for an individual patient in response to a licensed practitioner's prescription." The billing of multiple ingredients which are not combined, mixed or altered by a pharmacy is not a compound and the compound segment must not be used. Also, refer to Support of a Single Ingredient Compound Section 28.1.12.5 (Version D.0)

**Question**: Can the Compound Segment be used to submit a single claim for multiple products that cannot be compounded to a single product and must be dispensed as distinct products?


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Response**: The compound segment is for reporting more than one ingredient combined together in the fulfillment of a prescription order. The payer's request to use the compound segment does not comply with the compound definition or the standard. The two drugs are not compounded together in this scenario.

**Question**: If the Compound Segment cannot be used in this scenario, is there a means within the NCPDP Standard for the payer to manage the prescription claim limits and patient copay amounts across the unique claim billing transactions for each product?

**Response**: The initial reject will likely be for a duplicate therapy. The appropriate DUR code (possibly AD or 1B) may need to be sent. The payer may support an override via a prior authorization in order to account for copays, claim limits, dispensing fees, etc. A pharmacy may need to work with the payer for resolution.

Added December 2016-BP


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 16 VACCINE SERVICES – PHARMACY BENEFIT BILLING & PROCESSING

**Effective Date: August 2015 in preparation for the flu season**

## 16.1 OVERVIEW

This chapter outlines business cases to vaccine and administration in NCPDP Telecommunication Version D. 0 Claim Billing (B1/B3) transaction scenarios. The sections discuss primary and coordination of benefits of claim in processing related to vaccine and administration, and then provide questions and examples in explanation.

Use of Service Billing for billing of administration was discussed in great detail. While the Service Billing transactions (S1/S3) support the billing of a service only, it does not support the identification of the billed service (vaccine administration) and the associated product (vaccine product that is administered). The B1/B3 transactions do support the identification of both the vaccine product and administration. To maintain standardization across the industry and to support coordination of benefits claims processing, NCPDP recommends the use of a single B1/B3 transaction for the billing of the vaccine product and the vaccine administration.

In the situation where the vaccine product does not have an associated cost (e.g. free product) and the billed charges are for vaccine administration and product dispensing only, since the identification of the vaccine product is necessary, NCPDP recommends the use of a single B1/B3 transaction with the Basis of Cost Determination value "15" (Free product or no associated cost).

See also section "*Billing Transaction For Free Fills*".

## 16.2 NEW/MODIFIED CODE VALUES

### 16.2.1 REJECT CODES

The new Reject Codes (added as of 01/2015 External Code List©) referenced in this chapter fall under the October 2016 annual implementation date. Until the Reject Codes are available for use, it is recommended that the processor return the Reject Code Description as a text message in the Message (504-F4) or Additional Message Information (526-FQ) fields.

| Reject Code | Reject Code Description | Explanation/Definition |
|---|---|---|
| 816 | Pharmacy benefit exclusion, may be covered under patient's medical benefit | |
| 817 | Pharmacy benefit exclusion, covered under patient's medical benefit | Processor to return name and payer ID (if available) of medical benefit carrier within the Additional Message Information (526-FQ) |
| 818 | Medication administration not covered, plan benefit exclusion | |
| R0 | Professional Service Code of "MA" required for vaccine Incentive Fee Submitted | *Note: Existing Reject Code; modification to description approved in November 2014.* |

Note related to Medicare programs: Plans/processors should determine the applicable hierarchical rule sets to apply coverage determination (e.g. Medicare B versus D) edits versus vaccine medical benefit edits.

### 16.2.2 NEW BASIS VALUES


*** OFFICIAL RELEASE ***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Basis of Cost Determination (423-DN) and Compound Ingredient Basis of Cost Determination (490 –UE)

| Code | Description |
|---|---|
| 15 | Free product or no associated cost |

Basis of Reimbursement Determination (522-FM)

| Code | Description |
|---|---|
| 22 | Ingredient cost paid based on submitted Basis of Cost Free Product |

## 16.3 PHARMACY BENEFIT BILLING – PRIMARY VACCINE CLAIMS

### 16.3.1 QUESTION: WHEN BILLING A VACCINE CLAIM TO A PHARMACY BENEFIT USING THE NCPDP TELECOMMUNICATION STANDARD©, WHAT ARE THE RESPONSIBILITIES OF THE PHARMACY?

**Response:**

When billing a vaccine claim to the pharmacy benefit, using the NCPDP Telecommunication Standard©, the pharmacy responsibilities include:

1. Always identify the vaccine via the Product/Service ID and Qualifier (436-E1 and 407-D7)
2. Identify the billed quantity via the Quantity Dispensed (442-E7)
3. Identify the requested product reimbursement amount in the Ingredient Cost Submitted (409-D9)
4. Identify the requested dispensing fee reimbursement in the Dispensing Fee Submitted (412-DC)
5. Submit a Usual & Customary Charge (426-DQ)
6. Determine if
    1. Billing for a "**Vaccine Product only**" or
    2. Billing for a "**Vaccine Product and Administration**" or
    3. Billing for "**Administration of a Vaccine Product with no associated product cost**"
7. Submit an "MA" (Medication Administered) in the Professional Service Code (440-E5) if the vaccine is going to be administered
8. Submit an amount in the Incentive Amount Submitted (438-E3) when seeking reimbursement for the administration of the vaccine,
9. Determine if billing request was approved (Transaction Response Status (112-AN) of "P", "D", "C", or "Q") or denied (Transaction Response Status of "R") and review messages to determine vaccine administration "next steps".


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| NCPDP Telecommunication Field | 1. Vaccine Product Only | 2. Vaccine Product and Administration | 3. Administration of Vaccine Product with no associated vaccine product cost |
|---|---|---|---|
| **Transaction Code (103-A3)** | "B1" (or "B3") | "B1" (or "B3") | "B1" (or "B3") |
| **Product/ Service ID (407-D7)** | "03" NDC (for example) | "03" NDC (for example) | "03" NDC (for example) |
| **Quantity Dispensed (442-E7)** | Yes, varies (quantity dispensed) | Yes, varies (quantity dispensed) | Yes, varies (quantity dispensed) |
| **Fill Number (403-D3)** | 0 | 0 | 0 |
| **Days Supply (405-D5)** | 1 | 1 | 1 |
| **Professional Service Code (440-E5)** | Not used | "MA" | "MA" |
| **Ingredient Cost Submitted (409-D9)** | Yes, varies (drug cost) | Yes, varies (drug cost) | $0.00 |
| **Dispensing Fee Submitted (412-DC)** | Yes, varies (dispensing fee) | Yes, varies (dispensing fee) | Yes, varies (dispensing fee) |
| **Incentive Amount Submitted (438-E3)** | Not used | Yes, varies (incentive amount) | Yes, varies (incentive amount) |
| **Basis of Cost Determination (423-DN)** | Yes, varies | Yes, varies | "15" – Free product or no associated cost |

### 16.3.2 Question: How Do I Determine the Submitted Value in the Usual & Customary Charge for Vaccine Product and Administration Claim Billing?

**Response:**

The Usual & Customary Charge determination must follow these scenarios:

- Billing for reimbursement of a Vaccine Product only – Follow definition for Usual & Customary Charge and submit value that represents the vaccine product and associated dispensing.
- Billing for reimbursement of the Vaccine Product and Administration – Follow definition for Usual & Customary and submit value that represents the vaccine product, associated dispensing and administration fee.
- Billing for reimbursement of the Administration of a Vaccine Product with no associated product cost - Follow definition for Usual & Customary Charge and submit value that represents the product dispensing and administration.

### 16.3.3 Question: Should the Usual & Customary Charge on the Billing Request Resubmission Remain Unchanged? Alternatively, Should the Administration Fee be Removed?

Scenario:

- A pharmacy submits a billing request for a Vaccine Product and Administration.
- The pharmacy benefit processor rejects the billing request and indicates the Administration is not reimbursable.
- The pharmacy decides to administer the vaccine and forego the Administration fee reimbursement.
- The pharmacy resubmits the billing request without the Incentive Amount Submitted or "MA" in the Professional Service Code.

**Response:**

In this scenario, the pharmacy may resubmit the billing request with the appropriate Usual & Customary Charge.

### 16.3.4 Question: What Actions are Expected of the Pharmacy in the Scenario in Which a Billing Request for a Vaccine Product and Administration was Rejected by the Pharmacy Benefit Processor to Indicate that the Product is Reimbursable and the Administration Fee is Not Reimbursable?

**Response:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

When the pharmacy benefit processor denies the combined vaccine product and administration as not reimbursable, the pharmacy may determine that vaccine product only reimbursement is acceptable. In this scenario, the pharmacy must remove the "MA" (Medication Administered) from the Professional Service Code and remove the Incentive Amount Submitted (or submission of zero dollars) before re-submitting the billing request.

### 16.3.5 Question: Should the Submitted "Date of Service" Reflect the Date of the Billing Request or the Date in Which the Vaccine is Administered?

**Response:**

The submitted Date of Service must follow these scenarios:

- Billing for reimbursement of a Vaccine Product only – The Date of Service is the date that the vaccine product was dispensed.
- Billing for reimbursement of the Vaccine Product and Administration - The Date of Service is the date that the vaccine is administered.
- Billing for reimbursement of the Administration of a Vaccine Product with no associated product cost – The Date of Service is the date that the vaccine is administered.

### 16.3.6 Question: Can NCPDP Provide Inbound Billing Request Examples (Header, Claim, DUR/PPS, and Pricing Segments) for the following three vaccine claim billing examples?

1) Billing for reimbursement of Vaccine Product only
2) Billing for reimbursement of Vaccine Product and Administration
3) Billing for reimbursement of Administration of a Vaccine Product with no associated product cost

**Response:**

1) Billing for reimbursement of Vaccine Product only

*Only pertinent segments are shown.*

| Transaction Header Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 101-A1 | BIN Number | M | *610066* | |
| 102-A2 | Version/Release Number | M | *D0* | Transaction Format |
| 103-A3 | Transaction Code | M | *B1* | Rx Billing |
| 104-A4 | Processor Control Number | M | *1234567890* | |
| 109-A9 | Transaction Count | M | *1* | One occurrence |
| 202-B2 | Service Provider ID Qualifier | M | *01* | National Provider ID |
| 201-B1 | Service Provider ID | M | *4563663111bbbbb* | |
| 401-D1 | Date of Service | M | *20130915* | September 15, 2013 |
| 110-AK | Software Vendor/Certification ID | M | *bbbbbbbbbb* | |

| Claim Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *07* | Claim Segment |
| 455-EM | Prescription/Service Reference Number Qualifier | M | *1* | Rx billing |
| 402-D2 | Prescription/Service Reference Number | M | *1234567* | |
| 436-E1 | Product/Service ID Qualifier | M | *03* | NDC |
| 407-D7 | Product/Service ID | M | *66521011510* | Fluvirin 2012-2013 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| 442-E7 | QUANTITY DISPENSED | R | *500* | *0*.5 (ML) |
| 403-D3 | FILL NUMBER | R | *0* | Original dispensing for RX# |
| 405-D5 | DAYS SUPPLY | R | *1* | 1 Days supply |
| 406-D6 | COMPOUND CODE | R | *1* | Not a compound |
| 408-D8 | DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE | R | *0* | No product selection indicated |
| 414-DE | DATE PRESCRIPTION WRITTEN | R | *20130915* | September 15, 2013 |

| PRICING SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *11* | PRICING SEGMENT |
| 409-D9 | INGREDIENT COST SUBMITTED | R | *147l* | $14.79 |
| 412-DC | DISPENSING FEE SUBMITTED | Q | *50{* | $5.00 |
| 426-DQ | USUAL AND CUSTOMARY CHARGE | Q | *220{* | $22.00 |
| 430-DU | GROSS AMOUNT DUE | R | *197l* | $19.79 |
| 423-DN | BASIS OF COST DETERMINATION | Q | *01* | AWP |

Notes:

- When billing for a Product (without an administration ),
  - The submitted Transaction Code is a “B1” (Billing).
  - The claim Pricing Segment follows the Prescription Claim Request Formula.
  - The Product/Service ID Qualifier should be submitted with a value of the correct product (in this example “03” (NDC) and the Product/Service ID contain the NDC Number of the vaccine).
  - The Days Supply should be submitted with a value of “1”.
  - The Quantity Dispensed should be submitted with the value that represents the quantity of drug product administered.
  - The Professional Service Code of “MA” would not be sent.
  - An Incentive Amount associated to the administration is not submitted because the pharmacy is billing for the product only.

2) Billing for reimbursement of the Vaccine Product and Administration

*Only pertinent segments are shown.*

| TRANSACTION HEADER SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 101-A1 | BIN NUMBER | M | *610066* | |
| 102-A2 | VERSION/RELEASE NUMBER | M | *D0* | Transaction Format |
| 103-A3 | TRANSACTION CODE | M | *B1* | Rx Billing |
| 104-A4 | PROCESSOR CONTROL NUMBER | M | *1234567890* | |
| 109-A9 | TRANSACTION COUNT | M | *1* | One occurrence |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | M | *01* | National Provider ID |
| 201-B1 | SERVICE PROVIDER ID | M | *4563663111bbbbb* | |
| 401-D1 | DATE OF SERVICE | M | *20130915* | September 15, 2013 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| 110-AK | Software Vendor/Certification ID | M | *bbbbbbbbbb* | |

| Claim Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *07* | Claim Segment |
| 455-EM | Prescription/Service Reference Number Qualifier | M | *1* | Rx billing |
| 402-D2 | Prescription/Service Reference Number | M | *1234567* | |
| 436-E1 | Product/Service ID Qualifier | M | *03* | NDC |
| 407-D7 | Product/Service ID | M | *66521011510* | Fluvirin 2012-2013 |
| 442-E7 | Quantity Dispensed | R | *500* | 0.5 (ML) |
| 403-D3 | Fill Number | R | *0* | Original dispensing for RX# |
| 405-D5 | Days Supply | R | *1* | 1 Days supply |
| 406-D6 | Compound Code | R | *1* | Not a compound |
| 408-D8 | Dispense As Written (DAW)/Product Selection Code | R | *0* | No product selection indicated |
| 414-DE | Date Prescription Written | R | *20130915* | September 15, 2013 |

| DUR/PPS Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *08* | DUR/PPS Segment |
| 473-7E | DUR/PPS Code Counter | R | *1* | 1st DUR activity |
| 440-E5 | Professional Service Code | Q | *MA* | Medication Administered |

| Pricing Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *11* | Pricing Segment |
| 409-D9 | Ingredient Cost Submitted | R | *147I* | $14.79 |
| 412-DC | Dispensing Fee Submitted | Q | *50{* | $5.00 |
| 438-E3 | Incentive Amount Submitted | Q | *200{* | $20.00 |
| 426-DQ | Usual and Customary Charge | Q | *350{* | $35.00 |
| 430-DU | Gross Amount Due | R | *397I* | $39.79 |
| 423-DN | Basis of Cost Determination | Q | *01* | AWP |

Notes:

- When billing for a Product and Administration:
  - The submitted Transaction Code is a “B1” (Billing).
  - The submitted Prescription/Service Reference Number Qualifier (455-EM) is a “1” (Rx Billing)
  - The claim Pricing Segment follows the Prescription Claim Request Formula.
  - The Product/Service ID Qualifier should be submitted with a value of the correct product (in this example “03” (NDC) and the Product/Service ID contain the NDC Number of the vaccine).


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- The Days Supply should be submitted with a value of "1".
- The Quantity Dispensed should be submitted with the value that represents the quantity of drug product administered.
- The DUR/PPS Segment, with a "MA" (Medication Administered) in the Professional Service Code, is submitted to identify that the product was administered.
- The Incentive Amount Submitted is submitted to identify the pharmacy's charge for the vaccine administration.

3) Billing for reimbursement of Administration of a Vaccine Product with no associated product cost

In the situation where the vaccine product does not have an associated cost (e.g. free product) and the billed charges are for vaccine administration and product dispensing only, since the identification of the vaccine product is necessary, NCPDP recommends the use of a single B1/B3 billing transaction with the Basis of Cost Determination value "15" (Free product or no associated cost).

*Only pertinent segments are shown.*

| TRANSACTION HEADER SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 101-A1 | BIN NUMBER | M | *610066* | |
| 102-A2 | VERSION/RELEASE NUMBER | M | *D0* | Transaction Format |
| 103-A3 | TRANSACTION CODE | M | *B1* | Claim Billing |
| 104-A4 | PROCESSOR CONTROL NUMBER | M | *1234567890* | |
| 109-A9 | TRANSACTION COUNT | M | *1* | One occurrence |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | M | *01* | National Provider ID |
| 201-B1 | SERVICE PROVIDER ID | M | *4563663111bbbbb* | |
| 401-D1 | DATE OF SERVICE | M | *20130915* | September 15, 2013 |
| 110-AK | SOFTWARE VENDOR/CERTIFICATION ID | M | *bbbbbbbbbb* | |

| CLAIM SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *07* | CLAIM SEGMENT |
| 455-EM | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER | M | *1* | Claim billing |
| 402-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER | M | *7654321* | |
| 436-E1 | PRODUCT/SERVICE ID QUALIFIER | M | *03* | NDC |
| 407-D7 | PRODUCT/SERVICE ID | M | *66521011510* | Fluvirin 2012-2013 |
| 442-E7 | QUANTITY DISPENSED | Q | *500* | 0.5 (ML) |
| 403-D3 | FILL NUMBER | Q | *0* | Original dispensing for RX# |
| 405-D5 | DAYS SUPPLY | Q | *1* | 1 Days supply |
| 414-DE | DATE PRESCRIPTION WRITTEN | Q | *20130915* | September 15, 2013 |

| DUR/PPS SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *08* | DUR/PPS Segment |
| 473-7E | DUR/PPS CODE COUNTER | R | *1* | 1st DUR activity |
| 440-E5 | PROFESSIONAL SERVICE CODE | Q | *MA* | Medication Administered |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| PRICING SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *11* | PRICING SEGMENT |
| 409-D9 | INGREDIENT COST SUBMITTED | R | *0{* | $0.00 |
| 412-DC | DISPENSING FEE SUBMITTED | Q | *50{* | $5.00 |
| 438-E3 | INCENTIVE AMOUNT SUBMITTED | Q | *200{* | $20.00 |
| 426-DQ | USUAL AND CUSTOMARY CHARGE | Q | *350{* | $35.00 |
| 430-DU | GROSS AMOUNT DUE | R | *250{* | $25.00 |
| 423-DN | BASIS OF COST DETERMINATION | Q | *15* | Free product or no associated cost |

Notes:

- When billing for Administration of a Vaccine Product with no associated product:
  - The submitted Transaction Code is an "B1" (Claim Billing)
  - The submitted Prescription/Service Reference Number Qualifier (455-EM) is a "1" (Rx Billing)
  - The claim pricing segment follows the Prescription Claim Request Formula.
  - The Product/Service ID Qualifier should be submitted with a value of the correct product (in this example "03" (NDC) and the Product/Service ID contain the NDC Number of the vaccine).
  - The Days Supply should be submitted with a value of "1"
  - The Quantity Dispensed should be submitted with the value that represents the quantity of drug product administered
  - The DUR/PPS Segment, with a "MA" (Medication Administered) in the Professional Service Code, is submitted to identify that the product was administered.
  - The Incentive Amount Submitted is submitted to identify the pharmacy is seeking reimbursement for the administration of the product.
  - Basis of Cost Determination should be submitted with the value "15" (Free product or no associated cost)

### 16.3.7 QUESTION: WHEN SUBMITTING A PRESCRIPTION BILLING REQUEST FOR A VACCINE, WHAT VALUE SHOULD A PHARMACY SUBMIT IN THE DAYS SUPPLY?

**Response:**
When billing for a vaccine, it is recommended that the dispenser submit a value of 1 in the Days Supply.

### 16.3.8 QUESTION: WHICH NDC SHOULD BE SUBMITTED IN A VACCINE BILLING REQUEST WHEN A VACCINE HAS AN OUTER PACKAGE NDC AND AN INNER PACKAGE NDC?

**Response:**
The inner package NDC (the smallest package size provided with a unique NDC by the manufacturer) should be billed. For example, packages that have distinct inner package components will have a unique identifier on each component. If the company saleable unit is a box of 10 vials, the box of 10 vials will have an identifier that is different than the identifier on each vial. Refer to the ***NCPDP Product Identifiers Standard Implementation Guide***.

## 16.4 PHARMACY BENEFIT PROCESSING – PRIMARY CLAIMS

### 16.4.1 QUESTION: WHEN PROCESSING A VACCINE BILLING REQUEST USING THE NCPDP TELECOMMUNICATION STANDARD©, WHAT ARE THE RESPONSIBILITIES OF THE PHARMACY BENEFIT PROCESSOR?


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Response:**
The responsibilities of the pharmacy benefit processor, when processing a vaccine billing request using the NCPDP Telecommunication Standard©, are as follows:

- Identify the billing request scenario (Note: An "MA" (Medication Administered) in the Professional Service Code is the trigger that indicates if the billing request is also for a vaccine administration):
    1. Billing for reimbursement of **Vaccine Product only** or
    2. Billing for reimbursement of **Vaccine Product and Administration** or
    3. Billing for reimbursement of **Administration of a Vaccine Product with no associated product cost**
- Determine appropriateness of billing request scenario based on plan benefit design
    1. Vaccine product and administration covered under the pharmacy benefit
    2. Vaccine product covered, administration not covered under pharmacy benefit
    3. Vaccine product covered only when administered by the billing provider
    4. Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage not known
    5. Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage is known, but vaccine coverage unknown
    6. Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage for vaccine is known
- If claim billing request scenario is covered under the pharmacy benefit determine reimbursement structure. For example:
    1. Calculate product reimbursement
        1. Calculate Ingredient Cost Paid
        2. Calculate Dispensing Fee Paid
    2. Determine if vaccine administration fee is "Bundled" or "Separate"
        a. If "Bundled Reimbursement", use Incentive Amount Paid to balance total reimbursement
        b. If "Separate Reimbursement", calculate Incentive Amount Paid
    3. Calculate tax responsibilities
    4. Calculate Patient Pay Amount (Patient's financial responsibility)
    5. Calculate Total Amount Paid (Pharmacy receivable)
- If claim billing request scenario is not covered under the pharmacy benefit determine appropriate reject code(s)

#### *16.4.1.1 REJECT SCENARIO MATRIX*

| Billing Request Scenario for Vaccines | Vaccine product and administration covered under pharmacy benefit | Vaccine product covered, administration not covered under pharmacy benefit | Vaccine product covered only when administered by the billing provider | Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage not known | Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage is known, but vaccine coverage unknown | Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage for vaccine is known |
|---|---|---|---|---|---|---|
| Vaccine Product only:<br>Professional Service Code not equal to "MA"<br>Incentive Fee equal to $0 or not sent | N/A | N/A | ▪ "E3" (M/I Incentive Amount Submitted) **and**<br>▪ E5 (M/I Professional | ▪ "70" (Product/Service Not Covered – Plan benefit exclusion) | ▪ 816" (Pharmacy benefit exclusion, may be covered under patient's medical benefit.) | ▪ "817" (Pharmacy benefit exclusion, covered under patient's medical benefit.) |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Billing Request Scenario for Vaccines | Vaccine product and administration covered under pharmacy benefit | Vaccine product covered, administration not covered under pharmacy benefit | Vaccine product covered only when administered by the billing provider | Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage not known | Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage is known, but vaccine coverage unknown | Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage for vaccine is known |
|---|---|---|---|---|---|---|
| | | | Service Code), **and**<br>▪ Message: Vaccine administration by the billing provider required | | | ▪ Return Medical carrier information in the Additional Message Information (526-FQ) |
| Vaccine Product and Administration: Professional Service Code equal to "MA" Incentive Fee is greater than or equal to $0 | N/A | ▪ "818" (Medication administration not covered, plan benefit exclusion) | N/A | ▪ "70" (Product/Service Not Covered – Plan benefit exclusion)<br>▪ "818" (Medication administration not covered, plan benefit exclusion) | ▪ 816" (Pharmacy benefit exclusion, may be covered under patient's medical benefit.) | ▪ "817" (Pharmacy benefit exclusion, covered under patient's medical benefit.)<br>▪ Return Medical carrier information in the Additional Message Information (526-FQ) |
| Vaccine Administration & Other Applicable Fees: Ingredient Cost equal to $0, Basis of Cost Determination equal to "15", Professional Service Code equal to "MA" Incentive Fee greater than or equal to $0 | N/A | ▪ "818" (Medication administration not covered, plan benefit exclusion) | N/A | ▪ "70" (Product/Service Not Covered – Plan benefit exclusion)<br>▪ "818" – (Medication administration not covered, plan benefit exclusion) | ▪ 816" (Pharmacy benefit exclusion, may be covered under patient's medical benefit.) | ▪ "817" (Pharmacy benefit exclusion, covered under patient's medical benefit.)<br>▪ Return Medical carrier information in the Additional Message Information (526-FQ) |
| Intent of Billing Request Unknown:<br>Incentive Fee greater than $0, Professional Service Code not equal to MA | ▪ "R0" (Professional Service Code of "MA" required for vaccine Incentive Fee Submitted) | ▪ "E5" (M/I Professional Service Code) | ▪ "R0" (Professional Service Code of "MA" required for vaccine Incentive Fee Submitted) | ▪ "70" (Product/Service Not Covered – Plan benefit exclusion)<br>▪ "818" (Medication administration not covered, plan benefit exclusion) | ▪ 816" (Pharmacy benefit exclusion, may be covered under patient's medical benefit.) | ▪ "817" (Pharmacy benefit exclusion, covered under patient's medical benefit.)<br>▪ Return Medical carrier information in the Additional Message Information (526-FQ) |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Billing Request Scenario for Vaccines | Vaccine product and administration covered under pharmacy benefit | Vaccine product covered, administration not covered under pharmacy benefit | Vaccine product covered only when administered by the billing provider | Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage not known | Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage is known, but vaccine coverage unknown | Vaccine product and/or administration not covered under the pharmacy benefit, medical coverage for vaccine is known |
|---|---|---|---|---|---|---|
| Intent of Billing Request Unknown:<br>Incentive Fee not sent, Professional Service Code equal to MA | ▪ "E3" (M/I Incentive Amount Submitted) | ▪ "818" (Medication administration not covered, plan benefit exclusion | ▪ "E3" (M/I Incentive Amount Submitted) | ▪ "70" (Product/Service Not Covered – Plan benefit exclusion)<br>▪ "818" (Medication administration not covered, plan benefit exclusion) | ▪ 816" (Pharmacy benefit exclusion, may be covered under patient's medical benefit.) | ▪ "817" (Pharmacy benefit exclusion, covered under patient's medical benefit.)<br>▪ Return Medical carrier information in the Additional Message Information (526-FQ) |

*Note*: The new Reject Codes of "816", "817", "818" are not available for use until 10/15/2016. Until the Reject Codes are available for use, it is recommended that the processor return the Reject Code description as a text message in the Message (504-F4) or Additional Message Information (526-FQ) fields.

### 16.4.2 Question: When Processing a Billing Request for a Vaccine, What Value is Received in the Days Supply?

**Response:**

When processing a prescription billing request for a vaccine a value of "1" should be expected in the Days Supply.

### 16.4.3 Question: When Processing a Claim for a Vaccine Product and Administration, What is Meant by the Terms "Bundled Reimbursement" or "Separate Reimbursement"?

**Response:**

- "Bundled Reimbursement" refers to the scenario in which the contractual agreement applies a single reimbursement rate for the vaccine product and administration. The total reimbursement does not distinguish separate reimbursements for the vaccine product and administration service. NCPDP recommends that the pharmacy benefit processor calculate the vaccine product reimbursement first and use the Incentive Amount Paid to balance the financials.
- "Separate Reimbursement" refers to the scenario in which the contractual agreement separates the reimbursement rates for the vaccine product and administration.

### 16.4.4 Question: Can NCPDP Provide Response Examples (Claim, DUR/PPS, and Pricing Segments) for the Following Scenarios?

1. Billing for reimbursement of the Vaccine Product and Administration – Bundled Reimbursement
2. Billing for reimbursement of the Vaccine Product and Administration - Separate Reimbursement

**Response:**

1. Billing for reimbursement of the Vaccine Product and Administration – Bundled Reimbursement
   - The Ingredient Cost Paid is $12.51
   - The Dispensing Fee Paid is $2.00


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- The contracted Bundled Reimbursement is $30.00
- The Incentive Amount Paid is $15.49 ($30.00 (Bundled Reimbursement) less $12.51 (Ingredient Cost Paid) less $2.00 (Dispensing Fee Paid) equals $15.49 (Incentive Amount Paid)

*Only pertinent segments are shown.*

| Response Header Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 102-A2 | Version/Release Number | M | *D0* | Transaction Format |
| 103-A3 | Transaction Code | M | *B1* | Rx Billing |
| 109-A9 | Transaction Count | M | *1* | One occurrence |
| 501-F1 | Header Response Status | M | *A* | Accepted |
| 202-B2 | Service Provider ID Qualifier | M | *01* | National Provider ID |
| 201-B1 | Service Provider ID | M | *4563663111bbbbb* | |
| 401-D1 | Date of Service | M | *20130915* | September 15, 2013 |

| Response Status Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *21* | Response Status Segment |
| 112-AN | Transaction Response Status | M | *P or D* | Paid or Duplicate of Paid |

| Response Claim Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *22* | Response Claim Segment |
| 455-EM | Prescription/Service Reference Number Qualifier | M | *1* | Rx Billing |
| 402-D2 | Prescription/Service Reference Number | M | *1234567* | |

| Response Pricing Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *23* | Response Pricing Segment |
| 505-F5 | Patient Pay Amount | R | *100{* | $10.00 |
| 506-F6 | Ingredient Cost Paid | R | *125A* | $12.51 |
| 507-F7 | Dispensing Fee Paid | R | *20{* | $2.00 |
| 509-F9 | Total Amount Paid | R | *200{* | $20.00 |
| 521-FL | Incentive Amount Paid | Q | *154I* | $15.49 |
| 522-FM | Basis of Reimbursement Determination | R | *2* | Ingredient Cost reduced to AWP Pricing |
| 518-FI | Amount of Copay | Q | *100{* | $10.00 |

2. Billing for reimbursement of the Vaccine Product and Administration – Separate Reimbursement
   - The Ingredient Cost Paid is $12.51
   - The Dispensing Fee Paid is $2.00
   - The Incentive Amount Paid is $20.00


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

*Only pertinent segments are shown.*

| Response Header Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 102-A2 | Version/Release Number | M | *D0* | Transaction Format |
| 103-A3 | Transaction Code | M | *B1* | Rx Billing |
| 109-A9 | Transaction Count | M | *1* | One occurrence |
| 501-F1 | Header Response Status | M | *A* | Accepted |
| 202-B2 | Service Provider ID Qualifier | M | *01* | National Provider ID |
| 201-B1 | Service Provider ID | M | *4563663111bbbbb* | |
| 401-D1 | Date of Service | M | *20130915* | September 15, 2013 |

| Response Status Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *21* | Response Status Segment |
| 112-AN | Transaction Response Status | M | *P or D* | Paid or Duplicate of Paid |

| Response Claim Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *22* | Response Claim Segment |
| 455-EM | Prescription/Service Reference Number Qualifier | M | *1* | Rx Billing |
| 402-D2 | Prescription/Service Reference Number | M | *1234567* | |

| Response Pricing Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *23* | Response Pricing Segment |
| 505-F5 | Patient Pay Amount | R | *100{* | $10.00 |
| 506-F6 | Ingredient Cost Paid | R | *125A* | $12.51 |
| 507-F7 | Dispensing Fee Paid | R | *20{* | $2.00 |
| 521-FL | Incentive Amount Paid | Q | *200{* | $20.00 |
| 509-F9 | Total Amount Paid | R | *245A* | $24.51 |
| 522-FM | Basis of Reimbursement Determination | R | *2* | Ingredient Cost reduced to AWP Pricing |
| 518-FI | Amount of Copay | Q | *100{* | $10.00 |

### 16.4.5 Question: When Processing a Bundled Payment Claim, Can the Incentive Amount Paid be $0.00 or a Negative Dollar Amount?

**Response:**

Yes, the Incentive Amount Paid can be $0.00 or a negative dollar amount when processing a bundled payment because this field is used for balancing.

### 16.4.6 Question: When Processing a Pharmacy Billing Request for a Vaccine when the Pharmacy Benefit Processor Knows the Patient's Medical Benefit Covers the Vaccine Product, what Information is Returned by in the Claim?


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Response:**
In this scenario, the pharmacy benefit processor must return new Reject Code "817" (Pharmacy benefit exclusion, covered under patient's medical benefit) and return the name and Payer ID (if available) of the medical benefit carrier within the Additional Message Information (526-FQ). Until the new Reject Code is available, the processor should return Reject Code: "70" (Product not covered, plan benefit exclusion) with additional messaging indicating coverage is available under the medical benefit.

#### 16.4.7 Question: Does the Telecommunication Standard© Support the Billing from a Single Provider the Vaccine Product and the Administration Via Separate Transaction Types?

**Response:**
Yes, but while the Service transactions (S1/S3) support the billing of a service only, they do not support the identification of the billed service (vaccine administration) and the associated product (vaccine product that is administered). The Claim Billing transaction (B1) does support the identification of both the vaccine product and administration. To maintain standardization across the industry and to support coordination of benefits claims processing, NCPDP recommends the use of a single billing transaction for the billing of the vaccine product and the vaccine administration. Please refer to billing request example # 2 "*Billing for reimbursement of the Vaccine Product and Administration".*

In the situation where the vaccine product does not have an associated cost (e.g. free product) and the billed charges are for vaccine administration and product dispensing only, since the identification of the vaccine product is necessary, NCPDP recommends the use of a single claim billing transaction with the Basis of Cost Determination value "15" (Free product or no associated cost).

### 16.5 Coordination of Benefit Claims Processing

#### 16.5.1 Question: What Value does the Pharmacy Assign to the Other Payer Amount Paid Qualifier (342-HC) to Report the Vaccine Administration Fee (Incentive Amount Paid) Paid by the Previous Payer?

**Response:**
In Telecommunication Standard Version D.0©, a value of "05" (Incentive) should be submitted in the Other Payer Amount Paid Qualifier. Available in Telecommunication Standard Version E.1© and above, a value of "11" (Medication Administration) would be submitted in the Other Payer Amount Paid Qualifier (342-HC).

Note, the Other Payer Amount Paid values are reported based on the defined Total Amount Paid (509-F9) back-out order outlined within the section "*Other Amount Paid (565-J4) and COB*." Drug Benefit is calculated after all other amounts paid (e.g. Incentive Fee) have been backed out of Total Amount Paid (509-F9).

#### 16.5.2 Question: Can NCPDP Provide Other Payer Amount Paid COB Claim examples (COB Method 1) for the Following Two Scenarios?

- Billing for reimbursement of the Vaccine Product and Administration, and primary benefit was a bundled payment
- Billing for reimbursement of the Vaccine Product and Administration, and primary benefit was a separate payment

**Response:**
1. Billing for reimbursement of the Vaccine Product and Administration, and primary benefit was a bundled payment
   Primary claim response where bundled payment of $30 is represented across the response pricing fields
   - The Ingredient Cost Paid is $12.51


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- The Dispensing Fee Paid is $2.00
- The contracted bundled reimbursement is $30.00
- The Incentive Amount Paid is $15.49 ($30.00 (bundled reimbursement) less $12.51 (Ingredient Cost Paid) less $2.00 (Dispensing Fee Paid) equals $15.49 (Incentive Amount Paid))

*Only pertinent segments are shown.*

| Response Pricing Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *23* | Response Pricing Segment |
| 505-F5 | Patient Pay Amount | R | *100{* | $10.00 |
| 506-F6 | Ingredient Cost Paid | R | *125A* | $12.51 |
| 507-F7 | Dispensing Fee Paid | R | *20{* | $2.00 |
| 509-F9 | Total Amount Paid | R | *200{* | $20.00 |
| 521-FL | Incentive Amount Paid | Q | 154I | $15.49 |
| 522-FM | Basis of Reimbursement Determination | R | *02* | Ingredient cost reduced to AWP pricing |
| 518-FI | Amount of Copay | Q | *100{* | $10.00 |

COB Claim to Secondary Payer

| Transaction Header Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 101-A1 | BIN Number | M | *610066* | |
| 102-A2 | Version/Release Number | M | *D0* | Transaction Format |
| 103-A3 | Transaction Code | M | *B1* | Rx Billing |
| 104-A4 | Processor Control Number | M | *1234567890* | |
| 109-A9 | Transaction Count | M | *1* | One occurrence |
| 202-B2 | Service Provider ID Qualifier | M | *01* | National Provider ID |
| 201-B1 | Service Provider ID | M | *4563663111bbbbb* | |
| 401-D1 | Date of Service | M | *20130915* | September 15, 2013 |
| 110-AK | Software Vendor/Certification ID | M | *bbbbbbbbbb* | |

| Claim Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *07* | Claim Segment |
| 455-EM | Prescription/Service Reference Number Qualifier | M | *1* | Rx billing |
| 402-D2 | Prescription/Service Reference Number | M | *1234567* | |
| 436-E1 | Product/Service ID Qualifier | M | *03* | NDC |
| 407-D7 | Product/Service ID | M | *66521011510* | Fluvirin 2012-2013 |
| 442-E7 | Quantity Dispensed | R | *500* | 0.5 (ML) |
| 403-D3 | Fill Number | R | *0* | Original dispensing for RX# |
| 405-D5 | Days Supply | R | *1* | 1 Days supply |
| 406-D6 | Compound Code | R | *1* | Not a compound |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| 408-D8 | Dispense As Written (DAW)/Product Selection Code | R | *0* | No product selection indicated |
| 414-DE | Date Prescription Written | R | *20130915* | September 15, 2013 |
| 308-C8 | Other Coverage Code | R | *2* | Other coverage exists, payment collected |

| **DUR/PPS Segment** | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *08* | DUR/PPS Segment |
| 473-7E | DUR/PPS Code Counter | R | *1* | 1st DUR activity |
| 440-E5 | Professional Service Code | Q | *MA* | Medication Administered |

| **Pricing Segment** | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *11* | Pricing Segment |
| 409-D9 | Ingredient Cost Submitted | R | *147I* | $14.79 |
| 412-DC | Dispensing Fee Submitted | Q | *50{* | $5.00 |
| 438-E3 | Incentive Amount Submitted | Q | *200{* | $20.00 |
| 426-DQ | Usual and Customary Charge | Q | *350{* | $35.00 |
| 430-DU | Gross Amount Due | R | *397I* | $39.79 |
| 423-DN | Basis of Cost Determination | Q | *01* | AWP |

| **Coordination of Benefits/Other Payments Segment** | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *04* | Coordination of Benefits/Other Payments Segment |
| 337-4C | Coordination of Benefits/Other Payments Count | M | *1* | |
| 338-5C | Other Payer Coverage Type | M | *1* | Primary |
| 339-6C | Other Payer ID Qualifier | R | *03* | BIN # |
| 340-7C | Other Payer ID | Q | *999999* | ID assigned to payer |
| 443-E8 | Other Payer Date | Q | *20130915* | September 15, 2013 |
| 341-HB | Other Payer Amount Paid Count | R | *2* | Two occurrences |
| 342-HC | Other Payer Amount Paid Qualifier | R | *07* | Drug Benefit |
| 431-DV | Other Payer Amount Paid | Q | *45A* | $4.51 |
| 342-HC | Other Payer Amount Paid Qualifier | R | *05* | Incentive qualifier value to be used until value 11 – Medication Administration is available |
| 431-DV | Other Payer Amount Paid | Q | *154I* | $15.49 |

Secondary Payer applies separate payments (versus bundled payment) for vaccine drug product and administration. Negotiated price $12.51 + $2.00 + $20.00 = $34.51

- The Secondary's Ingredient Cost Paid Allowed Amount is $12.51
- The Secondary's Dispensing Fee Paid Allowed Amount is $2.00
- The Secondary's Incentive Amount Paid Allowed Amount is $20.00
- The Secondary's Other Payer Amount Recognized = $20.00 ($15.49 Primary Incentive Fee + $4.51 Primary Drug Benefit)


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Response Pricing Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *23* | Response Pricing Segment |
| 505-F5 | Patient Pay Amount | R | *{* | $0.00 |
| 506-F6 | Ingredient Cost Paid | R | *125A* | $12.51 |
| 507-F7 | Dispensing Fee Paid | R | *20{* | $2. 00 |
| 509-F9 | Total Amount Paid | R | *145A* | $14.51 |
| 521-FL | Incentive Amount Paid | Q | *200{* | $20.00 |
| 566-J5 | Other Payer Amount recognized | R | *200{* | $20.00 |
| 522-FM | Basis of Reimbursement Determination | R | *02* | Ingredient cost reduced to AWP pricing |
| 518-FI | Amount of Copay | Q | *{* | $*0*.00 |

Net amount to the pharmacy (Primary Bundled Payment/Secondary Separate Payment):
Primary Total Amount Paid (509-F9): $20.00
Secondary Total Amount Paid (509-F9): $14.51
Secondary Patient Pay Amount (505-F5): $ 0.00
Net Amount: $34.51

Alternate Scenario:
Secondary payer applies bundled payment (versus separate payment) for vaccine drug product and administration.
Negotiated bundled payment = $30.00

- The Secondary's Ingredient Cost Paid allowed amount is calculated as $12.51
- The Secondary's Dispensing fee allowed amount is calculated as $2.00
- The Secondary's Incentive Amount Paid Allowed amount is calculated as $15.49
- The Secondary's Other Payer Amount Recognized = $20.00 ($15.49 Primary Incentive Fee + $4.51 Primary Drug Benefit)

| Response Pricing Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *23* | Response Pricing Segment |
| 505-F5 | Patient Pay Amount | R | *{* | $0.00 |
| 506-F6 | Ingredient Cost Paid | R | *125A* | $12.51 |
| 507-F7 | Dispensing Fee Paid | R | *20{* | $2.00 |
| 509-F9 | Total Amount Paid | R | *100{* | $10.00 |
| 521-FL | Incentive Amount Paid | Q | *154I* | $15.49 |
| 566-J5 | Other Payer Amount recognized | R | *200{* | $20.00 |
| 522-FM | Basis of Reimbursement Determination | R | *02* | Ingredient cost reduced to AWP pricing |
| 518-FI | Amount of Copay | Q | *{* | $*0*.00 |

Net amount to the pharmacy (Primary Bundled Payment/Secondary Bundled Payment):
Primary Total Amount Paid (509-F9): $20.00
Secondary Total Amount Paid (509-F9): $10.00


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Secondary Patient Pay Amount (505-F5): $ 0.00
Net Amount: $30.00

2. Billing for reimbursement of the Vaccine Product and Administration and primary benefit was a separate payment

Primary claim response where separate payments apply to vaccine product and dispensing and vaccine administration

Negotiated price $12.51 + $2.00 + $20.00 = $34.51

- The Ingredient Cost Paid is $12.51
- The Dispensing Fee Paid is $2.00
- The Incentive Amount Paid is $20.00

*Only pertinent segments are shown.*

Primary Claim Response Pricing Segment:

| Response Pricing Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *23* | Response Pricing Segment |
| 505-F5 | Patient Pay Amount | R | *100{* | $10.00 |
| 506-F6 | Ingredient Cost Paid | R | *125A* | $12.51 |
| 507-F7 | Dispensing Fee Paid | R | *20{* | $2.00 |
| 521-FL | Incentive Amount Paid | Q | *200{* | $20.00 |
| 509-F9 | Total Amount Paid | R | *245A* | $24.51 |
| 522-FM | Basis of Reimbursement Determination | R | *2* | Ingredient Cost reduced to AWP Pricing |
| 518-FI | Amount of Copay | Q | *100{* | $10.00 |

COB Claim to Secondary Payer:

| Transaction Header Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 101-A1 | BIN Number | M | *610066* | |
| 102-A2 | Version/Release Number | M | *D0* | Transaction Format |
| 103-A3 | Transaction Code | M | *B1* | Rx Billing |
| 104-A4 | Processor Control Number | M | *1234567890* | |
| 109-A9 | Transaction Count | M | *1* | One occurrence |
| 202-B2 | Service Provider ID Qualifier | M | *01* | National Provider ID |
| 201-B1 | Service Provider ID | M | *4563663111bbbbb* | |
| 401-D1 | Date of Service | M | *20130915* | September 15, 2013 |
| 110-AK | Software Vendor/Certification ID | M | *bbbbbbbbbb* | |

| Claim Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *07* | Claim Segment |
| 455-EM | Prescription/Service Reference Number Qualifier | M | *1* | Rx billing |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| 402-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER | M | *1234567* | |
| 436-E1 | PRODUCT/SERVICE ID QUALIFIER | M | *03* | NDC |
| 407-D7 | PRODUCT/SERVICE ID | M | *66521011510* | Fluvirin 2012-2013 |
| 442-E7 | QUANTITY DISPENSED | R | *500* | 0.5 (ML) |
| 403-D3 | FILL NUMBER | R | *0* | Original dispensing for RX# |
| 405-D5 | DAYS SUPPLY | R | *1* | 1 Days supply |
| 406-D6 | COMPOUND CODE | R | *1* | Not a compound |
| 408-D8 | DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE | R | *0* | No product selection indicated |
| 414-DE | DATE PRESCRIPTION WRITTEN | R | *20130915* | September 15, 2013 |
| 308-C8 | OTHER COVERAGE CODE | R | *2* | Other coverage exists, payment collected |

| DUR/PPS SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *08* | DUR/PPS Segment |
| 473-7E | DUR/PPS CODE COUNTER | R | *1* | 1st DUR activity |
| 440-E5 | PROFESSIONAL SERVICE CODE | Q | *MA* | Medication Administered |

| PRICING SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *11* | PRICING SEGMENT |
| 409-D9 | INGREDIENT COST SUBMITTED | R | *147I* | $14.79 |
| 412-DC | DISPENSING FEE SUBMITTED | Q | *50{* | $5.00 |
| 438-E3 | INCENTIVE AMOUNT SUBMITTED | Q | *200{* | $20.00 |
| 426-DQ | USUAL AND CUSTOMARY CHARGE | Q | *350{* | $35.00 |
| 430-DU | GROSS AMOUNT DUE | R | *397I* | $39.79 |
| 423-DN | BASIS OF COST DETERMINATION | Q | *01* | AWP |

| COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *04* | COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT |
| 337-4C | COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT | M | *1* | |
| 338-5C | OTHER PAYER COVERAGE TYPE | M | *1* | Primary |
| 339-6C | OTHER PAYER ID QUALIFIER | R | *03* | BIN # |
| 340-7C | OTHER PAYER ID | Q | *999999* | ID assigned to payer |
| 443-E8 | OTHER PAYER DATE | Q | *20130915* | September 15, 2013 |
| 341-HB | OTHER PAYER AMOUNT PAID COUNT | R | *2* | Two occurrences |
| 342-HC | OTHER PAYER AMOUNT PAID QUALIFIER | R | *07* | Drug Benefit |
| 431-DV | OTHER PAYER AMOUNT PAID | Q | *45A* | $4.51 |
| 342-HC | OTHER PAYER AMOUNT PAID QUALIFIER | R | *05* | Incentive qualifier value to be used until value 11 for Medication Administration is available). |
| 431-DV | OTHER PAYER AMOUNT PAID | Q | *200{* | $20.00 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Secondary Payer applies separate payments (versus bundled payment) for vaccine drug product and administration. Negotiated price $12.51 + $2.00 + $20.00 = $34.51

- The Secondary's Ingredient Cost Paid Allowed Amount is $12.51
- The Secondary's Dispensing Fee Paid Allowed Amount is $2.00
- The Secondary's Incentive Amount Paid Allowed Amount is $20.00
- The Secondary's Other Payer Amount Recognized = $24.51 ($20.00 Primary Incentive Fee + $4.51 Primary Drug Benefit)

| RESPONSE PRICING SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *23* | RESPONSE PRICING SEGMENT |
| 505-F5 | PATIENT PAY AMOUNT | R | *{* | $0.00 |
| 506-F6 | INGREDIENT COST PAID | R | *125A* | $12.51 |
| 507-F7 | DISPENSING FEE PAID | R | *20{* | $2. 00 |
| 509-F9 | TOTAL AMOUNT PAID | R | *100{* | $10.00 |
| 521-FL | INCENTIVE AMOUNT PAID | Q | *2*00{ | $20.00 |
| 566-J5 | OTHER PAYER AMOUNT RECOGNIZED | R | *245A* | *2*4.51 |
| 522-FM | BASIS OF REIMBURSEMENT DETERMINATION | R | *02* | Ingredient Cost reduced to AWP Pricing |
| 518-FI | AMOUNT OF COPAY | Q | *{* | $*0*.00 |

Net Amount to the pharmacy (Primary Separate Payment /Secondary Separate Payment):

| | |
|---|---|
| Primary Total Amount Paid (509-F9): | $24.51 |
| Secondary Total Amount Paid (509-F9): | $10.00 |
| Secondary Patient Pay Amount (505-F5): | $ 0.00 |
| Net Amount: | $34.51 |

Alternate Scenario:

Secondary payer applies bundled payment (versus separate payment) for vaccine drug product and administration. Negotiated bundled payment = $30.00

- The Secondary's Ingredient Cost Paid allowed amount is calculated as $12.51
- The Secondary's Dispensing fee allowed amount is calculated as $2.00
- The Secondary's Incentive Amount Paid Allowed amount is calculated as $15.49
- The Secondary's Other Payer Amount Recognized = $20.00 ($15.49 Primary Incentive Fee + $4.51 Primary Drug Benefit)
    - Primary payer incentive amount paid was $20.00, however the Incentive Fee under the secondary's bundled payment amount is $15.49, therefore incentive amount recognized is $15.49
    - Drug benefit amount recognized is $4.51

| RESPONSE PRICING SEGMENT |
|---|


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| FIELD | FIELD NAME | CAT | VALUE | COMMENTS |
|---|---|---|---|---|
| 111-AM | SEGMENT IDENTIFICATION | M | *23* | RESPONSE PRICING SEGMENT |
| 505-F5 | PATIENT PAY AMOUNT | R | *{* | $0.00 |
| 506-F6 | INGREDIENT COST PAID | R | *125A* | $12.51 |
| 507-F7 | DISPENSING FEE PAID | R | *20{* | $2. 00 |
| 509-F9 | TOTAL AMOUNT PAID | R | *100{* | $10*.00* |
| 521-FL | INCENTIVE AMOUNT PAID | Q | *154I* | $15.49 |
| 566-J5 | OTHER PAYER AMOUNT RECOGNIZED | R | *200{* | *$20 00* |
| 522-FM | BASIS OF REIMBURSEMENT DETERMINATION | R | *02* | Ingredient Cost reduced to AWP Pricing |
| 518-FI | AMOUNT OF COPAY | Q | *{* | $*0*.00 |

Net Amount to the pharmacy (Primary Separate Payment/Secondary Bundled Payment):
Primary Total Amount Paid (509-F9): $24.51
Secondary Total Amount Paid (509-F9): $10.00
Secondary Patient Pay Amount (505-F5): $ 0.00
Net Amount: $34.51

### 16.5.3 QUESTION: WHAT VALUE SHOULD THE PHARMACY BENEFIT PROCESSOR RECOGNIZE IN THE OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) WHEN PROCESSING A COB BILLING REQUEST FOR A VACCINE PRODUCT AND ADMINISTRATION?

**Response:**
In Telecommunication Standard Version D.0©, a value of "05" (Incentive) should be recognized in the Other Payer Amount Paid Qualifier. Available in Telecommunication Standard Version E.1© and above, a value of "11" (Medication Administration) should be recognized in the Other Payer Amount Paid Qualifier, and the value of "05" would not be used in this situation.

### 16.5.4 QUESTION: HOW SHOULD THE PBM/PROCESSOR RESPOND TO AN NCPDP TELECOMMUNICATION STANDARD VERSION D.0© COORDINATION OF BENEFITS (COB) CLAIM THAT CONTAINS THE INDIVIDUAL OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT (OPPRA) COMPONENTS AND THE AGGREGATED PATIENT PAY AMOUNT?

**Response:**
Correctly formatted claims must contain **either** the Other Payer-Patient Responsibility Amount Qualifier (351-NP) value = 06 "Patient Pay Amount" **or** the individual OPPRA component(s). If the downstream payer/processor receives an improperly formatted COB Segment containing individual OPPRA components **and** the aggregated Other Payer-Patient Responsibility Amount Qualifier (351-NP) value = 06 and associated amount, the downstream payer/processor should reject the claim.

It is recommended to use Reject Code (511-FB) value = 443 – *Other Payer-Patient Responsibility Amount Grouping Incorrect* and messaging to provide additional information on the reason for the reject.

Sample Messaging:

Situation: The payer accepts the Other Payer-Patient Responsibility Amount Qualifier (351-NP) value = 06

Message: "Resubmit claim with OPPRA Count (353-NR) = 1 and OPPRA Qualifier (351-NP) = 06 and corresponding amount"


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Situation: The payer requires the pharmacy to pass through the specific patient pay fields in the OPPRA grouping
Message: “Resubmit claim with appropriate OPPRA Count (353-NR) along with OPPRA Qualifier (351-NP) values not including 06”

**Examples of how the COB/Other Payments Segment should be formatted using either the aggregate or the individual components**

**Example 1: Multiple discrete fields summing to patient pay amount**
Previous Payer Response:

| **RESPONSE PRICING SEGMENT (Excerpt)** | | | |
|---|---|---|---|
| Field | Field Name | Value | Comment |
| 111-AM | SEGMENT IDENTIFICATION | 23 | Response Pricing Segment |
| 505-F5 | PATIENT PAY AMOUNT | 260I | $26.09 |
| 509-F9 | TOTAL AMOUNT PAID | 500{ | $50.00 |
| 517-FH | AMOUNT APPLIED TO PERIODIC DEDUCTIBLE | 78C | $7.83 |
| 572-4U | AMOUNT OF COINSURANCE | 182F | $18.26 |

Request to Downstream Payer:
Example 1a. Request to Downstream Payer that Allows Patient Pay Qualifier 06:

| **COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT (Excerpt)** | | | |
|---|---|---|---|
| Field | Field Name | Value | Comment |
| 111-AM | SEGMENT IDENTIFICATION | 05 | COB/Other Payments Segment |
| 337-4C | COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT | 1 | One occurrence |
| 353-NR | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT | 1 | One occurrence |
| 351-NP | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER | 06 | Patient Pay Amount (505-F5) as reported by previous payer |
| 352-NQ | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT | 260I | $26.09 |

Example 1b. Request to Downstream Payer Using Discrete OPPRA Component(s)


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| COB OPPRA METHOD - COMPONENTS OF PATIENT PAY<br>COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT (Excerpt) | | | |
|---|---|---|---|
| Field | Field Name | Value | Comment |
| 111-AM | SEGMENT IDENTIFICATION | 05 | COB/Other Payments Segment |
| 337-4C | COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT | 1 | One occurrence |
| 353-NR | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT | 2 | Two occurrences |
| 351-NP | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER | 01 | Amount Attributed to Periodic Deductible as reported by previous payer |
| 352-NQ | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT | 78C | $7.83 |
| 351-NP | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER | 07 | Amount of Coinsurance as reported by previous payer |
| 352-NQ | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT | 182F | $18.26 |

Note: The qualifier 06 is not appropriate when the payer requests the discrete OPPRA components.

**Example 2: Single discrete field contributing to patient pay amount**

Previous Payer Response:

| RESPONSE PRICING SEGMENT (Excerpt) | | | |
|---|---|---|---|
| Field | Field Name | Value | Comment |
| 111-AM | SEGMENT IDENTIFICATION | 23 | Response Pricing Segment |
| 505-F5 | PATIENT PAY AMOUNT | 50{ | $5.00 |
| 509-F9 | TOTAL AMOUNT PAID | 500{ | $50.00 |
| 518-FI | AMOUNT OF COPAY | 50{ | $5.00 |

Example 2a. Request to Downstream Payer that Allows Patient Pay Qualifier 06:

| COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT (Excerpt) | | | |
|---|---|---|---|
| Field | Field Name | Value | Comment |
| 111-AM | SEGMENT IDENTIFICATION | 05 | COB/Other Payments Segment |
| 337-4C | COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT | 1 | One occurrence |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT (Excerpt) | | | |
|---|---|---|---|
| 353-NR | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT | 1 | One occurrence |
| 351-NP | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER | 06 | Patient Pay Amount (505-F5) as reported by previous payer |
| 352-NQ | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT | 50{ | $5.00 |

Example 2b. Request to Downstream Payer Using Discrete OPPRA Component(s)

| COB OPPRA METHOD - COMPONENTS OF PATIENT PAY<br>COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT (Excerpt) | | | |
|---|---|---|---|
| Field | Field Name | Value | Comment |
| 111-AM | SEGMENT IDENTIFICATION | 05 | COB/Other Payments Segment |
| 337-4C | COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT | 1 | One occurrence |
| 353-NR | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT | 1 | One occurrence |
| 351-NP | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER | 05 | Amount of Copay as reported by previous payer |
| 352-NQ | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT | 50{ | $5.00 |

Note: When the Other Payer-Patient Responsibility Amount Count (353-NR) is one, the Other Payer-Patient Responsibility Amount Qualifier (351-NP) does not have to be 06 – Patient Pay Amount (505-F5) as reported by previous payer. It may contain any Other Payer-Patient Responsibility Amount qualifier representing a discrete field contributing to patient pay.

Added 05/2025

## 16.6 USE OF SUBMISSION CLARIFICATION CODES AND COVID VACCINES

**Question:**

While only available under the Emergency Use Authorization (EUA), claims for US Government supplied COVID (EUA) vaccines had to be submitted with a dose-identifying Submission Clarification Code. Is a Submission Clarification Code (420-DK) value necessary for the new commercially available COVID vaccines (e.g.: COVID Vaccines 2023-2024) to identify a specific dose number?

**Response:**

No. As of the 9/11/2023 transition from the US Government supplied COVID (EUA) vaccines to the commercially available COVID vaccines, a Submission Clarification Code value is no longer necessary for processing NCPDP B1 claims for the vaccine and administration. The commercially available vaccines have been FDA approved (BLA) as single dose vaccines (refer to FDA Fact Sheets). Additionally, the


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

distinct AMA vaccine administration billing codes that were created for each COVID dose number (First, Second, Third, Booster) have been inactivated (Refer to the 8/14/2023 AMA COVID CPT Codes document reference).

Although pediatric vaccines are still under EUA, a Submission Clarification Code value is also no longer necessary on claims for these vaccines to indicate dose number(s).

*Added October 2023*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 17 UNIVERSAL CLAIM FORM (UCF)

## 17.1 EXPANDED DOLLAR AMOUNTS

**Question:**
How do I submit a dollar amount over $999,999.99 using the UCF?

**Response:**
When existing standard field lengths are not adequate to support business needs, trading partners should come to an agreement on how to utilize the Universal Claim Form for claim submission. This may include adding additional characters to a field. For example, drug costs in excess of $999,999.99 may require adding additional characters to the Ingredient Cost Submitted (UCF Field 81) and/or other currency fields. Trading partners should consider other downstream processes and data exchanges that may be impacted or may not support these larger dollar amounts.

*Added May 2019 – Expanded Dollar Fields TG*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 18 SAFE DISPOSAL OF MEDICATION

**Question:**
Many states and Federal programs require counseling on safe disposal of medication (e.g., opioids, controlled substances and other substances with environmental impact). There is also a variety of products available for the safe disposal of medication. How can the D.0 Telecommunication Standard© be used to submit a claim billing transaction for a safe disposal product and/or safe disposal counseling?

**Response:**
When billing a claim for a safe disposal product and/or safe disposal counseling, using the NCPDP Telecommunication Standard©, the pharmacy should first determine what scenario they are billing for:

1. Billing for a "**Safe Disposal Product Only**" or
2. Billing for a "**Safe Disposal Product and Counseling Service**" (may include re-billing or reversal/resubmission from product only to product and counseling service) or
3. Billing for a "**Counseling Service for a Safe Disposal Product with No Associated Product Cost**" (free product)
4. Billing of a "**Drug Product and Counseling Services for Safe Disposal**" (Safe Disposal may not use a safe disposal product)

Note: Billing for the Counseling Service for Safe Disposal without an associated product will be addressed in a different FAQ. It will be referred to WG1 Pharmacy Services Billing Task Group.

The scenario will allow the pharmacy to determine the appropriate values to submit in the DUR Segment, the Incentive Amount Submitted (438-E3), and the Basis of Cost Determination (423-DN).

Notes about pertinent fields and segments are shown in the tables below. Additional fields are required subject to NCPDP standards and trading partner agreement. It is recommended that if a payer provides reimbursement for counseling services for a safe disposal option in a claim billing transaction, that it is communicated in the payer sheet and/or a pharmacy bulletin.

| **Claim Segment** | | | | | | |
|---|---|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **1. Safe Disposal Product Only** | **2. Safe Disposal Product and Counseling Service** | **3. Counseling Service for a Safe Disposal Product with No Product Cost** | **4. Drug Product and Counseling Services for Safe Disposal** |
| 111-AM | Segment Identification | M | '07' (Claim Segment) | '07' (Claim Segment) | '07' (Claim Segment) | '07' (Claim Segment) |
| 455-EM | Prescription/Service Reference Number Qualifier | M | '1' (Rx Billing) | '1' (Rx Billing) | '1' (Rx Billing) | '1' (Rx Billing) |
| 402-D2 | Prescription/Service Reference Number | M | Unique number assigned by the pharmacy system. | Unique number assigned by the pharmacy system. | Unique number assigned by the pharmacy system. | Unique number assigned by the pharmacy system. |
| 436-E1 | Product/Service ID Qualifier | M | '03' NDC (for example) | '03' NDC (for example) | '03' NDC (for example) | '03' NDC (for example) |
| 407-D7 | Product/Service ID | M | Submit the appropriate Product/Service ID for the safe disposal product | Submit the appropriate Product/Service ID for the safe disposal product | Submit the appropriate Product/Service ID for the safe disposal product | Submit the appropriate Product/Service ID for the drug product |
| 442-E7 | Quantity Dispensed | R | Submit with the value that represents the quantity of safe disposal product dispensed | Submit with the value that represents the quantity of safe disposal product dispensed | Submit with the value that represents the quantity of safe disposal product dispensed | Submit with the value that represents the quantity of drug product dispensed |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | | | |
|---|---|---|---|---|---|---|
| 405-D5 | Days Supply | R | '1' (should be submitted with a one day supply) | '1' (should be submitted with a one day supply) | '1' (should be submitted with a one day supply) | Estimated number of days prescription fill will last |

If the claim being billed includes the counseling service (scenarios 2, 3, & 4), the Professional Service Code must be submitted which indicates request for reimbursement for patient education instruction.

| **DUR/PPS Segment** | | | | | | |
|---|---|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **1. Safe Disposal Product Only** | **2. Safe Disposal Product and Counseling Service** | **3. Counseling Service for a Safe Disposal Product with No Product Cost** | **4. Drug Product and Counseling Services for Safe Disposal** |
| 111-AM | Segment Identification | M | N/A | '08' (DUR/PPS Segment) | '08' (DUR/PPS Segment) | '08' (DUR/PPS Segment) |
| 440-E5 | Professional Service Code | Q | N/A | 'PE' (Patient Education/Instruction) Effective 20221015 'NM' (Non-medication counseling) should be used | 'PE' (Patient Education/Instruction) Effective 20221015 'NM' (Non-medication counseling) should be used | 'PE' (Patient Education/Instruction) Effective 20221015 'NM' (Non-medication counseling) should be used |

| **Pricing Segment** | | | | | | |
|---|---|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **1. Safe Disposal Product Only** | **2. Safe Disposal Product and Counseling Service** | **3. Counseling Service for a Safe Disposal Product with No Product Cost** | **4. Drug Product and Counseling Services for Safe Disposal** |
| 111-AM | Segment Identification | M | '11' (Pricing Segment) | '11' (Pricing Segment) | '11' (Pricing Segment) | '11' (Pricing Segment) |
| 409-D9 | Ingredient Cost Submitted | R | Submit the requested safe disposal product reimbursement amount | Submit the requested safe disposal product reimbursement amount | '0{' ($0) | Submit the requested drug product reimbursement amount |
| 412-DC | Dispensing Fee Submitted | Q | Submit the requested dispensing fee for the safe disposal product | Submit the requested dispensing fee for the safe disposal product | '0{' ($0) | Submit the requested dispensing fee for the drug product |
| 438-E3 | Incentive Amount Submitted | Q | N/A | Submit the requested incentive amount related to the counseling service | Submit the requested incentive amount related to the counseling service | Submit the requested incentive amount related to the counseling service |
| 426-DQ | Usual and Customary Charge | Q | Submit a U&C Charge | Submit a U&C Charge inclusive of safe disposal product and counseling service | Submit a U&C Charge for counseling service | Submit a U&C Charge inclusive of drug product and counseling service |
| 423-DN | Basis of Cost Determination | Q | Submit the appropriate Basis of Cost Determination value | Submit the appropriate Basis of Cost Determination value | '15' (Free product or no associated cost) | Submit the appropriate Basis of Cost Determination value |

Additional Considerations:

- Gross Amount Due (430-DU) should be calculated in accordance with the Request part of the Prescription Pricing Formulae as outlined in the Telecommunications Implementation Guide.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Incentive Amount Paid (521-FL) and other payer response fields should be accordance with the Response part of the Prescription Pricing Formulae as outlined in the Telecommunications Implementation Guide.
- Prescription Origin Code (419-DJ) may be required to bypass a payer's prescriber edits. The field should reflect whether the product was prescribed by a physician, pharmacist or other.
- The Professional Service Code (440-E5) of PE should be replaced with NM as of October 2022 annual ECL implementation.

Added November 2020, Updated August 2021

**Question:**
How should a payer/processor respond when a claim has been submitted for a safe disposal product and/or the counseling of a safe disposal product?

**Response:**
The claim response will vary depending on the specific billing scenario, if the product or service is covered, as well as what portion of the claim costs are covered. The first four scenarios are based on existing request billing transaction scenarios, and the fifth and sixth scenarios are new.

1. Billing for a "**Safe Disposal Product Only**"
2. Billing for a "**Safe Disposal Product and Counseling Service**" (may include re-billing or reversal/resubmission from product only to product and counseling service)
3. Billing for a "**Counseling Service for a Safe Disposal Product with No Associated Product Cost**" (free product)
4. Billing of a "**Drug Product and Counseling Services for Safe Disposal**" (Safe Disposal may not use a safe disposal product)
5. Incorrect Billing for a "**Safe Disposal or Drug Product and Incentive Fee without Associated Professional Service**"
6. Billing of a "**Drug Product with no Safe Disposal Counseling**" where payer indicates Safe Disposal Counseling may be a covered service or is required

In any scenario where the product or service is not covered, it is recommended that appropriate messaging be provided to identify additional options for further billing such as:

- An alternative covered product and/or service is available
- Another entity (e.g., medical) may cover that product or service
- An alternative method for billing the product or service may be needed

In any scenario where the claim has been rejected for "plan limitations exceeded", it is recommended that appropriate messaging be provided to clarify the limitation, specifically whether the limitation applied to the product and/or service.

1.1 Scenario 1 **– Billing for a "Safe Disposal Product Only"** – See possible claim response examples below:

| | | 112-AN | 511-FB | 548-6F | 506-F6 | 507-F7 | 521-FL | 509-F9 | 522-FM |
|---|---|---|---|---|---|---|---|---|---|
| **No** | **Response Scenario** | **Transaction Response Status** | **Reject Code** | **Approved Message Code** | **Ingredient Cost Paid** | **Dispensing fee paid** | **Incentive Amount Paid** | **Total Amount Paid** | **Basis of Reimbursement Determination** |
| 1.1a | Payer pays for product. | P (Paid) | N/A | N/A | Safe disposal product cost paid | Dispensing fee paid | N/A | Total amount paid | Code identifying how the reimbursement was calculated |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | 112-AN | 511-FB | 548-6F | 506-F6 | 507-F7 | 521-FL | 509-F9 | 522-FM |
|---|---|---|---|---|---|---|---|---|---|
| **No** | **Response Scenario** | **Transaction Response Status** | **Reject Code** | **Approved Message Code** | **Ingredient Cost Paid** | **Dispensing fee paid** | **Incentive Amount Paid** | **Total Amount Paid** | **Basis of Reimbursement Determination** |
| 1.1b | Payer rejects product as not covered. | R (Rejected) | 70 - Product/Service Not Covered - Plan/Benefit Exclusion | N/A | N/A | N/A | N/A | N/A | N/A |
| 1.1c | Payer rejects product for plan limitations exceeded. | R (Rejected) | 76 - Plan Limitations Exceeded | N/A | N/A | N/A | N/A | N/A | N/A |

1.2 Scenario 2 **– Billing for a "Safe Disposal Product and Counseling Service"** – See possible claim response examples below:

| | | 112-AN | 511-FB | 548-6F | 506-F6 | 507-F7 | 521-FL | 509-F9 | 522-FM |
|---|---|---|---|---|---|---|---|---|---|
| **No** | **Response Scenario** | **Transaction Response Status** | **Reject Code** | **Approved Message Code** | **Ingredient Cost Paid** | **Dispensing fee paid** | **Incentive Amount Paid** | **Total Amount Paid** | **Basis of Reimbursement Determination** |
| 1.2a | Payer pays for product & counseling service. | P (Paid) | N/A | N/A | Safe disposal product cost paid | Dispensing fee paid | Amount paid for counseling services rendered | Total amount paid | Code identifying how the reimbursement was calculated |
| 1.2b | Payer pays for safe disposal product but not the counseling service. | P (Paid) | N/A | *Effective 20221015: 053 (Drug/Product covered, Professional Service not covered) | Safe disposal product cost paid | Dispensing fee paid | $0.00 | Total amount paid | Code identifying how the reimbursement was calculated |
| | | | | | | | | | |
| 1.2c | Payer rejects safe disposal product and counseling, because safe disposal product not overed. | R (Rejected) | 70 - Product/Service Not Covered - Plan/Benefit Exclusion | N/A | N/A | N/A | N/A | N/A | N/A |
| 1.2d | Payer rejects safe disposal product and counseling, because plan limitations exceeded. | R (Rejected) | 76 - Plan Limitations Exceeded | N/A | N/A | N/A | N/A | N/A | N/A |

**New Approved Message Code will be available October 15, 2022; until then, there is no Approved Message Code that is recommended to be returned for that scenario.*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

1.3 Scenario 3 **– Billing for a "Counseling Service for a Safe Disposal Product with No Associated Product Cost" (free product)** – See possible claim response examples below:

| | | 112-AN | 511-FB | 548-6F | 506-F6 | 507-F7 | 521-FL | 509-F9 | 522-FM |
|---|---|---|---|---|---|---|---|---|---|
| **No** | **Response Scenario** | **Transaction Response Status** | **Reject Code** | **Approved Message Code** | **Ingredient Cost Paid** | **Dispensing fee paid** | **Incentive Amount Paid** | **Total Amount Paid** | **Basis of Reimbursement Determination** |
| 1.3a | Payer approves safe disposal product claim, only paying for the counseling service (per Basis of Cost Determination Submitted '15' - Free product or no associated cost). | P (Paid) | N/A | N/A | $0.00 | $0.00 | Amount paid for counseling services rendered | Total amount paid | 22 (Ingredient cost paid based on submitted Basis of Cost Free Product.) |
| 1.3b | Payer rejects safe disposal product and counseling, because safe disposal counseling not covered. | R (Rejected) | 70 - Product/Service Not Covered - Plan/Benefit Exclusion (Until 20221015)<br><br>Effective 20221015, use DE3 - Professional Service Not Covered - Plan/Benefit Exclusion | N/A | N/A | N/A | N/A | N/A | N/A |
| 1.3c | Payer rejects safe disposal product and counseling, because Safe disposal counseling plan limitations exceeded. | R (Rejected) | 76 - Plan Limitations Exceeded | N/A | N/A | N/A | N/A | N/A | N/A |
| 1.3d | Payer rejects safe disposal product and counseling, because Safe disposal product not covered, so counseling for the product is not covered. | R (Rejected) | *70 - Product/Service Not Covered - Plan/Benefit Exclusion | N/A | N/A | N/A | N/A | N/A | N/A |

**If the product may be or is covered under the medical benefit, it would be appropriate to return Reject Code 816 - Pharmacy Benefit Exclusion, May Be Covered Under Patient's Medical Benefit, or 817 - Pharmacy Benefit Exclusion, Covered Under Patient's Medical Benefit*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

1.4 Scenario 4 **– Billing for a "Drug Product and Counseling Services for Safe Disposal"** – See possible claim response examples below:

| | | 112-AN | 511-FB | 548-6F | 506-F6 | 507-F7 | 521-FL | 509-F9 | 522-FM |
|---|---|---|---|---|---|---|---|---|---|
| **No** | **Response Scenario** | **Transaction Response Status** | **Reject Code** | **Approved Message Code** | **Ingredient Cost Paid** | **Dispensing fee paid** | **Incentive Amount Paid** | **Total Amount Paid** | **Basis of Reimbursement Determination** |
| 1.4a | Payer pays for drug product and counseling service. | P (Paid) | N/A | N/A | Drug ingredient product cost paid | Dispensing fee paid | Amount paid for counseling services rendered | Total amount paid | Code identifying how the reimbursement was calculated |
| 1.4b | Payer pays for drug product but not the counseling. | P (Paid) | N/A | *Effective 20221015: 053 (Drug/Product covered, Professional Service not covered) | Drug ingredient product cost paid | Dispensing fee paid | $0.00 | Total amount paid | Code identifying how the reimbursement was calculated |
| 1.4c | Payer rejects product and counseling, because product not covered. | R (Rejected) | 70 - Product/Service Not Covered - Plan/Benefit Exclusion | N/A | N/A | N/A | N/A | N/A | N/A |
| 1.4d | Payer rejects product and counseling, because plan limitations exceeded. | R (Rejected) | 76 - Plan Limitations Exceeded | N/A | N/A | N/A | N/A | N/A | N/A |
| 1.4e | Payer rejects product and counseling, because safe disposal counseling not covered. | R (Rejected) | 70 - Product/Service Not Covered - Plan/Benefit Exclusion (Until 20221015)<br><br>Effective 20221015, use DE3 - Professional Service Not Covered - Plan/Benefit Exclusion | N/A | N/A | N/A | N/A | N/A | N/A |

**New Approved Message Code will be available October 15, 2022; until then, there is no Approved Message Code that is recommended to be returned for this scenario.*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

1.5 Scenario 5 **– Incorrect Billing for a "Safe Disposal or Drug Product and Incentive Fee without Associated Professional Service"**

The following response covers the billing request scenario where the claim is submitted for a safe disposal or drug product (non-vaccine) with an incentive fee, but no associated Professional Service code to indicate the reason for the incentive fee:

| | | 112-AN | 511-FB | 548-6F | 506-F6 | 507-F7 | 521-FL | 509-F9 | 522-FM |
|---|---|---|---|---|---|---|---|---|---|
| **No** | **Response Scenario** | **Transaction Response Status** | **Reject Code** | **Approved Message Code** | **Ingredient Cost Paid** | **Dispensing fee paid** | **Incentive Amount Paid** | **Total Amount Paid** | **Basis of Reimbursement Determination** |
| 1.5a | Payer rejects product and counseling because no Professional Service Code was submitted to account for the incentive amount submitted. | R (Rejected) | E5 - M/I Professional Service Code (Until 20221015)<br><br>Effective 20221015, Use DE4 - Professional Service Code Required when Incentive Fee is Submitted on Non-Vaccine Product. | N/A | N/A | N/A | N/A | N/A | N/A |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

1.6 Scenario 6 **– Billing of a "Drug Product with no Safe Disposal Counseling" where payer indicates Safe Disposal Counseling may be a covered service or is required**

The following responses cover the billing request scenarios where the claim is submitted for a drug product (non-vaccine) where there is no indication of counseling for safe disposal products with no Incentive Amount Submitted or associated Professional Service code to indicate that safe disposal counseling was performed. The payer communicates back to the pharmacy that the service is either required or covered.

| | | 112-AN | 511-FB | 548-6F | 439-E4 | 506-F6 | 507-F7 | 521-FL | 509-F9 | 522-FM |
|---|---|---|---|---|---|---|---|---|---|---|
| **No** | **Response Scenario** | **Transaction Response Status** | **Reject Code** | **Approved Message Code** | **Reason for Service Code** | **Ingredient Cost Paid** | **Dispensing fee paid** | **Incentive Amount Paid** | **Total Amount Paid** | **Basis of Reimbursement Determination** |
| 1.6a | Payer approves claim but indicates that counseling for safe disposal is covered. | P (Paid) | N/A | N/A | ED* | Drug ingredient product cost paid | Dispensing fee paid | N/A | Total amount paid | Code identifying how the reimbursement was calculated |
| 1.6b | Payer rejects drug claim because counseling for safe disposal is required for the product. | R (Rejected) | 88 | N/A | ED* | N/A | N/A | N/A | N/A | N/A |

*NOTES – Recommended messaging to accompany Reason for Service Code ED is as follows:

- DUR Free Text Message (544-FY) should contain "Safe Disposal Counseling" (30 characters)
- DUR Additional Text (570-NS) should contain additional payer instructions. (100 characters)

*Added August 2021*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 19 APPENDIX A. MODIFICATIONS TO THIS DOCUMENT

## 19.1 VERSION 2.0

Section "*Typographical Errors"* was added.

## 19.2 VERSION 3.0

**IMPORTANT:** Section "*Republication of Telecommunication Standard Implementation Guide Version D.0©*" was added.

## 19.3 VERSION 4.0

Section *"Date of Service (401-D1)"* was added to the section "*Typographical Errors*". Section "*Printable Characters*" added a clarification.

Section "*Long-Term Care (LTC) Pharmacy Claims Submission Recommendations for Version D.0*" was added.

## 19.4 VERSION 5.0

In section "*Typographical Errors"*, the following were noted:

In the Controlled Substance Reporting transaction, a "Note" on the Purchaser Segment inadvertently referenced the Patient Segment. It has been corrected to Purchaser Segment.

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

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

Subsection "*Claim Segment (07)*" has been added.
Subsection "*Patient Segment (01)*" has been added.
Section "*Response Segment Discussion*" has been added.

## 19.5 VERSION 6.0

Subsection "*Response Status Segment (21)*" has been added.
In section "*Typographical Errors"*, the following were noted:

In the Controlled Substance Reporting Reversal transaction, the Patient Segment chart was omitted. It has been added (version D.3).

In the Information Reporting Reversal diagrams, the Patient Segment was inadvertently included. The Patient Segment is not used in this transaction. It is deleted (version D.3).

In this section, under "*Telecommunication Standard Implementation Guide© Segments*", "*General*" subsection has been added.

In this section "*Appendix A. History of Document Changes Corrections"* was added.

## 19.6 VERSION 7.0

Question "*Pricing Segment (11)*", *"Clarification of net amount due in Coordination of Benefits"* has been added. This verbiage has been added to Telecom D.4.
Subsection "*Response Processing Guidelines*" has been added to "*Response Pricing Segment (23)*". This verbiage has been added to Telecom D.4.
Subsections "*Reject Code Guidance*" and "*Syntax Error*" have been added.
Question "*Benefit Stage*" has been added.
Question "*Health Plan-Funded Assistance Amount (129-UD)*" has been added.
Question "*Processor vs. Pharmacy Responsibility for Aggregating Other Payer Amounts*" was added.
Question "*Other Payer Coverage Type (338-5C) and Processing for Mid-Stream Payers*" was added.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 19.7 VERSION 8.0

An editorial correction was cited for the "*Response Coordination of Benefits/Other Payers Segment*". An editorial correction was cited for "*Internal Control Number (993-A7)"*.
An editorial correction was cited for "*Quantity Prescribed (460-ET)*".
An editorial correction was cited for "*Clinical Segment*".
The section "*Compound Segment (10)*" was added.
Section "*Pricing Segment (11)*", subsection "*Clarification of net amount due in Coordination of Benefits"* was updated.
Subsection *"Other Payer Amount Paid Qualifier (342-HC) Values Sunsetted"* was added.
Section *"Insurance Segment (04)", "Medicaid Indicator (360-2B)"* was added.
Section *"Appendix C. Medicare Part D and Multi-ingredient Compound processing"* was added as guidance only.
More guidance for Patient Residence was added from the May 2010 Work Group meetings in section "*Place of Service (307-C7) and Patient Residence (384-4X)*".

Section "*340B Processing*" was added.

In section "*Typographical Errors"*, Help Desk Phone Number Qualifier situation referred to the Number with field ID (550-F8).

## 19.8 VERSION 9.0

**IMPORTANT:** Section "*Republication of Telecommunication Standard Implementation Guide Version D.0©*", subsection "*August 2010*" was added.

Section "*Appendix D. Medicare Part D Topics*" was added.

To the extent possible, Coordination of Benefits questions and topics (excluding Medicare Part D) were moved to section "*Coordination of Benefits Information*".

Questions "*Three Options for Coordination of Benefits?*" and "*Multiple COB Options Per BIN/PCN?*" were added to the "*Coordination of Benefits Information*" section.

Section "*Other Coverage Code (308-C8)"* was added to the "*Request Segment Discussion*" section.

Section "*Not Used Data Element*" was added to the "*General Questions*" section.

Section ""*Other Payer Amount Paid Qualifier (342-HC) Values for Sales Tax"* was added.

In section "*Other Payer Amount Paid Qualifier (342-HC) Values Sunsetted*", the MSP calculation statements were incorrect. It said:
For MSP Calculations:

1. The Allowed amount = sum of Other Payer Amount Paid (431-DV) amounts (qualifiers applicable to MSP benefit) + sum of Other Payer-Patient Responsibility Amount (352-NQ) amounts
2. The Paid amount = sum of the Other Payer Amount Paid (431-DV) amounts (qualifiers applicable to the MSP benefit, e.g. 07 Drug Benefit)


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

3. The Co-insurance amount = Other Payer-Patient Responsibility Amount (352-NQ) amount where Other Payer-Patient Responsibility Amount Qualifier (351-NP) = 01 (Amount Applied to Periodic Deductible (517-FH) as reported by previous payer)
4. The Deductible amount = Other Payer-Patient Responsibility Amount (352-NQ) amount where Other Payer-Patient Responsibility Amount Qualifier (351-NP) = 05 (Amount of Copay (518-FI) as reported by previous payer)

Item 3 and 4 were incorrect. They have been corrected to
For MSP Calculations:

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

Section "*Claim Segment*" and "*Response Claim Segment*" were added to the "*Typographical Errors*" section.

Section "*Route of Administration (995-E2) and SNOMED Codes*" were added to the "*Claim Segment (07)*".

## 19.9 VERSION 10.0

Section "*Amount Attributed to Processor Fee (571-NZ)*" was added to the "*Response Pricing Segment (23)*".

Section "*Vaccine Administration*" was added to the "*General Questions*" section and the "*Appendix D. Medicare Part D Topics*" section.

Section "*Product/Service ID/Qualifier in Compounds*" and "*Dispense As Written (408-D8) Value 9 During Transition*" were added to section "*Request Segment Discussion", "Claim Segment (07)".*

Section "*BIN and PCN from Response to Request*" was added to the "*Appendix D. Medicare Part D Topics*" section.

A new question in section "*Benefit Stage*" has been added.

Section "*Additional Message Information Continuity (131-UG)*" has been added to "*Response Status Segment (21)"*.

Section "*Coupon Segment*", "*Prior Authorization Request And Billing Transaction*" was added due to an error in Telecom D.0.

## 19.10 VERSION 11.0

Section "*External Code List© Notables*" was added.

Question "*CMS Place of Service Codes?*" was added.

Additional information was added on the "*Route of Administration (995-E2) and SNOMED Codes*".


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Question "*Other Amount Paid (565-J4) and COB*" was added.

Question "*Other Payer Coverage Type (338-5C) is Unknown*" has been added.

*"Example 14: $100 Medicare Secondary Payer claim for brand drug; initial coverage limit already met; $500 remaining to meet TrOOP. Other Payer Amount Paid is $75" has been added.* All other examples in section "*Benefit Stage Rules and Examples*" were updated to show the Benefit Stage fields in the COB Segment.

Question "*Amount Attributed to Processor Fee (571-NZ)"* has added an additional clarification paragraph ("The enrollment fee must be received…..").

Section "*Response Patient Segment (29)*" has been added.

Question "*Medicaid ID Number (115-N5) and Cardholder ID (302-C2)*" has been added.

A typographical error was noted in section "*Controlled Substance Reporting (General) Examples*".

Section "*Dispensing Methodologies for LTC in PPACA*" has been added.

Section "*Benefit State Rules and Examples* "incorrectly referenced Total Amount Paid as 509-FN. The field id is 509-F9.

## 19.11 VERSION 12.0

Section "Typographical Errors", subsection "Telecommunication Standard Implementation Guide© Examples" has added "*Examples using Medigap ID (359-2A)*". Example "Billing – *Transaction Code B1 – Coordination of Benefits Scenarios Pharmacy Bills To Insurance Designated By Patient*" inadvertently listed Quantity Dispensed (442-E7) twice and in one subsection was missing Dispense As Written (408-D8).

Section "*Benefit Stage Qualifier values to Identify Claims Covered under the Not Part D portion of the Medicare D Plan"* has been added.

Section "*Notice of Appeal Rights*" has been renamed to "*Notice of Appeal Rights – Rejected Claim*". A new section "*Notice of Appeal Rights – Paid Claim*" has been added.

A new question was added to section "*Prescription Origin Code (419-DJ)*".

A new question "*Total Amount Paid (509-F9) Negative?*" was added.

A new question "*Adjust the Ingredient Cost Paid and Dispensing Fee Paid*" was added.

A new question "*Other Payer Amount Paid Qualifier (342-HC) Value 99?*" was added.

Section "*NCPDP Important External Code List© (ECL) Information*" was added.

## 19.12 VERSION 13.0

Section "Medicaid Subrogation Editorial Document" has been added. Section "*Medicaid Subrogation Claim Billing or Encounter*" has been copied from this document into the NCPDP ***Medicaid Subrogation Standard Implementation Guide Version 3.0© Questions, Answers and Editorial Updates*** document.

The "*CMS Place of Service Codes?*" link has been updated.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Section "*NCPDP Recommendations for 4Rx Usage in Medicare Part D Processing Documents*" has been added. Question "*Foreign Prescriber Identifier*" and "*Benefit Stage Required for Part D?"* have been added to the Medicare Part D section.

Question "*Total Amount Paid ((509-F9) Negative?*" includes additional guidance for two known business cases.

Section "*Workers' Compensation and COB*" was added.

Question "*Ingredient Cost Paid (506-F6) and Total Patient Responsibility Amount from Last Payer*" was added.

Section "*Other Payer Reject Code (472-6E*)" was added.

Question "*Other Payer-Patient Responsibility Amount (352-NQ) to each Payer?*" was added.

Question "*CMS' Definition of Primary Insurer's Payment*" was added.

Question "*Payable Components of Other Payer-Patient Responsibility Amounts*" was added.

Section "*Patient Paid Amount Submitted (433-DX)*" with questions has been added.

Section "*Use of Additional Message Information for Next Available Fill Date*" was added.

## 19.13 VERSION 14.0

A 10/2011 Update has been added to "*Route of Administration (995-E2) and SNOMED Codes*".

## 19.14 VERSION 15.0

Question "*Medicaid Pay only Applicable Components*" and "*Transition of Versions and COB*" have been added to section "*Coordination of Benefits Information*".

Question "*Government COB?*" was added to section "*Other Coverage Code (308-C8)*".

Question "*Component Pieces Not Sum to Patient Pay Amount?*" has been added to section "*Multiple COB Options Per BIN/PCN?*"

Question "*Valid Prescriber ID?*" was added to the Medicare Topic section.

The section "*Prescription Origin Code (419-DJ)*" was modified to remove the bullet "if" statements regarding transfers because they were written before the value 5 (Pharmacy - This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, intrachain transfers, file buys, software upgrades/migrations, and any reason necessary to "give it a new number." This value is also the appropriate value for "Pharmacy dispensing" when applicable such as BTC (behind the counter), Plan B, etc.) was added. This section also added new questions.

Section "*Reject Code "569" and Submission Clarification Code*" has been added to the "*Medicare Part D Topic*", "*Notice of Appeal Rights – Rejected Claim*" section.

Section "*Facility Segment*" has been added.

Section "*Use Of This Document*" includes information that when the Version D Editorial is published, it is effective for use. It was also added to the "*General Questions*" section.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

This question was removed from the document at this time because the WG1 Telecommunication FAQ Task Group felt that more information needed to be discussed and brought forward.

**Question:**

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

**Response:**

Use 1 (Written).

## 19.15 VERSION 16.0

Section "Response Status Segment (21)", subsection "*Additional Message Information Continuity (131-UG)*" the Comment in the table for the correct example had a typographical error for the Additional Message Information Qualifier (132-UH). For each value 01, 02, 03, etc., the comment should reflect the correct use statement "Used for first line of free form text with no pre-defined structure.", "Used for second line of free form text with no pre-defined structure.", "Used for third line of free form text with no pre-defined structure.", etc.

Section "*Coordination of Benefits Information*" added question "*Like Amounts Submitted as Incentive Fee*" and "*Drug Benefit*". Subsection "*Processor vs. Pharmacy Responsibility for Aggregating Other Payer Amounts*" added a new question.

Section "*Cost Share Calculation for Multi-Ingredient Compound Claims That Straddle the Coverage Gap and Catastrophic Phases*" was added to "*Appendix C. Medicare Part D and Multi-Ingredient Compound Processing*".

Section "*Basis of Reimbursement (423-DN) and Multi-Ingredient Compounds*" was added.

Question "*Additional Message Information Qualifier (132-UH) Appear More Than Once?*" was added.

Question "*Other Coverage Code (308-C8) to Submit When One Other Payer Has Paid $0?*" was added to section "*Other Coverage Code (308-C8)*".

In section "*Typographical Errors*", subsection "*Other Coverage Code (308-C8)"* was added.

## 19.16 VERSION 17.0

A correction for the SNOMED code for Mouth/Throat was added to "*Route of Administration (995-E2) and SNOMED Codes*". An important chart showing all the corrections since 2007 was added. "*Appendix E. Route of Administration Questions*" has been added.

**Important:** The section "*Prescription Origin Code (419-DJ)*" was modified to include the data element and values in the beginning of the section. **Responses to questions were modified** in section "*Use of Prescription Origin Code*".

**Question:**

If a prescriber sends an electronic prescription to a pharmacy, but the pharmacy is not "electronically prescribing-enabled yet" and the intermediary drops the prescription to fax, what Prescription Origin Code value would the pharmacy use on the claim submission? The Response was modified

From:

> Fax. If a prescriber sends an electronic prescription to a pharmacy, but the pharmacy is not "electronically prescribing-enabled yet" and the intermediary drops the prescription to fax, the Prescription Origin Code should represent how the prescription was received by the pharmacy.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

To:

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

**Question:**

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

From:

The prescriber sends an electronic prescription that the pharmacy cannot fill due to issues with the information received. If the pharmacy contacts the prescriber by telephone and as a result gets the information necessary to dispense, the Prescription Origin Code is 2 (Telephone) because the e-prescribing process did not provide a valid prescription.

If, as a result of the telephone call, the Prescriber cancels the original electronic prescription and sends a corrected electronic prescription that the pharmacy is able to dispense, then the Prescription Origin Code is 3 (Electronic - Prescription obtained via SCRIPT or HL7 Standard transactions.) because the e-prescribing process did result in a fillable prescription.

To:

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

New questions were added for Controlled Substance, Intermediate Care Facility, a tube, DAW clarification, and written authorization prescriptions to this section.

Section "*Duplicate Transaction*" was added to "*Response Status Segment (21)*".

Section "*Benefit Stage Implementation for 01/01/2013*" was added.

Sections "*Impact on Downstream Payer for Alternative/Formulary*", "*Other Impacts to Benefit Stage?*", "*Part D Sponsor Transition Notice or Denial Letter*", "*Coverage Gap and Amount Attributed to Coverage Gap (137-UP)*", and "*Non-Formulary Penalty and Coverage Gap*" were added.

## 19.17 VERSION 18.0

Section "*Hardcoded Values*" was added to "*Appendix D. Medicare Part D Topics*".
Section "*Dual Eligibility*" was added to "*Appendix D. Medicare Part D Topics*".
Section "*Prescriber Identification*" was added to "*Appendix D. Medicare Part D Topics*". Other questions in this section dealing with prescriber identification were moved into this section. Subsection "*Processing with Prescriber ID*" was added.

Section "*Foreign Prescriber Identifier*" was updated.

*From*

It is appropriate to use the value 08 State License qualifier for a foreign prescriber.

*To*

Prior to July 1, 2012, it is appropriate to use the value 08 State License qualifier for a foreign prescriber. The new value of 17 (Foreign Prescriber Identifier = a value used to identify a prescriber who practices outside of the United States and does not have a prescriber identifier issued from within the United States) was approved January 2012 and is available for use July 1, 2012. Please see the Emergency ECL document at http://www.ncpdp.org/Members/Standards-Lookup.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Section "*Days Supply (405-D5)*" and "*Unit of Measure (600-28) and Multi-Ingredient Compounds*" were added to "*Claim Segment (07)*".
Section "*Compound Ingredient Quantity (448-ED) Smaller than 3 Digits of Precision to the Right of the Decimal*" was added to "*Compound Segment (10)*".

## 19.18 VERSION 19.0

**Important:** Based on industry request, an enhancement was made to Telecommunication Standard Implementation Guide Version D.0 for Quantity Prescribed (460-ET). See section "*Enhancement of Telecommunication Standard Implementation Guide Version D.0© November 2012*".

Added references to the "*NCPDP Emergency Preparedness Resource*" information.

In section "*Route of Administration (995-E2) and SNOMED Codes*" the original mapping suggested the use of Intradermal. On the SNOMED file now, there is a Transdermal.

| | | | |
|---|---|---|---|
| 18 | Transdermal | 372464004<br>45890007 | Intradermal route (qualifier value)<br>Transdermal route (qualifier value) |

Question "*Like Amounts Submitted as Incentive Fee*" was updated with August DERF approval information.

Question "*Medicare Part D Claim Without Benefit Stage Fields?*" was added. Question "*Medicare Part D/Medicaid Benzodiazepine and Barbiturate Claims Processing Risks*" was added. A reference was also added to this section in "*Coordination of Benefits and Prior Authorization*".

Question "If a provider is on the OIG sanction list, disbarred from a government health care program, will this be reflected within NPI status on the NPI Registry?" was added to "*Prescriber Identification*" section. Question "Must the Part D Sponsor reject the Part D claim submitted with a foreign prescriber ID?" was added to section "*Foreign Prescriber Identifier*".

Question "*How can the NCPDP Telecommunication Standard© be leveraged to comply with the valid prescriber communication process required by CMS?*" was modified in section "*Processing with Prescriber ID*", as well as updates made to the matrix.

Section "*Prescriber ID and PDE Questions*" and "*Other Prescriber ID Questions*" were added.

Section "*Medicaid Allowed Amount and Prescription Response Formula*" was added.

In section "*Long-Term Care (LTC) Pharmacy Claims Submission Recommendations for Version D.0*" was updated to add more recent Special Packaging Indicator (429-DT) values, and section "Dispensing Methodologies for LTC in PPACA" was updated and is part of "*Appropriate Dispensing (Short Cycle) for LTC* ". Subsection "*Submission Clarification Code Combinations and Rejections*" and "*Appropriate Dispensing and Intermediate Care Facilities for* Individuals with Intellectual Disabilities (ICFIID) *and Institute of Mental Disease (IMD)*" were added.

Sections "*Notice of Appeal Rights – Rejected Claim*" and "*Notice of Appeal Rights – Paid Claim*" were designated with the following statement:
This applies to D.0 claims submitted on or after January 1, 2012. Modifications are denoted below in a new section stating "This applies to D.0 claims submitted on or after July 1, 2013".
Two new sections were created "*Notice of Medicare Drug Coverage Rights – Rejected Claim*" and "*Notice of Medicare Drug Coverage Rights – Paid Claim*" for the statement:
"This applies to D.0 claims submitted on or after July 1, 2013".

Section "*Benefit Stage Implementation for 07/01/2013*" was added.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 19.19 VERSION 20.0

Section "*Medigap ID (359-2A) Use*" was added to "*Insurance Segment (04)*".

Question "*Other Carrier Payment Meets or Exceeds Payable*" was added to "*Appendix D. Medicare Part D Topics*".

Question "*Total Amount Paid (509-F9) Negative?*" subsection "Transaction Click Fees" was updated to include bullets marked "(Added Version 20)".

Questions were added to section "*Prescriber Identification*", subsection "*Prescriber ID and PDE Questions*". A question was added to "*Valid Prescriber ID?*" section.

Questions "*Correct Telecom Version?*" and "*Leave Off Ingredients that are Identifiable by the Pharmacy and the Payer*" were added to section "*Compound Segment (10)*".

References to IDM were changed to IMD - Institute of Mental Disease.

Section "*Pricing Segment (11)*", subsection "*340B Processing*", an editorial note was added showing the complete definition of the values cited in the response.

## 19.20 VERSION 21.0

**Important:** Based on industry request, an enhancement was made to Telecommunication Standard Implementation Guide Version D.0 for Quantity Prescribed (460-ET). See section "*Enhancement of Telecommunication Standard Implementation Guide Version D.0© November 2012*". This section was updated with information 03/2013.

## 19.21 VERSION 22.0

Section "*Reversals and COB*" was added.

Section "*Recommendations on the Submission of Identifiable Ingredients that are Not Recognized by the Payer*" was added to "*Compound Segment (10)*".

The response to question "*Does CMS expect Part D Sponsors to validate the DEA Schedule down to the Narcotic/Non-Narcotic level?*" was modified in section "*Prescriber Identification*" to include information on the CFR and validation rules to assist implementers. Question "*Can CMS Assist with Industry Outreach for Entities that need Type 1 NPIs?*" was added to section "*Prescriber Identification*".

Question "*How should the Medicare Part D prescription claim and PDE be processed in the situation where the prescriber is not a HIPAA covered entity and refuses to obtain a Type 1 NPI? "* and "*How should the Medicare Part D prescription claim and PDE be processed in the situation with a deceased prescriber who did not obtain an NPI (where state law allows subsequent fills to process after a prescriber's death)?*" were added to section "*Prescriber ID and PDE Questions*". Question "*How should plan sponsors handle a controlled substance prescription claim where the prescriber's individual Type 1 NPI is submitted, however the prescriber is acting under the DEA registration of the hospital, to which the prescriber DEA registration ID field will be blank on the plan's prescriber data base?*" was added to section "*Valid Prescriber ID?*"

Section "*Long-Term Care (LTC) Pharmacy Claims Submission Recommendations For Version D.0*" was updated to clarify

- Two Patient Residence codes be used for qualifying LTC and only one code be used for Assisted Living.
- Paragraph "Prior to the CMS requirements for Appropriate Dispensing…" was added.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Recommendations were clarified. Pharmacy Service Type (147-U7) now recommends to see the External Code List©.
- Subsection "*Date of Service for LTC Billing Claim*" was added.
- The statement "Note, the regulatory requirement to dispense in 14 day or less increments is not directly linked to billing in equivalent increments" was added.
- "Note, although the CMS mandate applies to Brand Oral Solid Drugs…." was added.
- The bullet "All other SCC values are acceptable…" was added.
- The statement "The above are the old valid SCC values…" was added under the table of Submission Clarification Code values appropriate for LTC Short Cycle.
- The statement "The payers must accept the Patient Residence (384-4X) value for ICFMR/IMD…" was clarified.

## 19.22 VERSION 23.0

**Important updates were added to section "*Quantity Prescribed (460-ET)*".**

From the Data Dictionary©, section "*Appendix C – Telecommunication Phases with Flow Charts*" was moved into this document into section "General Questions", "Reject Code Guidance", "*Telecommunication Phases with Flow Chart*".

Question "A prescriber's DEA registration is expired and can only write scripts for schedules III – V in the plan's data base. The claim is for a schedule II medication….." was added to section "*Valid Prescriber ID?*"

Subsection "*Pricing Segment Contains Values 'as if' the Claim was Primary*" has been added to "*Pricing Segment (11)*". A reference to this same section was added in "*Coordination of Benefits Segment (05)*".

Subsection "*Brand Medically Necessary*" has been added to "*Response Pricing Segment (23)*".

Subsection "*Military Treatment Facilities – Government Billing the Government*" has been added to "*Appendix D. Medicare Part D Topics*".

Eligibility Verification examples from the Telecommunication Standard Implementation Guide© that were specific to Medicare Part D processing were moved into this document so as program changes occur, the implementation guide would not need to be modified. The examples were updated for more current dates and more concise scenarios. See section "*Eligibility Verification Examples*".

## 19.23 VERSION 24.0

For clarity when Reject Code (511-FB) values are referenced, the values in quotes show the 2 digit or 3 digit length as appropriate. The field is 3 digits so a trailing space is allowed, but can be truncated.

Section "*Improving the Value of the Claim Response with Additional Messaging*" was added with important guidance for the industry.

Reject Code value "43" was modified to remove "or expired". This is found in section "*Valid Prescriber ID?*" and the "Definition" matrix. Background:

> *Effective in May 2013, the Drug Enforcement Administration (DEA) changed the record layout for the DEA CSA database by adding a field for Activity - Active/Inactive. A value of "Active" indicates that the registrant is authorized for handling of controlled substances in the schedules and "Inactive" indicates the registrant is not authorized for handling of controlled substances in any schedule. With this new field, it becomes possible for an expired DEA registration to continue to be Active and authorized to prescribe for controlled substances (this scenario would indicate that the DEA number is still within the renewal process).*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Question "How should plan sponsors handle a controlled substance prescription claim where the prescriber's individual Type 1 NPI is submitted, however the prescriber is acting under the DEA registration of the hospital, to which the prescriber DEA registration ID field will be blank on the plan's prescriber data base?" in section "*Valid Prescriber ID?*" was updated to include clarification from CMS following the May 2013 HPMS memo.

In order to accurately reflect the data currently available from the DEA, the description of Reject Code (field 511-FB) "43" should be changed from Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive or expired to Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive.

Section "*ICD-9 Versus ICD-10 Information*" was added to "*General Questions*".
Section "*Veterinarian Identifiers*" was added to "*Valid Prescriber ID?"*
Section "*Long-Term Care (LTC) Pharmacy Claims Submission Recommendations for Version D.0*" subsection "*Qualifying the Pharmacy Service*" under "Home Infusion Therapy"

*Pharmacy Service Type (147-U7)* was updated

From

~~Please refer to the most current implemented version of the External Code List© for all valid values. Plans should be aware that they may receive Assisted Living Facility claims from any available "Pharmacy Service Type".~~

To

For a Home Infusion Therapy Provider Service use value = "3".

## 19.24 VERSION 25.0

Section "*Billing Transaction For Free Fills*" was added under "*Pricing Segment (11)*".
Section "*Use of This Document*", subsection "*How Soon Support This Document?*" was updated. The same question was updated in section "*General Questions*", "*How Soon Support This Document?*"

**Question:**
Once the Version D Editorial is published, how soon do implementers need to support?
**Response:**
When the Version D Editorial is published, it is effective for use.

Was modified to:

**Question:**
Once the Version D Editorial is published, how soon do implementers need to support?
**Response:**
When the Version D Editorial is published, it is effective for use *immediately unless the specific section or response lists an effective date*.

Section *"Appendix G. Support of This Document"* was added.

Section "*Benefit Stage Implementation for 10/01/2014*" was added with value "63".

## 19.25 VERSION 26.0

Section "*Quantity Prescribed (460-ET)*" was updated with information received 03/2014.

Section "*Multi-Ingredient Compound Processing*" was added. Questions from the "*Compound Segment*" section were moved into this section. Question "*Correlate Complexity in Compounding and DUR/PPS Level of Effort (474-8E)*" was added. Subsection "*Compound Ingredient Product Identifier and Qualifier Use*" was added.

Section "*Definition of a Valid Prescriber Matrix*" has added two rows (Medicare D claim: prescriber NPI is not listed on the Medicare D prescriber active enrollment file and Medicare D claim: prescriber NPI is listed on the


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Medicare D prescriber enrollment file as terminated.) and added a note to other rows (designated May 2014). Clarification was made in the document and the matrix:

From:
"PDEs will not reject if the Date of Service on the PDE is greater than or equal to the NPI deactivation date plus one year. This is true regardless of the reason for deactivation."

To:
"PDEs will not reject if the Date of Service on the PDE is < or = (NPI deactivation date + 1 year), regardless of the reason for deactivation."

A note was added after the chart in section "*Other Payer Reject Code (472-6E)*" to call out for the future that this chart was updated in Telecommunication version E6.

## 19.26 VERSION 27.0

Section "*Quantity Prescribed (460-ET)*" was updated with 08/2014 information.

Section "*Prescription Origin Code (419-DJ)*" and "*Important Note*" was updated to include information about the modification to the External Code List© description for Prescription Origin Code value 3 (Electronic) ", or electronically within closed systems" which was approved 08/2014. Per the Emergency ECL implementation recommendations, the modification is available to be used 04/01/2015.

Section "*Definition of a Valid Prescriber Matrix*" added one row (No active state license with prescriptive authority associated to submitted prescriber ID).

Question "*Part D Sponsors Applying Medicare Secondary Payer (MSP) Requirements*" was added.

Section "*Recommendations for Claim Reversal Processing for Telecommunication Version D.0*" was added.

## 19.27 VERSION 28.0

Section "*Prescription/Service Reference Number (455-EM) Value "3"*" was added to document the change.

Section "*Vaccine Services – Pharmacy Benefit Billing & Processing*" was added, with Effective Date: August 2015 in preparation for the flu season.

Subsection "*Dollar Field Not Received*" has been added to section "*Coordination of Benefits Information*".

## 19.28 VERSION 29.0

Section "Inactive State License" was added

The first question in Section" Processing with Prescriber ID" was modified.

Question "Does the 24 hour follow up requirement outlined under CMS 4157 (highlighted below) apply in any manner to Medicare Part D prescription claims submitted as of the enforcement date of CMS 4149 (§ 423.120(c)(5) and (6))?" was added to Section "Other Prescriber ID Questions"

## 19.29 VERSION 30.0

Sections "When should Reject Code 84 be used?", "Prescriber ID Rejections" and "State License Questions" were added.

Section "Specific Data Field Use Recommendations" and its' subsections were modified.

## 19.30 VERSION 31.0


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Sections "Negative Patient Pay Values" and "Date of Service (401-D1)" were added. An additional note was added to Section "Notice of Medicare Drug Coverage Rights – Rejected Claim".

## 19.31 VERSION 32.0

Sections "*ICD-10 Submission*", "*Level of Service*", "*Prescriber Segment (03)*", "*Provider Fees*" and "*Provisional Fill*" were added.

## 19.32 VERSION 33.0

Section "*Processing with Prescriber ID*" was modified. Sections "*Information Reporting Transactions*", "*How can the payers and providers leverage the NCPDP standard to comply with Section 507 of the MACRA legislation?*" and "*Appendix F. Point of Service Prescriber Validation Guidance Applicable to CMS 4159 and IFC 6107*" were added.

## 19.33 VERSION 34.0

An additional question was added to Section "340B Processing" Sections "Processing with Prescriber ID" and "Appendix F. Point of Service Prescriber Validation Guidance Applicable to CMS 4159 and IFC 6107" were modified.

## 19.34 VERSION 35.0

The response to "Provisional Fill" was updated. An additional "Question and Answer" was added to Appendix F. Many sections were modified by replacing the terms fill and refill with dispense/dispensing/dispensed.

## 19.35 VERSION 36.0

The following additional questions and responses were added: 3.1.10, 6.3.5, 6.3.6, 6.9 and 15.10.

## 19.36 VERSION 37.0

DERF 1482 changed the following terms in this document:

- Intermediate Care Facility /Mentally Retarded to Intermediate Care Facility/Individuals with Intellectual Disabilities
- ICFMR to ICFIID
- Mentally Retarded to Intellectually Disabled

DERF 1469 – a new question and response was added to Section 6.3.3 – Prescriber ID Rejections

Definition of a Valid Prescriber TG modified a response in Section 6.3.3 – Prescriber ID Rejections

Added Section 6.10 – UDI Conversion

## 19.37 VERSION 38.0

The COB TG added questions 10.12 and 10.13

The Compound TG revised the response to question 15.8

The FAQ TG added question 6.9

## 19.38 VERSION 39.0

Section 9 was replaced.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

The FAQ TG added question 6.1

## 19.39 VERSION 40.0

The COB TG added question 3.1.3.2

A new Section, Guidance for Opioid Limits, was added.

Sections 9.3.6, 9.3.8, and 9.5.2 were updated as a result of the WG14 LTPAC Billing Issues. Also refer to DERF 001581/ECL 000257.

## 19.40 VERSION 41.0

Corrected the values and descriptions in *Guidance for Opioid Limits - Claim Rejections*, **Recommended DUR Result of Service Codes** (441-E6). In the same section, **Long Term Care Exemptions to Opioid Policy** was added.

Added Section – Response Insurance Segment to address a question around the use of Network Reimbursement ID (545-2F).

## 19.41 VERSION 42.0

Section 7 – *Guidance for Opioid Limits* was replaced.

## 19.42 VERSION 43.0

Section 7 – *Guidance for Opioid Limits* was replaced.

Section 20.27 – Updated the eligibility timeframe for a Medicare Part D Eligibility Verification Transaction. This information is an update to what is published in the Implementation Guide.

Section 22 – Update added due to CMS rule.

Section 6.13 was added to provide guidance on drug recalls.

## 19.43 VERSION 44.0

Added question 10.12 - **OPPRA (352-NQ) Field Length Greater Than $999,999.99**

Section 7 – *Guidance for Opioid Limits* was replaced.

## 19.44 VERSION 45.0

Section 14.2.1.4 – Corrected typographical error.

Section 14.2.1.1 – Removed duplicates from the table.

Section 3.5.1 – Patient Residence (384-4X): Updated code description for Value 6 and updated name and code description for Value 15.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 19.45 VERSION 46.0

Updated the Quantity Prescribed Section.

Updated the CMS Place of Service Codes URL.

Added a Service Provider ID question and answer.

Updated the answer for question - Which NCPDP ECL Values (Reject Code, SCC, Approved message Code) should be used for Medicaid Ordering Referring Provider Requirements?

Added a Preferred Product Cost Share Incentive question and answer.

Added a new section – Universal Claim Form

Updated the Member Opioid/Benzodiazepine Lock-In Scenario – removed reject code 569

## 19.46 VERSION 47.0

Revised Date of Service for LTPAC Billing Claim Section

Modified MME Hard Stop; POS Override Not Allowed; Prescriber to Call Plan (potentially >200) Scenario Description of B9 and B11

Modified MME Prescriber Care Coordination Required (90-200, or >90) Scenario Description of C9 and C11

Modified Duplicative Therapy Soft Edit - Long Acting Opioids Scenario Description of D9 and D11

Modified Concurrent Use of Opioids & Benzodiazepines Scenario Description of E9 and E11

Modified Member Opioid/Benzodiazepine Lock-In by renumbering the scenario descriptions and adding two additional reject codes to Scenarios F1 and F2.

## 19.47 VERSION 48

Added new question and response to Section 10.13 Government COB

Revised 6.4.6 RPh Prescriptive Authority Validation

Modified Guidance for Opioid Limits.

Added Section 3.1.10.1 - Shortened Days Supply SCC Values

Added Section 3.1.10.2 - Approved Message Code and Shortened Days Supply SCC

Added Section 6.14 - Claim Adjudication Process for Opioid Utilization Rules

Added Section 3.5.2 – Species


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 19.48 VERSION 49

Added Section 10.2.5 - Medicare/Medicaid Part B COB

Modified the response to the following question in 6.4.3 - Prescriber ID Rejections: There are various provider exclusion files maintained by government entities, such as OIG excluded providers, Medicaid exclusions, CMS preclusions, etc. Can Reject Code A1 be used regardless of which exclusion file contains the submitted Provider/Prescriber ID?

Added the question - When a claim rejects based on a prescriber validation error, can the data source that triggered the reject be identified as part of the response? to Section 6.4.3 – Prescriber ID Rejections.

Modified Section 3.1 Quantity Prescribed (460-ET)

Deleted the Section on Place of Service (307-C7) and Patient Residence (384-4X) transition from Version 5.1 to Version D.0

## 19.49 VERSION 50

Corrected a field identifier in Section 4.3.5 – Total Amount Paid (509-F9) Negative? - Cash Discount Card Programs, second bullet.

Added Section on Emergency Fill

Added Section on Quantity Prescribed/Quantity Dispensed and Approved Message Code

Added Section on Quantity Prescribed and Quantity Dispensed

Added Section on LTC Service Outside of an LTC Setting

## 19.50 VERSION 51

Added Section on Safe Disposal of Medication

Added Section on Quantity Prescribed 30-day Reference

## 19.51 VERSION 52

Added Section on Communication of the Medicaid Benefit responsible for QMB Program Medicare Part B Coordination

## 19.52 VERSION 53

Added Section on How does a Plan qualify to use Government COB

Added Section on Insulin Pen Packaging Claim Adjudication Guidance

Added Section on Pharmacist Assessment Billing

Added Section on Can a BIN/PCN combination contain groups that use multiple COB methods


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 19.53 VERSION 54

Added Question on Identification and COB Impact of Plan-Sponsored Drug Discount Programs as Enhanced Benefits

Updated the first question and added a second question in the Safe Disposal of Medication Section.

Added Question on What Reject Code Should Be Used When A COB Claim Other Payer Loop Contains Both Paid Amount(s) and Reject Code(s)

## 19.54 VERSION 55

Added two new questions/responses in Section 3.1.1 – Days Supply (405-D5)

Added Section 6. 21 Lower Case Data Question/Response

## 19.55 VERSION 56

Added question regarding OPAP Qualifiers and Sales Tax

## 19.56 VERSION 57

Corrected typographical error in Appendix E, Question 7.

Section 5.1.7 Quantity Prescribed was removed as it is no longer applicable.

Added Section 3.1.3 - Interchangeable Biosimilar Products and DAW

Added Section 3.1.7.1 Route of Administration Values

## 19.57 VERSION 58

Added Section 3.5.2 – Patient Gender

## 19.58 VERSION 59

Updated the first question in Section 22.22.6 – State License Questions

Added the value “4R” to the table in Section 7.4.3.2 – DUR Result of Service Code (441-E5)

Added A7 to the table and renumbered the entries in Section 7.6.1 – Opioid Naïve Day Supply Limitation

Added B5 to the table and renumbered the entries in Section 7.6.2 - MME Hard Stop; POS Override Not Allowed; Prescriber to Call Plan (potentially >200)

Added C5 to the table and renumbered the entries in Section 7.6.3 - MME Prescriber Care Coordination Required (90-200, or >90)

Added D5 to the table and renumbered the entries in Section 7.6.4 - Duplicative Therapy Soft Edit - Long Acting Opioids

Added E5 to the table and renumbered the entries in Section 7.6.5 - Soft Stop for Concurrent Use of Conflicting Drug Categories *(e.g.; Opioids & Benzodiazepines, Opioids & Buprenorphine, Opioids & Antipsychotics)*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 19.59 VERSION 60

A question and response were added regarding which Patient Residence (384-4X) value is submitted when sending a claim for a patient being discharged from a LTC facility to an home.

## 19.60 VERSION 61

A question and response and two sub-questions and responses were added as Section 3.1.11.3 - PRESCRIBER DOES NOT CURRENTLY HAVE AN ACTIVE TYPE 1 NPI

## 19.61 VERSION 62

A question and response regarding Use of Submission Clarification Codes and Covid Vaccines was added as Section 16.6 - Use of Submission Clarification Codes and Covid Vaccines

## 19.62 VERSION 63

Replaced question 10.27 - Identification and Override To Plan Sponsored Drug Discount Pricing Program Benefit To Support Cob With Supplemental Payers

Added Section 6.22 – Pharmacist Services Billing

## 19.63 VERSION 64

The version limitation has been removed from Section 5.5.2 - Prescription/Service Reference Number (455-EM) Value "3"

Corrected the field number for Date of Service in Section 6.18 - Quantity Prescribed 30-day Reference

Added Section 6.4.8 – Reject Code 71: Prescriber ID Not Covered

Added Section 6.2 – Claims in Excess of $999,999.99

Added Section 3.1.3 – DAW Codes – Use of Values 9 and A

Added Section 6.24 – Transition to Commercial Covid Anti-Virals

## 19.64 VERSION 65

Replaced the third question in Section 6.5.3 – Prescriber ID Rejections

Added Section 6.25 – Coverage of a Duplicate Therapy Interaction

Added Section 22.28 - Medicare Prescription Payment Plan Program Frequently Asked Questions

## 19.65 VERSION 66

Removed the word, other, from the title of 10.12

Updated Section 3.1.8 - Route Of Administration (995-E2) and SNOMED CT Codes and Appendix E. Route Of Administration Questions

Added Section 6.26 - Insulin Administration – Delivery Device


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 19.66 VERSION 67

Replaced the FAQ in Section 3.8 - Prescriber Segment

Replaced the FAQ in Section 6.23 - Pharmacist Service Billing

Added Section 6.24 - Pharmacist Medication Administration

Revised Sections 24.12 – 24.13. Section 24.14 was eliminated as previous Sections 24.12 and 24.13 were combined

## 19.67 VERSION 68

At the request of the WG9 Medicare FAQ Task Group, the following question and response is removed.

3.6.4 Provider Fees

**Question:**

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

**Response:**

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

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

- Pay only the flat sales tax amount per prescription fee (currently at $0.10)
- Reject the claim. This may cause member disruption.

At the request of the WG1 Definition of a Valid Prescriber Task Group, the following question and response is removed.

22.22.3 (third question)

**Question:**

How can the NCPDP Telecommunication Standard© be leveraged to comply with the Medicare Part D prescriber validation and point of service communication process?

- CMS 4157-F Effective 01/01/2013
    - *"Sponsors will be required to so ensure in the following manner: (1) a sponsor must communicate at point-of-sale whether or not the prescriber NPI is active and valid; (2) if the sponsor communicates that the prescriber NPI is not active and valid, the sponsor must permit the pharmacy to confirm that the NPI is active and valid, or in the alternative, to correct it; (3) if the pharmacy confirms that the prescriber NPI is active and valid or corrects it, the sponsor must pay the claim if it is otherwise*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

*payable; and (4) if the pharmacy cannot or does not correct or confirm that the prescriber NPI is active and valid, the sponsor must require the pharmacy to resubmit the claim **(when necessary)**, which the sponsor must pay, if it is otherwise payable, unless there is an indication of fraud or the claim involves a prescription written by a foreign prescriber (where permitted by State law)."*

- *CMS 4159-F § 423.120(c)(6)(i) Regulation Effective 06/01/2015, Enforcement Effective 12/01/2015*
  - *Under § 423.120(c)(6)(i), in order for a Part D sponsor to submit to CMS a prescription drug event (PDE) record, the PDE must pertain to a claim for a Part D drug that was dispensed in accordance with a prescription written by a physician or eligible professional who is either (1) enrolled in Medicare in an approved status, or (2) has a valid opt-out affidavit on file with an A/B MAC.*
  - *Under § 423.120(c)(6)(iii), a Part D sponsor must deny or must require its PBM to deny a pharmacy claim for a drug (or a request for reimbursement from a Medicare beneficiary for a drug) if the claim does not meet the requirements of § 423.120(c)(6)(i) or (ii), respectively.*

**Response:**

New values and updated descriptions to existing values have been designated for the following fields:
Reject Code (511-FB)
Submission Clarification Code (420-DK)
Approved Message Code (548-6F)
Appropriate use of these values as outlined within the CMS 4157 and CMS 4159 matrices will provide the necessary communication between the provider and payer for prescriber ID validation and any subsequent retrospective reviews.

- CMS 4157-F Matrix – Medicare Part D Prescriber ID Requirements Effective 01/01/2013
- CMS 4159-F and IFC 6107 Matrix - Medicare Part D Prescriber Enrollment Requirements Enforcement Date 02/01/2017 (based on 03/01/2016 CMS Notice)
  - Refer to Appendix F for the comprehensive overview of point of service prescriber validation guidance that applies to CMS 4159 and IFC 6107.

Please reference all information within the " PROCESSING WITH PRESCRIBER ID" sections of this document, as the clarification and recommendations may not be reflected within the below matrix but may apply to your business needs.

**CMS 4157-F Matrix – Medicare Part D Prescriber ID Requirements Effective 01/01/2013**

The INTERIM Reject Code, Submission Clarification Code and Approved Message Code columns were specifically created to address the gap in time between the January 01, 2013 Part D effective date and the April 01, 2013 Emergency ECL Implementation date for the new values required to support the point of service prescriber validation communication process. CMS recognized the effects of this gap, where the October 01, 2012 Part D Plan Notice provided the following direction:

*To facilitate industry implementation of these new regulatory requirements, we will align our requirements for Type 1 NPIs on PDEs with the deadline for individual prescribers to obtain and disclose Type 1 NPIs. Therefore, we are announcing a two-step implementation process. Effective January 1, 2013, CMS will require sponsors to submit an active and valid NPI on PDE records; however, the NPI reported may be a group identifier if the prescriber has not yet obtained an individual NPI. Beginning May 6, 2013, sponsors must report only a Type 1 (individual) NPI on the PDE record. This delay will also allow the industry to align implementation of the requirement for an individual NPI with the new NCPDP emergency external code list© values related to the new NPI requirements approved at the August Work Group meetings.*

Point of service rejects implemented for the 2013 benefit year, should adhere to the values as outlined in the CMS 4157-F Matrix, the CMS Part D guidance and the April 1, 2013 NCPDP Emergency ECL effective date.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

The CMS 4157-F Prescriber Reject Matrix has been updated to reflect the following CMS Medicare Part D clarifications:

- 11/2012: De-activated NPIs and prescription refills
- 11/2012: 24 hour follow up for foreign prescriber rejections
- 11/2012: Notice of Medicare Drug Coverage Rights for foreign and sanctioned prescriber rejections
- 11/2012: Removal of interim values for NPI = Type 2 scenario row.
- 08/2014: Addition of new code values for state license validation

Added the Medicaid Prescriber Validation Flow to Appendix F - Section 24.14

Added Medicaid Prescriber Validation Reject Matrix to Appendix F - Section 24.15

## 19.68 VERSION 69

Section 3.1.3

1. Updated section title
2. Updated Question 1 & 2
3. Added new FAQ

At the request of the WG1 Definition of a Valid Prescriber Task Group, the following questions and responses are removed.

22.22.3 Processing with Prescriber ID

**Question:**

Based on the Medicare Part D prescriber validation rules effective January 1, 2013, can a Part D Sponsor accept the claim if the Type 1 NPI can be identified based on submitted non-NPI ID?

Situation: Pharmacy doesn't submit the Type 1 NPI, processor is able to cross walk from the submitted ID and find the Type 1 NPI; must the processor reject the claim?

*CMS Response:*

*The final regulation states that sponsors must submit PDEs with active and valid individual prescriber NPIs beginning 1/1/13. It also states that sponsors must ensure that the lack of an active and valid individual prescriber NPI does not unreasonably delay a beneficiary's access to a covered Part D drug by communicating at point-of-sale whether an NPI is active and valid. The preamble to the final rule recognized that such communication could be via claim rejection. If the sponsor communicates that the NPI is not active and valid, the final regulation states that the sponsor must permit the pharmacy to confirm that it is active and valid or correct it.*

**Response:**

In the situation where the Part D sponsor can identify the prescriber's Type 1 NPI based on the alternate prescriber ID submitted on the claim, per the CMS regulations effective January 1, 2013, the sponsor must engage in conversation with the pharmacy to ensure the prescriber ID is valid. There are two options available within the NCPDP Telecommunication Standard© to support the required communication.

1. Reject Response: Using a Reject Code that indicates a Type 1 NPI exists and should be submitted and may also include the NPI determined by the sponsor within the Additional Message field (526-FQ). Pharmacy to validate the NPI and when applicable resubmit the claim with the NPI.
    a. Reject Code: "619" (Prescriber Type 1 NPI Required) (Emergency DERF/ECL 001079/ECL 000125 approved at August 2012 Work Group meeting).
    b. When the Plan can find an NPI based on the prescriber ID submitted but rejects the claim the Plan may choose to provide this information in the Additional Message Information (526-FQ) as free text (using the qualifier values 1-9) to assist the pharmacy.
        i. Text to be returned as "PLAN'S PRESCRIBER NPI DATA: ##########"
2. Paid Response (where an override Submission Clarification Code is **not** submitted): Using an Approved Message Code (548-6F) "026" (Prescriber Type 1 NPI Required - Flagged for Retrospective Review) and should also include within the Additional Message field (526-FQ) as free


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

text (using the qualifier values 1-9) the NPI determined by the sponsor that will be submitted on the PDE, and should be used on future claims. Processor will not require the claim to be reprocessed.

a. Approved Message Code: "028" (Type 1 NPI Required, Claim Paid Based on Plan's Prescriber NPI Data).
b. When the plan pays and chooses to send a cross walked NPI on the PDE, they should also return the cross walked NPI in the Additional Message Information (526-FQ) as free text (using the qualifier values 1-9) to assist the pharmacy.
    i. Text to be returned as "PLAN'S PRESCRIBER NPI DATA: ##########"
c. In the situation where the pharmacy has submitted a Submission Clarification Code override with a prescriber NPI the plan/payer cannot validate, the plan/payer would leverage the prescriber ID provided by the pharmacy and not any internal cross-walked NPI.

As of the 12/01/2015 enforcement date for CMS 4159-F (§ 423.120(c)(5) and (6)), the above situation would not apply to Medicare Part D claims as the prescriber's Type 1 NPI must be submitted on claim.

**Question:**
Can CMS assist with industry outreach for entities that need Type 1 NPIs?
**Response:**
CMS has already provided outreach. Please refer to the October 19, 2012 CMS Transmittal R2567CP which was directed to physicians. Refer to page 14 "Announcement About Medicare Participation for Calendar Year 2013" http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2567CP.pdf

NCPDP has also drafted a Prescriber NPI Outreach Letter Template that is available at http://www.ncpdp.org/Resources/HIPAA under NPI.

### 22.22.3.2 Inactive state license

**Question:**
If there is no active state license for a prescriber, can you confirm what standard reject codes should be used? SCC codes?
**Response:**

| DEFINITION OF A VALID PRESCRIBER REJECT MATRIX WHEN PRESCRIBER TYPE 1 NPI IS REQUIRED and ALTERNATE ID MAY | | | | | | |
|---|---|---|---|---|---|---|
| Payer Determination of a Valid Prescriber based on the submitted Prescriber ID Qualifier and ID | Reject Code (511-FB) | Interim Reject Code (511-FB) (Prior to 04/2013) | Submission Clarification Code (420-DK) - Once a SCC is submitted and accepted, no further prescriber reject should apply for POS. | Interim Submission Clarification Code (420-DK) (Prior to 04//2013) | Approved Message Code (548-6F) | In M (P |
| No active state license with prescriptive authority associated to submitted prescriber ID | "777" (Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted) | N/A | 52 (Prescriber's State License with Prescriptive Authority has been validated | N/A | "YYY " (Unable to verify prescriber's active state license with prescriptive authority – Flagged for Retrospective Review) | "1 Pr or Re |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

22.22.7 Other Prescriber ID Questions

**Question:**

Does the 24 hour follow up requirement outlined under CMS 4157 (highlighted below) apply in any manner to Medicare Part D prescription claims submitted as of the enforcement date of CMS 4149 (§ 423.120(c)(5) and (6))?

*…effective January 1, 2013, that Part D sponsors must submit an active and valid individual prescriber NPI on any PDE record submitted to CMS. Revising our policy and the regulation text to require a Part D sponsor to ensure that the lack of an active and valid individual prescriber NPI on a network pharmacy claim does not unreasonably delay a beneficiary's access to a covered Part D drug. Sponsors will be required to so ensure in the following manner: (1) a sponsor must communicate at point-of-sale whether or not the prescriber NPI is active and valid; (2) if the sponsor communicates that the prescriber NPI is not active and valid, the sponsor must permit the pharmacy to confirm that the NPI is active and valid, or in the alternative, to correct it; (3) if the pharmacy confirms that the prescriber NPI is active and valid or corrects it, the sponsor must pay the claim if it is otherwise payable; and (4) if the pharmacy cannot or does not correct or confirm that the prescriber NPI is active and valid, the sponsor must require the pharmacy to resubmit the claim (when necessary), which the sponsor must pay, if it is otherwise payable, unless there is an indication of fraud or the claim involves a prescription written by a foreign prescriber (where permitted by State law). We would expect the back-and-forth between a sponsor and network pharmacy described previously to take no more than 24 hours, which means that sponsors will have to have controls in place to make sure network pharmacies resubmit claims where the sponsor has communicated an issue with the NPI and a pharmacy cannot or does not correct or confirm that the NPI is active an valid. if an active and valid prescriber ID is not included on the Part D claim, either the sponsor, or the pharmacy if in accordance with the contractual terms of the network pharmacy agreement, must follow up retrospectively to acquire an active and valid ID before the PDE may be submitted to CMS…*

*…further revising the regulation text to state that a Part D sponsor must not later recoup payment from a network pharmacy for a claim that does not contain an active and valid individual prescriber NPI on the basis that it does not contain one, unless the sponsor: (1) has complied with the POS requirements previously described; (2) has verified that a submitted NPI was not in fact active and valid; and (3) the agreement between the parties explicitly permits such recoupment….*

**Response:**

The 24 hour period described above is CMS guidance that applies to 423.120(c)(5), which is the current regulation in effect. It is not applicable to 423.120(c)(6), which will be enforced beginning December 1, 2015 per CMS HPMS memo of December 2014.

**Note:** As of 4/18/2018 due to CMS 4182, the 24-hour outreach is no longer a requirement.

Updated the following items

1. Section 22.22.3, Question 2
2. Section 22.22.4, Question 3
3. Section 22.22.7, Question 1

Added Question 16.5.4 - How should the PBM/processor respond to an NCPDP Telecommunication Standard Version D.0© Coordination of Benefits (COB) claim that contains the individual Other Payer-Patient Responsibility Amount (OPPRA) components and the aggregated patient pay amount?


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 19.69 VERSION 70

The diagram in Section 24.12 Medicare Part D Prescriber Validation Flow was updated. Step 14 had the reject values in the incorrect order.

Added Section 4.7 – Response DUR/PPS Segment

Added Section 10.30 - Other Payer Amount Paid Qualifiers (342-HC) For S1 (Service Billing) COB

Section 6.5.3 - Prescriber ID Rejections: Question 4 and Question 5 were combined into a modified Question 4. Question 5 was removed from this section and appears below.

At the request of the WG1 Definition of a Valid Prescriber Task Group, the following question and response was removed from Section 6.5.3 (Question 5).

**Question:**

When a claim rejects based on a prescriber validation error, can the data source that triggered the reject be identified as part of the response?

**Response:**

Yes, for the Telecommunication Standard Version D.0©, the Additional Message Information field (526-FQ) can be used to identify the data source that triggered the prescriber validation conflict. Up until the October 2020 Annual ECL, this information can be returned with the free text Additional Message Information Qualifiers (132-UH) 01-09. For example, when reject code 777 - Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted is returned, payers may return an Additional Message Information Qualifier (132-UH) of 01-09, depending on what other messaging is be returned on the particular claim, and the text "[Insert state code] STATE LICENSE" as part of the Additional Message Information field (526-FQ), indicating the prescriber's state license was identified as inactive/invalid based on the applicable state licensing board file.

As of the October 2020 Annual ECL, this information should be returned with the below new Additional Message Information Qualifiers (132-UH) and will be available as distinct response fields in the Telecommunication Standard Version F6© (E87-EV: Data Source of Invalid Provider Determination and E88-ZZ: State Code for Data Source of Invalid Provider Determination).

- 26 - INVALID PROVIDER DATA SOURCE
- 27 – INVALID PROVIDER DATA SOURCE STATE CODE

Please refer to the below chart for guidance on the specific values to return in the Additional Message Information field (526-FQ) for each of these qualifiers and the associated reject codes for the specific prescriber validation error.

| **Prescriber Validation Error** | **Reject Code** | **Additional Message Information Qualifier(s) (132-UH)** | **Additional Message Information (526-FQ)** | **Description of Invalid Provider Data Source** |
|---|---|---|---|---|
| Prescriber has been identified as an Excluded Prescriber via the OIG LEIE file | A1<br>ID Submitted is associated with an Excluded Prescriber | 26 - INVALID PROVIDER DATA SOURCE | **"OIG LEIE"** | "Office of Inspector General List of Excluded Individuals/Entities": List of all currently excluded individuals and entities as determined by OIG authority to exclude individuals and entities from Federally funded health care programs pursuant to section 1128 of the Social Security Act (Act) (and from Medicare and State health care programs under section 1156 of the Act). |
| Prescriber has been identified as an Excluded Prescriber via the SAM file | A1<br>ID Submitted is associated with an Excluded Prescriber | 26 - INVALID PROVIDER DATA SOURCE | **"SAM"** | "System for Award Management": The SAM Exclusions extract contains a list of all currently active exclusions in SAM. These include exclusions for Individuals, Firms, Special Entity Designations and Vessels.<br>https://www.sam.gov/SAM/pages/public/index.jsf<br>Note: SAM replaces General Services Administration (GSA) data source. |
| Prescriber has been identified as a Terminated/Excluded Medicaid Prescriber | A1<br>ID Submitted is associated with an Excluded Prescriber | 26 - INVALID PROVIDER DATA SOURCE<br>&<br>27 – INVALID PROVIDER DATA SOURCE STATE CODE | **"STATE MEDICAID EXCLUSION/TERMINATION"**<br>**&**<br>**2-character State Code of the applicable State** | State issued list of providers excluded/terminated from participation in the State Medicaid program. |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| | | | **Medicaid Exclusion file. Refer to state abbreviations within the ECL SHARED CODE LIST: State/Province Address** | |
| Prescriber/Provider has been identified as not enrolled with the State Medicaid program | 889<br>Prescriber Not Enrolled in State Medicaid Program<br><br>890<br>Pharmacy Not Enrolled in State Medicaid Program | 26 - INVALID PROVIDER DATA SOURCE<br>&<br>27 – INVALID PROVIDER DATA SOURCE STATE CODE | **"STATE MEDICAID ENROLLMENT"<br>&<br>2-character State Code of the applicable State Medicaid Enrollment file. Refer to state abbreviations within the ECL SHARED CODE LIST: State/Province Address** | State issued list of providers' enrollment status within the State Medicaid program. State Medicaid provider enrollment data aligns to CMS Medicaid and other federal provider screening requirements |
| Prescriber has been identified as a Precluded Prescriber | 929<br>ID Submitted Is Associated With A Precluded Prescriber<br><br>930<br>ID Submitted Is Associated To A Precluded Pharmacy * | 26 - INVALID PROVIDER DATA SOURCE | **"CMS PRECLUSION LIST"** | "Centers for Medicare and Medicaid Services" Preclusion List: A list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. |
| Prescriber's NPI has been identified as inactive or not found | 42<br>Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or is not found.<br><br>826<br>Prescriber NPI Submitted Not Found Within Processor's NPI File | 26 - INVALID PROVIDER DATA SOURCE | **"NPPES NPI"** | "National Plan and Provider Enumeration System - National Provider Identifier": NPPES assigns standard unique identifiers (NPI) for health care providers and health plans. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. |
| Prescriber's DEA has been identified as inactive, not found, or not registered with the applicable drug schedule | 43<br>Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive<br><br>44<br>Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found<br><br>46<br>Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA class | 26 - INVALID PROVIDER DATA SOURCE | **"NTIS DEA"** | "National Technical Information Service - Drug Enforcement Administration": DEA Active Controlled Substances Act (CSA) Registrants Database. Registration under the Act enables physicians, related practitioners, other established health organizations, pharmaceutical companies, and others to prescribe and handle controlled substances |
| Prescriber's state license has been identified as not active/valid | 777<br>Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted | 26 - INVALID PROVIDER DATA SOURCE<br>&<br>27 – INVALID PROVIDER DATA SOURCE STATE CODE | **"STATE LICENSE"<br>&<br>2-character State Code of the applicable State Licensing Board file. Refer to state** | Data from a state board or other state regulatory agency identifying individuals' and entities' license status to practice within a designated discipline and locality. |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| | | | **abbreviations within the ECL SHARED CODE LIST: State/Province Address** | |

Also refer to the question "There are various provider exclusion files maintained by government entities, such as OIG excluded providers, Medicaid exclusions, CMS preclusions, etc. Can reject code A1 be used regardless of which exclusion file contains the submitted provider/prescriber id?"

Section 6.5.5 - Which NCPDP ECL Values (Reject Code, SCC, Approved message Code) should be used for Medicaid Ordering Referring Provider Requirements was modified by removing references to 1/1/18: As of 1/1/18 with the creation of two new reject codes specific to this scenario and Note: Prior to 1/1/18, the recommendation was to use reject code 71 (Prescriber ID is Not Covered).

Section 6.5.6 - RPH Prescriptive Authority Validation was modified by removing the sentences noted below.

*Reject Code:*

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

*Approved Message Code (AMC):*

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

Section 6.5.7 – Service Provider ID – a minor editorial correction was made to the response.

Section 22.22.1 - Foreign Prescriber Identifier – modified the response

Section 22.22.2 – Valid Prescriber ID – removed the following question

**Question:** To facilitate a consistent claims adjudication process relative to prescriber ID validation, to prevent retrospective rejects based only on the prescriber data within the Part D sponsor's system, to eliminate the financial risk to the provider and the need to obtain new prescription orders from the physician due to conflicts in data files; can NCPDP guidance be developed to require the Part D sponsor to reject the claim at point of service when the prescriber ID submitted cannot be validated? In the event the reject is the result of the timing of data file updates, or a DEA renewal in process, can the provider resubmit the claim with a specific Submission Clarification code?

**Response:** WG1 Telecommunication approved two methods after long discussion. There was no consensus on one versus the other, but the need was shown for supporting one or the other. If needed, the topic will be evaluated in the future.

1. Reject method with overrides ***or***
2. A paid response with the method approved at August WG using Approved Message Code (548-6F) ***or***
    a. Prior to April 2012, Approved Message Codes ("019", "020", "021") and descriptions should be return in Additional Message Code (526-FQ)
    *b. Note, in this option, there is no opportunity for the pharmacy to convey additional information to the plan.*

Section 22.22.2 – Valid Prescriber ID – removed the hyperlink from the response regarding the definition of a narcotic: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCFR/CFRSearch.cfm?fr=1300.01

Section 22.22.2 – Valid Prescriber ID – modified the response to the question regarding DEA licenses and missing schedule(s)

Section 22.22.3 - Processing With Prescriber ID – added a sentence immediately following the section header

Section 22.22.3.1 - Definition Of A Valid Prescriber CMS 4157 Prescriber Reject Matrix was removed. Material is covered in Section 24.12 and 24.13.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 19.70 VERSION 71

Added an FAQ to Section 4.3.2 – Basis of Reimbursement Determination

Added Section 10.31 – Payer-to-Payer COB

Added Section 22.28 – Hepatitis B Vaccine Billing

Added Section 22.29 – Medicare Part B vs Medicare Part D Vaccine Billing

Updated Section 6.5.3 – Removed an extra word in the first question

Updated Section 22.22.5 – Removed the invalid links

Updated Section 22.22.6 – 2nd Question, removed the following bullet from the Response

- For the period between April 01, 2015 and October 15, 2015, Submission Clarification Code 42 (*Prescriber ID Submitted is active and prescribing requirements have been validated) should be used.*

Removed the following Questions and Responses from Section 22.22.4:

**Question:**

Does the Type 1 Prescriber NPI PDE requirement apply to claims with a date of service > 01/01/2013, or does it apply to all claims submitted on the PDE as of 01/01/2013, regardless of the claim date of service?

**Response:**

Per CMS, the requirement will be based on date of service.

**Question:**

How do NPI enumeration and deactivation dates, along with the claim date of service (DOS), determine whether or not an NPI can be considered "active" for inclusion on PDE?

(Question originally stated as: Are there any PDE rule sets which compare the NPI Enumeration Date, NPI De-activation Date, the claim Date of Service or Prescription Written date?)

**Response:**

Effective January 1, 2013, all PDEs must be submitted with an active and valid NPI. Per CMS, the final regulation preamble stated the meaning of "active and valid" is that "the NPI number is in the expected format/sequencing for such numbers and is listed as an active identifier in the National Plan and Provider Enumeration System (NPPES)." The following are clarifications related to the timing for what will be treated as an active NPI:

1. The claim date of service may be prior to the NPI enumeration date; however the NPI must be active and valid at the time of PDE submission.
2. If the NPI is active as of the Date of Service, if otherwise payable, the Plan Sponsor should accept the claim regardless of the claim transmission date.
3. If an NPI is available on the NPPES registry at the time of the dispensing, but is not yet on the data dissemination file at the time of the PDE processing, the PDE may reject with PDE reject 834 (NPI is not active for the date of service). The sponsor will have to resubmit the PDE after the NPI has been included in the next full replacement or weekly incremental NPI file.
4. Per CMS, "NPIs which are active and valid on DOS and deactivated before PDE submission will be considered active and valid." PDEs should not reject unless the deactivation date is retroactive to a date earlier than the DOS.
5. State prescribing laws dictate whether or not a prescription can be dispensed. Therefore after the NPI becomes deactivated it will be the sponsors' responsibility to ensure that appropriate state laws are being followed. To accommodate different state laws, PDEs will not reject if the Date of


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Service on the PDE is < or = (NPI deactivation date + 1 year), regardless of the reason for deactivation. Detailed guidance announcing these edits will be released by CMS in February 2013.

6. For PDEs submitted for claims with dates of services on or after May 6, 2013, plans must submit an individual NPI in the Prescriber ID field. PDEs submitted for claims with dates of service prior to May 6, 2013, the Type 2 NPI will be accepted (refer to 10/02/2012 CMS Notice).
    - In the event that Part D claims are subject to a declared emergency and the state has granted the pharmacist the authority to prescribe, for CY 2013 CMS will accept the **pharmacy's Type 2 NPI as the prescriber ID** on the submitted PDE. The *NCPDP Emergency Preparedness Information* document v1.3, provides resource information for the pharmacy industry for a declared emergency. (http://www.ncpdp.org/Resources/Emergency-Preparedness)
      Note: refer to Definition of a Valid Prescriber ECL Matrix above for reject, submission clarification, and approved message codes that may be used when the NPI is not yet available.

Section 22.26 Provisional Fill was removed.

**Question:**

How can claims paid under the provisional supply be identified? Is there a way to notify the pharmacy prior to the applicability date of CMS 4159 that the prescriber associated with the Medicare Part D prescription claim is not actively enrolled in Medicare?

**Response:**

Yes, until a specific Approved Message Code (548-6F) is available, the recommendation is to return the following standardized message within the Additional Information Message Field (526-FQ) - "*CMS 4159 Notify Prescriber: Prescriber must enroll in or opt-out of Medicare by 06/01/2016 for continued Part D coverage*". Note: In the event the applicability date changes, processors should adjust the message accordingly.

**Response (updated August 2016**):

An Approved Message Code was not created because it would not be available until after the applicability date of CMS 4159. Because the effective date was delayed to 2/1/17, the specific date in the message is removed. The recommended standardized message within the Additional Information Message Field (526-FQ) is:

"*CMS 4159 Notify Prescriber: Prescriber must enroll in or opt-out of Medicare ~~by 06/01/2016~~ for continued Part D coverage*".

The new message may be used prior to effective date as a notification on a paid claim (soft message) and in conjunction with reject code or approved message code after the effective date.

Added Section for Deceased Prescribers and NPPES NPI Deactivation Schedule - content was moved from Section 24.5 CMS Clarification to create the new section.

Added an FAQ to Section 3.3 – Coordination of Benefits Segment

Modified Section 10.5

## 19.71 VERSION 72

Removed the following paragraph from Appendix F. Point of Service Prescriber Validation Guidance Applicable to CMS 4159 and IFC 6107:

CMS final rule 4157, provision 423.120(c)(5) effective January 01, 2013 required an active an valid prescriber NPI to be submitted on the PDE and validation of controlled substance prescriptive authority. As a result of these requirements, new NCPDP Reject Codes (511-FB), Submission Clarification Codes (420-DK) and Approved Message Codes (548-6F) were added to the External Code List© to support the necessary point of service telecommunication process. Guidance in the form of a reject code matrix was also published within Version D Editorial Document


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

under section "PROCESSING WITH PRESCRIBER ID." CMS final rule 4159, provision 423.120(c)(6) and IFC 6107 which as of the publication of this document are applicable as of June 01, 2016, require prescriber Medicare enrollment/opt-out validation in coordination with an Other Authorized Prescriber (OAP) and provisional supply exception process. This appendix outlines these regulations, associated CMS guidance and provides implementation guidance through the use of new and updated NCPDP reject codes, submission clarification codes and approved message codes.

Deleted the timeline, CMS document references, CMS clarification, open area of concerns and the FAQs from Appendix F. Point of Service Prescriber Validation Guidance Applicable to CMS 4159 and IFC 6107.

Updated the Prescriber Related Submission Clarification Codes Table, the Scenario Validation Step in the Medicare Part D Prescriber Validation Reject Matrix and the Scenario Validation Step in the Medicaid Prescriber Validation Reject Matrix in Appendix F. Point of Service Prescriber Validation Guidance Applicable to CMS 4159 and IFC 6107

Added a question regarding the types of entities that can use the Telecommunication Standard© under the General Questions section.

## 19.72 VERSION 73

Updated Section 3.8 Prescriber Segment (03) FAQ

Updated Section 6.5.3 Prescriber ID Rejections – 2nd question

Updated Section 24.3 High Level Hierarchical Rules

Updated Section 24.4 Prescriber Related Reject Codes

Updated Section 24.6 Prescriber Related Approved Message Code 584-6F

Updated Section 23.1 Best Practices for Use of SNOMED CT Route of Administration Values - Question 1

Updated Section 3.1.8 Route of Administration (995-E2) and SNOMED CT Codes

Added Section 3.9 DUR/PPS Segment (08)

Added Section 6.29 Pharmacogenomic (PGx) Testing

## 19.73 VERSION 74

Updated Section 24.4 Prescriber Related Reject Codes


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 20 APPENDIX B. WHERE DO I FIND

## 20.1 ANSWERS MAY BE FOUND IN THE FOLLOWING DOCUMENTS

- NCPDP Telecommunication Standard Implementation Guide Version D.0©
- NCPDP Data Dictionary©
- NCPDP External Code List©
- NCPDP Telecommunication Version D Questions, Answers, and Editorial Updates (the "Editorial" document – this document)
- Future versions of the NCPDP Telecommunication Standard Implementation Guide©

Other resources:

- NCPDP HIPAA page http://www.ncpdp.org/Resources/HIPAA
- NCPDP standards process http://www.ncpdp.org/Standards/Standards-Development-Process
- Non-member to obtain standards http://www.ncpdp.org/Membership
- Member to obtain standards http://www.ncpdp.org/Members/Standards-Lookup

## 20.2 ADDITIONAL INFORMATION MAY BE FOUND IN THE FOLLOWING DOCUMENTS

Telecommunication Standard Implementation Guide Version D.1© and above

Although the usage of new fields or field changes in Version D.1 and above is not allowed in the implementation of Version D.0, the Version D.1 and above documents may provide additional clarification, as additional verbiage has been added (COB, Prior Authorization, et cetera). This verbiage is usually included in the Version D Editorial document.

## 20.3 PARTICULAR TOPICS MAY BE FOUND IN THE FOLLOWING DOCUMENTS

### 20.3.1 WHAT TRANSACTIONS ARE SUPPORTED FOR WHAT BUSINESS PURPOSES?

NCPDP Telecommunication Standard Implementation Guide©

- section "*Business Environment"*
- section "*Business Functions"*
- each transaction section such as "*Information Reporting Information*"

### 20.3.2 WHAT FIELDS CHANGED?

NCPDP Data Dictionary©

- section "*Appendix K. Publication Modifications*"

NCPDP Telecommunication Standard Implementation Guide© contains matrices which have legends that denote fields added and modified.

- section "*Transmission Structure*"

### 20.3.3 WHICH FIELDS ARE ALLOWED IN WHICH SEGMENTS?

NCPDP Telecommunication Standard Implementation Guide©

- section "*Structure Quick Reference*"
- each transaction section such as "*Claim Billing or Encounter Information*"

### 20.3.4 WHERE DO THE SEGMENTS BELONG?

NCPDP Telecommunication Standard Implementation Guide©

- section "*Transmission Structure*"
- each transaction section such as "*Claim Billing or Encounter Information*"
- section "*General Structural Overview*"


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### 20.3.5 What Are The Valid Responses For Each Transmission?

NCPDP Telecommunication Standard Implementation Guide©

- section "*Transmission Structure*"
- each transaction section such as "*Claim Billing or Encounter Information*"
- section "*Response Overview*"
- section "*Response Processing Guidelines"*

### 20.3.6 Recommended Use Of Dollar Fields And Calculated Amounts?

NCPDP Telecommunication Standard Implementation Guide©

- section "*Standard Conventions*"
- section "*Response Processing Guidelines"*
- section "*Specific Segment Discussion"*

### 20.3.7 Explain The Syntax Rules For Version D

NCPDP Telecommunication Standard Implementation Guide©

- section "*Standard Conventions*"
- section "*Framework"*
- section "*General Structural Overview*"

### 20.3.8 Documentation Dates

**Question:** Where do I obtain publication date information of the various version/releases of the Telecommunication Standard©?

**Response:** The Standards Matrix document should be referenced. The document can be found at http://www.ncpdp.org/Members/Standards-Lookup (lower left)
This document lists all of the NCPDP standard implementation guides, their status, and the appropriate Data Dictionary© and External Code Lists© to use.

### 20.3.9 What If I Have A New Question?

Send the question to NCPDP Council Office at ncpdp@ncpdp.org

### 20.3.10 CMS Place of Service Codes?

CMS has updated the website. The Place of Service Codes section is now visible to the public at https://www.cms.gov/medicare/coding/place-of-service-codes/place_of_service_code_set.html. There is a "Printer–Friendly Version" of the POS Code Set available as a download at the bottom of the Place of Service Code Set.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 21 APPENDIX C. MEDICARE PART D AND MULTI-INGREDIENT COMPOUND PROCESSING

**Proposed Multi-Ingredient Processing Rules for Medicare Part D for Telecom D.0**
**Guidance Only**

**The reader should be aware that this information is presented as guidance only. During NCPDP's Work Group 1 Telecommunication FAQ Task Group questions on multi-ingredient compounds and Medicare Part D processing were discussed. Pharmacies, vendors, payers, plans, and CMS representatives were involved in the discussion. This document was created from that effort. Once this document was "finalized", CMS reviewed to provide further input to questions. The following unofficial guidance was received from CMS and constitutes the best available information until CMS can issue formal guidance in future rulemaking.**

From CMS:
I have reviewed the NCPDP "Proposed Multi-Ingredient Processing Rules for Medicare Part D for Telecom D.0" document (attached) and believe that most of it is generally consistent with CMS policy regarding coverage of compounds under Part D. However, while they are not inconsistent with existing CMS policy and are in line with current CMS thinking, I believe some of the proposed business rules go beyond existing CMS policy and will require future rule-making by CMS to establish such requirements. Specifically, I do not believe our current policy addresses the following proposals:

- Page 1, proposed business rule 2a: If a compound is On-formulary, then all Part D ingredients are considered On-Formulary (even if the drug would be non-formulary as a single drug claim)
- Page 2, proposed business rule 3: Compounds can only be covered under one Medicare benefit
- Page 3, proposed business rule h (i): LICS/Catastrophic Copay/Coinsurance

(I should note that my comments are limited to the proposed business rules outlined in the 1st three pages of the document and do not encompass the specific examples that are also provided in the document.)

Since we have been asked, I would add that CMS also would need to establish new policy through rulemaking with respect to determine whether we would permit Part D enrollee financial responsibility for any non-covered ingredients of a covered Part D compound.

Finally, to the extent that this document does reflect current CMS policy, our expectation is that the rules will be followed with respect to processing claims for Part D compounds using D.0, and reporting PDEs for such claims, if D.0 is being used to process claims both before and after the 2012 mandatory implementation of D.0 as the new HIPAA standard.

In general we would not consider sponsors adopting those approaches (rule 2a, rule 3 or proposed business rule h (i): LICS/Catastrophic Copay/Coinsurance listed above) to be noncompliant with Part D rules.

*Tracey A. McCutcheon*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 21.1 KEY TERMS USED IN GENERAL ASSUMPTIONS

***Part D drug in compound:*** An ingredient within a compound that independently meets the definition of a Part D drug.

***Part D drug cost:*** The sum of the ingredient costs paid for Part D drugs in the compound plus the dispensing fee paid and sales tax paid for the entire compound.

***Enhanced drug in compound:*** An excluded drug within a compound covered under a Part D plan's enhanced benefit that would otherwise meet the definition of a Part D drug but for the fact that it is specifically excluded as a Part D drug under 42 CFR 423.100.

***OTC drug in compound:*** An excluded over-the-counter drug within a compound covered under a Part D plan's formulary.

***CMS excluded drug in compound:*** An excluded drug within a compound that is non-enhanced and non-OTC (such as bulk drugs and DESI drugs).

## 21.2 GENERAL ASSUMPTIONS

Subject to appeal, it is up to the Part D sponsors to determine if any drug, including a compound drug, is not a Part D drug. If the plan determines compound(s) is/are not Part D, then the following rules do not apply unless an appeal forces the plan to pay as Part D. If the plan determines that compound(s) is/are a Part D drug, then the following scenarios and rules apply:

Three scenarios:

1. Part D sponsor covers compounds (considers them Part D) and compounds that contain any Part D drug is considered formulary.
2. Part D sponsor covers compounds (considers them Part D) and compounds that contain any Part D drug is considered non-formulary.
3. Part D sponsor covers compounds (considers them Part D) and some compounds are formulary and some are not (based on plan benefit design).

**Claims submission recommendations:**

To determine if any drugs are not covered by Part D, the Pharmacy should initially bill without Submission Clarification Code (SCC) of 8. (From Telecom Imp Guide: A value 8 is resubmitted on a rejected compound prescription when the pharmacist decides to accept payment for all other ingredients, except those not covered by the plan.) If no drugs are covered by Part D, follow Part D Plan guidance (i.e. PA required) or follow normal process downstream. If the Pharmacy chooses to accept reimbursement for covered ingredients, resubmit with SCC of 8.

The reject should include the ingredients not covered in the message as well as the Reject Code Occurrence Indicator to point to the ingredients not covered. (See section 28.1.12.6 of imp guide for guidance.)

**The following business rules apply to processing of Multi-Ingredient Compound claims for Medicare Part D when using the Telecom D.0 Standard.**

1. Only compounds that contain at least one ingredient that independently meets the definition of a Part D drug may be covered under Part D.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

2. If sponsor accepts compounds under the benefit, sponsor can determine if all compounds are on or off formulary, or make a determination at an individual claim level.
    a. If a compound is On-formulary, then all Part D ingredients are considered On-Formulary (even if the drug would be non-formulary as a single drug claim).
    b. If a compound is Off-formulary, transition rules apply. Under transition all Part D ingredients in the compound must become payable as a result of that transition supply. If an exception is approved for an Off-Formulary compound, all Part D ingredients, but only Part D ingredients, are covered under the exception. Plans may contract to pay other components but may not charge cost sharing for non-Part D ingredients (per CMS policy).

3. Compounds can only be covered under one Medicare benefit:

    c. If a Compound contains a covered Part B ingredient:

    A claim that contains at least one ingredient confirmed to be covered under Part B is considered a Part B compound and will be rejected with "A5" (Not Covered Under Part D Law) and "A6" (This Medication May Be Covered Under Part B). It doesn't matter if other ingredients in the compound are not Part B ingredients. Refer to example #1.

    d. Else if a Compound contains an ingredient that might be covered under Part B but needs further analysis (e.g. prior authorization, place of residence, diagnosis):

    Compounds that contain at least one ingredient that is considered B vs. D, whether or not any other ingredient is a Part D drug, must be rejected for coverage determination purposes. Use Reject Code "A6" (This Medication May Be Covered Under Part B).

    e. Else if a Compound contains at least one Part D ingredient and no ingredients covered by Part B

    Compounds that contain at least one Part D ingredient will be covered under Part D. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the Part D drug cost (see definition above). Plans may contract to pay the pharmacy the additional ingredients that are not Part D but may only report the Part D covered components cost on their PDEs and in reconciliation. NOTE: Plans may determine if they will/will not cover an enhanced drug or an OTC as part of a compound that are normally covered as a single drug claim.

        i. Compounds that contain a Part D drug, but non-Part D drugs are not covered by the plan:

            1. If the compound contains at least one Part D drug and the pharmacy accepts reimbursement for only the covered Part D ingredients, the compound should be covered under Part D. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the Part D drug cost (see definition above). Refer to example 2.

        ii. Compounds that contain a Part D Drug and an Enhanced drug that is covered by the plan:

            1. If the compound contains at least one Part D drug and at least one excluded drug (e.g., diazepam) that is covered under an enhanced Part D benefit, the compound should be covered under Part D and the enhanced drug CANNOT be covered under the enhanced benefit. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the Part D drug cost (see definition above). Plans may not charge cost share for the enhanced ingredients. Plans may contract to pay the pharmacy the additional ingredients that are not Part D but may only report the Part D covered components cost as identified above. Refer to Example 3a.

        iii. Compounds that contain a Part D Drug and a non-covered non-Part D drug (OTC) that is covered by the plan.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

1. If the compound contains at least one Part D drug and at least one excluded drug that is NOT covered under an enhanced Part D benefit (think OTC), the compound should be covered under Part D. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the Part D drug cost (see definition above). As with single drug claims for OTCs, Plans may not charge cost share for the OTC ingredients. Plans may contract to pay the pharmacy the additional ingredients that are not Part D but may only report the Part D covered components cost as identified above. Refer to Example 3b.

iv. Compounds that contain a Part D covered drug and contain a CMS excluded drug that is covered by the plan

1. If the compound contains at least one ingredient that is a Part D drug and at least one excluded drug that is NOT covered under an enhanced Part D benefit and is not OTC, the compound should be covered under Part D. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the Part D drug cost (see definition above). Plans may not charge cost share for the non-Part D ingredients. Plans may contract to pay the pharmacy the additional ingredients that are not Part D but may only report the Part D covered components cost as identified above. Refer to example 3c.

f. Compounds that do not contain a Part D Drug but do contain Enhanced drugs that the plan reported as covered on their formulary.

i. If a Plan reported an enhanced drug as covered on their formulary, the Plan may choose to cover it in compounds, as well as in a single drug claim. Compounds that do not contain a Part D drug, but contain at least one Enhanced drug should be covered under the enhanced benefit. Calculations for PDE and applicable components of Patient Pay Amount Field 505-F5 are based only on the enhanced drug cost (defined as the sum of ingredient costs paid for the covered enhanced drugs in the compound plus dispensing fee paid and sales tax paid for the entire compound). Plans may not charge cost share for any other ingredients. Plans may contract to pay the pharmacy the additional ingredients that are not enhanced but may only report the enhanced components cost as identified above. Refer to example 4.

g. Compounds that do not contain a Part D drug, and do not contain an enhanced drug, but contain at least one OTC drug that the plan reported as covered on their formulary

i. If a Plan reported an OTC drug as covered on their formulary, the plan may choose to cover it in compounds, as well as in a single drug claim. Compounds that do not contain a Part D drug or an enhanced drug, but contain at least one OTC drug should be reported as OTC. Calculations for PDE are based only on the OTC drug cost (defined as ingredient costs paid for the covered OTCs in the compound plus dispensing fee paid and sales tax paid for the entire compound). Plans may not charge cost share for any ingredients within the OTC compound. Plans may contract to pay the pharmacy the additional ingredients that are not OTC but may only report the OTC components cost as identified above. Refer to example 5.

h. Copay/Coinsurance: Part D sponsors determine which benefit copay or coinsurance applies to compounds.

i. In addition, for LICS/Catastrophic Copay/Coinsurance: Part D sponsors must determine cost-sharing for copays defined by statute (i.e., brand or generic cost-sharing for LIS and catastrophic) the Part D sponsor should apply the cost-sharing that is applicable to the Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity).


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

i. On the 835, the individual ingredients of the compound are not reported. The first valid Product/Service ID which is an NDC number is submitted (the individual ingredient in the Compound Segment, not the zeroes required of Product/Service ID of the Claim Segment for a compound). – THIS NEEDS further discussion with WG45 and the work they are doing on the 835 to determine if the 835 and the PDE population logic should be the same.

## 21.3 PDE REPORTING

- For ALL Multi-Ingredient Compounds regardless of benefit category – Submit the NDC of the ingredient for the determined category with the highest line item computed ingredient cost (unit cost x quantity).
- Quantity – Submit the total quantity of the compound in its final form (as the pharmacy submitted) –using Quantity Dispensed (442-E7).
    - The total quantity reported on the PDE must match the value of Quantity Dispensed (442-E7) in the Claim Segment.
- Drug Costs – Report total "paid" drug costs for ingredients in the compound that independently meet the definition of a Part D drug. All Part D beneficiary cost-sharing amounts must be based upon only the costs associated with Part D ingredients. Part D "paid" drug costs = The sum of Part D ingredient costs paid plus the dispensing fee paid and sales tax paid for the entire compound
- If no Part D drugs exist in the compound and the compound includes covered enhanced drugs, report total Enhanced "paid" drug costs for all enhanced ingredients. Enhanced "paid" drug costs = The sum of Enhanced drug ingredient costs paid plus the dispensing fee paid and sales tax paid for the entire compound. Beneficiary cost-sharing amounts must be based upon only the costs related to the enhanced drugs.
- If only OTC drugs are covered in the compound report total paid for covered OTC drugs. OTC "paid" drug costs = The sum of OTC drug ingredient costs paid plus the dispensing fee paid and sales tax paid for the entire compound. No beneficiary cost sharing applies to an OTC compound.

## 21.4 COST SHARE CALCULATION FOR MULTI-INGREDIENT COMPOUND CLAIMS THAT STRADDLE THE COVERAGE GAP AND CATASTROPHIC PHASES

**Question:**

Per NCPDP Editorial Update (version 11.0, published February, 2011):

- Section 13.2, paragraph 3.e indicates that compounds with at least one Part D ingredient use a 'sum of Part D ingredients' rules for adjudication.
- Section 13.2, paragraph 3.h.i indicates that compounds that fall in the Catastrophic benefit phase must calculate copay/coinsurance by applying brand or generic cost sharing applicable to the 'Part D ingredient with the highest line item computed ingredient cost'.

If a processor receives a Part D compound claim (for example, 2 Part D ingredients … non LIS member) and the claim crosses the TrOOP Threshold into CAT, do we apply 'sum the Part D ingredients' rule or do we apply the 'highest cost D ingredient' rule?

*This question was discussed with Craig Miner (CMS), and he approved the following response:*

**Response:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

CMS will likely clarify specific rules for determining catastrophic copay for multi-ingredient compounds in future guidance. Until such time as that guidance is issued, Part D sponsors are not prohibited from implementing catastrophic copays for multi-ingredient Part D compounds based on how compounds are treated in other benefit levels. However, Part D sponsors may also determine the applicable catastrophic copays based on whether the most expensive Part D ingredient is a generic or a brand name drug. The latter approach would be most consistent with the CMS general policy goal of ensuring consistent application of statutory copays across the Part D program.

Examples have not been created for claims straddling the Coverage Gap and Catastrophic benefit phases to avoid any confusion that may occur if Part D plans are using different methods for determining Gross Drug Cost Before Out-of-Pocket Threshold for claims that have a percentage coinsurance less than 100% in Gap. However, examples are provided below for variations in cost share allowed for claims that fall fully in the Catastrophic phase.

Example 1: Defined Standard Benefit; multi-ingredient compound dispensed; most expensive ingredient is ANDA drug. Full claim cost falls in catastrophic. Part D sponsor determines cost share for compounds based on most expensive ingredient; therefore, $2.50 catastrophic copay applies.

| | Benefit Level Drug Cost | Patient Pay | Plan Pay |
|---|---|---|---|
| **Initial Coverage –** *25% coinsurance* | | | |
| **Coverage Gap –** *100% coinsurance* | | | |
| **Catastrophic -** *Greater of 5% or $2.50/$6.30* | $40.00 | $2.50 | $37.50 |
| **Total** | $40.00 | $2.50 | $37.50 |

Example 2: Enhanced Benefit; multi-ingredient compound dispensed; most expensive ingredient is ANDA drug. Full claim cost falls in catastrophic. Part D sponsor applies brand cost share to all compounds; therefore, $6.30 catastrophic copay applies.

| | Benefit Level Drug Cost | Patient Pay | Plan Pay |
|---|---|---|---|
| **Initial Coverage** – $40 copay | | | |
| **Coverage Gap –** *100% coinsurance* | | | |
| **Catastrophic -** *Greater of 5% or $2.50/$6.30* | $40.00 | $6.30 | $33.70 |
| **Total** | $40.00 | $6.30 | $33.70 |

## 21.5 EXAMPLE 1: MAPD PLAN COVERS THE PART D INGREDIENTS AND SOME OF THE NON-PART D INGREDIENTS OF THE COMPOUND

Because one of the covered ingredients is a “B” drug, the compound is treated like “B” and is rejected by the Part D plan. Label for B1 response column consistent on all examples.

| Ingredient | Drug | Substitution Indicator | Drug Type | Qty | Submitted IC | Contracted Rate | Payable IC | |
|---|---|---|---|---|---|---|---|---|
| 1 | A | SS Brand | Part D | 90.000 | $30.24 | $18.31 | $0.00 | |
| 2 | B | Generic | Part D | 1.375 | $0.90 | $0.68 | $0.00 | |
| 3 | C | MS Brand | Enhanced | 0.220 | $2.81 | $2.09 | $0.00 | |
| 4 | D | Generic | Enhanced | 0.110 | $2.84 | $2.12 | $0.00 | |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 5 | E | SS Brand | Part B | 108.290 | $20.62 | $12.37 | $0.00 | |
| | | | | | | | | D.0 Response |
| Reject Codes | | | | | | | | A5, A6 |

**Assumptions for Example 1:**

- Because there is one covered Part B drug in this compound, it must be billed under Part B. Compounds that contain at least one non-Part D drug ingredient that is covered under Medicare Part B (as prescribed and dispensed or administered) CANNOT be covered under Part D.
    - If this is a PDP plan, the claim will be rejected, as illustrated above, and must be submitted to the Part B payer.
    - .
- If any ingredients in the above compound were not covered, the claim would be rejected to identify to the pharmacy the non-covered ingredients. Reject Code combination "A5"/"A6" denotes the drug is Part B.
- If ingredient 5 above was a B vs. D drug, the claim would be rejected for a coverage determination.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 21.5.1 EXAMPLE 2: PDP ALTERNATE BASIC PLAN COVERS ONLY THE PART D INGREDIENTS OF THE COMPOUND

| Ingredient | Drug | Substitution Indicator | Drug Type | Qty | Submitted IC | Contracted Rate | Part D Payable | |
|---|---|---|---|---|---|---|---|---|
| 1 | A | SS Brand | Part D | 90.000 | $30.24 | $18.31 | $18.31 | |
| 2 | B | Generic | Part D | 1.375 | $0.90 | $0.68 | $0.68 | |
| 3 | C | MS Brand | Not B or D | 0.220 | $2.81 | $2.09 | $0.00 | |
| 4 | D | Generic | Part D | 0.110 | $2.84 | $2.12 | $2.12 | |
| 5 | E | SS Brand | Not B or D | 108.290 | $20.62 | $12.37 | $0.00 | |
| | | | | | | | | D.0 Response |
| Ingredient Total | A, B, D | | | | $57.41 | $35.57 | $21.11 | $21.11 |
| Dispensing Fee | | | | | | | $2.00 | $2.00 |
| Sales Tax | | | | | | | $1.00 | $1.00 |
| Total Cost | | | | | | | $24.11 | $24.11 |
| 20% Coinsurance | | | | | | | $4.82 | $4.82 |
| Plan Paid | | | | | | | $19.29 | $19.29 |

| PDE Cost Fields | | PDE Payment Fields | |
|---|---|---|---|
| Ingredient Cost | $21.11 | Patient Pay | $4.82 |
| Dispensing Fee | $2.00 | LICS Subsidy Amount | |
| Sales Tax | $1.00 | Other TrOOP | |
| Vaccine Admin Fee | | PLRO | |
| | | CPP | $19.29 |
| GDCB | $24.11 | NPP | |
| GDCA | | Drug Coverage Status Code | C |

| EOB Summary of Prescription Claims Processed from <mm/dd/yyyy> through <mm/dd/yyyy> | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of Service | Prescription [Claim] Number | Name of Drug | Quantity Dispensed | Amount <Plan Name> Paid | Amount You Paid | [Amount Paid by Secondary Coverage/Other Sources] | [Extra Help from Medicare] |
| 01/01/2012 | 1234567 | Compound | 199.995 | $19.29 | $4.82 | $0.00 | $0.00 |

**Assumptions for Example 2:**

- Pharmacy should bill without SCC to determine if any drugs are covered by Part D. If no drugs are covered by Part D, follow Part D Plan guidance (i.e. PA required) or follow normal process downstream. If any one of the ingredients in the rejected claim does not have a reject code associated with it (at least one drug is Part D payable), resubmit with SCC of 8.
- Compound is treated as Part D because there is at least one ingredient that independently meets the definition of a Part D drug and there are no Part B ingredients.


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Dispensing fee and sales tax for the entire compound should be included on the PDE and reported with the NDC of the Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity).
- Total cost of Part D ingredients + dispensing fee + tax for the entire compound applies to Drug Spend and is used to calculate Patient Pay, LICS, TrOOP
- TrOOP would be:
    - $ 4.82 if in initial coverage and 20% coinsurance for non-LICS members
- LICS copay (generic vs. brand) is based on the Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity)., which in this example is Drug A (brand).
    - $ 4.82 if in initial coverage of which $3.30 is LICS 2 copay and $1.52 is LICS Subsidy
- PDE would report NDC for Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity), with cost and payment fields applicable only to the covered Part D ingredients.
- Model EOB would report "Compound" as the drug name for all multi-ingredient compound claims.
    - The Part D EOB will not reflect the member's actual out of pocket if the pharmacy is allowed to bill the member for the cost of non-covered drugs in addition to Part D cost sharing.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### 21.5.2 EXAMPLE 3A: MAPD PLAN COVERS THE PART D INGREDIENTS AND ONE NON-PART D INGREDIENT (#3) IN THE COMPOUND

Because none of the covered ingredients is "B" and at least one of the covered ingredients is Part D, the compound is treated like Part D. Plan may choose to pay for non-Part D drugs; however, assumption is that no cost sharing may be charged for the non-Part D ingredients.

| Ingredient | Drug | Substitution Indicator | Drug Type | Qty | Submitted IC | Contracted Rate | Payable Part D | Payable Non-Part D |
|---|---|---|---|---|---|---|---|---|
| 1 | A | SS Brand | Part D | 90.000 | $30.24 | $18.31 | $18.31 | |
| 2 | B | Generic | Part D | 1.375 | $0.90 | $0.68 | $0.68 | |
| 3 | C | MS Brand | Enhanced | 0.220 | $2.81 | $2.09 | $0.00 | $2.09 |
| 4 | D | Generic | OTC | 0.110 | $2.84 | $2.12 | $0.00 | |
| 5 | E | SS Brand | Part D | 108.290 | $20.62 | $12.37 | $12.37 | |
| | | | | | | | | D.0 Response |
| Ingredient Total | All | | | | $57.41 | $35.57 | $31.36 | $33.45 |
| Dispensing Fee | | | | | | | $2.00 | $2.00 |
| 8% Sales Tax | | | | | | | $2.84 | $2.84 |
| Total Cost | | | | | | | $36.20 | $38.29 |
| 25% Coinsurance | | | | | | | $9.05 | $9.05 |
| Plan Paid | | | | | | | $27.15 | $29.24 |

| PDE Cost Fields | | PDE Payment Fields | |
|---|---|---|---|
| Ingredient Cost | $31.36 | Patient Pay | $9.05 |
| Dispensing Fee | $2.00 | LICS Subsidy Amount | |
| Sales Tax | $2.84 | Other TrOOP | |
| Vaccine Admin Fee | | PLRO | |
| | | CPP | $27.15 |
| GDCB | $36.20 | NPP | $0.00 |
| GDCA | | Drug Coverage Status Code | C |

| EOB Summary of Prescription Claims Processed from <mm/dd/yyyy> through <mm/dd/yyyy>_ | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of Service | Prescription [Claim] Number | Name of Drug | Quantity Dispensed | Amount <Plan Name> Paid | Amount You Paid | [Amount Paid by Secondary Coverage/Other Sources] | [Extra Help from Medicare] |
| 01/01/2012 | 1234567 | Compound | 199.995 | $27.15 | $9.05 | $0.00 | $0.00 |

**Assumptions for Example 3a:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Pharmacy should bill without SCC to determine if any drugs are covered by Part D. If no drugs are covered by Part D, follow Part D Plan guidance (i.e. PA required) or follow normal process downstream. If any one of the ingredients in the rejected claim does not have a reject code associated with it (at least one drug is Part D payable), resubmit with SCC of 8. The pharmacy may bill the member or other payer, as appropriate, for drugs not covered per reject code on previous claim.
- Compound is treated as Part D because there is at least one ingredient that independently meets the definition of a Part D drug and there are no Part B ingredients.
- Med D accumulations of Drug Spend and TrOOP are based on the sum of the covered Part D ingredients + dispensing fee + sales tax for the entire compound. The ingredient cost for the covered enhanced drug is excluded from Med D accumulations.
- PDE would report NDC for Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity), with cost and payment fields applicable only to the covered Part D ingredients. The ingredient cost associated with the enhanced drug is not reported on the PDE.
- Model EOB would report "Compound" as the drug name for all multi-ingredient compounds.
- The EOB will not match with the patient receipt from the pharmacy. The Part D Plan paid the pharmacy $29.24; however, the EOB will show a plan paid amount of $27.15 (excludes enhanced drug cost). The patient pay of $9.05 is the same on the receipt and EOB since no cost sharing was assessed on the non-Part D drug.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### 21.5.3 EXAMPLE 3B: MAPD PLAN COVERS THE PART D INGREDIENTS AND ONE NON-PART D INGREDIENT (#4) IN THE COMPOUND

Because none of the covered ingredients is "B" and at least one of the covered ingredients is Part D, the compound is treated like Part D. Plan may choose to pay for non-Part D drugs; however, assumption is that no cost sharing may be charged for the non-Part D ingredients.

| Ingredient | Drug | Substitution Indicator | Drug Type | Qty | Submitted IC | Contracted Rate | Payable Part D | Payable Non-Part D |
|---|---|---|---|---|---|---|---|---|
| 1 | A | SS Brand | Part D | 90.000 | $30.24 | $18.31 | $18.31 | |
| 2 | B | Generic | Part D | 1.375 | $0.90 | $0.68 | $0.68 | |
| 3 | C | MS Brand | Enhanced but not covered by plan | 0.220 | $2.81 | $2.09 | $0.00 | |
| 4 | D | Generic | OTC | 0.110 | $2.84 | $2.12 | $0.00 | $2.12 |
| 5 | E | SS Brand | Part D | 108.290 | $20.62 | $12.37 | $12.37 | |
| | | | | | | | | D.0 Response |
| Ingredient Total | All | | | | $57.41 | $35.57 | $31.36 | $33.48 |
| Dispensing Fee | | | | | | | $2.00 | $2.00 |
| Sales Tax | | | | | | | $1.00 | $1.00 |
| Total Cost | | | | | | | $34.36 | $36.48 |
| 25% Coinsurance | | | | | | | $8.59 | $8.59 |
| Plan Paid | | | | | | | $25.77 | $27.89 |

| PDE Cost Fields | | PDE Payment Fields | |
|---|---|---|---|
| Ingredient Cost | $31.36 | Patient Pay | $8.59 |
| Dispensing Fee | $2.00 | LICS Subsidy Amount | |
| Sales Tax | $1.00 | Other TrOOP | |
| Vaccine Admin Fee | | PLRO | |
| | | CPP | $25.77 |
| GDCB | $34.36 | NPP | $0.00 |
| GDCA | | Drug Coverage Status Code | C |

| EOB Summary of Prescription Claims Processed from <mm/dd/yyyy> through <mm/dd/yyyy>_ | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of Service | Prescription [Claim] Number | Name of Drug | Quantity Dispensed | Amount <Plan Name> Paid | Amount You Paid | [Amount Paid by Secondary Coverage/Other Sources] | [Extra Help from Medicare] |
| 01/01/2012 | 1234567 | Compound | 199.995 | $25.77 | $8.59 | $0.00 | $0.00 |

**Assumptions for Example 3b:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Pharmacy should bill without SCC to determine if any drugs are covered by Part D. If no drugs are covered by Part D, follow Part D Plan guidance (i.e. PA required) or follow normal process downstream. If any one of the ingredients in the rejected claim does not have a reject code associated with it (at least one drug is Part D payable), resubmit with SCC of 8. The pharmacy may bill the member or other payer, as appropriate, for drugs not covered per reject code on previous claim.
- Compound is treated as Part D because there is at least one ingredient that independently meets the definition of a Part D drug and there are no Part B ingredients.
- Med D accumulations of Drug Spend and TrOOP are based on the sum of the covered Part D ingredients + dispensing fee + sales tax for the entire compound. The ingredient cost for the covered OTC drug is excluded from Med D accumulations.
- PDE would report NDC for Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity), with cost and payment fields applicable only to the covered Part D ingredients. The ingredient cost associated with the OTC drug is not reported on the PDE.
- Model EOB would report "Compound" as the drug name for all multi-ingredient compounds.
- The EOB will not match with the patient receipt from the pharmacy. The Part D Plan paid the pharmacy $27.89; however, the EOB will show a plan paid amount of $25.77 (excludes OTC drug cost). The patient pay of $8.59 is the same as no cost sharing was assessed on the non-Part D drug.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 21.5.4 EXAMPLE 3C: MAPD PLAN COVERS THE PART D INGREDIENTS AND BOTH EXCLUDED NON-PART D INGREDIENTS (#3 & #4) IN THE COMPOUND

Because none of the covered ingredients is "B" and at least one of the covered ingredients is Part D, the compound is treated like Part D. Plan may choose to pay for non-Part D drugs; however, no cost sharing may be charged for the non-Part D ingredients.

| Ingredient | Drug | Substitution Indicator | Drug Type | Qty | Submitted IC | Contracted Rate | Payable Part D | Total Paid to Pharmacy |
|---|---|---|---|---|---|---|---|---|
| 1 | A | SS Brand | Part D | 90.000 | $30.24 | $18.31 | $18.31 | |
| 2 | B | Generic | Part D | 1.375 | $0.90 | $0.68 | $0.68 | |
| 3 | C | MS Brand | Excluded | 0.220 | $2.81 | $2.09 | $0.00 | $2.09 |
| 4 | D | Generic | Excluded | 0.110 | $2.84 | $2.12 | $0.00 | $2.12 |
| 5 | E | SS Brand | Part D | 108.290 | $20.62 | $12.37 | $12.37 | |
| | | | | | | | | D.0 Response |
| Ingredient Total | All | | | | $57.41 | $35.57 | $31.36 | $35.57 |
| Dispensing Fee | | | | | | | $2.00 | $2.00 |
| Sales Tax | | | | | | | $1.00 | $1.00 |
| Total Cost | | | | | | | $34.36 | $38.57 |
| 25% Coinsurance | | | | | | | $8.59 | $8.59 |
| Plan Paid | | | | | | | $25.77 | $29.98 |

| PDE Cost Fields | | PDE Payment Fields | |
|---|---|---|---|
| Ingredient Cost | $31.36 | Patient Pay | $8.59 |
| Dispensing Fee | $2.00 | LICS Subsidy Amount | |
| Sales Tax | $1.00 | Other TrOOP | |
| Vaccine Admin Fee | | PLRO | |
| | | CPP | $25.77 |
| GDCB | $34.36 | NPP | $0.00 |
| GDCA | | Drug Coverage Status Code | C |

| EOB Summary of Prescription Claims Processed from <mm/dd/yyyy> through <mm/dd/yyyy>_ | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date Prescription Filled | Prescription [Claim] Number | Name of Drug | Quantity Filled | Amount <Plan Name> Paid | Amount You Paid | [Amount Paid by Secondary Coverage/Other Sources] | [Extra Help from Medicare] |
| 01/01/2012 | 1234567 | Compound | 199.995 | $25.77 | $8.59 | $0.00 | $0.00 |

**Assumptions for Example 3c:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- Pharmacy should bill without SCC to determine if any drugs are covered by Part D. If no drugs are covered by Part D, follow Part D Plan guidance (i.e. PA required) or follow normal process downstream. If any one of the ingredients in the rejected claim does not have a reject code associated with it (at least one drug is Part D payable), resubmit with SCC of 8. The pharmacy may bill the member or other payer, as appropriate, for drugs not covered per reject code on previous claim.
- Compound is treated as Part D because there is at least one ingredient that independently meets the definition of a Part D drug and there are no Part B ingredients.
- Med D accumulations of Drug Spend and TrOOP are based on the sum of the covered Part D ingredients + dispensing fee + sales tax for the entire compound. The ingredient cost amounts for the covered non-Part D drugs are excluded from Med D accumulations.
- PDE would report NDC for Part D ingredient with the highest line item computed ingredient cost (unit cost x quantity), with cost and payment fields applicable only to the covered Part D ingredients. The ingredient cost amounts associated with the non-Part D drugs are not reported on the PDE.
- Model EOB would report "Compound" as the drug name for all multi-ingredient compounds.
  The EOB will not match with the patient receipt from the pharmacy. The Part D Plan paid the pharmacy $29.98; however, the EOB will show a plan paid amount of $25.77 (excludes enhanced & OTC drug costs). The patient pay of $8.59 is the same as no cost sharing was assessed on the non-Part D drugs.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 21.5.5 EXAMPLE 4: MAPD Plan covers the enhanced ingredients and OTC ingredients of the compound (no Part D drugs included)

Because one of the covered ingredients is an enhanced drug and none of the covered ingredients is Part B or Part D, the compound is treated like enhanced. Submit NDC of most expensive enhanced drug to the PDE and report costs and copays only related to the enhanced drugs. Plan may choose to pay the pharmacy for OTC ingredients based on contract, but no cost sharing may be assessed on these OTC ingredients.

| Ingredient | Drug | Substitution Indicator | Drug Type | Qty | Submitted IC | Contracted Rate | Payable Enhanced Part D | Payable Non-Part D |
|---|---|---|---|---|---|---|---|---|
| 1 | A | SS Brand | Enhanced | 90.000 | $30.24 | $18.31 | $18.31 | |
| 2 | B | Generic | OTC | 1.375 | $0.90 | $0.68 | $0.00 | $0.68 |
| 3 | C | MS Brand | Enhanced | 0.220 | $2.81 | $2.09 | $2.09 | |
| 4 | D | Generic | OTC | 0.110 | $2.84 | $2.12 | $0.00 | $2.12 |
| 5 | E | SS Brand | Enhanced | 108.290 | $20.62 | $12.37 | $12.37 | |
| | | | | | | | | D.0 Response |
| Ingredient Total | All | | | | $57.41 | $35.57 | $32.77 | $35.57 |
| Dispensing Fee | | | | | | | $2.00 | $2.00 |
| Sales Tax | | | | | | | $1.00 | $1.00 |
| Total Cost | | | | | | | $35.77 | $38.57 |
| 20% Coinsurance | | | | | | | $7.15 | $7.15 |
| Plan Paid | | | | | | | $28.62 | $31.42 |

| PDE Cost Fields | | PDE Payment Fields | |
|---|---|---|---|
| Ingredient Cost | $32.77 | Patient Pay | $7.15 |
| Dispensing Fee | $2.00 | LICS Subsidy Amount | |
| Sales Tax | $1.00 | Other TrOOP | |
| Vaccine Admin Fee | | PLRO | |
| | | CPP | $0.00 |
| GDCB | $0.00 | NPP | $28.62 |
| GDCA | | Drug Coverage Status Code | E |

| EOB Summary of Prescription Claims Processed from <mm/dd/yyyy> through <mm/dd/yyyy>_ | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of Service | Prescription [Claim] Number | Name of Drug | Quantity Dispensed | Amount <Plan Name> Paid | Amount You Paid | [Amount Paid by Secondary Coverage/Other Sources] | [Extra Help from Medicare] |
| 01/01/2012 | 1234567 | Compound | 199.995 | $28.62 | $7.15 | $0.00 | $0.00 |

**EOB Notes:**


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Some compound ingredients aren't generally covered by Medicare drug coverage and don't count toward your out-of-pocket or total drug costs or help you reach catastrophic coverage. See section [2] for more information.

**Assumptions for Example 4:**

- MAPD enhanced plan that covers enhanced drugs and OTC drugs in the compound.
- Compound is treated as enhanced because none of the covered ingredients is a Part B drug or a Part D drug and at least one of the ingredients is an "E" drug.
- The 20% coinsurance was computed only for the enhanced drugs. The cost for the OTC drugs was excluded since the assumption is that OTC drugs may be covered only with $0 cost share to the member.
- Med D accumulations of Drug Spend and TrOOP are bypassed.
- PDE would report the NDC for the enhanced ingredient with the highest line item computed ingredient cost (unit cost x quantity), with an ingredient cost amount equal to the sum of only the enhanced ingredients. Dispensing fee paid and sales tax paid are for the entire compound.
- Model EOB would report "Compound" for the drug name for all multi-ingredient compound claims.
- The EOB will not match with the patient receipt from the pharmacy. The Part D Plan paid the pharmacy $31.42; however, the EOB will show a plan paid amount of $28.62 (excludes OTC drug costs). The patient pay of $7.15 is the same as no cost sharing was assessed on the OTC drugs.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 21.5.6 EXAMPLE 5: MAPD PLAN COVERS THE OTC INGREDIENTS OF THE COMPOUND (NO PART D DRUGS INCLUDED)

Because all of the covered ingredients are OTC drugs and none of the covered ingredients is Part B or Part D, the compound is treated like OTC. Submit NDC of most expensive OTC drug to the PDE and report costs for all covered OTC drugs. No cost sharing may be assessed on OTC ingredients.

| Ingredient | Drug | Substitution Indicator | Drug Type | Qty | Submitted IC | Contracted Rate | Payable Part D | |
|---|---|---|---|---|---|---|---|---|
| 1 | A | SS Brand | OTC | 90.000 | $30.24 | $18.31 | $18.31 | |
| 2 | B | Generic | OTC | 1.375 | $0.90 | $0.68 | $0.68 | |
| 3 | C | MS Brand | OTC | 0.220 | $2.81 | $2.09 | $2.09 | |
| 4 | D | Generic | OTC | 0.110 | $2.84 | $2.12 | $2.12 | |
| 5 | E | SS Brand | OTC | 108.290 | $20.62 | $12.37 | $12.37 | |
| | | | | | | | | D.0 Response |
| Ingredient Total | All | | | | $57.41 | $35.57 | $35.57 | $35.57 |
| Dispensing Fee | | | | | | | $2.00 | $2.00 |
| Sales Tax | | | | | | | $1.00 | $1.00 |
| Total Cost | | | | | | | $38.57 | $38.57 |
| Patient Pay | | | | | | | $0.00 | $0.00 |
| Plan Paid | | | | | | | $38.57 | $38.57 |

| PDE Cost Fields | | PDE Payment Fields | |
|---|---|---|---|
| Ingredient Cost | $35.57 | Patient Pay | $0.00 |
| Dispensing Fee | $2.00 | LICS Subsidy Amount | |
| Sales Tax | $1.00 | Other TrOOP | |
| Vaccine Admin Fee | | PLRO | |
| | | CPP | $0.00 |
| GDCB | $0.00 | NPP | $38.57 |
| GDCA | | Drug Coverage Status Code | O |

| EOB Summary of Prescription Claims Processed from <mm/dd/yyyy> through <mm/dd/yyyy> | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of Service | Prescription [Claim] Number | Name of Drug | Quantity Dispensed | Amount <Plan Name> Paid | Amount You Paid | [Amount Paid by Secondary Coverage/Other Sources] | [Extra Help from Medicare] |
| 01/01/2012 | 1234567 | Compound | 199.995 | $38.57 | $0.00 | $0.00 | $0.00 |

**EOB Notes:**

Some compound ingredients aren't generally covered by Medicare drug coverage and don't count toward your out-of-pocket or total drug costs or help you reach catastrophic coverage. See section [2] for more information.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Assumptions for Example 5:**

- MAPD enhanced plan that covers OTC drugs in the compound.
- Compound is treated as OTC because none of the covered ingredients is a Part B drug, a Part D drug, or a covered enhanced drug and all of the ingredients are OTCs.
- The cost share for OTC drugs is always $0.
- Med D accumulations of Drug Spend and TrOOP are bypassed.
- PDE would report the NDC for the OTC ingredient with the highest line item computed ingredient cost (unit cost x quantity), and an ingredient cost amount equal to the sum of the covered OTC ingredients. Dispensing fee paid and sales tax paid are for the entire compound.
- Model EOB would report "Compound" for the drug name for all multi-ingredient compound claims.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

# 22 APPENDIX D. MEDICARE PART D TOPICS

## 22.1 HARDCODED VALUES

If information changes with Medicare Part D contractors, this document will be need to be updated for hardcoded BINs, PCN, telephone numbers, etc.

## 22.2 NOTICE OF APPEAL RIGHTS – REJECTED CLAIM

**Effective Date: January 1, 2012**

This applies to D.0 claims submitted on or after January 1, 2012. Modifications are denoted below in a new section stating "This applies to D.0 claims submitted on or after July 1, 2013".

**CMS Appeals and Grievance Notice Process Guidelines**

This was developed in anticipation of potential future CMS guidance requiring Part D Plans to direct their contracted pharmacies to provide beneficiaries with a Notice of Appeal Rights. The Notice should be provided based on information below. This is to ensure beneficiaries understand their rights when a Part D drug is rejected by the Part D Plan.

**PLAN/PROCESSOR ACTION**

**This applies to D.0 claims submitted on or after January 1, 2012.**

Part D Plans should assume denied drugs that are subject to transition requirement coverage will also be subject to the Notice of Appeal Rights requirement outside of the transition period.

If the beneficiary is not currently eligible for transition and has been prescribed a drug that is subject to transition requirement coverage, the plan's processor should return the following Reject Code in addition to all other applicable Reject Codes:

"569" (Provide Beneficiary with CMS Notice of Appeal Rights)

The Notice of Appeal Reject Code should not be returned in circumstances where transition coverage would not apply, such as:

- CMS Exclusion
- Medicare B vs. D Determination
- Drug not FDA Listed
- OTC
- Sanctioned Provider

These rejection reasons cannot effectively be appealed.

**PHARMACY ACTION**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

If the pharmacy receives a **REJECT** on a Part D claim and the claim contains the "569" (Provide Beneficiary with CMS Notice of Appeal Rights) Reject Code or free form message the beneficiary needs to know he or she has the right to appeal the rejection.

As a result of receiving this error code, the pharmacy should provide the beneficiary with the CMS Notice of Appeal Rights. The Notice of Appeal Rights is a standardized "handout" with CMS model language. The Notice will direct the beneficiary to use the phone number on the back of his or her Part D Plan card if the beneficiary chooses to appeal the reject.

When multiple claims deny with the Notice of Appeal Rights Reject Code, only one notice should be provided per pharmacy encounter or mail order package.

Mail Order Pharmacies are expected to mail/email the notice to the beneficiary based on the method of communication the beneficiary has chosen.

LTC pharmacies, serving LTC members, are exempt from providing the Notice of Appeal Rights to the beneficiary. These pharmacies do not dispense drugs to the beneficiary; they are dispensed to the facility.

### 22.2.1 Reject Code "569" and Submission Clarification Code

This applies to D.0 claims submitted on or after January 1, 2012. Modifications are denoted below in a new section stating "This applies to D.0 claims submitted on or after July 1, 2013".

**Question:**

How should Reject Code "569" (Provide Appeals Grievance Notice) work in conjunction with bypassed rejects using Submission Clarification Code 8 (Process Compound for Approved Ingredients)?

For example:

Pharmacy submits a compound for a member with 5 drugs in it. The following information is sent back to the pharmacy.

- Drug 1 - Rejected for "569"
- Drug 2 - Rejected for "569"
- Drug 3 - Rejected for "569"
- Drug 4 - Payable
- Drug 5 - Payable

What should happen in the case where the pharmacy uses Submission Clarification Code of 8 (Process Compound for Approved Ingredients) in this example? The question is if a compound claim initially rejects for "569" and the pharmacy uses Submission Clarification Code 8 indicating that they want the processor to pay the payable ingredients in the compound what should happen in this case? Is the pharmacy allowed to use Submission Clarification Code 8 in the below example or are they not allowed to use it and we should reject the entire compound?

**Response:**

1. There are rules for compounds submitted under a Part D BIN/PCN that contain (either Part B versus D) or Part B drugs (actually what the industry calls Part C drugs). Those rules state that any compound that contains either of these cannot be considered a Part D compound. The processor should not return the "569" or "018" because they are not Part D drugs and do not meet the appeal criteria.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

2. If the compound contains at least one ingredient that is considered a Part D ingredient (and does not fall in #1) and the claim is rejected under "569" "criteria":
    a. Reject Code "569" (and any other applicable claim level rejects) should be returned.
    b. Reject Codes that are specific to the ingredient should be returned.
    c. The pharmacy:
        i. Cannot resolve the reject, and provides the appeal notice to the patient. The claim is not paid by Part D.
        ii. May resubmit the claim with an SCC 8 (agreeing to accept only for covered ingredients) if the "569" is caused **because one/more ingredients are not approved**.
            1. If the Part D plan pays (SCC 8 is successful), appeal notice does not apply (no "018" is sent).
            2. If paid by co-administered insurance (not Part D) (SCC 8 is successful) and appeal notice does apply (018 is sent).

If the claim would have paid with an SCC 8 submitted originally, then the "569" should be returned.
If the compound is paid by Part D, then an appeal notice should not be provided.

## 22.3 Notice of Appeal Rights – Paid Claim

This applies to D.0 claims submitted on or after January 1, 2012. Modifications are denoted below in a new section stating "This applies to D.0 claims submitted on or after July 1, 2013".

DERF 1006 (approved 05/2011) requested a new Approved Message Code (548-6F) to identify claims not covered under the Part D portion but is paid under the co-administered supplemental portion of the member's benefit.

The situation is specific to when the beneficiary is enrolled in a plan to which the supplemental benefits are co-administered with the Part D benefit, and adjudication occurs within one transaction. A claim is submitted to a Part D BIN/PCN. The Part D plan does not cover the drug, however the drug is covered by a supplemental payer and that coverage is returned in the form of a paid response.

If the drug, not covered by the Part D Plan, meets the criteria for providing an appeal notice to the member, the paid claim response must contain an approval code so that the pharmacy can provide the member with the appeal notice. In the situation where the claim is covered by the supplemental payer the beneficiary will receive the notice that the drug was not covered by their Part D plan.

Approved Message Code (548-6F)

| | | |
|---|---|---|
| "018" | Provide Beneficiary With CMS Notice Of Appeal Rights | Claim for a Part D drug submitted to the plan's Medicare D BIN/PCN is not covered by the Part D plan and is outside the Part D transitional fill coverage period, but is paid under the plan's co-administered benefit or plan-sponsored negotiated price to the beneficiary. In this situation the member should be provided the Medicare Part D Appeal and Grievance Notice. |

## 22.4 Notice of Medicare Drug Coverage Rights – Rejected Claim


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

This applies to D.0 claims submitted on or after July 1, 2013.

**CMS Appeals and Grievance Notice Process Guidelines**

This appendix was developed to comply with CMS guidance for situations when Part D Plans need to direct their contracted pharmacies to provide beneficiaries with the notice entitled "Medicare Prescription Drug Coverage and Your Rights." The Notice should be provided based on information below. This is to ensure beneficiaries understand their coverage rights when a Part D prescription drug claim is rejected by the Part D Plan.

**PLAN/PROCESSOR ACTION**

**This applies to D.0 claims submitted on or after July 1, 2013.**

Based on CMS guidance, Part D Plans should provide the appropriate indicator to the participating pharmacy to provide the Notice to the patient for rejected claims that qualify for coverage determination.

The plan's processor should return the following Reject Code in addition to all other applicable Reject Codes:

"569"(Provide Notice: Medicare Prescription Drug Coverage and Your Rights)

Note: If there are more rejects than the allotted five occurrences, the "569" must be in one of the occurrences.

The Notice must be provided to the enrollee if the pharmacy receives a transaction response indicating the claim (contains all necessary data elements for adjudication) is not covered by the beneficiary's Part D benefit and the designated NCPDP Reject Code is returned.

The "569" Reject Code should not be returned in the following circumstances:

- Claim does not contain all necessary data elements for proper adjudication at POS
- Drug not listed on the participating CMS Manufacturer Labeler Code List (applicable for NDA and BLA)
- Drug not listed on the FDA Electronic List - NDC Structured Product Labeling Data Elements File (NSDE)
- Drug classified as Over The Counter (OTC)
- Submitted provider ID or prescriber ID is identified as a sanctioned provider
- Submitted prescriber ID is for a foreign prescriber with an identifier other than an NPI (this is not considered a clean claim)
- Claim is rejected only because of a "fill too soon/early fill" edit

Note: Claims that meet the definition of a compound should follow the rules, above, and have no different requirements.

Note: While it is applicable to return the 569 reject code for B vs. D determinations beginning July 1, 2013, it is not applicable to return the reject code if the drug is known to be a Part B drug.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**PHARMACY ACTION**

If the pharmacy is unable to resolve the Part D claim rejection which contains the "569" (Provide Notice: Medicare Prescription Drug Coverage and Your Rights) Reject Code the beneficiary needs to know he or she has the right to request a coverage determination.

As a result of receiving this Reject Code, the pharmacy should provide the beneficiary with the notice entitled "Medicare Prescription Drug Coverage and Your Rights." The Notice is a "handout" with standardized language. The Notice will direct the beneficiary to use the phone number on the back of his or her Part D Plan card if the beneficiary chooses to request a coverage determination.

When multiple claims reject with Reject Code "569", at minimum a single notice must be provided per patient pharmacy encounter or mail order package.

Non-retail network pharmacies (home infusion, LTC, mail order) are not exempt from the requirement to distribute the Notice. Refer to the CMS Prescription Drug Benefit Manual, Chapter 18, Section 40.3.1.

### 22.4.1 Reject Code "569" and Submission Clarification Code 8 (Compound Processing)

This applies to D.0 claims submitted on or after July 1, 2013.

**Question:**

How should Reject Code "569" (Provide Notice: Medicare Prescription Drug Coverage and Your Rights) work in conjunction with bypassed rejects using Submission Clarification Code 8 (Process Compound for Approved Ingredients)?

For example:

Pharmacy submits a compound for a member with 5 drugs in it and the claim is rejected. The following information is sent back to the pharmacy.

- Drug 1 - Rejected for "569"
- Drug 2 - Rejected for "569"
- Drug 3 - Rejected for "569"
- Drug 4 - Payable
- Drug 5 – Payable

What should happen in the case where the pharmacy uses Submission Clarification Code of 8 (Process Compound for Approved Ingredients) in this example? The question is if a compound claim initially rejects for "569" and the pharmacy uses Submission Clarification Code 8 indicating that they want the processor to pay the payable ingredients in the compound what should happen in this case? Is the pharmacy allowed to use Submission Clarification Code 8 in the below example or are they not allowed to use it and we should reject the entire compound?

**Response:**

Compounds submitted under a Part D BIN/PCN that contain one or more Part B versus D ingredients are not considered Part D. The processor should return the Reject Code "569" based upon the rules bulleted in section "*Notice of Medicare Drug Coverage Rights – Rejected Claim*" or Approved Message Code "018", when Benefit Stage Qualifier of 70 is applicable.

1. If the compound contains at least one ingredient that is considered a Part D ingredient (and does not fall in #1) and the claim is rejected under "569" "criteria":


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

a. Reject Code "569" (and any other applicable claim level rejects) should be returned.
b. Reject Codes that are specific to the ingredient should be returned.
c. The pharmacy:
    i. Cannot resolve the reject, and provides the Notice to the patient. The claim is not paid by Part D.
    ii. May resubmit the claim with an SCC 8 (agreeing to accept only for covered ingredients) if the "569" is caused **because one/more ingredients are not approved**.
        1. If the Part D plan pays (SCC 8 is successful), the Notice does not apply.
        2. If not covered by the Part D plan but is paid under the plan-sponsored negotiated discounted price to the beneficiary and Benefit Stage Qualifier of "70" is applicable, the Notice does apply ("018" is sent).

## 22.5 Notice of Medicare Drug Coverage Rights – Paid Claim

This applies to D.0 claims submitted on or after July 1, 2013.

Approved Message Code "018" should be returned when the Part D drug not paid by Part D plan benefit, is paid by the beneficiary under plan-sponsored negotiated pricing. Plan-sponsored negotiated pricing refers to drugs not covered under the insured benefit design but are offered to beneficiaries under a negotiated discounted price. In this scenario, the beneficiary's out-of-pocket expense is 100% of the plan's negotiated discounted pricing with the pharmacy.

Note: In this scenario, Benefit Stage Qualifier field (393-MV) value "70" will be returned and trigger the generation of the "018".

If the drug, not covered by the Part D Plan, meets the criteria for providing the Notice to the member, the paid claim response must contain an Approved Message Code so that the pharmacy can provide the member with the Notice.

Approved Message Code (548-6F)

| | | |
|---|---|---|
| "018" | Provide Notice: Medicare Prescription Drug Coverage and Your Rights | Claim for a Part D drug submitted to the plan's Medicare D BIN/PCN is not covered by the Part D plan but is paid by the beneficiary per a plan-sponsored negotiated price. In this situation the member should be provided the notice entitled "Medicare Prescription Drug Coverage and Your Rights". |

## 22.6 Benefit Stage Rules and Examples

### 22.6.1 Benefit Stage Rules

1. The sum of the benefit stage amounts must equal Patient Pay Amount (505-F5) plus Total Amount Paid (509-FN).
    a. There is an exception to this. See "*Republication of Telecommunication Standard Implementation Guide Version D.0© August 2010*", subsection "*Benefit Stage Formula*".
2. All benefit stage qualifiers and amounts should be based on where the member would have been in the benefit if they had been in the non LIS benefit. This will ensure the beneficiary is not hindered from receiving a benefit that might be available to them from a supplemental payer.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

3. When the LIS benefit does not have a deductible, if the member would have been in the deductible stage in the non LIS benefit, return the Deductible Benefit Stage Qualifier (01) and applicable benefit stage amount. Return the LIS patient pay amount as Amount of Copay (518-FI) or Amount of Coinsurance (572-4U).
4. If the LIS benefit does not have a coverage gap and the member would have been in the coverage gap stage in the non LIS benefit, return the Coverage Gap Benefit Stage Qualifier (03) and applicable benefit stage amount. Report the LIS patient pay amount as Amount of Copay (518-FI) or Amount of Coinsurance (572-4U)
5. The supplemental payer should use benefit stage qualifiers and amounts to determine if supplemental coverage applies. Use the Other Payer-Patient Responsibility Qualifier(s) and Amount(s) and/or the Other Payer Amount Paid Qualifier(s) and Amount(s) to determine the amount payable under the supplemental plan.

## 22.6.2 COST SHARE PARAMETERS USED IN EXAMPLES 1 THRU 6

| | Non-LIS Cost Share | LIS Category Code 1 | LIS Category Code 4 |
|---|---|---|---|
| Deductible | 100% to $310 DED limit | $2.50 generics/$6.30 brands | 100% to $63 DED limit |
| Initial Coverage | 25% to $2830 Initial Coverage limit | $2.50 generics/$6.30 brands | 15% to Initial Coverage limit |
| Coverage Gap | 100% to $4550 TrOOP limit | $2.50 generics/$6.30 brands | 15% to TrOOP limit |
| Catastrophic | > 5%/$2.50 for generics<br>> 5%/$6.30 for brands | $0 | $2.50 for generics<br>$6.30 for brands |

### *22.6.2.1 EXAMPLE 1: $50 CLAIM - AMOUNT REMAINING TO MEET DEDUCTIBLE IS $310*

**Response Pricing Segment**

| Field | Response Pricing Segment Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $50.00 | $6.30 | $50.00 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | $50.00 | | $50.00 |
| 518-FI | Amount Of Copay | 05 | | $6.30 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | | | |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/ Non-Preferred Formulary Selection | 11 | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $0.00 | $43.70 | $0.00 |
| 392-MU | Benefit Stage Count | | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | | 01 (DED) | 01 (DED) | 01 (DED) |
| 394-MW | Benefit Stage Amount | | $50.00 | $50.00 | $50.00 |

© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**COB/Other Payments Segment**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 1 | 1 | 1 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 01 | 05 | 01 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $50.00 | $6.30 | $50.00 |
| 392-MU | Benefit Stage Count | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | 01 (DED) | 01 (DED) | 01 (DED) |
| 394-MW | Benefit Stage Amount | $50.00 | $50.00 | $50.00 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### *22.6.2.2 EXAMPLE 2: $50 CLAIM - AMOUNT REMAINING TO MEET NON-LIS DEDUCTIBLE IS $260. AMOUNT REMAINING TO MEET LIS 4 DEDUCTIBLE IS $13*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $50.00 | $6.30 | $18.55 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | $50.00 | | $13.00 |
| 518-FI | Amount Of Copay | 05 | | $6.30 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | | | $5.55 |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/ Brand Non-Preferred Formulary Selection | 11 | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $0.00 | $43.70 | $31.45 |
| 392-MU | Benefit Stage Count | | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | | 01 (DED) | 01 (DED) | 01 (DED) |
| 394-MW | Benefit Stage Amount | | $50.00 | $50.00 | $50.00 |

Rule 3

Rule 2

Rule 1

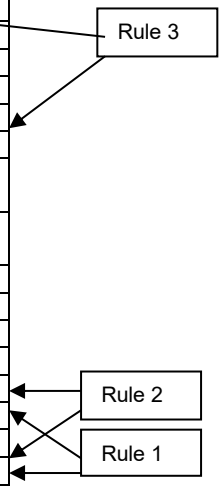
**COB/Other Payments Segment**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 1 | 1 | 2 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 01 | 05 | 01 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $50.00 | $6.30 | $13.00 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | | | 07 |
| 352-NQ | Other Payer-Patient Responsibility Amount | | | $5.55 |
| 392-MU | Benefit Stage Count | 1 | 1 | 1 |
| 93-MV | Benefit Stage Qualifier | 01 (DED) | 01 (DED) | 01 (DED) |
| 394-MW | Benefit Stage Amount | $50.00 | $50.00 | $50.00 |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### *22.6.2.3 EXAMPLE 3: $50 CLAIM - AMOUNT REMAINING TO MEET NON-LIS DEDUCTIBLE IS $10. LIS 4 DEDUCTIBLE ALREADY MET*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $20.00 | $6.30 | $7.50 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | $10.00 | | |
| 518-FI | Amount Of Copay | 05 | | $6.30 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | $10.00 | | $7.50 |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/ Brand Non-Preferred Formulary Selection | 11 | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $30.00 | $43.70 | $42.50 |
| 392-MU | Benefit Stage Count | | 2 | 2 | 2 |
| 393-MV | Benefit Stage Qualifier | | 01 (DED) | 01 (DED) | 01 (DED) |
| 394-MW | Benefit Stage Amount | | $10.00 | $10.00 | $10.00 |
| 393-MV | Benefit Stage Qualifier | | 02 (INIT) | 02 (INIT) | 02 (INIT) |
| 394-MW | Benefit Stage Amount | | $40.00 | $40.00 | $40.00 |




**COB/Other Payments Segment**

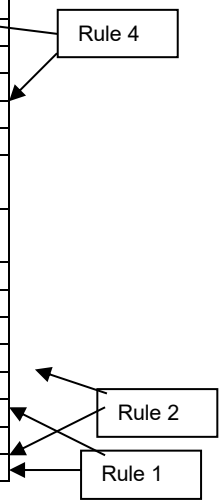
| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 2 | 1 | 1 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 01 | 05 | 07 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $10.00 | $6.30 | $7.50 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 07 | | |
| 352-NQ | Other Payer-Patient Responsibility Amount | $10.00 | | |
| 392-MU | Benefit Stage Count | 2 | 2 | 2 |
| 393-MV | Benefit Stage Qualifier | 01 (DED) | 01 (DED) | 01 (DED) |
| 394-MW | Benefit Stage Amount | $10.00 | $10.00 | $10.00 |
| 393-MV | Benefit Stage Qualifier | 02 (INIT) | 02 (INIT) | 02 (INIT) |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| 394-MW | Benefit Stage Amount | $40.00 | $40.00 | $40.00 |

### *22.6.2.4 EXAMPLE 4: $50 CLAIM - AMOUNT REMAINING TO MEET INITIAL COVERAGE LIMIT IS $10*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $42.50 | $6.30 | $7.50 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | | | |
| 518-FI | Amount Of Copay | 05 | | 6.30 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | $2.50 | | $7.50 |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/ Brand Non-Preferred Formulary Selection | 11 | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | $40.00 | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $7.50 | $43.70 | $42.50 |
| 392-MU | Benefit Stage Count | | 2 | 2 | 2 |
| 393-MV | Benefit Stage Qualifier | | 02 (INIT) | 02 (INIT) | 02 (INIT) |
| 394-MW | Benefit Stage Amount | | $10.00 | $10.00 | $10.00 |
| 393-MV | Benefit Stage Qualifier | | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | | $40.00 | $40.00 | $40.00 |




**COB/Other Payments Segment**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 2 | 1 | 1 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 07 | 05 | 07 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $2.50 | $6.30 | $7.50 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 12 | | |
| 352-NQ | Other Payer-Patient Responsibility Amount | $40.00 | | |
| 392-MU | Benefit Stage Count | 2 | 2 | 2 |
| 393-MV | Benefit Stage Qualifier | 02 (INIT) | 02 (INIT) | 02 (INIT) |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| 394-MW | Benefit Stage Amount | $10.00 | $10.00 | $10.00 |
| 393-MV | Benefit Stage Qualifier | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | $40.00 | $40.00 | $40.00 |

### *22.6.2.5 EXAMPLE 5: $50 CLAIM - INITIAL COVERAGE LIMIT OF $2830 ALREADY MET. AMOUNT REMAINING TO MEET TROOP IS $2000*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $50.00 | $6.30 | $7.50 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | | | |
| 518-FI | Amount Of Copay | 05 | | $6.30 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | | | $7.50 |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/ Brand Non-Preferred Formulary Selection | 11 | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | $50.00 | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $0.00 | $43.70 | $42.50 |
| 392-MU | Benefit Stage Count | | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | | $50.00 | $50.00 | $50.00 |

Rule 4

Rule 2

Rule 1

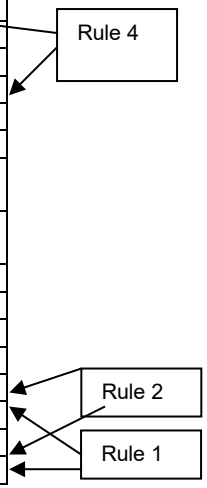
**COB/Other Payments Segment**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 1 | 1 | 1 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 12 | 05 | 07 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $50.00 | $6.30 | $7.50 |
| 392-MU | Benefit Stage Count | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | $50.00 | $50.00 | $50.00 |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### *22.6.2.6 EXAMPLE 6: $50 CLAIM - AMOUNT REMAINING TO MEET TROOP IS $20*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $26.30 | $6.30 | $3.00 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | | | |
| 518-FI | Amount Of Copay | 05 | $6.30 | $6.30 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | | | $3.00 |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/ Brand Non-Preferred Formulary Selection | 11 | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | $20.00 | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $23.70 | $43.70 | $47.00 |
| 392-MU | Benefit Stage Count | | 2 | 2 | 2 |
| 393-MV | Benefit Stage Loop Qualifier | | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | | $20.00 | $20.00 | $20.00 |
| 393-MV | Benefit Stage Qualifier | | 04 (CAT) | 04 (CAT) | 04 (CAT) |
| 394-MW | Benefit Stage Amount | | $30.00 | $30.00 | $30.00 |




**COB/Other Payments Segment**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 2 | 1 | 1 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 05 | 05 | 07 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $6.30 | $6.30 | $3.00 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 12 | | |
| 352-NQ | Other Payer-Patient Responsibility Amount | $20.00 | | |
| 392-MU | Benefit Stage Count | 2 | 2 | 2 |
| 393-MV | Benefit Stage Loop Qualifier | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | $20.00 | $20.00 | $20.00 |
| 393-MV | Benefit Stage Qualifier | 04 (CAT) | 04 (CAT) | 04 (CAT) |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| 394-MW | Benefit Stage Amount | $30.00 | $30.00 | $30.00 |

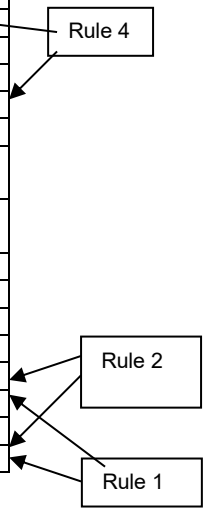

© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 22.6.3 COST SHARE PARAMETERS USED IN EXAMPLES 7 THRU 9

| | Non-LIS Cost Share | LIS Category Code 1 | LIS Category Code 4 |
|---|---|---|---|
| Deductible | N/A | N/A | N/A |
| Initial Coverage | 25% to $2830 Initial Coverage limit | $2.50 generics/$6.30 brands | 15% to Initial Coverage limit |
| Coverage Gap | 50% to $4550 TrOOP limit | $2.50 generics/$6.30 brands | 15% to TrOOP |
| Catastrophic | > 5%/$2.50 for generics<br>> 5%/$6.30 for brands | $0 | $2.50 for generics<br>$6.30 for brands |

### *22.6.3.1 EXAMPLE 7: $50 CLAIM - AMOUNT REMAINING TO MEET INITIAL COVERAGE LIMIT IS $10*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $22.50 | $6.30 | $7.50 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 17-FH | Amount Applied To Periodic Deductible | 01 | | | |
| 518-FI | Amount Of Copay | 05 | | 6.30 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | $2.50 | | $7.50 |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/ Brand Non-Preferred Formulary Selection | 11 | | | |
| 37-UP | Amount Attributed To Coverage Gap | 12 | $20.00 | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $27.50 | $43.70 | $42.50 |
| 392-MU | Benefit Stage Count | | 2 | 2 | 2 |
| 393-MV | Benefit Stage Qualifier | | 02 (INIT) | 02 (INIT) | 02 (INIT) |
| 394-MW | Benefit Stage Amount | | $10.00 | $10.00 | $10.00 |
| 393-MV | Benefit Stage Qualifier | | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | | $40.00 | $40.00 | $40.00 |




**COB/Other Payments Segment**

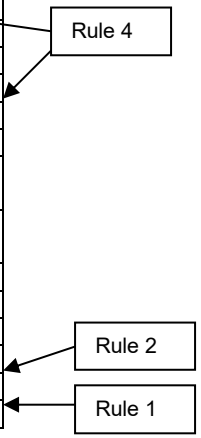
| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 2 | 1 | 1 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 07 | 05 | 07 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $2.50 | $6.30 | $7.50 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 12 | | |
| 352-NQ | Other Payer-Patient Responsibility Amount | $20.00 | | |
| 392-MU | Benefit Stage Count | 2 | 2 | 2 |
| 393-MV | Benefit Stage Qualifier | 02 (INIT) | 02 (INIT) | 02 (INIT) |
| 4-MW | Benefit Stage Amount | $10.00 | $10.00 | $10.00 |
| 393-MV | Benefit Stage Qualifier | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | $40.00 | $40.00 | $40.00 |

### *22.6.3.2 EXAMPLE 8: $50 CLAIM - INITIAL COVERAGE LIMIT OF $2830 ALREADY MET. AMOUNT REMAINING TO MEET TROOP IS $2000*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $25.00 | $6.30 | $7.50 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | | | |
| 518-FI | Amount Of Copay | 05 | | $6.30 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | | | $7.50 |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/ Brand Non-Preferred Formulary Selection | 11 | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | $25.00 | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $25.00 | $43.70 | $42.50 |
| 392-MU | Benefit Stage Count | | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | | $50.00 | $50.00 | $50.00 |




**COB/Other Payments Segment**

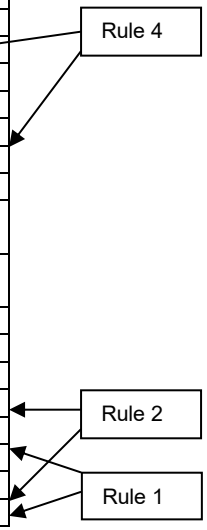
| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 1 | 1 | 1 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 12 | 05 | 07 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $25.00 | $6.30 | $7.50 |
| 392-MU | Benefit Stage Count | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | $50.00 | $50.00 | $50.00 |

### *22.6.3.3 EXAMPLE 9: $100 CLAIM - INITIAL COVERAGE LIMIT OF $2830 ALREADY MET. AMOUNT REMAINING TO MEET TROOP IS $20*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $26.30 | $6.30 | $6.00 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | | | |
| 518-FI | Amount Of Copay | 05 | 6.30 | $6.30 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | | | $6.00 |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/ Brand Non-Preferred Formulary Selection | 11 | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | $20.00 | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $73.70 | $93.70 | $94.00 |
| 392-MU | Benefit Stage Count | | 2 | 2 | 2 |
| 393-MV | Benefit Stage Qualifier | | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | | $40.00 | $40.00 | $40.00 |
| 393-MV | Benefit Stage Qualifier | | 04 (CAT) | 04 (CAT) | 04 (CAT) |
| 394-MW | Benefit Stage Amount | | $60.00 | $60.00 | $60.00 |




**COB/Other Payments Segment**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 2 | 1 | 1 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 05 | 05 | 07 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $6.30 | $6.30 | $6.00 |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 12 | | |
| 352-NQ | Other Payer-Patient Responsibility Amount | $20.00 | | |
| 392-MU | Benefit Stage Count | 2 | 2 | 2 |
| 393-MV | Benefit Stage Qualifier | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | $40.00 | $40.00 | $40.00 |
| 393-MV | Benefit Stage Qualifier | 04 (CAT) | 04 (CAT) | 04 (CAT) |
| 394-MW | Benefit Stage Amount | $60.00 | $60.00 | $60.00 |

## 22.6.4 COST SHARE PARAMETERS USED IN EXAMPLE 10

| | Non-LIS Cost Share | LIS Category Code 1 | LIS Category Code 4 |
|---|---|---|---|
| Deductible | N/A | N/A | N/A |
| Initial Coverage | $10 to $2830 Initial Coverage limit | $2.50 generics/$6.30 brands | 15% to Initial Coverage limit |
| Coverage Gap | 100% to $4550 TrOOP limit | $2.50 generics/$6.30 brands | 15% to TrOOP limit |
| Catastrophic | > 5%/$2.50 for generics<br>> 5%/$6.30 for brands | $0 | $2.50 for generics<br>$6.30 for brands |

### *22.6.4.1 EXAMPLE 10: $100 CLAIM FOR BRAND DRUG. AMOUNT REMAINING TO MEET INITIAL COVERAGE LIMIT IS $50*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $60.00 | $6.30 | $15.00 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | | | |
| 518-FI | Amount Of Copay | 05 | 10.00 | 6.30 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | | | $15.00 |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/ Brand Non-Preferred Formulary Selection | 11 | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | $50.00 | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $40.00 | $93.70 | $85.00 |
| 392-MU | Benefit Stage Count | | 2 | 2 | 2 |
| 393-MV | Benefit Stage Qualifier | | 02 (INIT) | 02 (INIT) | 02 (INIT) |
| 394-MW | Benefit Stage Amount | | $50.00 | $50.00 | $50.00 |
| 393-MV | Benefit Stage Qualifier | | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | | $50.00 | $50.00 | $50.00 |

© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**COB/Other Payments Segment**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 2 | 1 | 1 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 05 | 05 | 07 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $10.00 | $6.30 | $15.00 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 12 | | |
| 352-NQ | Other Payer-Patient Responsibility Amount | $50.00 | | |
| 392-MU | Benefit Stage Count | 2 | 2 | 2 |
| 393-MV | Benefit Stage Qualifier | 02 (INIT) | 02 (INIT) | 02 (INIT) |
| 394-MW | Benefit Stage Amount | $50.00 | $50.00 | $50.00 |
| 393-MV | Benefit Stage Qualifier | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | $50.00 | $50.00 | $50.00 |

## 22.6.5 COST SHARE PARAMETERS USED IN EXAMPLES 11

| | Non-LIS Cost Share | LIS Category Code 1 | LIS Category Code 4 |
|---|---|---|---|
| Deductible | N/A | N/A | N/A |
| Initial Coverage | $20 to $4550 TrOOP limit | $2.50 generics/$6.30 brands | 15% to TrOOP limit |
| Catastrophic | > 5%/$2.50 for generics<br>> 5%/$6.30 for brands | $0 | $2.50 for generics<br>$6.30 for brands |

### *22.6.5.1 EXAMPLE 11: $100 CLAIM – NO COVERAGE GAP; AMOUNT REMAINING TO MEET TROOP IS $500*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $20.00 | $6.30 | $15.00 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | | | |
| 518-FI | Amount Of Copay | 05 | 20.00 | 6.30 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | | | $15.00 |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/ Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/ | 11 | | | |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | | |
|---|---|---|---|---|---|
| | Brand Non-Preferred Formulary Selection | | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $80.00 | $93.70 | $85.00 |
| 392-MU | Benefit Stage Count | | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | | 02 (INIT) | 02 (INIT) | 02 (INIT) |
| 394-MW | Benefit Stage Amount | | $100.00 | $100.00 | $100.00 |

Rule 2

Rule 1

**COB/Other Payments Segment**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 1 | 1 | 1 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 05 | 05 | 07 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $20.00 | $6.30 | $15.00 |
| 392-MU | Benefit Stage Count | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | 02 (INIT) | 02 (INIT) | 02 (INIT) |
| 394-MW | Benefit Stage Amount | $100.00 | $100.00 | $100.00 |

## 22.6.6 COST SHARE PARAMETERS USED IN EXAMPLES 12

| | Non-LIS Cost Share | LIS Category Code 1 | LIS Category Code 4 |
|---|---|---|---|
| Deductible | 100% to $310 limit; brands only | $2.50 generics/$6.30 brands | 100% to $63 DED limit |
| Initial Coverage | $10 generics/$50 brands to $4550 TrOOP limit | $2.50 generics/$6.30 brands | 15% to TrOOP limit |
| Catastrophic | > 5%/$2.50 for generics<br>> 5%/$6.30 for brands | $0 | $2.50 for generics<br>$6.30 for brands |

### *22.6.6.1 EXAMPLE 12: $50 CLAIM FOR GENERIC DRUG – NO DEDUCTIBLE FOR GENERICS; AMOUNT REMAINING TO MEET BRAND NON-LIS DEDUCTIBLE IS $100. LIS DEDUCTIBLE ALREADY MET*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $10.00 | $2.50 | $7.50 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | | | |
| 518-FI | Amount Of Copay | 05 | $10.00 | $2.50 | |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | | |
|---|---|---|---|---|---|
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | | | $7.50 |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/Brand Non-Preferred Formulary Selection | 11 | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $40.00 | $47.50 | $42.50 |
| 392-MU | Benefit Stage Count | | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | | 02 (INIT) | 02 (INIT) | 02 (INIT) |
| 394-MW | Benefit Stage Amount | | $50.00 | $50.00 | $50.00 |

Rule 2

Rule 1

**COB/Other Payments Segment**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 1 | 1 | 1 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 05 | 05 | 07 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $10.00 | $2.50 | $7.50 |
| 392-MU | Benefit Stage Count | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | 02 (INIT) | 02 (INIT) | 02 (INIT) |
| 394-MW | Benefit Stage Amount | $50.00 | $50.00 | $50.00 |

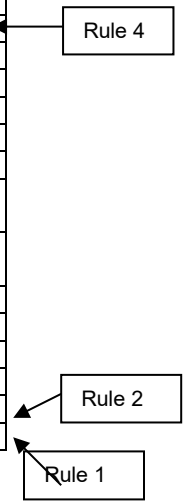
## 22.6.7 COST SHARE PARAMETERS USED IN EXAMPLES 13

| | Non-LIS Cost Share | LIS Category Code 1 | LIS Category Code 4 |
|---|---|---|---|
| Deductible | 100% to $310 limit; brands only | $2.50 generics/$6.30 brands | 100% to $63 DED limit |
| Initial Coverage | $1 generics/ $50 brands to $2830 Initial Coverage limit | $2.50 generics/$6.30 brands | 15% to Initial Coverage limit |
| Coverage Gap | $1 generics /100% brands to $4550 TrOOP limit | $2.50 generics/$6.30 brands | 15% to TrOOP limit |
| Catastrophic | > 5%/$2.50 for generics<br>> 5%/$6.30 for brands | $0 | $2.50 for generics<br>$6.30 for brands |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### *22.6.7.1 EXAMPLE 13: $20 CLAIM FOR GENERIC DRUG; INITIAL COVERAGE LIMIT ALREADY MET; $500 REMAINING TO MEET TROOP. NON-LIS GENERIC COPAY APPLIES BECAUSE IT IS LESS THAN LIS COPAY*

| Field | Field Name | Maps to OPPR Qualifier | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | 06 | $1.00 | $1.00 | $1.00 |
| 523-FN | Amount Attributed To Sales Tax | 03 | | | |
| 517-FH | Amount Applied To Periodic Deductible | 01 | | | |
| 518-FI | Amount Of Copay | 05 | | $1.00 | $1.00 |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | 04 | | | |
| 571-NZ | Amount Attributed To Processor Fee | 13 | | | |
| 572-4U | Amount Of Coinsurance | 07 | | | |
| 133-UJ | Amount Attributed To Provider Network Selection | 10 | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | 02 | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | 08 | | | |
| 136-UN | Amount Attributed To Product Selection/Brand Non-Preferred Formulary Selection | 11 | | | |
| 137-UP | Amount Attributed To Coverage Gap | 12 | $1.00 | | |
| 129-UD | Health Plan-Funded Assistance Amount | 09 | | | |
| 509-F9 | Total Amount Paid | | $19.00 | $19.00 | $19.00 |
| 392-MU | Benefit Stage Count | | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | | $20.00 | $20.00 | $20.00 |




**COB/Other Payments Segment**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 353-NR | Other Payer-Patient Responsibility Amount Count | 1 | 1 | 1 |
| 351-NP | Other Payer-Patient Responsibility Amount Qualifier | 12 | 05 | 05 |
| 352-NQ | Other Payer-Patient Responsibility Amount | $1.00 | $1.00 | $1.00 |
| 392-MU | Benefit Stage Count | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | $20.00 | $20.00 | $20.00 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### *22.6.7.2 EXAMPLE 14: $100 MEDICARE SECONDARY PAYER CLAIM FOR BRAND DRUG; INITIAL COVERAGE LIMIT ALREADY MET; $500 REMAINING TO MEET TROOP. OTHER PAYER AMOUNT PAID IS $75.*

**B1 Response from Primary Payer (not Med D plan)**

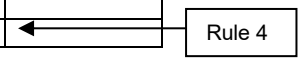
| Field | Field Name | Primary Payer Amount |
|---|---|---|
| 505-F5 | Patient Pay Amount | $25.00 |
| 523-FN | Amount Attributed To Sales Tax | |
| 517-FH | Amount Applied To Periodic Deductible | |
| 518-FI | Amount Of Copay | $25.00 |
| 520-FK | Amount Exceeding Periodic Benefit Maximum | |
| 571-NZ | Amount Attributed To Processor Fee | |
| 572-4U | Amount Of Coinsurance | |
| 133-UJ | Amount Attributed To Provider Network Selection | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | |
| 136-UN | Amount Attributed To Product Selection/Brand Non-Preferred Formulary Selection | |
| 137-UP | Amount Attributed To Coverage Gap | |
| 129-UD | Amount Attributed to Health Plan-Funded Assistance Amount | |
| 566-J5 | Other Payer Amount Recognized | |
| 509-F9 | Total Amount Paid | $75.00 |

**COB/Other Payments Segment sent to Med D plan – Other Payer Amount Paid Billing**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 1 | 1 | 1 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 341-HB | Other Payer Amount Paid Count | 1 | 1 | 1 |
| 342-HC | Other Payer Amount Paid Qualifier | 07 | 07 | 07 |
| 341-DV | Other Payer Amount Paid | $75.00 | $75.00 | $75.00 |

**B1 Response from Medicare Part D plan (MSP claim)**

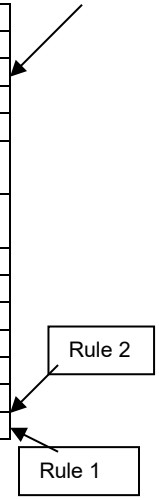
| Field | Field Name | Non-LIS Amount | LIS 1 Amount | LIS 4 Amount |
|---|---|---|---|---|
| 505-F5 | Patient Pay Amount | $25.00 | $2.50 | $15.00 |
| 523-FN | Amount Attributed To Sales Tax | | | |
| 517-FH | Amount Applied To Periodic Deductible | | | |
| 518-FI | Amount Of Copay | | $2.50 | |





*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | | |
|---|---|---|---|---|
| 520-FK | Amount Exceeding Periodic Benefit Maximum | | | |
| 571-NZ | Amount Attributed To Processor Fee | | | |
| 572-4U | Amount Of Coinsurance | | | $15.00 |
| 133-UJ | Amount Attributed To Provider Network Selection | | | |
| 134-UK | Amount Attributed To Product Selection/Brand Drug | | | |
| 135-UM | Amount Attributed To Product Selection/Non-Preferred Formulary Selection | | | |
| 136-UN | Amount Attributed To Product Selection/Brand Non-Preferred Formulary Selection | | | |
| 137-UP | Amount Attributed To Coverage Gap | $25.00 | | |
| 129-UD | Amount Attributed to Health Plan-Funded Assistance Amount | | | |
| 566-J5 | Other Payer Amount Recognized | $75.00 | $75.00 | $75.00 |
| 509-F9 | Total Amount Paid | $0.00 | $22.50 | $10.00 |
| 392-MU | Benefit Stage Count | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | $100.00 | $100.00 | $100.00 |




**COB/Other Payments Segment sent to tertiary plan (not Med D) – Other Payer Amount Paid Billing**

| Field | Field Name | Non-LIS | LIS 1 | LIS 4 |
|---|---|---|---|---|
| 337-4C | Coordination of Benefits/Other Payments Count | 2 | 2 | 2 |
| 338-5C | Other Payer Coverage Type | 01 | 01 | 01 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 123456 | 123456 | 123456 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 341-HB | Other Payer Amount Paid Count | 1 | 1 | 1 |
| 342-HC | Other Payer Amount Paid Qualifier | 07 | 07 | 07 |
| 341-DV | Other Payer Amount Paid | $75.00 | $75.00 | $75.00 |
| 338-5C | Other Payer Coverage Type | 02 | 02 | 02 |
| 339-6C | Other Payer ID Qualifier | 03 | 03 | 03 |
| 340-7C | Other Payer ID | 987654 | 987654 | 987654 |
| 443-E8 | Other Payer Date | 20120101 | 20120101 | 20120101 |
| 341-HB | Other Payer Amount Paid Count | 1 | 1 | 1 |
| 342-HC | Other Payer Amount Paid Qualifier | 07 | 07 | 07 |
| 341-DV | Other Payer Amount | $0.00 | $22.50 | $10.00 |
| 392-MU | Benefit Stage Count | 1 | 1 | 1 |
| 393-MV | Benefit Stage Qualifier | 03 (GAP) | 03 (GAP) | 03 (GAP) |
| 394-MW | Benefit Stage Amount | $100.00 | $100.00 | $100.00 |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 22.7 Benefit Stage Qualifier Values to Identify Claims Covered under the Not Part D Portion of the Medicare D Plan

Benefit Stage Qualifier values to identify claims covered under the Not Part D portion of the Medicare D plan, and eliminate the need for separate BIN/PCN processing requirements. The distinct Benefit Stage qualifier values identify the claim as covered under the Part C, Enhanced EGWP or co-administered supplemental portion of the Medicare D plan benefit. The distinct Benefit Stage Qualifier value would also be transmitted to the downstream Medicare D supplemental or SPAP plan, allowing the payer to determine if the claim was covered under the Part D, Part C, etc. benefit.

Note: It is important to remember that Benefit Stage Qualifiers (BSQ) have changed since inception and effective dates for implementation should be reviewed as to which BSQ should be used when.

| Claim Submitted Under Part D BIN/PCN | |
|---|---|
| Benefit Under Which the Claim is Paid | Benefit Stage Qualifier |
| Part D Deductible | 01 - Deductible |
| Part D Initial Benefit | 02 - Initial Benefit |
| Part D Coverage Gap | 03 - Coverage Gap |
| Part D Catastrophic | 04 - Catastrophic |
| Part D Enhanced or OTC (E and O drugs) | Benefit Stage Not Reported |
| Medicare Advantage portion of MA-PD (Part C) | 50 - Not Paid Under Part D, Paid Under Part C |
| Supplemental portion of Primary claim or paid as a Co-administered benefit (e.g. EGWP, Commercial Wrap, SPAP) | 60 - Not Paid Under Part D, Paid Under Supplemental Benefit Only |

- **Rules for New values:**
  a) The new benefit stage qualifiers are intended to be used on a standalone basis. The Benefit Stage Count would always be 1, when the new qualifiers (50, 60, 70, 80) are used.
  b) Whenever either of these qualifiers is used, the corresponding benefit stage amount should be populated with the total amount of the claim.

- **Rules for value = 50:**
  **a) The phase qualifier = 50 (Not paid under Part D, paid under Part C) should be used in the following situations only:**
    - This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN
    - The claim is NOT paid by the Part D plan benefit.
    - The claim IS paid for by Part C benefit (MA portion of the MA-PD).
    - When the qualifier value of 50 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
    - The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.

- **Rules for value = 60:**
  **a) The Phase qualifier = 60 (Not Paid under Part D, Paid under supplemental benefit only) should be used in the following situations only**
    - This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided.
    - This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit).
    - The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
- The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.

- **Rules for value = 70:**
  - **a) The Phase qualifier = 70 (Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing)**
    - This qualifier applies to co-administered claims where claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.
    - The claim is for a Part D drug, but is NOT paid by the Part D plan benefit (e.g. drug is non-formulary, quantity limit or step therapy required). The beneficiary is provided access to a negotiated discount rate (e.g. discount card).
    - There is only beneficiary payment on these claims (505-F5 Patient Pay Amount).
    - When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
    - The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid (would be zero in this instance), and 566-J5 Other Payer Amount Recognized (would be zero instance)) of the claim.
- **Rules for value = 80:**
  - **a) The Phase qualifier = 80 (Non-Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing)**
    - This qualifier applies to co-administered claims where claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.
    - The claim is for drug NOT covered by Part D that is NOT paid by the Part D plan benefit (e.g. drug is non-formulary, quantity limit or step therapy required). The beneficiary is provided access to a negotiated discount rate (e.g. discount card).
    - There is only beneficiary payment on these claims (505-F5 Patient Pay Amount).
    - When the qualifier value of 80 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.
    - The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid (would be zero in this instance), and 566-J5 Other Payer Amount Recognized (would be zero instance)) of the claim.

## *Business Cases Supporting Need for New Benefit Stage Qualifiers:*

***1)*** **Medicare D MA-PD Plan – Part D and Part C BIN/PCNs *(addressed with Benefit Stage Qualifier = 50)***

a) Pharmacy cannot determine whether claim is covered under the Part D or Part C benefit, to be able to determine whether claim should be submitted under the Part D or Part C BIN/PCN.
   - If/When Part C BIN/PCN is known, this will result in multiple active plan codes for single Medicare D plan benefit in the patient's profile, significantly increasing risks of rejects.

b) Processor determines whether claim is covered under Part D or Part C.
   - If claim is submitted to Part B BIN/PCN, claim may be accepted under Part C and should have been accepted under Part D.
   - Multiple ID cards required, or both Part D and Part C BIN/PCNs must be printed on the same ID card, and require continued maintenance.
   - Part C BIN/PCN not returned on Medicare D E1 response.
   - Even If required BIN/PCN is returned on the rejected response, not all pharmacy systems would be automated to ensure the claim was processed to the applicable BIN/PCN. Relying on manual processes, to read and react to reject detail, will result in customer service issues.

c) Medicare D Supplemental plans still lacking Part D or Part C identifier on COB claims.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

d) Medicaid plans lacking MA-PD identifier on COB claims to determine dual eligible beneficiary is enrolled in a Medicare Advantage plan versus Medicare B FFS. Since member is not enrolled in the Medicare FFS plan, the non-real-time auto-cross process would not occur.
   - An MA-PD (Part C) identifier would provide the necessary trigger for Medicaid processor to accept the NCPDP point of service COB claim, versus rejecting as Submit to Primary and in-appropriately expecting the Part B copay to process via the Medicare FFS auto-cross.

***2)*** **EGWP Medicare D Plan with Enhanced Benefits *(addressed with Benefit Stage Qualifier = 60)***

a) Pharmacy cannot determine whether claim is covered under the Part D or EGWP Enhanced benefit, to be able to determine whether claim should be submitted under the Part D or alternate BIN/PCN.
   - If/When alternate B BIN/PCN is known, this will result in multiple active plan codes for single Medicare D plan benefit in the patient's profile, significantly increasing risks of rejects.

b) Processor determines whether claim is covered under Part D or EGWP Enhanced benefit.
   - If claim is submitted to alternate BIN/PCN, claim may be accepted under EGWP Enhanced and should have been accepted under Part D.
   - Multiple ID cards required, or both Part D and Alternate (EGWP Enhanced) BIN/PCNs must be printed on the same ID card, and require continued maintenance.
   - Alternate BIN/PCN not returned on Medicare D E1 response.
   - Even If required BIN/PCN is returned on the rejected response, not all pharmacy systems would be automated to ensure the claim was processed to the applicable BIN/PCN. Relying on manual processes, to read and react to reject detail, will result in customer service issues

c) Medicare D Supplemental plans still lacking Part D or Not Part D identifier on COB claims.

**3) Medicare D Plan + co-administered supplemental payer *(addressed with Benefit Stage Qualifier = 60)***
**(Same processor administering both benefits where one pharmacy response is provided).**

a) Claim submitted under the Medicare D BIN/PCN and is not covered under the Medicare D benefit, but is fully covered under the co-administered benefit that is supplemental to Part D.
   - Pharmacy cannot determine whether claim is covered under the Part D or co-administered benefit, to be able to determine whether claim should be submitted under the Part D or alternate BIN/PCN.
   - Processor may not be able to accept POS primary or OCC3 COB claim for co-administered benefit.
   - If/When alternate B BIN/PCN for co-administered benefit is available, this will result in multiple active plan codes for single Medicare D plan benefit in the patient's profile, significantly increasing risks of rejects, or duplicate claims.
   - Claims paid under the co-administered benefit lacking a specific identifier to determine that claim did not pay under Part D even though it was submitted to Part D BIN/PCN.

## *Additional Analysis:*

**D.0 Structure:** The Benefit Stage Qualifier Count Max is 4, however adding the 50 or 60 qualifiers would not present a risk of increasing the count, as these business cases are only used when the claim is not paid under Part D and therefore would not overlap stages and the Benefit Stage Count would be 1.

**Consistency with Current Approach:** The addition of these new values for Benefit Stage Qualifier is consistent with the rules currently in place for this field, as specified in the NCPDP Telecom Implementation Guide (section "Claim Billing or Encounter Information"), and copied below for reference. In other words, the Benefit Stage Qualifier and Benefit Stage Amount fields will continue to be blank if the member is not in a Medicare Part D program.

From NCPDP Telecommunication Implementation Guide:

| | | | |
|---|---|---|---|
| 393-MV | BENEFIT STAGE QUALIFIER | Q***R*** | Claim Billing/Encounter:<br>Required if Benefit Stage Amount (394-MW) is used.<br>Must only have one value per iteration - value must not be repeated. |
| 394-MW | BENEFIT STAGE AMOUNT | Q***R*** | Claim Billing/Encounter:<br>Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | |
|---|---|---|---|
| | | | Medicare Part D program that requires reporting of benefit stage specific financial amounts.<br>Required if necessary for state/federal/regulatory agency programs. |

**Excessive (orphan) Information Reporting (N) Transactions:** There has been some discussion regarding excessive (orphan) N transactions. The proposed new Benefit Stage Qualifier values provide a mechanism to address some of these concerns. The Information Reporting Task Group will address how to use these new Benefit Stage Qualifier values to reduce excessive (orphan) N transactions.

### *Summary:*

**To eliminate the risks associated to the above business cases, DERF 1005 (approved 05/2011) requests new Benefit Stage Qualifiers to identify claims submitted to a Part D BIN/PCN covered by entities other than Part D.**

- This eliminates the need for separate BIN/PCN processing requirements for the situations identified above. In addition, this proposal helps identify the payment source for claims paid under co-administered benefits.

- The distinct Benefit Stage Qualifier value would also be transmitted to the downstream Medicare D supplemental or Medicaid FFS plan, allowing the plan to determine if the claim was covered under the Part D, Part C, etc. benefit. The information currently provided in the Other Payer ID field would also remain consistent to the beneficiary, eliminating confusion by the downstream payer when validating against their TPL eligibility file, that the appropriate plan was billed as primary.

RISK – CMS has indicated that EGWP's should be treated like Part D plans and only cover Part D allowable drugs. Since there is not clear guidance to refer to presently, the approach to allow these claims to be submitted through the Part D BIN/PCN is being allowed with the indication in the response that these are not Part D covered drugs. Guidance may be forthcoming which may no longer allow this approach and could be retroactive.

NOTE: These new values may not be utilized prior to 01/01/2012 due to potential negative impact to downstream payers.

NOTE: In 05/2012 enhancements were approved to the Benefit Stage Qualifier values and will be effective 01/01/2013. These are shown in section "*Benefit Stage Implementation for 01/01/2013*".

## 22.8 BENEFIT STAGE IMPLEMENTATION FOR 01/01/2013

**Effective Date: January 1, 2013**

In 05/2012, DERF 001056/Emergency ECL 000111 was approved, with an effective date of 01/01/2013. Implementation Recommendations:

1. Benefit Stage Qualifier (393-MV) value 60 (Not paid under Part D, paid as or under a supplemental benefit only) and the use of Approved Message Code field (548-6F) value 018 (Provide Beneficiary With CMS Notice Of Appeal Rights) with value 60 will be sunset as of 01/01/2013.
    a. Benefit Stage Qualifier (393-MV) value 60 would only be available for use on claims with dates of service of 12/31/2012 and prior.
2. New Benefit Stage Qualifier (393-MV) values 61 or 62 to replace the value of 60 are available for use as of 01/01/2013.
3. New Benefit Stage Qualifier (393-MV) value 90 is available for use as of 01/01/2013.

Benefit Stage Qualifier (393-MW) values: (yellow marks revision or addition)

| Value | Description prior to 01/01/2013 | Revised Description as of 05/2012 DERF 001056/Emergency ECL 000111. Effective 01/01/2013 |
|---|---|---|
| **50** | Not paid under Part D, paid under Part C benefit (for MA-PD plan)<br>• This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN<br>• The claim is NOT paid by the Part D plan benefit | No change. |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | |
|---|---|---|
| | • The claim IS paid for by Part C benefit (MA portion of the MA-PD)<br>• When the qualifier value of 50 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim | |
| **60** | Not paid under Part D, paid as or under a supplemental benefit only<br>• This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided.<br>• This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit)<br>• The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.<br>• When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim | Not paid under Part D, paid as or under a supplemental benefit only<br>• This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided.<br>• This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit)<br>• The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.<br>• When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim<br>• Since 60 is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur:<br>1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value 018 – "Provide Beneficiary With CMS Notice Of Appeal Rights"<br>2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 60 will be returned without the Approved Message Code value of 018.<br><br>Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.<br><br>Benefit Stage Qualifier (393-MV) value 60 would only be available for use on claims with dates of service of 12/31/2012 and prior. |
| **61** | | Part D drug not paid by Part D plan benefit, paid as or under a co-administered benefit only<br>• This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.<br>• The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit.<br>• When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim<br>• The Approved Message Code field (548-6F) must be returned with a value 018 – "Provide Beneficiary With CMS Notice Of Appeal Rights"<br><br>Benefit Stage Qualifier (393-MV) values 61 or 62 to replace the value of 60 are available for use as of 01/01/2013. |
| **62** | | Non-Part D/non-qualified drug not paid by Part D plan benefit, paid as or under a co-administered benefit only<br>• This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided.<br>• The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit.<br>• When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | |
|---|---|---|
| | | Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.<br><br>Benefit Stage Qualifier (393-MV) values 61 or 62 to replace the value of 60 are available for use as of 01/01/2013. |
| **70** | Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing<br>• This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non-formulary, quantity limit, etc.)<br>• When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. | Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing<br>• This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non-formulary, quantity limit, etc.)<br>• When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.<br>• For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value 018 – "Provide Beneficiary With CMS Notice Of Appeal Rights" |
| **80** | Non-Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing<br>• This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered under Part D law (i.e. excluded drugs).<br>• When the qualifier value of 80 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. | Non-Part D drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing<br>• This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the ~~Part D~~ drug is not covered under Part D law (i.e. excluded drugs).<br>• When the qualifier value of 80 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. |
| **90** | | Enhanced or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan<br>• When the qualifier value of 90 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.<br><br>Benefit Stage Qualifier (393-MV) value 90 is available for use as of 01/01/2013. |

## 22.9 BENEFIT STAGE IMPLEMENTATION FOR 07/01/2013

**Effective Date: July 1, 2013**

In 11/2012, DERF 001098/Emergency ECL 000132 was approved, with an effective date of 07/01/2013. This DERF/ECL modified Approved Message Code (548-6F) value "018" and associated changes to Benefit Stage Qualifier.

1. CMS has determined the notice, "Medicare Prescription Drug Coverage and Your Rights," should only be returned in the following instance.
    a. When the Part D drug not paid by Part D plan benefit, is paid by the beneficiary under plan-sponsored negotiated pricing. Plan-sponsored negotiated pricing refers to drugs not covered under the insured benefit design but are offered to beneficiaries under a negotiated discounted price. In this scenario, the beneficiary's out-of-pocket expense is 100% of the plan's negotiated discounted pricing with the pharmacy.
2. Prescription Drug Benefit Manual, Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals will be updated by CMS.
3. Approved Message Code value "018" is only applicable for certain values of Benefit Stage Qualifier.

Approved Message Code (548-6F)


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | |
|---|---|
| "018" | Provide Notice: Medicare Prescription Drug Coverage and Your Rights - Claim for a Part D drug submitted to the plan's Medicare D BIN/PCN is not covered by the Part D plan but is paid by the beneficiary per a plan-sponsored negotiated price. In this situation the member should be provided the notice entitled "Medicare Prescription Drug Coverage and Your Rights". |

Benefit Stage Qualifier (393-MW) values: (yellow marks revision or addition)

| Value | Description prior to 07/01/2013 | Revised Description as of 11/2012 DERF 001098/Emergency ECL 000132. Effective 07/01/2013 |
|---|---|---|
| **50** | Not paid under Part D, paid under Part C benefit (for MA-PD plan)<br>• This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN<br>• The claim is NOT paid by the Part D plan benefit<br>• The claim IS paid for by Part C benefit (MA portion of the MA-PD)<br>• When the qualifier value of 50 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim | No change. |
| **60** | Not paid under Part D, paid as or under a supplemental benefit only<br>• This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided.<br>• This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit)<br>• The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.<br>• When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim<br>• Since 60 is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur:<br>1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value 018 – "Provide Beneficiary With CMS Notice Of Appeal Rights"<br>2. For non Part D/non qualified drugs Benefit Stage Qualifier 60 will be returned without the Approved Message Code value of 018.<br><br>Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.<br><br>Benefit Stage Qualifier (393-MV) value 60 would only be available for use on claims with dates of service of 12/31/2012 and prior. | Not paid under Part D, paid as or under a supplemental benefit only<br>• This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided.<br>• This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit)<br>• The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.<br>• When the qualifier value of 60 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim<br>• Since 60 is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur:<br>1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value 018 – ~~"Provide Beneficiary With CMS Notice Of Appeal Rights"~~ "Provide Notice: Medicare Prescription Drug Coverage and Your Rights"<br>2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 60 will be returned without the Approved Message Code value of 018.<br><br>Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.<br><br>Benefit Stage Qualifier (393-MV) value 60 would only be available for use on claims with dates of service of 12/31/2012 and prior. |
| **61** | Part D drug not paid by Part D plan benefit, paid as or under a co-administered benefit only<br>• This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.<br>• The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit.<br>• When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim | Part D drug not paid by Part D plan benefit, paid as or under a co-administered insured benefit only<br>• This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.<br>• The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit.<br>• When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim |


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | |
|---|---|---|
| | • The Approved Message Code field (548-6F) must be returned with a value 018 – "Provide Beneficiary With CMS Notice Of Appeal Rights"<br><br>Benefit Stage Qualifier (393-MV) values 61 or 62 to replace the value of 60 are available for use as of 01/01/2013. | ~~• The Approved Message Code field (548-6F) must be returned with a value 018 – "Provide Beneficiary With CMS Notice Of Appeal Rights"~~<br><br>Benefit Stage Qualifier (393-MV) values 61 or 62 to replace the value of 60 are available for use as of 01/01/2013. |
| **62** | Non-Part D/non-qualified drug not paid by Part D plan benefit, paid as or under a co-administered benefit only<br>• This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided.<br>• The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit.<br>• When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim<br><br>Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.<br><br>Benefit Stage Qualifier (393-MV) values 61 or 62 to replace the value of 60 are available for use as of 01/01/2013. | No change. |
| **70** | Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing<br>• This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non-formulary, quantity limit, etc.)<br>• When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.<br>• For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value 018 – "Provide Beneficiary With CMS Notice Of Appeal Rights" | Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing<br>• This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non-formulary, quantity limit, etc.)<br>• When the qualifier value of 70 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.<br>• For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value 018 – ~~"Provide Beneficiary With CMS Notice Of Appeal Rights"~~ "Provide Notice: Medicare Prescription Drug Coverage and Your Rights" |
| **80** | Non-Part D drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing<br>• This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the drug is not covered under Part D law (i.e. excluded drugs).<br>• When the qualifier value of 80 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. | No change. |
| **90** | Enhanced or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan<br>• When the qualifier value of 90 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.<br><br>Benefit Stage Qualifier (393-MV) value 90 is available for use as of 01/01/2013. | No change. |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| Value | Description prior to 10/1/2014 | Revised Description as of 10/1/2014 |
|---|---|---|
| 50 | | No change. |
| 60 | | No change. |
| 61 | | No change. |
| 62 | | No change. |
| 63 | Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid under Medicaid benefit only of the Medicare/Medicaid (MMP) plan.<br>• This qualifier applies to Medicare/Medicaid (MMP) plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided.<br>• The claim is NOT paid by the Part D plan benefit but is paid under the Medicaid benefit only of the Medicare/Medicaid (MMP) plan.<br>• When the qualifier of 63 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.<br>• The field 394-MW Benefit Stage Amount should be populated with the total amount (total of 505-F5 Patient Pay Amount, 509-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. Note: Non-qualified drugs are defined as not meeting the definition of Part D drug. | Added |
| 70 | | No change. |
| 80 | | No change. |
| 90 | | No change. |

## 22.11 IMPACT ON DOWNSTREAM PAYER FOR ALTERNATIVE/FORMULARY

**Question/Statement:**
NCPDP needs to consider the impact to the downstream payer due to the beneficiary not being steered towards a therapeutic alternative medication or a drug that is on the formulary.

**Response:**
Based on the 4Rx Guidance, and the Medicare D plan's benefit design, the claim may be paid under the Medicare D unique BIN/PCN, but not paid under Part D. New Benefit Stage Qualifier (393-MW) values 50, 60, 70 and 80 were added the External Code List© to address these situations. These values were approved through the Emergency ECL process and are effective January 01, 2012. Benefit Stage Qualifier values 70 and 80 are used when the claim is paid by the beneficiary under the plan-sponsored negotiated pricing. Supplemental payers who meet the situation as defined in the NCPDP Telecommunication vD.0 Implementation Guide, may request the Benefit Stage fields to be submitted on coordination of benefit claims. The supplemental payer may leverage the Benefit Stage Qualifiers (353-MW) to determine their coverage rules. **Note value 60 (to be replaced by two new values) is sunsetted as of 01/01/2013 and the clarifications to 70, 80, and the new values are to be used by 01/01/2013.**

## 22.12 OTHER IMPACTS TO BENEFIT STAGE?

**Question/Statement:**
NCPDP will also need to flow through the following examples

- B vs. D drugs to determine how this negotiated pricing would be NOT applied and still force the claim to be billable under B.
- Hospice drugs billable under Medicare Part A and make sure that these drugs are not sent through negotiated pricing and still billable under A.
- Claims using patient location code/patient residence and ensuring these rules apply before negotiated pricing.

**Response:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

If there is other coverage under other components of Medicare, these claims would not be appropriate for negotiated pricing or discount card. ECL descriptions for Benefit Stage Qualifier 80 will be modified to reflect this detail. See section "*Benefit Stage Implementation for 01/01/2013*".

## 22.13 PART D SPONSOR TRANSITION NOTICE OR DENIAL LETTER?

**Question:**

Beneficiary with medication not covered under Medicare Part D where the discounted price is provided to the beneficiary. An appeal notice goes to the beneficiary. Will the Part D sponsor still send their transition notices or their denial letters for the drug not on the formulary or limited by clinical criteria?

**Response:**

- Within transition
  1. Transition notices are only sent when the drug is paid.
  2. Benefit Stage Qualifiers 1-4 would be sent.
  3. Applies to TrOOP.
- Outside transition

  The beneficiary would receive the Standardized Pharmacy Notice (CMS -10147) for Appeal when the claim is paid under the Medicare D unique BIN/PCN for the specific situations outlined in the grid in section "*Benefit Stage Implementation for 01/01/2013*" where Approved Message Code 018 is referenced.
  1. Transition notice is not sent.
  2. Does not apply to TrOOP.

## 22.14 BENEFIT STAGE REQUIRED FOR PART D?

### 22.14.1 CAN NON-GOVERNMENT PROCESSOR REQUIRE?

**Question:**

Can a non-government processor make the Benefit Stage fields required if patient has Medicare Part D? In other words, if a pharmacy submits to Medicare Part D, and then attempts a COB claim (based on Other Payer-Patient Responsibility Amounts and OCC=8) to us, will we know the patient has Medicare Part D? If we cannot receive the Benefit Stage fields, is there any other way to know that the patient is covered by Medicare Part D?

**Response:**

NCPDP Telecommunication Standard vD.0© defines the situations in which the Benefit Stage fields can be requested for COB claim billing as:

- When the plan is a participant in the Medicare D program that requires reporting of the benefit stage specific financial amounts or;
- Required if necessary for state/federal/regulatory agency programs

The sum of the Benefit Stage Amounts, reflect the allowed amount or contracted rate between the Medicare D plan and the provider. To comply with the defined situations and to prevent un-authorized disclosure of contractual financial information, a non-government program or a program that does not participate in the Medicare D patient financial reporting process (e.g. TrOOP) cannot require the Benefit Stage fields be submitted on COB claims.

Neither the NCPDP Telecommunication Standard vD.0© nor the most current ECL publication contain a field or value available to the B1 claim billing transaction that would identify the patient as Medicare D eligible. The COB claim billing transaction does support the Other Payer ID (340-7C) and the Other Payer ID Qualifier (339-6C). The values submitted in these fields, may assist in identifying the previous payer as a Medicare D plan.

Other Payer ID – ID assigned to the payer
Other Payer ID Qualifier – Code Qualifying the Other Payer ID
Other Payer ID Qualifier Values (07/2011 ECL Publication)


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

- 01 - National Payer ID-Code indicating that the information to follow is the National Payer Identifier mandated under HIPAA. This identification system is currently under development; therefore this Code is not in use
- 02 - Health Industry Number (HIN)-A 9 digit alphanumeric number used to identify health care entities such as veterinarians, animal clinics, and health care provider facilities. The number is assigned by HIBCC.
- 03 - Bank Information Number (BIN) Card Issuer ID or Bank ID Number assigned by ANSI used for network routing. Now defined by ANSI as the Issuer Identification Number (IIN). This may also be the Processor ID, assigned by NCPDP.
- 04 - National Association of Insurance Commissioners (NAIC)-A unique number for each company that does business in the United States as assigned by NAIC. A company may have multiple NAIC Codes to represent subsidiary companies under a main company.
- 05 - Medicare Carrier Number–A number assigned by the carrier or intermediary which administers the Medicare health insurance program. *NOTE: This value is associated to Medicare Part B carriers and is not returned on the B1 claim response.*
- 99 - Other-Different from those implied or specified

In the situation where the COB payer is not eligible to receive the Benefit Stage information but needs to know if Part D coverage applied, the following Other Payer ID options may address the business need:

- Option 1: Use Qualifier "03" where the BIN of the previous payer would always be transmitted. Note: Effective January 1, 2012 Medicare Part D Plans must use a unique BIN or BIN/PCN combination.
- Option 2: Use Qualifier "99" where the COB payer identifies the Other Payer ID values. To promote consistency in the industry, NCPDP recommends that the values be "MEDD" and "OTHER". The provider must transmit appropriate value based on classification of previous payer. Provider may choose to leverage the response Benefit Stage Qualifiers "01" – "04" to determine that Part D coverage applied. Note: Pharmacy systems may not be able to automate this process.

The implementation of the National Health Plan ID (HPID) may provide a future solution.

### 22.14.2 MEDICARE PART D CLAIM WITHOUT BENEFIT STAGE FIELDS?

**Question:**

If the claim is paid under the Medicare D unique BIN/PCN, why doesn't it include a Benefit Stage Qualifier and associated Benefit Stage Amount?

**Response:**

Prior to January 1, 2013 there may be situations where a Benefit Stage Qualifier would not be returned on a Part D claim. These situations should be limited to:

- Prior to July 1, 2012: The discretionary enforcement of HIPAA standards where compliant use of the NCPDP Telecommunication Standard Version D.0© was not enforced and some Version 5.1 claims were submitted.
- Prior to July 1, 2012: Benefit Stage Qualifier logic for a paid response may have been based on the implementation of the unique BIN/PCN; however CMS Regulatory requirement for unique 4Rx was not enforced until July 1, 2012. For more information see ***Recommendations for Effective 4Rx Usage in Medicare Part D Processing***
- Prior to January 1, 2013: There is no Benefit Stage Qualifier available for enhanced and OTC drugs which are covered by the Part D Plan and do not count towards TrOOP.

All claims with Dates of Service as of January 1, 2013 paid under a Medicare Part D BIN/PCN should contain the applicable Benefit Stage Qualifier(s) and the associated Benefit Stage Amount(s). As a result the benefit stage information will be available for COB claims as required by law. Refer to the Benefit Stage Qualifier values in the External Code List© and "*Benefit Stage Implementation for 01/01/13*" section.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

## 22.15 COVERAGE GAP AND AMOUNT ATTRIBUTED TO COVERAGE GAP (137-UP)

**Question:**

When the Medicare D claim falls within the Coverage Gap benefit stage, should the Amount Attributed to Coverage Gap (137-UP) always be returned?

**Response:**

Please see section "*Benefit Stage Rules*". Other than the condition outlined in # 4 below, when the claim falls within the Coverage Gap benefit stage, the Amount Attributed To Coverage Gap must be returned.

1. The sum of the benefit stage amounts must equal Patient Pay Amount (505-F5) plus Total Amount Paid (509-FN). There is an exception to this. See "*Republication of Telecommunication Standard Implementation Guide Version D.0© August 2010*", subsection "*Benefit Stage Formula*".
2. All benefit stage qualifiers and amounts should be based on where the member would have been in the benefit if they had been in the non LIS benefit. This will ensure the beneficiary is not hindered from receiving a benefit that might be available to them from a supplemental payer.
3. When the LIS benefit does not have a deductible, if the member would have been in the deductible stage in the non LIS benefit, return the Deductible Benefit Stage Qualifier (01) and applicable benefit stage amount. Return the LIS patient pay amount as Amount of Copay (518-FI) or Amount of Coinsurance (572-4U).
4. If the LIS benefit does not have a coverage gap and the member would have been in the coverage gap stage in the non LIS benefit, return the Coverage Gap Benefit Stage Qualifier (03) and applicable benefit stage amount. **Report the LIS patient pay amount as Amount of Copay (518-FI) or Amount of Coinsurance (572-4U).**

**Question:**

Does the Amount Attributed to Coverage Gap (137-UP) reflect the patient liability amount before or after the coverage gap discount applies?

**Response:**

- The components of the Patient Pay Amount must sum to the value reported in Patient Pay Amount (505-F5); therefore the value returned in the Amount Attributed to Coverage Gap (137-UP) should reflect the patient's coverage gap liability amount after the required discount applies.
- Payers supplemental to Medicare D, requiring the components of Patient Pay to be submitted on the COB claim, when applicable (non-duals) would receive:
    a. The Other Payer Patient Responsibility Amount Qualifier of 12 (Amount Attributed to Coverage Gap)
    b. The associated Other Payer Patient Responsibility Amount as the amount after the coverage gap discount applied
    c. The Benefit Stage Qualifier of 03 (Coverage Gap)
    d. The associated Benefit Stage Amount as the full coverage gap amount prior to the discount
- Please refer to example # 5 under section *"$50 Claim – Initial Coverage Limit of $2830 Already Met. Amount Remaining to Meet TrOOP is $2000*".

## 22.16 NON-FORMULARY PENALTY AND COVERAGE GAP

**Question:**

If the claim incurs a non-formulary penalty and also falls within the coverage gap, how should the components of patient pay be returned?

**Response:**

Non-formulary penalties no longer apply to Part D.

## 22.17 VACCINE ADMINISTRATION

**Question:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

In the v5.1 editorial document we speak to Vaccine Administration Claims for Medicare Part D and Usual and Customary. I am looking for guidance on the Vaccine Administration Claims and Usual and Customary going forward. Does the recommendation carry forward from v5.1 where for just Medicare Part D that the Usual and Customary field includes the Vaccine Administration Fee? What about for a Commercial Vaccine Administration Claim, does the same apply; the vaccine administration fee is included in Usual and Customary? Need clarification for vD.0.

**Response:**

Medicare Part D should be handled the same way in version 5.1 and D.0. For all other payers - If the vaccine administration fee is part of the drug benefit cost, the Medicare Part D-based claim billing method can be used. If the vaccine administration fee is not part of the drug benefit cost, the claim billing is used for the drug benefit cost, and the service billing is to be used to bill the administration fee.

It is also suggested that instruction be added to the payer sheet for which way the payer does it.

## 22.18 BIN AND PCN FROM RESPONSE TO REQUEST

**Question:**

Processors are to use the Response COB Segment to report other payer Information to pharmacies. Today this is done in parsed messages (with Medicare Part D). When we parsed, the guidance was that BIN should always be 6 characters and PCN 10 – no truncation. If no PCN, it should still be reported as 10 spaces. Or if PCN less than 10, it should be padded with spaces to make the value 10.

Are we to assume that carries over to populating these fields in this segment? BIN is pretty straight forward because all BINs are 6 so while the Other Payer ID field takes 10, as long as we use the BIN Qualifier, the field size should be okay to truncate to 6.

But normally we recommend truncation – yet I think in the case of Other Payer Processor Control Number we probably should not.

**Response:**

In Version 5.1, the Other Health Insurance (OHI) is forced into a fixed length area. So if the Other Payer PCN is not used in this OHI environment, 10 spaces are returned. In Version D.0, the Other Payer PCN if not used, should not be sent – this is the recommendation. The pharmacy would submit the PCN on the subsequent claim header with blanks.

While not recommended, the processor could return the Other Payer PCN with spaces. Either way the pharmacy would submit the subsequent claim with a PCN of 10 spaces.

The alphanumeric padding rules of left justified and right filled must be followed.

For example –

the Other Payer BIN is “600429”,
the payer does not use a PCN,
so the Other Payer PCN field would be sent on the response as “ “ or not sent. Either way is correct, although the recommendation is to not send.
When the pharmacy submits a subsequent claim,
the header BIN contains 600429,
the PCN contains “ “.

## 22.19 CMS’ DEFINITION OF PRIMARY INSURER’S PAYMENT

**Question:**


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

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

In the CMS instructions for MSP pricing and calculation rules, CMS refers to Primary Insurer's payment or Primary payment in many of the rules for pricing the MSP claim. We are looking for an Industry consensus on CMS's definition of Primary Insurer's payment. We believe the following to be true but wanted to get the COB Task Groups thoughts.

When determining the amount the other payer(s) paid (Primary Insurer's Payment) on MSP claims (claim examples attached):

The current processor should only sum/recognize the "like" amounts (qualifiers) that would be paid if paying as primary.

If the sum of Other Payer "like" amounts (qualifiers) that are recognized exceed the negotiated price (calculated as if paying as primary):

- Other Payer Amount Recognized on the pharmacy response is reduced to equal the Negotiated Total Cost
- Apply Other Payer Amount Recognized from pharmacy response to Member's Drug Spend
- Report the sum of all Other Payer "like" amounts (including amounts exceeding Negotiated Total Cost) on the PDE in PLRO

The CMS MSP instructions are dated April 26, 2006. Section (17.4.2) contains the pricing and calculation rules.

**Response:**

Yes, primary insurer's payment is based on other payer "like" amounts. This is accomplished by summarizing "like" Other Payer Amount Paid dollars across all prior payers and then using these values against current payers ""like" contractual amounts to reduce the liability for the current payer (Part D).

OTHER PAYER AMOUNT PAID QUALIFIER

| Qualifier Field ID | Qualifier Value | Qualifier Definition |
|---|---|---|
| 342-HC | 06 | Cognitive Services |
| 342-HC | 05 | Incentive |
| 342-HC | 01 | Delivery |
| 342-HC | 02 | Shipping |
| 342-HC | 03 | Postage |
| 342-HC | 04 | Administrative |
| 342-HC | 09 | Compound Prep Cost |
| 342-HC | 10 | Sales Tax |
| 342-HC | 07 | Drug Benefit |

This means Drug Benefit dollars paid by prior payers should be used to reduce Drug Benefit dollars (negotiated) that would be part of Part D if Part D was primary. Delivery dollars paid by prior payers would reduce delivery dollars paid by the current payer (Part D). If delivery is not part of the agreement with the current payer, the dollars paid for delivery by prior payers cannot be used to reduce the current payer's liability.

| **Pharmacy to Primary** | | | **Pharmacy to Secondary** | | |
|---|---|---|---|---|---|
| **Field** | **Qualifier** | **Amount** | **Field** | **Qualifier** | **Amount** |
| Ingredient Cost Submitted | | $110.00 | Ingredient Cost Submitted | | $110.00 |
| Dispensing Fee Submitted | | $2.50 | Dispensing Fee Submitted | | $2.50 |
| Incentive Amount Submitted | | $25.00 | Incentive Amount Submitted | | $25.00 |
| Flat Sales Tax Amount Submitted | | $6.00 | Flat Sales Tax Amount Submitted | | $6.00 |
| Other Amount Claimed Submitted | 01 - Delivery | $10.00 | Other Amount Claimed Submitted | 01 - Delivery | $10.00 |
| Other Amount Claimed Submitted | 02 - Shipping | $1.25 | Other Amount Claimed Submitted | 02 - Shipping | $1.25 |
| Other Amount Claimed Submitted | 03 - Postage | $3.25 | Other Amount Claimed Submitted | 03 - Postage | $3.25 |
| Gross Amount Due | | $158.00 | Gross Amount Due | | $158.00 |
| | | | **COB Loop #1** | | |
| | | | Other Payer Amount Paid - Primary | 01 - Delivery | $9.00[1] |
| | | | Other Payer Amount Paid - Primary | 02 - Shipping | $0.00[1] |
| | | | Other Payer Amount Paid - Primary | 03 - Postage | $0.00[1] |
| | | | Other Payer Amount Paid - Primary | 05 - Incentive | $20.00[1,3] |
| | | | Other Payer Amount Paid - Primary | 07 - Drug Benefit | $82.00[1,3] |


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

| | | | Other Payer Amount Paid - Primary | 10 - Sales Tax | $5.00[1,3] |
|---|---|---|---|---|---|
| **Primary Response** | | | **Secondary Response** | | |
| **Field** | **Qualifier** | **Amount** | **Field** | **Qualifier** | **Amount** |
| Ingredient Cost Paid | | $105.00 | Ingredient Cost Paid | | $80.00[2] |
| Dispensing Fee Paid | | $2.00 | Dispensing Fee Paid | | $2.00[2] |
| Flat Sales Tax Amount Paid | | $5.00 | Flat Sales Tax Amount Paid | | $4.50[2] |
| Incentive Amount Paid | | $20.00 | Incentive Amount Paid | | $15.00[2] |
| Other Amount Paid | 01 - Delivery | $9.00 | Other Amount Paid | 01 - Delivery | $0.00[2] |
| Other Amount Paid | 02 - Shipping | $0.00 | Other Amount Paid | 02 - Shipping | $0.00[2] |
| Other Amount Paid | 03 - Postage | $0.00 | Other Amount Paid | 03 - Postage | $0.00[2] |
| Patient Pay Amount | | $25.00 | **Other Payer Amount Recognized** | | $101.50[2] |
| Total Amount Paid | | $116.00 | Patient Pay Amount | | $0.00 |
| | | | Total Amount Paid | | $0.00 |
| | | | **Benefit Stage** | **02 - Initial Coverage** | $101.50[4] |

1. Total Other Payer Amount Paid (431-DV) submitted = $116.00 ($9+$20+$82+$5)
2. Sum of secondary paid fields is $101.50. Secondary negotiated amount: ($80+$2+$4.50+$15) is lower than the sum of OPAP like values therefore Other Payer Amount Recognized is reduced to the negotiated rate OF $101.50.
3. Other Payer Amount 'Like Values" Recognized is $107.00 ($5.00+$20+$82)
4. DED PLRO = $101.50
5. PDE PLRO = $107.00

| **PDE FIELDS** | | |
|---|---|---|
| GDCB | | $101.50[4] |
| GDCA | | $0.00 |
| Patient Pay Amount | | $0.00 |
| LICS | | $0.00 |
| Other TrOOP | | $0.00 |
| PLRO | | $107.00[5] |
| CPP | | $0.00 |
| NPP | | $0.00 |

## 22.20 DUAL ELIGIBILITY

**Question:**

How does the NCPDP Telecommunication Standard© support the communication of the primary Medicare D plan 4-RX data when a Medicaid beneficiary is flagged as a dual eligible?

**Response:**

Reject Code "41" (Submit to Primary Payer) and "AE" (QMB-Bill Medicare) are currently available to indicate patient has other coverage or is Medicare eligible. Since these Reject Codes do not uniquely identify a dual eligible beneficiary, DERF/ECL 001082/000126 was approved in August 2012 to provide the following Reject Code changes:

| Value Suggested | Value Definition *(required)* | Value Explanation *(required)* |
|---|---|---|
| 620 | This Product/Service may be covered under Medicare Part D | |
| 621 | This Medicaid Patient is Medicare Eligible | This patient is eligible for Medicare but may not yet be enrolled. If no enrollment found attempt to use Medicare's temporary prescription drug program. |
| A6 | This Product/Service May Be Covered Under Medicare Part B | This Product/Service May Be Covered Under Medicare Part B and Therefore May Not Be Covered Under the Medicare Part D Basic Benefit for This Beneficiary. |

In the situation where Medicaid agencies/processors are aware that a patient also has Medicare eligibility (i.e. Dual Eligible), it is recommended that the processor return a more specific NCPDP Reject Code than "41" (Submit to primary payer). The above Reject Codes should be used as of the **October 2013** annual ECL implementation.

Prior to the October 2013 annual ECL implementation, it is recommended that NCPDP Reject Code value of "41" (Submit to Primary Payer) or "AE" (QMB – bill Medicare) be returned.


*** OFFICIAL RELEASE***
© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

If the Medicaid Program can distinguish between Part B and Part D drugs, the appropriate NCPDP Reject Code should be returned (A6-Part B or 620-Part D).

If the Medicaid Program **cannot** distinguish between Part B and Part D drugs, the Medicaid Processor should return the more generic NCPDP Reject Code of "621" (This Medicaid patient is Medicare eligible).
When Reject Codes "AE", "41", "A6", "620" or "621" are used as referenced above, the following freeform message should also be returned in Additional Message Information (526-FQ) (with appropriate qualifiers): "SUBMIT MEDICARE ELIGIBILITY INQUIRY (E1); IF ENROLLMENT IS NOT FOUND, SUBMIT TO THE MEDICARE LIMITED INCOME NET PROGRAM – BIN 015599 PCN 05440000. HELP DESK: 800-783-1307".

Note: The above text is specific to the 2012 Medicare Limited Income Newly Eligible Transition Program.

## 22.21 PART D SPONSORS APPLYING MEDICARE SECONDARY PAYER (MSP) REQUIREMENTS

**Question:**

How should Part D sponsors address the following CMS guidance found within Medicare Prescription Drug Manual, Chapter 14 revised 8/23/2013, in section 50.12 Applying Medicare Secondary Payer (MSP) Requirements?

> *…. absent information on the COB file that Part D is secondary for a Part D enrollee, should the sponsor receive a secondary claim, the claim cannot be paid. Instead, the sponsor should determine if the enrollee has coverage that is primary to Medicare and, if so, report this information to the COB contractor via ECRS to update CMS.*

**Response:**

The following recommendations are based on review of current guidance and discussions with CMS.

1. When plan has established it should only pay primary and:
    a. Pharmacy submits a primary claim.
        i. The Medicare Part D processor would adjudicate based on plan coverage rules.
    b. Pharmacy submits a COB claim with Other Coverage Code value of "2" or "3" or "4":
        i. The Medicare Part D Plan must reject the COB claim. Until a new Reject Code value is available, use Reject Code "7M" (Discrepancy Between Other Coverage Code And Other Coverage Information On File).
            1. August 2014 note: A DERF will be submitted for a new Reject Code (Plan enrollment file does not indicate other coverage primary to Medicare).
        ii. The plan should also return the additional message "Instruct patient to call Medicare at 1-800-MEDICARE to report changes in other coverage" unless the primary payer rejected for coverage termination reasons.
            a. If the plan is able to establish credible primary coverage other than Part D that is not Workers' Compensation, Black Lung or liability, sponsors may report this information through the Electronic Correspondence Referral System (ECRS)
                i. To report drug coverage, use an ECRS Prescription Drug Inquiry.
2. When the plan has established it should only pay secondary (MSP) and:
    a. Pharmacy submits a primary claim.
        i. The plan must reject the claim with Reject Code "41" (Submit to Primary) and return available OHI information in the Response COB/Other Payers Segment and/or the Additional Message Field.
    b. Pharmacy submits COB claim with OCC "2" or "4".
        i. The Medicare Part D processor would adjudicate based on plan coverage rules.
    c. Pharmacy submits COB claim with OCC "3".
        i. For claims processing, the Medicare Part D processor would adjudicate based on plan coverage rules.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

ii. For eligibility maintenance the plan should follow their established process for determining whether MSP requirements continue to apply (e.g. claims where other payer reject code indicates other coverage has terminated).

a. When the plan sponsor has established that MSP no longer applies, as directed in CMS guidance the Part D plan should report this information to the COBC contractor via ECRS.

i. To report drug coverage, use an ECRS Prescription Drug Inquiry. (Refer to CMS guidance for the reporting of credible coverage other than Part D.)

ii. To update an existing drug record, use an ECRS Prescription Drug Assistance Request.

http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter14.pdf

# 22.22 PRESCRIBER IDENTIFICATION

## 22.22.1 FOREIGN PRESCRIBER IDENTIFIER

**Question:**

For Medicare Part D pharmacy claims, where can I obtain information about the proper identifier qualifier value to use for a foreign prescriber?

**Response:**

It is appropriate to use the Prescriber ID Qualifier (466-EZ) value "17" (Foreign Prescriber Identifier = a value used to identify a prescriber who practices outside of the United States and does not have a prescriber identifier issued from within the United States) which was available for use July 1, 2012. See the April 4, 2011 *NOTE TO: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties*
*SUBJECT: Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*
at http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Announcement2012final.pdf Search for "foreign prescriber".

*Modified August 2025*

**Question:**

Must the Part D Sponsor reject the Part D claim submitted with a foreign prescriber ID?

**Response:**

*Note the ability for a foreign prescriber to write a prescription that is valid under state law is only relevant in a couple of states.*

1. If there isn't an active and valid NPI for the foreign prescriber and the claim is submitted with a Prescriber ID Qualifier value of "17" (Foreign Prescriber), the Part D prescriber validation rule allows a different action by the sponsor than when a domestic prescriber is involved.

   The sponsor is not required to pay the claim and 24-hour follow up is not required per CMS guidance. The claim will be rejected (Reject Code: "543" (Prescriber ID Qualifier Value Not Supported)). The pharmacy should not try to resubmit using Submission Clarification Code as overrides. The patient can pay cash or see a prescriber who is covered under the plan benefit. Per CMS this is not considered a clean claim; therefore, the Notice of Medicare Drug Coverage Rights is not required.
2. If there is an active and valid NPI for the foreign prescriber and the claim is submitted with a Prescriber ID Qualifier value of 01 (NPI)
   - The sponsor must pay the claim if it is otherwise payable (i.e. treat as any other prescription claim with an active and valid prescriber NPI).

## 22.22.2 VALID PRESCRIBER ID?

Background

*Effective 01/01/2012, Part D sponsors must ensure that the acceptable prescriber Identifiers (NPI, DEA Number, UPIN, State License) are active and valid. Sponsors should not reject the claim solely on the basis of an invalid prescriber ID, unless the issue can be resolved at point of service. If*


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

*retrospective review is conducted, the Part D sponsors are responsible for reporting a valid prescriber ID on the PDE. Part D sponsors will also be required to confirm the validity of DEA numbers on Schedule II-V drug claims or map NPIs on these claims to the prescriber's DEA numbers. In addition, sponsors will be required to confirm that the controlled substance is within the prescriber's scope of practice to prescribe.*

*There are multiple prescriber data base vendors available in the market, where data matching rules may vary. As a result, the prescriber detail within the provider's system may be different than the prescriber detail in the payer's system for the single prescriber ID submitted on the claim. The timing of file updates may result in a situation where the provider has access to the current information (newly licensed prescriber) however the payer system does not have a record for this prescriber. Additionally, the administrative processes currently used by the DEA to renew prescriber DEA licenses produces in-accurate results within the DEA source file (NTIS) available to the industry. For example, the source file will report the DEA license as EXPIRED, however the DEA renewal process is in progress, where the prescriber receives an authorization letter from the DEA office indicating the DEA license number can be used.*

**Question:**

Does CMS expect Part D Sponsors to validate the DEA Schedule down to the Narcotic/Non-Narcotic level?
Situation: A prescriber's DEA license is associated to the applicable DEA schedules (2, 3, 4, 5). The DEA further delineates the schedules as Narcotic and Non-Narcotic, where Non-Narcotic is listed as 2N, or 3N. Not all drug compendia may provide a Narcotic or Non-Narcotic classification. Based on the lack of a narcotic identifier on the drug files, does CMS expect sponsors to be editing to that level?

*CMS Response:*
*As noted in the CY 2012 Call Letter, the DEA Schedule policy does not supersede or alter pharmacy obligations relative to DEA registrants under the Controlled Substances Act and DEA rules.*

**Response:**

CMS does not expect Part D Sponsors to validate the DEA Schedule down to the Narcotic/Non-Narcotic level.

However, systematic validation may be available based on data elements on the drug compendia files. (Note: The DEA schedule and a narcotic box will eventually be on the HDMA form used by the wholesalers to send info to the compendia. As an additional resource, WG2 Structured Product Label Task Group will ask FDA to generate an Index of Narcotics on the Dailymed website.)

The industry uses the CFR - Code of Federal Regulations Title 21 for the definition of a narcotic.

> *Narcotic drug* means any of the following whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:
>
> > (1) Opium, opiates, derivatives of opium and opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation. Such term does not include the isoquinoline alkaloids of opium.
> > (2) Poppy straw and concentrate of poppy straw.
> > (3) Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine and derivatives of ecgonine or their salts have been removed.
> > (4) Cocaine, its salts, optical and geometric isomers, and salts of isomers.
> > (5) Ecgonine, its derivatives, their salts, isomers and salts of isomers.
> > (6) Any compound, mixture, or preparation which contains any quantity of any of the substances referred to in paragraphs (1) through (5) of this definition.

*Updated August 2025*

See chart below.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

Validation rules:

- If the Prescriber has DEA schedule of 2, 2N, 3, 3N it must be **an exact match** to the drug DEA schedule of 2, 2N, 3, 3N.
- If the Prescriber has DEA schedule of 4, the match to drug DEA schedule of 4 **or** 4N is valid.
- If the Prescriber has DEA schedule of 5, the match to drug DEA schedule of 5 **or** 5N is valid.

Gray square is not applicable

| | | Drug DEA Schedule | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 2 | 2N | 3 | 3N | 4 | 4N | 5 | 5N |
| Prescriber DEA Schedule | 2 | Exact Match Only Valid | | | | | | | |
| | 2N | | Exact Match Only Valid | | | | | | |
| | 3 | | | Exact Match Only Valid | | | | | |
| | 3N | | | | Exact Match Only Valid | | | | |
| | 4 | | | | | 4 or 4N Valid | 4 or 4N Valid | | |
| | 5 | | | | | | | 5 or 5N Valid | 5 or 5N Valid |

Examples:

1. Prescriber has a DEA schedule of 2 and does not have 2N, and the drug DEA schedule is 2N
    a. Check is not valid since the match of 2N must be exact.
2. Prescriber has a DEA schedule of 3N and does not have 3, and the drug DEA schedule is 3.
    a. Check is not valid since the match of 3 must be exact.
3. Prescriber has a DEA schedule of 4 and the drug DEA schedule is 4N
    a. Check is valid since the match for 4 is 4 or 4N.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Question:**
If a provider is on the OIG sanction list, disbarred from a government health care program, will this be reflected within NPI status on the NPI Registry?

**Response:**
A provider's NPI which may be listed with the OIG LEIE may not necessarily be listed as deactivated on the NPPES. The NPPES deactivation code of Fraud is specific to a provider's ID being compromised and not that this particular provider has committed fraud. NPPES only indicates whether the NPI is active, and does not track whether the ID is excluded from government programs.

*"CMS and the Enumerator do not report fraudulent provider issues to enrolling health plans. Issues involving health care providers who are fraudulent are handled by the enrolling health plan. If a government agency detected fraud, they should alert the health plans who have enrolled the provider (if the information is pertinent to the other health plans). From a NPI perspective, the provider is eligible to obtain/retain the NPI as long as the provider continues to meet the definition of a health care provider as defined at 45 CFR 160.103. Please keep in mind that a health care provider who has committed fraud with one health plan may still be actively/legitimately enrolled with other health plans, which means the provider still has a need for the NPI to remain active."*

**Question**
Pharmacies have encountered prescribers whose DEA Licenses do not list one or more schedules as being permitted, even though the prescribers may believe their DEA Licenses should have authority for the missing schedule(s). How can a prescriber update details of his/her current registration to include all appropriate schedules?

**Response:**
As outlined in the 2012 CMS Call Letter, "Effective January 1, 2012 Part D sponsors will be required to confirm the validity of DEA numbers on Schedule II-V drug claims or map NPIs on these claims to the prescriber's DEA numbers. In addition, sponsors will be required to confirm that the controlled substance is within the prescriber's scope of practice to prescribe."

In the event the prescriber's DEA registration incurs an administrative error, an individual with a CURRENT or NEW/Pending DEA License may follow up with the DOJ DEA registration site at https://www.deadiversion.usdoj.gov/drugreg/registration.html

For any additional assistance you may contact one of the following:

- DEA.Registration.Help@usdoj.gov
- DEA Call Center 1-800-882-9539

*Updated August 2025*

**Question:**
How should plan sponsors handle a controlled substance prescription claim where the prescriber's individual Type 1 NPI is submitted, however the prescriber is acting under the DEA registration of the hospital, to which the prescriber DEA registration ID field will be blank on the plan's prescriber data base?

**Response:**
In the situation where the processor is not able to identify a DEA number to be associated to the submitted individual prescriber NPI, the claim would reject as Reject Code "44" (Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found). After validation, the pharmacy would resubmit the claim with the Submission Clarification Code 45 (Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule). Note: pharmacy systems may be able to proactively recognize the prescriber relationship to a hospital and could submit the Submission Clarification Code 45 on the initial submission prior to any reject. The elimination of the reject will mitigate patient care delays and improve beneficiary experience. Per CMS, the DEA Schedule registration information is not submitted on the PDE. In this instance, sponsors can assume


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

the prescription was dispensed in accordance with applicable controlled substances law, as our policy does not supersede or alter pharmacy obligations relative to DEA registrants under the Controlled Substance Act and DEA rules. From the Part D perspective, the process is completed when the pharmacy submits the Submission Clarification Code 45.

Clarification received from CMS following the May 2013 HPMS memo supports the above recommendations:

> "CMS' policy is that Medicare Part D claims should not be denied solely on the basis that sponsors do not find an individual DEA number for the prescriber and thus are unsure of the prescriber's DEA status. We do not believe that sponsors have reasonable access to the information necessary to research the relationship of individual prescribers to group DEA numbers, and have not required this in our guidance.
>
> However, Part D drugs must be dispensed pursuant to a valid prescription under all applicable state and federal laws in order to be covered. Therefore, CMS' policy also does not supersede or alter pharmacy obligations relative to DEA registrants under the Controlled Substance Act and DEA rules. This means that CMS continues to expect sponsors to take reasonable steps to ensure that their network pharmacies are complying with these rules without unreasonably delaying a beneficiary's access to medications.
>
> If the Task Group agrees that the Reject Code 44 and subsequent Submission Clarification Code 45 demonstrates that the pharmacy has met its obligations, then CMS does not see a reason to eliminate them for Part D claims, nor to revise the referenced response."

**Question:**
A prescriber's DEA registration is expired and can only write scripts for schedules III – V in the plan's data base. The claim is for a schedule II medication. The claim rejects for "43" (Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive). After the pharmacy enters a Submission Clarification Code of 43 should the claim pay and allow the schedule II medication or should the claim also have rejected "46" Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA class? This would mean the pharmacy would have to submit two Submission Clarification Codes on the claim 43 and 46 to get the claim to pay?

**Response:**
This example is a scenario of a timing issue. The plan's database differs from what the pharmacy has actually validated with the prescriber. The prescriber has updated their DEA registration and Schedule II-V are now included. This information may take time to funnel through the industry.

The plan should return all applicable Reject Codes on the initial response (Reject Code "43" and "46"). The pharmacy will validate the active status and prescriptive authority of the prescriber. When validated, the claim can be resubmitted with the Submission Clarification Code 43 (Prescriber's DEA is active with DEA Authorized Prescriptive Right.)

While not recommended, in the event the plan only returns a single Reject Code when multiple errors are evident, the pharmacy would have to resubmit the claim with the applicable Submission Clarification Code for the initial Reject Code and then respond to any subsequent rejects.

### 22.22.3 PROCESSING WITH PRESCRIBER ID

Please also see Section 24.12 Medicare Part D Prescriber Validation Flow and Section 24.13 Medicare Part D Prescriber Validation Reject Matrix.


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

**Question:**

Will CMS require an override process when the submitted Prescriber ID results in a Missing/Invalid (M/I) Prescriber ID (Reject Code = "25") reject?

Situation: Should Part D sponsors interpret the below CMS regulation to also apply to prescription claims where the submitted prescriber ID does not meet the formatting rules for the associated prescriber ID qualifier? In these situations, the plan sponsor is unable to attempt to validate the submitted ID to a prescriber data source. For example, the Prescriber ID Qualifier is submitted as "01" (NPI); however, the submitted prescriber ID does not meet the Luhn formula.

*2013 Part D Regulation:*

> *"For these reasons, and in response to comments, we are revising our policy and the regulation text to require a Part D sponsor to ensure that the lack of an active and valid individual prescriber NPI on a network pharmacy claim does not unreasonably delay a beneficiary's access to a covered Part D drug. Sponsors will be required to so ensure in the following manner: (1) a sponsor must communicate at point-of-sale whether or not the prescriber NPI is active and valid; (2) if the sponsor communicates that the prescriber NPI is not active and valid, the sponsor must permit the pharmacy to confirm that the NPI is active and valid, or in the alternative, to correct it; (3) if the pharmacy confirms that the prescriber NPI is active and valid or corrects it, the sponsor must pay the claim if it is otherwise payable; and (4) if the pharmacy cannot or does not correct or confirm that the prescriber NPI is active and valid, the sponsor must require the pharmacy to resubmit the claim* ***(when necessary)****, which the sponsor must pay, if it is otherwise payable, unless there is an indication of fraud or the claim involves a prescription written by a foreign prescriber (where permitted by State law)."*

**Response:**

There is no override to Reject Code (511-FB) value 25. The highlighted guidance does not refer to Reject Code (511-FB) value 25 *M/I Prescriber ID* when used for formatting issues.

Updated 05/2025; 08/2025


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use

### *22.22.3.1 HOW CAN THE PAYERS AND PROVIDERS LEVERAGE THE NCPDP STANDARD TO COMPLY WITH SECTION 507 OF THE MACRA LEGISLATION?*

***SEC. 507. REQUIRING VALID PRESCRIBER NATIONAL PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.***

*Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:*

*"(4) REQUIRING VALID PRESCRIBER NATIONAL PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.—*

*"(A) IN GENERAL.—For plan year 2016 and subsequent plan years, the Secretary shall require a claim for a covered part D drug for a part D eligible individual enrolled in a prescription drug plan under this part or an MA–PD plan under part C to include a prescriber National Provider Identifier that is determined to be valid under the procedures established under subparagraph (B)(i).*

*"(B) PROCEDURES.—*

*"(i) VALIDITY OF PRESCRIBER NATIONAL PROVIDER IDENTIFIERS.—The Secretary, in consultation with appropriate stakeholders, shall establish procedures for determining the validity of prescriber National Provider Identifiers under subparagraph (A).*

*"(ii) INFORMING BENEFICIARIES OF REASON FOR DENIAL.—The Secretary shall establish procedures to ensure that, in the case that a claim for a covered part D drug of an individual described in subparagraph (A) is denied because the claim does not meet the requirements of this paragraph, the individual is properly informed at the point of service of the reason for the denial.*

*"(C) REPORT.—Not later than January 1, 2018, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the effectiveness of the procedures established under subparagraph (B)(i).".*

**Response:**

In accordance with MACRA legislation section 507 effective 01/01/2016, prescriptions will no longer be covered under Medicare Part D if written by a prescriber who does not have a valid Type 1 NPI. The legislation also requires the pharmacy when the claim rejects as a result of the prescriber NPI requirement, to notify the beneficiary the reason the claim could not be covered under Medicare Part D. To support these requirements, the Part D claim response must include the appropriate information to indicate the claim does not meet MACRA requirements. This can be achieved through the use of a standardized Additional Information Message, and specific reject codes. Refer to the below chart for additional information as new reject codes will be available April and July 2016, through the Emergency ECL process. Once reject code 829 is available for use, it should be returned in addition to the specific reject code reflecting the prescriber validation error.

CMS is currently drafting an example of information expected to be communicated verbally to the beneficiary. The information will be published as soon as it is available.

| NCPDP Values and Standard Messaging | 01/01/2016 – 03/31/2016 | 04/01/2016 | 07/01/2016 |
|---|---|---|---|
| 511-FB:<br>Reject Code | – 25 – M/I PRESCRIBER ID<br>– 56 – NON-MATCHED PRESCRIBER ID<br>– 42: PLAN'S PRESCRIBER DATA BASE INDICATES THE PRESCRIBER ID SUBMITTED IS INACTIVE OR EXPIRED<br>– 619: PRESCRIBER TYPE 1 NPI REQUIRED | – 829 - Pharmacy Must Notify beneficiary: Claim not covered due to failure to meet Medicare Part D active, valid prescriber NPI requirements<br>– 25 – M/I PRESCRIBER ID<br>– 56 – NON-MATCHED PRESCRIBER ID<br>– 42: PLAN'S PRESCRIBER DATA BASE INDICATES THE | – 829 - Pharmacy Must Notify beneficiary: Claim not covered due to failure to meet Medicare Part D active, valid prescriber NPI requirements<br>– 25 – M/I PRESCRIBER ID<br>– 56 – NON-MATCHED PRESCRIBER ID<br>– 42: PLAN'S PRESCRIBER DATA BASE INDICATES THE PRESCRIBER ID |

| | | | |
|---|---|---|---|
| | – A2: ID SUBMITTED IS ASSOCIATED TO A DECEASED PROVIDER<br>– EZ – M/I Prescriber ID Qualifier<br>– 543 - Prescriber ID Qualifier Value Not Supported | PRESCRIBER ID SUBMITTED IS INACTIVE OR EXPIRED<br>– 619: PRESCRIBER TYPE 1 NPI REQUIRED<br>– A2: ID SUBMITTED IS ASSOCIATED TO A DECEASED PROVIDER42: PRESCRIBER ID SUBMITTED IS INACTIVE<br>– EZ – M/I Prescriber ID Qualifier<br>– 543 - Prescriber ID Qualifier Value Not Supported | SUBMITTED IS INACTIVE OR EXPIRED<br>– 619: PRESCRIBER TYPE 1 NPI REQUIRED<br>– A2: ID SUBMITTED IS ASSOCIATED TO A DECEASED PROVIDER42: PRESCRIBER ID SUBMITTED IS INACTIVE<br>– 832 – Prescriber NPI not found therefore NPI active status Medicare enrollment prescriptive authority could not be validated<br>– EZ – M/I Prescriber ID Qualifier<br>– 543 - Prescriber ID Qualifier Value Not Supported |
| 526-FQ: Additional Information Message | Strongly Recommend: *Pharmacy Must Notify beneficiary: Claim not covered due to failure to meet Medicare Part D active, valid prescriber NPI requirements* | Optional: *Pharmacy Must Notify beneficiary: Claim not covered due to failure to meet Medicare Part D active, valid prescriber NPI requirements* | Optional: *Pharmacy Must Notify beneficiary: Claim not covered due to failure to meet Medicare Part D active, valid prescriber NPI requirements* |

## 22.22.4 PRESCRIBER ID AND PDE QUESTIONS

**Question:**

The *NCPDP Emergency Preparedness Information* document v1.18, provides resource information for the pharmacy industry for a declared emergency. (http://www.ncpdp.org/Resources/Emergency-Preparedness) In the Prescriber Segment, guidance is given for submission of the pharmacy's NPI in emergency situations when the pharmacist may prescribe.

In the event that Part D claims are subject to a declared emergency, and the state has granted the pharmacist the authority to prescribe, will CMS accept the **pharmacy's Type 2 NPI as the prescriber ID** on the submitted PDE?

**Response:**

CMS Response: "For CY 2013, the answer is yes."

In the HPMS memo dated April 3, 2020, it states, "CMS was later made aware of State laws that allow for prescribing flexibilities when a state of emergency is declared and recognized that "the prescriber of the drug" may not have a Type 1 NPI. For example, if a State allows a pharmacist to prescribe during a declared state of emergency, and that pharmacist does not have a Type 1 NPI, the pharmacist may provide the pharmacy's Type 2 (organization) NPI on the claim.

Consequently, when there is a declared state of emergency, CMS allows a Type 2 NPI in the Prescriber ID field on the PDE if it is the same NPI in the Service Provider ID field. This emergency exception must only be used when, under State law, the prescription from a pharmacist would be a valid prescription."

Updated 05/2025

**Question:**

What should be submitted on the PDE as the prescriber ID for Part D vaccines administered by the pharmacy/pharmacist or clinic/nurse?

**Response:**

- CMS requires the PDE to be submitted with an active and valid type 1 NPI. For vaccines, this may be the NPI of one of the following prescribers:
  - a prescriber who has written a prescription for the product
  - a prescriber who has issued an established protocol for the product
  - a mid-level or alternate care provider (pharmacist, nurse practitioner, mid-wife, etc.) who is administering the vaccine who has prescriptive authority per state law
- In the event that the plan's database does not include the NPIs of mid-level and/or alternate care providers, the point of service communication process may require the Submission Clarification Code (420-DK) override of 42 (Prescriber ID Submitted is active and prescribing requirements have been validated).
- Note, for emergency situations please see previous question.

**Question:**
How should the Medicare Part D prescription claim and PDE be processed in the situation where the prescriber is not a HIPAA covered entity and refuses to obtain a Type 1 NPI?

**Response:**
CMS response: The vast majority of prescribers are either HIPAA covered entities themselves, or even more commonly, have a member, employment, or contractual relationship with an organization covered health care provider. In both instances, the prescribers must obtain an NPI. For the very limited instances when a Part D sponsor has verified that a prescriber does not have an NPI and the sponsor has been unable to persuade the prescriber to obtain one, the sponsor may report this instance to HHS/CMS/OESS as a possible violation of HIPAA Administrative Simplification requirements by an organization covered health care provider or covered entity. Please see http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Enforcement/index.html to learn more about the HIPAA Enforcement process and how to file a complaint.

In the event that the prescriber does not obtain an individual Type 1 NPI, the Part D Sponsor will not be able to submit the PDE. There is not a PDE exception process for this situation. The sponsor must administer the benefit and update the accumulators correctly.

**Question:**
How should the Medicare Part D prescription claim and PDE be processed in the situation with a deceased prescriber who did not obtain an NPI (where state law allows subsequent dispensing to process after a prescriber's death)?

**Response:**
CMS Response: In this situation, which we believe will be extremely rare; the Part D sponsor will not be able to submit the PDE. There is not a PDE exception process for this situation. The sponsor must administer the benefit and update the accumulators correctly. (It is understood that this situation will eventually resolve itself in time.)

### 22.22.5 VETERINARIAN IDENTIFIERS

**Question:**
Are veterinarian prescribers identified with an NPI?

**Response:**
No.
Per CMS: Veterinarians do not meet the regulatory definition of "health care provider" and are thus ineligible for NPI numbers (unless they meet the definition in some other capacity).

1. If pharmacies dispense medications for non-humans, the claims are not submitted with a NPI for the prescriber.
2. If a processor only supports NPI as the prescriber ID, all claims must be for humans. In other words, the processor would not support claims for non-humans.

3. If a processor supports a veterinary program or offers a discount program regardless of species (i.e. human and non-human), they should allow the State License (or DEA) on these claims.
4. Processors should clearly identify on their payer sheets how veterinarian prescribed claims are identified and submitted (non-human claim supports prescriber ID State License (or DEA)).

*Updated November 2025*

## 22.22.6 STATE LICENSE QUESTIONS

**Question:**
Which Reject Code (511-FB) value should be returned when the payer/processor is unable to identify an active state license number with prescriptive authority for the submitted prescriber ID?

**Response:**
If the payer/processor determines based on the plan's prescriber data that an active and valid state license with prescriptive authority cannot be found for the submitted prescriber ID, reject code 777 *(Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted)* should be returned with the rejected response. Reject Code 777 was published in the October 2014 Emergency ECL Addendum for use as of April 1, 2015.
It is important to note the term "ACTIVE," as it is used in the description of reject code 777, should **NOT** be determined by the expiration date of the state license on file; rather, it should be determined by the ACTIVE/INACTIVE status indicator associated to the applicable prescriber state license. Prescribers may have state licenses with an expiration date in the past but also have an ACTIVE status, as many states apply grace periods to license expiration dates. For example, an MDR – Medical Doctor state license with a past expiration date of 1/1/2022 and an ACTIVE status should be considered an ACTIVE prescriber with prescriptive authority.

Additionally, the term "prescriptive authority," as it is used in the description of reject code 777, should be determined by the prescriber state license type and not the self-reported taxonomy.

Updated 12/2022

**Question:**
Which Submission Clarification Code (420-DK) value should be used when a claim is resubmitted as a result of the payer/processor's reject for no active state license with prescriptive authority on the plan's prescriber data base, however the pharmacy has validated the prescriber's license to be active and valid?

**Response:**
Submission Clarification Code 52 (*Prescriber's state license with prescriptive authority has been validated- Indicates the prescriber ID submitted is associated to a healthcare provider with the applicable state license that grants prescriptive authority*) would be used when the pharmacy determines the prescriber's state license is active and with the applicable prescriptive authority.

- Submission Clarification Code 52 was published in the April 2015 Emergency ECL Addendum and is available for use as of October 15, 2015.

It was determined that a unique Submission Clarification Code (420-DK) value is needed to allow payer/processors and pharmacies to manage the hierarchical rule set that includes Medicare Part D prescriber validation. The unique value allows for distinct rule sets to apply based on the specific prescriber validation step. For example:

- Submission Clarification Code 42 would only be used for prescriber validation conflicts which occur prior to the Medicare prescriber enrollment check

Distinct Submission Clarification Code values would be used for Medicare enrollment conflicts and each prescriber validation check thereafter (e.g. active and valid state license).

*Updated November 2025*

## 22.22.7 OTHER PRESCRIBER ID QUESTIONS

**Question:**
Is the plan obligated to reimburse the patient for Direct Member Reimbursement (DMR) where the plan is unable to obtain a valid prescriber NPI?

**Response:**

No, the plan is not obligated. Based on guidance in 42 CFR § 423.120(c)(5), CMS says, "*With respect to requests for reimbursement submitted by Medicare beneficiaries, a Part D sponsor may not make payment to a beneficiary dependent upon the sponsor's acquisition of an active and valid individual prescriber NPI, unless there is an indication of fraud. If the sponsor is unable to retrospectively acquire an active and valid individual prescriber NPI, the sponsor may not seek recovery of any payment to the beneficiary solely on that basis."* Per section (c)(6)(iv), *"a Part D sponsor must deny, or must require its PBM to deny, a request for reimbursement from a Medicare beneficiary if the request pertains to a Part D drug that was prescribed by an individual who is identified by name in the request and included on the preclusion list."*

Updated 05/2025

**Question:**
When does the Medicare Part D plan sponsor need to provide 24 hour follow up with the pharmacy due to a prescriber validation error?

**Response:**
- Refer to prescriber validation reject scenario matrix in Version D Editorial.
- Medicare Part D plan sponsors should have policies in place consistent with CMS guidance for all prescriber validation reject scenarios identified within the matrix.

### 22.22.8 DECEASED PRESCRIBERS AND NPPES NPI DEACTIVATION SCHEDULE

**Question:**
Can CMS provide access to the NPI de-activation reason code so that it can be used to support potential beneficiary outreach prior to the estimated next fill date. This will mitigate patient access to care concerns.

**Response:**
***CMS Response 01/11/2016:*** *We can't release the deactivation codes as there is potential fraud related information.*

**Question:**
Can CMS clarify what the estimated time period is between a prescriber's death date and the date in which the NPI is de-activated in NPPES? Would CMS consider supporting at least a 30 day period before the NPI is de-activated, so as to mitigate patient access to care concerns?

**Response:** ***CMS Response 01/11/2016:*** *The NPI customer service team always waits at least 30 days before taking any deactivation action due to death. The timer starts when the team learns of the death (through the SSA's weekly file, or from the provider's office staff), not when the actual death occurred. This alone can add more 5-10 days to that range.*

*Added November 2025*

## 22.23 MEDICARE PART D/MEDICAID BENZODIAZEPINE AND BARBITURATE CLAIMS PROCESSING RISKS

**Question:**
How should Medicare and Medicaid handle the processing of benzodiazepine and barbiturates?

**Response:**
Medicaid may be billed as primary due to barbiturates previously being excluded under Medicare Part D and the patient's Medicaid plan being set as the primary payer for this prescription or drug. If Medicaid is billed as primary, per CMS guidance, the claim should be rejected as P/A required rather than code "41" (Submit to Primary) to avoid patient care disruptions.

While this specific question is relative to the conditional coverage of barbiturates in the 2013 benefit year there is an overall need to address prior authorization requirements with COB processing.

The claim denied by Medicare Part D will be represented in the COB Segment within the Other Payer Reject Code (472-6E) field. Other Payer Reject Codes may include:

- "75" (P/A Required)

- "3Y" (P/A Denied) Note: Reject Code is not commonly used today as payers P/A review process is not linked to the claims adjudication system.
- "70" (Product/Service Not Covered – Plan Benefit Exclusion)
- "MR" (Product Not on Formulary)
- "39" (M/I Diagnosis Code)
- "80" (Drug/Diagnosis Mismatch)

If the COB claim contains any of the above Other Payer Reject Code (472-6E) values, the Medicaid plan may choose to accept and pay the claim or deny using Reject Code (511-FB) values "75" (P/A Required) or "39" (M/I Diagnosis Code) confirming the patient's disease state.

| ***Other Payer Reject Code*** | ***Medicaid COB Claim Response Recommendation*** |
|---|---|
| "75" (P/A Required)* | *Reject as P/A required or diagnosis required to validate Medicare Part D determination of drug not covered.* |
| "39" (M/I Diagnosis Code)* | *Reject as P/A required or diagnosis required to validate Medicare Part D determination of drug not covered.* |
| "70" (Product/Service Not Covered – Plan Benefit Exclusion)* | *Reject as P/A required or diagnosis required to validate Medicare Part D determination of drug not covered.* |
| "MR" (Product Not on Formulary)* | *Reject as P/A required or diagnosis required to validate Medicare Part D determination of drug not covered.* |
| "80" (Drug/Diagnosis Mismatch)* | *Reject as P/A required or diagnosis required to validate Medicare Part D determination of drug not covered.* |
| "3Y" (P/A Denied)** | *Options are to accept or reject the claim as P/A required or diagnosis required if additional information is needed for documentation.* |
| Any other Reject Codes not listed above | *Reject using standard processes* |

*Unable to determine if Reject Codes are from initial reject or subsequent to a P/A request being denied where processor returns the same reject code.

**Intent was to be used with the P/A Request And Billing Transaction (P1) and P/A Request Only (P4) therefore not commonly used with the Billing Transaction (B1).

This business case is not limited to Medicare Part D/Medicaid claims for benzodiazepine and barbiturates. The effort to obtain a prior authorization approval cannot be effectively communicated by the pharmacy to the downstream payer unless the rejected claim response includes reject code "3Y" (P/A Denied) when the prior authorization request has been denied. Currently most processor systems do not link prior authorization denials to the claims processing. The following short and long term Industry recommendations should address this business case.

**Short Term Recommendation:** Downstream payers should not automatically assume that the P/A has not been requested. (This assumes that the pharmacy software is reporting all prior payers reject code values on the claim.) Until such time as the industry links the P/A process to indicate the pending status or rejection of a P/A request within the payers adjudication system, downstream payers need to develop processes to evaluate the actual status of Other Payer Reject Code "75" (P/A Required). For example, Patient is a Part D beneficiary, drug is a barbiturate and prior payer has rejected the claim for "P/A Required" and by verbal or other communication provider has determined the P/A has been denied.

**Long Term Recommendation:** Payers need to refine the P/A process to log the status of the request; approved, pending or denied in order to provide the information back on a claim so that downstream payers may react accordingly. This minimizes additional pharmacy provider intervention downstream.

## 22.24 OTHER CARRIER PAYMENT MEETS OR EXCEEDS PAYABLE

**Question:**

When Medicare D Plan is paying second (MSP) and the 1st payer met or exceeded the payable, CMS guidance is to not reject the claim with a "74" (Other Carrier Payment Meets Or Exceeds Payable) but rather return a $0 claim (patient and net check are both $0). What would the pharmacy collect from the patient in these situations? Using the example below would the pharmacy collect nothing ($0) because the patient pay is $0 from the secondary payer or would the pharmacy realize that the secondary payer Medicare Part D plan paid nothing and collect the patient pay from the 1st payer of $50?

For example:

Payer #1 (commercial plan)
Ingredient cost $200
Dispensing fee $5
Incentive/Admin $0
Sales tax $10
Response from Payer #1
Ingredient cost $190
Dispensing fee $2
Incentive/Admin $0
Sales tax $9
Net check $151
Patient pay $50

Payer #2 (Medicare D plan)
Ingredient cost $200
Dispensing fee $5
Incentive/Admin $0
Sales tax $10
Other payer paid $151
Response from Payer #2
Ingredient cost $100
Dispensing fee $2
Incentive/Admin $0
Other Payer Amount Recognized $102
Sales tax $0
Net check $0
Patient pay $0

**Response:**
In general when processing COB claims:

- If secondary payer does not have COB benefit, then claim could reject
- If secondary does have COB benefit and their allowed amount is less than primary paid amount then:
  - A paid response may be returned as Patient Pay Amount (505-F5) equal to $0 and Total Amount Paid (509-F9) equal to $0

  Or
  - A rejected response may be returned using Reject Code (511-FB) value of "74" (Other Carrier Payment Meets Or Exceeds Payable)
- When a COB paid response is based on Other Payer Amount Paid (431-DV) it must include the Ingredient Cost Paid (506-F6), Dispensing Fee Paid (507-F7), etc. as if paying primary and represent within Other Payer Amount Recognized (566-J5) the like Other Payer Amount Paid values (431-DV) recognized in the reimbursement calculation.
- For a COB claim where Patient Pay Amount and Total Amount Paid are returned as $0, the Patient Pay Amount collected by the pharmacy would be based on the contractual agreement between the pharmacy and the COB payer.

Per CMS MSP guidance dated April 26, 2006 "*If the primary payment is greater than or equal to the negotiated price, no other payments are made."* Per NCPDP standards, primary payment as referenced in the statement above would be the recognized Other Payer Amount Paid values using like value comparison. From the CMS MSP guidance:

*"17.4.2 Pricing and calculation rules"*
*In the logic for pricing and adjudicating an MSP claim under Part D, the provider/pharmacy receives at least the Part D plan's negotiated price for the drug. Payments are applied to this price in the following order: primary insurer's payment, beneficiary cost sharing liability under the Part D PBP, and finally the Part D plan picks up any remaining balance. In other words, the primary payment reduces plan-paid amounts first, then beneficiary liabilities. If the primary payment*

*is greater than or equal to the negotiated price, no other payments are made. In particular, plans shall use the following steps to price an MSP claim and populate a PDE record:*

*1.1.1 Price or re-price the claim according to the Part D plan's negotiated price for the drug. In the GDCB or GDCA field, report the negotiated price if the drug is covered or $0 if the drug is non-covered.*

*1.1.2 Report the primary payment amount in the PLRO field. Note that if PLRO ≥ gross drug cost (negotiated price), all other payment amounts on the PDE record are $0."*

**EXAMPLE # 1**

| **Example 1: Secondary Submission for Other Payer Amount Paid where COB payer pays a remaining amount.** | | |
|---|---|---|
| 101-A1 | BIN NUMBER | 123456 |
| 102-A2 | VERSION/RELEASE NUMBER | D0 |
| 103-A3 | TRANSACTION CODE | B1 |
| 104-A4 | PROCESSOR CONTROL NUMBER | XYZ*bbbbbbb* |
| 109-A9 | TRANSACTION COUNT | 1 |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | 01 |
| 201-B1 | SERVICE PROVIDER ID | 1234567890 |
| 401-D1 | DATE OF SERVICE | 20100409 |
| 110-AK | SOFTWARE VENDOR/CERTIFICATION ID | *bbbbbbbbbb* |
| | **PATIENT SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 01 |
| 304-C4 | DATE OF BIRTH | 19350316 |
| 305-C5 | PATIENT GENDER CODE | 1 (Male) |
| | **INSURANCE SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 04 |
| 302-C2 | CARDHOLDER ID | 1122345 |
| | …. | |
| 303-C3 | PERSON CODE | 01 |
| 306-C6 | PATIENT RELATIONSHIP CODE | 1 (self) |
| | **CLAIM SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 07 |
| 455-EM | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER | 1 |
| 402-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER | 200345 |
| 436-E1 | PRODUCT/SERVICE ID QUALIFIER | 03 |
| 407-D7 | PRODUCT/SERVICE ID | 0078038005 |
| 442-E7 | QUANTITY DISPENSED | 90000 |
| 403-D3 | FILL NUMBER | 0 |
| 405-D5 | DAYS SUPPLY | 90 |
| 406-D6 | COMPOUND CODE | 1 |
| 408-D8 | DISPENSE AS WRITTEN/PRODUCT SELECTION CODE | 1 |
| 308-C8 | OTHER COVERAGE CODE | 2 |
| **Field #** | **PRICING SEGMENT** | |
| 409-D9 | INGREDIENT COST SUBMITTED | $93.00 |
| 412-DC | DISPENSING FEE SUBMITTED | $6.00 |
| 430-DU | GROSS AMOUNT DUE | $99.00 |
| 426-DQ | USUAL AND CUSTOMARY | $105.00 |
| | **COB SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 05 |
| 337-4C | COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT | 1 |
| 338-5C | OTHER PAYER COVERAGE TYPE | 01 (Primary) |
| 339-6C | OTHER PAYER ID QUALIFIER | 03 |
| 340-7C | OTHER PAYER ID | 789123 |
| 443-E8 | OTHER PAYER DATE | 20100409 |
| 341-HB | OTHER PAYER AMOUNT PAID COUNT | 1 |
| 342-HC | OTHER PAYER AMOUNT PAID QUALIFIER | 07<br>Drug Benefit |
| 431-DV | OTHER PAYER AMOUNT PAID | $90.00 |
| | **TRANSACTION RESPONSE** | |
| | | |

| | | |
|---|---|---|
| 102-A2 | VERSION/RELEASE NUMBER | D0 |
| 103-A3 | TRANSACTION CODE | B1 |
| 109-A9 | TRANSACTION COUNT | 1 |
| 501-F1 | HEADER RESPONSE STATUS | A |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | 01 |
| 201-B1 | SERVICE PROVIDER ID | 1234567890 |
| 401-D1 | DATE OF SERVICE | 20100409 |
| | **RESPONSE STATUS SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 21 |
| 112-AN | TRANSACTION RESPONSE STATUS | P |
| 503-F3 | AUTHORIZATION NUMBER | 123654987321 |
| | **RESPONSE CLAIM SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 22 |
| 455-EM | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER | 1 |
| 402-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER | 200345 |
| | **RESPONSE PRICING SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 23 |
| 506-F6 | INGREDIENT COST PAID | $89.00 |
| 507-F7 | DISPENSING FEE PAID | $3.00 |
| 566-J5 | OTHER PAYER AMOUNT RECOGNIZED* | $90.00 |
| 505-F5 | PATIENT PAY AMOUNT | $0.00 |
| 509-F9 | TOTAL AMOUNT PAID | $2.00 |
| 572-4U | AMOUNT OF COINSURANCE | $0.00 |
| 522-FM | BASIS OF REIMBURSEMENT DETERMINATION | 01 (AWP) |

The pricing of the COB claim is likely to be different from the amount paid by the first payer. The net pay may be more or less (and could be the same). Depending on payment parameters of the COB payer, the patient may or may not have a copay (COB does not automatically mean the patient copay results in zero).

**EXAMPLE #2**

| **Secondary Submission for Other Payer Amount Paid where that amount is greater than COB Payer's rate.**<br>***Submission criteria the same, payment response is different.***<br><br>**Part D MSP requirement PDE Instructions 4/27/2006 Section 17.4.2 noted below example** | | |
|---|---|---|
| 101-A1 | BIN NUMBER | 123456 |
| 102-A2 | VERSION/RELEASE NUMBER | D0 |
| 103-A3 | TRANSACTION CODE | B1 |
| 104-A4 | PROCESSOR CONTROL NUMBER | XYZ*bbbbbbb* |
| 109-A9 | TRANSACTION COUNT | 1 |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | 01 |
| 201-B1 | SERVICE PROVIDER ID | 1234567890 |
| 401-D1 | DATE OF SERVICE | 20100409 |
| 110-AK | SOFTWARE VENDOR/CERTIFICATION ID | *bbbbbbbbb* |
| | **PATIENT SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 01 |
| 304-C4 | DATE OF BIRTH | 19350316 |
| 305-C5 | PATIENT GENDER CODE | 1 (Male) |
| | **INSURANCE SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 04 |
| 302-C2 | CARDHOLDER ID | 1122345 |
| | | |
| 303-C3 | PERSON CODE | 01 |
| 306-C6 | PATIENT RELATIONSHIP CODE | 1 (self) |
| | **CLAIM SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 07 |
| 455-EM | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER | 1 |
| 402-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER | 200345 |
| 436-E1 | PRODUCT/SERVICE ID QUALIFIER | 03 |
| 407-D7 | PRODUCT/SERVICE ID | 0078038005 |

| | | |
|---|---|---|
| 442-E7 | QUANTITY DISPENSED | 90000 |
| 403-D3 | FILL NUMBER | 0 |
| 405-D5 | DAYS SUPPLY | 90 |
| 406-D6 | COMPOUND CODE | 1 |
| 408-D8 | DISPENSE AS WRITTEN PRODUCT SELECTION CODE | 1 |
| 308-C8 | OTHER COVERAGE CODE | 2 |
| **Field #** | **PRICING SEGMENT** | |
| 409-D9 | INGREDIENT COST SUBMITTED | $93.00 |
| 412-DC | DISPENSING FEE SUBMITTED | $6.00 |
| 430-DU | GROSS AMOUNT DUE | $99.00 |
| 426-DQ | USUAL AND CUSTOMARY | $105.00 |
| | **COB SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 05 |
| 337-4C | COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT | 1 |
| 338-5C | OTHER PAYER COVERAGE TYPE | 01 (Primary) |
| 339-6C | OTHER PAYER ID QUALIFIER | 03 |
| 340-7C | OTHER PAYER ID | 789123 |
| 443-E8 | OTHER PAYER DATE | 20100409 |
| 341-HB | OTHER PAYER AMOUNT PAID COUNT | 1 |
| 342-HC | OTHER PAYER AMOUNT PAID QUALIFIER | 07<br>Drug Benefit |
| 431-DV | OTHER PAYER AMOUNT PAID | $90.00 |
| | **TRANSACTION RESPONSE** | |
| | | |
| 102-A2 | VERSION/RELEASE NUMBER | D0 |
| 103-A3 | TRANSACTION CODE | B1 |
| 109-A9 | TRANSACTION COUNT | 1 |
| 501-F1 | HEADER RESPONSE STATUS | A |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | 01 |
| 201-B1 | SERVICE PROVIDER ID | 1234567890 |
| 401-D1 | DATE OF SERVICE | 20100409 |
| | **RESPONSE STATUS SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 21 |
| 112-AN | TRANSACTION RESPONSE STATUS | P |
| 503-F3 | AUTHORIZATION NUMBER | 123654987322 |
| | **RESPONSE CLAIM SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 22 |
| 455-EM | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER | 1 |
| 402-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER | 200345 |
| | **RESPONSE PRICING SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 23 |
| 506-F6 | INGREDIENT COST PAID | $86.00 |
| 507-F7 | DISPENSING FEE PAID | $3.00 |
| 566-J5 | OTHER PAYER AMOUNT RECOGNIZED* | $89.00 |
| 505-F5 | PATIENT PAY AMOUNT | $0.00 |
| 509-F9 | TOTAL AMOUNT PAID | $0.00 |
| 572-4U | AMOUNT OF COINSURANCE | $0.00 |
| 522-FM | BASIS OF REIMBURSEMENT DETERMINATION | 01 (AWP) |

* Since $90.00 was already paid and the net due pharmacy *per this payer contract* is $89.00, Other Payer Amount Recognized is the amount of dollars from Other Payer Amount Paid 'used' in order for Total Amount Paid to balance.

17.4.2 Pricing and calculation rules
In the logic for pricing and adjudicating an MSP claim under Part D, the provider/pharmacy receives at least the Part D plan's negotiated price for the drug. Payments are applied to this price in the following order: primary insurer's payment, beneficiary cost sharing liability under the Part D PBP, and finally the Part D plan picks up any remaining balance. In other words, the primary payment reduces plan-paid amounts first, then beneficiary liabilities. If the primary payment is greater than or equal to the negotiated price, no other payments are made.

**EXAMPLE #3**

| Secondary Submission for Other Payer Amount Paid where that amount is greater than COB Payer's rate.<br>*Submission criteria the same, Response is Denied*<br><br>For non-Part D claims, Trading Partner Agreement determines whether COB Payer Pays Zero or Rejects. | | |
|---|---|---|
| 101-A1 | BIN NUMBER | 123456 |
| 102-A2 | VERSION/RELEASE NUMBER | D0 |
| 103-A3 | TRANSACTION CODE | B1 |
| 104-A4 | PROCESSOR CONTROL NUMBER | XYZ*bbbbbbb* |
| 109-A9 | TRANSACTION COUNT | 1 |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | 01 |
| 201-B1 | SERVICE PROVIDER ID | 1234567890 |
| 401-D1 | DATE OF SERVICE | 20100409 |
| 110-AK | SOFTWARE VENDOR/CERTIFICATION ID | *bbbbbbbbbb* |
| | **PATIENT SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 01 |
| 304-C4 | DATE OF BIRTH | 19350316 |
| 305-C5 | PATIENT GENDER CODE | 1 (Male) |
| | **INSURANCE SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 04 |
| 302-C2 | CARDHOLDER ID | 1122345 |
| 303-C3 | PERSON CODE | 01 |
| 306-C6 | PATIENT RELATIONSHIP CODE | 1 (self) |
| | **CLAIM SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 07 |
| 455-EM | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER | 1 |
| 402-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER | 200345 |
| 436-E1 | PRODUCT/SERVICE ID QUALIFIER | 03 |
| 407-D7 | PRODUCT/SERVICE ID | 0078038005 |
| 442-E7 | QUANTITY DISPENSED | 90000 |
| 403-D3 | FILL NUMBER | 0 |
| 405-D5 | DAYS SUPPLY | 90 |
| 406-D6 | COMPOUND CODE | 1 |
| 408-D8 | DISPENSE AS WRITTEN/PRODUCT SELECTION CODE | 1 |
| 308-C8 | OTHER COVERAGE CODE | 2 |
| **Field #** | **PRICING SEGMENT** | |
| 409-D9 | INGREDIENT COST SUBMITTED | $93.00 |
| 412-DC | DISPENSING FEE SUBMITTED | $6.00 |
| 430-DU | GROSS AMOUNT DUE | $99.00 |
| 426-DQ | USUAL AND CUSTOMARY | $105.00 |
| | **COB SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 05 |
| 337-4C | COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT | 1 |
| 338-5C | OTHER PAYER COVERAGE TYPE | 01 (Primary) |
| 339-6C | OTHER PAYER ID QUALIFIER | 03 |
| 340-7C | OTHER PAYER ID | 789123 |
| 443-E8 | OTHER PAYER DATE | 20100409 |
| 341-HB | OTHER PAYER AMOUNT PAID COUNT | 1 |
| 342-HC | OTHER PAYER AMOUNT PAID QUALIFIER | 07<br>Drug Benefit |
| 431-DV | OTHER PAYER AMOUNT PAID | $90.00 |
| | **TRANSACTION RESPONSE** | |
| | | |
| 102-A2 | VERSION/RELEASE NUMBER | D0 |
| 103-A3 | TRANSACTION CODE | B1 |
| 109-A9 | TRANSACTION COUNT | 1 |
| 501-F1 | HEADER RESPONSE STATUS | A |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | 01 |

| | | |
|---|---|---|
| 201-B1 | SERVICE PROVIDER ID | 1234567890 |
| 401-D1 | DATE OF SERVICE | 20100409 |
| | **RESPONSE STATUS SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 21 |
| 112-AN | TRANSACTION RESPONSE STATUS | R |
| 503-F3 | AUTHORIZATION NUMBER | 123654987323 |
| 510-FA | REJECT COUNT | 1 |
| 511-FB | REJECT CODE | 74 |
| 130-UF | ADDITIONAL MESSAGE INFORMATION COUNT | 1 |
| 132-UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER | 01 |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | *text message if desired* |
| | *Reject "74" (Other Carrier Payment Meets Or Exceeds Payable)* | |
| | | |
| | **RESPONSE CLAIM SEGMENT** | |
| 111-AM | SEGMENT IDENTIFICATION | 22 |
| 455-EM | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER | 1 |
| 402-D2 | PRESCRIPTION/SERVICE REFERENCE NUMBER | 200345 |

## 22.25 MILITARY TREATMENT FACILITIES – GOVERNMENT BILLING THE GOVERNMENT

**Question:**
A Part D member who has commercial coverage as secondary was visiting someone at a military base. For some reason this person went to the base for a prescription.

The military base pharmacy is telling us that they cannot bill Medicare Part D as 'government' doesn't bill 'government'. So military base pharmacy is billing the commercial coverage who is rejecting for 41 – Bill Other Payer since the commercial coverage is a secondary benefit and the claim submitted is for a primary benefit.

Processor for commercial coverage expects a COB claim as they 'need to see' that billing to the other payer, who is primary, was attempted. But military base pharmacy says they can't do this and are unable to submit a COB claim.

Typical thought would be that pharmacy would require member to pay 100% since the pharmacy is out of network and then member would submit the claim for reimbursement. But that did not seem to happen in this case. The military base pharmacy wants the commercial coverage to have override capability to allow non-COB claim to process under the commercial secondary benefit. How should this situation be addressed?

**Response (Based on information provided by CMS):**
If the claim is submitted to the supplemental payer, the supplemental payer is under no obligation to pay as primary to accommodate the pharmacy or member.

Per CMS information: The VA and Military Treatment Facility (MTF), by law, cannot bill Medicare. The VA or MTF pharmacy should direct the member to an in-network pharmacy or require the member to pay cash.

If the member is unable to reasonably access a network pharmacy and elects to pay cash, the claim could be submitted by the member for reimbursement and the Medicare Part D plan would determine if the member met the plan's out-of-network access requirements. The Medicare Part D sponsor may deny the direct member reimbursement (DMR) claim because it's not a covered Medicare Part D drug unless it's accessed from a network pharmacy or meets the out-of-network access requirements.

## 22.26 ELIGIBILITY VERIFICATION

**Question**:
In Section 6.1.1 of the Implementation Guide, the timeframe used by the Facilitator to determine eligibility is up to 90 days prior to or later than the current date. Is this timeframe still accurate?

**Answer**:
No. Pharmacies may submit eligibility transactions with the Date of Service (401-D1) up to 9 months prior to or 4 months in the future from the current date. The effective date of this change was May 23, 2013.

Added November 2018

## 22.26.1 ELIGIBILITY MEDICARE PART D TO FACILITATOR – REQUEST – COULD NOT FIND THIS MEMBER

Member never had Medicare Part D coverage in the past, does not have current Part D coverage, and has no future Part D Coverage based upon the date of service submitted. (Could not find this member. Cardholder ID not found. )
Date of Request: 10-01-2012
Date of Service: 08-01-2012
Response: Rejected Response

| TRANSACTION HEADER SEGMENT | | | | |
|---|---|---|---|---|
| FIELD | FIELD NAME | CAT | VALUE | COMMENTS |
| 101-A1 | BIN NUMBER | M | *011727* | |
| 102-A2 | VERSION/RELEASE NUMBER | M | *E3* | Transaction Format |
| 103-A3 | TRANSACTION CODE | M | *E1* | Eligibility verification |
| 104-A4 | PROCESSOR CONTROL NUMBER | M | *2222222222* | |
| 109-A9 | TRANSACTION COUNT | M | *1* | One occurrence |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | M | *01* | National Provider ID |
| 201-B1 | SERVICE PROVIDER ID | M | *4563663111bbbbb* | |
| 401-D1 | DATE OF SERVICE | M | *20120801* | August 1, 2012 |
| 110-AK | SOFTWARE VENDOR/CERTIFICATION ID | M | *98765bbbbb* | |

| PATIENT SEGMENT | | | | |
|---|---|---|---|---|
| FIELD | FIELD NAME | CAT | VALUE | COMMENTS |
| 111-AM | SEGMENT IDENTIFICATION | M | *01* | PATIENT SEGMENT |
| 304-C4 | DATE OF BIRTH | Q | *19620615* | Born June 15, 1962 |
| 305-C5 | PATIENT GENDER CODE | Q | *1* | Male |
| 310-CA | PATIENT FIRST NAME | Q | *SAMUEL* | |
| 311-CB | PATIENT LAST NAME | Q | *JONES* | |
| B08-7A | PATIENT STREET ADDRESS LINE 1 | Q | *123 MAIN STREET* | |
| 323-CN | PATIENT CITY ADDRESS | Q | *MY TOWN* | |
| 324-CO | PATIENT STATE/PROVINCE ADDRESS | Q | *CO* | |
| 325-CP | PATIENT ZIP/POSTAL CODE | Q | *34567* | |

| INSURANCE SEGMENT | | | | |
|---|---|---|---|---|
| FIELD | FIELD NAME | CAT | VALUE | COMMENTS |
| 111-AM | SEGMENT IDENTIFICATION | M | *04* | INSURANCE SEGMENT |
| 302-C2 | CARDHOLDER ID | M | *123456789* | The HICN (Health Insurance Claim Number, Part A, B, or C), SSN, or RRB. |

### *22.26.1.1 ELIGIBILITY MEDICARE PART D TO FACILITATOR – REJECT RESPONSE - COULD NOT FIND THIS MEMBER*

Eligibility Rejected Response – Patient could not be found

| RESPONSE HEADER SEGMENT | | | | |
|---|---|---|---|---|
| FIELD | FIELD NAME | CAT | VALUE | COMMENTS |
| 102-A2 | VERSION/RELEASE NUMBER | M | *E3* | Transaction Format |
| 103-A3 | TRANSACTION CODE | M | *E1* | Eligibility Verification |
| 109-A9 | TRANSACTION COUNT | M | *1* | One occurrence |
| 501-F1 | HEADER RESPONSE STATUS | M | *A* | Accepted |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | M | *01* | National Provider ID |
| 201-B1 | SERVICE PROVIDER ID | M | *4563663111bbbbb* | |
| 401-D1 | DATE OF SERVICE | M | *20120801* | August 1, 2012 |

| RESPONSE STATUS SEGMENT | | | | |
|---|---|---|---|---|
| FIELD | FIELD NAME | CAT | VALUE | COMMENTS |
| 111-AM | SEGMENT IDENTIFICATION | M | *21* | RESPONSE STATUS SEGMENT |
| 112-AN | TRANSACTION RESPONSE STATUS | M | *R* | Rejected |
| 510-FA | REJECT COUNT | R | *1* | |
| 511-FB | REJECT CODE | R | *N1* | No Patient Match Found |
| 130-UF | ADDITIONAL MESSAGE INFORMATION COUNT | R | *1* | 1 occurrence |

| | | | | |
|---|---|---|---|---|
| 132-UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER | R | *01* | Used for first line of free form text with no pre-defined structure. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | Q | *TRANSACTION MESSAGE TEXT* | For illustrative purposes only. Up to 40 Bytes |

## 22.26.2 ELIGIBILITY MEDICARE PART D TO FACILITATOR – REQUEST – FOUND MEMBER BUT NO COVERAGE

Member had Medicare Part D Coverage in the past but does not have current Part D coverage.
(Found member but no coverage for the date of service submitted.)
Date of Request: 10/01/2012
Date of Service: 08/01/2012
Response: Rejected Response- Member has no Medicare Part D coverage as of date of service submitted.

| TRANSACTION HEADER SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 101-A1 | BIN NUMBER | M | *011727* | |
| 102-A2 | VERSION/RELEASE NUMBER | M | *E3* | Transaction Format |
| 103-A3 | TRANSACTION CODE | M | *E1* | Eligibility verification |
| 104-A4 | PROCESSOR CONTROL NUMBER | M | *2222222222* | |
| 109-A9 | TRANSACTION COUNT | M | *1* | One occurrence |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | M | *01* | National Provider ID |
| 201-B1 | SERVICE PROVIDER ID | M | *4563663111bbbbb* | |
| 401-D1 | DATE OF SERVICE | M | *20120801* | August 1, 2012 |
| 110-AK | SOFTWARE VENDOR/CERTIFICATION ID | M | *98765bbbbb* | |

| PATIENT SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *01* | PATIENT SEGMENT |
| 304-C4 | DATE OF BIRTH | Q | *19620615* | Born June 15, 1962 |
| 305-C5 | PATIENT GENDER CODE | Q | *1* | Male |
| 310-CA | PATIENT FIRST NAME | Q | *SAMUEL* | |
| 311-CB | PATIENT LAST NAME | Q | *JONES* | |
| B08-7A | PATIENT STREET ADDRESS LINE 1 | Q | *123 MAIN STREET* | |
| 323-CN | PATIENT CITY ADDRESS | Q | *MY TOWN* | |
| 324-CO | PATIENT STATE/PROVINCE ADDRESS | Q | *CO* | |
| 325-CP | PATIENT ZIP/POSTAL CODE | Q | *34567* | |

| INSURANCE SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *04* | INSURANCE SEGMENT |
| 302-C2 | CARDHOLDER ID | M | *123456789* | The HICN (Health Insurance Claim Number, Part A, B, or C), SSN, or RRB. |

### *22.26.2.1 ELIGIBILITY MEDICARE PART D TO FACILITATOR – REJECT RESPONSE – FOUND MEMBER BUT NO COVERAGE*

Eligibility Rejected Response – Patient found but no Part D Coverage for Date of Service **submitted**

| RESPONSE HEADER SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 102-A2 | VERSION/RELEASE NUMBER | M | *E3* | Transaction Format |
| 103-A3 | TRANSACTION CODE | M | *E1* | Eligibility Verification |
| 109-A9 | TRANSACTION COUNT | M | *1* | One occurrence |
| 501-F1 | HEADER RESPONSE STATUS | M | *A* | Accepted |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | M | *01* | National Provider ID |
| 201-B1 | SERVICE PROVIDER ID | M | *4563663111bbbbb* | |
| 401-D1 | DATE OF SERVICE | M | *20120801* | August 1, 2012 |

| RESPONSE PATIENT SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *29* | RESPONSE PATIENT SEGMENT |
| 310-CA | PATIENT FIRST NAME | M | *SAMUEL* | |
| 311-CB | PATIENT LAST NAME | Q | *JONES* | |
| 304- C4 | DATE OF BIRTH | Q | *19620615* | Born June 15, 1962 |

Note: This Patient data is from the Facilitator's system. It is not echoed back from the submission information.

| Response Status Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *21* | Response Status Segment |
| 112-AN | Transaction Response Status | M | *R* | Rejected |
| 510-FA | Reject Count | R | *1* | |
| 511-FB | Reject Code | R | *65* | Patient is Not Covered |
| 130-UF | Additional Message Information Count | R | *1* | 1 occurrence |
| 132-UH | Additional Message Information Qualifier | R | *01* | Used for first line of free form text with no pre-defined structure. |
| 526-FQ | Additional Message Information | Q | *TRANSACTION MESSAGE TEXT* | For illustrative purposes only. Up to 40 Bytes |

## 22.26.3 Eligibility Medicare Part D to Facilitator – Request- Member Has Current Medicare Part D Coverage and No Other Coverage

Date of Request: 10/01/2012
Date of Service: 08/01/2012
Response: Approved

| Transaction Header Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 101-A1 | BIN Number | M | *011727* | |
| 102-A2 | Version/Release Number | M | *E3* | Transaction Format |
| 103-A3 | Transaction Code | M | *E1* | Eligibility verification |
| 104-A4 | Processor Control Number | M | *2222222222* | |
| 109-A9 | Transaction Count | M | *1* | One occurrence |
| 202-B2 | Service Provider ID Qualifier | M | *01* | National Provider ID |
| 201-B1 | Service Provider ID | M | *4563663111bbbbb* | |
| 401-D1 | Date of Service | M | *20120801* | August 1, 2012 |
| 110-AK | Software Vendor/Certification ID | M | *98765bbbbb* | |

| Patient Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *01* | Patient Segment |
| 304-C4 | Date of Birth | Q | *19620615* | Born June 15, 1962 |
| 305-C5 | Patient Gender Code | Q | *1* | Male |
| 310-CA | Patient First Name | Q | *SAMUEL* | |
| 311-CB | Patient Last Name | Q | *JONES* | |
| B08-7A | Patient Street Address Line 1 | Q | *123 MAIN STREET* | |
| 323-CN | Patient City Address | Q | *MY TOWN* | |
| 324-CO | Patient State/Province Address | Q | *CO* | |
| 325-CP | Patient Zip/Postal Code | Q | *34567* | |

| Insurance Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *04* | Insurance Segment |
| 302-C2 | Cardholder ID | M | *123456789* | The HICN (Health Insurance Claim Number, Part A, B, or C), SSN, or RRB. |

### *22.26.3.1 ELIGIBILITY MEDICARE PART D TO FACILITATOR – APPROVED RESPONSE - MEMBER HAS CURRENT MEDICARE PART D COVERAGE AND NO OTHER COVERAGE*

Eligibility Approved Response

| Response Header Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 102-A2 | Version/Release Number | M | *E3* | Transaction Format |
| 103-A3 | Transaction Code | M | *E1* | Eligibility Verification |
| 109-A9 | Transaction Count | M | *1* | One occurrence |
| 501-F1 | Header Response Status | M | *A* | Accepted |
| 202-B2 | Service Provider ID Qualifier | M | *01* | National Provider ID |
| 201-B1 | Service Provider ID | M | *4563663111bbbbb* | |
| 401-D1 | Date of Service | M | *20120801* | August 1, 2012 |

| Response Insurance Additional Information Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *27* | Response Insurance Additional Information Segment |
| 139-UR | Medicare Part D Coverage Code | M | *1* | Primary |
| 138-UQ | CMS Low Income Cost Sharing (LICS) Level | Q | *Y* | Yes |
| 240-U1 | Contract Number | Q | *ABCXUX333* | |
| 926-FF | Formulary ID | Q | *F33H12XU* | |
| 757-U6 | Benefit ID | Q | *123* | |

| Response Patient Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *29* | Response Patient Segment |
| 310-CA | Patient First Name | M | *SAM* | |
| 311-CB | Patient Last Name | Q | *JONES* | |
| 304- C4 | Date Of Birth | Q | *19620615* | Born June 15, 1962 |

Note: This Patient data is from the Facilitator's system. It is not echoed back from the submission information.

| Response Status Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *21* | Response Status Segment |
| 112-AN | Transaction Response Status | M | *A* | Approved |
| 503-F3 | Authorization Number | Q | *123456789123456789* | |
| 130-UF | Additional Message Information Count | R | *1* | 1 occurrence |
| 132-UH | Additional Message Information Qualifier | R | *01* | Used for first line of free form text with no pre-defined structure. |
| 526-FQ | Additional Message Information | Q | *TRANSACTION MESSAGE TEXT* | For illustrative purposes only. Up to 40 Bytes |

| Response Coordination of Benefits/Other Payers Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 111-AM | Segment Identification | M | *28* | Response Coordination of Benefits/Other Payers Segment |
| 355-NT | Other Payer ID Count | M | *1* | One occurrence |
| 338-5C | Other Payer Coverage Type | M | *01* | Primary |
| 339-6C | Other Payer ID Qualifier | R | *03* | BIN |
| 340-7C | Other Payer ID | Q | *123456* | |
| 991-MH | Other Payer Processor Control Number | Q | *9876543210* | |
| 356-NU | Other Payer Cardholder ID | Q | *456789123* | |
| 992-MJ | Other Payer Group ID | Q | *789123* | |
| 142-UV | Other Payer Person Code | Q | *01* | 01 = Other Payer assigned person code |
| 143-UW | Other Payer Patient Relationship Code | Q | *1* | |
| 127-UB | Other Payer Help Desk Number | Q | *5556861111* | Primary Payer listed Help Desk Telephone Number - in this instance is the Part D help desk |
| 144-UX | Other Payer Benefit Effective Date | Q | *20120101* | January 1, 2012 |
| 145-UY | Other Payer Benefit Termination Date | Q | *20120930* | September 30, 2012 |

### 22.26.4 Eligibility Medicare Part D to Facilitator – Request – Member Has Current Medicare Part D Coverage (Primary) and Current Other Coverage

Date of Request: 10/01/2012

Date of Service: 08/01/2012

Member is effective as of date of service with Medicare Part D as primary (01/01/2012 through 09/30/2012) Member is effective as of date of service with Other Payer "A" as secondary (02/01/2012 through 11/30/2012)

Member is effective as of date of service with Other Payer "B" as tertiary (08/01/2012 through12-31-2012)

Response: Approved

Loops of Coordination of Benefits/Other Payments Segment show three Other Coverages in the order shown above.

| Transaction Header Segment | | | | |
|---|---|---|---|---|
| **Field** | **Field Name** | **Cat** | **Value** | **Comments** |
| 101-A1 | BIN Number | M | *011727* | |
| 102-A2 | Version/Release Number | M | *E3* | Transaction Format |

| | | | | |
|---|---|---|---|---|
| 103-A3 | TRANSACTION CODE | M | *E1* | Eligibility verification |
| 104-A4 | PROCESSOR CONTROL NUMBER | M | *2222222222* | |
| 109-A9 | TRANSACTION COUNT | M | *1* | One occurrence |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | M | *01* | National Provider ID |
| 201-B1 | SERVICE PROVIDER ID | M | *4563663111bbbbb* | |
| 401-D1 | DATE OF SERVICE | M | *20120801* | August 1, 2012 |
| 110-AK | SOFTWARE VENDOR/CERTIFICATION ID | M | *98765bbbbb* | |

| PATIENT SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *01* | PATIENT SEGMENT |
| 304-C4 | DATE OF BIRTH | Q | *19620615* | Born June 15, 1962 |
| 305-C5 | PATIENT GENDER CODE | Q | *1* | Male |
| 310-CA | PATIENT FIRST NAME | Q | *SAMUEL* | |
| 311-CB | PATIENT LAST NAME | Q | *JONES* | |
| B08-7A | PATIENT STREET ADDRESS LINE 1 | Q | *123 MAIN STREET* | |
| 323-CN | PATIENT CITY ADDRESS | Q | *MY TOWN* | |
| 324-CO | PATIENT STATE/PROVINCE ADDRESS | Q | *CO* | |
| 325-CP | PATIENT ZIP/POSTAL CODE | Q | *34567* | |

| INSURANCE SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *04* | INSURANCE SEGMENT |
| 302-C2 | CARDHOLDER ID | M | *123456789* | The HICN (Health Insurance Claim Number, Part A, B, or C), SSN, or RRB. |

### *22.26.4.1 ELIGIBILITY MEDICARE PART D TO FACILITATOR – APPROVED RESPONSE – MEMBER HAS CURRENT MEDICARE PART D COVERAGE (PRIMARY) AND CURRENT OTHER COVERAGE*

Eligibility Approved Response With More Than Two Payers

| RESPONSE HEADER SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 102-A2 | VERSION/RELEASE NUMBER | M | *E3* | Transaction Format |
| 103-A3 | TRANSACTION CODE | M | *E1* | Eligibility Verification |
| 109-A9 | TRANSACTION COUNT | M | *1* | One occurrence |
| 501-F1 | HEADER RESPONSE STATUS | M | *A* | Accepted |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | M | *01* | National Provider ID |
| 201-B1 | SERVICE PROVIDER ID | M | *4563663111bbbbb* | |
| 401-D1 | DATE OF SERVICE | M | *20120801* | August 1, 2012 |

| RESPONSE INSURANCE ADDITIONAL INFORMATION SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *27* | RESPONSE INSURANCE ADDITIONAL INFORMATION SEGMENT |
| 139-UR | MEDICARE PART D COVERAGE CODE | M | *1* | Primary |
| 138-UQ | CMS LOW INCOME COST SHARING (LICS) LEVEL | Q | *Y* | Yes |
| 240-U1 | CONTRACT NUMBER | Q | *ABCXUX333* | |
| 926-FF | FORMULARY ID | Q | *F33H12XU* | |
| 757-U6 | BENEFIT ID | Q | *123* | |

| RESPONSE PATIENT SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *29* | RESPONSE PATIENT SEGMENT |
| 310-CA | PATIENT FIRST NAME | M | *SAM* | |
| 311-CB | PATIENT LAST NAME | Q | *JONES* | |
| 304- C4 | DATE OF BIRTH | Q | *19620615* | Born June 15, 1962 |

Note: This Patient data is from the Facilitator's system. It is not echoed back from the submission information.

| RESPONSE STATUS SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *21* | RESPONSE STATUS SEGMENT |
| 112-AN | TRANSACTION RESPONSE STATUS | M | *A* | Approved |
| 503-F3 | AUTHORIZATION NUMBER | Q | *123456789123456789* | |
| 130-UF | ADDITIONAL MESSAGE INFORMATION COUNT | R | *1* | 1 occurrence |

| | | | | |
|---|---|---|---|---|
| 132-UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER | R | *01* | Used for first line of free form text with no pre-defined structure. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | Q | *TRANSACTION MESSAGE TEXT* | For illustrative purposes only. Up to 40 Bytes |

| RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *28* | RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT |
| 355-NT | OTHER PAYER ID COUNT | M | *3* | 3 occurrences |
| 338-5C | OTHER PAYER COVERAGE TYPE | M | *01* | Primary |
| 339-6C | OTHER PAYER ID QUALIFIER | R | *03* | BIN |
| 340-7C | OTHER PAYER ID | Q | *123456* | This is the Medicare Part D payer based on the Medicare Part D Coverage Code (139-UR) = 1 (Primary) |
| 991-MH | OTHER PAYER PROCESSOR CONTROL NUMBER | Q | *9876543210* | |
| 356-NU | OTHER PAYER CARDHOLDER ID | Q | *456789123* | |
| 992-MJ | OTHER PAYER GROUP ID | Q | *789123* | |
| 142-UV | OTHER PAYER PERSON CODE | Q | *010* | 01 = Other Payer assigned person code. |
| 143-UW | OTHER PAYER PATIENT RELATIONSHIP CODE | Q | *1* | Cardholder |
| 127-UB | OTHER PAYER HELP DESK NUMBER | Q | *5556861111* | Primary Payer listed Help Desk Telephone Number - in this instance is the Part D help desk |
| 144-UX | OTHER PAYER BENEFIT EFFECTIVE DATE | Q | *20120101* | January 1, 2012 |
| 145-UY | OTHER PAYER BENEFIT TERMINATION DATE | Q | *20120930* | September 30, 2012 |
| 338-5C | OTHER PAYER COVERAGE TYPE | M | *02* | Secondary |
| 339-6C | OTHER PAYER ID QUALIFIER | R | *03* | BIN |
| 340-7C | OTHER PAYER ID | Q | *888555* | Other Payer A |
| 991-MH | OTHER PAYER PROCESSOR CONTROL NUMBER | Q | *8522542311* | |
| 356-NU | OTHER PAYER CARDHOLDER ID | Q | *23456789* | |
| 992-MJ | OTHER PAYER GROUP ID | Q | *888222* | |
| 142-UV | OTHER PAYER PERSON CODE | Q | *00* | 00 = Other Payer assigned person code |
| 143-UW | OTHER PAYER PATIENT RELATIONSHIP CODE | Q | *1* | Cardholder |
| 127-UB | OTHER PAYER HELP DESK NUMBER | Q | *5558884444* | Other Payer A Help Desk Telephone Number |
| 144-UX | OTHER PAYER BENEFIT EFFECTIVE DATE | Q | *20120201* | February 1, 2012 |
| 145-UY | OTHER PAYER BENEFIT TERMINATION DATE | Q | *20121130* | November 30, 2012 |
| 338-5C | OTHER PAYER COVERAGE TYPE | M | *03* | Tertiary |
| 339-6C | OTHER PAYER ID QUALIFIER | R | *03* | BIN |
| 340-7C | OTHER PAYER ID | Q | *552233* | Other Payer B |
| 991-MH | OTHER PAYER PROCESSOR CONTROL NUMBER | Q | *0987654321* | |
| 356-NU | OTHER PAYER CARDHOLDER ID | Q | *553322123* | |
| 992-MJ | OTHER PAYER GROUP ID | Q | *123456* | |
| 142-UV | OTHER PAYER PERSON CODE | Q | *00* | 00 = Other Payer assigned person code |
| 143-UW | OTHER PAYER PATIENT RELATIONSHIP CODE | Q | *1* | Cardholder |
| 127-UB | OTHER PAYER HELP DESK NUMBER | Q | *5558885555* | Other Payer B Help Desk Telephone Number |
| 144-UX | OTHER PAYER BENEFIT EFFECTIVE DATE | Q | *20120801* | August 1, 2012 |
| 145-UY | OTHER PAYER BENEFIT TERMINATION DATE | Q | *20121231* | December 31, 2012 |

## 22.26.5 ELIGIBILITY MEDICARE PART D TO FACILITATOR – REQUEST – MEMBER HAS CURRENT MEDICARE PART D COVERAGE AND NO OTHER COVERAGE (DATE OF SERVICE IS BASED UPON ALLOWED FUTURE DATE RANGE)

Date of Request: **10/01/2011**

Date of Service: 01/01/2012 **note this is a future date**

Member is effective as of date of service with Medicare Part D as primary (01/01/2012 through 09/30/2012)

Response: Approved

| TRANSACTION HEADER SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 101-A1 | BIN NUMBER | M | *011727* | |
| 102-A2 | VERSION/RELEASE NUMBER | M | *D0* | Transaction Format |
| 103-A3 | TRANSACTION CODE | M | *E1* | Eligibility verification |
| 104-A4 | PROCESSOR CONTROL NUMBER | M | *2222222222* | |
| 109-A9 | TRANSACTION COUNT | M | *1* | One occurrence |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | M | *01* | National Provider ID |

| | | | | |
|---|---|---|---|---|
| 201-B1 | SERVICE PROVIDER ID | M | *4563663111bbbbb* | |
| 401-D1 | DATE OF SERVICE | M | *20120101* | January 1, 2012 |
| 110-AK | SOFTWARE VENDOR/CERTIFICATION ID | M | *98765bbbbb* | |

| PATIENT SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *01* | PATIENT SEGMENT |
| 304-C4 | DATE OF BIRTH | Q | *19620615* | Born June 15, 1962 |
| 305-C5 | PATIENT GENDER CODE | Q | *1* | Male |
| 310-CA | PATIENT FIRST NAME | Q | *SAMUEL* | |
| 311-CB | PATIENT LAST NAME | Q | *JONES* | |
| 322-CM | PATIENT STREET ADDRESS | Q | *123 MAIN STREET* | |
| 323-CN | PATIENT CITY ADDRESS | Q | *MY TOWN* | |
| 324-CO | PATIENT STATE/PROVINCE ADDRESS | Q | *CO* | |
| 325-CP | PATIENT ZIP/POSTAL ZONE | Q | *34567* | |

| INSURANCE SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *04* | INSURANCE SEGMENT |
| 302-C2 | CARDHOLDER ID | M | *123456789* | The HICN (Health Insurance Claim Number, Part A, B, or C), SSN, or RRB. |

### *22.26.5.1 ELIGIBILITY MEDICARE PART D TO FACILITATOR – APPROVED RESPONSE – MEMBER HAS CURRENT MEDICARE PART D COVERAGE AND NO OTHER COVERAGE*

Eligibility Approved Response

| RESPONSE HEADER SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 102-A2 | VERSION/RELEASE NUMBER | M | *D0* | Transaction Format |
| 103-A3 | TRANSACTION CODE | M | *E1* | Eligibility Verification |
| 109-A9 | TRANSACTION COUNT | M | *1* | One occurrence |
| 501-F1 | HEADER RESPONSE STATUS | M | *A* | Accepted |
| 202-B2 | SERVICE PROVIDER ID QUALIFIER | M | *01* | National Provider ID |
| 201-B1 | SERVICE PROVIDER ID | M | *4563663111bbbbb* | |
| 401-D1 | DATE OF SERVICE | M | *20120101* | January 1, 2012 |

| RESPONSE INSURANCE ADDITIONAL INFORMATION SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *27* | RESPONSE INSURANCE ADDITIONAL INFORMATION SEGMENT |
| 139-UR | MEDICARE PART D COVERAGE CODE | M | *1* | Primary |

| RESPONSE INSURANCE ADDITIONAL INFORMATION SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 138-UQ | CMS LOW INCOME COST SHARING (LICS) LEVEL | Q | *Y* | Yes |
| 240-U1 | CONTRACT NUMBER | Q | *ABCXUX333* | |
| 926-FF | FORMULARY ID | Q | *F33H12XU* | |
| 757-U6 | BENEFIT ID | Q | *123* | |

| RESPONSE PATIENT SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *29* | RESPONSE PATIENT SEGMENT |
| 310-CA | PATIENT FIRST NAME | M | *SAM* | |
| 311-CB | PATIENT LAST NAME | Q | *JONES* | |
| 304- C4 | DATE OF BIRTH | Q | *19620615* | Born June 15, 1962 |

Note: This Patient data is from the Facilitator's system. It is not echoed back from the submission information.

| RESPONSE STATUS SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *21* | RESPONSE STATUS SEGMENT |
| 112-AN | TRANSACTION RESPONSE STATUS | M | *A* | Approved |
| 503-F3 | AUTHORIZATION NUMBER | Q | *123456789123456789* | |

| | | | | |
|---|---|---|---|---|
| 130-UF | ADDITIONAL MESSAGE INFORMATION COUNT | R | *1* | 1 occurrence |
| 132-UH | ADDITIONAL MESSAGE INFORMATION QUALIFIER | R | *01* | Used for first line of free form text with no pre-defined structure. |
| 526-FQ | ADDITIONAL MESSAGE INFORMATION | Q | *TRANSACTION MESSAGE TEXT* | For illustrative purposes only. Up to 40 Bytes |

| RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT | | | | |
|---|---|---|---|---|
| **FIELD** | **FIELD NAME** | **CAT** | **VALUE** | **COMMENTS** |
| 111-AM | SEGMENT IDENTIFICATION | M | *28* | RESPONSE COORDINATION OF BENEFITS/OTHER PAYERS SEGMENT |
| 355-NT | OTHER PAYER ID COUNT | M | *1* | One occurrence |
| 338-5C | OTHER PAYER COVERAGE TYPE | M | *01* | Primary |
| 339-6C | OTHER PAYER ID QUALIFIER | R | *03* | BIN |
| 340-7C | OTHER PAYER ID | Q | *123456* | |
| 991-MH | OTHER PAYER PROCESSOR CONTROL NUMBER | Q | *9876543210* | |
| 356-NU | OTHER PAYER CARDHOLDER ID | Q | *456789123* | |
| 992-MJ | OTHER PAYER GROUP ID | Q | *789123* | |
| 142-UV | OTHER PAYER PERSON CODE | Q | *01* | 01 = Other Payer assigned person code |
| 143-UW | OTHER PAYER PATIENT RELATIONSHIP CODE | Q | *1* | |
| 127-UB | OTHER PAYER HELP DESK NUMBER | Q | *5556861111* | Primary Payer listed Help Desk Phone Number - in this instance is the Part D help desk |
| 144-UX | OTHER PAYER BENEFIT EFFECTIVE DATE | Q | *20120101* | January 1, 2012 |
| 145-UY | OTHER PAYER BENEFIT TERMINATION DATE | Q | *20120930* | September 30, 2012 |

## 22.27 MEDICARE PRESCRIPTION PAYMENT PLAN PROGRAM FREQUENTLY ASKED QUESTIONS

Medicare Prescription Payment Plan Program Frequently Asked Questions can be found in the *NCPDP WG9 MEDICARE PART D QUESTIONS AND ANSWERS* document located here.

Added May 2024

## 22.28 HEPATITIS B VACCINE BILLING

**Question:**
Hepatitis B vaccine can be covered under either Medicare Part B or Part D depending on the patient's risk of contracting the infection. What information should the pharmacy submit on the claim to allow the payer to make the payment determination?

**Response:**
The new External Code List (ECL) values below have been created for use with existing ECL values to support a standardized point of service process to communicate whether the patient is at low risk or moderate to high risk of becoming infected with the hepatitis B virus to determine Medicare Part B or Part D coverage.

**Reason for Service Code (439-E4):**
One new Reason for Service Code (439-E4) value has been created for the payer to return on a rejected response, indicating more information is needed to complete vaccine billing.

- UE – Hepatitis B Risk Determination Required
  *Code indicating that risk of contracting Hepatitis B is needed to determine Medicare Part B or Medicare Part D coverage for Hepatitis B vaccination.*

**Result of Service Code (441-E6):**
Three new Result of Service Code (441-E6) values have been created for the pharmacy to communicate the patient's risk of contracting the hepatitis B virus.

- 5D – Low Risk of Hepatitis B
  *Low risk of contracting hepatitis B as defined by CMS guidelines.*

- 5E – Medium/High Risk of Hepatitis B
  *Medium to high risk of contracting Hepatitis B includes vaccine status unknown by patient, no prior vaccination, and/or other risk factors as defined by CMS guidelines.*
- 5H - Unknown Exposure/Risk
  *Exposure or risk to determine vaccine coverage is unknown to pharmacy.*

Pharmacies could proactively submit an applicable Result of Service Code (441-E6) value to identify the patient's risk of contracting the hepatitis B virus.

If the information is not on the submitted claim and is necessary for the payer to complete the claim adjudication process, payers can initiate the point of service communication process using the specified ECL values as outlined below.

Refer to the Vaccine Billing DUR Code Set Sample Matrices at the end of this FAQ for a combination of Reason for Service (439-E4) and Result of Service Code (441-E6) code values that could be submitted on the request.

**POINT OF SERVICE CLAIMS PROCESSING GUIDANCE BASED ON MEDICARE PLAN TYPE**

**PDP - Prescription Drug Plan (Part D Benefit ONLY, No Part B) for Hepatitis B Vaccine**

1. Hepatitis B vaccine claim submitted
2. If the Result of Service Code (441-E6) field does not contain one of the new risk values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*
   ii. Reason For Service Code (439-E4): UE - *Hepatitis B Risk Determination Required*
3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of EU – *Hepatitis B Risk Determination Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
   i. 5D – Low Risk of Hepatitis B
      - Payer Response: Claim continues to adjudicate under the PDP benefit
   ii. 5E – *Medium/High Risk of Hepatitis B*
      - Payer Response: Claim rejects with Reject Code (511-FB): A6 – *This Product/Service May Be Covered Under Medicare Part B*
   iii. 5H - Unknown Exposure/Risk
      - Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
   i. P0 - Patient consulted
      *Consultation with the patient to clarify or collect additional information*
   ii. M0 - Prescriber consulted
      *Communication with prescriber related to collection of information or clarification of a drug therapy concern.*
   iii. R0 - Pharmacist consulted other source
      *Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.*

**MA Only - Medicare Advantage (Part B Benefit ONLY, No Part D) for Hepatitis B Vaccine**

1. Hepatitis B vaccine claim submitted
2. If the Result of Service Code (441-E6) field does not contain one of the new risk values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – DUR Reject Error
   ii. Reason For Service Code (439-E4): UE - Hepatitis B Risk Determination Required
3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of XX – *Hepatitis B Risk Determination Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:

iii. 5D – *Low Risk of Hepatitis B*
   a. Payer Response: Claim rejects with Reject Code (511-FB): 620 – *This Product/Service May Be Covered Under Medicare Part D*

iv. 5E – *Medium/High Risk of Hepatitis B*
   a. Claim continues to adjudicate under the MA Only benefit

v. 5H - Unknown Exposure/Risk
   a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights

4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
   i. P0 - Patient consulted
   *Consultation with the patient to clarify or collect additional information*
   ii. M0 - Prescriber consulted
   *Communication with prescriber related to collection of information or clarification of a drug therapy concern.*
   iii. R0 - Pharmacist consulted other source
   *Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.*

**MAPD – Medicare Advantage Prescription Drug (Part B+D BENEFITS) for Hepatitis B Vaccine**

1. Hepatitis B vaccine claim submitted
2. If the Result of Service Code (441-E6) field does not contain one of the new risk values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – DUR Reject Error
   ii. Reason For Service Code (439-E4): UE - *Hepatitis B Risk Determination Required*
3. Pharmacy resubmits claim with one of the below Result of Service Code values:
   i. 5D – *Low Risk of Hepatitis B*
   Payer Response: Claim continues to adjudicate under the MAPD Part D benefit
   ii. 5E – *Medium/High Risk of Hepatitis B*
   Payer Response: Claim continues to adjudicate under the MAPD Part B benefit
   iii. 5H - Unknown Exposure/Risk
   Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
   i. P0 - Patient consulted
   *Consultation with the patient to clarify or collect additional information*
   ii. M0 - Prescriber consulted
   *Communication with prescriber related to collection of information or clarification of a drug therapy concern.*
   iii. R0 - Pharmacist consulted other source
   *Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.*

**Vaccine Billing DUR Code Set Sample Claim Request Matrices**

| Scenario | Request: Reason for Service Code (439-E4) | Professional Service Code (440-E5) *Only submitted if specified in trading partner agreement* | Result of Service Code (441-E6) |
|---|---|---|---|
| Pharmacy Proactively Submits Hepatitis B Risk Determination | UE – Hepatitis B Risk Determination Required | P0 - Patient Consulted<br>M0 – Prescriber Consulted<br>R0 – Pharmacy Consulted Other Sources | 5D- Low Risk of Hepatitis B, or<br>5E – Medium/High Risk of Hepatitis B<br>5H - Unknown Exposure/Risk |
| Plan Returns Reject 88 - DUR Error with Reason for Service Code EU – Hepatitis B Risk Determination Required | UE – Hepatitis B Risk Determination Required | P0 - Patient Consulted<br>M0 – Prescriber Consulted<br>R0 – Pharmacy Consulted Other Sources | 5D- Low Risk of Hepatitis B, or<br>5E – Medium/High Risk of Hepatitis B<br>5H - Unknown Exposure/Risk |

Added December 2025

## 22.29 MEDICARE PART B VS MEDICARE PART D VACCINE BILLING

**Question:**
For vaccines that can be covered under either Medicare Part B or Part D depending on the patient's circumstances, what information should the pharmacy submit on the claim to allow the payer to make the payment determination?

**Response:**
The new External Code List (ECL) values below have been created for use with existing ECL values to support a standardized point of service process to communicate information about Part B vs Part D vaccines. For selected vaccines, such as tetanus and rabies, the pharmacy will indicate whether the patient is getting the vaccine due to possible exposure due to illness or injury (i.e., post-exposure, such as a puncture wound or animal bite) or whether it's needed for general prevention or upcoming travel (i.e., pre-exposure).

**Reason for Service Code (439-E4):**
One new Reason for Service Code (439-E4) value has been created for the payer to return on a rejected response, indicating more information is needed to complete vaccine billing.

- UF – Pre- vs Post-Exposure Vaccine Information Required
  *Code indicating the reason for the vaccine administration is needed to determine coverage.*

**Result of Service Code (441-E6):**
Three new Result of Service Code (441-E6) values have been created for the pharmacy to communicate whether the vaccine is being administered pre- or post-exposure.

- 5F – Maintenance/Travel Vaccine
  *Vaccine is administered as part of maintenance/routine vaccine schedule or in preparation for travel.*
- 5G – Post-Exposure Vaccine
  *Vaccine is administered in response to an injury or direct exposure to a disease or condition.*
- 5H - Unknown Exposure/Risk
  *Exposure or risk to determine vaccine coverage is unknown to pharmacy.*

Pharmacies could proactively submit an applicable Result of Service Code (441-E6) value to identify the reason for vaccine.

If the information is not on the submitted claim and is necessary for the payer to complete the claim adjudication process, payers can initiate the point of service communication process using the specified ECL values as outlined below.

Refer to the Vaccine Billing DUR Code Set Sample Matrices at the end of this FAQ for a combination of Reason for Service (439-E4) and Result of Service Code (441-E6) code values that could be submitted on the request.

**POINT OF SERVICE CLAIMS PROCESSING GUIDANCE BASED ON MEDICARE PLAN TYPE**

**PDP - Prescription Drug Plan (Part D Benefit ONLY, No Part B) for Pre- vs Post-Exposure Vaccine**

1. Claim submitted for a vaccine covered by Part D for general prevention/ travel.
2. If the Result of Service Code (441-E6) field does not contain one of the new reason for vaccine values, the claim may reject as follows:
    i. Reject Code (511-FB): 88 – *DUR Reject Error*
    ii. Reason For Service Code (439-E4): UF – *Pre- or Post-Exposure Vaccine Information Required*
3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of UF – *Pre- or Post-Exposure Vaccine Information Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
    i. 5F – *Maintenance/Travel Vaccine*
        a. Payer Response: Claim continues to adjudicate under the PDP benefit
    ii. 5G – *Post-Exposure Vaccine*
        a. Payer Response: Claim rejects with Reject Code (511-FB): A6 – *This Product/Service May Be Covered Under Medicare Part B*
    iii. 5H - Unknown Exposure/Risk
        a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    *Consultation with the patient to clarify or collect additional information*
    ii. M0 - Prescriber consulted
    *Communication with prescriber related to collection of information or clarification of a drug therapy concern.*
    iii. R0 - Pharmacist consulted other source
    *Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.*

**MA Only - Medicare Advantage (Part B Benefit ONLY, No Part D) for Pre- vs Post-Exposure Vaccine**

1. Claim submitted under Part B for post-exposure prevention (ex: tetanus, rabies, hepatitis A)
2. If the Result of Service Code (441-E6) field does not contain one of the new reason for vaccine values, the claim may reject as follows:
    i. Reject Code (511-FB): 88 – *DUR Reject Error*
    ii. Reason For Service Code (439-E4): UF - *Pre- or Post-Exposure Vaccine Information Required*
3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of UF – *Pre- or Post-Exposure Vaccine Information Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
    i. 5F – *Maintenance/Travel Vaccine*
        a. Payer Response: Claim rejects with Reject Code (511-FB): 620 – *This Product/Service May Be Covered Under Medicare Part D*
    ii. 5G – *Post-Exposure Vaccine*
        a. Claim continues to adjudicate under the MA Only benefit
    iii. 5H - *Unknown Exposure/Risk*
        a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights

4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    *Consultation with the patient to clarify or collect additional information*
    ii. M0 - Prescriber consulted
    *Communication with prescriber related to collection of information or clarification of a drug therapy concern.*
    iii. R0 - Pharmacist consulted other source
    *Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.*

**MAPD – Medicare Advantage Prescription Drug (Part B+D BENEFITS) for Pre- vs Post-Exposure Vaccine**

1. Claim submitted for a vaccine covered by Part D for general prevention/travel and under Part B for post-exposure prevention (ex: tetanus, rabies, hepatitis A)
2. If the Result of Service Code (441-E6) field does not contain one of the new reason for vaccine values, the claim may reject as follows:
    i. Reject Code (511-FB): 88 – *DUR Reject Error*
    ii. Reason For Service Code (439-E4): UF - *Pre- or Post-Exposure Vaccine Information Required*
3. Pharmacy resubmits claim with one of the below Result of Service Code values:
    i. 5F – *Maintenance/Travel Vaccine*
        a. Payer Response: Claim continues to adjudicate under the MAPD Part D benefit
    ii. 5G – *Post-Exposure Vaccine*
        a. Payer Response: Claim continues to adjudicate under the MAPD Part B benefit
    iii. 5H - *Unknown Exposure/Risk*
        a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    *Consultation with the patient to clarify or collect additional information*
    ii. M0 - Prescriber consulted
    *Communication with prescriber related to collection of information or clarification of a drug therapy concern.*
    iii. R0 - Pharmacist consulted other source
    *Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.*

**Vaccine Billing DUR Code Set Sample Claim Request Matrices**

| **Scenario** | **Request: Reason for Service Code (439-E4)** | **Professional Service Code (440-E5)** ***Only submitted if specified in trading partner agreement*** | **Result of Service Code (441-E6)** |
|---|---|---|---|
| Pharmacy Proactively Submits Vaccine Purpose | UF – Pre- or Post-Exposure Vaccine Information Required | P0 - Patient Consulted<br>M0 – Prescriber Consulted<br>R0 – Pharmacy Consulted Other Sources | 5F- Maintenance/Travel Vaccine, or<br>5G – Post-Exposure Vaccine<br>5H - Unknown Exposure/Risk |
| Plan Returns Reject 88 - DUR Error with Reason for Service Code UF – Pre- or Post-Exposure Vaccine | UF – Pre- or Post-Exposure Vaccine Information Required | P0 - Patient Consulted<br>M0 – Prescriber Consulted<br>R0 – Pharmacy Consulted Other Sources | 5F- Maintenance/Travel Vaccine, or<br>5G – Post-Exposure Vaccine<br>5H - Unknown Exposure/Risk |

# 23 APPENDIX E. ROUTE OF ADMINISTRATION QUESTIONS

## 23.1 BEST PRACTICES FOR USE OF SNOMED CT ROUTE OF ADMINISTRATION VALUES

1. **Question:** Which "edition" of SNOMED CT Route of Administration data should be used and where can it be located?
   **Response:** The Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) United States (US) Edition is the official source of SNOMED CT for use in US healthcare systems, as referenced by United States Core Data for Interoperability (USCDI) and the Interoperability Standards Advisory (ISA).

   The National Library of Medicine (NLM) distributes the US Edition of SNOMED CT, which is a standalone release that combines the content of both the US Extension and the International releases of SNOMED CT.

   The SNOMED CT Route of Administration subset is publicly available on the NLM Value Set Authority Center (VSAC) web site Value Set Authority Center (nih.gov).

   NCPDP's External Code List© (ECL) entry for Route of Administration (995-E2) points to NLM's VSAC for the list of values and includes a link with instructions for how to download the data. These instructions can also be found here.

   To ensure consistent values and processes across trading partners, NCPDP recommends using the downloadable list of codes published by NLM.

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

   *Updated June 2026*

2. **Question**: If a SNOMED CT Route of Administration code is listed on the NLM VSAC site, a payer/processor choose to not support the code and reject the claim?
   **Response:** NCPDP does not dictate business requirements. If their business warrants it, the payer/processor may choose to not cover or support a code and deny a claim with Reject Code (511-FB) values such as 552 (Route of Administration Value Not Supported), 9Q (Route of Administration Submitted Not Covered) or other applicable values.

   However, Reject Code value E2 (M/I Route of Administration) should not be used to communicate that the code is not supported or covered.

3. **Question:** If a processor does not recognize a value being submitted in Route of Administration (995-E2) because they are using a different version of NLM's SNOMED CT ROA subset than the pharmacy, what is the appropriate reject code?
   **Response:** When an unrecognized value is submitted in field Route of Administration (995-E2) and the processor is requiring the field data, the reject code E2 (M/I Route of Administration) should be used.

   To minimize the potential for unrecognized values due to trading partners referencing different versions of the published SNOMED CT Route of Administration codes, it is recommended that all industry participants regularly update their internal databases with the biannually published list from NLM.

   Note: Please also review FAQ #2 above.

## 23.2 TIMING CONSIDERATIONS

1. **Question:** How should the industry support the changes within the SNOMED CT vocabulary which occurs outside the NCPDP ECL timelines?
   **Response:** The NCPDP External Code List© timelines were developed and approved by the NCPDP membership for values that occur **within** the NCPDP External Code List© publications. The vocabulary owners (FDA for NDC, HHS for ICD, NLM for SNOMED, NCI for FMT DoseForm, etc.) are based on the schedule established by these entities

for their products. As the industry implements, for example NDC or ICD-9 updates outside of the NCPDP External Code List© timeline, so implementation of SNOMED is based on NLM's publication dates.

2. **Question:** How often is a version of SNOMED released?
   **Response:** The US Edition of SNOMED CT is released bi-annually in the months of March and September. Trading partners should make every effort to ensure the latest code sets have been downloaded and integrated into their systems.

   **Trading partners are strongly encouraged to not use retired and/or ambiguous codes that are not valid Route of Administration codes per SNOMED CT guidance.**

   **As stated in the Quick Reference Chart in the *NCPDP Use of External Code Lists© and Vocabularies* for code set updates that do not require immediate use, it is recommended external code set updates be implemented within 180 days of their publication.**

## 23.3 Route of Administration in the NCPDP Telecommunication Standard©

1. **Question:** Is Route of Administration (995-E2) required in NCPDP transactions?
   **Response:** No. The Route of Administration (995-E2) is not mandatory or required in NCPDP transactions. The field is situational. Entities that wish to receive the field are to denote the situation when the field is required. The submission of Route of Administration (995-E2) in transactions helps to further clarify the compound being submitted or to override a default route referenced for the product.

2. **Question:** In the Telecommunication Standards© lower than Version F8, the field length for Route of Administration (995-E2) is 11 characters, however some values within the SNOMED CT Route of Administration Code set are greater than 11 characters. Is there guidance on how to transmit and process values greater than 11 characters in the Telecommunication Standards© lower than Version F8?
   **Response:** We recommend using the first 11 digits and truncating the remaining digits as applicable. This recommendation is based on the February 2022 analysis of the code set which indicates truncation would not create duplicates. In Versions F8 and greater, the field length is 20 characters.

3. **Question:** What is the purpose of "Appendix H. Route of Administration Transition" in the Telecommunication Standard Implementation Guide Version D.0©?
   **Response:**
   This appendix was only presented for transition purposes to Telecommunication Standard Version C.4© and above. If you were an entity that used the original two-digit Compound Route of Administration (452-EH) values in versions prior to Telecommunication Standard Version C.4©, this appendix was added to assist in transition from the NCPDP code values formerly found in Compound Route of Administration (452-EH) in the Compound Segment (prior to Version C.4) to the Route of Administration (995-E2) in the Claim Segment (supported in Version C.4 and above), which only uses Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT).

   If you did not use the original two-digit Compound Route of Administration (452-EH) values in Telecommunication Standard Version C.3© and below, "Appendix H. Route of Administration Transition" was not intended to be used. The valid SNOMED CT Route of Administration codes are to be used for Telecommunication Standard Version C.4© and above.

   Please note that the SNOMED values listed in "Appendix H. Route of Administration Transition" were valid as of the transition in 2011. However, the SNOMED values have continued to evolve since that time, and the SNOMED values in Appendix H should no longer be considered accurate. Instead, please reference the current published SNOMED Route of Administration values as linked on the NCPDP ECL web lookup tool.
   **Note: "Appendix H. Route of Administration Transition" is sunset in Version E.0 of the implementation guide.**

4. **Question:** Are the values in "Appendix H. Route of Administration Transition" in the Telecommunication Standard Implementation Guide© the only values to use?

   **Response:**

   No. The SNOMED codes listed were only given to assist if an entity was using the original two-digit Compound Route of Administration (452-EH) values. If you did not use the original two-digit Compound Route of Administration (452-EH) values, "Appendix H. Route of Administration Transition" should not be used.

   **Note: "Appendix H. Route of Administration Transition" is sunset in Version E.0 of the implementation guide.**

   Please note that the SNOMED values listed in "Appendix H. Route of Administration Transition" were valid as of the transition in 2011. However, the SNOMED values have continued to evolve since that time, and the SNOMED values in Appendix H should no longer be considered accurate. Instead, please reference the current published SNOMED Route of Administration values as linked on the NCPDP ECL web lookup tool.

5. **Question:** Can the old Compound Route of Administration (452-EH) codes be used in Telecom D.0 if they are sufficient for the client's needs?

   **Response:** No. For Telecommunication Standard Version D.0© and above, only the SNOMED CT Route of Administration codes are to be used.

6. **Question:** Can both be used for Compound Route of Administration (452-EH) - the old NCPDP codes where they work, and the SNOMED CT Route of Administration codes used for the missing situations not covered by NCPDP codes?

   **Response:** No. In one version of the Telecommunication Standard© multiple code lists cannot be used for the Compound Route of Administration (452-EH). For Telecommunication Standard Version C.4© and above, the SNOMED CT Route of Administration codes are to be used.

*Entire Appendix Updated August 2024*

# 24 APPENDIX F. POINT OF SERVICE PRESCRIBER VALIDATION GUIDANCE APPLICABLE TO CMS 4159 AND IFC 6107

## 24.1 INTRODUCTION

**Update October 2018:**

CMS rule 4182-F replaces the Medicare Prescriber Enrollment requirement under CMS 4159 and IFC 6107 with the Medicare Precluded Provider requirement. While the effective date of this provision is January 1, 2019, refer to CMS FAQ's which indicates point-of-service (POS) edits will apply as of April 1, 2019. Information below will be updated as additional guidance is provided by CMS.

Updated March 2026

## 24.2 BACKGROUND:

- **CMS 4157-F** Effective 01/01/2013
  - *"Sponsors will be required to so ensure in the following manner: (1) a sponsor must communicate at point-of-sale whether or not the prescriber NPI is active and valid; (2) if the sponsor communicates that the prescriber NPI is not active and valid, the sponsor must permit the pharmacy to confirm that the NPI is active and valid, or in the alternative, to correct it; (3) if the pharmacy confirms that the prescriber NPI is active and valid or corrects it, the sponsor must pay the claim if it is otherwise payable; and (4) if the pharmacy cannot or does not correct or confirm that the prescriber NPI is active and valid, the sponsor must require the pharmacy to resubmit the claim **(when necessary)**, which the sponsor must pay, if it is otherwise payable, unless there is an indication of fraud or the claim involves a prescription written by a foreign prescriber (where permitted by State law)."*

- **CMS 4159-F § 423.120(c)(6)(i)** *Regulation Effective 06/01/2015, Enforcement Effective 02/01/2017*
  - *Under § 423.120(c)(6)(i), in order for a Part D sponsor to submit to CMS a prescription drug event (PDE) record, the PDE must pertain to a claim for a Part D drug that was dispensed in accordance with a prescription written by a physician or eligible professional who is either (1) enrolled in Medicare in an approved status, or (2) has a valid opt-out affidavit on file with an A/B MAC.*
  - *Under § 423.120(c)(6)(iii), a Part D sponsor must deny or must require its PBM to deny a pharmacy claim for a drug (or a request for reimbursement from a Medicare beneficiary for a drug) if the claim does not meet the requirements of § 423.120(c)(6)(i) or (ii), respectively.*

- **IFC 6107** *Regulation Effective 06/01/2015, Enforcement Effective 06/01/2016*
  - *Under these revised requirements, pharmacy claims and beneficiary requests for reimbursement for Medicare Part D prescriptions, written by prescribers other than physicians and eligible professionals who are permitted by state or other applicable law to prescribe medications, will not be rejected at the point of sale or denied by the plan if all other requirements are met.*
  - *In addition, a plan sponsor will not reject a claim or deny a beneficiary request for reimbursement for a drug when prescribed by a prescriber who does not meet the applicable enrollment or opt out requirement without first providing provisional coverage of the drug and individualized written notice to the beneficiary. This interim final rule with comment period also revises certain terminology to be consistent with existing policy and to improve clarity.*

## 24.3 HIGH LEVEL HIERARCHICAL RULES

**Question**: What are the recommended hierarchical rules for prescriber validation?

**Response**: NCPDP recommends the following order for prescriber validation, but processors may have unique situations that require a different order of validation steps.

- Validate Prescriber ID submitted is an NPI
- Validate NPI (status and format)
- Validate Deceased Date
- Validate Prescriber OIG Status
- Validate NPI Medicare Preclusion List/State Medicaid Program
- Validate Controlled Substance Prescriptive Authority
- Validate State Prescriptive Authority

See Medicare Part D Prescriber Validation Flow.
See Medicaid Prescriber Validation Flow.

*Updated June 2026*

## 24.4 PRESCRIBER RELATED REJECT CODES

| 511-FB Code | NCPDP Reject Code Description | Emergency ECL Dates |
|---|---|---|
| **A1** | ID Submitted is associated with a Sanctioned Prescriber<br><br>Value Limitation:<br>Refer To Reject Code A1 FAQ In Editorial Document.<br>Applicable to state/federal program exclusion list only. | |
| **A2** | ID Submitted is associated to a Deceased Prescriber | |
| **EZ** | M/I Prescriber ID Qualifier | |
| **25** | M/I Prescriber ID | |
| **42** | Plan's Prescriber database indicates the Prescriber ID Submitted is inactive or expired | 04/02/2013 |
| **43*** | Plan's Prescriber database indicates the associated DEA to submitted Prescriber ID is inactive<br><br>Value Limitation:<br>Value definition sunset for use in Telecommunication Standard Version EB© or greater | 07/01/2014 |
| **44*** | Plan's Prescriber database indicates the associated DEA to submitted Prescriber ID Is not found<br><br>Value Limitation:<br>Value definition sunset for use in Telecommunication Standard Version EB© or greater | 07/01/2014 |
| **46*** | Plan's Prescriber database indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule<br><br>Value Limitation: | |

| 511-FB Code | NCPDP Reject Code Description | Emergency ECL Dates |
|---|---|---|
| | Value definition sunset for use in Telecommunication Standard Version EB© or greater | |
| **543** | Prescriber ID Qualifier Value Not Supported | |
| **56** | Non-Matched Prescriber ID | |
| **569** | Provide Notice: Medicare Prescription Drug Coverage and Your Rights<br><br>07/01/2016 Value Limitation:<br>Reject Code 569 must not be sent with Reject Code 829 as Reject Code 829 is a reject that cannot be appealed.<br>Telecom Emergency Implementation Date for restricted use of the value 569 is July 01, 2016. | 07/01/2016 |
| **619** | Prescriber Type 1 NPI Required | 04/01/2013 |
| **777** | Plan's Prescriber database not able to verify active state license with prescriptive authority for Prescriber ID Submitted | 04/01/2015 |
| **826** | Prescriber NPI Submitted Not Found Within Processor's NPI File<br><br>Comment:<br>Used in place of reject code 56 when the submitted Prescriber ID Qualifier (466-EZ) = 01 and the submitted Prescriber ID (411-DB) meets the NPI format/check digit but is not found on the processor/payers prescriber file. | |
| **829** | Pharmacy Must Notify beneficiary:<br>Claim not covered due to failure to meet Medicare Part D active, valid prescriber NPI requirements.<br><br>07/01/2016 Value Limitation:<br>Reject Code 829 must not be sent with Reject Code 569 as Reject Code 829 is a reject that cannot be appealed.<br>Telecom Emergency Implementation Date for restricted use of the value 829 is July 01, 2016. | 04/01/2016 – Reject Code available for use<br><br>07/01/2016 – Value Limitation added |

* Definition is applicable to Telecom Version E9 and lower. The definition changes in Telecom versions EB and greater.

*Updated August 2026*

## 24.5 Prescriber Related Submission Clarification Codes

| 420-DK Code | NCPDP SCC Description | New Emergency ECL Dates |
|---|---|---|
| **42** | Prescriber ID Submitted is valid and prescribing requirements have been validated. | |

| 420-DK Code | NCPDP SCC Description | New Emergency ECL Dates |
|---|---|---|
| | Value of 42 does not apply to prescriber ~~Medicare~~ enrollment status. | |
| **43** | Prescriber's DEA is active with DEA Authorized Prescriptive Right. | 04/01/2013 |
| **45** | Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule | 04/01/2013 |
| **46** | Prescriber's DEA has prescriptive authority for this drug DEA Schedule | 04/01/2013 |
| **49** | Prescriber does not currently have an active Type 1 NPI | |
| **52** | Prescriber's state license with prescriptive authority has been validated- Indicates the prescriber ID submitted is associated to a healthcare provider with the applicable state license that grants prescriptive authority. | 10/15/2015 |
| **55** | Prescriber Enrollment in State Medicaid Program has been validated.<br><br>Value Limitation:<br>Used when overriding rejection for Prescriber Not Enrolled in State Medicaid Program. | 01/01/2018 |

Updated March 2026

## 24.6 PRESCRIBER RELATED APPROVED MESSAGE CODES 548-6F

| 548-6F CODE | DESCRIPTION | Emergency ECL Dates |
|---|---|---|
| **019** | The Submitted Prescriber ID is inactive or expired – Flagged for Retrospective Review - The claim paid, however, the combination of Prescriber ID qualifier (466-EZ) and Prescriber ID (411-DB) provided on the transaction was inactive or expired in the processor's system. | 04/01/2013 |
| **020*** | For the Submitted Prescriber ID, the associated DEA Number is Not Found – Flagged for Retrospective Review - The claim paid for a controlled substance, however, a valid DEA number could not be found (within the processor's system) using the combination of Prescriber ID qualifier (466-EZ) and Prescriber ID (411-DB) provided on the transaction. | 04/01/2012 |
| **021*** | For the Submitted Prescriber ID, the associated DEA Number is Inactive or Expired – Flagged for Retrospective Review - The claim paid for a controlled substance, however, an active DEA number could not be found (within the processor's system) using the | 04/01/2013 |

| 548-6F CODE | DESCRIPTION | Emergency ECL Dates |
|---|---|---|
| | combination of Prescriber ID qualifier (466-EZ) and Prescriber ID (411-DB) provided on the transaction. | |
| **022*** | For the submitted Prescriber ID, the associated DEA Number does not allow this drug DEA Schedule – Flagged for Retrospective Review | 04/01/2013 |
| **024** | The submitted Prescriber ID is Not Found - Flagged for Retrospective Review<br><br>07/01/2016 Value Limitation:<br>As of the applicability date of CMS 4159-F (423.120 (c)(6)), Approved Message Code 024 will no longer be valid for Medicare Part D claims. Refer to alternate reject code/submission clarification code/approved message code when NPI number cannot be found. Telecom Emergency Implementation Date for restricted use of the value 024 is July 01, 2016. | 07/01/2016 |
| **025** | The submitted Prescriber ID is associated to a Deceased Prescriber – Flagged for Retrospective Review | 04/01/2013 |
| **026** | Prescriber Type 1 NPI Required - Flagged for Retrospective Review<br><br>07/01/2016 Value Limitation:<br>As of the 01/01/2016 effective date of MACRA legislation section 507 and the applicability date of CMS 4159-F (423.120 (c)(6)), Approved Message Code 026 will no longer be valid for Medicare Part D claims. Telecom Emergency Implementation Date for restricted use of the value 026 is July 01, 2016. | 07/01/2016 |
| **027** | The submitted Prescriber DEA does not allow this drug DEA Schedule – Flagged for Retrospective Review<br><br>07/01/2016 Value Limitation:<br>As of the 01/01/2016 effective date of MACRA legislation section 507 and the applicability date of CMS 4159-F (423.120 (c)(6)), Approved Message Code 027 will no longer be valid for Medicare Part D claims. Telecom Emergency Implementation Date for restricted use of the value 027 is July 01, 2016. | 07/01/2016 |
| **028** | Type 1 NPI Required, Claim Paid Based on Plan's Prescriber NPI Data - When the plan pays and chooses to send a cross walked NPI on the PDE<br><br>07/01/2016 Value Limitation: | 07/01/2016 |

| 548-6F CODE | DESCRIPTION | Emergency ECL Dates |
|---|---|---|
| | As of the 01/01/2016 effective date of MACRA legislation section 507 and the applicability date of CMS 4159-F (423.120 (c)(6)), Approved Message Code 028 will no longer be valid for Medicare Part D claims. Telecom Emergency Implementation Date for restricted use of the value 028 is July 01, 2016. | |
| **032** | Plan's Prescriber database not able to verify active state license with prescriptive authority for Prescriber ID Submitted, flagged for retrospective review. | 04/01/2015 |
| **044** | Plan's Prescriber data base determined prescriptive authority criteria not met, flagged for retrospective review.<br>Value Limitation:<br>To be returned when reject code 876 applied and SCC 42 was accepted. | 07/01/2017 |
| **045** | Prescriber active enrollment with Medicaid Fee For Service/MCO required. Flagged for retrospective review.<br>Value Limitation:<br>Value returned only if Submission Clarification Code 55 (Prescriber Enrollment in State Medicaid Program has been validated) was accepted. | 01/01/2018 |

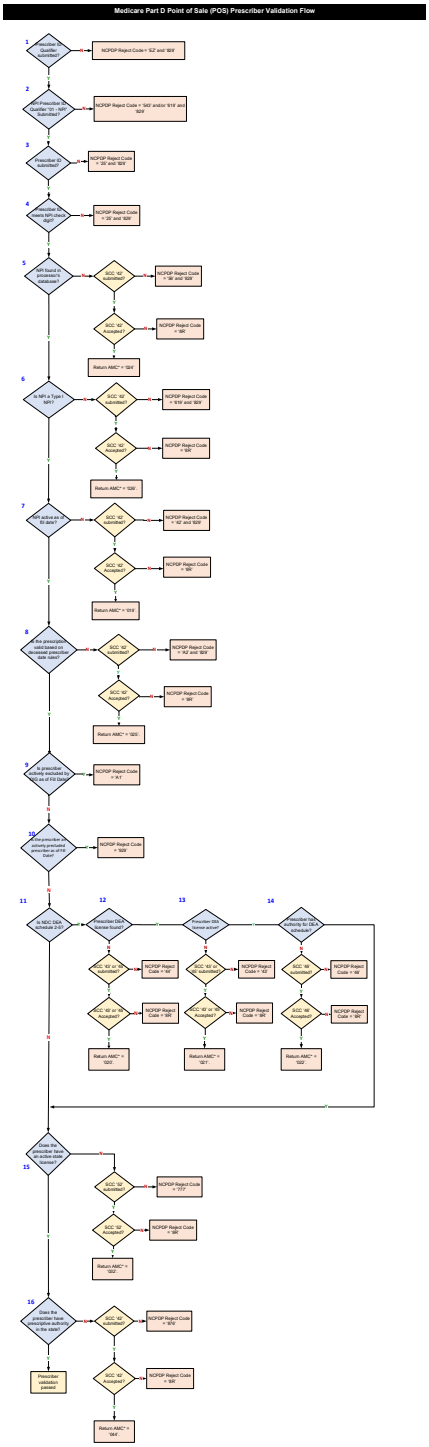
*Definition is applicable to Telecommunication Standard Version E9© and lower. The definition changes in Telecommunication Standard Versions EB© and greater.

*Updated June 2026*

## 24.7 MEDICARE PART D PRESCRIBER VALIDATION FLOW

The below flow diagram provides the steps and recommended edit order to validate the various prescriber aspects when processing Medicare Part D claims. The flow diagram is based on the current state of the industry as of Fall 2024.

Please note, prescriber validation will cease after pharmacy verification as indicated with a Submission Clarification Code and acceptance by the processor as indicated with an Approved Message Code. Retrospective review may occur by the processor.



Note: Reject Code (511-FB) value 829 may not be returned with Reject Code (511-FB) value 569 because it is not appealable.
829 = Pharmacy Must Notify Beneficiary: Claim Not Covered Due To Failure To Meet Medicare Part D Active, Valid Prescriber NPI Requirements.

569 = Provide Note: Medicare Prescription Drug Coverage and Your Rights

*Processor/PBM may reject transaction for other reasons such as formulary restrictions, safety edits (DUR), etc. post prescriber validation. So long as no other rejections occur, a paid transaction should return specified AMC.

Prescriber validation will cease after pharmacy verification as indicated with a Submission Clarification Code and acceptance by the processor as indicated with an Approved Message Code. Retrospective review may occur by the processor.

Updated August 2025

## 24.8 MEDICARE PART D PRESCRIBER VALIDATION REJECT MATRIX

The below matrix provides the steps and recommended edit order to validate the various prescriber aspects when processing Medicare Part D claims. The matrix is based on the current state of the industry as of Fall 2024.

| Validation Step | | Processor Response if Step Not Met | | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|---|
| Edit Order (Suggested) | Scenario: If scenario met, follow rejects, SCCs and AMCs | Reject Code 511-FB | Reject Code Description | Appeal or MACRA (Secondary Reject Code: Not Stand-alone) | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| 1 | Prescriber ID Qualifier (466-EZ) is not Submitted | EZ | M/I Prescriber ID Qualifier | 829 | N/A | N/A | N/A | N/A | N/A | N/A |
| 2 | Prescriber ID Qualifier (466-EZ) is not "01 – NPI" (e.g., ID = 17 Foreign Prescriber) | 543 And/Or 619 | Prescriber ID Qualifier Value Not Supported Prescriber Type 1 NPI Required | 829 | N/A | N/A | N/A | N/A | N/A | N/A |
| 3 | Prescriber ID (411-DB) is not Submitted | 25 | M/I Prescriber ID | 829 | N/A | N/A | N/A | N/A | N/A | N/A |
| 4 | Prescriber ID (411-DB) does not Meet~~s~~ NPI Check Digit | 25 | M/I Prescriber ID | 829 | N/A | N/A | N/A | N/A | N/A | N/A |
| 5 | NPI is not found in processor's database | 56 | Non-Matched Prescriber ID Task Group Comment: Used when the submitted Prescriber ID meets the format/check digit but is not found in the | 829 | 42 | Prescriber ID Submitted is valid and prescribing requirements have | 024 | The submitted Prescriber ID is Not Found – Flagged for Retrospective Review | 8R | Submission Clarification Code Value Not Supported |

| Validation Step | | Processor Response if Step Not Met | | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|---|
| Edit Order (Suggested) | Scenario: If scenario met, follow rejects, SCCs and AMCs | Reject Code 511-FB | Reject Code Description | Appeal or MACRA (Secondary Reject Code: Not Stand-alone) | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| | | | processor/payer prescriber database. | | | been validated Task Group Comment: If pharmacy submits SCC 42 and then the NPI is found not valid, the PDE will reject. | | | | |
| 6 | NPI is not Type 1 NPI | 619 | Prescriber Type 1 NPI Required | 829 | 42 | Prescriber ID Submitted is valid and prescribing requirements have been validated | 026 | Prescribe Type 1 NPI Required - Flagged for Retrospective Review | 8R | Submission Clarification Code Value Not Supported |
| 7 | NPI is not active as of Fill Date | 42 | Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired | 829 | 42 | Prescriber ID Submitted is valid and prescribing requirements have | 019 | The Submitted Prescriber ID is inactive or expired - Flagged for | 8R | Submission Clarification Code Value Not Supported |

| Validation Step | | Processor Response if Step Not Met | | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|---|
| Edit Order (Suggested) | Scenario: If scenario met, follow rejects, SCCs and AMCs | Reject Code 511-FB | Reject Code Description | Appeal or MACRA (Secondary Reject Code: Not Stand-alone) | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| | | | | | | been validated | | Retrospective Review The claim paid, however, the combination of Prescriber ID Qualifier (466-EZ) and Prescriber ID (411-DB) provided on the transaction was inactive or expired in the processor's system. | | |
| 8 | Prescription is not Valid Based on Deceased Prescriber Date Rules | A2 | ID Submitted is associated to a Deceased Prescriber | 829 | 42 | Prescriber ID Submitted is valid and prescribing requirements have | 025 | The submitted Prescriber ID is associated to a Deceased | 8R | Submission Clarification Code Value Not Supported |

| Validation Step | | Processor Response if Step Not Met | | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|---|
| Edit Order (Suggested) | Scenario: If scenario met, follow rejects, SCCs and AMCs | Reject Code 511-FB | Reject Code Description | Appeal or MACRA (Secondary Reject Code: Not Stand-alone) | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| | | | | | | been validated. | | Prescriber – Flagged for Retrospective Review | | |
| 9 | Prescriber ID is Actively Excluded by OIG as of Fill Date | A1 | ID Submitted is Associated with an Excluded Prescriber | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 10 | Prescriber is Actively Precluded as of Fill Date | 929 | ID Submitted Is Associated With A Precluded Prescriber | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

| Validation Step | | Processor Response if Step Not Met | | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|---|
| Edit Order (Suggested) | Scenario: If scenario met, follow rejects, SCCs and AMCs | Reject Code 511-FB | Reject Code Description | Appeal or MACRA (Secondary Reject Code: Not Stand-alone) | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| 11 | Is NDC DEA Schedule 2 – 5? If yes, continue to step 12. If no, continue to step 15. | | | | | | | | | |
| 12 | Prescriber DEA License is not Found | 44 | Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found | N/A | 43<br><br>45 | Prescriber's DEA is active with DEA Authorized Prescriptive Right. Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this | 020 | For the Submitted Prescriber ID, the associated DEA Number is Not Found – Flagged for Retrospective Review Value Limitation: Value definition sunsetted | 8R | Submission Clarification Code Value Not Supported |

| Validation Step | | Processor Response if Step Not Met | | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|---|
| Edit Order (Suggested) | Scenario: If scenario met, follow rejects, SCCs and AMCs | Reject Code 511-FB | Reject Code Description | Appeal or MACRA (Secondary Reject Code: Not Stand-alone) | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| | | | | | | drug DEA Schedule | | for use in Telecommunication Version EB and greater. | | |
| 13 | Prescriber DEA License is not Active | 43 | Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive | N/A | 43<br><br>45 | Prescriber's DEA is active with DEA Authorized Prescriptive Right.<br><br>Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule | 021 | For the Submitted Prescriber ID, the associated DEA Number is Inactive or Expired – Flagged for Retrospective Review. Value Limitation: Value definition sunsetted for use in Telecommunication | 8R | Submission Clarification Code Value Not Supported |

| Validation Step | | Processor Response if Step Not Met | | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|---|
| Edit Order (Suggested) | Scenario: If scenario met, follow rejects, SCCs and AMCs | Reject Code 511-FB | Reject Code Description | Appeal or MACRA (Secondary Reject Code: Not Stand-alone) | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| | | | | | | | | Version EB and greater. | | |
| 14 | Prescriptive Authority not met for DEA Schedule | 46 | Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule | N/A | 46 | Prescriber's DEA has prescriptive authority for this drug DEA Schedule | 022 | The submitted Prescriber DEA does not allow this drug DEA Schedule – Flagged for Retrospective Review Value Limitation: Value definition sunsetted for use in Telecommunication | 8R | Submission Clarification Code Value Not Supported |

| Validation Step | | Processor Response if Step Not Met | | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|---|
| Edit Order (Suggested) | Scenario: If scenario met, follow rejects, SCCs and AMCs | Reject Code 511-FB | Reject Code Description | Appeal or MACRA (Secondary Reject Code: Not Stand-alone) | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| | | | | | | | | Version EB or greater. | | |
| 15 | Prescriber does not have Active State License | 777 | Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted | N/A | 52 | Prescriber's state license with prescriptive authority has been validated-Indicates the prescriber ID submitted is associated to a healthcare provider with the applicable state license that grants prescriptive authority. | 032 | Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted, flagged for retrospective review. | 8R | Submission Clarification Code Value Not Supported |
| 16 | Prescriber does not have Prescriptive | 876 | Prescriptive Authority Restrictions Apply, Criteria Not Met | N/A | 42 | Prescriber ID Submitted | 044 | Plan's Prescriber database | 8R | Submission Clarification Code Value |

| Validation Step | | Processor Response if Step Not Met | | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|---|
| Edit Order (Suggested) | Scenario: If scenario met, follow rejects, SCCs and AMCs | Reject Code 511-FB | Reject Code Description | Appeal or MACRA (Secondary Reject Code: Not Stand-alone) | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| | Authority in the State | | Comment: Used when state regulatory restrictions are imposed on specific prescriber types (e.g., mid-level practitioners such as pharmacists, nurse practitioners and physician assistants). Additional messaging should describe criteria not met. | | | is valid and prescribing requirements have been validated. Value Limitation: Value of 42 does not apply to prescriber enrollment status. | | determined prescriptive authority criteria not met, flagged for retrospective review. Value Limitation: To be returned when reject code 876 applied and SCC 42 was accepted. | | Not Supported |

Note: Reject Code (511-FB) value 829 may not be returned with Reject Code (511-FB) value 569 because it is not appealable.

829 = Pharmacy Must Notify Beneficiary: Claim Not Covered Due To Failure To Meet Medicare Part D Active, Valid Prescriber NPI Requirements.

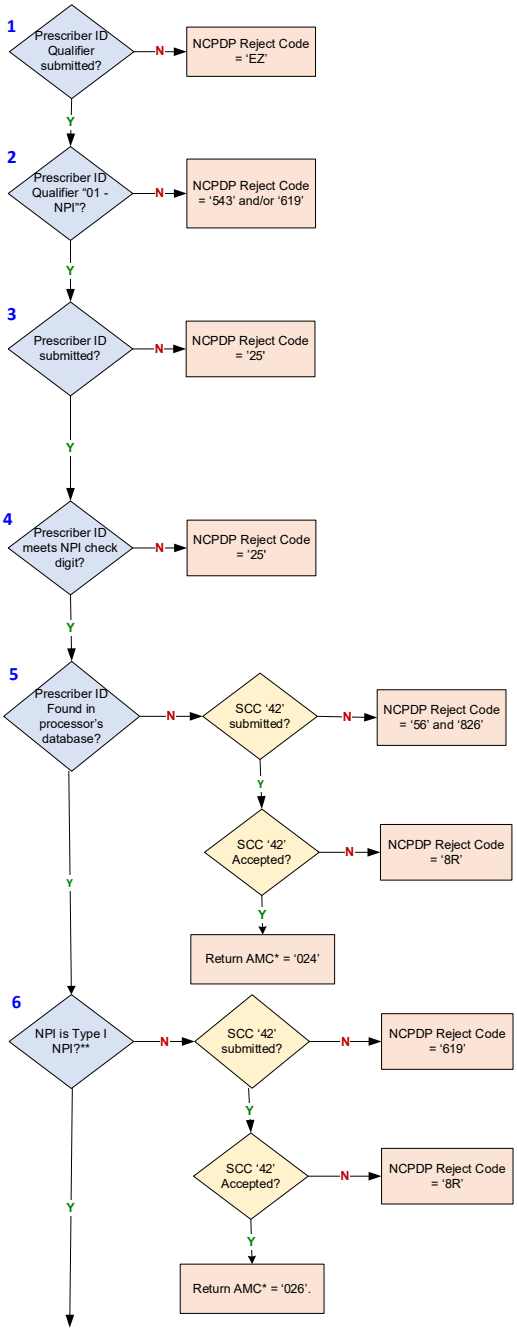
569 = Provide Notice: Medicare Prescription Drug Coverage and Your Rights

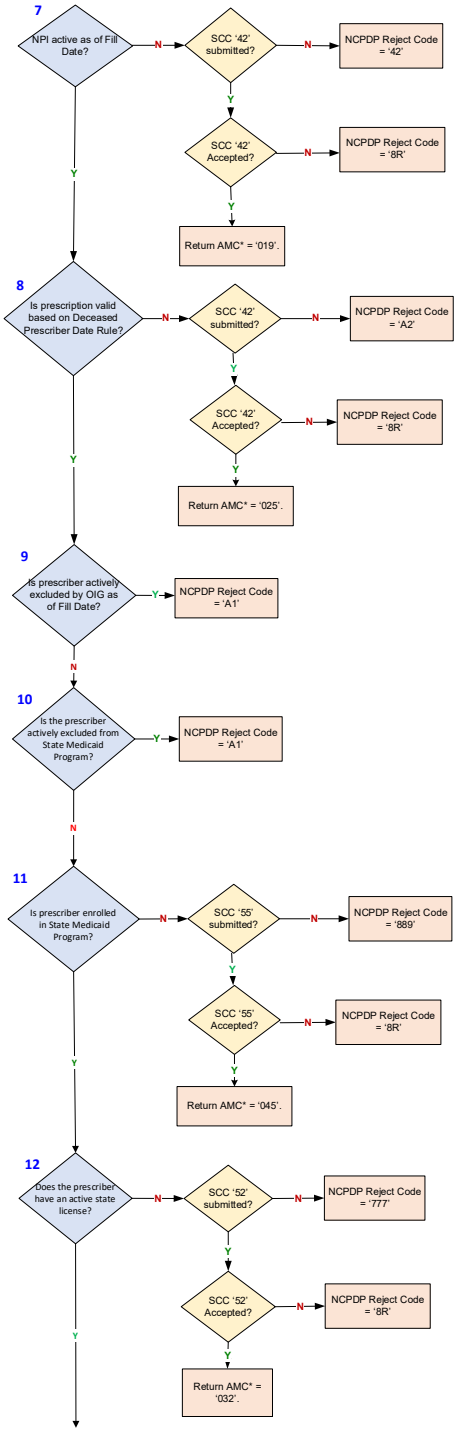
*Processor/PBM may reject transaction for other reasons such as formulary restrictions, safety edits (DUR), etc. post prescriber validation. So long as no other rejections occur, a paid transaction should return specified AMC.

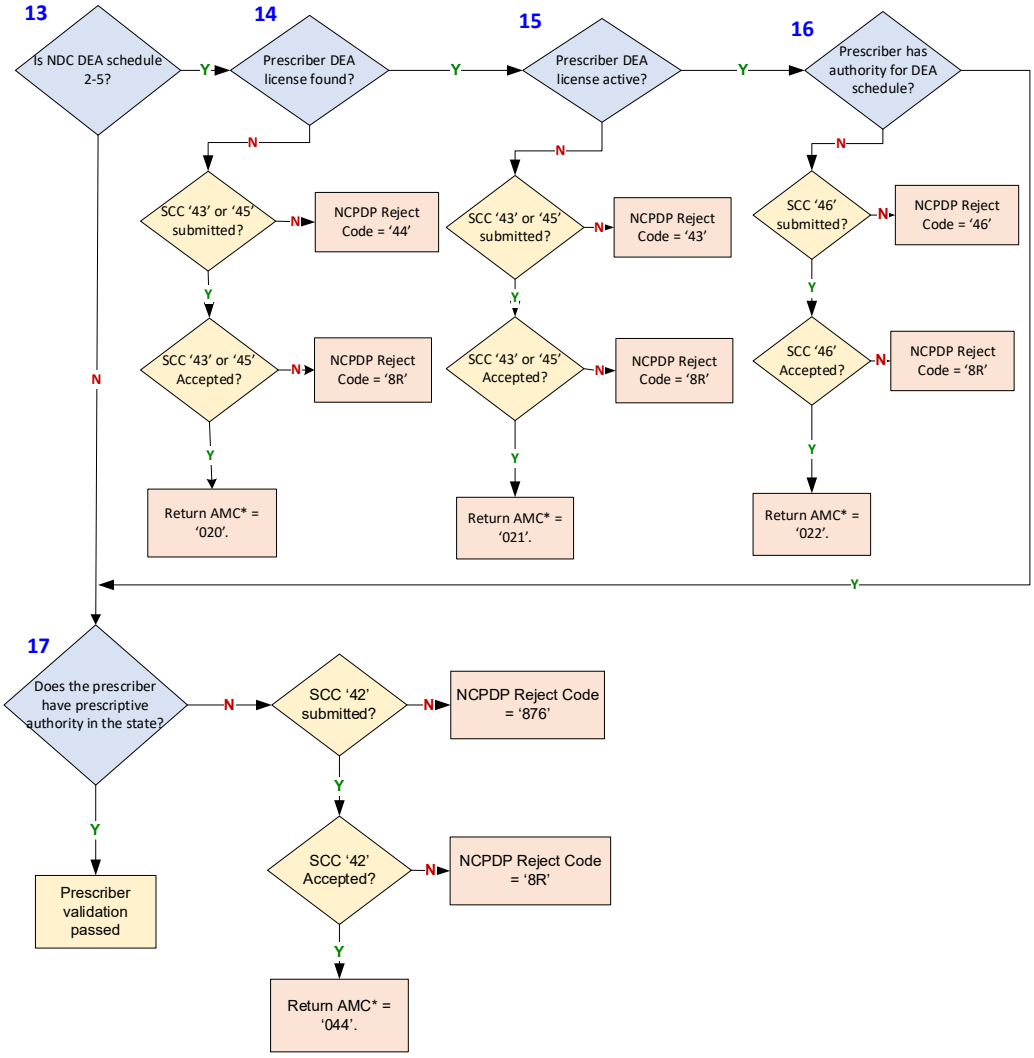
The processor cannot validate prescriber authority if the NPI is not on file in the processor's system. Prescriber validation will cease after pharmacy verification as indicated with a Submission Clarification Code and acceptance by the processor as indicated with an Approved Message Code. Retrospective review may occur by the processor.

# 24.9 MEDICAID PRESCRIBER VALIDATION FLOW

**Medicaid Part D Point of Sale (POS) Prescriber Validation Flow**




7
NPI active as of Fill Date?
N
SCC '42' submitted?
N
NCPDP Reject Code = '42'
Y
SCC '42' Accepted?
N
NCPDP Reject Code = '8R'
Y
Return AMC* = '019'.
Y
8
Is prescription valid based on Deceased Prescriber Date Rule?
N
SCC '42' submitted?
N
NCPDP Reject Code = 'A2'
Y
SCC '42' Accepted?
N
NCPDP Reject Code = '8R'
Y
Return AMC* = '025'.
Y
9
Is prescriber actively excluded by OIG as of Fill Date?
Y
NCPDP Reject Code = 'A1'
N
10
Is the prescriber actively excluded from State Medicaid Program?
Y
NCPDP Reject Code = 'A1'
N
11
Is prescriber enrolled in State Medicaid Program?
N
SCC '55' submitted?
N
NCPDP Reject Code = '889'
Y
SCC '55' Accepted?
N
NCPDP Reject Code = '8R'
Y
Return AMC* = '045'.
Y
12
Does the prescriber have an active state license?
N
SCC '52' submitted?
N
NCPDP Reject Code = '777'
Y
SCC '52' Accepted?
N
NCPDP Reject Code = '8R'
Y
Return AMC* = '032'.
Y




*Processor/PBM may reject transaction for other reasons such as formulary restrictions, safety edits (DUR), etc. post prescriber validation. So long as no other rejections occur, a paid transaction should return specified AMC.

The processor cannot validate prescriber authority if the NPI is not on file in the processor's system. Prescriber validation will cease after pharmacy verification as indicated with a Submission Clarification Code and acceptance by the processor as indicated with an Approved Message Code. Retrospective review may occur by the processor.

**Industry feedback indicates Medicaid claims processing is usually limited to Type 1 NPI prescriber ID only. Other Prescriber ID Qualifier (466-EZ) may be accepted based on trading partner agreement.

*Added February 2025*

## 24.10 MEDICAID PRESCRIBER VALIDATION REJECT MATRIX

The matrix below provides the steps and recommended edit order to validate the various prescriber aspects when processing Medicaid claims. The matrix is based on the current state of the industry as of Winter 2025.

| Validation Step Edit Order (Suggested) | Scenario– If scenario met, follow rejects, SCCs and AMCs | Processor Response if Step Not Met | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|
| | | Reject Code 511-FB | Reject Code Description | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| 1 | Prescriber ID Qualifier (466-EZ) is not Submitted | EZ | M/I Prescriber ID Qualifier | N/A | N/A | N/A | N/A | N/A | N/A |
| 2 | Prescriber ID Qualifier (466-EZ) is not ”01 – NPI” | 543 and/or 619 | Prescriber ID Qualifier Value Not Supported Prescriber Type 1 NPI Required | N/A | N/A | N/A | N/A | N/A | N/A |
| 3 | Prescriber ID (411-DB) is not Submitted | 25 | M/I Prescriber ID | N/A | N/A | N/A | N/A | N/A | N/A |
| 4 | Prescriber ID (411-DB) does not meet Prescriber ID Meets NPI Check Digit | 25 | M/I Prescriber ID | N/A | N/A | N/A | N/A | N/A | N/A |
| 5 | Prescriber ID is not Found in Processor's Database | 56 or | Non-Matched Prescriber ID | 42 | Prescriber ID Submitted is valid and prescribing requirements have been validated. Value Limitation: Value of 42 does | 024 | The submitted Prescriber ID is Not Found – Flagged for Retrospective Review | 8R | Submission Clarification Code Value Not Supported |

| Validation Step Edit Order (Suggested) | Scenario– If scenario met, follow rejects, SCCs and AMCs | Processor Response if Step Not Met | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|
| | | Reject Code 511-FB | Reject Code Description | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| | | 826 | Prescriber NPI Submitted Not Found Within Processor's NPI File | | not apply to prescriber enrollment status. Additional Guidance: SCC 42 does not indicate the pharmacy validated prescriber enrollment in Medicaid. | | | | |
| 6 | NPI is not Type 1 NPI** | 619 | Prescriber Type 1 NPI Required | 42 | Prescriber ID Submitted is valid and prescribing requirements have been validated Value Limitation: Value of 42 does not apply to prescriber enrollment status. | 026 | Prescriber Type 1 NPI Required - Flagged for Retrospective Review | 8R | Submission Clarification Code Value Not Supported |
| 7 | NPI is not Active as of Fill Date | 42 | Plan's Prescriber Database Indicates The Prescriber ID Submitted Is Inactive Or Expired | 42 | Prescriber ID Submitted is valid and prescribing requirements have been validated Additional Guidance: SCC 42 does not indicate the pharmacy validated prescriber enrollment in Medicaid. | 019 | The Submitted Prescriber ID is inactive or expired - Flagged for Retrospective Review. *The claim paid; however, the combination of Prescriber ID Qualifier (466-EZ) and Prescriber ID (411-DB) provided on the transaction was inactive or expired in the processor's system.* | 8R | Submission Clarification Code Value Not Supported |

| Validation Step Edit Order (Suggested) | Scenario– If scenario met, follow rejects, SCCs and AMCs | Processor Response if Step Not Met | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|
| | | Reject Code 511-FB | Reject Code Description | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| 8 | Prescription is not Valid Based on Deceased Prescriber Date Rule | A2 | ID Submitted Is Associated To A Deceased Prescriber | 42 | Prescriber ID Submitted is valid and prescribing requirements have been validated Additional Guidance: SCC 42 does not indicate the pharmacy validated prescriber enrollment in Medicaid. | 025 | The submitted Prescriber ID is associated to a Deceased Prescriber - Flagged for Retrospective Review. | 8R | Submission Clarification Code Value Not Supported |
| 9 | Prescriber ID is not Actively Excluded by OIG as of Fill Date | A1 | ID Submitted Is Associated With An Excluded Prescriber | N/A | N/A | N/A | N/A | N/A | N/A |
| 10 | Prescriber is not Actively Excluded from State Medicaid Program | A1 | ID Submitted Is Associated With An Excluded Prescriber | N/A | N/A | N/A | N/A | N/A | N/A |
| 11 | Prescriber is not Enrolled in State Medicaid Program | 889 | Prescriber Not Enrolled in State Medicaid Program | 55 | Prescriber Enrollment in State Medicaid Program has been validated. | 045 | Prescriber active enrollment with Medicaid Fee For Service/MCO required. Flagged for retrospective review. Value Limitation: Value returned only if Submission Clarification Code 55 (Prescriber Enrollment in State Medicaid Program has been validated) was accepted. | 8R | Submission Clarification Code Value Not Supported |

| Validation Step Edit Order (Suggested) | Scenario– If scenario met, follow rejects, SCCs and AMCs | Processor Response if Step Not Met | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|
| | | Reject Code 511-FB | Reject Code Description | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| 12 | Prescriber does not have Active State License | 777 | Plan's Prescriber Database Not Able to Verify Active State License With Prescriptive Authority For Prescriber ID Submitted | 52 | Prescriber's state license with prescriptive authority has been validated. *Indicates the prescriber ID submitted is associated to a healthcare provider with the applicable state license that grants prescriptive authority.* | 032 | Plan's Prescriber database not able to verify active state licenses with prescriptive authority for Prescriber ID Submitted, flagged for retrospective review. | 8R | Submission Clarification Code Value Not Supported |
| 13 | Is NDC DEA Schedule 2 – 5?<br>If yes, continue to step 14.<br>If no, continue to step 17. | | | | | | | | |
| 14 | Prescriber DEA License is not Found | 44 | Plan's Prescriber Database Indicates The Prescriber DEA Number Is Not Found | 43<br><br>45 | Prescriber's DEA is active with DEA Authorized Prescriptive Right.<br><br>Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule. | 020 | Prescriber DEA number is not found in processor's system. Paid claim flagged for retrospective review.<br>Value Limitation: Used in Telecommunication Standard Version EB© or greater but not in lower versions. | 8R | Submission Clarification Code Value Not Supported |

| Validation Step Edit Order (Suggested) | Scenario– If scenario met, follow rejects, SCCs and AMCs | Processor Response if Step Not Met | | Pharmacy Response to Processor Reject | | Processor Returns Value if SCC Accepted | | Processor Returns Value if SCC Rejected | |
|---|---|---|---|---|---|---|---|---|---|
| | | Reject Code 511-FB | Reject Code Description | SCC 420-DK | SCC Description | AMC* 548-6F | AMC Description | Reject Code 511-FB | Reject Code Description |
| 15 | Prescriber DEA License is not Active | 43 | Plan's Prescriber Database Indicates The Prescriber DEA Number Is Inactive or Expired | 43<br><br>45 | Prescriber's DEA is active with DEA Authorized Prescriptive Right.<br><br>Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule. | 021 | Prescriber DEA number in the processor's system is inactive/expired. Paid claim flagged for retrospective review.<br>Value Limitation: Used in Telecommunication Standard Version EB© or greater but not in lower versions. | 8R | Submission Clarification Code Value Not Supported |
| 16 | Prescriptive Authority not met for DEA Schedule | 46 | Plan's Prescriber Database Indicates The Prescriber DEA Number Does Not Allow This Drug DEA Class | 46 | Prescriber's DEA has prescriptive authority for this drug DEA Schedule | 022 | Prescriber DEA number in the processor's system does not allow for this drug DEA schedule. Paid claim flagged for retrospective review.<br>Value Limitation: Used in Telecommunication Standard Version EB© or greater but not in lower versions. | 8R | Submission Clarification Code Value Not Supported |
| 17 | Prescriber does not have Prescriptive Authority in the State | 876 | Prescriptive Authority Restrictions Apply, Criteria Not Met | 42 | Prescriber ID Submitted is valid and prescribing requirements have been validated.<br>Additional Guidance: SCC 42 does not indicate | 044 | Plan's Prescriber database determined prescriptive authority criteria not met, flagged for retrospective review. | 8R | Submission Clarification Code Value Not Supported |

| Validation Step Edit Order (Suggested) | Scenario– If scenario met, follow rejects, SCCs and AMCs | Processor Response if Step Not Met<br>Reject Code 511-FB | Reject Code Description | Pharmacy Response to Processor Reject<br>SCC 420-DK | SCC Description | Processor Returns Value if SCC Accepted<br>AMC* 548-6F | AMC Description | Processor Returns Value if SCC Rejected<br>Reject Code 511-FB | Reject Code Description |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | the pharmacy validated prescriber enrollment in Medicaid. | | Value Limitation: To be returned when reject code 876 applied and SCC 42 was accepted. | | |

*Processor/PBM may reject transaction for other reasons such as formulary restrictions, safety edits (DUR), etc. post prescriber validation. So long as no other rejections occur, a paid transaction should return the specified AMC. The processor cannot validate prescriber authority if the NPI is not on file in the processor's system. Prescriber validation will cease after pharmacy verification as indicated with a Submission Clarification Code and acceptance by the processor as indicated with an Approved Message Code. Retrospective review may occur by the processor.

**Industry feedback indicates Medicaid claims processing is usually limited to Type 1 NPI prescriber ID only. Other Prescriber ID Qualifier (466-EZ) may be accepted based on trading partner agreement.

Updated March 2026

# 25 APPENDIX G. SUPPORT OF THIS DOCUMENT

As of February 2014, when the Version D Editorial is published, it is effective for use *immediately unless the specific section or response lists an effective date*.

For NCPDP task groups that bring forward recommendations to this document, the task group is asked to determine if there is a specific effective date for implementation of the question or guidance. If there is no specific effective date, the next publication date of the Version D Editorial is the effective date. (This has been the default.) On occasion there has been an effective date included (e.g. regulation requirements, Medicare Part D implementation timing, etc.).

The submitter of the question may supply a possible effective date. An effective date might be determined if entities might have to change existing processing and need some lead time. The task group(s) or the work group(s) reviewing the question may override the submitter to modify the date, suggest a date is none is given, or remove the date. For items that are just general questions, clarifications, effective date can be not applicable. We don't want the effective date discussion to be cumbersome for each question.

Section "*Appendix A. Modifications to This Document*" beginning with version 25 will include a table to designate any items in that publication that were approved with an effective date. For example only:

| Section/Topic | Effective Date: January 1, 2015 |
|---|---|


© National Council for Prescription Drug Programs, Inc.
Copyrighted Materials - See Copyright Statement for Allowed Use