Companion Document

to Supplement the NCPDP Version 5.1 Batch Transaction Standard 1.1 Billing Request

For Coordination of Benefits (COB) Exchanges

with Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

NCPDP Implementation and Testing

NCPDP is the approved ANSI format to submit retail pharmacy claims. Each retail pharmacy that transmits retail drug claims electronically must use the NCPDP Batch Standard version 1.1. The NCPDP standard will be accepted for retail pharmacy drug claims only. Claims for supplies and services must be billed using version 4010A1 of the ANSI ASC X12N 837 and must be submitted in a separate transmission from the NCPDP retail drug claims.

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

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

The NCPDP Standards, Implementation Guides and Data Dictionary can be obtained at www.ncpdp.org for a fee of $650.00 or by becoming a member for $550.00. (These prices were valid at the time of publication but are subject to change by the NCPDP organization.)

Note: Non-retail pharmacies are to bill using the X12N 837 4010 A1.

National Drug Code (NDC)

Pharmacies are required to transmit the NDC in the NCPDP standard for identification of prescription drugs dispensed through a retail pharmacy. The NDC replaces the 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 or on paper. Claims for supplies, equipment, services or other care for submitters sent to DME MACs or carriers electronically or on paper are to be billed using HCPCS.

General Requirements:

1. This guide was created to provide DME MAC specific requirements when creating an NCPDP claim file. This document contains valid values for elements appropriate for billing of DME MACs and lists only the segments and elements which apply to a DME MAC claim.
2. Suppliers will create the Billing Request transaction as required in the NCPDP standard and as clarified within this document.
3. Only Segments and Fields that are “Mandatory” (M) are to be sent to the DME MACs in the standard, or shown as “Required” (R) or “Situational” (S) in this document. If a Segment or Field is marked as “Situational”, it is only sent if the data condition stated applies. If a field is not shown in this document, or if a data condition is not met, it may not be included in a Medicare claim sent to a DME MAC. 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.
4. Medicare will only accept and process Batch Transactions using the NCPDP Batch Standard version 1.1 with the Telecommunication Standard version 5.1. The Batch Standard is a file transmission of one header, one or more detail records, and one trailer. The detail records are built using the

Telecommunication Standard version 5.1, with one or more transactions (claims) per transmission (one detail record).

5. Medicare will only accept and process Billing Transactions (value B1 in the Transaction Header Segment, Transaction Code field 103-A3).
6. The following segments are required for Medicare processing:
   - Patient Segment
   - Insurance Segment
   - Prescriber Segment
   - Claim Segment
   - Pricing Segment
   - Clinical Segment
7. Suppliers may submit up to four detail record transactions per detail record transmission except for compound billings. Only one detail record transaction per detail record transmission is allowed when billing for a multi-ingredient prescription.
8. The Prior Authorization Segment, the Coordination of Benefits/Other Payments Segment and the Compound Segment are to be used for Medicare when certain conditions apply.
9. Data elements that are defined by a qualifier must contain valid and appropriate information for that qualifier.
10. Delimiters must be used to distinguish and separate data elements and segments as specified in the NCPDP standard.
11. The transaction must adhere to the data conventions as stated in section 2.5 of the NCPDP Telecommunication Standard Implementation Guide version 5.1.
12. 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 NCPDP implementation guide. 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.

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

Compound Drugs

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

1. The Compound Route of Administration field (452-EH) will be used to distinguish the Nebulizer Drug Compounds from Other Drug Compounds. This field is the route of administration of the complete compound mixture. The valid values Medicare will use in this field are:
   3 - Nebulizer Compounds
   11 - 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). Compounds for inhalation drugs should only be used for multiple active ingredients. For single active ingredients, use the Claim segment. Additionally, for Nebulizer drugs, suppliers must adhere to the following data requirements in the Compound Segment of the inbound NCPDP claim:
   A. The Compound Ingredient Basis of Cost Determination field (490-UE), should equal "09" (Other) to identify the ingredient that would normally be assigned a KP modifier.
   B. All other drugs in the Compound Segment will be assigned a KQ modifier by Medicare during processing to ensure proper completion of the claim.

Parenteral Nutrition Products

Parenteral nutrition claims must be billed on the X12N 837 using HCPCS codes.

Enteral Nutrition Products

Enteral nutrition claims must be billed on the X12N 837 using HCPCS codes.

End Stage Renal Disease (ESRD)

ESRD drug claims must be billed on the X12N 837 using HCPCS codes.

Epoetin (EPO)

All EPO associated with ESRD must be billed on the X12N 837.

Non-ESRD EPO must be billed either on the NCPDP by retail pharmacists or on the X12N 837 by professional pharmacists.

Home Infusion Products

Claims for home infusion products must be billed on the ASC X12N 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.

Coordination of Benefits (COB)

Certain trading partners cannot accept the NCPDP version 5.1 batch standard 1.1 for COB crossover purposes due to a lack of certain data elements within the transaction that they consider essential for adjudication. The workaround instructions below were created to furnish COB trading partners with the necessary claim data to enable them to accept crossover claims for processing through the national Coordination of Benefits Agreement (COBA) process. The 15-digit Internal Control Number (ICN)/Claim Control Number (CCN) that identifies a Medicare processed claim will appear in field 330-CW- (Alternate ID) within the "Claim Segment" portion of the NCPDP COB file. (NOTE: Bytes 16-19 will contain spaces.) The ICN will enable the trading partner to determine that an adjustment to an original claim occurred, since adjustments necessitate a change to the ICN.

- A Patient Assignment of Benefits Indicator default value of "Y" will be included in field 330-CW (Alternate ID) in byte 20.
- Trading partners will receive notice that, per CMS regulations, drugs will always be paid as mandatory assignment. The claim format will not be revised to include an "A" Provider Assignment of Benefits Indicator in some alternative field.
- The HICN will always be passed in "Patient ID" (field 332-CY with a "99-other" qualifier in field 331-CX Patient Id qualifier). The "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's policy number on claim-based Medigap crossovers that was sent on the inbound transaction in the Alternate-Id field (field 330-CW carried within the "Claim Segment").
- For non claim based Medigap crossovers, the "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's policy number as submitted on the carriers eligibility file.
- For Medicaid crossovers, the "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's Medicaid policy number as submitted on the carriers eligibility file.
- If the beneficiary's policy number is not available the "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's HICN.

- The retail pharmacy's (supplier) name and address will be populated in lieu of the Facility Name and Address in the 500-byte-free formatted field when the 'Patient Location' field (307-C7) equals “1” (home).

Medigap

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

1. The Group Id (301-C1) on the insurance segment is not blank.
2. For Coordination of Benefits (COB) related to Medigap, the Patients Medigap Plan Id Number will be submitted in the Alternate Id (330-CW) in the Claim segment.
3. The Medigap Insurer Id (OCNA 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

On a Medicaid crossover claim, the Medicare beneficiary’s 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 following fields must be submitted in order to allow Medicare to determine that a beneficiary has claim based Medicaid coverage and to specify the source of the coverage:

1. The Group Id (301-C1) on the Insurance segment is not blank.
2. The two position state alpha code followed by the word “MEDICAID” must be submitted in the Group Id (301- C1) in the Insurance segment.
   Example: “XXMEDICAID” such as NYMEDICAID or FLMEDICAID

MSP Claims

When Medicare is the secondary payer, (MSP) pharmacies must complete the following fields:

1. The Original Submitted Amount will be sent in the Gross Amount Due (430-DU) on the Pricing Segment;
2. All other amounts reported in 431-DV will be qualified as follows in the Other Payer Amount Paid Qualifier (342-HC):

   The Primary Amount Paid (08) - What the payer actually paid versus what was allowed;
   The Primary Allowed Amount (99) - What the payer actually allowed;
   The Obligated to Accept Amount (07) - The amount that the pharmacy has contracted with the original payer, as the amount the pharmacy will accept for payment.

Partial Fills

Medicare does not process the partial and completion billing for prescriptions as described in the NCPDP Telecommunication Standard Implementation Guide. Medicare should be billed the actual dispensed amount. When submitting partial fill claims to Medicare, pharmacies must submit the Actual Quantity Dispensed in element 442-E7.

Prior Authorization Segment

The NCPDP standard contains a 500-position field in the Prior Authorization Segment (498-PP Prior Authorization Supporting Documentation) that supports one occurrence of narrative information. Retail pharmacies must use this narrative field to submit the following information relating as required for Medicare claims processing:

A) Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF)
B) Narrative Supporting Documentation
C) Facility Name and Address
D) Modifiers for compound drugs

The matrix starting on page 12 of this document provides detailed instruction for formatting these 500 positions when the narrative field is being used to submit any of the information.

NCPDP VERSION 1.1 MEDICARE BILLING REQUEST BATCH TRANSACTIONS

Usage requirements: M=Mandatory in Standard; R=Required for Medicare implementation; S=Situational usage as defined

Only Mandatory, Required and Situational fields (that apply to Medicare) are reported in this matrix. It is possible that Situational fields that do not apply to Medicare but which do apply to a secondary payer could also be included in a claim sent to Medicare. Submitted situational fields that are not used for Medicare adjudication are stored in a repository so they can be included in any COB claim subsequently prepared for the claim. Prior to being stored, these fields are edited to validate that a correct qualifier has been used and that any NPI reported meets the NPI regulation format/content criteria, but in the event a legacy identifier is reported for one of these providers, a search is not conducted in the Medicare NPI Crosswalk to see if an NPI can be identified for that provider. Situational fields not used by Medicare for example, could include the pharmacy ID segment fields (465-EY, qualifier and 601-45, number) and the primary care provider segment fields (468-23, qualifier and 421-DL, number). Effective May 23, 2008, even though not applicable to Medicare, if a legacy number is submitted for a provider whose information does not apply to Medicare, or if a NPI is reported for such a provider but the NPI does not meet the basic format/content criteria as defined in the NPI regulation, Medicare will not send the claim to a COB trading partner or a Medigap plan. Medicare will not issue a claim to a secondary payer with a provider identifier other than an NPI as that would be a violation of the NPI reporting requirement.

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
Batch Header Record			**M**	
7∅1	Segment Identification	∅∅	M	
88∅-K6	Transmission Type	T, R, E	M	Medicare will only send "T" Transaction
88∅-K1	Sender Id	16003, 17003, 18003, 19003	M	The sender identifier as directed by the Medicare Administrative Contractor from whom the transaction is sent: 16003 Jurisdiction A DME MAC 17003 Jurisdiction B DME MAC 18003 Jurisdiction C DME MAC 19003 Jurisdiction D DME MAC
8∅6-5C	Batch Number		M	This number must match the Batch Number (8∅6-5C) in the Batch Trailer
88∅-K2	Creation Date		M	
88∅-K3	Creation Time		M	
7∅2	File Type	P or T	M	"T" for a test file "P" for a production file
1∅2-A2	Version/Release Number	11	M	
88∅-K7	Receiver ID		M	Trading Partner ID assigned by the Medicare Coordination of Benefits Contractor (COBC)
Batch Detail Record			**M**	
7∅1	Segment Identification	G1	M	
88∅-K5	Transaction Reference Number		M	
Transaction Header Segment			**M**	
1Ø1-A1	BIN Number		M	Assigned BIN number for network routing
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B1	M	
1Ø4-A4	Processor Control Number		M	Submit the Patient Account Number
1Ø9-A9	Transaction Count	1,2,3,4	M	Carriers will support up to four claims per transmission
2Ø2-B2	Service Provider ID Qualifier	∅1, ∅4	M	∅1 – National Provider Identifier (NPI) *** The NPI is mandatory effective May 23, 2008** ∅4 – Medicare National Supplier Clearinghouse Number

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
2Ø1-B1	Service Provider ID		M	Enter the NPI or NSC number *** The NPI is mandatory effective May 23, 2008** * Only one Service Provider ID can be submitted in the Transaction Header Segment
4Ø1-D1	Date of Service		M	From Date of Service
11Ø-AK	Software Vendor/Certification ID		M	
Patient Segment			**M**	
111-AM	Segment Identification	Ø1	R	Patient Segment
331-CX	Patient ID Qualifier	99	R	99 - Other
332-CY	Patient ID		R	Medicare HICN
3∅4-C4	Date of Birth		M	
3∅5-C5	Patient Gender Code	∅, 1,2	R	Use code 1 or 2
31∅-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	
325-CP	Patient ZIP/Postal Zone		R	
3∅7-C7	Patient Location	1, 2, 3, 4, 5, 6, 7, 8, 9, 1∅, 11	R	1 – Home 2 – Inter-care 3 – Nursing Home 4 – Long Term/Extended Care 5 – Rest Home 6 – Boarding Home 7 – Skilled Care Facility 8 – Sub-acute Care Facility 9 – Acute Care Facility 1∅ – Outpatient 11– Hospice
Insurance Segment			**M**	
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID		M	Beneficiary's COB Policy Number Claim Based Crossover – Policy number from the Trading Partner's eligibility file Medigap – Policy number submitted on the inbound transaction Medicaid – Beneficiary's Medicaid policy number Policy Number Not Available – Medicare HICN
312-CC	Cardholder First Name		R	Enter Beneficiary first name
313-CD	Cardholder Last Name		R	Enter Beneficiary last name
3∅1-C1	Group ID		S	Required when Patient has MEDIGAP coverage (Enter the OCNA number) Or When patient has MEDICAID coverage (Enter the two position state alpha code followed by the word MEDICAID). Example: "XXMEDICAID"
3∅6-C6	Patient Relationship Code	1, 2, 3, 4	R	Medicare can only accept code 1
Prescriber Segment			**R**	
111-AM	Segment Identification	Ø3	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	∅1, ∅6	R	∅1 – National Provider Identifier *** The NPI is mandatory effective May 23, 2008** ∅6 – UPIN
411-DB	Prescriber ID		R	Enter the NPI or UPIN number *** The NPI is mandatory effective May 23, 2008** * Only one Prescriber ID can be submitted in the

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
				Prescriber Segment
427-DR	Prescriber Last name		R	
498-PM	Prescriber Phone Number		S	Used when submitting a CMN or DIF
COB/Other Payments Segment			**S**	**Required when other insurance processing is involved**
111-AM	Segment Identification	Ø5	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	∅1, ∅2, ∅3	M	∅1 – Primary ∅2 – Secondary ∅3 – Tertiary
339-6C	Other Payer ID Qualifier	99	R	Use 99 for a Medicare-assigned identifier if known. After National Plan ID is mandated, use only ∅1
34∅-7C	Other Payer ID		R	
443-E8	Other Payer Date		R	
341-HB	Other Payer Amount Paid Count	1 - 9	R	
342-HC	Other Payer Amount Paid Qualifier	∅7, ∅8, 99	R	∅7 – Drug Benefit to report the OTA (Contract Amount). ∅8 – Sum of All Benefits to report the Primary Paid Amount. 99 (1st Iteration) – Primary Deductible Amount 99 (2nd Iteration) – Primary Coinsurance Amount
431-DV	Other Payer Amount Paid		R	If other payer processed claim, but made no payment, enter zero for paid amount and enter appropriate rejection code
471-5E	Other Payer Reject Count		S	Use only when a previous payer paid less than the full amount of the charge and provided a rejection code on the remittance
473-6E	Other Payer Reject Code		S	Use only when a previous payer paid less than the full amount of the charge and provided a rejection code on the remittance
Claim Segment			**M**	
111-AM	Segment Identification	∅7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	Blank, 1, 2	M	Blank – Not Specified 1 – Rx Billing 2 – Service Billing
4Ø2-D2	Prescription/Service Reference Number		M	
4Ø3-D3	Fill Number	Ø, 1-99	R	Ø – Original dispensing 1-99 – Refill number
436-E1	Product/Service ID Qualifier	ØØ, ∅3	M	ØØ – used when compound is being submitted ∅3 – NDC, used for drugs and solutions
4Ø7-D7	Product/Service ID		M	
4Ø8-D8	Dispense As Written (DAW) / Product Selection Code	∅, 1, 2, 3, 4, 5, 6, 7, 8, 9,	R	∅ – No Product Selection Indicated 1 – Substitution Not Allowed by Prescriber 2 – Substitution Allowed-Patient Requested Product Dispensed 3 – Substitution Allowed-Pharmacist Requested Product Dispensed 4 – Substitution Allowed-Generic Drug Not in Stock 5 – Substitution Allowed-Brand Drug Dispensed as a Generic 6 – Override 7 – Substitution Not Allowed-Brand Drug Mandated by Law 8 – Substitution Allowed-Generic Drug Not Available in Marketplace

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
				9 – Other
414-DE	Date Prescription Written		R	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
458-SE	Procedure Modifier Count	1, 2, 3, 4	S	Used only when a procedure modifier code applies. Up to four modifiers can be sent
459-ER	Procedure Modifier Code		S	Used only when a procedure modifier code applies. Up to four modifiers can be sent
442-E7	Quantity Dispensed		R	
4∅5-D5	Days Supply		R	Used for the amount of days the prescription is estimated to last
4∅6-D6	Compound Code	∅, 1, 2	R	∅ – Not specified 1 – No compound 2 – Compound
3∅8-C8	Other Coverage Code	∅∅-∅8	S	Used only when other coverage exists
33∅-CW	Alternate Id		S	For COB claims from Medicare: Bytes 1-15 will be populated with the 15-digit Medicare Internal Control Number (ICN) / Claim Control Number (CCN) to identify the claim. Bytes 16-19 will be spaces. Byte 20 will be populated with the default value "Y" to indicate Patient Assignment of Benefits.
6∅∅-28	Unit of Measure	EA, GM, ML	R	
Pricing Segment			**M**	
111-AM	Segment Identification	11	M	Pricing Segment
412-DC	Dispensing Fee Submitted		S	For dates of service after 1/1/06. A value in this field will automatically create the dispensing fee HCPCS code and amount as shown below. The dispensing fee will be subtracted from the Gross Amount Due. Dispensing Fee Codes and Amounts: New codes: Q∅51∅ = $5∅ (one time fee for 1st immunosuppressive prescription after transplant) Q∅51∅ = $24 (1st immunosuppressive prescription after transplant with an incentive amount submitted) Q∅511 = $24 (1st immunosuppressive prescription in 30 day period) Q∅512 = $16 (subsequent immunosuppressive prescription in 30 day period) G∅333 = $57 (Initial inhalation dispensing fee) Q∅513 = $33 (30 day inhalation dispensing fee) Q∅514 = $66 (90 day inhalation dispensing fee)
438-E3	Incentive Amount		S	Suppliers are to include the $24 Q∅510 when sending it along with another dispensing fee for that drug.
433-DX	Patient Paid Amount Submitted		S	Used only when the beneficiary or someone acting on behalf of the beneficiary made a payment for this service
43∅-DU	Gross Amount Due		R	The total submitted amount for this transaction
Compound Segment			**S**	**Required when submitting a compounded formulation with multiple active ingredients**
111-AM	Segment Identification	1Ø	M	Compound Segment
45Ø-EF	Compound Dosage Form		M	

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
	Description Code			
451-EG	Compound Dispensing Unit Form Indicator	1, 2, 3	M	1 – each 2 – gram 3 – milliliters
452-EH	Compound Route of Administration	3, 11	M	3 – Inhalation. This code will be used to identify Nebulizer Compounds 11 – Oral. This code will be used to identify Immunosuppressive Compounds
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	∅3	M	∅3 – NDC Medicare will only recognize NDC codes
489-TE	Compound Product ID		M	
448-ED	Compound Ingredient Quantity		M	
449-EE	Compound Ingredient Drug Cost		R	This will be used as the submitted amount when Medicare creates the service line for this ingredient
49∅-UE	Compound Ingredient Basis Of Cost Determination	Blank, ∅1, ∅2, ∅3, ∅4, ∅5, ∅6, ∅7, ∅9	S	Blank – Not specified ∅1 – AWP (Average Wholesale Price) ∅2 – Local Wholesaler ∅3 – Direct ∅4 – EAC (Estimated Acquisition Cost) ∅5 – Acquisition ∅6 – MAC (Maximum Allowable Cost) ∅7 – Usual & Customary ∅9 – Other ** Required for Inhalation compounds to identify the ingredient that should receive Medicare's KP modifier
Prior Authorization Segment			**S**	1. Required when sending CMN or DIF information. (** Effective for dates of service on or after April 1, 2006, providers are no longer required to submit a DIF when billing for immunosuppressive drugs.) 2. Required when Patient Location (3∅7-C7) is other than home to report Facility Name / Address Information 3. Required when sending Medicare narrative information 4.Required when sending modifier information for a compound ingredient
111-AM	Segment Identification	12	M	Prior Authorization Segment
498-PA	Request Type	1, 2, 3	M	1 – Any request type not included in 2 or 3 below 2 – Recertification CMNs or DIFs 3 – Revision CMNs or DIFs
498-PB	Request Period Date –Begin		M	CMN or DIF Initial Date when sending CMN or DIF Information Or Date of Service when sending Prior Authorization segment when a CMN or DIF is not included
498-PC	Request Period Date- End		M	CMN or DIF Recertification or Revision date when sending CMN information.
498-PD	Basis of Request	PR	M	PR – Plan Requirement
498-PE	Authorized Representative First Name		S	Use to report first name of representative payee for Medicare payment
498-PF	Authorized Representative Last Name		S	Use to report last name of representative payee for Medicare payment
498-PG	Authorized Representative Street Address		S	Use to report street address of representative payee for Medicare payment
498-PH	Authorized Representative State/Province Address		S	Use to report representative payee zip code information for Medicare payment
498-PJ	Authorized Representative Zip/Postal Zone		S	Use to report representative payee state information for Medicare payment
498-PP	Prior Authorization Supporting Documentation Free text		S	Use when sending CMN or DIF information, Facility Name/Address Information, Narrative

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
				Information or informational modifiers for compound drugs. Refer to the attached Prior Authorization Segment Supporting Document for further details
Clinical Segment			**R**	
111-AM	Segment Identification	13	M	Clinical Segment
491-VE	Diagnosis Code Count	1-4	R	Medicare will only process up to a maximum of four diagnosis codes
492-WE	Diagnosis Code Qualifier	∅1	R	∅1 – ICD9-CM diagnosis codes
424-DO	Diagnosis Code		R	The decimal point specified in the ICD9-CM code listing is required
Batch Trailer Record			**M**	
7∅1	Segment Identification	99	M	
8∅6-5C	Batch Number		M	This number must match the Batch Number (8∅6-5C) in the Batch Header
751	Record Count		M	
5∅4-F4	Message		M	

Prior Authorization Segment Supporting Documentation Field 498-PP (Medicare Mapping)

R/S: R=Required for Medicare implementation; S=Situational usage as defined

	Element Attributes					
Description	**ID**	**R/S**	**Start**	**Length**	**Values**	**Medicare Note**
498-PP Prior Auth Supporting Doc.			**1**	**5ØØ**		
					CMN - Certificate of Medical Necessity	CMN - Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information
					CNA - Medicare CMN or DIF and Narrative	CNA - Indicates that the Supporting documentation that follows is Medicare required CMN or DIF and narrative information
					CFA - Medicare CMN or DIF and Facility Name and Address	CFA - Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information and Facility Name and Address
					CSA - Medicare CMN or DIF and Supplier Name and Address	CSA - Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information and Supplier Name and Address **NOTE: CSA IS USED FOR OUTBOUND COB PROCESSING. IF CSA IS RECEIVED ON THE INBOUND PRIOR AUTHORIZATION SEGMENT, THE CLAIM WILL BE REJECTED.**
					CNF - Medicare CMN or DIF, Narrative, and Facility Name and Address	CNF - Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and Facility Name and Address
					CNS - Medicare CMN or DIF, Narrative, and Supplier Name and Address	CNS - Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and Supplier Name and Address **NOTE: CNS IS USED FOR OUTBOUND COB PROCESSING. IF CNS IS RECEIVED ON THE INBOUND PRIOR AUTHORIZATION SEGMENT, THE CLAIM WILL BE REJECTED.**
Authorization Information Qualifier	AN	R	1	3		
					FAC - Facility Name and Address	FAC - Indicates that the Supporting documentation that follows is Medicare required Facility Name and address
					FAN - Facility Name and Address and Narrative	FAN - Indicates that the Supporting documentation that follows is Medicare required Facility Name and Address and narrative information
					SAC - Supplier Name and Address	SAC - Indicates that the Supporting documentation that follows is Medicare required Supplier Name and address **NOTE: SAC IS USED FOR OUTBOUND COB PROCESSING. IF SAC IS RECEIVED ON THE INBOUND PRIOR AUTHORIZATION SEGMENT, THE CLAIM WILL BE REJECTED.**
					SAN - Supplier Name and Address and Narrative	SAN - Indicates that the Supporting documentation that follows is Medicare required Supplier Name and Address and narrative information **NOTE: SAN IS USED FOR OUTBOUND COB PROCESSING. IF SAN IS RECEIVED ON THE INBOUND PRIOR AUTHORIZATION SEGMENT, THE CLAIM WILL BE REJECTED.**
					NAR - Narrative for Medicare Claim	NAR - Indicates that the Supporting documentation that follows is Medicare required Narrative Information
					MMN – Modifier and Certificate of Medical Necessity	MMN - Indicates that the Supporting documentation that follows is Medicare modifier information and CMN or DIF

						information
					MNA – Modifier and Medicare CMN or DIF and Narrative	MNA - Indicates that the Supporting documentation that follows is Medicare modifier information, CMN or DIF information and narrative information
					MFA – Modifier and Medicare CMN or DIF and Facility Name and Address	MFA - Indicates that the Supporting documentation that follows is Medicare modifier information, CMN or DIF information and Facility Name and Address
					MNF – Modifier and Medicare CMN or DIF, Narrative, and Facility Name and Address	MNF - Indicates that the Supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and Facility Name and Address
					MAC – Modifier and Facility Name and Address	MAC - Indicates that the Supporting documentation that follows is Medicare modifier information and Facility Name and Address
					MAN – Modifier and Facility Name and Address and Narrative	MAN - Indicates that the Supporting documentation that follows is Medicare modifier information, narrative information and Facility Name and Address
					MFA – Modifier and Medicare CMN or DIF and Facility Name and Address and Narrative	MFA - Indicates that the Supporting documentation that follows is Medicare modifier information, narrative information and Facility Name and Address
					MNS – Modifier and Medicare CMN or DIF and Facility Name and Address and Narrative	MNS - Indicates that the Supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and Supplier Name and Address **NOTE: MNS IS USED FOR OUTBOUND COB PROCESSING. IF MNS IS RECEIVED ON THE INBOUND PRIOR AUTHORIZATION SEGMENT, THE CLAIM WILL BE REJECTED.**
					MSA – Authorization Document Qualifier	MSA - Indicates that “MMN” or “MFA” was found on the inbound Prior Authorization segment’s Authorization Documentation Qualifier and the Retail Pharmacy Name and Address are present.
					MSC – Modifier and Supplier Name and Address	MSC - Indicates that the Supporting documentation that follows is Medicare modifier information, and Supplier Name and Address **NOTE: MSC IS USED FOR OUTBOUND COB PROCESSING. IF MSC IS RECEIVED ON THE INBOUND PRIOR AUTHORIZATION SEGMENT, THE CLAIM WILL BE REJECTED.**
					MSN – Modifier and Supplier Name and Address and Narrative	MSN - Indicates that the Supporting documentation that follows is Medicare modifier information, narrative information and Supplier Name and Address **NOTE: MSN IS USED FOR OUTBOUND COB PROCESSING. IF MSN IS RECEIVED ON THE INBOUND PRIOR AUTHORIZATION SEGMENT, THE CLAIM WILL BE REJECTED.**
					MAR – Modifier and Narrative for Medicare claim	MAR - Indicates that the Supporting documentation that follows is Medicare modifier information and narrative Information
					MOD – Modifier	MOD - Indicates that the Supporting documentation that follows is Medicare modifier information

Data Elements for Medicare CMN or DIF Form ∅8.∅2 Only		**Effective for dates of service on or after April 1, 2006, providers are no longer required to submit a DIF when billing for immunosuppressive drugs.**				
Description	**ID**	**R/S**	**Start**	**Length**	**Values**	**Medicare Notes**
Form Identifier	AN	R	4	6	∅8.∅2	∅8.∅2 - Immunosuppressive Drug CMN or DIF
Ordering Physician First Name	AN	R	1∅	12		
Ordering Physician Address	AN	R	22	3∅		
Ordering Physician City	AN	R	52	2∅		
Ordering Physician State	AN	R	72	2		
Ordering Physician Zip	AN	R	74	15		
Certificate on File Ind	AN	R	89	1	Y or N	This certifies that the supplier has a CMN or DIF on file available for the DME MAC to review if necessary
Signature Date	DT	R	9∅	8	CCYYMMDD	Date the supplier signed the CMN or DIF form
Question ∅1A - HCPCS	AN	S	98	11	valid drug HCPCS code	Drug prescribed
Question ∅1B - MG	N∅	S	1∅9	4	∅∅∅1 thru 9999	Dosage in Milligrams of the Drug prescribed in question ∅1A
Question ∅1C - Times Per Day	N∅	S	113	2	∅1 - 99	Frequency of administration of Drug Prescribed in question ∅1A
Question ∅2A - HCPCS	AN	S	115	11	Valid drug HCPCS code spaces are valid	Drug prescribed
Question ∅2B - MG	N∅	S	126	4	∅∅∅∅ thru 9999	Dosage in Milligrams of the Drug prescribed in question ∅2A
Question ∅2C - Times Per Day	N∅	S	13∅	2	∅∅ - 99	Frequency of administration of Drug Prescribed in question ∅2A
Question ∅3A - HCPCS	AN	S	132	11	Valid drug HCPCS code spaces are valid	Drug prescribed
Question ∅3B - MG	N∅	S	143	4	∅∅∅∅ thru 9999	Dosage in Milligrams of the Drug prescribed in question ∅3A
Question ∅3C - Times Per Day	N∅	S	147	2	∅∅ - 99	Frequency of administration of Drug Prescribed in question ∅3A
Question ∅4	AN	S	149	1	Y or N	Has the Patient had an organ transplant that was covered by Medicare?
Question ∅5A	AN	S	15∅	1	1, 2, 3, 4, 5, 6, 7, 8, 9	Which organ (s) have been transplanted? (List most recent transplant) 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other
Question ∅5B	AN	S	151	1	Spaces, 1, 2, 3, 4, 5, 6, 7, 8, 9	Which organ (s) have been transplanted? Spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other

Description	**ID**	**R/S**	**Start**	**Length**	**Values**	**Medicare Notes**
Question ∅5C	AN	S	152	1	Spaces, 1, 2, 3, 4, 5, 6, 7, 8, 9	Which organ (s) has been transplanted?

						Spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other
Question 11	DT	S	153	8	CCYYMMDD	Date Patient was discharged from the hospital following this transplant surgery
Question 12	AN	S	161	1	Y or N	Was there a prior transplant failure of this same organ?
Filler	AN	S	162	19		Space for possible expansion of data required for Immunosuppressive CMN or DIF
Data Elements for Medicare Required Narrative Data						
Description	**ID**	**R/S**	**Start**	**Length**	**Values**	**Medicare Notes**
Narrative	AN	S	181	8∅	Free Form Text	
Data Elements for Medicare Required Facility name and Address Data						**Required when Patient Location is not ∅1 – Home When Patient Location is ∅1, these fields will be populated with the retail pharmacy's (supplier) name and address.**
Description	**ID**	**R/S**	**Start**	**Length**	**Values**	**Medicare Notes**
Facility Name	AN	R	261	27		
Facility Address	AN	R	288	3∅		
Facility City	AN	R	318	2∅		
Facility State	AN	R	338	2		
Facility Zip	AN	R	34∅	15		
Data elements for Modifier	AN	S	355	100		Indicates the two-byte ingredient number followed by the two-position modifier. (The two-byte ingredient number can only be 01-25)
Filler	AN	S	455	46		Space for possible expansion of data required for Medicare processing

Issue	**CMS COB Information**
Capitalized data	The CMS will format COB data in upper case.
Gap Fill Data	The CMS uses gap fill data that complies with the IG syntax requirements with the understanding that the data may not appear valid. An inbound claim could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum and maximum lengths, etc.) requirements needed to prepare a HIPAA-compliant outbound NCPDP transaction. The "gap fill" data meets the data element minimum length requirement of an outbound NCPDP transaction if insufficient data are available for entry in a required data element. The selected values will not include any special characters, low values, high values, or "all spaces" and will be useable with every type of data where this situation could occur (decimal (R), identifier (ID), date (DT), etc.) except for alphanumeric (string) or numeric (Nn). The CMS will use "UNKNOWN" to gap fill alphanumeric data and zeros to gap fill numeric data to meet minimum length requirements. The CMS shall not gap fill data elements with pre-defined implementation guide values such as qualifiers and data elements that refer to a valid code source.
Other Payer Amount Paid qualifier field	The NCPDP has approved the following use of qualifiers for reporting Medicare COB amounts: "07" = Medicare Allowed Amount "08" = Medicare Paid Amount "99" = Deductible Amount "99" = Coinsurance Amount "99" = Co-Payment Amount NOTE: **The first occurrence of "99" will indicate the Deductible Amount.** The second occurrence of "99" will indicate the Coinsurance Amount. The third occurrence "99" will indicate the Co-Payment Amount.
NCPDP Data	CMS will send out on NCPDP COB, all data that is received on the inbound NCPDP claim regardless as whether Medicare needs the data to process the claim. Any extraneous non-Medicare data will be edited for syntax, but not data content.