DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

MEMORANDUM

TO: **All Part D Plan Sponsors**

FROM: **Gary Bailey, Deputy Director**

RE: **New Part D Claims Rejection Messages**

DATE: **March 29, 2006**

With the implementation of the Medicare Prescription Drug Benefit, issues have arisen at point of sale that indicate the need to clarify certain claims rejection situations that are specific to Part D. These include claims rejections for drugs excluded from Part D coverage as mandated by the Medicare Modernization Act and drugs that are covered under Medicare Part B for the particular beneficiary. Adoption of standardized coding and messages notifying pharmacists of claims rejections in these two situations would address the identified need.

A Work Group of the National Council for Prescription Drug Programs (NCPDP) has approved a process for using structured reject coding in the message field of the billing transaction response that will provide the additional information to clarify the specific reason for rejection in the aforementioned two situations. This process is consistent with the current NCPDP 5.1 standard and CMS strongly encourages your rapid adoption and use of this new standardized procedure.

A copy of the new procedure is attached with the permission of NCPDP. The leading text in the attachment is included to place the new procedure, described in item 6, in context. The new material has been added to the NCPDP *Telecommunication Version 5 Questions, Answers and Editorial Updates* document now available on the NCPDP website at www.ncpdp.org.

If you have any questions about this issue, please contact your account manager. Thank you for your continued assistance with the implementation of the Part D benefit.

15.8 Billing Transaction (B1) Response

15.8.1 Billing Response Rules

1) For Medicare Part D processing using Telecommunication Standard Version 5.1, only one transaction per transmission is permitted because:

- There is a need for the sequencing of the TrOOP update before the next claim is processed. The TrOOP should be updated before subsequent claims are processed.
- The Fields, Message (5Ø4-F4) and Additional Message Information (526-FQ) are used to support the secondary/tertiary additional information from the Prescription Drug Plan (PDP). Message (5Ø4-F4) is in the Header Segment and Additional Message Information (526-FQ) is in the Response Message Segment. Since part of the information is at the transmission level (header) and part of the information is at the transaction level, allowing for more than one transaction per transmission would cause a mismatch of data contained in field Message (5Ø4-F4) and Additional Message Information (526-FQ) to exist. As an additional note, new fields were incorporated in Telecommunication Standard Implementation Guide Version C.1 and above for this use.
- The additional insurance message must be displayed in field Message (5Ø4-F4) and overflow information must appear in field Additional Message Information (526-FQ) after the brand/generic processor messages (which are described in section "NCPDP Batch Standards – Medicare-Related Questions", subsection "Differential Price and Transitional Assistance").

2) Each additional individual insurance message must not be split (e.g. ADDINS:1 or ADDINS:2) between the Message (5Ø4-F4) and Additional Message Information (526-FQ) fields.

3) The data should be truncated whenever possible following NCPDP truncation rules:

- BIN value is required and must not be truncated.
- PCN value must not be truncated. Spaces must be sent if no PCN is required by the plan.
- If other fields are not required by the plan, field names with no data must be sent (e.g. send GP:; when no Group ID is required by the plan). It is strongly recommended that the data be truncated.
- ADDINS:2 (and subsequent) must begin immediately after the "&" from the previous ADDINS information if the data does not overflow into the Additional Message Information (526-FQ) field. For overflow into the Additional Message Information (526-FQ) field of two or more messages, the second and subsequent messages must begin immediately after the "&" of the previous ADDINS information.

4) Use of Parsing Characters is required as follows when triggered by "PRIMARY;" or "ADDINS:1;" starting in byte one of the Message (5Ø4-F4):

- Colon ":" separates field name from value
- Semi colon ";" separates different fields
- Ampersand "&" separates different additional insurance information or denotes the end of each additional insurance information data

5) Placement of any other information that the Processor sends:

- On a PAID response must appear AFTER additional insurance information, beginning in the next available byte of Additional Message Information (526-FQ). The brand/generic savings information will appear first only when the Brand/Generic Savings Amount is greater than zero. In this case the Tag ("CMS") will appear in

bytes 1-4 (byte 4 being a space); the Brand/Generic Message will appear in bytes 5-4Ø (byte 4Ø being a space); the Dollar Amount will appear in bytes 41-5Ø (byte 5Ø being a space). The ADDINS information will appear beginning with byte 51. Any remaining processor messaging will appear after the last ADDINS message.

- On a REJECTED response must appear AFTER additional insurance information beginning in the next available byte of Additional Message Information (526-FQ).
- On either a PAID or REJECTED response, if there is no additional insurance information sent, processor messaging will appear in either Message (5Ø4-F4) or Additional Message Information (526-FQ) according to the rules of the standard.

6) Placement of further clarifying Medicare errors the Processor sends:

Due to HIPAA constraints, new Reject Code (511-FB) values cannot be used in the Telecommunication Standard Version 5.1. However, with the advent of the Medicare Part D program, there is a need to clarify reject situations. The use of free text was examined, but with the Additional Insurance information, Brand/Generic Copay information, and processor specific messages, the Message (5Ø4-F4) and Additional Message Information (526-FQ) fields can rapidly be exhausted. The task group determined a codified structure solution allows more flexibility as more clarifying reject situations are recognized. The codified values are the actual Reject Codes going forward in a future version of the External Code List.

- On a REJECTED response after all the above rules have been applied, the Processor may return structured reject codes that further clarify Medicare responses.
- The string is &ECL;RC:### ;RC:### ;RC:### ;&
  - Where ECL is the tag for this section.
  - Where RC is the tag for the field Reject Code.
  - Where ### is the actual Reject Code (511-FB) ***value*** assigned.
  - The actual Reject Code is **up to three characters** in length.
  - There may be as many Reject Codes as fit or are needed to further explain. (The example string above shows three RC, but there may be as few as one RC or as many as fit in the space available or are needed to explain further.)
- Use of Parsing Characters is required as follows when triggered by “ECL;”
  - Colon “:” separates field name from value
  - Semi colon “;” separates different fields
  - Ampersand “&” denotes the beginning **and** end of the structured reject code information data
- The &ECL;RC:### ;RC:### ;RC:### ;& construction cannot be split. It must appear in its entirety in either field Message (5Ø4-F4) or Additional Message Information (526-FQ).
- The structured reject codes must appear after all other reject messages, including processor specific messages.
- The use of the structured reject codes is to augment the explanation of the current Reject Codes (511-FB). Processors must continue to use the Reject Codes (e.g. as code 41: Submit Bill to Other Processor or Primary Payer, or code 7Ø Product/Service Not Covered) for items that are not covered under Medicare Part D, but the structured reject codes provide for more information until they can be used as true Reject Codes in 511-FB in a later version of the Telecommunication Standard named under HIPAA.

15.8.2 Example of Messages

…other examples in the document…..

15.8.2.6 Example 6: A PDP Rejects The Claim Because They Should Be Billed As A Supplemental Payer With Structured Reject Codes

Reject with code 41: Submit Bill to Other Processor or Primary Payer
The following additional insurance information must be sent when the information is available. In this example Medicare is the Secondary Payer (ADDINS:1). Note, other processor-specified reject messages come after additional insurance information. Structured Reject Codes follow (example only).

Message (5Ø4-F4)
PRIMARY;BN:123456;PN:1234567890;GP:123465789012345;ID:1234567890 1234567890;PC:001;PH:8001234567;&ADDINS:1;BN:654321;PN:0987654321;GP:543210987654321;ID:0987654321098765432 1;PC:100;PH:8007654321;&
Additional Message Information (526-FQ)
PROCESSOR SPECIFIC REJECT MESSAGES WOULD BEGIN HERE &ECL;RC:A5;RC:A6;&

15.9.1.3 Rejected Response On Primary Claim From PDP To Pharmacy With Structured Reject Code

RESPONSE HEADER SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
1Ø2-A2	VERSION/RELEASE NUMBER	*51*	5.1 Transaction Format
1Ø3-A3	TRANSACTION CODE	*B1*	Rx Billing
1Ø9-A9	TRANSACTION COUNT	*1*	One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	*A*	Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	*Ø7*	NCPDP Provider ID
2Ø1-B1	SERVICE PROVIDER ID	*4563663bbbbbbbb*	
4Ø1-D1	DATE OF SERVICE	*2ØØ6Ø313*	March 13, 2ØØ6
RESPONSE MESSAGE SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*2Ø*	RESPONSE MESSAGE SEGMENT
The Following Fields are Optional:			
5Ø4-F4	MESSAGE	*PRIMARY;BN:123456;PN:1234567890;GP:123465789012345;ID:1234567890123456789;PC:001;PH:8001234567;&*	.

RESPONSE STATUS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	*R*	Rejected
The Following Fields are Optional:			
51Ø-FA	REJECT COUNT	*3*	
511-FB	REJECT CODE	*41*	Submit Bill To Other Processor Or Primary Payer
511-FB	REJECT CODE	*26*	M/I Unit Of Measure
511-FB	REJECT CODE	*55*	Non-Matched Product Package Size
526-FQ	ADDITIONAL MESSAGE INFORMATION	*NEW PAYER SHEETS EFFECTIVE ON JUNE 1*	Processor Specific Message followed by structured reject code

		WILL BE MAILED ON MAY 1&ECL;RC:A5;&	for "Not Covered Under Part D Law".
549-7F	HELP DESK PHONE NUMBER QUALIFIER	*Ø3*	Processor/PBM
55Ø-8F	HELP DESK PHONE NUMBER	*6Ø2357Ø862*	

RESPONSE CLAIM SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	*22*	CLAIM SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	*1*	Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	*1234567*	

Structured Reject Codes

This list is maintained in the Version 5 Editorial document for the Reject Codes that can be used in the structured reject code area. These same values are actual Reject Codes (511-FB) that are supported in future versions of the Telecommunication Standard. See the External Code List.

Reject Code	Description	Explanation
A5	"Not Covered Under Part D Law"	This reject message would be used for drugs which are excluded from coverage under basic Part D benefits as mandated by the MMA
A6	"This medication may be covered under Part B Medication and therefore cannot be covered under the Part D basic benefit for this beneficiary"	