

# Pharmacy Billing Manual

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# Pharmacy

## Requirements and Benefits

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This manual explains many of the Department of Health Care Policy and Financing's (Department) policies regarding billing, provider responsibilities and Colorado Medical Assistance Program benefits. Providers should also consult the [Code of Colorado Regulations](#) (10 C.C.R. 2505-10 Section 8.100) for further guidance regarding benefits and billing requirements.

### **1990 OBRA Rebate Program**

Federal regulation requires that drug manufacturers sign a national rebate agreement with the Centers for Medicaid and Medicare Services (CMS) to participate in the state Medical Assistance Program. Drugs produced by companies that have signed a rebate agreement (participating companies) are generally a Colorado Medical Assistance Program benefit but may be subject to restrictions. In addition, some products are excluded from coverage and are listed in the Restricted Products section. The Medical Assistance Program does not provide reimbursement for products by manufacturers that have not signed a rebate agreement unless the Department has made a determination that the availability of the drug is essential, such drug has been given 1-A rating by the Food and Drug Administration (FDA), and prior authorized.

### **Prior Authorization Request (PAR) Process**

Drugs that are considered regular Colorado Medical Assistance Program benefits do not require PAR. Certain restricted drugs require prior authorization before they are covered as a benefit of the Medical Assistance Program.

**The procedure to request a PAR and the medications that require a PAR are outlined in Appendix P- Prior Authorization Procedures and Criteria located in the Pharmacy Prior Authorization Policies section of the Department's website ([colorado.gov/hcpf](http://colorado.gov/hcpf)).**

Prior authorization requests are reviewed by the Department or the Department's fiscal agent, Xerox State Healthcare. All pharmacy PARs must be telephoned and/or faxed by the prescribing physician or physician's agent to the Prescription Drug Card System (PDCS) Pharmacy Support numbers identified in Appendix P. Notification of PAR approval or denial is sent to each of the following parties:

- Requesting physician
- Proposed rendering provider (if identified on the PAR)
- Member

In addition to stating whether the PAR has been approved or denied, the notification letter identifies the member's appeal rights. Only members have the right to appeal a PAR decision.

If additional information is requested in order to process the PAR, the physician should provide the information by phone or fax.

**Approval of a PAR does not guarantee payment.** Prior Authorization Requests only assures that the approved service is medically necessary and considered to be a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet claim submission requirements before payment can be made. Some claim submission requirements include: timely filing, eligibility requirements, pursuit of third party resources and required attachments included. **A PAR approval does not override any of the claim submission requirements.**

## Medications Requiring a PAR

- Certain restricted drugs
- Non-preferred agents subject to the Preferred Drug List (PDL)
- Over-the-counter drugs that are not a regular Colorado Medical Assistance Program benefit
- Some Home Intravenous (IV) solutions
- Total Parenteral Nutrition (TPN) therapy and drugs

## Guidelines Used by the Department for Determining PAR Criteria

In determining what drugs should be subject to prior authorization, the Department applies the following criteria:

- Significance of impact on the health of the Colorado Medical Assistance Program population or costs to the Colorado Medical Assistance Program
- Required monitoring of prescribing protocols to protect both the long-term efficacy of the drug and the public health
- Potential for, or a history of, drug diversion and other illegal utilization
- Appearance of the Colorado Medical Assistance Program usage in amounts inconsistent with non-medical assistance program usage patterns, after adjusting for population characteristics
- Clinical efficacy compared to other drugs in that class of medications
- Availability of more cost effective comparable alternatives
- Procedures where inappropriate utilization has been reported in medical literature
- Performing auditing services with constant review on drug utilization

## Generic Mandate

Most brand-name drugs with a generic therapeutic equivalent are not covered by the Colorado Medical Assistance Program.

Members can receive a brand name drug **without** a PAR if:

1. Only a brand name drug is manufactured.
2. A generic drug is not therapeutically equivalent to the brand name drug.
3. The Department has determined the final cost of the brand name drug is less expensive.
4. The drug is for the treatment of:
  - a. Biologically based mental illness as defined in C.R.S 10-16-104 (5.5);
  - b. Treatment of cancer;
  - c. Treatment of epilepsy; or
  - d. Treatment of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Members may receive a brand name drug **with** a PAR if:

1. A member has tried the generic equivalent but is unable to continue treatment on the generic drug.
2. The physician is of an opinion that a transition to the generic equivalent of a brand-name drug would be unacceptably disruptive to the patient's stabilized drug regimen.

The [Prior Authorization Form](#) is available on the Department's website→For Our Providers→Provider Services→[Forms](#)→Pharmacy.

## **Dispensing Requirements**

### **Refill Too Soon Policy**

For DEA Schedule 2 through 5 drugs, 85% of the days' supply of the last fill must lapse before a drug can be filled again. For non-scheduled drugs, 75% of the days' supply of the last fill must lapse before a drug can be filled again. If the appropriate numbers of days have not lapsed, the claim will be denied as a refill-too-soon unless there has been a change in the dosing. If a Medicaid member enters or leaves a nursing facility, the member may require a refill-too-soon override in order to receive their drugs. A PAR must be submitted by contacting the PA Helpdesk at 1-800-365-4944.

### **Tamper Resistant Prescription Pads**

All Medicaid providers are required to use tamper-resistant prescription pads for written prescriptions. This requirement stems from the Social Security Act, 42 U.S.C. 1396b(i)(23), which lists three (3) different characteristics to be integrated into the manufacture of prescription pads. Prescriptions must be written on tamper-resistant prescription pads that meet all three of the stated characteristics. More information about Tamper-Resistant Prescription Pads/Paper requirements and features can be found in the Pharmacy section of the Department's website.

### **Compounded Prescriptions**

A compounded prescription (a prescription where two (2) or more ingredients are combined to achieve a desired therapeutic effect) must be submitted on the same claim. A PAR is only necessary if an ingredient in the compound is subject to prior authorization. Pharmacies may use the number 8 in field 420-DK instead of obtaining a PA for non-covered ingredients to allow the claim to pay for the ingredients that are considered a covered benefit. The Colorado Medical Assistance Program does not pay a compounding fee.

### **Partial Fills and/or Prescription Splitting**

Prescriptions cannot be dispensed in quantities less than the physician ordered unless the quantity ordered is more than a 100-day supply for maintenance medications and 30-day supply for non-maintenance medications. Partial fills are not allowed.

### **Emergency Three-Day Supply**

In an emergency, when a PAR cannot be obtained in time to fill the prescription, pharmacies may dispense a 72-hour supply (3 days) of covered outpatient prescription drugs to an eligible member by calling the Department's PA Helpdesk for approval. Refer to Appendix P in the [Billing Manuals](#) section of the Department's website for the PA Helpdesk phone number. An emergency situation is any condition that is life threatening or requires immediate medical intervention.

### **Lost/Stolen/Damaged/Vacation Prescriptions**

The Department does not pay for early refills when needed for a vacation supply.

The Colorado Medical Assistance Program will cover lost, stolen, or damaged medications once per lifetime for each member. Stolen prescriptions will require a copy of the police report to be submitted to the Department before approval will be granted. The replacement request and verification must be submitted to the Department within 60 days of the last refill of the medication.

## Counseling

A pharmacist or pharmacist designee shall offer counseling regarding the drug therapy to each Medicaid patient with a new prescription. The offer to counsel shall be face-to-face communication whenever practical or by telephone. A pharmacist shall not be required to counsel a patient or caregiver when the patient or caregiver refuses such consultation. The pharmacist shall retain signatures from Medicaid members indicating that counseling was offered.

## Override Codes

**Prior Authorization Type Code 1** – Use for emergency only. This code is no longer allowed to override a PAR requirement. Please see the current policy for processing an emergency three-day supply above.

**Prior Authorization Type Code 2** – Refill too soon. This code is no longer an override for the refill too soon edit. If a member has a change in dosage, the point of sale system will ignore the refill too soon edit. If a member is going into or out of a nursing home and is in need of medication, the pharmacy must request an authorization from the PA Helpdesk.

**Prior Authorization Type Code 4** – Copay exemption for pregnant/postpartum members. This code can only be used for female members who are pregnant or 60 days postpartum to exempt the member from co-payments.

**DAW 1** – Prescriber requests brand. This code is required for brand name products that have a generic equivalent to override FUL reimbursement. A prior authorization may also be necessary if the drug is not excluded from the generic mandate.

## Co-payment Exclusions

Applicable co-payment is automatically deducted from the provider's payment during claims processing. Providers can collect co-payment from the member at the time of service or establish other payment methods. Services cannot be withheld if the member is unable to pay the co-payment.

The following categories of members are exempt from co-payment:

- Members who are age 18 and younger
- Members residing in a nursing facility
- All services to women in the maternity cycle. The maternity cycle is the time period during the pregnancy and sixty days post-partum. Pharmacies need to use a Prior Authorization Type Code 4 code to waive the copayment for women in the maternity cycle.

## Reversals

If the member does not pick up the prescription from the pharmacy within 14 calendar days, the prescription must be reversed on the 15th calendar day. The pharmacy must retain a record of the reversal on file in the pharmacy for audit purposes. Pharmacies that have an electronic tracking system shall review prescriptions in will-call status on a daily basis and enter a reversal of prescriptions not picked up within ten (10) days of billing. In no case shall prescriptions be kept in will-call status for more than 14 days.

## Retention of Records

Source documents and source records used to create pharmacy claims shall be maintained in such a way that all electronic media claims can be readily associated and identified. These source documents, in addition to any work papers and records used to create electronic media claims, shall be retained by the provider for six (6) years and shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents.

## Mail Order

Qualifying Medicaid fee-for-service members may receive their outpatient maintenance medications from mail order pharmacies.

In order to qualify, a Medicaid member must have:

1. A physical hardship that prohibits him or her from obtaining their maintenance medications from a local pharmacy, **or**
2. Third party insurance that allows the use of a mail order pharmacy to obtain their maintenance medications.

A member or the member's physician must complete and submit an enrollment form to the Department that attests the member meets one of the qualifying criteria.

If a mail order pharmacy submits a pharmacy claim for a member that has not enrolled for the mail order benefit, the claim will be denied. The National Council for Prescription Drug Program (NCPDP) edit that will appear at the point-of-sale is an 85, with text indicating that the claim did not process. This denial will appear as edit PB85 on the Provider Claim Report (PCR), with information indicating the claim did not process.

Out-of-state mail order pharmacies are permitted to enroll as Medicaid providers but may only mail maintenance medications to members who have applied for the mail order pharmacy benefit.

Local pharmacies, which are not mail order pharmacies, may continue to occasionally mail any type of outpatient medication to any fee-for-service Medicaid members without the members having to enroll for the mail order pharmacy benefit.

## Restricted Products

The Colorado Medical Assistance Program restricts or excludes coverage for some drug categories. More information may be obtained in Appendix P in the [Billing Manuals](#) section of the Department's website.

Restricted products by participating companies are covered as follows:

- None*      *No products in the category are Medical Assistance Program benefits.*
- Limited*      *Prior authorization requests for some products may be approved based on medical necessity.*
- All*      *All products in this category are regular Medical Assistance Program benefits.*

Category	Benefits
Anorexia (weight loss)	None
Weight gain	Limited
Cosmetic purposes or hair growth	None
Cough and cold *	Limited
DESI drugs **	None
Non-rebateable products	None
Fertility	None
Non-prescription drugs	Aspirin, Insulin; others Limited
Prenatal vitamins	All for females. None for males.
Other vitamins	Limited
Benzodiazepines	Limited
Barbiturates	Limited
Smoking cessation	Limited

\* *Cough and cold products: Cough and cold products include combinations of narcotic and non-narcotic cough suppressants, expectorants and/or decongestants. Single agent antihistamines are not considered to be cough and cold products and are regular Medical Assistance Program benefits.*

\*\* *DESI drugs: DESI drugs are products that are declared "less than effective" by the FDA and are not a benefit of the Medical Assistance program.*

## **Exclusions**

The following are not benefits of the Colorado Medical Assistance Program:

- DESI drugs and any drug if by its generic makeup and route of administration, it is identical, related, or similar to a less than effective drug identified by the FDA
- Drugs classified by the U.S.D.H.H.S. FDA as "investigational" or "experimental"
- Dietary needs or food supplements (see Appendix Y for a list)
- Medicare Part D drugs for Part D eligible members
- Drugs manufactured by pharmaceutical companies not participating in the Colorado Medical Assistance Program
- Fertility drugs
- IV equipment (for example, Venopaks dispensed without the IV solutions). Nursing facilities must furnish IV equipment for their patients
- Personal care items such as mouth wash, deodorants, talcum powder, bath powder, soap (of any kind), dentifrices, etc.
- Spirituous liquors of any kind
- Erectile dysfunction drugs

The following are not **pharmacy** benefits of the Colorado Medical Assistance Program:

- Drugs administered in physician's office; these must be billed by the physician as a medical benefit using a CMS 1500 Claim Form or through the Colorado Medical Assistance Program Web Portal ([Web Portal](#))
- Drugs administered in clinics; these must be billed by the clinic using a CMS 1500 claim form or through the Web Portal
- Drugs administered in a dialysis unit are part of the dialysis fee or billed using a CMS 1500 claim form or through the Web Portal
- Drugs administered in the hospital are part of the hospital fee
- Durable Medical Equipment (DME); these must be billed as a medical benefit using a CMS 1500 claim form or through the Web Portal

## **Pharmacy Helpdesk**

The Department's fiscal agent provides a support Helpdesk. The Helpdesk is available to answer provider claim submission and basic drug coverage questions (refer to PDCS Pharmacy Support numbers found on the Department's website→For Our Providers→Provider Services→[Billing Manuals](#)→Appendices→Appendix B.

The Helpdesk is available 24 hours a day seven days a week.

## **Billing Information**

The Colorado Medical Assistance Program uses the National Council on Prescription Drug Programs (NCPDP) electronic format and the Pharmacy Claim Form (PCF) to submit prescription drug claims. Both electronic and paper claims are processed by the PDCS. The PDCS provides claim, provider, eligibility, and prior authorization request interfaces with the Medicaid Management Information System (MMIS). All electronic claims must be submitted through a pharmacy switch vendor. Claims that cannot be submitted through the vendor must be submitted on paper. Please refer to the specific rules and requirements regarding electronic and paper claims below.

### **Timely Filing Requirements**

Pharmacy claims must be submitted electronically and within the timely filing period, with few exceptions. Timely filing for electronic and paper claim submission is 120 days from the date of service.

Pharmacies should retrieve their PCR via the File and Report Service (FRS) through the [Web Portal](#). Claims that do not result in the Colorado Medical Assistance Program authorizing reimbursement for services rendered may be resubmitted. If a claim is denied, the pharmacy should follow the procedure set forth below for **rebilling denied claims**. If a resolution is not reached, a pharmacy can **ask for reconsideration** from the Department's fiscal agent. If the reconsideration is denied, the final option is to **appeal the reconsideration**.

### **Rebilling Denied Claims**

Pharmacies may electronically rebill denied claims when the claim submission is within 120 days of the date of service. Claims that are older than 120 days are still considered timely if received within 60 days of the last denial. Pharmacies should continue to rebill until a final resolution has been reached. Pharmacies must keep records of all claim submissions, denials, and related documentation until final resolution of the claim.

Copies of all forms necessary for submitting claims are also available on the Pharmacy Billing Procedures and Forms web page of the Department's website. Instructions on how to complete the PCF are available in this manual. All necessary forms should be submitted to the Department's fiscal agent at:

#### **Claims and PARs Submission**

P.O. Box 30

Denver, CO 80201-0090

There are four (4) exceptions to the 120-day rule: Delayed Processing by Third Party Payers, Retroactive Member Eligibility, Delayed Notification to the Pharmacy of Eligibility and Extenuating Circumstances. Each of these exceptions is detailed below along with the specific instructions for submitting claims.

#### **Delayed Processing by Third Party Payers**

The Colorado Medical Assistance Program is the payer of last resort. When timely filing expires due to delays in receiving third party payment or denial documentation, the Department's fiscal agent is authorized to consider the claim as timely if received within 60 days from the date of the third party payment or denial **or** within 365 days of the date of service, whichever occurs first. Pharmacies must complete third party information on the PCF and submit documentation from the third party payer of payment or lack of payment.

#### **Retroactive Member Eligibility**

If the timely filing period expires due to a delayed or back-dated member eligibility determination, the claim is considered timely if received within 120 days of the date that the member appears on state eligibility files.

Pharmacies can submit these claims electronically or by paper. If a pharmacy chooses to submit these claims by paper, complete a PCF and attach the Retroactive Backdate Letter from the county to each claim to verify the member's eligibility.

Pharmacies may submit claims electronically by obtaining a PAR through the PA Helpdesk. The pharmacy must fax the Retroactive Eligibility Letter from the county to the PA Helpdesk at 1-888-772-9696. The pharmacy should receive a confirmation fax from the PA Helpdesk within 24 hours. If a confirmation is not received within 24 hours, the pharmacy should call the PA Helpdesk at 1-800-365-4944. Once the confirmation fax is received, the pharmacy has 120 days from the date the member was granted backdate eligibility to electronically submit claims from the date of eligibility.

### **Delayed notification to the pharmacy of eligibility**

Pharmacies are expected to take appropriate and reasonable action to identify Colorado Medical Assistance Program eligibility in a timely manner. If a pharmacy is made aware of eligibility after 120 days from the date of service, the pharmacy can submit the PCF paper claim form along with [Certification & Request for Timely Filing Extension Delayed Eligibly Notification](#). This form is specifically for the requests of a timely filing extension caused by delayed eligibility notification. Because pharmacies must attach a completed Certification & Request for Timely Filing Extension Delayed Eligibly Notification form to each claim, these claims must be submitted by paper. The Certification & Request for Timely Filing Extension Delayed Eligibly Notification form can be found in the [Forms](#) section of the Department's website.

### **Extenuating circumstances**

Requests for timely filing waivers for extenuating circumstances must be made in writing and must contain a detailed description of the circumstance that was beyond the control of the pharmacy. Exceptions are granted only when the pharmacy is able to document that appropriate action was taken to meet filing requirements, and that the pharmacy was prevented from filing as the result of extenuating unforeseen and uncontrollable circumstances. Pharmacy employee negligence, employer failure to provide sufficient, well-trained employees, or failure to properly monitor the activities of employees and agents (e.g., billing services) are not considered extenuating circumstances beyond the pharmacy provider's control. The detailed description of the extenuating circumstances must be attached to the PCF and mailed to the Department's fiscal agent.

### **Request for Reconsideration**

When a pharmacy has exhausted all authorized rebilling procedures and has not been paid for a claim, the pharmacy may submit a Request for Reconsideration to the Department's fiscal agent.

**We recommend that pharmacies contact the Department's fiscal agent provider services at 1-800-237-0757 before submitting a request for reconsideration.**

Requests for Reconsideration must be filed in writing with the Department's fiscal agent within 60 days of the most recent claim or prior reconsideration denial.

Copies of all PCRs, electronic claim rejections, and/or correspondence documenting compliance with timely filing and 60-day rule requirements must be submitted with the Request for Reconsideration. A Request for Reconsideration will display on the PCR as a paid or denied claim without specifying that it is a claim for reconsideration.

An additional request for reconsideration may be submitted within 60 days of the reconsideration denial if information can be corrected or if additional supporting information is available. The resubmitted request must be completed in the same manner as an original reconsideration request.

The Request for Reconsideration Form and instructions are available in the Provider Services [Forms](#) section of the Department website.

**Appealing Reconsideration Denials**

If a pharmacy disagrees with the final decision of the Department’s fiscal agent, the pharmacy may file an appeal with the Office of Administrative Courts.

Representation by an attorney is usually required at administrative hearings. Appeals to the Office of Administrative Courts must be filed in writing within 30 days from the mailing date of the reconsideration denial. Appeals may be sent to:

Office of Administrative Courts  
 1525 Sherman Street – 4<sup>th</sup> Floor  
 Denver, CO 80203

**Paper Claim Submission Requirements**

With few exceptions, providers are required to submit claims electronically. Electronically mandated claims submitted on paper are processed, denied, and marked with the message “Electronic Filing Required”.

**The following claims can be submitted on paper and processed for payment:**

- Providers who consistently submit five (5) or fewer claims per month
- Claims that are more than 120 days from the date of service that require special attachments
- Reconsideration claims

Providers can submit only one (1) claim per submission on the PCF; however, compound claims can be submitted. Providers must submit accurate information. The use of inaccurate or false information can result in the reversal of claims.

The PCF should be submitted to the Department’s fiscal agent at:

**Claims and PARs Submission**  
 P.O. Box 30  
 Denver, CO 80201-0090.

**Instructions for Completing the Pharmacy Claim Form**

Below are the completion instructions for the Colorado Pharmacy Claim Form (PCF-2) for Pharmacy Providers. The form is one-sided and requires an authorized signature. Providers must follow the instructions below and may only submit one (prescription) per claim. The claim may be a multi-line compound claim. If there is more than a single payer a D.0 electronic transaction must be submitted

\*\*\* **Please note:** The format for entering a date is different than the date format in the POS system \*\*\*

FIELD	VALUE	COMMENT
<b>I. Client Information</b>		
Client’s Medicaid ID #	Client’s 7-character Medical Assistance Program ID	Required
Group ID	Colorado	Default value on claim form
Relationship Code	1=Cardholder	Default value on claim form
Client’s Name	Last, First, MI	Required
Other Coverage Code	0=Not specified 1=No other cov identified 2=Other cov exists-Pymt collected 3=Other cov exists-Claim not covered 4=Other cov exists-Pymt not collected	Required when submitting a claim for member w/ other coverage
Client’s DOB	MM/DD/YYYY	Required

FIELD	VALUE	COMMENT
<b>II. Pharmacy Information</b>		
Service Provider ID	NPI=National Provider Identifier	Required
Service Provider ID Qualifier	01=NPI-National Provider Identifier	Required
<b>III. Prescriber Information</b>		
Prescriber's Last Name	Last Name of Prescriber	Required
Prescriber's Phone #	Prescriber's Phone #	Required
Prescriber's ID	Prescriber's NPI, CO State License or DEA #	Required
Prescriber's ID Qualifier	01=National Provider Identifier 12=Drug Enforcement Administration (DEA#) 08=CO State License #	Required
<b>IV. Claim Information (Claim must be for same client as listed above)</b>		
Prescription #	Prescription # Assigned by Pharmacy	Required
Date Written	MM/DD/YYYY	Required
Date Filled	MM/DD/YYYY	Required
Fill #	00=Original 01-99=# of Refills Fill	Required
Prescription # Qualifier	0=Blank 1=Rx Billing	Required
Days Supply	# of Days Prescription is Prescribed	Required
DAW Codes	0=No Generic Available or Generic Medication 1=Physician Requested	Required when the valid values are appropriate for submission of the claim
PA Type Code	0=Not Specified 4=Pregnant or 60 Days Postpartum	Required when the client is pregnant or 60 days postpartum
Quantity Prescribed	Metric Decimal Quantity	Required-If claim is for a compound prescription, list total # of units for claim
Quantity Dispensed	Metric Decimal Quantity	Required-If claim is for a compound prescription, list total # of units for claim
Product ID	NDC #	Required-If claim is for a compound prescription, enter "COMPOUND RX"
Product ID Qualifier	00=If Claim is a Compound Claim 03=National Drug Code (NDC)	Required-If claim is for a compound prescription, enter "00"
Submitted Ingredient Cost		Required-Enter total ingredient costs even if claim is for a compound prescription
Total Charge		Required-Pharmacy's Usual and Customary Charge
Gross Amount Due		Required
<b>V. Other Payer Information</b>		

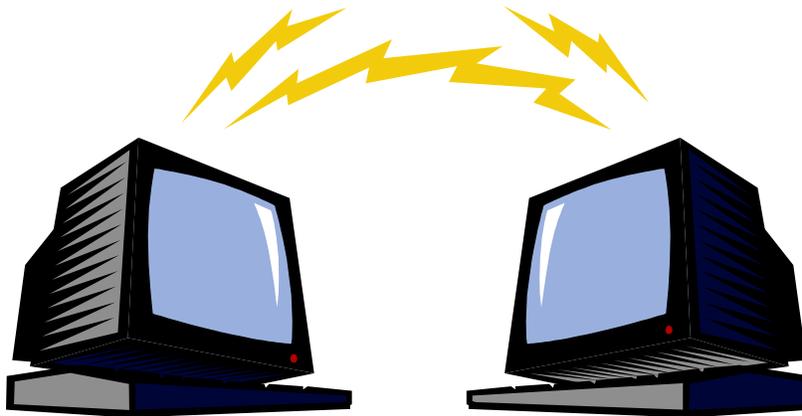
FIELD	VALUE	COMMENT
Other Payer Cov Type	01=Primary	Required if Other Cov Code equals 2, 3, or 4
Other Payer Date	MM/DD/YYYY	Required if Other Cov Code equals 2, 3, or 4
Other Payer \$ Paid		Required if Other Cov Code equals 2, 3, or 4
Other Payer \$ Paid Qualifier	02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Required if Other Cov Code equals 2, 3, or 4
Other Payer Reject Code	Value from Prior Payer	Required if Other Cov Code equals 3
Other Payer Patient Responsibility \$	Value from Prior Payer	Required if Other Cov Code equals 4
Other Payer Patient Responsibility \$ Qualifier	01=Amount Applied to Periodic Deductible Copay 05=Amount of 5.1) 06=Patient Pay Amount (only if Prior Payer was still in NCPDP version 5.1) 07=Amount of Coinsurance	Required if Other Cov Code equals 4
Compound Claim	Blank 0=Not Specified 1=Not a Compound Claim 2=Claim is a Compound Claim	Required when claim is for a compound prescription
Diagnosis Code Qualifier	01=ICD9 Code on Prescription (adoption date to be announced) 02=ICD10	
Diagnosis Code	ICD9 Code on Prescription ICD10 (adoption date to be announced)	Required if this information can be used in place of prior auth
RX Override	8=Process Compound Claim for Approved Ingredients * In the future, Colorado plans to utilize other Rx Override fields.	Conditional-Needed to process claim for approved ingredients when claim is for a compound prescription
If the claim is a compound claim, complete the bottom section of the claim form to indicate each ingredient name, NDC quantity, and cost. Remember that there is a limit of one prescription per claim form.		
Ingredient Name	Ingredient Name	Required when the claim is for a compound prescription
NDC	NDC Number of the Ingredient	Required when the claim is for a compound prescription
Quantity	Metric Decimal Quantity Dispensed	Required when the claim is for a compound prescription
Ingredient Cost Submitted		Required when the claim is for a compound prescription

## Electronic Claim Submission Requirements

Interactive claim submission is a real-time exchange of information between the provider and the Colorado Medical Assistance Program. The provider creates interactive claims one at a time and transmits them by toll-free telephone through a switch company to the Colorado Department's fiscal agent claims processor. The Department's fiscal agent claims processor reviews the claim and immediately returns a status of paid or denied for each transaction to the provider's personal computer. If the claim is denied, the Department's fiscal agent claims processor sends one or more denial reason(s) that identify the problem(s).

Interactive claim submission must comply with Colorado D.0 Requirements. Providers must submit accurate information. The use of inaccurate or false information can result in the reversal of claims.

- An optional data element means that the user should be prompted for the field but does not have to enter a value.
- Drug Utilization Review (DUR) information, if applicable, will appear in the message text of the response.
- Electronic claim submissions must meet timely filing requirements.



## D.0 General Information

The following are the Payer Sheets for D.0 Effective January 1, 2012, pharmacy transactions must meet D.0 requirements. Pharmacies must code their systems for Colorado D.0 transactions using the information provided below.

### Transactions Supported

**Payer:** Please list each transaction supported with the segments, fields, and pertinent information on each transaction.

Transaction Code	Transaction Name
B1	Billing
B3	Rebill

### Field Legend for Columns

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	<b>M</b>	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	<b>R</b>	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	<b>RW</b>	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Fields that are not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the template.



## Claim Billing/Claim Rebill Transaction

The following lists the segments and fields in a Claim Billing or Claim Rebill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
1Ø1-A1	BIN NUMBER	610084	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	DRCOPROD = Production	M	
1Ø9-A9	TRANSACTION COUNT	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = NPI	M	
2Ø1-B1	SERVICE PROVIDER ID	NPI Number	M	
4Ø1-D1	DATE OF SERVICE	CCYYMMDD	M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	This will be provided by the provider's software vender	M	If no number is supplied, populate with zeros

Insurance Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

Insurance Segment Segment Identification (111-AM) = "Ø4"		Claim Billing/Claim Rebill		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø2-C2	CARDHOLDER ID	Client's 7 character alpha-numeric Medical Assistance Program ID	M	
3Ø1-C1	GROUP ID	Colorado	R	
3Ø6-C6	PATIENT RELATIONSHIP CODE	1=Cardholder	R	

Patient Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

Patient Segment Segment Identification (111-AM) = "Ø1"		Claim Billing/Claim Rebill		
<i>Field</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø4-C4	DATE OF BIRTH	CCYYMMDD	R	
3Ø5-C5	PATIENT GENDER CODE	Ø=Not Specified 1=Male 2=Female	R	
311-CB	PATIENT LAST NAME		R	Required field in D.0
335-2C	PREGNANCY INDICATOR	Blank=Not Specified 1=Not pregnant 2=Pregnant	RW	Required when submitting a claim for a pregnant member

	<b>Patient Segment Segment Identification (111-AM) = "Ø1"</b>			<b>Claim Billing/Claim Rebill</b>
<i>Field</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
384-4X	PATIENT RESIDENCE	Ø=Not specified 1=Home 3=Nursing Facility 4=Assisted Living Facility 6=Group Home 9=Intermediate Care Facility/Mentally Retarded 11=Hospice 15=Correctional Institution	R	

<b>Claim Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
This payer does not support partial fills	X	



	<b>Claim Segment Segment Identification (111-AM) = "Ø7"</b>			<b>Claim Billing/Claim Rebill</b>
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Number assigned by the pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code	M	
4Ø7-D7	PRODUCT/SERVICE ID	NDC Number	M	
442-E7	QUANTITY DISPENSED	Metric Decimal Quantity	R	
4Ø3-D3	FILL NUMBER	Ø = Original Dispensing 1-99 = Number of refills	R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	1 = Not a compound 2 = Compound	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Ø = No product selection indicated 1 = Physician request	R	All other DAW Codes will deny
414-DE	DATE PRESCRIPTION WRITTEN	CCYYMMDD	R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	Required if Submission Clarification Code (42Ø-DK) is used.
42Ø-DK	SUBMISSION CLARIFICATION CODE	8 = Process Compound for Approved Ingredients	RW	"8" Required to allow payment for covered ingredients and ignore and not pay for non-covered ingredients in a compound

Claim Segment Segment Identification (111-AM) = "Ø7"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø8-C8	OTHER COVERAGE CODE	Ø=Not Specified 1=No other Coverage Identified 2=Other coverage exists-payment collected 3=Other coverage exists-this claim not covered 4=Other coverage exists-payment not collected (this value will be accepted beginning January 1, 2012).	RW	Medicaid is always the payer of last resort. In order to bill Medicaid for claims where the client has a third party insurer, pharmacies must first bill the third party insurer prior to billing Medicaid.  Completion of this field is required when submitting a claim for a recipient who has other coverage.  <b>Refer to the Other Coverage Code Quicksheet available in the Pharmacy Billing Procedures and <a href="#">Forms section</a> of the Department's website (<a href="http://colorado.gov/hcpf">colorado.gov/hcpf</a>).</b>
461-EU	PRIOR AUTHORIZATION TYPE CODE	Ø = Not specified 4 = Exemption from Copay	RW	Enter '4' to indicate that the client is in the maternity cycle
995-E2	ROUTE OF ADMINISTRATION	SNOMED CT Value	RW	Required when the Rx is a compound  New Field – replaces 452-EH in 5.1 Compound Segment

Pricing Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

Pricing Segment Segment Identification (111-AM) = "11"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		RW	Required if necessary as component part of Gross Amount Due
426-DQ	USUAL AND CUSTOMARY CHARGE		R	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.
430-DU	GROSS AMOUNT DUE		R	

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	

Prescriber Segment Segment Identification (111-AM) = "03"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	01=National Provider Identifier (NPI) 08=State License # 12=DEA#	R	
411-DB	PRESCRIBER ID	NPI State License Number Drug Enforcement Agency (DEA) Number	R	

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		

If the Payer supports the Coordination of Benefits/Other Payments Segment, only one scenario method shown above may be supported per template. The template shows the Coordination of Benefits/Other Payments Segment that must be used for each scenario method. The Payer must choose the appropriate scenario method with the segment chart, and delete the other scenario methods with their segment charts. See section Coordination of Benefits (COB) Processing for more information.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE	Blank=Not Specified Ø1=Primary Ø2=Secondary - Second Ø3=Tertiary - Third Ø4=Quaternary - Fourth Ø5=Quinary - Fifth	M	
443-E8	OTHER PAYER DATE	CCYYMMDD	RW	Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	Required if Other Payer Amount Paid Qualifier (342-HC) is used.

<b>Coordination of Benefits/Other Payments Segment</b> <b>Segment Identification (111-AM) = "Ø5"</b>				<b>Claim Billing/Claim Rebill</b> Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø1=Delivery Ø2=Shipping Ø3=Postage Ø4=Administrative Ø5=Incentive Ø6=Cognitive Service Ø7=Drug Benefit Ø9=Compound Preparation Cost 1Ø=Sales Tax	RW	Required when there is payment from another source.  Required if Other Payer Amount Paid (431-Dv) is used.
431-DV	OTHER PAYER AMOUNT PAID	\$\$\$\$\$\$cc	RW	Required if other payer has approved payment for some/all of the billing.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	Required if Other Payer Reject Code (472-6E) is used.  <i>Payer Requirement:</i> Required if OCC = 3
472-6E	OTHER PAYER REJECT CODE		RW	Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered).
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.  <i>Payer Requirement:</i> Required if OCC = 4

	<b>Coordination of Benefits/Other Payments Segment</b> <b>Segment Identification (111-AM) = "Ø5"</b>			<b>Claim Billing/Claim Rebill</b> Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>

351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø1=Amount Applied to Periodic Deductible (517-FH) Ø2=Amount Attributed to Product Selection/Brand Drug (134-UK) Ø3=Amount Attributed to Sales Tax (523-FN) Ø4=Amount Exceeding Periodic Benefit Maximum (52Ø-FK) Ø5=Amount of Copay (518-FI) Ø6=Patient Pay Amount (5Ø5-F5) Ø7=Amount of Coinsurance (572-4U)	RW	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.  <i>Payer Requirement:</i> Required if OCC = 4. Colorado will only reimburse for amounts submitted with qualifiers Ø1, Ø5, and Ø7.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø8=Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) Ø9=Amount Attributed to Health Plan Assistance Amount (129-UD) 1Ø=Amount Attributed to Provider Network Selection (133-UJ) 11=Amount Attributed to Product	RW	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.  <i>Payer Requirement:</i> Required if OCC = 4. Colorado will only reimburse for amounts submitted with qualifiers Ø1, Ø5, and Ø7.

	<b>Coordination of Benefits/Other Payments Segment</b> <b>Segment Identification (111-AM) = "Ø5"</b>			<b>Claim Billing/Claim Rebill</b> Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>
		Selection/Brand Non-Preferred Formulary Selection (136-UN)		

351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	12=Amount Attributed to Coverage Gap (137-UP) 13=Amount Attributed to Processor Fee (571-NZ)	RW	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.  <i>Payer Requirement:</i> Required if OCC = 4. Colorado will only reimburse for amounts submitted with qualifiers Ø1, Ø5, and Ø7.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	\$\$\$\$\$\$\$\$cc	RW	<i>Payer Requirement:</i> Required if OCC = 4

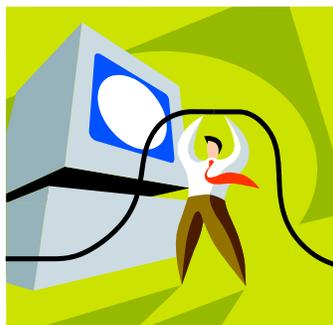
<b>DUR/PPS Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill</b> If Situational, <i>Payer Situation</i>
This Segment is situational	X	



	<b>DUR/PPS Segment Segment Identification (111-AM) = "Ø8"</b>			<b>Claim Billing/Claim Rebill</b>
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	Required if DUR/PPS Segment is used.
439-E4	REASON FOR SERVICE CODE	See Attached list of valid values	RW	Required when there is a conflict to resolve or reason for service to be explained.
44Ø-E5	PROFESSIONAL SERVICE CODE	See Attached list of valid values	RW	Required when there is a professional service to be identified.
441-E6	RESULT OF SERVICE CODE	See Attached list of valid values	RW	Required when There is a result of service to be submitted.

<b>Compound Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill</b> If Situational, <i>Payer Situation</i>
This Segment is situational	X	Required when billing for a compound

<b>Clinical Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill</b> If Situational, <i>Payer Situation</i>
This Segment is situational	X	Required for coverage of certain drugs in place of prior authorization as identified on State website



Clinical Segment Segment Identification (111-AM) = "13"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DØ) are used.
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1 = ICD9 Ø2 = ICD1Ø (10/01/2014)	RW	Required if Diagnosis Code (424-DØ) is used.
424-DO	DIAGNOSIS CODE	ICD9 ICD1Ø (10/01/2014)	RW	Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.  Required if this information can be used in place of prior authorization.

\*\* End of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template\*\*



# Response Claim Billing/Claim Rebill Payer Sheet Template

## **Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) Response**

**\*\* Start of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template\*\***

CLAIM BILLING/CLAIM REBILL PAID (OR DUPLICATE OF PAID) RESPONSE

The following lists the segments and fields in a Claim Billing or Claim Rebill response (Paid or Duplicate of Paid) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is situational	X	Segment sent if required for clarification

Response Message Segment Segment Identification (111-AM) = "20"				Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	MESSAGE	Text Message	RW	Required if text is needed for clarification or detail.

Response Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

Response Insurance Segment Segment Identification (111-AM) = "25"				Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
301-C1	GROUP ID		R	Used to identify the group number used in claim adjudication.
524-FO	PLAN ID		R	Used to identify the actual plan ID that was used in claim adjudication.

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	<b>Response Status Segment Segment Identification (111-AM) = "21"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
503-F3	AUTHORIZATION NUMBER	17-digit TCN	R	
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.

<b>Response Claim Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	X	



	<b>Response Claim Segment Segment Identification (111-AM) = "22"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

<b>Response Pricing Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID		R	
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		R	Populated with zeros
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.
509-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		RW	Required if Ingredient Cost Paid (506-F6) is greater than zero (Ø).

	<b>Response Pricing Segment Segment Identification (111-AM) = "23"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>
514-FE	REMAINING BENEFIT AMOUNT		R	Populated with zeros.
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		R	Populated with zeros.
518-FI	AMOUNT OF COPAY		R	Patient Copay
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM		R	Populated with zeros.

<b>Response DUR/PPS Segment Questions</b>	<b>Check</b>	<b>Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation</b>
This Segment is situational	X	Sent to provide information about DUR conflicts

	<b>Response DUR/PPS Segment Segment Identification (111-AM) = "24"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE		RW	Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE		RW	Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR		RW	Required if needed to supply additional information for the utilization conflict.

	<b>Response DUR/PPS Segment Segment Identification (111-AM) = "24"</b>			<b>Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)</b>
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>
530-FU	PREVIOUS DATE OF FILL	CCYYMMDD	RW	Required if needed to supply additional information for the utilization conflict.
531-FV	QUANTITY OF PREVIOUS FILL		RW	Required if needed to supply additional information for the utilization conflict.
532-FW	DATABASE INDICATOR	1 = First DataBank – a drug database company	RW	Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR		RW	Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE		RW	Required if needed to supply additional information for the utilization conflict.



## Claim Billing/Claim Rebill Accepted/Rejected Response

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected <i>If Situational, Payer Situation</i>
This Segment is situational	X	Segment sent if required for reject clarification

	Response Message Segment Identification (111-AM) = "2Ø"			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	MESSAGE	Text Message	RW	Required if text is needed for clarification or detail.

Response Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational		

	Response Insurance Segment Segment Identification (111-AM) = "25"			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø1-C1	GROUP ID		R	Used to identify the actual group ID used during adjudication.
524-FO	PLAN ID		R	Used to identify the actual plan ID used during adjudication.

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER	17-digit TCN	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR			Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Required if Additional Message Information (526-FQ) is used.

Response Status Segment Segment Identification (111-AM) = "21"				Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

Response Claim Segment Segment Identification (111-AM) = "22"				Claim Billing/Claim Rebill Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, <i>Payer Situation</i>
This Segment is situational	X	

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing/Claim Rebill Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE		RW	Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE		RW	Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR		RW	Required if needed to supply additional information for the utilization conflict.
530-FU	PREVIOUS DATE OF FILL	CCYYMMDD	RW	Required if needed to supply additional information for the utilization conflict.
531-FV	QUANTITY OF PREVIOUS FILL		RW	Required if needed to supply additional information for the utilization conflict.
532-FW	DATABASE INDICATOR	1 = First DataBank – a drug database company	RW	Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR		RW	Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE		RW	Required if needed to supply additional information for the utilization conflict.

## Claim Billing/Claim Rebill Rejected/Rejected Response

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Billing/Claim Rebill Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	VERSION/RELEASE NUMBER	DØ	M	
103-A3	TRANSACTION CODE	B1, B3	M	
109-A9	TRANSACTION COUNT	Same value as in request	M	
501-F1	HEADER RESPONSE STATUS	R = Rejected	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
201-B1	SERVICE PROVIDER ID	Same value as in request	M	
401-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected <i>If Situational, Payer Situation</i>
This Segment is situational	X	Segment sent if required for reject clarification

	Response Message Segment Identification (111-AM) = "2Ø"			Claim Billing/Claim Rebill Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	MESSAGE	Text Message	RW	Required if text is needed for clarification or detail.

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
503-F3	AUTHORIZATION NUMBER	17-digit TCN	RW	Required if needed to identify the transaction.
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	Required if a repeating field is in error, to identify repeating field occurrence.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.

\*\* End of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template\*\*

**Reason for Service Codes (439-E4): DUR Conflict Codes**

Code	Meaning	Code	Meaning
AT	Additive Toxicity	LD	Low Dose Alert
CH	Call Help Desk	LR	Under Use Precaution
DA	Drug Allergy Alert	MC	Drug Disease Precaution
DC	Inferred Drug Disease Precaution	MN	Insufficient Duration Alert
DD	Drug-Drug Interaction	MX	Excessive Duration Alert
DF	Drug Food Interaction	OH	Alcohol Precaution
DI	Drug Incompatibility	PA	Drug Age Precaution
DL	Drug Lab Conflict	PG	Drug Pregnancy Alert
DS	Tobacco Use Precaution	PR	Prior Adverse Drug Reaction
ER	Over Use Conflict	SE	Side Effect Alert
HD	High Dose Alert	SX	Drug Gender Alert
IC	Iatrogenic Condition Alert	TD	Therapeutic Duplication
ID	Ingredient Duplication		

**Professional Service Codes (Valid Values for 440-E5)**

Code	Meaning	Code	Meaning
MA	Medication Administration – use for Vaccine Administration	PØ	Patient Consulted - patient interaction
MØ	Prescriber Consulted - MD Interface	RØ	Pharmacist Consulted Other Source - Pharmacist reviewed

**Result of Service Codes (Valid Values for 441-E6)**

Code	Meaning	Code	Meaning
1A	Filled As Is – False Positive	1F	Filled – Different Quantity
1B	Filled Prescription As Is	1G	Filled after prescriber approval
1C	Filled With Different Dose	2A	Not Filled
1D	Filled With Different Directions	2B	Not Filled – Directions Clarified

# NCPDP Version D.0 Claim Reversal Template

## Request Claim Reversal Payer Sheet Template

**\*\* Start of Request Claim Reversal (B2) Payer Sheet Template\*\***

### Field Legend for Columns

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	<b>M</b>	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	<b>R</b>	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	<b>RW</b>	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	unlimited

### Claim Reversal Transaction

The following lists the segments and fields in a Claim Reversal Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

Transaction Header Segment Questions	Check	Claim Reversal <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Claim Reversal
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
1Ø1-A1	BIN NUMBER	610084	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	

Transaction Header Segment				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
104-A4	PROCESSOR CONTROL NUMBER	DRCOPROD = Production DRCOACCP = Test	M	
109-A9	TRANSACTION COUNT	DRCOPROD = Production DRCOACCP = Test	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = NPI	M	
201-B1	SERVICE PROVIDER ID	NPI Number	M	
401-D1	DATE OF SERVICE	CCYYMMDD	M	
110-AK	SOFTWARE VENDOR / CERTIFICATION ID	This will be provided by the provider's software vender	M	If no number is supplied, populate with zeros

Insurance Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent	X	



	<b>Insurance Segment Segment Identification (111-AM) = "Ø4"</b>			<b>Claim Reversal</b>
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>
3Ø2-C2	CARDHOLDER ID		M	
3Ø1-C1	GROUP ID	Colorado	R	

<b>Claim Segment Questions</b>	<b>Check</b>	<b>Claim Reversal</b> <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	<b>Claim Segment Segment Identification (111-AM) = "Ø7"</b>			<b>Claim Reversal</b>
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>Payer Usage</b>	<b>Payer Situation</b>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Number assigned by the pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code	M	
4Ø7-D7	PRODUCT/SERVICE ID	NDC Number	M	
4Ø3-D3	FILL NUMBER	Ø = Original Dispensing 1-99 = Number of refills	R	
3Ø8-C8	OTHER COVERAGE CODE	Ø=Not Specified 1=No other Coverage Identified 2=Other coverage exists- payment collected 3=Other coverage exists- this claim not covered 4=Other coverage exists- payment not collected	RW	Required when submitting a claim for a recipient who has other coverage.

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Reversal If Situational, <i>Payer Situation</i>
This Segment is situational	X	Required for COB claim reversals

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Reversal
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	

\*\* End of Request Claim Reversal (B2) Payer Sheet Template\*\*



### Pharmacy Revisions Log

Revision Date	Additions/Changes	Pages	Initials
08/25/2003	Reformatted / Updated Provider Manuals for HIPAA Compliance		sz/dm
09/17/2003	Added General paper and electronic section– added information provided by ACS/State Pharmacy committee to Billing section		sz
10/17/2003	Updated and formatted for web.		jg
12/31/2003	Updated and formatted for web.		jg
01/01/2008	Updated and formatted information		ke
04/1/2008	Added PCF information		ke
05/24/2008	Provider NPI requirement to Payer Sheet and PCF		ke
08/1/2009	Mail Order and Web site references		ke
10/01/2011	Added D.0 Payer Sheet		ss
12/23/2011	Added updated PCF instructions		ss
10/04/2013	Added Refill too soon Policy Removed other payer amount and other payer amount paid qualifier Under Claims Billing table, field 104-A4, under payer situation removed DRCODV55 D.0 test and DRCOACCP test Under payer situation, removed qualifier and 06 should be used as previous payer Version 5.1 Under value, revised date in field 492-WE and 424-DO to 10/01/2014 Removed general information before claim billing/rebill paid (or duplicate of paid) response table Removed general info for request claim reversal payer sheet template Updated/removed dates, revised PA to PAR, added PA/Pharmacy Helpdesk information as appropriate,	7 28 42 50 53 55 69 Throughout	cc
10/09/2013	Updated TOC Formatted Fixed link for Other Coverage Code Quicksheet	i-iii Throughout	jg
8/11/2014	Updated references of CO1500 to CMS 1500	Page 6	MM
8/11/2014	Updated all web links to reflect new Department website	Throughout	MM
9/30/14	Updated the document revision date to 9/14 as the Pharmacy Billing Manual was published then.	Throughout	MM
12/04/2014	Updated the address to the Office of Administrative Courts	11	mc

