Pharmacy Online Processing System (POPS) Billing Guide

NCPDP Telecommunications Standard D.0

(May 2017)

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1.0 Introduction

MassHealth contracts with Conduent to process retail pharmacy claims in the National Council for Prescription Drug Programs (NCPDP) version D.0 format. All MassHealth pharmacy claims must be submitted to the Pharmacy Online Processing System ("POPS").

Conduent operates POPS under the general framework of standards and protocols established by NCPDP. Pharmacy providers must work with their software and switch vendors to ensure compliance such that all practice management software must be capable of submitting the following transactions to the MassHealth POPS: B1/B3, B2.

Switches

- Emdeon eRX Network: 1-866-379-6389
- RelayHealth: 1-800-388-2316
- QS1: 1-800-845-7558

This billing guide includes the D.0 payer sheets and contains pertinent information for submitting pharmacy drug claims to the MassHealth POPS. This document is updated regularly. The revision date represents the most recent date that this document was updated. Please ensure that you are using the most current version of this document. For detailed information about updates to this document, please refer to the version table in Section 8.0 of this document.

MassHealth has used NCPDP D.0 payer sheet templates as the basis for our payer sheets. (Materials are reproduced with the consent of the National Council for Prescription Drug Programs, Inc. 2010 NCPDP.)

2.1 Claim Submission Formats – B1 and B3

BIN NUMBER	**009555**
DESTINATION	**CONDUENT**
ACCEPTING	**CLAIM ADJUDICATION (B1-BILLING AND B3-REBILL TRANSACTIONS)**
FORMAT	**NCPDP D.0**

2.2 Request Claim Billing/Claim Rebill Payer Sheet

Field Legend for Columns

Payer Usage Column	Value	Explanation	Payer Situation Column
Mandatory	M	The field is mandatory for the segment in the designated transaction.	No
Required	R	The field has been designated with the situation of "required" for the segment in the designated transaction.	Yes
Qualified Requirement	Q	The situations designated have qualifications for usage (required if x, not required if y).	Yes
Qualified Requirement for Medicaid Subrogation Only	QM	The situations designated have qualifications for usage (required if x, not required if y) for Medicaid subrogation.	Yes
Informational Only	I	The field is for informational purposes only for the transaction.	Yes
Not Used	N	The field is not used for the segment for the transaction.	No

Payer Usage Column	Value	Explanation	Payer Situation Column
Repeating	***R***	The three asterisks, R, and three asterisks designate a field is repeating. **Example:** Q***R*** means a situationally qualified field that repeats. **Example:** N***R*** means a not used field that repeats when used.	Yes

Please Note: 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 table lists the segments and fields applicable to MassHealth in a claim billing or claim rebill transaction for the NCPDP version D.0. Claim billing includes pharmacy billing transactions B1 and B3.

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situational*
This segment is always sent.	X	
Source of certification IDs required in software vendor/certification ID (110-AK) is payer issued.	X	
Source of certification IDs required in software vendor/certification ID (110-AK) is switch/VAN issued.		
Source of certification IDs required in software vendor/certification ID (110-AK) is not used.		

	Transaction Header Segment			Claim Billing/ Claim Rebill	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
101-A1	BIN Number	009555	M		9(6)
102-A2	Version/Release Number	D0	M		X(2)
103-A3	Transaction Code	B1, B3	M		X(2)
104-A4	Processor Control Number	MASSPROD for production transactions	M		X(10)
109-A9	Transaction Count	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences	M		X(1)
202-B2	Service Provider ID Qualifier	01 – National provider identifier	M		X(2)
201-B1	Service Provider ID		M		X(15)
401-D1	Date of Service	CCYYMMDD	M		9(8)
110-AK	Software Vendor/Certification ID		M	The MassHealth registration number assigned to software as part of initial certification.	X(10)

Insurance Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This segment is always sent.	X	

	Insurance Segment Segment Identification (111-AM) = 04			**Claim Billing/ Claim Rebill**	
Field #	*NCPDP FIELD NAME*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
302-C2	Cardholder ID		M	The 12-digit MassHealth member ID number	X(20)
312-CC	Cardholder First Name		R	Refer to Section 7.0 for more information.	X(12)
313-CD	Cardholder Last Name		R	Refer to Section 9.0 for more information.	X(15)
314-CE	Home Plan		N		
524-FO	Plan ID		I		
309-C9	Eligibility Clarification Code		N		
301-C1	Group ID	MassHealth CMSP HSN	R	Refer to Section 7.0 for more information.	X(15)
303-C3	Person Code		N		
306-C6	Patient Relationship Code	0=Not specified 1=Cardholder	N		
359-2A	Medigap ID		QM		X(20)
360-2B	Medicaid Indicator		QM		X(2)
361-2D	Provider Accept Assignment Indicator	Y=Assigned N=Not assigned	QM		X(1)
997-G2	CMS Part D Defined Qualified Facility	Y=CMS-qualified facility N=Not a CMS-qualified assigned	QM		X(1)
115-N5	Medicaid ID Number		QM		X(20)
116-N6	Medicaid Agency Number		N		

Patient Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This segment is always sent.	X	
This segment is situational.		

	Patient Segment Segment Identification (111-AM) = 01			**Claim Billing/Claim Rebill**	
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
331-CX	Patient ID Qualifier		N		X(2)
332-CY	Patient ID		N		
304-C4	Date of Birth	CCYYMMDD	R	Refer to Section 7.0 for more information.	9(8)
305-C5	Patient Gender Code	1=Male 2=Female	R	Refer to Section 7.0 for more information.	9(1)
310-CA	Patient First Name		I		X(12)
311-CB	Patient Last Name		I		X(15)
322-CM	Patient Street Address		N		
323-CN	Patient City Address		N		
324-CO	Patient State / Province Address		N		

	Patient Segment Segment Identification (111-AM) = 01			**Claim Billing/Claim Rebill**	
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
325-CP	Patient Zip/Postal Zone		N		
326-CQ	Patient Phone Number		N		
307-C7	Place of Service (formerly patient location)	1=Pharmacy 2=Unassigned 3=School 4=Homeless Shelter 5=Indian Health Service Free-standing Facility 6=Indian Health Service Provider-based Facility 7=Tribal 638 Free-standing Facility 8=Tribal 638 Provider-based Facility 9=Prison/Correctional Facility 10=Unassigned 11=Office 12=Home 13=Assisted Living Facility 14=Group Home 15=Mobile Unit 16=Temporary Lodging 17=Walk-in Retail Health Clinic 18=Place of Employment-worksite- 19=Off Campus-Outpatient Hospital 20=Urgent Care Facility 21=Inpatient Hospital 22=On Campus-Outpatient Hospital 23=Emergency Room – Hospital 24=Ambulatory Surgical Center 25=Birthing Center 26=Military Treatment Facility 27-30=Unassigned 31=Skilled Nursing Facility 32=Nursing Facility 33=Custodial Care Facility 34=Hospice 35-40=Unassigned 41=Ambulance – Land 42=Ambulance – Air or Water 43-48=Unassigned 49=Independent Clinic 50=Federally Qualified Health Center	I		9(2)

	Patient Segment **Segment Identification (111-AM) = 01**			**Claim Billing/Claim Rebill**	
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
307-C7 (*cont*.)	Place of Service (formerly patient location)	51=Inpatient Psychiatric Facility 52=Psychiatric Facility – Partial Hospitalization 53=Community Mental Health Center 54=Intermediate Care Facility/Intellectual Disabilities 55=Residential Substance Abuse Treatment Facility 56=Psychiatric Residential Treatment 57=Non-residential Substance Abuse Treatment Facility 58-59=Unassigned Facility 60=Mass Immunization Center 61=Comprehensive Inpatient Rehab Facility 62=Comprehensive Outpatient Rehabilitation Facility 63-64=Unassigned 65=End-Stage Renal Disease Treatment 66-70=Unassigned 71=Public Health Clinic 72=Rural Health Clinic 73-80=Unassigned 81=Independent Laboratory 82-98=Unassigned 99=Other Place of Service			
333-CZ	Employer ID		N		
334-1C	Smoker/Nonsmoker Code	Yes=Smoker No=Nonsmoker	Q		X(1)
335-2C	Pregnancy Indicator	Blank=Not specified 1=Not pregnant 2=Pregnant	Q		X(1)
350-HN	Patient E-Mail Address		N		
384-4X	Patient Residence	1=Home 2=Skilled Nursing Facility 3=Nursing Facility 4=Assisted Living Facility 5=Custodial Care Facility 6=Group Home 11=Hospice	R		9(2)

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This segment is always sent.	X	
This payer supports partial fills.	X	
This payer does not support partial fills.		

Partial Fills

The claim segment describes scenarios about partial fills and completion fills. A partial fill occurs when a pharmacy does not have the full quantity of a drug specified by a prescription to dispense to a patient. The pharmacy dispenses the available quantity. A claim may be submitted for this type of fill, known as a partial fill, whether or not the patient returns to obtain the remainder of the drug quantity (sometimes the patient does not return for the remainder). If the patient does return and receives the remainder of the drug quantity, a claim submitted for this transaction is known as a completion fill.

A pharmacy can submit the following types of claims:

- partial – whenever there is a partial fill on a covered drug;
- completion with a previous partial claim – whenever a partial fill for which a previous claim was submitted has a completion fill; and
- completion without a previous partial.

The table below lists the fields that are required for partial-fill transactions, completion-fill transactions, or both.

Field Name Used with Partial, Completion, or Both
456-EN (Associated prescription/service reference number) Completion
457-EP (Associated prescription/service date) Completion
343-HD (Dispensing status) Both
344-HF (Quantity intended to be dispensed) Both
345-HG (Days' supply intended to be dispensed) Both

	Claim Segment Segment Identification (111-AM) = 07			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
455-EM	Prescription/Service Reference Number Qualifier	1=Rx billing	M		X(1)
402-D2	Prescription/Service Reference Number		M	The prescription number assigned must be unique for each member/ drug combination within a dispensing pharmacy.	9(12)
436-E1	Product/Service ID Qualifier	00=Not Specified 01=Universal Product Code (UPC) 02=Health-related item (HRI) 03=National Drug Code (NDC)	M	00=Not Specified can only be used for a compound claim	X(2)

	Claim Segment Segment Identification (111-AM) = 07			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
407-D7	Product/Service ID		M	If CC, this field should be zero filled.	X(19)
456-EN	Associated Prescription/Service Reference Number		Q	Required if the completion transaction in a partial fill (dispensing status (343-HD)=C (completed)). Required if the dispensing status (343-HD)=P (partial fill) and there are multiple occurrences of partial fills for this prescription.	9(12)
457-EP	Associated Prescription/Service Date	CCYYMMDD	Q	Required if the completion transaction in a partial fill (dispensing status (343-HD)=C (completed)). Required if associated prescription/service reference number (456-EN) is used. Required if the dispensing status (343-HD)=P (partial fill) and there are multiple occurrences of partial fills for this prescription.	9(8)
458-SE	Procedure Code Count		N		
459-ER	Procedure Modifier Code		N		
442-E7	Quantity Dispensed	Metric decimal quantity	R	For CC, enter the quantity of the drug in its compounded form.	s9(7)v999
403-D3	Fill Number	0=Original dispensing 1 to 11=Refill number	R		9(2)
405-D5	Days Supply		R	On partial-fill transactions, specify only whole days dispensed.	9(3)
406-D6	Compound Code	1=Not a compound 2=Compound code	R		9(1)
408-D8	Dispense as Written (DAW)/Product Selection Code	0=No product selection indicated 1=Physician request 5=Brand used as generic 7=Brand, no substitution allowed 9=Brand Preferred by MassHealth	R	MassHealth only allows value=7 when Medicare D is the primary payer	X(1)
414-DE	Date Prescription Written	CCYYMMDD	R		9(8)
415-DF	Number of Refills Authorized	0 through 11	R		9(2)

	Claim Segment Segment Identification (111-AM) = 07			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
419-DJ	Prescription Origin Code	1=Written on tamper-resistant prescription pad 2=Telephone 3=Electronic 4=Facsimile 5=Pharmacy	R	MassHealth will only recognize and allow the use of value=5 to cover situations defined in the Massachusetts Board of Registration in Pharmacy Regulation: 247 CMR 9.02.	9(1)
354-NX	Submission Clarification Code Count	Maximum count of three	R		9(1)
420-DK	Submission Clarification Code	01=No override 02=Other Override 03=Vacation Supply – The pharmacist is indicating that the cardholder has requested a vacation supply of the medicine. 04=Lost Prescription – The pharmacist is indicating that the cardholder has requested a replacement of medication that has been lost. 05=Therapy Change –The pharmacist is indicating that the physician has determined that a change in therapy was required; either that the medication was used faster than expected, or a different dosage form is needed, etc. 06=Starter Dose – The pharmacist is indicating that the previous medication was a starter dose and now additional medication is needed to continue treatment. 07=Medically Necessary – The pharmacist is indicating that this medication has been determined by the physician to be medically necessary. 08=Process Compound for Approved Ingredients 09=Encounters	R***R***	MassHealth requires this field be populated on each claim. MassHealth evaluates the submitted valid values supported in this field periodically and will deny claim submissions if the submitted field is omitted or the value is not supported Value of 08 allows for processing the compound claim with all (covered and noncovered) ingredients. To select submission clarification code of 08, the compound code value must be 2.	9(2)

	Claim Segment Segment Identification (111-AM) = 07			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
420-DK (*cont.*)	Submission Clarification Code	10=Meets Plan Limitations –The pharmacy certifies that the transaction is in compliance with the program's policies and rules that are specific to the particular product being billed. 11=Certification on File – The supplier's guarantee that a copy of the paper certification, signed and dated by the physician, is on file at the supplier's office. 12=DME Replacement Indicator – Indicator that this certification is for a DME item replacing a previously purchased DME item. 13=Payer-Recognized Emergency/Disaster Assistance Request – The pharmacist is indicating that an override is needed based on an emergency/disaster situation recognized by the payer. 14=Long-Term Care (LTC) Leave of Absence – The pharmacist is indicating that the cardholder requires a short-fill of a prescription due to a leave of absence from the LTC facility 15=LTC Replacement Medication – Medication has been contaminated during administration in a LTC setting. 16=LTC Emergency Box (kit) or Automated Dispensing Machine – Indicates that the transaction is a replacement supply for doses previously dispensed to the patient after hours. 17=LTC Emergency Supply Remainder – Indicates that the transaction is for the remainder of the drug originally begun from an emergency kit.			

	Claim Segment Segment Identification (111-AM) = 07			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
420-DK (*cont.*)	Submission Clarification Code	18=LTC Patient Admit/Readmit Indicator – Indicates that the transaction is for a new dispensing of medication due to the patient's admission or readmission status. 19=remainder billed to a subsequent payer when Medicare Part A expires. Used only in LTC settings. 20=340B – Indicates that, prior to providing service, the pharmacy has determined the product being billed is purchased, pursuant to rights available under Section 340B of the Public Health Act of 1992, including sub-ceiling purchases authorized by Section 340B (a)(10) and those made through the Prime Vendor Program (Section 340B(a)(8)). 21=LTC Dispensing: Seven days or less not applicable – Seven-days or less dispensing is not applicable due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e., vacation supply, leave of absence, ebox, splitter dose). Medication quantities are dispensed as billed. 22=LTC Dispensing: Seven days – Pharmacy dispenses medication in seven-day supplies. 23=LTC Dispensing: Four days – Pharmacy dispenses medication in four-day supplies. 24=LTC Dispensing: Three days – Pharmacy dispenses medication in three-day supplies. 25=LTC Dispensing: Two days – Pharmacy dispenses medication in two-day supplies.		20=340B: Value of 20 only applies to 340B claims where the drug/product's NDC is pulled from 340B inventory. **Claims submitted for a 340B carve-out drug or DME product will deny.**	

	Claim Segment Segment Identification (111-AM) = 07			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
420-DK (*cont.*)	Submission Clarification Code	26=LTC Dispensing: One day – Pharmacy or remote (multiple shifts) dispenses medication in one-day supplies. 27=LTC Dispensing: 4-3 days – Pharmacy dispenses medication in four-day, then three-day supplies. 28=LTC Dispensing: 2-2-3 days – Pharmacy dispenses medication in two-day, then two-day, then three-day supplies. 29=LTC Dispensing: Daily and three-day weekend – Pharmacy or remote dispensed daily during the week and combines multiple-days dispensing for weekends. 30=LTC Dispensing: Per shift dispensing – Remote dispensing per shift (multiple med passes). 31=LTC Dispensing: Per med pass dispensing – Remote dispensing per med pass. 32=LTC Dispensing: PRN on-demand – Remote dispensing on demand as needed. 33=LTC Dispensing: Seven-day or less dispensing method not listed above – Cycle not represented in codes 22-31. 99=Other		99=Other: drug/product is exempt from Medicare D wrap threshold	
460-ET	*Quantity Prescribed*		*Q*	MassHealth requires this field be populated when the Product/Service ID (407-D7) is a schedule II medication	9(7)v999

	Claim Segment Segment Identification (111-AM) = 07			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
308-C8	Other Coverage Code	00=Not specified by patient 01=No other coverage has been identified. 02=Other coverage exists. Payment was collected. 03=Other coverage exists. This claim is not covered. 04=Other coverage exists; payment not collected	R	MassHealth requires this field be populated on each claim. Submitters must use value 00=not specified by patient if no other MassHealth-supported values apply. MassHealth will reject the claim if a COB segment is submitted and the Other Coverage Code value is not equal to 02, 03, or 04. MassHealth will reject the claim if a COB segment is not submitted and Other Coverage Code value is equal to 02, 03, or 04. A value of 04 must be used only when the other payer has paid $0 because 100% of the allowed amount was applied to the patient responsibility. For multiple other insurances, if different payers returned different outcomes (02 – other coverage exists – payment collected, 04 – other coverage exists – payment not collected, 03 – other coverage exists – claim not covered), then use this hierarchy (02, 04, 03) for determining the value to enter in the other coverage code field.	9(2)
429-DT	Special Packaging Indicator (Formerly Unit Dose Indicator)	0=Not specified 1=Not unit dose 2=Manufacturer unit dose 3=Pharmacy unit dose 4=Custom packaging 5=Multi-drug compliance packaging 6=Remote Device Unit Dose – Drug is dispensed at the facility, via a remote device, in a unit of use package.	I		9(1)

	Claim Segment Segment Identification (111-AM) = 07			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
429-DT (*cont.*)	Special Packaging Indicator (Formerly Unit Dose Indicator)	7=Remote Device Multi- drug Compliance – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8=Manufacturer Unit of Use Package (not unit dose) – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long-term- care claims.			
453-EJ	Originally Prescribed Product/Service ID Qualifier	01=Universal Product Code (UPC) 02=Health-related item (HRI) 03=National Drug Code (NDC)	N		
445-EA	Originally Prescribed Product/Service Code		N		
446-EB	Originally Prescribed Quantity		Q		s9(7)v999
330-CW	Alternate ID		N		
454-EK	Scheduled Prescription ID Number		N		
600-28	Unit of Measure	EA=Each GM=Grams ML=Milliliters	I	Not required for compound claim-Use field 451-EG instead.	X(2)
418-DI	Level of Service	03=Emergency	Q		9(2)
461-EU	Prior Authorization Type Code	0=Not specified 1=Prior authorization	Q		9(1)
462-EV	Prior Authorization Number Submitted		Q	Required entry for claims submitted on behalf of 340B clinics for indirect billing. Authorization number is provided during registration.	9(11)
463-EW	Intermediary Authorization Type ID		N		
464-EX	Intermediary Authorization ID		N		

	Claim Segment Segment Identification (111-AM) = 07			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
343-HD	Dispensing Status	Blank=Not specified P=Partial C=Completion	Q	This field is used and required only for partial-fill/complete actions. A value of P is required along with the quantity and days' supply intended to be dispensed on the initial fill. A value of C will be required on the completion fill along with the associated pharmacy/service reference number and associated pharmacy/service date. If transaction is a B3-rebill, you cannot submit a dispensing status of P (partial) or C (completion). Values of P and C are valid only for B1.	X(1)
344-HF	Quantity Intended to be Dispensed		Q	Required for the partial fill or the completion fill of a prescription.	s9(7)v999
345-HG	Days Supply Intended to be Dispensed		Q	Required for the partial fill or the completion fill of a prescription.	9(3)
357-NV	Delay Reason Code	1=Proof of eligibility unknown or unavailable 2=Litigation 3=Authorization delay 4=Delay in certifying provider 5=Delay in supplying billing forms 7=Third-party processing delay 8=Delay in eligibility determination 9=Original claims rejected 10=Administrative delay in the prior approval process 11=Other 12=Received late with no exceptions	Q	Required when needed to specify the reason that submission of the transaction has been delayed.	9(2)
391-MT	Patient Assignment Indicator (Direct Member Reimbursement Indicator)		N		
995-E2	Route of Administration	54471007=Buccal 372449004=Dental 417985001=Enteral 372454008=Gastro-enteral 421503006=Hemodialysis 424494006=Infusion	Q	This field should be populated only when billing for a multi-ingredient compound using a valid value recognized by MassHealth.	X(11)

	Claim Segment Segment Identification (111-AM) = 07			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
995-E2 (*cont.*)	Route of Administration	78421000=Intramuscular 72607000=Intrathecal 58100008=Intraarterial 112239003=Inhalation 424109004=Injection 372464004=Intradermal 38239002=Intra-peritoneal 47625008=Intravenous 404817000=Intravenous Piggyback 404816009=Intravenous Push 47056001=Irrigation 46713006=Nasal 5445002=Ophthalmic 26643006=Oral 372473007=Oromucosal 10547007=Otic 421032001=Peritoneal 37161004=Rectal 34206005=Subcutaneous 37839007=Sublingual 6064005=Topical 45890007=Transdermal 90028008=Urethral 16857009=Vaginal			
996-G1	Compound Type	01=Anti-infective 02=Ionotropic 03=Chemotherapy 04=Pain management 05=TPN/PPN 06=Hydration 07=Ophthalmic 99=Other	Q	Required when compound code (CC)=2	X(2)
147-U7	Pharmacy Service Type	1=Community/retail pharmacy services 2=Compounding pharmacy Services 3=Home infusion therapy provider services 4=Institutional pharmacy services	Q	Required for members with commercial insurance that use mail order pharmacies.	9(2)

	Claim Segment Segment Identification (111-AM) = 07			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
147-U7 (*cont.*)	Pharmacy Service Type	5=LTC pharmacy services 6=Mail order pharmacy services 7=Managed care organization pharmacy 8=Specialty care pharmacy services 99=Other			

Pricing Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
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*	*Field Format*
111-AM	Segment Identification		M		X(2)
409-D9	Ingredient Cost Submitted		R		s9(6)v99
412-DC	Dispensing Fee Submitted		R	When billing for DME items the dispensing fee submitted must = zero, per MassHealth regulation	s9(6)v99
477-BE	Professional Service Fee Submitted		N		
433-DX	Patient Paid Amount Submitted		Q	When MassHealth is the primary payer, enter the copay amount the pharmacy received from the patient for the prescription dispensed. This field is not used in coordination of benefit transactions.	s9(6)v99
438-E3	Incentive Amount Submitted		Q	When billing for both vaccine serum obtained at a cost to the pharmacy and vaccine administration, use this field for the vaccine administration fee.	s9(6)v99
478-H7	Other Amount Claimed Submitted Count		N		
479-H8	Other Amount Claimed Submitted Qualifier		N		
480-H9	Other Amount Claimed Submitted		N		
481-HA	Flat Sales Tax Amount Submitted		N		
482-GE	Percentage Sales Tax Amount Submitted		N		

	Pricing Segment Segment Identification (111-AM) = 11			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
483-HE	Percentage Sales Tax Rate Submitted		N		
484-JE	Percentage Sales Tax Basis Submitted		N		
426-DQ	Usual And Customary Charge		R		s9(6)v99
430-DU	Gross Amount Due		R	Whether billing MassHealth as the primary payer or a secondary payer, this amount follows the formula outlined in the D.0 Implementation Guide (Section 28.1.10.1) and adheres to the definition of Usual & Customary Charge defined in 101 CMR 331.00: Prescribed Drugs.	s9(6)v99
423-DN	Basis of Cost Determination	00=Default 01=Average wholesale price (AWP) 02=Local wholesaler 03=Direct 04=Estimated acquisition cost (EAC) 05=Acquisition 06=Maximum allowable cost (MAC) 07=Usual and customary – The pharmacy's price for the medication for a cash paying person on the day of dispensing. 08=340B/ disproportionate share pricing/public health 09=Other 10=Average sales price (ASP) 11=Average manufacturer price (AMP) 12=Wholesale acquisition cost (WAC) 13=Special patient pricing – The cost calculated by the pharmacy for the drug for this special patient	R	08=340B/ disproportionate share pricing/public health- Applies to 340B claims where the drug/product's NDC is pulled from 340B inventory. Claims submitted with a 08 value for either a 340B carve-out drug or DME product will deny	X(2)

Pharmacy Provider Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This segment is always sent.		Not supported at this time

	Pharmacy Provider Segment Segment Identification (111-AM) = 02			**Claim Billing/Claim Refill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
465-EY	Provider ID Qualifier		R		X(2)
444-E9	Provider ID		R		X(15)

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

	Prescriber Segment Segment Identification (111-AM) = 03			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
466-EZ	Prescriber ID Qualifier	01=National provider identifier (NPI)	R		X(2)
411-DB	Prescriber ID		R	MassHealth requires the individual NPI of the prescriber be entered on all claim transactions, a practice location with a New England address and a taxonomy code that demonstrates clinical appropriateness to write prescriptions.	X(15)
427-DR	Prescriber Last Name		R		X(15)
498-PM	Prescriber Phone Number		I		9(10)
468-2E	Primary Care Provider ID Qualifier	01=National provider identifier (NPI)	I		X(2)
421-DL	Primary Care Provider ID		I		X(15)
470-4E	Primary Care Provider Last Name		I		X(15)
364-2J	Prescriber First Name		I		
365-2K	Prescriber Street Address		N		
366-2M	Prescriber City Address		N		
367-2N	Prescriber State/Province Address		N		
368-2P	Prescriber Zip/Postal Zone		N		

Coordination of Benefits/Other Payments Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.	X	Required only for secondary, tertiary, etc., claims.
Scenario 1 – Other payer amount paid, repetitions only		
Scenario 2 – Other payer-patient responsibility amount repetitions, and benefit stage repetitions only		

Scenario 3 – Other payer amount paid, other payer-patient responsibility amount, and benefit stage repetitions present (government programs)	X	

All pharmacy claims submitted to POPS are adjudicated for other insurance coverage, also known as third-party liability (TPL). The billing pharmacy must indicate that the member's other insurance was billed prior to submitting the claim to MassHealth. Therefore, all billing pharmacies must have online split-billing capability. After billing the primary payer, enter the appropriate information for the required split-billing fields on the claim submission (see below).

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = 05**			**Claim Billing/Claim Rebill** Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
337-4C	Coordination of Benefits/Other Payments Count	Maximum count of nine	M		9(1)
338-5C	Other Payer Coverage Type	01=Primary 02=Secondary 03=Tertiary 04=Quaternary-fourth 05=Quinary-fifth 06=Senary-sixth 07=Septenary-seventh 08=Octonary-eighth 09=Nonary-ninth	M***R***		X(2)
339-6C	Other Payer ID Qualifier	03=BIN 99=Other	R***R***	MassHealth accepts BIN on a limited basis. Refer to Section 6.0 TPL Billing for additional information.	X(2)
340-7C	Other Payer ID		R	MassHealth accepts BIN on a limited basis. Refer to Section 6.0 TPL Billing for additional information.	X(10)
443-E8	Other Payer Date	CCYYMMDD	R		9(8)
341-HB	Other Payer Amount Paid Count	Maximum count of nine	Q		9(1)
342-HC	Other Payer Amount Paid Qualifier	Blank=not specified 01=Delivery Cost – An indicator which signifies the amount claimed for the costs related to the delivery of a product or service 02=Shipping Cost – The amount claimed for transportation of an item	Q***R***	MassHealth requires that one of these occurrences **must** contain the payment dollars associated with the drug benefit (07=Drug Benefit).	X(2)

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = 05**			**Claim Billing/Claim Rebill** Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
342-HC (*cont.*)	Other Payer Amount Paid Qualifier	03=Postage Cost – The amount claimed for the mailing of an item 04=Administrative Cost – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance 05=Incentive -- An indicator that signifies the dollar amount paid by the other payer, which is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g., collection of survey data, counseling plan enrollees, or vaccine administration) 06=Cognitive Service — An indicator that signifies the dollar amount paid by the other payer, which is related to the pharmacist's interaction with a patient or caregiver that is beyond the traditional dispensing/patient instruction activity (e.g., therapeutic regiment review; recommendation for additional, fewer or different therapeutic choices) 07=Drug Benefit — An indicator that signifies the dollar amount paid by the other payer, which is related to the plan's drug benefit			

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = 05**			**Claim Billing/Claim Rebill** Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
342-HC (*cont*.)	Other Payer Amount Paid Qualifier	09=Compound Preparation Cost Submitted – The amount claimed for the preparation of the compound 10=Sales Tax – An Indicator that signifies the dollar amount paid by the other payer, which is related to sales tax			
431-DV	Other Payer Amount Paid	s$$$$$$cc	Q***R***		s9(6)v99
471-5E	Other Payer Reject Count	Maximum count of five	Q	Only populated when claim denies from a prior payer (i.e., Medicare or private)	9(2)
472-6E	Other Payer Reject Code		Q***R***	MassHealth regulation (450.316) requires submitters to bill all other payers before submitting a claim to MassHealth. Those bills must be submitted In accordance with each payer's billing and authorization requirements to obtain appropriate reimbursement. Accordingly, MassHealth will not adjudicate a secondary claim containing any reject code that indicates the original claim submitted to the upstream payer contained Missing and or Invalid information. Therefore, if a secondary claim submitted to MassHealth results in a denial claim with a Reject Code 6E, the submitter must correct and rebill the upstream payer before rebilling MassHealth.	X(3)
353-NR	Other Payer-Patient Responsibility Amount Count	Maximum count of 25	Q		9(2)

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = 05**			**Claim Billing/Claim Rebill** Scenario 3 – Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
351-NP	Other Payer-Patient Responsibility Amount Qualifier	01=Deductible 04=Benefit Maximum 05=Copay 06=Patient Pay Amount 07=Coinsurance 09=Health Plan Assistance Amount	Q***R***	MassHealth only supports the values listed. MassHealth will deny a claim submitted with a qualifier of any other value, even if the corresponding other payer-patient responsibility amount (352-NQ) is $0. If the prior payer returns Patient Responsibility Amounts utilizing component fields, submit a separate occurrence for any non-zero component, with the applicable qualifier (351- NP) and corresponding $$ amount (352-NQ). MassHealth only recognizes the use of qualifier 06-Patient Pay Amount when the prior payer does not return Patient Responsibility Amounts at a component level. When value 09 is submitted, the corresponding other payer-patient responsibility amount (352-NQ) must be a negative amount.	X(2)
352-NQ	Other Payer-Patient Responsibility Amount		Q***R***		s9(8)v99
392-MU	Benefit Stage Count	Maximum count of four.	Q		9(1)
393-MV	Benefit Stage Qualifier	Blank not specified 01=Deductible 02=Initial benefit 03=Coverage gap (donut hole) 04=Catastrophic coverage	Q***R***		X(2)
394-MW	Benefit Stage Amount		Q***R***		s9(8)v99

Workers' Compensation Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.		Segment not supported.

	Workers' Compensation Segment **Segment Identification (111-AM) = 06**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
434-DY	Date of Injury		M		
315-CF	Employer Name				
316-CG	Employer Street Address				
317-CH	Employer City Address				
318-CI	Employer State/Province Address				
319-CJ	Employer Zip/Postal Zone				
320-CK	Employer Phone Number				
321-CL	Employer Contact Name				
327-CR	Carrier ID				
435-DZ	Claim/Reference ID				
117-TR	Billing Entity Type Indicator				
118-TS	Pay to Qualifier				
119-TT	Pay to ID				
120-TU	Pay to Name				
121-TV	Pay to Street Address				
122-TW	Pay to City Address				
123-TX	Pay to State/Province Address				
124-TY	Pay to Zip/Postal Zone				
125-TZ	Generic Equivalent Product ID Qualifier				
126-UA	Generic Equivalent Product ID				

DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.	X	

	DUR/PPS Segment **Segment Identification (111-AM) = 08**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
473-7E	DUR/PPS Code Counter	Maximum of nine occurrences	R		9(1)
439-E4	Reason for Service Code	DD=Drug-drug interaction HD=High dose ID=Ingredient duplication TD=Therapeutic duplication ER=Early refill	Q***R***	Not used with 474-8E/ Level of Effort when billing for preparing a compound prescription. Not required when Professional Service Code (440-E5)=MA	X(2)

	DUR/PPS Segment **Segment Identification (111-AM) = 08**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
440-E5	Professional Service Code	MA=Medication administration M0=Prescriber consulted R0=Pharmacist consulted other source	Q***R***	Not used with 474-8E/ Level of Effort when billing for preparing a compound prescription.	X(2)
441-E6	Result of Service Code	1A=Filled as is, false positive 1B=Filled prescription, as is 1C=Filled, with different dose 1D=Filled, with different directions 1E=Filled, with different drug 1F=Filled, with different quantity 1G=Filled, with prescriber approval	Q***R***	Not used with 474-8E/ Level of Effort when billing for preparing a compound prescription. Not required when Professional Service Code (440-E5)=MA	X(2)
474-8E	DUR/PPS Level of Effort	00 =Not specified 11=Level 1 – Less than five min. 12=Level 2 – Less than 15 min. 13=Level 3 – Less than 30 min. 14=Level 4 – Less than one hour 15=Level 5 – Greater than one hour	Q***R***	Must submit when billing for a compound prescription with a fill date of 04/01/2017 or later. MassHealth recognized values: 11- Compounded drugs whose dispensing involves the mixing two or more commercially prepared products 12 - Compounded drugs whose dispensing involves compounding lotions, shampoos, suspensions, or the mixing of powders or liquids into cream, ointment, or gel base 13 - Compounded drugs whose dispensing involves compounding capsules, troches, suppositories, or pre-filled syringes 14 - Compounded drugs needing a sterile environment when mixing	9(2)

	DUR/PPS Segment **Segment Identification (111-AM) = 08**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
475-J9	DUR Coagent ID Qualifier		I***R***	Not used with 474-8E/ Level of Effort when billing for preparing a compound prescription.	X(2)
476-H6	DUR Coagent ID		I***R**	Not used with 474-8E/ Level of Effort when billing for preparing a compound prescription.	X(19)

Coupon Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.		Segment not supported.

	Coupon Segment **Segment Identification (111-AM) = 09**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
485-KE	Coupon Type		M		X(2)
486-ME	Coupon Number		M		X(15)
487-NE	Coupon Value Amount		Q		s9(6)v99

Compound Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.	X	Segment is required when provided medication involves the compounding of two or more drugs. Refer to information below for specifics.

Compound Claims

Pharmacy compound claims must be submitted through POPS for payment. All claims for compounds must be submitted online and must contain more than one ingredient. Each ingredient of the compound must be submitted.

- Each compound claim is limited to a maximum of 15 ingredient lines. Providers can submit only a single compound transaction within a single transmission.
  - Noncovered ingredients will cause a claim to be denied. Each ingred ient is subjected to the edits and audits within claim adjudication. If a claim is denied because of a noncovered ingredient, the provider may agree to accept payment for the approved ingredients making up the compound. To do this, enter a value of 08 (08=Process Compound for Approved Ingredients)in the Submission Clarification Code (Field 420-DK). This allows the pharmacy to communicate acceptance of payment for approved ingredients only and for the POPS

system to process the compound for these approved ingredients. Compound reversals are processed like other D.0 transactions.

- Compounds may not be submitted as partial fills.

- Compound claims must contain a DUR/PPS Segment with a distinct row, where DU R / PPS Level of Effort (474-8E) contains a MassHealth supported value and fields Reason for Service (439-E4), Professional Service Code (440-E5), Result of Service Code (441-E6), DUR Co-Agent ID Qualifier (475-J9) and DUR Co-Agent ID (476-H6) are not submitted. However in an effort to accommodate system that are not able to suppress fields 439-E4, 440-E5, 441-E6, 475-J9 or 476-H6 on the row that communicates compound preparation effort, MassHealth will ignore if the submitted value is equal to spaces. Failure to submit this unique row will result in the claim being denied with NCPDP reject code 8E –M/I DUR/PPS Level Of Effort.
- MassHealth will retrospectively examine Level of Effort values entered on a compounded claim

	Compound Segment **Segment Identification (111-AM) = 10**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
450-EF	Compound Dosage Form Description Code	Blank=Not specified 01=Capsule 02=Ointment 03=Cream 04=Suppository 05=Powder 06=Emulsion 07=Liquid 10=Tablet 11=Solution 12=Suspension 13=Lotion 14=Shampoo 15=Elixir 16=Syrup 17=Lozenge 18=Enema	M		X(2)
451-EG	Compound Dispensing Unit Form Indicator	1=Each 2=Grams 3=Milliliters	M		9(1)
447-EC	Compound Ingredient Component Count	Maximum 15 ingredients	M		9(2)
488-RE	Compound Product ID Qualifier	01=Universal Product Code (UPC) 02=Health-related item (HRI)	M***R***		X(2)
488-RE (*cont.*)	Compound Product ID Qualifier	03=National Drug Code (NDC) (default)			
489-TE	Compound Product ID		M***R***		X(19)
448-ED	Compound Ingredient Quantity		M***R***	Metric decimal Equivalent	s9(7)v999
449-EE	Compound Ingredient Drug Cost		R***R***		s9(7)v99
490-UE	Compound Ingredient Basis of	00=Default	R***R***		X(2)

	Compound Segment **Segment Identification (111-AM) = 10**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
	Cost Determination	01=Average wholesale price (AWP) 02=Local wholesaler 03=Direct 04=Estimated acquisition cost (EAC) 05=Acquisition 06=Maximum allowable cost (MAC) 07=Usual and customary (default) 08=340B Drug pricing 09=Other 10=Average sales price (ASP) 11=Average manufacturer price (AMP) 12=Wholesale acquisition cost (WAC) 13=Special patient pricing			
362-2G	Compound Ingredient Modifier Code Count	Maximum count of 10	I		9(2)
363-2H	Compound Ingredient Modifier Code		I***R***		X(2)

Clinical Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.	X	

	Clinical Segment **Segment Identification (111-AM) = 13**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
491-VE	Diagnosis Code Count	Maximum count of five	N		
492-WE	Diagnosis Code Qualifier		N***R***		
424-DO	Diagnosis Code		N***R***		
493-XE	Clinical Information Counter	Maximum five occurrences supported	Q		9(1)
494-ZE	Measurement Date	CCYYMMDD	Q***R***		9(8)
495-H1	Measurement Time	HHMM	Q***R***		9(4)

	Clinical Segment **Segment Identification (111-AM) = 13**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
496-H2	Measurement Dimension	Blank=Not specified 01=Blood pressure (BP) 02=Blood glucose level 03=Temperature 04=Serum creatinine (SCr) 05=HbA1c 06=Sodium (Na+) 07=Potassium (K+) 08=Calcium (Ca++) 09=Serum glutamic-oxaloacetic transaminase (SGOT) 10=Serum glutamic-pyruvic transaminase (SCPT) 11=Alkaline phosphatase 12=Serum theophylline level 13=Serum digoxin level 14=Weight 15=Body surface area (BSA) 16=Height 17=Creatinine clearance (CrCl) 18=Cholesterol 19=Low-density lipoprotein (LDL) 20=High-density lipoprotein (HDL) 21=Triglycerides (TG) 22=Bone mineral density (BMD T-Score) 23=Prothrombin time (PT)	Q***R***		

	Clinical Segment **Segment Identification (111-AM) = 13**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
496-H2 (cont.)	Measurement Dimension	24=Hemoglobin (Hb; Hgb) 25=Hematocrit (Hct) 26=White blood cell count (WBC) 27=Red blood cell count (RBC) 28=Heart rate 29=Absolute neutrophil count (ANC) 30=Activated partial thromboplastin time (APTT) 31=CD4 count 32=Partial thromboplastin time (PTT) 33=T-cell count 34=International Normalized Ratio (INR) 99=Other			X(2)
497-H3	Measurement Unit	Blank=Not specified 01=Inches (in) 02=Centimeters (cm) 03=Pounds (lb) 04=Kilograms (kg) 05=Celsius (C) 06=Fahrenheit (F) 07=Meters squared (m^2) 08=Milligrams per deciliter (mg/dl) 09=Units per milliliter (U/ml) 10=Millimeters of mercury (mmHg) 11=Centimeters squared (cm^2) 12=Millimeters per minute (ml/min)	Q***R***		X(2)

	Clinical Segment **Segment Identification (111-AM) = 13**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
497-H3 (*cont.*)	Measurement Unit	13=Percentage (%) 14=Milliequivalent (mEq/ml) 15=International units per liter (IU/l) 16=Micrograms per milliliter (mcg/ml) 17=Nanograms per milliliter (ng/ml) 18=Milligrams per milliliter (mg/ml) 19=Ratio 20=SI units 21=Millimoles (mmol/l) 22=Seconds 23=Grams per deciliter (g/dl) 24=Cells per cubic millimeter (cells/cu mm) 25=1,000,000 cells per cubic millimeter (million cells/cu mm) 26=Standard deviation 27=Beats per minute			
499-H4	Measurement Value	Blood pressure entered in XXX/YYY format in which XXX=systolic, /=divider, and YYY is diastolic. Temperature entered in XXX.X format always includes decimal point. Request clinical segment.	Q***R***		X(15)

Additional Documentation Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.		Segment not supported.

	Additional Documentation Segment **Segment Identification (111-AM) = 14**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
369-2Q	Additional Documentation Type ID		M		

	Additional Documentation Segment **Segment Identification (111-AM) = 14**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
374-2V	Request Period Begin Date				
375-2W	Request Period Recert/Revised Date				
373-2U	Request Status				
371-2S	Length of Need Qualifier				
370-2R	Length of Need				
372-2T	Prescriber/Supplier Date Signed				
376-2X	Supporting Documentation				
377-2Z	Question Number/Letter Count	Maximum count of 50			
378-4B	Question Number/Letter				
379-4D	Question Percent Response				
380-4G	Question Date Response				
381-4H	Question Dollar Amount Response				
382-4J	Question Numeric Response				
383-4K	Question Alphanumeric Response				

Facility Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.		Segment not supported.

	Facility Segment **Segment Identification (111-AM) = 15**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
336-8C	Facility ID				
385-3Q	Facility Name				
386-3U	Facility Street Address				
388-5J	Facility City Address				
387-3V	Facility State/Province Address				
389-6D	Facility Zip/Postal Zone				

Narrative Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.		Segment not supported.

	Narrative Segment **Segment Identification (111-AM) = 16**			**Claim Billing/Claim Rebill**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
390-BM	Narrative Message				

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

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

The following table lists the segments and fields in a claim billing or claim rebill response (paid or duplicate of paid) transaction for the NCPDP version D.0. Claim billing includes pharmacy billing transactions B1 and B3.

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

	Response Transaction Header Segment			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
102-A2	Version/Release Number	D0	M		X(2)
103-A3	Transaction Code	B1, B3	M		X(2)
109-A9	Transaction Count	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences	M		X(1)
501-F1	Header Response Status	A=Accepted	M		X(1)
202-B2	Service Provider ID Qualifier	01 – National provider identifier	M		X(2)
201-B1	Service Provider ID		M		X(15)
401-D1	Date of Service	CCYYMMDD	M		9(8)

Response Message Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This segment is always sent.	X	
This segment is situational.		*Provide general information when used for transmission-level messaging.*

	Response Message Segment **Segment Identification (111-AM) = 20**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
504-F4	Message		Q		X(200)

Response Insurance Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This segment is always sent.	X	
This segment is situational.		

	Response Insurance Segment **Segment Identification (111-AM) = 25**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
301-C1	Group ID	MassHealth CMSP HSN	R	Refer to Section 7.0 for more information.	X(15)
524-FO	Plan ID		R		
545-2F	Network Reimbursement ID		N		
568-J7	Payer ID Qualifier		N		
569-J8	Payer ID		N		
115-N5	Medicaid ID Number		N		
116-N6	Medicaid Agency Number		N		
302-C2	Cardholder ID		N		

Response Patient Segment Questions	**Check**	**Claim Billing/Claim Rebill** **Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This segment is always sent.	X	
This segment is situational.		

	Response Patient Segment **Segment Identification (111-AM) = 29**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
310-CA	Patient First Name		R		X(12)
311-CB	Patient Last Name		R		X(15)
304-C4	Date of Birth	CCYYMMDD	R		9(8)

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

	Response Status Segment **Segment Identification (111-AM) = 21**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
112-AN	Transaction Response Status	P=Paid D=Duplicate of paid	M		X(1)
503-F3	Authorization Number		R		X(20)
547-5F	Approved Message Code Count	Maximum count of five	N		
548-6F	Approved Message Code		N***R***		

	Response Status Segment **Segment Identification (111-AM) = 21**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
130-UF	Additional Message Information Count	Maximum count of eight	Q		9(2)
132-UH	Additional Message Information Qualifier	01	Q***R***		X(2)
526-FQ	Additional Message Information		Q***R***		X(40)
131-UG	Additional Message Information Continuity	+	Q***R***		X(1)
549-7F	Help Desk Phone Number Qualifier		N		
550-8F	Help Desk Phone Number		N		

Response Claim Segment Questions	**Check**	**Claim Billing/Claim Rebill** **Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This segment is always sent.	X	

	Response Claim Segment **Segment Identification (111-AM) = 22**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
455-EM	Prescription/Service Reference Number Qualifier	1=Rx billing	M		X(1)
402-D2	Prescription/Service Reference Number		M		9(12)
551-9F	Preferred Product Count	Maximum count of six	N		
552-AP	Preferred Product ID Qualifier		N***R***		
553-AR	Preferred Product ID		N***R***		
554-AS	Preferred Product Incentive		N***R***		
555-AT	Preferred Product Cost Share Incentive		N***R***		
556-AU	Preferred Product Description		N***R***		

Response Pricing Segment Questions	**Check**	**Claim Billing/Claim Rebill** **Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This segment is always sent.	X	

	Response Pricing Segment **Segment Identification (111-AM) = 23**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
505-F5	Patient Pay Amount		R		s9(6)v99
506-F6	Ingredient Cost Paid		Q		s9(6)v99
507-F7	Dispensing Fee Paid		Q		s9(6)v99

	Response Pricing Segment **Segment Identification (111-AM) = 23**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
557-AV	Tax Exempt Indicator		N		
558-AW	Flat Sales Tax Amount Paid		N		
559-AX	Percentage Sales Tax Amount Paid		N		
560-AY	Percentage Sales Tax Rate Paid		N		
561-AZ	Percentage Sales Tax Basis Paid		N		
521-FL	Incentive Amount Paid		Q		
562-J1	Professional Service Paid		N		
563-J2	Other Amount Paid Count	Maximum count of three	Q		9(1)
564-J3	Other Amount Paid Qualifier	09=Compound preparation cost	Q***R***	For 09=Compound prescription cost, this field contains the additional cost for the dispensing of compounds as per MassHealth regulation.	X(2)
565-J4	Other Amount Paid		Q***R***		s9(6)v99
566-J5	Other Payer Amount Recognized		Q		s9(6)v99
509-F9	Total Amount Paid		R		s9(6)v99
522-FM	Basis of Reimbursement Determination		R		9(2)
523-FN	Amount Attributed to Sales Tax		N		
512-FC	Accumulated Deductible Amount		N		
513-FD	Remaining Deductible Amount		N		
514-FE	Remaining Benefit Amount	999999.00	R	For claims processed under Group ID (301-C1) of CMSP, this field will reflect the actual amount of remaining benefit, which has an annual cap.	s9(6)v99
517-FH	Amount Applied to Periodic Deductible		N		
518-FI	Amount of Copay		Q		s9(6)v99
520-FK	Amount Exceeding Periodic Benefit Maximum		Q	For claims processed under Group ID (301-C1) CMSP, this field will reflect the cutback dollars on a claim that resulted in the benefit cap being reach. This amount is added to the dollars reported in Patient Paid Amount (505-F5).	
346-HH	Basis of Calculation – Dispensing Fee		N		
347-HJ	Basis of Calculation – Copay	01=Quantity dispensed	Q		X(2)

	Response Pricing Segment **Segment Identification (111-AM) = 23**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
		02=Quantity intended to be dispensed 03=Usual and customary/ prorated 04=Waived due to partial fill 99=Other			
348-HK	Basis of Calculation – Flat Sales Tax		N		
349-HM	Basis of Calculation – Percentage Sales Tax		N		
571-NZ	Amount Attributed to Processor Fee		N		
575-EQ	Patient Sales Tax Amount		N		
574-2Y	Plan Sales Tax Amount		N		
572-4U	Amount of Coinsurance		N		
573-4V	Basis of Calculation – Coinsurance		N		
392-MU	Benefit Stage Count	Maximum count of four	Q		9(1)
393-MV	Benefit Stage Qualifier	Blank=Not specified 01=Deductible 02=Initial benefit 03=Coverage gap (donut hole) 04=Catastrophic coverage	Q***R***		X(2)
394-MW	Benefit Stage Amount		Q***R***		s9(6)v99
577-G3	Estimated Generic Savings		N		
128-UC	Spending Account Amount Remaining		N		
129-UD	Health Plan-Funded Assistance Amount		N		
133-UJ	Amount Attributed to Provider Network Selection		N		
134-UK	Amount Attributed to Product Selection/Brand Drug		N		
135-UM	Amount Attributed to Product Selection/Nonpreferred Formulary Selection		N		
136-UN	Amount Attributed to Product Selection/Brand Nonpreferred Formulary Selection		N		
137-UP	Amount Attributed to Coverage Gap		N		
148-U8	Ingredient cost contracted/ Reimbursable amount		N		
149-U9	Dispensing fee contracted/ Reimbursable amount		N		

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.	X	

	Response DUR/PPS Segment Segment Identification (111-AM) = 24			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
567-J6	DUR/PPS Response Code Counter	Maximum nine occurrences supported.	Q		9(1)
439-E4	Reason for Service Code	DD=Drug-drug interaction HD=High dose ID=Ingredient duplication TD=Therapeutic duplication ER=Early refill	Q***R***		X(2)
528-FS	Clinical Significance Code		Q***R***		X(1)
529-FT	Other Pharmacy Indicator		Q***R***		9(1)
530-FU	Previous Date of Fill		Q***R***		9(8)
531-FV	Quantity of Previous Fill		Q***R***		s9(7)v999
532-FW	Database Indicator		Q***R***		X(1)
533-FX	Other Prescriber Indicator		Q***R***		9(1)
544-FY	DUR Free Text Message		Q***R***		X(30)
570-NS	DUR Additional Text		Q***R***		X(100)

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.	X	

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = 28			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
355-NT	Other Payer ID Count	Maximum count of three	M		9(1)
338-5C	Other Payer Coverage Type	01=Primary 02=Secondary 03=Tertiary	M***R***		X(2)
339-6C	Other Payer ID Qualifier	Blank=Not specified 03=BIN 99=Other	Q***R***		X(2)

	Response Coordination of Benefits/Other Payers Segment **Segment Identification (111-AM) = 28**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**	
340-7C	Other Payer ID		Q***R***		X(10)
991-MH	Other Payer Processor Control Number		Q***R***		X(10)
356-NU	Other Payer Cardholder ID		N***R***		
992-MJ	Other Payer Group ID		Q***R***		X(15)
142-UV	Other Payer Person Code		N***R***		
127-UB	Other Payer Help Desk Phone Number		N***R***		
143-UW	Other Payer Patient Relationship Code		N***R***		
144-UX	Other Payer Benefit Effective Date		N***R***		
145-UY	Other Payer Benefit Termination Date		N***R***		

2.4 Claim Billing/Claim Rebill Accepted/Rejected Response

The following table lists the segments and fields in a claim billing or claim rebill response (accepted or rejected) transaction for the NCPDP version D.0. Claim billing includes pharmacy billing transactions B1 and B3.

Response Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This segment is always sent.	X	

	Response Transaction Header Segment			**Claim Billing/Claim Rebill Accepted/Rejected**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
102-A2	Version/Release Number	D0	M		X(2)
103-A3	Transaction Code	B1, B3	M		X(2)
109-A9	Transaction Count	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences	M		X(1)
501-F1	Header Response Status	A=Accepted	M		X(1)
202-B2	Service Provider ID Qualifier		M		X(15)
201-B1	Service Provider ID		M		X(15)
401-D1	Date of Service	CCYYMMDD	M		9(8)

Response Message Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This segment is always sent.	X	
This segment is situational.		

	Response Message Segment **Segment Identification (111-AM) = 20**			**Claim Billing/Claim Rebill Accepted/Rejected**	

Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
504-F4	Message		Q		X(200)

Response Insurance Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This segment is always sent.	X	
This segment is situational.		

	Response Insurance Segment **Segment Identification (111-AM) = 25**			**Claim Billing/Claim Rebill Accepted/Rejected**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
301-C1	Group ID	MassHealth CMSP HSN	R	If the system determined that CMSP or Health Safety Net (HSN) was the payer of the claim, then the Group ID (301-C1) within this response transaction will contain a value of CMSP or **HSN**. Please check with your software vendor, to ensure that this information is captured in your system and available to payment reconciliation processes.	X(15)
524-FO	Plan ID		Q		
545-2F	Network Reimbursement ID		N		
568-J7	Payer ID Qualifier		N		
569-J8	Payer ID		N		

Response Patient Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This segment is always sent.	X	
This segment is situational.		

	Response Patient Segment **Segment Identification (111-AM) = 29**			**Claim Billing/Claim Rebill Accepted/Rejected**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
310-CA	Patient First Name		Q		X(12)
311-CB	Patient Last Name		Q		X(15)
304-C4	Date of Birth	CCYYMMDD	Q		9(8)

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

	Response Status Segment Segment Identification (111-AM) = 21			Claim Billing/Claim Rebill Accepted/Rejected	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
112-AN	Transaction Response Status	R=Rejected	M		X(1)
503-F3	Authorization Number		R		X(20)
510-FA	Reject Count	Maximum count of five	R		9(2)
511-FB	Reject Code		R***R***	This field is mandatory when a reject response is returned.	X(3)
546-4F	Reject Field Occurrence Indicator		Q***R***	This is the number of rejected fields.	9(2)
547-5F	Approved Message Code Count		N		
548-6F	Approved Message Code		N***R***		
130-UF	Additional Message Information Count	Maximum count of eight	Q		9(2)
132-UH	Additional Message Information Qualifier	01	Q***R***		X(2)
526-FQ	Additional Message Information		Q***R***		X(40)
131-UG	Additional Message Information Continuity	+	Q***R***		X(1)
549-7F	Help Desk Phone Number Qualifier		N		
550-8F	Help Desk Phone Number		N		

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, *Payer Situation*
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*	*Field Format*
111-AM	Segment Identification		M		X(2)
455-EM	Prescription/Service Reference Number Qualifier	1=Rx billing	M		X(1)
402-D2	Prescription/Service Reference Number		M		9(12)
551-9F	Preferred Product Count	Maximum count of six	N		
552-AP	Preferred Product ID Qualifier		N***R***		
553-AR	Preferred Product ID		N***R***		
554-AS	Preferred Product Incentive		N***R***		
555-AT	Preferred Product Cost Share Incentive		N***R***		

	Response Claim Segment **Segment Identification (111-AM) = 22**			**Claim Billing/Claim Rebill Accepted/Rejected**	
556-AU	Preferred Product Description		N***R***		
114-N4	Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)		N		

Response DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.	X	

	Response DUR/PPS Segment **Segment Identification (111-AM) = 24**			**Claim Billing/Claim Rebill Accepted/Rejected**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
567-J6	DUR/PPS Response Code Counter	Maximum nine occurrences supported	Q		9(1)
439-E4	Reason For Service Code	DD=Drug-drug interaction HD=High dose ID=Ingredient duplication TD=Therapeutic duplication ER=Early refill	Q***R***		X(2)
528-FS	Clinical Significance Code		Q***R***		X(1)
529-FT	Other Pharmacy Indicator		Q***R***		9(8)
530-FU	Previous Date of Fill		Q***R***		9(8)
531-FV	Quantity of Previous Fill		Q***R***		s9(7)v999
532-FW	Database Indicator		Q***R***		X(1)
533-FX	Other Prescriber Indicator		Q***R***		9(1)
544-FY	DUR Free Text Message		Q***R***		X(30)
570-NS	DUR Additional Text		Q***R***		

Response Coordination of Benefits/Other Payers Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.	X	

	Response Coordination of Benefits/Other Payers Segment **Segment Identification (111-AM) = 28**			**Claim Billing/Claim Rebill Accepted/Rejected**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
355-NT	Other Payer ID Count	Maximum count of three.	M		

	Response Coordination of Benefits/Other Payers Segment **Segment Identification (111-AM) = 28**			**Claim Billing/Claim Rebill Accepted/Rejected**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
338-5C	Other Payer Coverage Type	01=Primary 02=Secondary 03=Tertiary	M***R***		X(2)
339-6C	Other Payer ID Qualifier	Blank=Not specified 03=BIN 99=Other	Q***R***		X(2)
340-7C	Other Payer ID		Q***R***		X(10)
991-MH	Other Payer Processor Control Number		Q***R***		X(10)
356-NU	Other Payer Cardholder ID		N***R***		
992-MJ	Other Payer Group ID		Q***R***		X(15)
142-UV	Other Payer Person Code		N***R***		
127-UB	Other Payer Help Desk Phone Number		N***R***		
143-UW	Other Payer Patient Relationship Code		N***R***		
144-UX	Other Payer Benefit Effective Date		N***R***		
145-UY	Other Payer Benefit Termination Date		N***R***		

2.5 Claim Billing/Claim Rebill Rejected/Rejected Response

The following table lists the segments and fields in a claim billing or claim rebill response (rejected/rejected) transaction for the NCPDP version D.0. Claim billing includes pharmacy billing transactions B1 and B3.

Response Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill Rejected/Rejected** If Situational, *Payer Situation*
This segment is always sent.	X	

	Response Transaction Header Segment			**Claim Billing/Claim Rebill Rejected/Rejected**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
102-A2	Version/Release Number	D0	M		X(2)
103-A3	Transaction Code	B1, B3	M		X(2)
109-A9	Transaction Count	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences	M		X(1)
501-F1	Header Response Status	R=Rejected	M		X(1)
202-B2	Service Provider ID Qualifier	01 – National provider identifier	M		X(2)
201-B1	Service Provider ID		M		X(15)
401-D1	Date of Service	CCYYMMDD	M		9(8)

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, *Payer Situation*
This segment is always sent.	X	
This segment is situational.		

	Response Message Segment Segment Identification (111-AM) = 20			Claim Billing/Claim Rebill Rejected/Rejected	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		
504-F4	Message		Q		X(200)

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, *Payer Situation*
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*	*Field Format*
111-AM	Segment Identification		M		X(2)
112-AN	Transaction Response Status	R=Rejected	M		X(1)
503-F3	Authorization Number		R		X(20)
510-FA	Reject Count	Maximum count of five	R		9(2)
511-FB	Reject Code		R***R***		X(3)
546-4F	Reject Field Occurrence Indicator		Q***R***		X(3)
130-UF	Additional Message Information Count	Maximum count of eight	Q		9(2)
132-UH	Additional Message Information Qualifier	01	Q***R***		X(2)
526-FQ	Additional Message Information		Q***R***		X(40)

	Response Status Segment Segment Identification (111-AM) = 21			Claim Billing/Claim Rebill Rejected/Rejected	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
131-UG	Additional Message Information Continuity	+	Q***R***		X(1)
549-7F	Help Desk Phone Number Qualifier		N		
550-8F	Help Desk Phone Number		N		

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

3.1 Claim Submission Format – B2

BIN NUMBER 009555
DESTINATION CONDUENT
ACCEPTING CLAIM ADJUDICATION (B2 REVERSAL TRANSACTIONS)
FORMAT NCPDP D.0

3.2 Request for Claim Reversal Payer Sheet

Field Legend for Columns

Payer Usage Column	Value	Explanation	Payer Situation Column
Mandatory	M	The field is mandatory for the segment in the designated transaction.	No
Required	R	The field has been designated with the situation of 'required' for the segment in the designated transaction.	No
Qualified Requirement	Q	The situations designated have qualifications for usage (required if x, not required if y).	Yes
Informational Only	I	The field is for informational purposes only for the transaction.	Yes
Not Used	N	The field is not used for the segment for the transaction.	No
Repeating	***R***	The three asterisks, R, and three asterisks designates a field is repeating. **Example:** Q***R*** means a situationally qualified field that repeats. **Example:** N***R*** means a not used field that repeats when used.	Yes

Claim Reversal Transaction

The following table lists the segments and fields in a claim reversal transaction for the NCPDP version D.0. Claim reversal transaction includes pharmacy billing transactions B2.

Transaction Header Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*
This segment is always sent.	X	
Source of certification IDs required in software vendor/certification ID (110-AK) is payer issued.	X	
Source of certification IDs required in software vendor/certification ID (110-AK) is switch/VAN issued.		
Source of certification IDs required in software vendor/certification ID (110-AK) is not used.		

	Transaction Header Segment			Claim Reversal	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
101-A1	BIN Number	009555	M		9(6)
102-A2	Version/Release Number	D0	M		X(2)
103-A3	Transaction Code	B2	M		X(2)
104-A4	Processor Control Number	MASSPROD for production transactions	M		X(10)

	Transaction Header Segment			**Claim Reversal**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
109-A9	Transaction Count	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences	M	For B2/S2 (reversal) transactions, transaction count must be a value of 1, 2, 3, or 4. If this transaction is for a compound claim, the transaction count value must be 1.	X(1)
202-B2	Service Provider ID Qualifier	01=National provider identifier (NPI)	M		X(2)
201-B1	Service Provider ID		M		X(15)
401-D1	Date of Service	CCYYMMDD	M		9(8)
110-AK	Software Vendor/Certification ID		M	The MassHealth registration number assigned to software as part of initial certification.	X(10)

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

	Insurance Segment **Segment Identification (111-AM) = 04**			**Claim Reversal**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
302-C2	Cardholder ID		M	12-digit MassHealth ID number	X(20)
301-C1	Group ID	MassHealth CMSP HSN	R		X(15)

Claim Segment Questions	**Check**	**Claim Reversal** If Situational, *Payer Situation*
This segment is always sent.	X	

	Claim Segment **Segment Identification (111-AM) = 07**			**Claim Reversal**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
455-EM	Prescription/Service Reference Number Qualifier	1=Rx billing	M		X(1)
402-D2	Prescription/Service Reference Number		M		9(12)
436-E1	Product/Service ID Qualifier	00=Not Specified 01=Universal Product Code (UPC)	M	00=Not Specified can only be used for a compound claim.	X(2)

	Claim Segment **Segment Identification (111-AM) = 07**			**Claim Reversal**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
436-E1 (*cont.*)	Product/Service ID Qualifier	02=Health-related item (HRI) 03=National Drug Code (NDC)			
407-D7	Product/Service ID		M		X(19)
403-D3	Fill Number		Q		9(2)
308-C8	Other Coverage Code		Q		9(2)
147-U7	Pharmacy Service Type		Q	Required for members with commercial insurance that use mail order pharmacies.	

Pricing Segment Questions	**Check**	**Claim Reversal** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.		Segment not supported.

	Pricing Segment **Segment Identification (111-AM) = 11**			**Claim Reversal**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
438-E3	Incentive Amount Submitted		Q		
430-DU	Gross Amount Due				

Coordination of Benefits/Other Payments Segment Questions	**Check**	**Claim Reversal** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.		Segment not supported.

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = 05**			**Claim Reversal**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
337-4C	Coordination of Benefits/Other Payments Count	Maximum count of nine	M		9(1)
338-5C	Other Payer Coverage Type		M		9(1)

DUR/PPS Segment Questions	**Check**	**Claim Reversal** If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.		Segment not supported.

	DUR/PPS Segment **Segment Identification (111-AM) = 08**			**Claim Reversal**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
473-7E	DUR/PPS Code Counter	Maximum of nine occurrences			9(1)
439-E4	Reason for Service Code				X(2)
440-E5	Professional Service Code				X(2)
441-E6	Result of Service Code				X(2)

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

3.3 Claim Reversal Accepted/Approved Response

The following table lists the segments and fields in a claim reversal response (accepted/approved) transaction for the NCPDP version D.0.

Response Transaction Header Segment Questions	**Check**	**Claim Reversal – Accepted/Approved** If Situational, *Payer Situation*
This segment is always sent.	X	

	Response Transaction Header Segment			**Claim Reversal – Accepted/Approved**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
102-A2	Version/Release Number	D0	M		X(2)
103-A3	Transaction Code	B2	M		X(2)
109-A9	Transaction Count	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences	M	For B2 (reversal) transactions, the transaction count will be a value of 1, 2, 3, or 4. If this transaction is for a compound claim, the transaction count value must be 1.	X(1)
501-F1	Header Response Status	A=Accepted	M		X(1)
202-B2	Service Provider ID Qualifier	01 – National provider identifier (NPI)	M		X(2)
201-B1	Service Provider ID		M		X(15)
401-D1	Date of Service	CCYYMMDD	M		9(8)

Response Message Segment Questions	**Check**	**Claim Reversal – Accepted/Approved** If Situational, *Payer Situation*
This segment is always sent.	X	
This segment is situational.		

	Response Message Segment **Segment Identification (111-AM) = 20**			**Claim Reversal – Accepted/Approved**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
504-F4	Message		Q		X(200)

Response Status Segment Questions	**Check**	**Claim Reversal – Accepted/Approved** If Situational, *Payer Situation*
This segment is always sent.	X	

	Response Status Segment **Segment Identification (111-AM) = 21**			**Claim Reversal – Accepted/Approved**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
112-AN	Transaction Response Status	A=Approved	M		X(1)
503-F3	Authorization Number		R		X(20)
547-5F	Approved Message Code Count	Maximum count of five	N		
548-6F	Approved Message Code		N***R***		
130-UF	Additional Message Information Count	Maximum count of eight	Q		9(2)
132-UH	Additional Message Information Qualifier	01	Q***R***		X(2)
526-FQ	Additional Message Information		Q***R***		X(40)
131-UG	Additional Message Information Continuity	+	Q***R***		X(1)
549-7F	Help Desk Phone Number Qualifier		N		
550-8F	Help Desk Phone Number		N		

Response Claim Segment Questions	**Check**	**Claim Reversal – Accepted/Approved** If Situational, *Payer Situation*
This segment is always sent.	X	

	Response Claim Segment **Segment Identification (111-AM) = 22**			**Claim Reversal – Accepted/Approved**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
455-EM	Prescription/Service Reference Number Qualifier	1=Rx billing	M		X(1)
402-D2	Prescription/Service Reference Number		M		9(12)

Response Pricing Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, *Payer Situation*
This segment is always sent.		
This segment is situational.		Segment not supported.

	Response Pricing Segment Segment Identification (111-AM) = 23			Claim Reversal – Accepted/Approved	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
521-FL	Incentive Amount Paid		Q		
509-F9	Total Amount Paid				

3.4 Claim Reversal Accepted/Rejected Response

The following table lists the segments and fields in a claim reversal response (accepted/rejected) transaction for the NCPDP version D.0.

	Response Transaction Header Segment			Claim Reversal – Accepted/Rejected	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
102-A2	Version/Release Number	D0	M		X(2)
103-A3	Transaction Code	B2	M		X(2)
109-A9	Transaction Count	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences	M	For B2 (reversal) transactions, the transaction count will be a value of 1, 2, 3, or 4. If this transaction is for a compound claim, the transaction count value must be 1.	X(1)
501-F1	Header Response Status	A=Accepted	M		X(1)
202-B2	Service Provider ID Qualifier	01 – National provider identifier (NPI)	M		X(2)
201-B1	Service Provider ID		M		X(15)
401-D1	Date of Service	CCYYMMDD	M		9(8)

Response Message Segment Questions	Check	Claim Reversal - Accepted/Rejected If Situational, *Payer Situation*
This segment is always sent.	X	
This segment is situational.		

	Response Message Segment Segment Identification (111-AM) = "20"			Claim Reversal – Accepted/Rejected	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
504-F4	Message		Q		X(200)

Response Status Segment Questions	Check	Claim Reversal - Accepted/Rejected If Situational, *Payer Situation*
This segment is always sent.	X	

	Response Status Segment Segment Identification (111-AM) = 21			Claim Reversal – Accepted/Rejected	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
112-AN	Transaction Response Status	R=Rejected	M		X(1)
503-F3	Authorization Number		R		X(20)
510-FA	Reject Count		R		9(2)
511-FB	Reject Code		R***R***		X(3)
546-4F	Reject Field Occurrence Indicator		Q***R***		9(2)
130-UF	Additional Message Information Count	Maximum count of eight	Q		9(2)
132-UH	Additional Message Information Qualifier	01	Q***R***		X(2)
526-FQ	Additional Message Information		Q***R***		X(40)
131-UG	Additional Message Information Continuity	+	Q***R***		X(1)
549-7F	Help Desk Phone Number Qualifier		N		
550-8F	Help Desk Phone Number		N		

Response Claim Segment Questions	Check	Claim Reversal - Accepted/Rejected If Situational, *Payer Situation*
This segment is always sent.	X	

	Response Claim Segment Segment Identification (111-AM) = 22			Claim Reversal – Accepted/Rejected	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
455-EM	Prescription/Service Reference Number Qualifier	1=Rx billing	M	For transaction code of B2 in the response claim segment, the prescription/service reference number qualifier (455-EM) is 1 (Rx billing).	X(1)
402-D2	Prescription/Service Reference Number		M		9(12)

3.5 Claim Reversal Rejected/Rejected Response

The following table lists the segments and fields in a claim reversal response (rejected) transaction for the NCPDP version D.0.

Response Transaction Header Segment Questions	**Check**	**Claim Reversal - Rejected/Rejected** If Situational, *Payer Situation*
This segment is always sent.	X	

	Response Transaction Header Segment			**Claim Reversal – Rejected/Rejected**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
102-A2	Version/Release Number	D0	M		X(2)
103-A3	Transaction Code	B2	M		X(2)
109-A9	Transaction Count	1=One occurrence 2=Two occurrences 3=Three occurrences 4=Four occurrences	M	For B2 (reversal) transactions, the transaction count will be a value of 1, 2, 3, or 4. If this transaction is for a compound claim, the transaction count value must be 1.	X(1)
501-F1	Header Response Status	R=Rejected	M		X(1)
202-B2	Service Provider ID Qualifier	01 – National provider identifier (NPI)	M		X(2)
201-B1	Service Provider ID		M		X(15)
401-D1	Date of Service	CCYYMMDD	M		9(8)

Response Message Segment Questions	**Check**	**Claim Reversal – Rejected/Rejected** If Situational, *Payer Situation*
This segment is always sent	X	
This segment is situational		

	Response Message Segment **Segment Identification (111-AM) = 20**			**Claim Reversal – Rejected/Rejected**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
504-F4	Message		Q		X(200)

Response Status Segment Questions	**Check**	**Claim Reversal - Rejected/Rejected** If Situational, *Payer Situation*
This segment is always sent.	X	

	Response Status Segment **Segment Identification (111-AM) = 21**			**Claim Reversal – Rejected/Rejected**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
111-AM	Segment Identification		M		X(2)
112-AN	Transaction Response Status	R=Rejected	M		X(1)
503-F3	Authorization Number		R		X(20)

	Response Status Segment **Segment Identification (111-AM) = 21**			**Claim Reversal – Rejected/Rejected**	
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	*Field Format*
510-FA	Reject Count	Maximum count of five	R		9(2)
511-FB	Reject Code		R***R***		X(3)
546-4F	Reject Field Occurrence Indicator		N		
130-UF	Additional Message Information Count	Maximum count of eight	Q		9(2)
132-UH	Additional Message Information Qualifier	01	Q***R***		X(2)
526-FQ	Additional Message Information		Q***R***		X(40)
131-UG	Additional Message Information Continuity	+	Q***R***		X(1)
549-7F	Help Desk Phone Number Qualifier		N		
550-8F	Help Desk Phone Number		N		

**** End of Claim Reversal (B2) Response Payer Sheet ****

4.0 Third-Party Liability (TPL) Billing

If the pharmacy becomes aware that the MassHealth member has other pharmacy insurance coverage, the pharmacy must complete the Third-Party Liability (TPL) indicator form and submit it to MassHealth for verification. To access the TPL indicator form, go to www.mass.gov/masshealth. On the left side, choose Provider Library, then MassHealth Provider Forms. The form will be listed as Third-Party Liability Indicator [TPLI-MH].

Pharmacies submitting claims for members with other insurance will need to submit the claims to all other payers before submitting drug claims to MassHealth's pharmacy system. Also, there are billing requirements for communicating other insurance information that must be contained in the claim submission, depending on the prior payer and the outcome (paid/denied) of a claim. Further, the outcome of a claim impacts whether the other insurance information represented on a claim can be submitted with a bank information number (BIN) or the MassHealth-specific carrier code assigned to the Pharmacy Benefit Manager (PBM) administering that drug benefit. For MassHealth, that PBM is Conduent.

MassHealth's TPL carrier code information is available on the Web at www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/masshealth-provider-manual-appendices.html. Choose Appendix C: Third-Party Liability Codes. Claims submitted for services for which a member has other pharmacy coverage insurance will be denied unless the claim has been previously submitted to all other payers.

In addition, the carrier-code value chosen and submitted in the Other Payer ID (340-7C) field must be consistent with the member's eligibility (e.g., Medicare vs. Commercial). Claims submitted to MassHealth where the TPL carrier code conflicts with the member's eligibility cannot be overridden. MassHealth will return an error message similar to:

'SUBMITTED OTHER PAYER ID DOES NOT MEET MASSHEALTH CRITERIA FOR DIRECT TPL OVERRIDE.'

If the claim is denied, the billing pharmacy receives a response transaction from the pharmacy system of either NCPDP reject code 41, AE, or A6, with an additional explanation of benefits (EOB) reason code and additional message text.

Based upon MassHealth regulations at 130 CMR 450.317, MassHealth will pay the lowest of:

- the member's liability, as reported in the patient-paid amount by the other insurers including coinsurance, deductibles, and copayments;
- the provider's charges minus the other insurer's payments; or
- the maximum allowable amount payable under MassHealth payment methodology minus the other insurer's payments.

For Medicare Part D, refer to MassHealth regulations at 130 CMR 406.414(C) for guidance.

Below are some billing scenarios which MassHealth provides for clarification and pharmacy use when submitting drug claims to MassHealth for members with other insurance. If MassHealth's, other insurance business rules are not followed, the claim may be denied by MassHealth and the response transaction will include Reject Code 7M – Discrepancy between Other Coverage Code and Other Coverage Information on file.

Medicare B

For claims approved by the Medicare B processor – Other Payer ID Qualifier must be equal to 99 and the corresponding Other Payer ID must be one of the Medicare B carrier codes listed in Appendix C.

For claims denied by the Medicare B processor – Other Payer ID Qualifier must be equal to 99 and the corresponding Other Payer ID must be one of the Medicare B carrier codes listed in Appendix C.

Note: Only a Medicare B carrier code may be used to override a member's B coverage when there is no claim payment.

Medicare C or D

For claims approved by the Medicare C or D processor – Other Payer ID Qualifier must be equal to 99 and the corresponding Other Payer ID must be one of the Medicare C or D carrier codes listed in Appendix C.

For claims denied by the Medicare C or D processor – Other Payer ID Qualifier must be equal to 99 and the corresponding Other Payer ID must be one of the Medicare C or D carrier codes listed in Appendix C, assuming the claim meets the MassHealth One-Time Supplies requirement.

Note

1. Only a Medicare C or D carrier code may be used to override a member's C or D coverage when there is no payment.
2. Medications excluded from Medicare D Drug Program will continue to be covered for MassHealth members who are dually eligible for both Medicare and MassHealth and when the drug is covered by MassHealth. Claims submitted to MassHealth for these excluded medications do not require the completion of a Coordination of Benefits/Other Payment Segment.

Commercial

For claims approved by the Commercial processor – Other Payer ID Qualifier must be equal to 99 and the corresponding Other Payer ID must be one the Commercial codes listed in Appendix C; or the Other Payer ID Qualifier must be equal to 03 and the corresponding Other Payer ID (BIN) must be known to the Pharmacy Online Processing System (POPS) system.

Note: Any known carrier code or BIN can be used to override any coverage type when there is payment for the other payer.

For claims denied by the Commercial processor – Other Payer ID Qualifier must be equal to 99 and the corresponding Other Payer ID must be one the Commercial codes listed in Appendix C; or the Other Payer ID Qualifier must be equal to 03 and the corresponding Other Payer ID (BIN) must be known to the Pharmacy Online Processing System (POPS) system.

Note: Only a commercial carrier code may be used to override a member's commercial coverage when there is no payment.

If additional assistance is required, please contact the MassHealth Pharmacy Technical Help Desk at 1-866-246-8503. The Help Desk staff cannot update a member's demographic information, nor can they modify a member's other insurance information.

5.0 90-Day Waiver Procedures

POPS claims received more than 90 days, but less than 12 months, from the date of service will receive NCPDP reject code 81 (claim exceeds filing limit). The billing pharmacy can obtain a 90-day waiver form from the MassHealth Pharmacy Technical Help Desk at 1-866-246-8503. This form is included in Appendix A of this document and can be photocopied. The completed form and supporting information can also be faxed to Conduent at 1-866-566-9315. If approved, the billing pharmacy will receive notification that the claim can be submitted to POPS.

Please Note: TPL or split-bill claims submitted within 90 days of the primary carrier's EOB date do not require a 90-day waiver.

Providers may apply for a 90-day waiver only in the following circumstances.

- Reprocessing of a claim (originally paid ordenied)
- Retroactive member enrollment
- Retroactive provider enrollment

Claims older than 12 months are not considered for "90-day waivers." A review of these claims may be requested by completing the Request for Claim Review form located in the Provider Online Service Center portal. Additionally the Final Deadline Appeal Unit has adopted the industry standard claim review form: www.mass.gov/eohhs/docs/masshealth/bull-2012/all-226.pdf.

6.0 Claims Over $99,999.99

Claims greater than $99,999.99 can be billed online, but these claims will require MassHealth approval. Providers must contact the MassHealth Pharmacy Technical Help Desk at 1-866-246-8503 to initiate the request.

7.0 Special Topics and References

Children's Medical Security Plan (CMSP) Claims

As of June 27, 2016, the Pharmacy Online Processing System (POPS) will accept claims for pharmacy services to members in the Children's Medical Security Plan (CMSP). CMSP is a MassHealth program of primary and preventive medical and dental coverage for eligible children under the age of 19 who are Massachusetts residents at any income level, who do not qualify for MassHealth (except MassHealth Limited for some), and who are uninsured.

The CMSP-covered pharmacy services for each member consists of prescription drugs up to $200 per state fiscal year, and $300 per state fiscal year for equipment and supplies related to asthma and diabetes.

CMSP-covered drugs are subject to a copayment of $4.00 for a brand name drug and $3.00 for a generic drug. There will be no copayments for equipment or supplies. There will also be no copayments or benefit limits for drugs covered under MassHealth Limited for a CMSP member who has both CMSP and MassHealth Limited.

Cardholder First Name: Claims must contain the member's first name (field #312-CC). When a claim for a member is received in POPS without the cardholder first name field populated, the pharmacy system will reject that claim and send a message back to the pharmacy.

Cardholder Last Name: Claims must contain the member's last name (field #313-CD). When a claim for a member is received in POPS without the cardholder last name field populated, the pharmacy system will reject that claim and send a message back to the pharmacy.

Group ID: Claims must contain a Group ID (field #301-C1) of either **MassHealth** for individuals eligible for Massachusetts Medicaid, **CMSP** for individuals eligible for Children's Medical Security Plan or **HSN** for Pharmacies enrolled in the Health Safety Net program**.**

Pharmacies enrolled in the **Health Safety Net (HSN) program** and dispensing medications or OTC products to HSN-eligible members must submit claims with a Group ID value (field #301-C1) of **HSN** for those claims. When a claim for a member with HSN coverage is received in POPS with a Group ID value (field # 301-C1) of MassHealth, POPS will return a reject code of 65 – Patient Not Covered, with a response message similar to 'RESUBMIT CLAIM WITH HSN AS THE GROUP ID.'

Some members are eligible for multiple programs. Therefore, it is recommended that submitters utilize the Eligible Verification System (EVS) within MMIS to determine specific coverage. There is an implied hierarchy where MassHealth is first, CMSP is second, and HSN is third.

Date of Birth: Claims must contain the member's date of birth (field # 304-C4). When a claim for a member is received in POPS with a non-matching date of birth, the pharmacy system will reject that claim and send a message back to the pharmacy.

Patient Gender Code: Claims must contain the member's gender code (field # 305-C5). When a claim for a member is received in POPS without the gender code field populated, the pharmacy system will reject the claim and send a message back to the pharmacy.

Pharmacies may use the MassHealth Eligibility Verification System (EVS) or contact the MassHealth Technical Help Desk (available 24/7) at 1-866-246-8503 to understand the on-file demographics (e.g., date of birth) for the MassHealth, Children's Medical Security Plan or Health Safety Net member. Please note that call center staff cannot change a member's demographic information. Instead, the **MassHealth member** must contact MassHealth Customer Service Team (CST) at 1-800-841-2900 for assistance (Hours: Monday – Friday, excluding holidays, 8:00 a.m. – 5:00 p.m.). The **Health Safety Net (HSN) member** must contact 1-877-910-2100 for assistance (Hours: Monday – Friday, excluding holidays, 8:00 a.m. – 4:00 p.m.). Pharmacies with questions involving Health Safety Net members should contact the HSN Help Desk at 1-800-609- 7232 for assistance (Hours: Monday – Friday, excluding holidays, 8:00 a.m. – 4:00 p.m.).

MassHealth Brand Name Preferred Over Generic Drug List

The MassHealth Brand Name Preferred over Generic Drug List identifies the brand name drugs, including any applicable PA requirements, which MassHealth prefers over their generic equivalents because the net cost of the brand name drugs adjusted for rebates is lower than the net cost of the generic equivalents. Preferring lower-cost brand name drugs allows MassHealth the ability to provide medications at the lowest possible costs. This list may be updated often and is subject to change at any time. Pharmacies should indicate the dispensing of a preferred brand using the Dispense as Written (408-D8) or DAW=9.

Other: Some aspects of the billing process are of a narrower perspective than is the target of this billing guide. As such, the more commonly mentioned ones are identified below and an authoritative

source of information is identified.

Topic	Reference
MassHealth 340B Program	MassHealth pharmacy regulations at 130 CMR 406.404

To view the MassHealth pharmacy regulations, go to www.mass.gov/masshealth. Click the Regulations button on the left under MassHealth. Click on MassHealth Provider Regulations then scroll down the page to the pharmacy regulations (130 CMR 406.000).

8.0 Version Table

Vers	Date	Section	Description
1.0	2001	Original document created	Internal document developed
2.0	10/03	First major revision of publication	Implemented NCPDP version 5.1 format. Internal document developed
3.0	11/06	Section 3.7 payment segment updated. Deleted text in Sections 7 (Payer Sheet E1) and 8 (Response E1).	First production version issued.
4.0	08/07	Sections 2.1, 2.4, 2.7, 2.10, 3.1-3.2, 4.1, and 5.1.1 have been updated with new NPI information.	Production version issued
5.0	07/08	Sections 2.4 and 2.6 have been updated to reflect two new CMS initiatives – Tamper-proof prescription pads and NPI.	Production version issued
6.0	03/09	Sections 2.0, 2.4, and 9.0 have been updated to reflect changes in Coverage Code 4. This code is no longer permitted. There will be a change to the current software to reflect this code removal.	Production version issued
7.0	05/09	Various segments in Sections 2.0, 3.0, and 4.0 have been updated to reflect software changes in support for NewMMIS go live. Section 9.0 has also been updated to provide links to the TPL indicator form and carrier code information.	Production version issued
8.0	08/09	Section 9.0	TPL billing code descriptions revised
9.0	02/10	New Section 13.0 – Pharmacy Administered Flu Vaccines was added to the billing guide. Two field value changes were made to Section 2.9 – DUR/PPS Segment 08, and Section 3.1.4 – Response Pricing Segment 23, to reflect the new Section 13.0. These two section changes also apply to Payer sheet B1/B3.	Production version issued
10.0	08/10	Appendix B has been updated.	Production version issued
11.0	11/10	Section 8.0 – Temporary ID Cards/Newborn IDs has been removed and all subsequent sections have been renumbered. Section 12.0 – Pharmacy	Production version issued

Vers	Date	Section	Description
		Administered Flu Vaccines has been updated. Section 14.0 – Where to Get Help has been updated. Section 15.0 – Appendix B has been removed.	
12.0	06/11	Full document revision to reflect NCPDP Telecommunications Standard D.0.	Billing Guide for NCPDP version D.0 effective January 1, 2012
12.1	08/11	Changes to the following fields. • 109-A9 • 338-5C • 339-G3 • 351-NP • 423-DN • 490-UE • 524-FO	Billing Guide for NCPDP version D.0 effective January 1, 2012
12.2	10/11	Changes to the following fields. • 334-1C • 342-HC • 361-2D • 564-J3 • 565-J4 • 997-G2 Correction to supported status of S1/S3 transaction, Prescriber Segment Questions	Billing Guide for NCPDP version D.0 effective January 1, 2012
13.0	1/12	Changes to the following fields. • 441-E6 • 439-E4 • 405-D5 • 442-E7	Billing Guide for NCPDP version D.0 effective January 1, 2012
13.1	5/12	Changes to the following fields. • 995-E2 • 339-6C • 340-7C Changes to the following sections. Section 6.0: TPL Billing Section 9.0: Special Topics and References Section 11.0: Where to Get Help 430-DU 471-5E	Revisions to Route of Administration values Updates and clarifications for TPL Billing • Added words to 339-6C and 340-7C that cross-reference to 6.0 TPL Billing. • Revised Section 6.0 and added additional specifics for various other insurance scenarios in support of the transition to NCPDP D.0 transmission standard. Added some words regarding Date of Birth claim rejections and steps to resolve any issues. Deleted reference and fax number for ID Card Request Forms since this process is no longer valid. Reworded 'Payer description' and removed term "downstream' Reworded 'Payer description' and removed term "upstream'
14.0	3/2013	312-CC 313-CD	Added words to indicate a cross-reference to Section 9.0 Added words to indicate a cross-reference to Section 9.0

Vers	Date	Section	Description
14.0 (*cont*.)		301-C1	Added words to inbound segment instructions to indicate a cross-reference to Section 9.0; added words to response segment instructions to assist pharmacies to resolve rejections for an incorrect group ID value for HSN members.
		304-C4	Added words to indicate a cross-reference to Section 9.0
		305-C5	Added words to indicate a cross-reference to Section 9.0
		402-D2	Added words to clarify that each prescription/service reference number assigned by a pharmacy must be unique
		406-D6	Deleted value 0=Not specified. Not a valid value
		420-DK	Added clarification words
		308-C8	Added clarification words
		479-H8	Added clarification words
		480-H9	Added clarification words
		423-DN	Changed Payer Usage from 'Q' to 'R'
		351-NP	Added new valid value and added clarification words
		475-J9	Deleted value 22. Not a valid value
		Section 6.0	Added clarification words
		Section 9.0	Added clarification words
14.1	8/2013	420-DK	Removed Value 00= not specified Removed the corresponding clarification words from the Payer Situation column
14.2	1/2017	Section 1.0	Updated QS1 phone number
		301-C1	Added CMSP as a value
		307-C7	Updated list of valid valuesl
		436-E1	Added new value 00=Not Specified
		384-4X	Removed value 14=homeless shelter
		408-D8	Added DAW values 7=Brand, no substitution allowed and 9=Brand Preferred by Plan
		420-DK	Added clarification words
		460-ET	Added segment
		468-2E	Updated list of valid values
		995-ET	Updated list of valid values
		412-DC	Added clarification words
		423-DN	Added clarification words
		411-DB	Added clarification words
		462-EV	Deleted words regarding Return to Stock program as that program is defunct
		472-6E	Added clarification words
		475-J9	Updated list of valid values
		478-H7 479-H8 479-H9	Changed Payer Usage value to "N" and deleted words in all other columns as these fields were designated for claims submitted to the Return to Stock program
		Pharmacy Provider Segment	Removed words regarding Collaborative Therapy Management, which is future state for MassHealth
		S1/S2	Deleted sections 4 and 5 – Services Transaction billing instructions as these transactions have not been implemented
		Section 4.0	Added clarification words
		Section 7.0	Added clarification words
		Section 9.0	Updated contact information
		All sections	Xerox Technical Help Desk to MassHealth Technical Help Desk

Vers	Date	Section	Description
14.3	3.20.17	DUR/PPS Segment: 439-E4	 Added clarification words in Payer Situation column
		440-E5	Changed Payer Usage Value to Q and added clarification words in Payer Situation column
		441-E6	Added clarification words in Payer Situation column
		474-8E	Changed Payer Usage Value to Q and added clarification words in Payer Situation column
		475-J9	Added clarification words in Payer Situation column
		476-H6	Added clarification words in Payer Situation column
		Compound Claims Segment – clarification words	Updated the description to include new MassHealth Compound Claim submission requirements.
		Response Pricing Segment: 514-FE	 Added in words in Payer Situation column for clarification of CMSP claim responses
		520-FK	Changed Payer Usage Value to Q and added words in Payer Situation column for clarification of CMSP claim responses
14.4	5.16.17	Billing Guide all sections	Replaced references to “Xerox” with “Conduent”
		Section 7.0	Deleted the listed HSN Aid Categories.
		Section 9.0	Updated the HSN Helpdesk hours of operation

9.0 Where to Get Help

Billing and Claims

MassHealth Pharmacy Technical Help Desk:
Phone: 1-866-246-8503 (**available 24/7**)

Member Eligibility

MassHealth Customer Service: 1-800-841-2900
Automated Voice Response (AVR): 1-800-554-0042

Health Safety Net (HSN)

Pharmacies with questions involving Health Safety Net members should contact the HSN Help Desk:
1-800-609-7232 (Hours: Monday – Friday, excluding holidays, 8:00 a.m. – 4:00 p.m.)
Pharmacies with billing questions should contact the MassHealth Technical HelpDesk:
Phone: 1-866-246-8503 (**available 24/7**)

Pharmacy Prior Authorization

University of Massachusetts Medical School
Phone: 1-800-745-7318
Fax: 1-877-208-7428

Drug Utilization Review (DUR) Program
Commonwealth Medicine
University of Massachusetts Medical School
P.O. Box 2586
Worcester, MA 01613-2586

Non-Pharmacy Prior Authorization

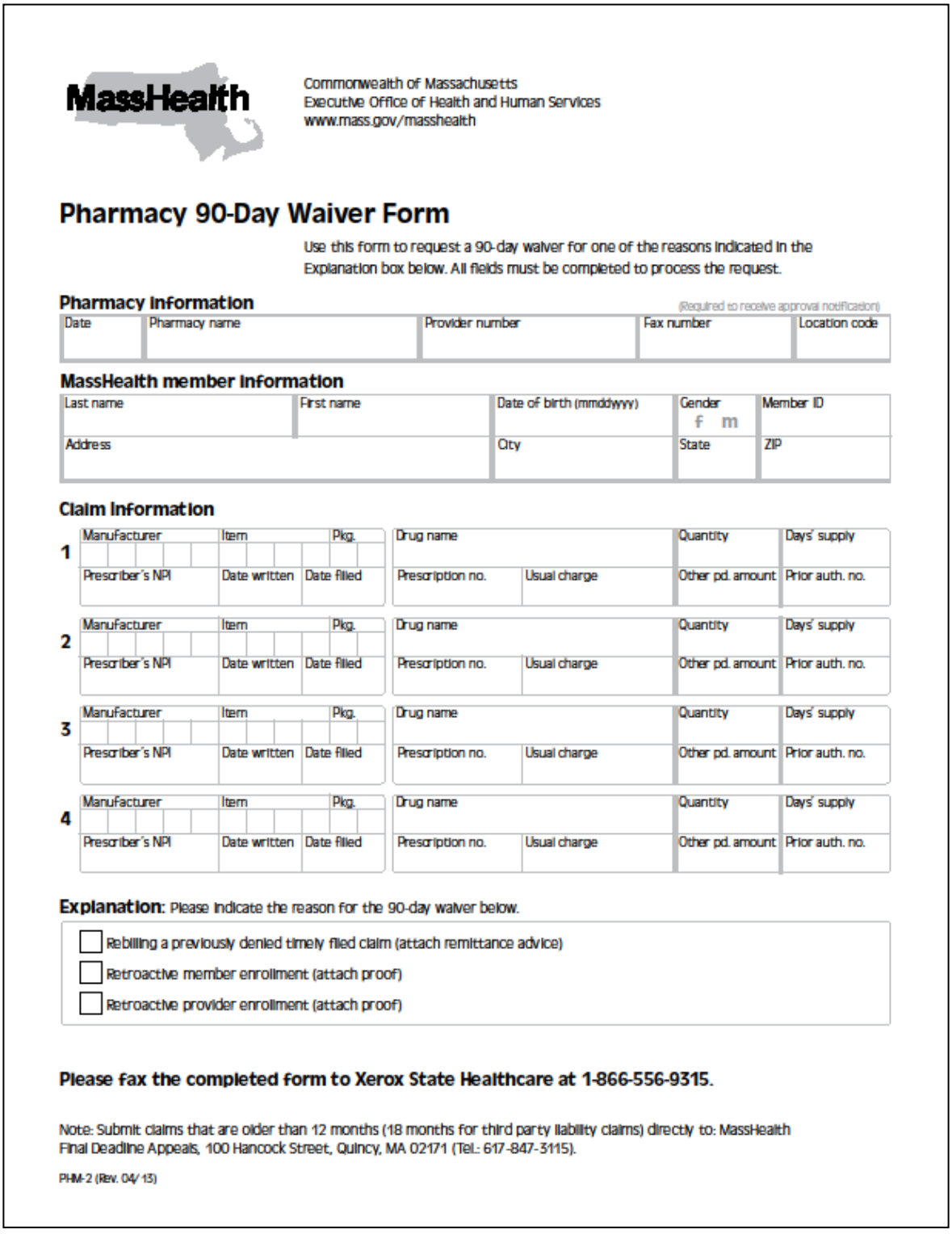
Prior authorization requests for non-pharmacy services, including nutritional products, enteral products, diapers, medical/hospital equipment, private-duty nursing, and personal care attendants should be sent to the following address.

MassHealth
Attn: Prior Authorization
100 Hancock Street, 6th Floor Quincy,
MA 02171
Phone: 1-800-862-8341

Provider Enrollment and Credentialing

MassHealth Customer Service
Attn: Provider Enrollment and Credentialing
P.O. Box 9162
Canton, MA 02021
Phone: 1-800-841-2900
Fax: 617-988-8974
Hours: Monday-Friday 8:00 a.m. – 5:00 p.m. (excluding holidays) E-mail: providersupport@mahealth.net

Appendix: Pharmacy 90-Day Waiver Form



MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

Pharmacy 90-Day Waiver Form

Use this form to request a 90-day waiver for one of the reasons indicated in the Explanation box below. All fields must be completed to process the request.

Pharmacy information

(Required to receive approval notification)

Date	Pharmacy name	Provider number	Fax number	Location code

MassHealth member information

Last name	First name	Date of birth (mmddyyyy)	Gender f m	Member ID
Address		City	State	ZIP

Claim information

	Manufacturer	Item	Pkg.	Drug name		Quantity	Days' supply
1	Prescriber's NPI	Date written	Date filled	Prescription no.	Usual charge	Other pd. amount	Prior auth. no.
2	Manufacturer	Item	Pkg.	Drug name		Quantity	Days' supply
	Prescriber's NPI	Date written	Date filled	Prescription no.	Usual charge	Other pd. amount	Prior auth. no.
3	Manufacturer	Item	Pkg.	Drug name		Quantity	Days' supply
	Prescriber's NPI	Date written	Date filled	Prescription no.	Usual charge	Other pd. amount	Prior auth. no.
4	Manufacturer	Item	Pkg.	Drug name		Quantity	Days' supply
	Prescriber's NPI	Date written	Date filled	Prescription no.	Usual charge	Other pd. amount	Prior auth. no.

Explanation: Please indicate the reason for the 90-day waiver below.

- ☐ Rebilling a previously denied timely filed claim (attach remittance advice)
- ☐ Retroactive member enrollment (attach proof)
- ☐ Retroactive provider enrollment (attach proof)

Please fax the completed form to Xerox State Healthcare at 1-866-556-9315.

Note: Submit claims that are older than 12 months (18 months for third party liability claims) directly to: MassHealth Final Deadline Appeals, 100 Hancock Street, Quincy, MA 02171 (Tel.: 617-847-3115).

PHM-2 (Rev. 04/13)