

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 827	Date: December 23, 2010
	Change Request 7255

SUBJECT: Medicare Fee-For-Service (FFS) National Council for Prescription Drug Programs (NCPDP) Version D.0 Companion Guide

I. SUMMARY OF CHANGES: The purpose of this change request is to instruct the Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC)s, Common Electronic Data Interchange (CEDI) contractor in populating and posting a Medicare FFS Companion guide for NCPDP Version D.0.

EFFECTIVE DATE: January 25, 2011

IMPLEMENTATION DATE: January 25, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

N/A

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENT:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 827	Date: December 23, 2010	Change Request: 7255
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SUBJECT: Medicare Fee-For-Service (FFS) National Council for Prescription Drug Programs (NCPDP) Version D.0 Companion Guide

Effective Date: January 25, 2011

Implementation Date: January 25, 2011

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing the next version of the Health Insurance Portability and Accountability Act (HIPAA) transactions. The Secretary of the Department of Health and Human Services (DHHS) has adopted Accredited Standards Committee (ASC) X12 Version 5010 and the NCPDP Version D.0 as the next HIPAA transaction standards for covered entities to exchange HIPAA transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

Effective Date of the regulation:	March 17, 2009
Level I compliance by:	December 31, 2010
Level II compliance by:	December 31, 2011
All covered entities have to be fully compliant on:	January 1, 2012

Level I compliance means “that a covered entity can demonstrate that it could create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing.”

Level II compliance means “that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards.”

The DHHS has promulgated in the Final Rules provisions which permit dual use of existing standards (ASC X12 4010A1 and NCPDP 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date until the January 1, 2012, compliance date to facilitate testing subject to trading partner agreement.

The purpose of this change request is to instruct the Durable Medical Equipment Medicare Administrative Contractor (MAC)s, Common Electronic Data Interchange contractor in populating and posting a Medicare FFS Companion guide for NCPDP Version D.0. The CMS is issuing a newly formatted Companion Guide for the new version to come into alignment with industry standards. The format of Medicare’s new companion guide will utilize a standard template and provide consistent language applicable across all MAC jurisdictions, while allowing organization specific information to be included within a common structure.

Estimates for this CR should include a breakdown as part of the Level of Effort (LOE) response, utilizing the following table to be included in the “Estimate-Specific Comments” portion of the LOE template, to follow the Investment Lifecycle Phases.

Investment Lifecycle Phase	Total Hours	Total Cost
*Pre-Implementation/CR Review		
Design & Engineering Phase		
Development Phase		

Testing Phase		
Implementation Phase		

NOTE: The Pre-Implementation/CR Review costs will not be funded under the unique funding situation for the 5010/D.0 project, but instead out of the MAC’s pot of hours for Pre-Implementation/CR Review.

B. Policy: The CMS will implement the new HIPAA standard as adopted by the Secretary. Final Rules were published in the Federal Register on January 16, 2009, by the DHHS: 45 CFR Part 162.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an “X” in each applicable column)										
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H I I E R	Shared-System Maintainers				OTH ER	
							F I S S	M C S	V M S	C W F		
7255.1	Contractors shall, review and provide feedback on the attached NCPDP Version D.0 companion guide.											CEDI
7255.2	Contractors shall post the attached NCPDP Version D.0 companion guide document to their Medicare Web sites.											CEDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an “X” in each applicable column)										
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H I I E R	Shared-System Maintainers				OTH ER	
							F I S S	M C S	V M S	C W F		
	None.											

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: for all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jason Jackson (410) 786-6156; Jason.Jackson3@cms.hhs.gov
Amisha Pandya (410) 786-0690; Amisha.Pandya@cms.hhs.gov

Post-Implementation Contact(s): Jason Jackson (410) 786-6156; Jason.Jackson3@cms.hhs.gov
Amisha Pandya (410) 786-0690; Amisha.Pandya@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*:

N/A

Section B: For *Medicare Administrative Contractors (MACs)*, include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment (1)

National Government Services, Inc.
Common Electronic Data Interchange

Companion Guide
Communications/Connectivity Information

Instructions related to Transactions based on
NCPDP Telecommunication Standard Version D.0
NCPDP Batch Standard Version 1.2

Companion Guide Version Number: 1.0
[Date]

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated National Council for Prescription Drug Program (NCPDP) version D.0. Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by NCPDP's copyrights and Fair Use statement.

Communications/Connectivity Information (CCI)

1. Communications/Connectivity Introduction

1.1 Scope

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes provisions for administrative simplification that directs the federal government to adopt national standards for automated transfer of certain health care data between health care payers, plans, providers, and clearinghouses. The initial final rule was published August 17, 2000, became effective October 16, 2000 and was fully implemented October 16, 2003.

The Health Insurance Portability and Accountability Act commissioned the use of the National Council for Prescription Drug Programs (NCPDP) format for retail pharmacies that transmit retail drug claims electronically. The Modifications Final Rule later mandated a change to the NCPDP version to be used by retail pharmacies as the HIPAA standard. Retail pharmacies must use the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Version D.0 and Batch Standard Version 1.2 by January 1, 2012.

In addition, on October 13, 2010 an announcement of maintenance changes was published in the Federal Register notifying of correction information referenced in the NCPDP Version D Editorial Document. The corrections are included in the Telecommunication D.0 guide dated August 2010.

The NCPDP standard will be accepted for DME MAC retail pharmacy drug claims only. DME MAC claims for supplies and services must be billed using version 5010 of the ANSI X12 837 and must be submitted in a separate transmission from the NCPDP retail drug claims.

The NCPDP Batch Standard Implementation Guide (IG) version 1.2, Telecommunication Standard Implementation Guide (IG) version D.0, External Code List (ECL) and Data Dictionary are available for NCPDP members to download from the NCPDP website (www.ncdp.org). The NCPDP Version D Editorial Document is freely available at http://www.ncdp.org/public_documents.aspx?vDed.

1.2 Overview

This Companion Guide includes information needed to commence and maintain communication exchange with Medicare. In addition, this Companion Guide has been written to assist you in designing and implementing transaction standards to meet Medicare's processing standards. This information is organized in the sections listed below:

- **Getting Started:** This section includes information related to system operating hours, provider data services, and audit procedures. Information concerning Trading Partner registration and the Trading Partner testing process is also included in this section.

- Implementation and Transaction Testing: This section includes detailed transaction testing information as well as certification requirements needed to complete transaction testing with Medicare.
- Connectivity with the Payer / Communications: This section includes information on Medicare's transmission procedures as well as communication and security protocols.
- Contact Information: This section includes EDI customer service, EDI technical assistance, provider services and applicable web sites.
- Control Segments/Envelopes: Details of the Medicare usage of the NCPDP D.0 records.
- Acknowledgments and Reports: This section contains information on the TRN Acknowledgement and the NCPDP Transmission Response Report showing accepted and rejected files and/or claims for all transaction acknowledgments sent by Medicare and report inventory.
- CCI Additional Information: This section contains information related to implementation checklist, transmission examples, Trading Partner Agreements and other resources.
- Medicare NCPDP Version D.0 Payer Sheet:

1.3 References and Additional Information

The following Web sites provide additional documentation necessary for exchanging NCPDP claim transactions with CEDI.

NCPDP information including purchase of the NCPDP guides:

www.ncpdp.org

NCPDP 5.1 to D.0 Side by Side Comparison:

<http://www.cms.gov/MFFS5010D0/Downloads/NCPDP51toD0.pdf>

CMS Web page for X12 version 5010 and NCPDP version D.0:

<http://www.cms.gov/MFFS5010D0/>

CEDI website:

www.ngscedi.com

2. Getting Started

2.1 Working Together

NGS must conduct an analysis of the capability of each supplier, billing agent or clearinghouse who contacts CEDI to begin the exchange of DME electronic transactions including claims, electronic remittance advice, and claim status inquiry/response. CEDI will assign an EDI submitter identification number (Trading Partner ID) to those approved to use CEDI.

Suppliers who will be using a third party (billing agent or clearinghouse) to exchange electronic transactions with CEDI are required to have an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and requirements that apply to the supplier in regard to viewing or use of Medicare beneficiary data. The supplier must also not share their personal EDI access number and password with any billing agent, clearinghouse, network service vendor, and/or to anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim; and that no other non-staff individuals or entities may be permitted to use a supplier's EDI number and password to access Medicare systems.

Third parties must obtain and use their own unique EDI access number and password from those Medicare contractors to whom they will send or from whom they will receive EDI transactions. A supplier must obtain an NPI and furnish that NPI to their Medicare contractor prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. A supplier's EDI number and password serve as a supplier's electronic signature and the supplier would be liable if any entity with which the supplier improperly shared the ID and password performed an illegal action while using that ID and password. A supplier's or Trading Partner's EDI access number and password are not part of the capital property of the supplier's or Trading Partner's operation. A new owner must obtain their own EDI access number and password. EDI transactions are to be presented as the normal mode of business for Medicare claims, claim status, and remittance. Where the provider does not have the related capability CEDI will inform the providers of available options to begin use of EDI, e.g., list of vendors, clearinghouses and billing services and availability of Medicare's free software.

2.2 Trading Partner and Supplier Enrollment

A CEDI Trading Partner is any entity (supplier, billing service, clearinghouse, or software vendor) that transmits electronic data to or receives electronic data from CEDI.

To enroll with CEDI to send NCPDP claims, complete the on-line enrollment forms located on the CEDI Web site, www.ngscedi.com.

- CMS EDI Enrollment Agreement Form: Used to enroll in electronic claim transmission.
- Supplier Submitter Action Request Form: Used to apply for a trading partner/submitter ID to log in and send claim files. This form is also used to indicate the type of transactions requested for the trading partner/submitter ID.
- Supplier Authorization Form: Used to authorize a third party biller or clearinghouse to send the electronic claims for the supplier.

CEDI enrollment documents are completed and submitted on-line. After completing any of the on-line forms, select the "Submit" button, which will generate a page to print, sign, date and fax to the number located on the printed form. All forms for the same request must be faxed under one coversheet.

Submitted enrollment forms will be issued Request ID (RID) numbers which will appear on the printed copy of the form. The RID number can be used to track the submitted form.

When CEDI forms are submitted, an acknowledgment email will be generated and sent back to the email address entered on the form. Once the request has been approved and processed, a setup confirmation will be sent via email. For security purposes, confirmation of enrollment requests for a new trading partner/submitter ID requiring a password will be sent in two emails. The trading partner/submitter ID and connectivity information will be included in the first email and the password will be sent in the second email.

Instructions on how to complete enrollment forms are included on the CEDI Web site.

2.3 Vendor Testing and Approval

NCPDP is the HIPAA approved format to submit DME MAC retail pharmacy drug claims. Each retail pharmacy that transmits retail drug claims electronically must use the NCPDP Batch Standard IG version 1.2 and Telecommunication Standard IG version D.0 beginning January 1, 2012. The NCPDP standard is accepted for retail pharmacy drug claims only. Claims for supplies and services must be billed using the ASC X12 837 claims format and must be submitted in a separate transmission from the NCPDP retail drug claims.

A pharmacy that elects to use a third party for translation services is liable for those costs.

Retail pharmacies, third party billers and software vendors not previously approved to submit NCPDP claims who are planning to exchange electronic retail pharmacy drug claims with Medicare must schedule testing with CEDI prior to transmission of their first actual retail drug claim file. There is no charge for this system testing.

Retail pharmacies and third parties, who elect to use a software vendor that has been approved for NCPDP by CEDI, are not required to test.

To begin testing NCPDP transactions with CEDI:

1. Test files for NCPDP should be submitted under the Test Vendor Login ID (begins with a V08). If you are not sure you have a Vendor Test ID, send an email to ngs.cedihelpdesk@wellpoint.com requesting the ID be sent to you. If it is discovered that you do not have a Vendor Test Login ID number, you will be asked to complete the Trading Partner Test ID Request form in order to obtain one.
2. You will be assigned a contact at CEDI who will work with you as you test the NCPDP transaction.
3. You will be asked to inform your testing contact when a test file is being submitted.
4. Test files cases should contain no more than 25 claims and contain real data.
5. All test claims will receive a Transmission Response indicating whether they have passed or rejected.
6. If test claims pass, the vendor will receive an email asking how they want their vendor information to appear on the Passed Entity list on the www.ngscedi.com website.
7. If test claims do not pass, the vendor will be asked to fix the errors and send another test file in until they have successfully passed testing.

2.3.1 Trading Partner Testing

Trading Partners do not need to test if they are using an approved software vendor.

Trading Partners may go to www.ngscedi.com, click on the Resource Materials link, then click on the Approved Entities List to see if their vendor has passed testing or to locate an approved vendor.

3. National Council for Prescription Drug Programs Implementation

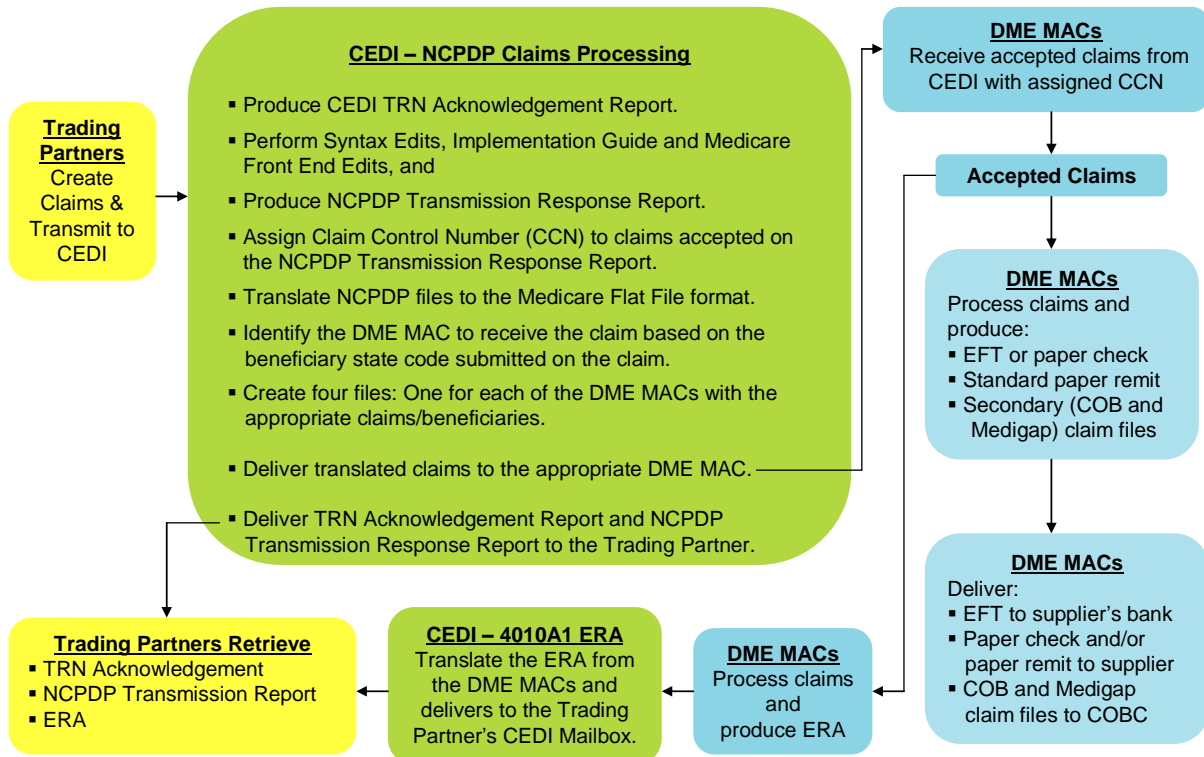
NCPDP is the HIPAA approved format to submit DME MAC retail pharmacy drug claims. Each retail pharmacy that transmits retail drug claims electronically must use the NCPDP Batch Standard IG version 1.2 in conjunction with Telecommunication Standard IG version D.0 – commonly referred to collectively as “NCPDP D.0”. The NCPDP standard will be accepted for retail pharmacy drug claims only. Claims for supplies and services must be billed using version 5010 of the ANSI ASC X12 837 claims format and must be submitted in a separate transmission from the NCPDP retail drug claims.

The NCPDP Batch Standard Implementation Guide (IG) version 1.2, Telecommunication Standard Implementation Guide (IG) version D.0, External Code List (ECL) and Data Dictionary are available for NCPDP members to download from the NCPDP website (www.ncdp.org). The NCPDP Version D Editorial Document is freely available at http://www.ncdp.org/public_documents.aspx#vDed).

4. Connectivity with the Payer / Communications

4.1 Process flows

CEDI NCPDP Version D.0 Claims Transactions



4.2 Transmission Administrative Procedures

[This section provides specific transmission procedures.]

This will be updated at a later time.

4.2.1 Re-transmission procedures

CEDI does not require any identification of a previous transmission of a claim. All claims sent should be marked as original transmissions.

4.3 Communication Protocols

All CEDI Trading Partners must use a Network Service Vendor (NSV) to connect to the CEDI Gateway to exchange electronic transactions. The NSV provides a secure, continuous connection for CEDI Trading Partners. The NSVs who provide connectivity to CEDI are listed on the CEDI website.

To receive additional information on the services provided from these network service vendors and pricing structures, please use the contact information provided on the CEDI Web site.

4.4 Security Protocols

Guidelines for Creating a “Good” Password

Most security breaches are a direct result of users selecting “bad” passwords. The selection of a “good” password is critical to ensuring the security and integrity of your health care information. A good password is one that is difficult for others to guess and yet is easily remembered by the user.

DO

The following basic guidelines should help when creating a password:

- Must be eight characters in length
- Must include both alphabetic and numeric characters in the password
- Must contain a special character; for example: ! \$ %
- Passwords are case sensitive
- Passwords will expire every sixty days

DON'T

- Do not use your user ID or any permutation of it as the password
- Do not use your company name, department name, or any permutation of it as a password
- Do not use your name or initials in any form
- Do not use family members or pets as part of the password
- Do not use swear words or obscene words; they're among the first words tried when guessing passwords
- Do not write down your password

- Do not use any form of date such as month, day, year, etc.

5. Contact information

5.1 CEDI CUSTOMER SERVICE AND TECHNICAL ASSISTANCE

For support of CEDI NCPDP claims submissions, contact the CEDI Help Desk at:

Phone: 866-311-9184

E-mail: ngs.cedihelpdesk@wellpoint.com

Information is also available on the CEDI Web site at: www.NGSCEDI.com.

5.2 DME MAC SUPPLIER SERVICE

DME MAC Jurisdiction Contact Information

Jurisdiction A – NHIC, Inc.

NHIC supports the following states: CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT

Customer Service: 866-590-6731

Automated Interactive Voice Response (IVR) System: 866-419-9458

Electronic Funds Transfer (EFT) Status Inquiries: 866-563-0049

Web site: www.medicarenhic.com

Jurisdiction B – National Government Services, Inc.

National Government Services supports the following states: IL, IN, KY, OH, MI, MN, and WI

Provider Contact Center: 866-590-6727

Automated IVR System: 877-299-7900

Web site: www.NGSMedicare.com

Jurisdiction C – Cigna Government Services

Cigna supports the following states: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, PR, SC, TN, TX, VA, VI, and WV

Customer Service: 866-270-4909

Automated IVR System: 866-238-9650

Web site: www.cignagovernmentservices.com

Jurisdiction D – Noridian Administrative Services

Noridian supports the following states: AK, AS, AZ, CA, GU, HI, ID, IA, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY

Supplier Contact Center: 866-243-7272

Automated IVR System: 877-320-0390

Web site: www.noridianmedicare.com

6. Control Segments / Envelopes

Details of the Medicare usage of the NCPDP D.0 records are covered under Section 8.2 Trading Partner Agreement.

7. Acknowledgements and Reports

CEDI will return the TRN Acknowledgement and the NCPDP Transmission Response Report showing accepted and rejected files and/or claims.

7.1 TRN ACKNOWLEDGMENTS

A TRN Transaction Acknowledgment will be generated as the first level of reporting to indicate the file received was either (1) in good enough form to be recognized as an NCPDP file and will be passed on to the next level of editing, or (2) not recognized as an NCPDP file and cannot be passed on to the next level of editing or (3) that the format/version being submitted is not valid for the trading partner submitting the file.

The TRN will mirror the TRNs generated for X12 CEDI claims where there is a heading indicating "Transaction Acknowledgment", as well as the Timestamp, File name, Trading Partner ID, file size, indication of whether file format was recognized, and indication that subsequent reports will follow (if applicable).

Report Name: The TRN report name begins with "Trn" followed by a sequence number (ex. Trn00424).

Timeframe: The TRN report is typically delivered immediately back to the Trading Partner. If the TRN is not received within two hours, contact the CEDI Help Desk at 1-866-311-9184

TRN Example:

Transaction Acknowledgement

Time Stamp = 20090724144037

File Name = NCPDP1.dat

Trading Partner Id = B08012345

Original File size = 7797

This message indicates the file was accepted at the TRN level editing.

No input validation problemssubsequent reports to follow***

1 envelope processed out of 1 identified

7.2 NCPDP TRANSMISSION RESPONSE REPORT

General Information

- The NCPDP Transmission Response is the second level of acknowledgment for NCPDP vD.0 claims and will be used to report acceptance or rejection of the batch file as well as acceptance or rejection of each individual claim within the batch. If the claim file submitted contains errors, the response file can denote up to 5 errors per claim -- based on all levels of editing. If the claims contain no errors at any level, the response file will denote the Medicare claim control number (CCN) and the DME MAC jurisdiction to which the claim will be distributed.
- **The Transmission Response is a codified electronic response file – unlike the reports generated for version 5.1. The vendor who maintains your NCPDP claim billing software will need to be engaged to ensure these response files will be understandable to the end user in your billing office.**
- Multiple claim batches cannot be sent within the same physical file. In the event that multiple claim batches are received within the same physical file, only one Transmission Response file will be returned notating the error “Multi Batches Not Allowed”.

Report Name: The NCPDP Transmission Response file name begins with “RESP” followed by the input file name and a sequence number

Example: Input File Name: NCPDP1

Report Name: RESP.NCPDP1.0025.

Timeframe: The NCPDP Transmission Response is typically delivered immediately back to the Trading Partner. If the NCPDP Transmission Response is not received within two hours, contact the CEDI Help Desk at 1-866-311-9184.

Matching the Transmission Response File to Original Input

The 806-5C batch number from the batch header record on the originally submitted file will be returned back on the Transmission Response in the 806-5C field in the batch header record. Consequently, the 880-K5 Transaction Reference Number from each batch detail (G1) record will be returned back on the Transmission Response in the 880-K5 field in the batch detail (G1) record.

Understanding the Transmission Response

- There can be various ‘views’ of the Transmission Response generated based on the original claim reporting scenario. Consequently, based on the NCPDP standard, there are multiple fields within the response which will denote the acceptance or rejection at various levels within the transaction. However, Medicare has also incorporated use of the 504-F4

Response Message field in an effort to clearly denote the overall designation for each claim. The following exhibits are intended to portray the varying “views” response statuses within each level of the response file.

All Claims Accepted Example:

The following is the NCPDP Transmission Response for a batch of four claims where all claims are accepted. Each claim will have an AM20 segment with the “F4” field tag followed by acronym “CCN”, followed by the DME MAC destination payer, followed by the actual Claim Control Number (CCN).

```
00R16003      2118000201007161657T12TP00001
G1111111111D0B11A011234567893
20100405  AM20  F4CCN16003YYJJBBBBSS000  AM25  C211111111A  AM29  CA
JOHNTEST CBSMITHLAST C419400523  AM21  ANC  7F01  8F8663119184  AM22
EM1  D2102737  G1222222222D0B11A011234567893
20100405  AM20  F4CCN17003YYJJBBBBSS000  AM25  C211111111A  AM29  CA
JANETEST CBDOELAST C419410624  AM21  ANC  7F01  8F8663119184  AM22
EM1  D2102737  G1333333333D0B11A011234567893
20100405  AM20  F4CCN18003YYJJBBBBSS000  AM25  C211111111A  AM29  CA
JOEYTEST CBJONESLAST C419420725  AM21  ANC  7F01  8F8663119184  AM22
EM1  D2102737  G1444444444D0B11A011234567893
20100405  AM20  F4CCN19003YYJJBBBBSS000  AM25  C211111111A  AM29  CA
JADETEST CBMILLERLAST C419430826  AM21  ANC  7F01  8F8663119184  AM2
2  EM1  D2102737
9921180000000000006
```

Claims Rejected Example

The following is the NCPDP Transmission Response for a batch containing two claims -- where both claims were rejected. The "FA" field in the AM21 segment will reflect the number of reasons for rejection. The "FB" field will reflect the reject code (reason for rejection). There can be up to five reject codes on the response.

Refer to Appendix A of the NCPDP ECL for a listing of the reject codes.

With this example, the first claim has no errors at the "transmission level" (i.e. claim level), however, there are two errors at the "transaction level" (i.e. line item level). Therefore, although the 501-F1 Header Response Status = "A", the entire claim is being rejected by Medicare as denoted by the "CLAIM REJECTED" reference in the AM20 504-F4 Message field. The second claim contains errors at both "transmission" (i.e. claim) and "transaction" (i.e. line) levels; therefore, the 501-F1 Header Response Status = "R" as well as the message "CLAIM REJECTED" in the AM20 504-F4 Message field.

```

00R16003          1001000201007161657T12TP00001
  G1222222222D0B11A011234567893  20090415  AM20  F4CLAIM
REJECTED  AM25  C2111111111A  AM29  CAJOHNFIRST  CBSMITHLAST  C419400
527  AM21  ANR  FA01  FBE3  7F01  8F8663119184  AM22  EM1  D2102737  G1
2222222222D0B11R011234567893  20090415  AM20  F4CLAIM
REJECTED  AM21  ANR  FA02  FBK5  FBE3  7F01  8F8663119184
9910010000000000004
    
```

Rejected Batch Example

When an entire batch of claims is being rejected due to batch level errors, the 880-K6 Transmission Type in the Response Batch Header will = "E" (Error), and the Batch Trailer record will contain a readable message in field 504-F4 denoting the reason for rejection.

```

00E16003          2120000201007170915T12TP00001
99212000000000000041-DUPLICATE FILE
    
```

CCI Additional Information

8.1 IMPLEMENTATION CHECKLIST

Steps for going live with CEDI - pulled from the Companion document – it will need to be updated as we gain more knowledge.

8.2 TRADING PARTNER AGREEMENT

This trading partner agreement (TPA) is specific to processing of the inbound NCPDP claims transaction in the National Government Services CEDI processing system. The TPA provides additional documentation solely for the purpose of clarification. The TPA gives information to the Trading Partner that will simplify implementation and provide a successful submission and acceptance of the inbound claims transmission.

EDI Trading Partner Agreements ensure the integrity of the electronic transaction process. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes provisions for administrative simplification that directs the federal government to adopt national standards for automated transfer of certain health care data between health care payers, plans, providers, and clearinghouses. The final rule was published August 17, 2000, became effective October 16, 2000 and was fully implemented October 16, 2003.

Each retail pharmacy that transmits retail drug claims electronically must use the National Council for Prescription Drug Programs (NCPDP) Telecommunication standard Version D.0 and Batch Standard Version 1.2 by January 1, 2012. The NCPDP standard will be accepted for DME MAC retail pharmacy drug claims only. DME MAC claims for supplies and services must be billed using version 5010 of the ANSI X12 837 claims format and must be submitted in a separate transmission from the NCPDP retail drug claims.

The NCPDP Batch Standards IG, Telecommunication Standard IG, External Code List (ECL), and Data Dictionary can be obtained at www.ncpdp.org for a fee.

This document includes references to fields/values based on the June 2010 version of the ECL. ECL updates will be monitored quarterly by CEDI. System changes will be made as deemed necessary based on the quarterly reviews. Consequently, changes to this document will take place in conjunction with any future changes being made by Medicare to accommodate modifications to the ECL.

Note: Nonretail pharmacies are to bill using the ANSI X12 837 5010.

CEDI will generate a local “TRN” and NCPDP Standard Transmission Response file to acknowledge all retail pharmacy claim bills submitted in NCPDP version D.0. Refer to the *CEDI NCPDP Front-End Manual* -- available on the CEDI Web site (www.NGSCEDI.com) for detailed information.

National Drug Code

Pharmacies are required to transmit the national drug code (NDC) in the NCPDP standard for identification of prescription drugs dispensed through a retail pharmacy. The NDC replaces the Healthcare Common Procedure Coding System (HCPCS) codes for retail pharmacy drug transactions billed to DME MACs via the NCPDP standard.

Note: DME MACs must accept NDC codes for oral anti-cancer drugs billed electronically and via paper. All other paper and electronic 837 claims are to be billed using HCPCS.

General Requirements

1. This guide was created to provide the CEDI and DME MAC specific requirements to suppliers and Trading Partners for creating an incoming NCPDP D.0 file. This document contains DME MAC valid values for elements and lists only the segments and elements which apply to a DME MAC claim.
2. Suppliers will create the Billing Request transaction (value "B1" in field 103-A3 of the Transaction Header segment) as required in the NCPDP standard and as clarified within this document.
3. Only segments and fields that are "Mandatory" (M) in the standard, or shown as "Required" (R) or "Situational" (S) should be sent. If a Segment or Field is marked as "Situational", it is only sent if the data condition stated applies. If a data condition is not met, it need not be submitted for Medicare claim bills. If a claim is to be sent to another payer by Medicare for secondary payment, and a situational field applies to the secondary payer, it should be included in the claim sent to Medicare even if the situation does not apply to Medicare. Any other optional fields not listed in this document can also be included on the claim for purposes of forwarding that data onto the subsequent payer.
4. Fields designated as Not Used for the D.0 Telecommunication Standard, B1 Claim Billing transaction will be 'ignored' and not sent forward to secondary payers.
5. Medicare will only accept and process Batch Transactions using the NCPDP Batch Standard version 1.2 with the Telecommunication Standard version D.0. The Batch Standard is a file transmission of one header, one or more detail records, and one trailer (multiple batches within one physical file will be rejected). The detail records are built using the Telecommunication Standard version D.0, where one detail record is submitted for each claim transaction.
6. Medicare will only accept and process Billing Transactions (value B1 in the Transaction Header Segment, Transaction Code field 103-A3) with the Rx Billing indicator "1" in the Prescription/Service Reference Number Qualifier field 455-EM.
7. The following segments are required for Medicare processing:
 - Patient Segment (AM01)

- Insurance Segment (AM04)
 - Prescriber Segment (AM03)
 - Claim Segment (AM07)
 - Pricing Segment (AM11)
 - Clinical Segment (AM13)
8. Suppliers may submit up to four detail record transactions (i.e. AM07 Claim Segments) per detail record transmission except for compound billings. Only one detail record transaction (i.e. one AM07 Claim Segment) per detail record transmission is allowed when billing for a multi-ingredient prescription.
 9. The Facility Segment (AM15) must be submitted when the Place of Service field 307-C7 is not = 12 (home).
 10. The Coordination of Benefits/Other Payments Segment (AM05) and the Compound Segment (AM10) are to be used for Medicare only when those reporting scenarios apply to the claim.
 11. The Additional Documentation segment (AM14) must not be submitted as there are no CMN forms that apply to NCPDP claims. If submitted, the segment and associated fields will be subjected to IG level editing in addition to being rejected for submission.
 12. The Pharmacy Provider (AM02), Worker's Comp (AM06), Coupon (AM09), and Narrative (AM16) segments may be reported as deemed necessary by the submitter. If submitted, these segments and associated fields will be subjected to IG level editing.
 13. Data elements defined by a qualifier must contain valid and appropriate information for that qualifier.
 14. Delimiters must be used to distinguish and separate data elements and segments as specified in the NCPDP standard.
 15. The transaction must adhere to the standard conventions as stated in Section 33 of the NCPDP Telecommunication Standard Implementation Guide version D.0.
 16. As per the Telecommunication standard IG, lower case characters are not allowed.
 17. Zip codes must not include hyphens and positions 6 through 9 must not be all zeros.
 18. Medicare will only process a format of 9(5)V99 for monetary fields rather than the maximum format of 9(7)V99 as specified in the IG. A monetary amount of 9(7)V99 would far exceed Medicare coverage parameters. Medicare will reject monetary entries larger than 9(5)V99 as they are assumed to be data entry transcription or another manual error.

Note: Under HIPAA compliancy rules, plans are permitted to reject transactions that exceed coverage parameters, even if compliant with IG requirements.

Compound Drugs

Compounded drugs will be billed using the Compound Segment in the NCPDP standard. Compounded Prescription guidance includes:

1. The Route of Administration field (995-E2) will be used to distinguish the Nebulizer Drug compounds from other drug compounds and will indicate the route of the complete compound mixture. The valid Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT®) codes that Medicare will accept in this field are:
 - 112239003 – “By inhalation (route)” (i.e. Nebulizer Compounds)
 - 26643006 – “Oral route” (i.e. Immunosuppressive Compounds)
2. The sum of the Compound Ingredient Drug Cost field (449-EE) will equal the Gross Amount Due field (430-DU) minus the Dispensing Fee Submitted field (412-DC) and the Incentive Amount Submitted (438-E3).
3. Compounds for inhalation drugs should only be used for multiple active ingredients. For single active ingredients, use the claim segment.

Parenteral Nutrition Products

Parenteral nutrition claims must be billed on the ANSI X12 837 using HCPCS codes.

Enteral Nutrition Products

Enteral nutrition claims must be billed on the ANSI X12 837 using HCPCS codes.

End-Stage Renal Disease

ESRD drug claims must be billed on the ANSI X12 837 using HCPCS codes.

Epoetin

EPO claims associated with ESRD must be billed on the ANSI X12 837.

Non-ESRD EPO must be billed either on the NCPDP by retail pharmacists or on the ANSI X12 837 by professional pharmacists.

Home Infusion Products

Claims for home infusion products must be billed on the ANSI X12 837 using the HCPCS codes to identify the drug and related supply. Home infusion pharmacies are professional pharmacies and will not use the NCPDP format for submitting claims to Medicare.

Medigap

The following fields must be submitted in order to allow Medicare to determine that a beneficiary has Medigap coverage:

1. For coordination of benefits (COB) related to Medigap, the Patients Medigap Plan ID Number will be submitted in the Medigap ID field (359-2A) in the Insurance segment.
2. The Medigap Insurer ID (COBA number) will be submitted in the Group ID (301-C1) in the Insurance segment.

Note: Medigap takes priority when there is dual Medigap and Medicaid in a claim-based situation.

Medicaid

For Medicaid crossover claims, the Medicare beneficiary's Health Insurance Claim (HIC) number must be entered in the Cardholder ID field (302-C2) if the eligibility file received from Medicaid or the trading partner does not have a Medicaid Beneficiary ID in the Supplemental ID field. If there is a Medicaid Beneficiary ID number in the Supplemental ID field, the Medicaid Beneficiary ID number must be entered in the Cardholder ID field (302-C2).

In addition, the two character state code indicating where Medicaid coverage exists must be submitted in the Medicaid Indicator field (360-2B) in the Insurance segment.

Medicare Secondary Payer (MSP) Claims

When Medicare is the secondary payer (MSP), pharmacies must complete the following fields in order for Medicare to calculate the Other Payer Allowed and Obligated to Accept amounts:

1. The Original Submitted Amount will be sent in the Gross Amount Due (430-DU) on the Pricing segment;
2. The Other Payer Paid Amount Qualifier field 342-HC should be reported with qualifier value "07" (drug benefit) in conjunction with the associated amount in the Other Payer Paid Amount field 431-DV.
3. The Other Payer Responsibility Amount Qualifier field 351-NP should be reported with qualifier value "01" in conjunction with the associated amount in the Other Payer Responsibility Amount field 352-NQ to indicate deductible. To indicate coinsurance, field 351-NP should be reported with qualifier "07" in conjunction with the associated amount in 352-NQ.

Partial Fills

Medicare does not process the partial and completion billing for prescriptions as described in the NCPDP Telecommunication Standard Implementation Guide. The Dispensing Status

field 343-HD must not be used for Medicare claim bills. Instead, pharmacies must submit the Actual Quantity Dispensed in element 442-E7 regardless of whether the prescription is designated within the pharmacy system as a partial or completion of a partial fill.

Quantity Dispensed

Medicare requires the Quantity Dispensed in the 442-E7 field of the AM07 segment to be in the format 9(7)V999. Quantities must be submitted with additional values to the right of the implied decimal. The actual decimal point is not submitted.

For example:

- The quantity "1" would be submitted as "1000"
- The quantity "240" would be submitted as "240000"
- The quantity "30.5" would be submitted as "30500"

9. MEDICARE NCPDP VERSION D.0 PAYER SHEET

Usage requirements:

M=Mandatory in Standard

R=Required for Medicare implementation

S=Situational usage as defined

9.1 REQUEST CLAIM BILLING TRANSACTION PAYER SHEET

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
Batch Header Record			M	
701	Segment Identification	00	M	
880-K6	Transmission Type	T, R, E	M	Medicare only accepts "T" Transaction
880-K1	Trading Partner ID (Submitter ID)		M	Enter the trading partner/submitter ID number assigned by CEDI
806-5C	Batch Number		M	This number must match the Batch Number (806-5C) in the Batch Trailer
880-K2	Creation Date		M	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
880-K3	Creation Time		M	Format = HHMM HH = Hour MM = Minute
702	File Type	P or T	M	P = Production T = Test
102-A2	Version/Release Number	12	M	The batch version number must be "12" for NCPDP Batch Standard Version 1.2
880-K7	Receiver ID	16003, 17003, 18003, 19003	M	DME MAC Contractor ID. Any of the IDs below may be submitted to CEDI regardless of the DME MAC that will process the claim. 16003 Jurisdiction A 17003 Jurisdiction B 18003 Jurisdiction C 19003 Jurisdiction D
Batch Detail Record			M	

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

701	Segment Identification	G1	M	
880-K5	Transaction Reference Number		M	When multiple detail records are submitted, the reference number must be unique within the batch file.
Transaction Header Segment			M	
101-A1	BIN Number		M	Assigned BIN number for network routing Entering all zeros or all 9's is valid for Medicare.
102-A2	Version/Release Number	D0	M	The version/release number must be "D0" for NCPDP Telecommunication Standard Version D.0
103-A3	Transaction Code	B1	M	
104-A4	Processor Control Number		M	Submit the Patient Account Number
109-A9	Transaction Count	1,2,3,4	M	Indicate the number of lines for the claim. This must match the number of 111-AM(07) segments. Valid Values for Non-Compound Claims: 1 – One Occurrence 2 – Two Occurrences 3 – Three Occurrences 4 – Four Occurrences Valid Values for Compound Claims: 1 – One Occurrence
202-B2	Service Provider ID Qualifier	01	M	01 – National Provider Identifier (NPI) *The NPI was mandatory effective May 23, 2008
201-B1	Service Provider ID		M	Enter the NPI number * Only one Service Provider ID can be submitted in the Transaction Header Segment. * The NPI was mandatory effective May 23, 2008

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

401-D1	Date of Service		M	From Date of Service Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
110-AK	Software Vendor/Certification ID		M	(must not be space filled)
Patient Segment			R	
111-AM	Segment Identification	01	R	Patient Segment
304-C4	Date of Birth		M	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
305-C5	Patient Gender Code	0,1,2	R	Medicare only accepts values 1 & 2: 1 – Male 2 – Female
307-C7	Place of Service	01, 03, 04, 05, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 25, 26, 31, 32, 33, 34, 41, 42, 49, 50, 51, 52, 53, 54, 55, 56, 57, 60, 61, 62, 65, 71, 72, 81, 99	R	Indicate the 2 digit place of service code representing where the patient received their pharmacy services.
310-CA	Patient First Name		R	
311-CB	Patient Last Name		R	
322-CM	Patient Street Address		R	
323-CN	Patient City Address		R	
324-CO	Patient State/Province Address		R	

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

325-CP	Patient /Postal Zone		R	The ZIP code must be a valid 5 or 9 digit USPS ZIP code and must not include hyphens or all zeros in 6 th thru 9 th positions..
Insurance Segment			M	
111-AM	Segment Identification	04	M	Insurance Segment
302-C2	Cardholder ID		M	Enter Beneficiary HIC number
312-CC	Cardholder First Name		R	Enter Beneficiary first name
313-CD	Cardholder Last Name		R	Enter Beneficiary last name
301-C1	Group ID		S	Used only when Patient has MEDIGAP coverage (Enter the COBA number)
306-C6	Patient Relationship Code	1	R	Medicare can only accept code "1"
361-2D	Provider Accept Assignment Indicator	Y, N	R	Indicate whether provider accepts assignment (Note: Medicare adjudication rules for Mandatory Assignment may cause the assignment indicator to be flipped from non-assigned to assigned during claim processing). Valid Values: Y – Yes N – No
Prescriber Segment			R	
111-AM	Segment Identification	03	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	01	R	01 – National Provider Identifier *The NPI was mandatory effective May 23, 2008
411-DB	Prescriber ID		R	Enter the NPI number * Only one Prescriber ID can be submitted in the Prescriber Segment *The NPI was mandatory effective May 23, 2008
427-DR	Prescriber Last name		R	

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

COB/Other Payments Segment			S	Required when other insurance processing is involved
111-AM	Segment Identification	05	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count	1	M	Medicare accepts only one primary payer
338-5C	Other Payer Coverage Type	01, 02, 03, 04, 05, 06, 07, 08, 09	M	01=Primary 02=Secondary 03=Tertiary 04=Quaternary 05=Quinary 06=Senary 07=Septenary 08=Octonary 09=Nonary
339-6C	Other Payer ID Qualifier	blank, 01, 02, 03, 04, 05, 99	R	Use 05 for a Medicare-assigned identifier if known. (After National Plan ID is mandated, use only 01.)
340-7C	Other Payer ID		R	
341-HB	Other payer amount paid count	1– 9	S	
342-HC	Other Payer Amount Paid Qualifier	blank, 01, 02, 03, 04, 05, 06, 07, 09	S	07 – Drug Benefit to report the drug benefit amount paid by the other payer.
431-DV	Other Payer Amount Paid		S	If other payer processed claim, but made no payment, enter zero for paid amount The maximum value is 99999.99.
471-5E	Other Payer Reject Count	1 - 5	S	Use only when a previous payer paid less than the full amount of the charge and provided a rejection code on the remittance
472-6E	Other Payer Reject Code	NCPDP Reject Code values defined in ECL APPENDIX A1	S	Use only when a previous payer paid less than the full amount of the charge and provided a rejection code on the remittance
353-NR	Other Payer-Patient Responsibility Amount Count	1 - 25	S	Use only when patient has financial responsibility to share cost with other payer

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

351-NP	Other Payer-Patient Responsibility Amount Qualifier	blank, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13	S	Use only when patient has financial responsibility to share cost with other payer
352-NQ	Other Payer-Patient Responsibility Amount		S	Use only when patient has financial responsibility to share cost with other payer
Claim Segment			M	
111-AM	Segment Identification	07	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1	M	Only value '1' is allowed for Claim Billing (B1) transactions. 1 – Rx Billing
402-D2	Prescription/Service Reference Number		M	
436-E1	Product/Service ID Qualifier	00, 03	M	00 – Used when compound is being submitted 03 – NDC, used for drugs and solutions
407-D7	Product/Service ID		M	
458-SE	Procedure Modifier Count	1 - 10	S	Used only when a procedure modifier code applies. Up to ten modifiers can be reported per NDC.
459-ER	Procedure Modifier Code		S	Used only when a procedure modifier code applies. Up to ten modifiers can be reported per NDC.
442-E7	Quantity Dispensed		R	Format = 9(7)V999 Zero is not valid
403-D3	Fill Number	0, 1-99	R	0 – Original dispensing 1-99 – Refill number
405-D5	Days Supply		R	Used for the amount of days the prescription is estimated to last. Zero is not valid
406-D6	Compound Code	1, 2	R	1 – No compound 2 – Compound

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

408-D8	Dispense As Written (DAW) / Product Selection Code	0, 1, 2, 3, 4, 5, 6, 7, 8, 9	R	<p>0 =No Product Selection Indicated</p> <p>1=Substitution Not Allowed by Prescriber</p> <p>2=Substitution Allowed-Patient Requested Product Dispensed</p> <p>3=Substitution Allowed- Pharmacist Selected Product Dispensed</p> <p>4=Substitution Allowed-Generic Drug Not in Stock</p> <p>5=Substitution Allowed-Brand Drug Dispensed as a Generic</p> <p>6=Override</p> <p>7=Substitution Not Allowed- Brand Drug Mandated by Law</p> <p>8=Substitution Allowed-Generic Drug Not Available in Marketplace</p> <p>9= Other (5.1)/Substitution Allowed By Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product To Be Dispensed (D.0)</p>
414-DE	Date Prescription Written		R	<p>Format = CCYYMMDD</p> <p>CC – Century</p> <p>YY – Year</p> <p>MM – Month</p> <p>DD – Day</p>
600-28	Unit of Measure	EA, GM, ML	S	<p>To be reported when information could result in different coverage, pricing, or patient financial responsibility.</p> <p>EA – Each</p> <p>GM – Grams</p> <p>ML – Milliliters</p>
391-MT	Patient Assignment Indicator	Y, N	R	<p>Indicate whether the patient assigned his/her benefits to the provider (Medicare will not assume the patient assigned benefits to the provider).</p> <p>Valid Values:</p> <p>Y – Yes</p> <p>N – No</p>

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

995-E2	Route of Administration	112239003 26643006	S	For compounds, indicate the route of the complete compound mixture. NOTE: This field will be used to distinguish nebulizer compounds from other compounds. 112239003 – “By inhalation (route)” 26643006 – “Oral route”
Pricing Segment				
111-AM	Segment Identification	11	M	Pricing Segment
409-D9	Ingredient Cost Submitted		R	Product component cost of the dispensed prescription. Included in Gross Amount Due.
412-DC	Dispensing Fee Submitted		R	Dispensing fee submitted by pharmacy. Included in Gross Amount Due. Zero is a valid value. Questions regarding the dispensing fee amount should be directed to the DME MAC that will process the claim.
438-E3	Incentive Amount		R	Amount represents the contractually agreed upon incentive fee paid for specific services rendered. Included in Gross Amount Due. Zero is a valid value. Questions regarding the incentive fee amount should be directed to the DME MAC that will process the claim.
433-DX	Patient Paid Amount Submitted		S	Used when the beneficiary or someone acting on behalf of the beneficiary made a payment for this service (Beneficiary Paid Amount)
430-DU	Gross Amount Due		R	The total submitted amount for this transaction. Zero is not valid for this field.

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

Compound Segment			S	Required when submitting a compounded formulation with multiple active ingredients
111-AM	Segment Identification	10	M	Compound Segment
450-EF	Compound Dosage Form Description Code	blank, 01, 02, 03, 04, 05, 06, 07, 10, 11, 12, 13, 14, 15, 16, 17, 18	M	Blank=Not Specified 01=Capsule 02=Ointment 03=Cream 04=Suppository 05=Powder 06=Emulsion 07=Liquid 10=Tablet 11=Solution 12=Suspension 13=Lotion 14=Shampoo 15=Elixir 16=Syrup 17=Lozenge 18=Enema
451-EG	Compound Dispensing Unit Form Indicator	1, 2, 3	M	1 – Each 2 – Grams 3 – Milliliters
447-EC	Compound Ingredient Component (Count)	1–25	M	Medicare will accept up to 25 ingredients in one compound mixture
488-RE	Compound Product ID Qualifier	03, 99	M	03 – NDC 99 – Other
489-TE	Compound Product ID		M	Product identification of the ingredient used in the compound.
448-ED	Compound Ingredient Quantity		M	The metric decimal quantity of the compound included in the compound mixture. Zero is not valid.
449-EE	Compound Ingredient Drug Cost		R	This will be used as the submitted amount when Medicare creates the service line for this ingredient
362-2G	Compound Ingredient Modifier Code Count	1 - 10	S	Used only when a procedure modifier code applies. Up to ten modifiers can be reported per compound ingredient.
363-2H	Compound Ingredient Modifier Code		S	Used only when a procedure modifier code applies. Up to ten modifiers can be reported per compound ingredient.

Clinical Segment			R	
111-AM	Segment Identification	13	M	Clinical Segment
491-VE	Diagnosis Code Count	1-5	R	A maximum of five diagnosis codes can be reported on each clinical segment.
492-WE	Diagnosis Code Qualifier	01	R	01 – ICD9
424-DO	Diagnosis Code		R	The ICD9-CM diagnosis code may include the decimal point.
Facility Segment			S	Required when Place of Service field 307-C7 is other than '12' (home).
111-AM	Segment Identification	15	M	Facility Segment
385-3Q	Facility Name		R	Name identifying location of the service rendered.
386-3U	Facility Street Address		R	
388-5J	Facility City		R	
387-3V	Facility State/Province		R	
389-6D	Facility Zip/Postal Zone		R	The ZIP code must be a valid 5 or 9 digit USPS ZIP code and must not include hyphens or all zeros in 6 th thru 9 th positions.
Batch Trailer Record			M	
701	Segment Identification	99	M	
806-5C	Batch Number		M	This number must match the Batch Number (806-5C) in the Batch Header
751	Record Count		M	
504-F4	Message		M	(must be at least space filled to maximum positions)

9.2 CLAIM BILLING ACCEPTED RESPONSE

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
Batch Header Record			M	
701	Segment Identification	00	M	
8800-K6	Transmission Type	R	M	
8800-K1	Trading Partner ID (Submitter ID)		M	Trading partner/submitter ID number from original inbound batch header field 880-K7.
8006-5C	Batch Number		M	Batch Number from original inbound batch header field 806-5C.
880-K2	Creation Date		M	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
880-K3	Creation Time		M	Format = HHMM HH = Hour MM = Minute
702	File Type	P or T	M	P = Production T = Test (from original inbound batch header field 702).
102-A2	Version/Release Number	12	M	The batch version number from original inbound batch header field 102-A2.
880-K7	Receiver ID	16003, 17003, 18003, 19003	M	Receiver ID (DME MAC contractor ID) from original inbound batch header field 880-K1.
Batch Detail Record			M	
701	Segment Identification	G1	M	
880-K5	Transaction Reference Number		M	Reference number from original inbound batch detail field 880-K5.
Transaction Header Segment			M	
102-A2	Version/Release Number	D0	M	The version/release number from original inbound Transaction Header field 102-A2.

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

103-A3	Transaction Code	B1	M	
109-A9	Transaction Count	1,2,3,4	M	The transaction count from original inbound Transaction Header field 109-A9.
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	
Response Message Segment			R	
111-AM	Segment Identification	20	R	Response Message Segment
504-F4	Message	CCN16003YYJJBBBBSS000 (where positions 1-3 are constant "CCN", positions 4 – 8 equate to the DME MAC contractor ID to which the claim is being distributed, and positions 9 – 22 equate to the Medicare claim control number assigned to the accepted claim).	R	Represents ultimate CEDI determination of acceptance or rejection. Accepted claims will reflect the DME MAC contractor ID where the accepted claim will be forwarded as well as the claim control number.
Response Insurance Segment			R	
111-AM	Segment Identification	25	M	Response Insurance Segment
302-C2	Cardholder ID	Same value as in request	R	
Response Patient Segment			R	
111-AM	Segment Identification	29	M	Response Patient Segment
310-CA	Patient First Name	Same value as in request	R	
311-CB	Patient Last Name	Same value as in request	R	
304-C4	Date of Birth	Same value as in request	R	
Response Status Segment			S	

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	C	M	
549-7F	Help Desk Phone Number Qualifier	01	R	
550-8F	Help Desk Phone Number	8663119184	R	Format =AAEEENNNNXXXXXXXXX X AAA=Area Code EEE=Exchange Code NNNN=Number XXXXXXXXX=Extension CEDI HELPDESK PHONE NUMBER: 8663119184
Response Claim Segment			M	
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1	M	Only value '1' is allowed for Claim Billing (B1) transactions. 1 – Rx Billing
402-D2	Prescription/Service Reference Number	same value as in request	M	Leading zeros will be truncated on Response.
Batch Trailer Record			M	
701	Segment Identification	99	M	
806-5C	Batch Number		M	Batch Number from original inbound batch header field 806-5C.0
751	Record Count		M	Calculated number of records in batch (i.e. G1 data detail records plus header & trailer).
504-F4	Message	(spaces)	M	(space filled to maximum positions)

9.3 CLAIM BILLING REJECTED RESPONSE

COMMON ELECTRONIC DATA INTERCHANGE COMPANION DOCUMENT

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
Batch Header Record			M	
701	Segment Identification	00	M	
880-K6	Transmission Type	R	M	
880-K1	Trading Partner ID (Submitter ID)		M	Trading partner/submitter ID number from original inbound batch header field 880-K7
806-5C	Batch Number		M	Batch Number from original inbound batch header field 806-5C
880-K2	Creation Date		M	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
880-K3	Creation Time		M	Format = HHMM HH = Hour MM = Minute
702	File Type	P or T	M	P = Production T = Test (From original inbound batch header field 702).
102-A2	Version/Release Number	12	M	The batch version number from original inbound batch header field 102-A2.
880-K7	Receiver ID	16003, 17003, 18003, 19003	M	Receiver ID (DME MAC contractor ID) from original inbound batch header field 880-K1.
Batch Detail Record			M	
701	Segment Identification	G1	M	
880-K5	Transaction Reference Number		M	Reference number from original inbound batch detail field 880-K5.
Response Transaction Header Segment			M	
102-A2	Version/Release Number	D0	M	From original inbound Transaction Header field 102-A2.
103-A3	Transaction Code	B1	M	

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109-A9	Transaction Count	1,2,3,4	M	<p>The transaction count from original inbound Transaction Header field 109-A9.</p> <p>NOTE: If original count is not valid ECL value, response will reflect '1' and only one AM21 segment will be returned. If original count is valid ECL value, but not equal to actual count of transactions (i.e. AM07 segments), response will reflect the actual calculated count of transactions and one AM21 segment will be returned for each recognized transaction (i.e. for each AM07 line item).</p>
501-F1	Header Response Status	A or R	M	<p>A = transmission accepted (however transaction rejected & therefore overall claim will be rejected).</p> <p>R = Transmission rejected and transaction rejected (therefore overall claim will be rejected).</p> <p>Message field 504-F4 in AM20 segment is ultimate CEDI determination of acceptance or rejection.</p>
202-B2	Service Provider ID Qualifier	Same values as in request	M	
201-B1	Service Provider ID	Same values as in request	M	
401-D1	Date of Service	Same values as in request	M	
Response Insurance Segment			S	This segment is NOT USED when there are only errors at the Transmission Level.
111-AM	Segment Identification	25	M	Response Insurance Segment
302-C2	Cardholder ID	Same value as in request	R	

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Response Patient Segment			S	This segment is NOT USED when there are only errors at the Transmission Level.
111-AM	Segment Identification	29	M	Response Patient Segment
310-CA	Patient First Name	Same values as in request	R	
311-CB	Patient Last Name	Same values as in request	R	
304-C4	Date of Birth	Same values as in request	R	
Response Message Segment			R	
111-AM	Segment Identification	20	R	Response Message Segment
504-F4	Message	CLAIM REJECTED	R	Represents ultimate CEDI determination of acceptance or rejection. Rejected claims will always reflect constant message "Claim Rejected".
Response Status Segment			M	
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	R	M	NOTE: When there are transmission level errors, every identifiable transaction will be denoted with an "R"
510-FA	Reject Count	Maximum count of 5.	R	
511-FB	Reject Code	ECL Appendix A reject codes.	R	Can be repeated up to 5 times
546-4F	Reject Field Occurrence Indicator	Maximum of 25.	S	Required if a repeating field is in error, to identify repeating field occurrence.
549-7F	Help Desk Phone Number Qualifier	01	R	
550-8F	Help Desk Phone Number	8663119184	R	Format= AAEEENNNNXXXXXXXXX AAA=Area Code EEE=Exchange Code NNNN=Number XXXXXXXX=Extension CEDI HELPDESK PHONE NUMBER: 8663119184

Response Claim Segment			S	This segment is NOT USED when there are only errors at the Transmission Level.
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1	M	Only value '1' is allowed for Claim Billing (B1) transactions. 1 – Rx Billing
402-D2	Prescription/Service Reference Number	same value as in request	M	NOTE: Leading zeros will be truncated on response.
Batch Trailer Record			M	
701	Segment Identification	99	M	
806-5C	Batch Number		M	Batch Number from original inbound batch header field 806-5C
751	Record Count		M	Calculated number of records in batch (i.e. G1 data detail records plus header & trailer).
504-F4	Message	(spaces)	M	(space filled to maximum positions)

9.4 CLAIM BILLING BATCH REJECTED RESPONSE

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
Batch Header Record			M	
701	Segment Identification	00	M	
880-K6	Transmission Type	E	M	
880-K1	Trading Partner ID (Submitter ID)		M	Trading partner/submitter ID number from original inbound batch header field 880-K7.
806-5C	Batch Number		M	Batch Number from original inbound batch header field 806-5C.
880-K2	Creation Date		M	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day

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880-K3	Creation Time		M	Format = HHMM HH = Hour MM = Minute
702	File Type	P or T	M	P = Production T = Test (from original inbound batch header field 702).
102-A2	Version/Release Number	12	M	The batch version number from original inbound batch header field 102-A2.
880-K7	Receiver ID	16003, 17003, 18003, 19003	M	Receiver ID (DME MAC contractor ID) from original inbound batch header field 880-K1.
Batch Trailer Record			M	
701	Segment Identification	99	M	
806-5C	Batch Number		M	Batch Number from original inbound batch header field 806-5C.
751	Record Count		M	Calculated number of records in batch (i.e. G1 data detail records plus header & trailer).
504-F4	Message	1-xxxxxxxxxx 2-xxxxxxxx	M	Free form error message (preceded by number & hyphen to denote beginning & end of each message).

10. Frequently Asked Questions

1. What is the D.0 Implementation?
The Centers for Medicare and Medicaid Services (CMS) is underway with implementation activities to convert from National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0.
2. Why change from the current NCPDP version 5.1 to NCPDP version D.0?
The Version D.0 for NCPDP claims incorporated the changes necessitated by the requirements of the Medicare Prescription Drug Improvement and Modernization Act and requests submitted by the industry to accommodate changing business needs.
3. What types of claims can be sent using the NCPDP version D.0?
Only retail pharmacy drug claims will be able to be submitted using the D.0 version. Regular DME claims will still need to be transmitted using the ANSI ASC X12 version 5010.
4. When does the transition to the new Version D.0 format begin?
Internal testing of the format will begin January 1, 2010.
External testing will begin January 1, 2011.
All software used to submit Durable Medical Equipment NCPDP claims must be using the new format by January 1, 2012.

11. CCI Change Summary

[At a minimum, this section details the changes between this version and the previous version.]