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

CENTER FOR BENEFICIARY CHOICES

July 7, 2006

Memorandum To: All Part D plans

Subject: State to Plan Reconciliation Project

From: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group

As you are aware, the Centers for Medicare & Medicaid Services (CMS) has taken numerous actions to ensure that full benefit dual eligible individuals, and other low-income subsidy beneficiaries continue to receive needed medications as they make the transition to drug coverage under the new Medicare Part D drug benefit. Some states have found it necessary to provide additional assistance to full benefit dual eligibles and other low-income subsidy eligible beneficiaries in order to facilitate their transition into Medicare Part D. As part of a demonstration project, commonly referred to as the State-to-Plan Reconciliation project, CMS will reimburse a large portion of the states' incurred costs associated with the additional assistance states have provided.

This letter is intended to provide an overview for Part D plans of the State-to-Plan Reconciliation project, to outline the Part D plan's role in this effort, and to provide plans with some important contact information. Attachment I to this document provides questions and answers related to this project. Attachment II outlines some important file layout information of which plans need to be aware.

Background - CMS to Reimburse States under a Demonstration

Under a demonstration project under the authority of section 402 of the Social Security Amendments of 1967, CMS will pay states for expenditures that fall into one or a combination of the following categories:

- Full Part D drug costs (but not including Medicare required cost sharing amounts) for low-income subsidy entitled and full benefit dual eligible beneficiaries who did not have access to their benefits at the pharmacy during the start-up period;
- Costs from covering inappropriate levels of cost sharing for Part D drugs for low-income subsidy entitled beneficiaries that should have been reduced by the low-income cost sharing subsidy; and
- Administrative costs associated with either the aforementioned coverage and/or with assisting the low-income subsidy entitled and full benefit dual eligible beneficiaries in being properly enrolled into a Part D plan.

- Administrative costs associated with the costs of participation in this demonstration.

CMS has designed a process in which states under the demonstration will submit information to a CMS contractor awarded to Public Consulting Group (PCG) on costs that the state incurred related to the provision of Part D drugs to dual eligible and low-income subsidy entitled beneficiaries during their transition to Part D. This information will include claims-level data on payments to pharmacies, as well as information detailing administrative costs eligible for reimbursement under the demonstration. States will then work with CMS and its contractor to establish reimbursement parameters based on each state's liability for either primary or secondary payments on Part D claims for each category of subsidy-eligible beneficiaries.

The State-to-Plan Reconciliation Project consists of two major steps summarized as follows:

Step 1. Eligibility Verification

Participating states will submit to CMS files containing all the beneficiaries for whom it paid an eligible claim from January 1 to no later than March 31, 2006. The purpose of the eligibility check is to ensure that the individuals for whom the state has been paying claims are Medicare beneficiaries (entitled to either Medicare A or B) and if eligible, the beneficiary is enrolled in a Part D plan. Beneficiaries who are matched between CMS and state files will have their enrollment in Part D plans verified (or expedited if the beneficiary is full dual and was not assigned to a plan). The state will then submit its paid claims data file to CMS' contractor for claims incurred on behalf of these eligible individuals.

CMS's contractor, PCG, will receive the states' initial eligibility verification response files and any additional updates and will use these to perform appropriate eligibility edits on the claim files that the states submit for reimbursement under this project. Additionally, PCG will screen the claims data for Part D excluded drugs using the excluded drug file filter from the Drug Data Processing System.

Step 2. Claims Payments

Generally, CMS will be making several payment transactions to the states participating in the demonstration. Most States will receive an initial payment from CMS for claims costs, and an initial payment for administrative costs. States will create the claims report using the NCPDP 1.1 standard batch format in accordance with instructions provided by PCG. Based upon the information submitted by the state to PCG, CMS will make an initial payment equivalent to 95% of the total amount initially claimed. For full benefit dual eligible beneficiaries, this payment will cover what the state paid on behalf of the Part D beneficiary, except for an adjustment to reflect estimated Part D cost sharing. The second payment for claims cost will account for the remaining 5% payment previously withheld, and any adjustments due to the reconciliation with the plans.

States with SPAPs will follow the same process as the payments made to the Medicaid agency, except that repayments will be reduced by amounts that the SPAP would have incurred as the

secondary payer, had the claims been properly coordinated at the point-of-sale. CMS and PCG will discuss specific SPAP benefit packages and appropriate claim adjustments with each SPAP.

The Part D Plan's Role

Once PCG receives the initial set of claims data from the states, and states receive their payment from CMS, PCG will submit claims to the Part D plans using the NCPDP 1.1 batch format based on the attached instructions from PCG regarding the file layout and response file transmission. PCG will aggregate all the state claims into plan-specific batch files. The claims submitted in these batch files will have already been verified by CMS and PCG as eligible claims, including being screened by CMS' excluded drug file filter. Plans should not reject any claim through this process for eligibility or benefit coverage issues. Thus, Part D plans should suspend edits for formulary drugs, prior authorization, and safety and supply limits since these claims cover the initial Part D transition period (January 1, 2006 through March 31, 2006) and are deemed to be covered Part D drugs under the CMS 90 day transition policy.

The Part D plans will adjudicate these claims and send a response file back to PCG. The response files will require the Plan Sponsor to only fill out sections in the pricing segment and further only those that apply on the specific claim. Those fields are highlighted in the file structure layout provided in Attachment II.

Plans should adjudicate claims using their average (network) plan allowable amounts so that the response file will indicate the amount the plan would have been responsible for had it been the primary payer. Since state pharmacy ID numbers could not be matched to NABP/NCPDP numbers, actual network pharmacy contract payment terms cannot be used.

"Payments" on the adjudicated claims will not be made to PCG, but should be accounted for as liabilities. PCG will work with the plan and the state to resolve any rejected claims between the state and the plan. These payments will be recouped from future plan payments from CMS via the Automated Plan Payment System (APPS).

Plans will also be responsible for submitting Prescription Drug Event (PDEs) for each claim paid under the demonstration. CMS will update the Drug Data Processing System (DDPS) and publish PDE guidance explaining data submission specific to the State to Plan Reconciliation project. Plans should not submit State to Plan Reconciliation PDEs until they are advised that DDPS changes have been completed. Further guidance on PDE submissions will be forthcoming

Next Steps

In order to initiate the State-to-Plan Reconciliation project with Part D plans, PCG wants to identify a key contact person(s) within each Part D organization who will facilitate communication and address any connectivity or waiver related issues as they may arise. **By July 14, 2006, please e-mail the name and contact information to cbeatty@pcgus.com.**

If you have immediate questions regarding the transmission of claims data to your plan, please refer to PCG's contact list provided at the end of Attachment II. General questions regarding the

demonstration may be directed to Christine Hinds Christine.hinds@cms.hhs.gov or (410)786-4578.

Thank you in advance for your efforts on this important project.

Attachment I

I. General Plan Reconciliation Questions

1. Does CMS know when Medicaid agencies turned on and off their systems? Are states still continuing to pay for claims that should be covered by Part D?

Although the dates that states began paying Part D claims varies from state to state, several states started paying claims as early as January 1, 2006. Some states still continue to pay for claims that appear to have been erroneously rejected by Part D plans. However, the demonstration project only provides reimbursement for costs incurred on claims made through March 8th for the majority of the states participating in the demonstration project, with extensions granted to a few states. No extension is beyond March 31, 2006.

2. Is there any additional guidance on how a plan will resolve discrepancies with the claims file submitted by PCG?

The claims submitted in the NCPCP 1.1 batch file will have already been verified by CMS and PCG as eligible claims, including being screened by CMS' excluded drug file filter. Plans are instructed to remove edits for formulary drugs, prior authorization, and safety and supply limits since these claims cover the initial Part D transition period (January 1, 2006 through March 31, 2006). Therefore, no claims should be rejected. If there is a discrepancy on the claim submitted by PCG, the plan should work with PCG to correct the claim.

3. When would an Explanation of Benefits (EOB) need to be sent to plan members?

Changes to the EOB due to the State-to-Plan reconciliation process, if any, can be reflected in the next monthly EOB sent to the beneficiary.

4. How will the State-to-Plan reconciliation process affect TrOOP? Will plans need to retroactively update the TrOOP accumulator for these revised claims?

The Part D plan should assess the impact that these claims have on the beneficiary's TrOOP and should ensure that the TrOOP accumulator is adjusted to reflect the retroactive period.

5. Will Part D plans be able to collect rebates from manufacturers for these drugs?

Since the Part D plan and the Federal government through the low-income subsidy will eventually be paying the majority of the beneficiary's prescription drug costs through this demonstration, we expect Part D plans to collect rebates applicable to these claims.

6. What fields will be populated in the batch claims file?

We have attached PCG's instructions regarding the required fields in the batch file.

7. Is the HICN a required element on the NCPDP 1.1 batch file?

CMS will provide the HICN to PCG and it will be included in the batch file sent by PCG.

8. What will be the format for sending the processed claims back to PCG?

Attached are instructions from PCG regarding the format plans should follow when providing a response to PCG.

9. Will we be notified when plan payment offsets will occur, and will plans have an opportunity to validate the accuracy before processing?

Plan payments will be based upon the plan's customary allowable payment for the claims submitted by PCG. Plan payment amounts will not be made to PCG, but should be accounted for as a liability account. Plan payments via the Automated Plan Payment System (APPS) will be reduced based upon these amounts. At this time, payment recoupment from APPS will probably occur sometime later this calendar year.

10. How will plan member co-pays be offset against plan liability?

Part D plans will not be liable for the beneficiary's copays that should have been collected at the pharmacy. CMS will not be reimbursing states for Part D beneficiary copays.

II. Frequently Asked Questions on the NCPDP 1.1 format version for the 402 Waiver.

1. What is the purpose of this file?

This claims file is intended to capture amounts PAID IN ACTUAL by state agencies over the waiver period for Part D covered drugs for dual eligibles, and in this phase of the State to Plan Reconciliation project, to identify the AMOUNT THAT THE PLAN WOULD HAVE BEEN RESPONSIBLE FOR in the transaction had the program and plan been in effect at a proper level for the individual participant at the time of service.

2. How many claims files will a state or PCG send to the Plan?

PCG will allow for limited submission of the claims file from each state, and will allow for ideally no more than two live file passes of claims data for each state to be submitted to each relevant Plan.

- The first pass is designed to capture the majority of claims experienced by the state and will include all known Part D claims for the waiver period from that state.
- The second pass of claims files from the state is designed to capture any paper claims run out, as well as to allow the states the opportunity to resubmit denied claims that have been remedied or eligibilities that have been adjusted with CMS.

3. What is the response file format required from the Plans?

The response files are required to be in the listed 1.1 batch file format and Plan sponsors are only required to fill in two fields in the pricing segment on each claim submitted. The pricing segment fields that are required for the Plan to fill out are highlighted in the next attachment.

Attachment II

PLEASE REFER TO THE NCPDP 1.1 DATA DICTIONARY FOR FIELD FORMATTING AND LENGTH REQUIREMENTS TO ENSURE FILE ACCURACY.

NOTE: The file structure listed below will be the structure used in the files sent by PCG to the Plan Sponsor on record for the participant. This file structure will also be used for response files to come back to PCG from the Plan Sponsors. The Plan will be responsible for populating the two highlighted fields on the Pricing Segment of each claim as outlined below.

The color coding in the file structure does not affect the files submitted to the Plans nor does it impact the required response files to come from the Plans. The colors denotations in the file structure description attached here were used in Phase I of the project in the data exchange with the state agencies as a way to show required fields in BLACK TEXT, situational fields in BLUE TEXT, and all optional fields in RED TEXT.

The following pages go over in greater detail each of the fields comprising the claim format to be submitted by the State to PCG and subsequently to be submitted by PCG to the Plan Sponsor on CMS record. Optional fields noted in red are to be populated with data obtained from CMS files

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT
409-D9	INGREDIENT COST SUBMITTED	*557{*	Ingredient cost submitted by Provider on original claim. If not available then submit the amount Medicaid was billed by provider on original claim. Field Format is s9(6)v99
412-DC	DISPENSING FEE SUBMITTED	*45{*	Dispensing fee submitted by Provider on original claim. Field Format is s9(6)v99
426-DQ	USUAL AND CUSTOMARY CHARGE	*587{*	Usual and Customary charge submitted by provider on original claim. Field Format is s9(6)v99
433-DX	PATIENT PAID AMOUNT SUBMITTED	*55{*	Amount the Pharmacy received from the patient for prescription dispensed

505-F5	PATIENT PAY AMOUNT	*0*	Amount paid by the patient, or assumed to have been paid as the co-pay.
43Ø-DU	**GROSS AMOUNT DUE**	***546{***	**The net amount Plan Sponsor should have paid to provider - Field Format is 9(6)v99**
804-5B	*AMOUNT BILLED*	*601{*	*Total Amount the pharmacy billed on original claim. Field Format is s9(6)v99*
600-78	**PRODUCT CO-PAY**		**C0-pay for the product recognized by the Plan. Field format *9(3)v99***
423-DN	BASIS OF COST DETERMINATION	x(2)	Code indicating the method by which 'Ingredient Cost Submitted' (Field 4Ø9-D9) was calculated.

43Ø-DU	**GROSS AMOUNT DUE**

***This field is <u>required.</u> It should contain the net amount that the Plan recognizes would have been due the provider at the time of service had the program and Plan been in proper effect for the participant, and this is the total dollar amount that the Plan Sponsor will recognize as oweable to CMS for this transaction.**

600-78	**PRODUCT CO-PAY**

***This field is <u>required.</u> This field should contain the amount that the Plan recognizes as the appropriate co-pay given the individual participant and the respective drug.**

For additional clarification or information, please directly contact the PCG claims reconciliation manager for this CMS project, Colin Beatty. A claims coordinator will be established for your state and can be contacted directly as well.

CMS Claims Manager	Claims Coordinator	Claims Coordinator
Colin Beatty 148 State Street Boston, MA 02109 (617) 426-2026 ext 1345 cbeatty@pcgus.com	Darrin Shaffer 101 N. 1st Ave. Suite 1850 Phoenix, AZ 85003 (602) 324-5005 dshaffer@pcgus.com	Deb Johnson 16 Corp. Woods Blvd Albany, NY (518) 465-4395 djohnson@pcgus.com

The following pages go over in greater detail each of the fields comprising the claim format to be submitted by the State to PCG and subsequently to be submitted by PCG to the Plan Sponsor on CMS record.

Batch Transaction Header:

Standard 1.1 is a real time transaction; 5.1 creates a batch setting.

Batch Transaction Header (NCPDP 5.1 ENVELOPE)						
Field	**Field Name**	**Type**	**Length**	**Start**	**End**	**Value**
880-K4	Text Indicator	A/N	1	1	1	Start of Text (Stx) = X'02'
701	Segment Identifier	A/N	2	2	3	00 = File Control (header).
880-K6	Transmission Type	A/N	1	4	4	T = Transaction
880-K1	Sender ID	A/N	24	5	28	
			2	5	6	State abbreviation claims are coming from (NY)
			17	7	23	Submitter should enter blanks
			5	24	28	Submitter should enter “MED-D”
806-5C	Batch Number	N	7	29	35	Submitter defined value. Must match trailer.
880-K2	Creation Date	N	8	36	43	CCYYMMDD
880-K3	Creation Time	N	4	44	47	HHMM
702	File Type	A/N	1	48	48	P = Production, T= Test
102-A2	Version/Release Number	A/N	2	49	50	51
880-K7	Receiver ID	A/N	24	51	74	Submitter should enter PCGMED-D
880-K4	Text Indicator	A/N	1	75	75	End of Text (Etx) = X'03'

Detail Data Record

Detail Data Record						
Field	**Field Name**	**Type**	**Length**	**Start**	**End**	**Value**
880-K4	Text Indicator	A/N	1	1	1	Start of Text (Stx) = X'02'
701	Segment Identifier	A/N	2	2	3	G1 = Detail Data Record
880-K5	Transaction Reference Number	A/N	10	4	13	Submitter should enter blanks
	NCPDP Data Record		Varies	**14**	Varies	Actual claim detail information starts here- variable length- Detail Record
880-K4	Text Indicator	A/N	1	Varies	Varies	End of Text (Etx) = X'03'

I - Detail Record:

Detail record Header (The header for each claim record)			
FIELD	FIELD NAME	VALUE	COMMENTS
1Ø1-A1	**BIN NUMBER**	***000000***	**Six positions (leave zeros if not data)**
1Ø2-A2	**VERSION/RELEASE NUMBER**	***51***	**Enter value of '51' for the 5.1 Transaction Format**
1Ø3-A3	**TRANSACTION CODE**	***B1***	**Rx billing = B1**
1Ø4-A4	**PROCESSOR CONTROL NUMBER**	***WAIVERbbbb***	**Submitter must submit the word "WAIVER" followed by four (4) spaces.**
1Ø9-A9	**TRANSACTION COUNT**	***1***	**One prescription per data role, all others will be ignored.**
2Ø2-B2	**SERVICE PROVIDER ID QUALIFIER**	***Ø7***	**07= NCPDP provider ID (NABP)**
2Ø1-B1	SERVICE PROVIDER ID	*1234567bbbbbbbb*	7 digit dispensing pharmacy NCPDP #
4Ø1-D1	DATE OF SERVICE	*2ØØØØ115*	Ccyymmdd
11Ø-AK	**SOFTWARE VENDOR/CERTIFICATION ID**	***0000000000***	**Populate with 10 zeros**

1Ø1-A1	BIN Number

***This field is <u>optional</u>.** Recommended to leave with zeros.

1Ø4-A4	**Processor Control Number**

***This field is <u>required</u>.** Should submit the word WAIVER followed by 4 spaces.

2Ø2-B2	Service Provider ID Qualifier

Ø5=Medicaid
Ø7=NCPDP Provider ID
Ø8=State License
11=Federal Tax ID

***This field is <u>required</u>.** We prefer it be populated with 07 – NCPDP (NABP) Numbers however if this is not available please use one of the other choices provided on the list above.

2Ø1-B1	Service Provider ID

***This field is <u>required</u>.** We prefer it be populated with the NCPDP (NABP) Numbers however if this is not available please use one of the other choices provided on the list above.

4Ø1-D1	Date of Service

***This field is <u>required</u>.** This should be the date that the prescription was filled.

11Ø-AK	**Software Vendor/Certification ID**

***This field is <u>required</u>.** It should be populated by 10 zeros.

II - Patient Segment:

PATIENT SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	**SEGMENT IDENTIFICATION**	***Ø1***	**PATIENT SEGMENT**
331-CX	**PATIENT ID QUALIFIER**	***99 =OTHER***	**99=Other ID**
332-CY	PATIENT ID	*55389012*	Populate with Patients Medicaid ID (RID)
31Ø-CA	PATIENT FIRST NAME	*JOHN*	Max 12 bytes
311-CB	PATIENT LAST NAME	*DOE*	Max 15 bytes
322-CM	PATIENT STREET ADDRESS	*1234 ANY STREET*	Max 30 bytes
323-CN	PATIENT CITY ADDRESS	*ANYWHERE*	Max 20 bytes
324-CO	PATIENT STATE/PROVINCE ADDRESS	*AZ*	Max 2 bytes
325-CP	PATIENT ZIP/POSTAL ZONE	*850331234*	Max 15 bytes
304-C4	PATIENT DATE OF BIRTH	*19600810*	Ccyymmdd
305-C5	PATIENT GENDER CODE		1= Male 2= Female
307-C7	PATIENT LOCATION	*VALID VALUES: 01-11 (SEE NCPDP STANDARDS)*	Code Identifying the location of patient when receiving pharmacy services.
333-CZ	EMPLOYER ID	*ID ASSIGNED TO EMPLOYER*	Max 15 bytes

307-C7	Patient Location

Code identifying the location of the patient when receiving pharmacy services.

Ø=Not specified
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
1Ø=Outpatient
11=Hospice

***This field is <u>optional.</u>** If individual was in an LTC facility at the time of service please identify by using a value of 3. Use a value of 5 when identifying a beneficiary residing in an Assisted Living facility to ensure proper adjudication and payment. If this field is not tracked by the State either omit the field altogether or default to 0. This field will be matched to the CMS Institutional Status Indicator to locate those individuals not subject to the co-pay levels of non-institutionalized part D participants.

333-CZ	Employer ID

***This field is <u>optional</u>.**

332-CY	Patient ID

***This field is <u>Required</u>.** This will be the field that is matched back to the MMA file for re-verification of eligibility over this waiver period. It corresponds with the State SMA ID (the state Medicaid Identifier code for the beneficiary, provided by the state) and is in position 33-52 of the MMA file structure exchanged with CMS.

III - Insurance Segment:

INSURANCE SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	**SEGMENT IDENTIFICATION**	***04***	**INSURANCE SEGMENT**
3Ø2-C2	CARDHOLDER ID	*123456789*	SSN#/HIC#
3Ø6-C6	**PATIENT RELATIONSHIP CODE**	***1***	**Cardholder =1, Spouse=2 Child=3, should only be 1**
600-95	**PLAN ID QUALIFIER**	***Z***	***Z=mutually agreed upon***
524-FO	PLAN ID	*21456789*	PDP Plan ID- Max 8 bytes, contains the 5 digit contract ID code and 3 digit plan qualifier suffix code
600-94	PLAN ID CODE	*assigned to identify the plan ID*	Max 17 bytes
734	PLAN ID EFFECTIVE DATE	*20060101*	Ccyymmdd
600-96	PLAN NAME	*The name of the plan*	Max 30 Bytes
3Ø1-C1	GROUP ID	*MEDDRX129*	Group ID# Max 15
309-C9	ELIGIBILITY CLARIFICATION CODE	*1*	Was the eligibility clarified Y/N off of the CMS MMA waiver eligibility file **Value of "0" is not verified Value is "1" if verified**
464-EX	INTERMEDIARY AUTHORIZATION ID	*2323232323*	ID assigned to State by COBC (Must be prefixed with zeros to a length of 11).
600-01	CLIENT ID CODE	*Code identifying MCO enrollment*	Max bytes 17 Only applies for persons enrolled in MCO's
303-C3	PERSON CODE	*Code identifying SPAP enrollment*	Max bytes 3 Only applies to persons enrolled in SPAP's
712	EFFECTIVE DATE	*2ØØØØ11Ø*	*Medicaid effective date* Ccyymmdd
545-2F	NETWORK REIMBURSEMENT PROVIDER ID	*Ø712345789*	7 digit Provider ID number assigned by PCG to States and SPAP's

3Ø2-C2	CARDHOLDER ID	*123456789*	SSN#/HIC#

***This field is <u>required</u>. Must contain either SSN or HIC. RID is not acceptable in this field.**

524-FO	Plan ID
600-94	Plan ID Code
734	Plan ID effective Date
600-96	Plan Name

***These fields are optional,** unless Medicaid acted as secondary payer when the patient was not recognized as full dually eligible at time of purchase, but was enrolled in a Part D plan. States are strongly encouraged to populate this information if known in order to mitigate any discrepancies in the archive of info held by the state versus what is recognized by CMS. Failure to populate this information will not limit the states' ability to collect reimbursements, but it will potentially limit their capacity to dispute denied claims effectively.*

734	Plan ID effective Date

****This field is optional.** This field should show the earliest date of Medicare Part D eligibility known.

600-01	Client ID Code

***This field is situational. It is required if individual is enrolled in a Managed Care Organization.** The field should contain that MCO number.

303-C3	Person Code

****This field is situational. It is required if individual is enrolled in a State Pharmacy Assistance Program.** The field should contain that SPAP number.

712	Effective Date

***This field is required.** This field should show the earliest date of Medicaid eligibility and should overlap date of service.

545-2F	NETWORK REIMBURSEMENT PROVIDER ID

***This field is required.** This is the ID assigned to the agency by PCG found in this document below.

IV - Claim Segment:

CLAIM SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	**SEGMENT IDENTIFICATION**	***Ø7***	**CLAIM SEGMENT**
455-EM	**RX/SERVICE REF NUMBER QUALIFIER**	***1***	**1 = RX Billing**
4Ø2-D2	RX NUMBER/SERVICE REF NUMBER	*1234567*	Prescription number assigned by provider – numeric only Max 7 bytes
436-E1	**PRODUCT/SERVICE ID QUALIFIER**	***Ø3***	**03= NDC code**
4Ø7-D7	PRODUCT/SERVICE ID	*ØØØØ2554Ø134*	NDC code. Max 19 bytes If a Compound Segment; Provide the NDC Code of the active ingredient OR provide the compound information in the optional compound segment.
442-E7	QUANTITY DISPENSED	*1ØØØØ*	Metric quantity decimal implied 9(7)v999 9999999.999
4Ø3-D3	FILL NUMBER	*Ø*	0=Original 1-99 = refill number Max 2 byte
4Ø5-D5	DAYS SUPPLY	*1Ø*	# of days supply Max 3 bytes
4Ø6-D6	COMPOUND CODE	*1*	0=not specified 1= not a compound 2=Compound
4Ø8-D8	DAW/PRODUCT SELECTION CODE	*Ø*	Value must be equal to 0 – 9. No other values will be except. See NCPDP data dictionary for value definitions
414-DE	DATE PRESCRIPTION WRITTEN	*2ØØØØ11Ø*	Ccyymmdd
415-DF	NUMBER OF REFILLS AUTHORIZED	*0*	0= not specified/ 1-99
308-C8	OTHER COVERAGE CODE	*2*	2= Other coverage exists/payment collected, Medicaid acted as secondary payer 1= No other coverage known, Medicaid acted as primary payer
735	OTHER COVERAGE EFFECTIVE DATE	*2ØØØØ1Ø1*	Ccyymmdd
460-ET	QUANTITY PRESCRIBED	*1ØØØØ*	Metric quantity decimal implied 9(7)v999 9999999.999
343-HD	DISPENSING STATUS	*C*	P=Initial Fill C= completion fill – required on Partial fill claims only
344-HF	QUANTITY INTENDED TO BE DISPENSED	*0*	Required only on partial fill claims
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	*000*	Required only on partial fill claims
425-DP	DRUG TYPE	*0*	0= not specified 1= single source brand 2= Branded Generic 3= Generic 4= OTC (over the counter)
33Ø-CW	ALTERNATE ID	*ØØØ7712345789*	Provider/Medicaid Claim # (ICN/TCN#) Max 20 bytes
464-EX	INTERMEDIARY AUTHORIZATION ID	*2323232323*	ID assigned to State by COBC (Must be prefixed with zeros to a length of 10.
418-DI	LEVEL OF SERVICE	*1*	Enter poverty level code 1,2,3

544-FY	FREE FORM TEXT FIELD	*TEXT*	Free form text for additional notations – Max 30 bytes

436-E1	**PRODUCT/SERVICE ID QUALIFIER**
4Ø7-D7	PRODUCT/SERVICE ID

***These fields are <u>Required</u>.** The NDC Code and qualifier are required in these fields for non-compound drugs and in compound drugs where the state can provide the NDC code for the active ingredient (forgoing the compound segment); alternatively, if the drug is compound the NDC codes are located in the compound drug claim segment.

4Ø6-D6	Compound Code

***This field is <u>required</u>**. It should contain 0, 1, or 2, with 0 as a default if information not known. 1 is used in non-compounded drugs, and 2 is used for compound drugs.

4Ø8-D8	DAW/Product Selection Code

Ø=No Product Selection Indicated-This is the field default value that is appropriately used for prescriptions where product selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed.

1=Substitution Not Allowed by Prescriber- This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written.

2=Substitution Allowed-Patient Requested Product Dispensed-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.

3=Substitution Allowed-Pharmacist Selected Product Dispensed-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.

4=Substitution Allowed-Generic Drug Not in Stock-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.

5=Substitution Allowed-Brand Drug Dispensed as a Generic-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity.

6=Override-This value is used by various claims processors in very specific instances as defined by that claims processor and/or its client(s).

7=Substitution Not Allowed-Brand Drug Mandated by Law-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.

8=Substitution Allowed-Generic Drug Not Available in Marketplace-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable.

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

***This field is <u>required</u>**. It is to be used primarily to identify cases where generic drug was requested but substituted for. If the field is not data stored/tracked please default to 0 or omit field.

308-C8	Other Coverage Code

***This field is <u>required</u>**. This field is to be used where Medicaid acted as secondary payor and other coverage was identified at the time of service and in these instances, the field should contain a 2. Where Medicaid acted as primary payor and no other insurance is known, the field should contain a 1.

735	Other Coverage effective date

Date on which the other coverage code is effective and required if Other Coverage Code is submitted.

***This field is <u>situational</u>** and is to be used when other insurance coverage is known.

460-ET	Quantity Prescribed

***This field is <u>situational</u>**. This is only required on partial fills.

343-HD	DISPENSING STATUS

***This field is <u>situational</u>**. This is only required on partial fills.

344-HF	QUANTITY INTENDED TO BE DISPENSED

***This field is <u>situational</u>**. This is only required on partial fills.

345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED

***This field is <u>situational</u>**. This is only required on partial fills.

425-DP	Drug Type

0= not specified
1= single source brand
2= Branded Generic
3= Generic
4= OTC (over the counter)

*** This field is <u>required</u>. It is not sent in on the NCPDP transaction but can be sourced from the drug file and NDC codes.**

464-EX	INTERMEDIARY AUTHORIZATION ID

ID assigned to State by COBC (Must be prefixed with zeros to a length of 10.

***This field is <u>optional</u>**. If the ID has been assigned and is known, the field is to be populated.

418-DI	LEVEL OF SERVICE

Enter poverty level code 1,2,3

***This field is <u>required.</u>** It can be sourced from state dual eligible status files and should denote federal poverty level / low income status (LIS). For the purposes of this waiver process, the persons should be full dual eligible or under 100% FPL which is denoted by a 1. Dual eligibles under 135% FPL (i.e. QMB, SLMB) are denoted by a 2, and those with low income status (LIS) that fall between 135% and 150% FPL are denoted by a 3. **Where not available, default should be a 2.**

544-FY	Free Form Text Field

***This field is <u>optional</u>**. It is in Response DUR segment in NCPDP guide but is to be used for other state specific information pertinent to the claims waiver process that can not be captured elsewhere. If used, please notify PCG prior to file submission.

V - COB Segment:

COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT			
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**
111-AM	**SEGMENT IDENTIFICATION**	***05***	**COB SEGMENT**
337-4C	**COB/OTHER PAYMENTS COUNT**	***1***	**One occurrence**
338-5C	**OTHER PAYER COVERAGE TYPE**	***02***	**02= Secondary** **03= Tertiary**
339-6C	**OTHER PAYER ID QUALIFIER**	***99***	**99= Other**
340-7C	OTHER PAYER ID	*Aetna*	Populate with text name of plan sponsor Max 10 bytes
443-E8	OTHER PAYER DATE	*20060120*	ccyymmdd (date Aetna paid MED-D RX claim)
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	*07*	07= Drug Benefit
431-DV	OTHER PAYER AMOUNT PAID	*100{*	$10.00 – Amount Aetna Paid
817-5E	CO-PAY AMOUNT		Patient Co-Pay amount

The entire COB segment is situational. IT IS REQUIRED WHEN MEDICIAD ACTED AS SECONDARY PAYER. If the claim has both a secondary and tertiary payor you may submit to COB segments; please designate 02 or 03 in field 338-5C.

337-4C	COB/Other payments count
338-5C	Other Payer coverage type
339-6C	Other Payer ID Qualifier
340-7C	Other Payer ID
443-E8	Other Payer Date
342-HC	Other Payer Amount Paid Qualifier
431-DV	Other Payer Amount Paid

***These fields are <u>required</u> if the COB segment is sent. In Other Payer ID indicate known plan sponsor or other primary paying insurance.**

817-5E	CO-PAY AMOUNT

***This field is <u>optional</u> if the COB segment is sent. This is the co-pay amount collected at the point of purchase based on assumption that other payer was primary. It is assumed that Medicaid paid a portion of this paid amount (reflected later in 430-DU); If this data is unavailable default to 00000}.**

VI - Pricing Segment:

PRICING SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	SEGMENT IDENTIFICATION	*11*	PRICING SEGMENT
409-D9	INGREDIENT COST SUBMITTED	*557{*	Ingredient cost submitted by Provider on original claim. If not available then submit the amount Medicaid was billed by provider on original claim. Field Format is s9(6)v99
412-DC	DISPENSING FEE SUBMITTED	*45{*	Dispensing fee submitted by Provider on original claim. Field Format is s9(6)v99
426-DQ	USUAL AND CUSTOMARY CHARGE	*587{*	Usual and Customary charge submitted by provider on original claim. Field Format is s9(6)v99
433-DX	PATIENT PAID AMOUNT SUBMITTED	*55{*	Amount the Pharmacy received from the patient for prescription dispensed
505-F5	**PATIENT PAY AMOUNT**	***0***	**Amount paid by the patient, or assumed to have been paid as the co-pay.**
43Ø-DU	**GROSS AMOUNT DUE**	***546{***	**The net amount Plan Sponsor should have paid to provider - Field Format is s9(6)v99**
804-5B	*AMOUNT BILLED*	*601{*	*Total Amount the pharmacy billed on original claim. Field Format is s9(6)v99*
600-78	**PRODUCT CO-PAY**		**C0-pay for the product recognized by the Plan. Field format *9(3)v99***
423-DN	BASIS OF COST DETERMINATION	x(2)	Code indicating the method by which 'Ingredient Cost Submitted' (Field 4Ø9-D9) was calculated.

409-D9	Ingredient Cost Submitted

***This field is <u>required.</u> If not available, provide amount Medicaid was billed by provider on original claim.**

412-DC	Dispensing Fee Submitted

***This field is <u>required.</u> If not known or not broken out of claim amount, put 0.**
****DO NOT PUT DISPENSING FEE HERE IF ALSO INCLUDED IN FIELD 430-DU.**

426-DQ	Usual and Customary Charge

***This field is <u>required.</u>**

433-DX	Patient Paid Amount Submitted

***This field is <u>optional.</u>** This is the amount actually collected from the patient at time of service.

505-F5	Patient Pay Amount

***This field is <u>required.</u> This is the amount of assumed co-pay patient obligation that Medicaid net out of the claim amount in accordance with assumed co-pay levels. This is the amount that the provider assumed responsibility for and either absorbed, collected from the patient or from some other entity.**

430-DU	Gross Amount Due

***This field is <u>required</u>. This is the amount that Medicaid actually paid out to the pharmacy.**

804-5B	Amount Billed

***This field is <u>required</u>. This is the amount that the pharmacy billed IN TOTAL on the original actual claim. This should include any dispensing fees, co-pays later net out by Medicaid, or other portions.**

600-78	Generic Product Co-pay

***This field is <u>optional</u>.**

423-DN	BASIS OF COST DETERMINATION

Blank=Not Specified
ØØ=Not Specified
Ø1=AWP (Average Wholesale Price)
Ø2=Local Wholesaler
Ø3=Direct
Ø4=EAC (Estimated Acquisition Cost)
Ø5=Acquisition
Ø6=MAC (Maximum Allowable Cost)
Ø7=Usual & Customary
Ø9=Other

***This field is <u>required</u>. If not tracked please populated with 00**

VII - Compound Segment:

COMPOUND SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	Segment Identification	1Ø	Compound Segment
45Ø-EF	Compound Dosage Form Description Code		Max Length 2 Dosage form of the complete compound mixture.
451-EG	Compound Dispensing Unit Form Indicator		1=Each 2=Grams 3=Milliliters
452-EH	Compound Route of Administration		Code for the route of administration of the complete compound mixture.
447-EC	Compound Ingredient Component (Count)		Max Length 2 Format 9(2) Count of compound product IDs (both active and inactive) in the compound mixture submitted.
488-RE	Compound Product ID Qualifier	03	Repeating Ø3=National Drug Code (NDC)
489-TE	Compound Product ID		Repeating Max Length 19
448-ED	Compound Ingredient Quantity		Repeating Format 9(7)v999
449-EE	Compound Ingredient Drug Cost		Repeating

The entire Compound segment is situational. SUBMIT A MAXIMUM OF 5 REPEATING FIELDS (488-RE, 489-TE, 448-ED, 449-EE) WHEN THE FILLED DRUG WAS A COMPOUND *AND YOU ARE UNABLE TO IDENTIFY THE ACTIVE INGREDIENT OF THE DRUG AND PLACE IT IN FIELD 407-D7. POPULATING THE 407-D7 WITH THE ACTIVE INGREDIENT NDC CODE IS THE CMS and PLAN PREFERRED METHOD FOR PROCESSING COMPOUND DRUG CLAIMS*.

If you utilize the Compound Segment, Field 447-EC will contain a number from 1 to 5 depending on the number of components included.

45Ø-EF	Compound Dosage Form Description Code

Ø1=Capsule
Ø2=Ointment
Ø3=Cream
Ø4=Suppository
Ø5=Powder
Ø6=Emulsion
Ø7=Liquid
1Ø=Tablet
11=Solution
12=Suspension
13=Lotion
14=Shampoo
15=Elixir
16=Syrup
17=Lozenge
18=Enema

452-EH	Compound Route of Administration

1=Buccal
2=Dental
3=Inhalation
4=Injection
5=Intraperitoneal
6=Irrigation
7=Mouth/Throat
8=Mucous Membrane
9=Nasal
1Ø=Ophthalmic
11=Oral
12=Other/Miscellaneous
13=Otic
14=Perfusion
15=Rectal
16=Sublingual
17=Topical
18=Transdermal
19=Translingual
2Ø=Urethral
21=Vaginal
22=Enteral

VIII - Prescriber Segment:

PRESCRIBER SEGMENT			
FIELD	FIELD NAME	VALUE	COMMENTS
111-AM	**SEGMENT IDENTIFICATION**	***Ø3***	**PRESCRIBER SEGMENT**
466-EZ	**PRESCRIBER ID QUALIFIER**	***12***	**12= DEA number Max 2 bytes.**
411-DB	PRESCRIBER ID	*NH1234567*	Max 15 bytes. Id assigned to subscriber by DEA.

466-EZ	Prescriber ID Qualifier

***This field is <u>required</u>. Preferably this should contain the number 12 for DEA number, if you do not track the DEA number you may use one of the identifiers below.**

Ø5=Medicaid
Ø8=State License
12=Drug Enforcement Administration (DEA)
99=Other

411-DB	Prescriber ID

***This field is <u>required</u>. Preferably this should contain the number 12 for DEA number, if you do not track the DEA number you may use one of the identifiers on this list above.**

Batch Trailer Record:

TRANSACTION TRAILER SECTION						
Field	**Field Name**	**Type**	**Length**	**Start**	**End**	**Value**
880-K4	**Text Indicator**	**A/N**	**1**	**1**	**1**	**Start of Text (Stx) = X'02'**
701	**Segment Identifier**	**A/N**	**2**	**2**	**3**	**99 = File Trailer**
806-5C	Batch Number	N	7	4	10	Submitter defined value. Must match header
751	Record Count	N	10	11	20	Count of transmitted records
504-F4	Message	A/N	35	21	55	Not a required field. (free form text – 35 bytes)
880-K4	**Text Indicator**	**A/N**	**1**	**56**	**56**	**End of Text (Etx) = X'03'**

Provider Numbers assigned to agencies:

To fill field 545-2F of the NCPDP 1.1 claims file

State Medicaid Agencies

State	Provider #
Alabama	2000001
Alaska	2000002
Arizona[1]	2000003
Arkansas	2000004
California	2000005
Colorado	2000006
Connecticut	2000007
D.C.	2000008
Delaware	2000009
Florida	2000010
Georgia	2000011
Hawaii	2000012
Idaho	2000013
Illinois	2000014
Indiana	2000015
Iowa	2000016
Kansas	2000017
Kentucky	2000018
Louisiana	2000019
Maine	2000020
Maryland	2000021
Massachusetts	2000022
Michigan	2000023
Minnesota	2000024
Mississippi	2000025
Missouri	2000026
Montana	2000027
Nebraska	2000028
Nevada	2000029
New Hampshire[2]	2000030
New Jersey	2000031
New Mexico	2000032
New York[3]	2000033
North Carolina	2000034
North Dakota	2000035

State Medicaid Agencies

State (cont.)	Provider #
Ohio	2000036
Oklahoma	2000037
Oregon	2000038
Pennsylvania	2000039
Rhode Island	2000040
South Carolina	2000041
South Dakota	2000042
Tennessee	2000043
Texas	2000044
Utah	2000045
Vermont[4]	2000046
Virginia	2000047
Washington	2000048
West Virginia	2000049
Wisconsin	2000050
Wyoming	2000051

SPAPs

State	Provider #
AK	1000001
AK	1000002
CT	1000003
DE	1000004
HA	1000005
IL	1000006
ME	1000007
MD	1000008
MA	1000009
MO	1000010
MO	1000011
MO	1000012
MT	1000013
MT	1000014
NV	1000015
NV	1000016
NJ	1000017
NJ	1000018
NJ	1000019
NY	1000020
NY	1000021
PA	1000022
PA	1000023
PA	1000024
RI	1000025
RI	1000026
VT	1000027
WI	1000028
WY	1000029
WY	1000030