MassHealth
Standard Companion Guide
National Council of Prescription Drug Programs (NCPDP) Post-Adjudication V51

Refers to the Implementation Guide Based on NCPDP Post Adjudication Standard Version 51

March 2026

Disclosure Statement

This MassHealth Standard Companion Guide ("Companion Guide") serves as a companion document to the corresponding American National Standard Institute (ANSI) National Council of Prescription Drug Programs (NCPDP) Post Adjudicated Standard Version 51. MassHealth strongly encourages its Trading Partners to use this Companion Guide in conjunction with the NCPDP Implementation Guide version 51 to develop the HIPAA batch transaction.

To request a copy of the NCPDP Standard Formats or for more information contact the National Council for Prescription Drug Programs, Inc. The HIPAA implementation guide can be accessed at: www.ncpdp.org.

This document supplements but does not contradict, disagree, oppose, or otherwise modify the NCPDP version 51 implementation specification in a manner that will make its implementation by users out of compliance.

About MassHealth

In Massachusetts, the Medicaid, and Children's Health Insurance Program (CHIP) are combined into one program called MassHealth. MassHealth provides comprehensive health insurance and dental coverage for eligible individuals, families, and people with disabilities across the Commonwealth of Massachusetts. The program serves over 2.4 million residents in the state. MassHealth's coverage is managed and facilitated through an array of programs, including Fee for Service, accountable care organizations (ACOs), and managed care organizations (MCOs), which enable members to choose the plan that best meets their needs. The agency is nationally recognized for providing high-quality care in an innovative and cost-effective manner. See www.mass.gov/masshealth.

MassHealth's Standardized Encounter Data Program (SENDPro)

MassHealth requires that Managed Care Entities (MCE)s submit encounter data to the agency on a bi-weekly basis through its SENDPro solution, with plans to move to weekly in the future. See Encounter Submission Guidelines in Section 7 for additional details on submission frequency. SENDPro manages trading partner information, facilitates the exchange of HIPAA ASC X12 and NCPDP transactions, validates HIPAA compliance, and produces acknowledgments for each submitted file. Additional details about SENDPro are detailed below.

Contact for Additional Information

Please note: Updates to be included in future versions of the Companion Guide.

MassHealth Encounter Data Support Services
Email: TBD
Phone Number: TBD

MassHealth Data Warehouse
XXXXX

Preface

This *MassHealth Standard Companion Guide* to the *NCPDP Post Adjudication Standard Implementation Guide* and associated addenda adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with MassHealth. The *MassHealth Standard Companion Guide* is not intended to convey information that in any way exceeds or replaces the requirements or uses of data expressed in the Implementation Guides. Neither the Executive Office of Health and Human Services nor MassHealth is responsible for any action or inaction, or the effects of such action or inaction, taken in reliance on the contents of this guide.

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1. Introduction

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires MassHealth and all other health insurance payers in the United States to comply with the electronic data interchange (EDI) standards for healthcare as established by the Secretary of the U.S. Department of Health and Human Services (HHS). The National Council for Prescription Drug Programs (NCPDP) Post Adjudication Standard Implementation Guide is intended to meet an industry need to supply detailed drug and utilization information after the claim has been adjudicated.

This document is intended to provide information from MassHealth to its Trading Partners that provides the information necessary to exchange Electronic Data Interchange (EDI) NCPDP transactions with the agency. This includes information about specific data requirements, registration, testing, and support.

SCOPE

This Companion Guide (CG) is to be used in addition to the NCPDP Post Adjudication Standard Implementation Guide Version 51, Data Dictionary, and External Code list.

This Companion Guide assumes compliance with all segments and data elements contained in the NCPDP Post Adjudication Standard version 51. It defines the requirements for HIPAA transactions submitted to and/or received from MassHealth.

OVERVIEW

MassHealth created this Companion Guide for MassHealth Managed Care Entities (Trading Partners) to supplement the NCPDP Post Adjudication Standard Implementation Guide Version 51. This guide contains MassHealth-specific instructions related to the following.

- Data formats, content, codes, business rules, and characteristics of the electronic transaction
- Technical requirements and transmission options
- Information on testing procedures that each Trading Partner must complete before transmitting electronic transactions

The information in this document outlines MassHealth's requirements for HIPAA standard electronic encounter data reporting. The following standards are in addition to those outlined in the MassHealth provider manuals. These standards in no way supersede MassHealth regulations.

Where applicable, trading partners must use this guide in conjunction with the information available in your MassHealth provider manual.

REFERENCES

The Implementation Guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, healthcare payer, or government agency. The Implementation Guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all healthcare providers and their Trading Partners. It is critical that your IT staff or software vendor review this document in its entirety and follow the stated requirements to exchange files with MassHealth while maintaining HIPAA compliance.

The Implementation Guides for NCPDP and all other HIPAA standard transactions are available electronically at www.ncpdp.org.

ADDITIONAL INFORMATION

The intended audience for this document is the technical and operational staff responsible for generating, submitting, receiving, and reviewing electronic healthcare transaction.

2. Getting Started

WORKING WITH MASSHEALTH

Managed Care Entity (MCE) Trading Partners can exchange electronic healthcare transactions with MassHealth by directly uploading and downloading transactions via the SENDPro portal, Secure File Transfer Protocol (SFTP), or system-to-system using the SENDPro's connectivity submission method. Submitters must determine whether they will use SFTP or the industry standard, Simple Object Access Protocol (SOAP)/Web Services Description Language (WSDL), or Hypertext Transfer Protocol (HTTP) Multipurpose Internet Mail Extensions (MIME) Multipart Web service to support the submission of encounter data to MassHealth.

After determining the transmission method, each Trading Partner must successfully complete testing of the connectivity protocol and the HIPAA transaction. Additional information is in the next section of this companion guide. After successful completion of testing, trading partners may exchange production transactions with MassHealth.

TRADING PARTNER REGISTRATION

All MassHealth Trading Partners are required to sign a Trading Partner Agreement (TPA), as described in Section 8. If you have elected to use a third party to perform electronic transactions on your behalf, they will also be required to complete a TPA. If you or your submitter have already completed this form, you are not required to complete it again.

CERTIFICATION AND TESTING OVERVIEW

All MCE Trading Partners that exchange electronic batch transactions with MassHealth must complete Trading Partner testing. At the completion of testing, Trading Partners will receive approval from MassHealth to submit transactions in the production environment.

Test transactions exchanged with MassHealth should include a representative sample of the various types of encounter scenarios that Managed Care Entities would normally submit to MassHealth. This includes typical transactions received from enrolled health plan providers that were then adjudicated by your organization. Please see Section 3 for additional information on testing.

3. Testing with SENDPro

Each MCE Trading Partner must complete testing. Trading Partner testing includes HIPAA compliance testing, as well as validating the use of conditional, optional, and mutually defined components of the transaction.

SENDPro will process de-identified transactions in a test environment to verify that the file structure and content meet HIPAA standards and MassHealth-specific data and business requirements. MassHealth will also verify the quality of the data submitted within the test files. MCEs will receive responses for every test file submitted. MCEs should review NCPDP acknowledgement and 277 Data Reporting Acknowledgement (277DRA) reports for errors, make the appropriate corrections, and resubmit updated test files. Section 7 of this Companion Guide provides a brief description of the ACK and 277DRA reports.

Please note: Trading partners will not be allowed to submit encounter data transactions in the production environment until they have successfully passed both data quality validation and HIPAA standards testing. Once this testing and certification is complete and approved by MassHealth, the Trading Partner may submit transactions to MassHealth's SENDPro for processing.

PRE-TESTING ACTIVITIES

In order for MCEs to submit/receive EDI files, access the SENDPro Portal, and access reports, they will need to be onboarded into the Commonwealth of Massachusetts' Virtual Gateway (VG) and MOVEit applications.

Virtual Gateway Onboarding

The Virtual Gateway (VG) is used to access the SENDPro Portal and reports. MCEs can submit EDI files via the SENDPro Portal. MCEs will need to establish a VG organization ID in the VG. Once a VG organization ID is established, MCE-designated users will be able to be onboarded.

MOVEit Onboarding

MOVEit is used to submit EDI files to MassHealth/SENDPro and also to deliver EDI response messages from MassHealth/SENDPro. Files can be sent through SFTP in MOVEit via a service account or manually through individual user accounts. MassHealth will reach out to MCEs 30-60 days prior to trading partner testing to request business, technical, and test user contact information as part of the Testing Team Roster spreadsheet. Once this information is provided to MassHealth, it is submitted to create a service account and individual user accounts.

File Encryption Key Exchange

EDI files exchanged to and from SENDPro must be PGP encrypted. MassHealth will reach out to MCEs to exchange keys to encrypt/decrypt files submitted to and received from SENDPro.

TRADING PARTNER TESTING

MassHealth has specified testing scenarios that are required to be passed prior to MCEs being certified to submit encounters to SENDPro in production. MCEs are required to submit test files in multiple submissions for every MCE product – one set for MCO/ACO, one set for SCO, and one set for One Care (when applicable). Paid and denied files are expected to be submitted independently for each submission, except for the error test file submission.

During testing, MCEs are expected to provide claims associated with select test scenarios for each claim type

(NCPDP paid and denied) to evaluate the readiness of MCEs to submit data in Production. The suggested lookback period for providing scenario examples is two years prior to the testing period. However, if no claims can be found within this period, it is highly recommended to look back five years, rather than mocking up the data to meet the scenario. If needed, please consult the SENDPro team if unable to source data for certain scenarios for further guidance.

Note that a submission is considered a failure in the following scenarios. The MCE would need to resubmit the file(s) in order to proceed.

(1) The full file is rejected

(2) All records are rejected, or

(3) Fewer than 50% of records are accepted (with the exception of the first Submission of TPT1)

Please contact MassHealth for full details on Trading Partner Testing scenarios.

4. Connectivity with SENDPro/Communications

This section outlines how MCE Trading Partners may connect and communicate with MassHealth to exchange NCPDP transactions via the SENDPro application.

TRANSMISSION ADMINISTRATIVE PROCEDURES

System Availability

While the system is typically available 24 hours a day, seven days a week, except for scheduled maintenance windows, please ensure that files are submitted only from 8 a.m. ET Monday 8 to 6 p.m. ET Friday. . Files submitted after 6 p.m. ET Friday will undergo processing once SENDPro completes its maintenance window.

Transmission File Size

Transmission sizes are defined based on the following two factors.

- Number of segments/records allowed by HIPAA Standards
- File size limitations – assumes each MCE will be assigned a designated weekday for file submissions in the PROD environment post SENDPro go-live after TPT2 completion.
    - Maximum of 85,002 lines in the NCPDP file (which includes header/trailer, DE, and CD/CE records) which includes 85,000 claims along with the two header and trailer lines
    - For files containing compound claims, no more than 10% of the claims in the file (up to 8,500 claims) may be compound records. The number of non-compound claims must not exceed 68,000. In total, this results in a maximum of 85,000 lines per file, calculated as 68,000 non-compound claims plus two lines for each compound claim (8,500 compound × 2).

Please note that SENDPro does not unzip or decompress files. Transmit all files in an unzipped or uncompressed format. Due to stated file size limitations, MCEs may need to break their encounters into multiple files. Please note that file sequencing is not preserved in MassHealth's processing, and that files submitted in a specific order by the MCE may be processed in parallel or out of order by MassHealth. This may cause cascading errors as later versions of claims are rejected because the original claim is in a file that is taking longer to process. Therefore, MassHealth recommends that MCEs group related claims in the same file, to reduce this risk.

Transmission Errors

Upon the submission of the file by the trading partner and its successful reception by SENDPro, responses in the form of ACK acknowledgment transactions are generated within one hour of file ingestion. These generated responses will be deposited into the relevant folder on the trading partner's SFTP server.

SENDPro generates ACK acknowledgements for files that conform to HIPAA standards related to syntax and data integrity and also includes rejections for files that do not meet HIPAA standards.

Production File-naming Convention

For Inbound transactions, use the below naming convention.

senderid_transtype_datetime_env_adj_{suff}.ext

- **senderid** is the PID/SL of the trading partner who is sending or receiving the file, in lower case.
- **transtype** is ncpdp.
- **datetime** is the datetime of the file submission, in MMDDYYYYhhmmss format, using 24-hour format in Eastern time (GMT-5).
- **env** is the environment in which the file is to be processed. Allowable values include the following.
    - prod
    - test
- **adj** is the adjudication type for the files. Allowable values include the following.
    - pd (for files containing only claims with Paid adjudication status)
    - de (for files containing only claims with Denied adjudication status)
- **ext** is the extension for the file. Allowable values include the following.
    - .edi
    - .pgp
    - .edi.pgp
- **suff** is the optional suffix. See more detail below.

For example, a paid production NCPDP file submitted on January 4, 2024, at 2:30 p.m. ET, by a Trading Partner with a ten-digit PID/SL: of "110025617d" might be named the following.

110025617d_ncpdp_01042024143000_prod_pd.edi

If a file is intended for a specific request, it is essential to include this specificity in the naming convention to facilitate easy identification of the file, by using an alpha suffix. This is only to be used for applicable pre-approved MassHealth defined projects and will be communicated directly to MCEs. Files submitted in this format without MassHealth's preapproval will be rejected. In the case of this process, the naming convention is as follows.

senderid_transtype_datetime_env_adj_xxx.ext

The three-character alpha suffix *xxx* defines the exception when needed. For example, a paid production NCPDP file submitted on January 4, 2024, at 2:30 p.m. EST, by a Trading Partner with a ten-digit PID/SL: of "110025617D", for special project "XYZ", might be named the following.

110025617d_ncpdp_01042024143000_prod_pd_xyz.edi

For outbound response files, the following convention is used

senderid_transtype_datetime_env_adj_transactionid_resp.ext

- **senderid** is the PID/SL of the trading partner who is sending or receiving the file, in lower case.
- **transtype** is pacdri.
- **datetime** is the datetime of the file submission, in MMDDYYYYhhmmss format, using 24-hour format in Eastern time (GMT-5).
- **env** is the environment in which the file is to be processed. Allowable values include the following.
    - prod
    - test
- **adj** is the adjudication type for the files. Allowable values are:
    - pd (for files containing only claims with Paid adjudication status)
    - de (for files containing only claims with Denied adjudication status)
- **transactionid** is the unique identifier given to the file during processing
- **resp** is the type of response file
    - 277dra
    - ack
- **ext** is the extension for the file. Allowable values include the following.
    - .json
    - .edi
- **suff** is the optional suffix. See more detail below.

For example, the 277 DRA from a paid production NCPDP file submitted on January 4, 2024, at 2:30 p.m. EST, by a Trading Partner with a ten-digit PID/SL: of "110025617D" might be named the following.

110025617d_ncpdp_01042024143000_prod_pd_6f8792a6-1546-4729-b6ff-f2efd0b22ae9_277dra.edi

If a file is intended for a specific request, it is essential to include this specificity in the naming convention to facilitate easy identification of the file, by using an alpha suffix. This is only to be used for applicable pre-approved MassHealth defined projects and will be communicated directly to MCEs. Files submitted in this format without MassHealth's preapproval will be rejected. In the case of this process, the naming convention is as follows.

senderid_transtype_datetime_env_adj_xxx_transactionid_resp.ext

The three-character alpha suffix *xxx* defines the exception when needed. For example, the 277 DRA from a paid production NCPDP file submitted on January 4, 2024, at 2:30 p.m. EST, by a Trading Partner with a ten-digit PID/SL: of "110025617D", for special project "XYZ", might be named the following.

110025617d_ncpdp_01042024143000_prod_pd_xyz_6f8792a6-1546-4729-b6ff-f2efd0b22ae9_277dra.edi

RETRANSMISSION PROCEDURE

SENDPro does not require any identification of a previous transmission of a file. SENDPro processes each file independently of other files; therefore, all files sent should be marked as original transmissions unless otherwise directed by MassHealth.

COMMUNICATION PROTOCOL SPECIFICATIONS

SENDPro offers Council for Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) connectivity submission methods using one of the two Envelope Standards: HTTP MIME Multipart or Simple Object Access Protocol (SOAP)/Web Services Description Language (WSDL). However, this rule is not intended to require trading partners to remove existing connections that do not match the rule, nor is it intended to require that all CAQH CORE trading partners must use one of these methods for all new connections. SENDPro provides the following methods for submitting batch EDI transaction files.

CONNECTIVITY SUBMISSION METHOD

MCE trading partners can send NCPDP Transactions to MassHealth using one or both of the following methods.

- Batch using Secure File Transfer Protocol (SFTP): MCEs submit files directly to MOVEit folders via a MOVEit service account.
- SENDPro Web Portal (MFTP - MOVEit File Transfer protocol): MCE users log in to the Virtual Gateway (VG) and navigate to the SENDPro Portal to access MOVEit through their user account to manually upload or download files.

Please refer to communications from MassHealth MCE Communications for additional details.

5. Contact Information

EDI CUSTOMER SERVICE

MassHealth Encounter Data Support Services

Days Available: Monday through Friday

Time Available: TBD

Email: TBD

Phone: TBD

Fax: TBD

EDI TECHNICAL ASSISTANCE

MassHealth Encounter Data Technical Support Services

Days Available: Monday through Friday

Time Available: TBD

Email: TBD

Phone: TBD

Fax: TBD

Please note: Support for Trading Partner Testing will be communicated by MassHealth prior to testing commencement. Further details will be provided in the next version of the Companion Guide.

APPLICABLE WEBSITES/EMAIL

Centers for Medicare & Medicaid Services (CMS)

- CMS is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the electronic Health Care Transactions and Code Sets Model Compliance Plan. See https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.

Committee on Operating Rules for Information Exchange (CORE)

- A multiphase initiative of CAQH, CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care. See www.caqh.org.

Council for Affordable Quality Healthcare (CAQH)

- CAQH is a nonprofit alliance of health plans and trade associations working to simplify healthcare administration through industry collaboration on public-private initiatives. Through two initiatives—the Committee on Operating Rules for Information Exchange (CORE) and Universal Provider Data source (UPD)—CAQH aims to reduce administrative burden for providers and health plans. See www.caqh.org.

MassHealth (MH)

- The MassHealth website assists providers with HIPAA billing and policy questions, as well as enrollment support. See www.mass.gov/masshealth.

National Committee on Vital and Health Statistics (NCVHS)

- The National Committee on Vital and Health Statistics was established by Congress to serve as an advisory body to the U.S. Department of Health and Human Services on health data, statistics, and national health information policy. See www.ncvhs.hhs.gov.

National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. See www.ncpdp.org.

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. See http://www.wpc-edi.com/.

6. MassHealth-Specific Business Rules and Limitations

This section describes MassHealth's business rules, including for the following examples.

- Reporting specific scenarios, such as coordination of benefits (COB), amounts paid, secondary provider identifiers, void and replacements, and file and claim level corrections.
- Communicating MassHealth-specific edits

MCEs must comply with industry-standard Implementation Guides (IGs), specifications governing healthcare administrative transactions. MassHealth Companion Guides supplement IGs with MassHealth Medicaid–specific business rules and requirements, including those needed to meet state and federal reporting requirements and related regulatory obligations. Unless the MassHealth Companion Guide explicitly states that situational fields are not required, MassHealth requires MCEs to submit all situational-field information in the IG when covered services are rendered to MassHealth members.

Before submitting encounter claims to MassHealth, please review the appropriate HIPAA implementation guide and MassHealth companion guide to ensure the NCPDP transaction will comply with MassHealth's requirements.

The following sections outline recommendations, instructions, and conditional data requirements for claims submitted to MassHealth. This information is designed to help Trading Partners construct transactions in a manner that will allow MassHealth to efficiently process claims.

ENCOUNTER-SUBMISSION GUIDELINES

In steady state, MCEs will submit on a weekly basis. With MassHealth permission, MCEs may enter production on bi-weekly cadence. MCEs submitting on a bi-weekly basis will be given at least six months' notice of requirement to move to weekly submission cadence. If for any reason (including special projects) the MCE needs to submit off-cycle EDI files, they must first consult with MassHealth to determine what day they can submit these file(s). MCEs should never submit EDI files, other than on the designated submission days, without first receiving permission from MassHealth.

In order to balance the load for SENDPro processing MassHealth is asking MCEs to only submit EDI files on assigned days. Staggering submissions will reduce the risk of overload to the system that could cause issues and potentially rework. MCEs will be assigned a specific day of the week to submit their standard encounters file (original, adjustment, and voids) to SENDPro.

When constructing the file, submitters should order encounters by their adjudication dates. Encounters must be sorted chronologically by Adjudication Date (578) under Claim Category, as failure to do so may lead to rejections due to void and adjustment sequencing within the same file. Note that duplicate claims submitted to MassHealth, in the same or in separate files, will result in rejections.

If for any reason (including special projects) the MCE needs to submit off-cycle EDI files, they must first consult with MassHealth to determine what day they can submit these file(s). MCEs should never submit EDI files, other than on the designated submission days, without first receiving permission from MassHealth.

MassHealth will accept EDI files submitted within the bi-weekly period only for submissions of claims that were previously rejected by MassHealth.

Transactions should be submitted to MassHealth only to directly support services that have or will be provided directly to MassHealth members. MassHealth strongly encourages all submitters to ensure that redundant or excessive transactions are not submitted for processing.

ERROR THRESHOLD SPECIFICATIONS

Within SENDPro, there is an error threshold pertaining to the upfront edits and validations conducted by the SENDPro EDI application. This limitation has been implemented to address situations involving significant issues that may lead to an unusually high volume of errors. Details are below:

- For NCPDP, the 9,999 error threshold applies at the file level. If the number of claim-level errors exceeds 9,999 during processing in SENDPro, then any subsequent claims in the file will be rejected without being validated.
- The ACK JSON and 277DRA files will report error details and status only on the claims that were validated. ACK JSON will include the message "Message": "Processing truncated due to error limit breach" in this scenario.
- Claims not processed due to exceeding the 9,999 error limit are not reported in the response files; only claims before the threshold receive specific reject reasons in the JSON/Cognos.
- We have observed that in the high error scenarios, there tends to be just a few unique errors that are repeated across claims and drive the high volume of errors. Fixing these known errors often resolves other errors and helps achieve the MH 97% threshold through resubmissions.

ENCOUNTER SENDER/SUBMITTER IDS

For Encounter submissions, SENDPro supports three approaches:

- Parent organizations can submit on their own behalf.
- Parent organizations can submit files on behalf of their affiliates.

See Appendix C. Transmission Examples for more details on how to populate sender and submitter IDs.

TRANSFORMED MEDICAID STATISTICAL INFORMATION SYSTEM (TMSIS)

MassHealth is required to submit TMSIS information to the Centers for Medicare & Medicaid Services (CMS) on a monthly basis. That information includes both medical and pharmacy managed care encounter data. The encounter data that MCEs submit to MassHealth is integral to the completeness and accuracy of that information. Furthermore, CMS requires and assesses completeness and accuracy of critical data elements that must be included in every relevant encounter when applicable. MCEs must submit any/all federally required TMSIS data within the transaction in order to ensure compliance. However, it's especially important that the following data elements are included in every applicable encounter data submission to MassHealth:

Data Element	Notes
Provider ID/Service Location (PID/SL)	For Prescriber and Service Provider
Detail and Total Allowed Amounts	For all NCPDP claims
Detail and Total Medicaid Paid Amounts	For all NCPDP claims

Data Element	Notes
Detail and Total Billed Amounts	For all NCPDP claims
Medicare Paid, Deductible, Copay, and Coinsurance Amounts	For all NCPDP claims
Present and Valid NPI values	For all provider types (Prescriber and Service Provider)

NATIONAL PROVIDER IDENTIFIER (NPI)

MassHealth expects MCEs to provide the Pharmacy and Prescriber provider National Provider Identifier (NPI) in the SERVICE PROVIDER ID (201-B1) and PRESCRIBER ID (411- DB) fields respectively.

Note that Provider Social Security Numbers (SSNs) should never be submitted to MassHealth.

SECONDARY PROVIDER IDENTIFIERS

In addition to the NPI, MassHealth expects Managed Care Entities to populate secondary provider identifiers in the appropriate NCPDP fields as illustrated in the following table.

Field ID	NCPDP Field	IG Definition	MassHealth Description
202-B2-alt	SERVICE PROVIDER ID QUALIFIER (ALTERNATE)	Code qualifying the alternate Service Provider ID (201-B1-alt)	Pharmacy Alternate ID Qualifier - 05
201-B1-alt	SERVICE PROVIDER ID (ALTERNATE)	Alternate ID assigned to a pharmacy	Pharmacy Internal Provider Number
	SERVICE PROVIDER LOCATION ID	Use filler position 4440 – 4459	Pharmacy Internal Provider Location ID
	SERVICE PROVIDER PIDSL	Use filler position 4430 – 4439	Pharmacy PID/SL
466-EZ	PRESCRIBER ID QUALIFIER (ALTERNATE)	Code qualifying the alternate Prescriber ID (411-DB-alt)	Prescriber Alternate ID Qualifier - 05
411-DB-alt	PRESCRIBER ID (ALTERNATE)	Alternate ID assigned to a prescriber	Prescriber Internal Provider Number
	PRESCRIBER LOCATION ID	Use filler position 4410 – 4429	Prescriber Internal Provider Location ID
	PRESCRIBER PIDSL	Use filler position 4400 – 4409	Prescriber PID/SL
	SUBMITTER ENTITY PIDSL	Use filler position 4460 – 4469	Submitter Entity PID/SL

ORIGINAL, VOID, AND REPLACEMENT TRANSACTIONS

MassHealth strongly recommends that MCEs follow the approach below to report adjustments, overpayments, and recoveries. Note that failure to follow these instructions by attempting to void/adjust a claim with no original or by attempting to adjust the same original more than once will result in rejections.

Void Transactions: Use Record Type "**Void**" to report a full, 100% void/recovery of a previously paid claim. This requires the submitter to do the following.

- Use Record Status Code (399) "3" in Claim Category Segment to completely void/cancel the paid transaction. This will ensure a complete void of a previously submitted claim.

Replacement Transactions: Use Record Type "**Replacement**" to report an adjustment/partial recovery (less than 100% of the original payment amount). This requires the submitter to do the following.

- Use Record Status Code (399) “4” in Claim Category Segment to adjust or modify a previously paid transaction.

Upon receipt of a void or replacement transaction, MassHealth will validate the adjustments/voids linked to the original claim.

Follow guidance in Appendix B. Business Scenarios and Appendix C. Transmission Examples to construct adjustments and voids. This guidance reflects the daisy chain process and how to reference and tie back to a previous submission. SENDPro expects to receive the NCPDP post-adjudicated encounters from MCEs and will return the corresponding 277DRA.

Any claim submitted with record status code = 1 is considered paid. Denied claims will always be submitted with record status code = 2 and that will be considered denied.

We are expecting all denied claims to always be original for the reasons listed below:

a. Denied claim cannot adjust a previously submitted paid and partially paid claim since that should be sent as a void in the paid claims file

b. Denied claim cannot adjust a previously submitted denied claim

c. Paid claim can adjust a previously submitted denied claim

The concept of amendments does not exist in SENDPro. Please submit amendments as adjustments going forward.

If an MCE needs to make a correction, they should send a void for the claim that needs a correction and then submit a new, original claim with the corrected information.

TRANSMISSION CORRECTION

Transmission Action (981-JV) and Record Indicator (398) are used to manage transmission corrections of pharmacy claims. Instructions on how to use these values for the transmission correction process will be provided by MassHealth when required. These transmission corrections are to be used only for exceptions that are pre-approved by MassHealth; any use outside of these exceptions will result in file rejections. This section is only applicable in the following exception situations.

File Level Correction

Transmission Action (981-JV): At the file level, specifies the action to be applied to all records contained within the file. For transmission corrections, use the following value.

"C" for Correction/Adjustment to a previous batch

Otherwise, always use the following value for regular submissions.

"O" for Original Submission

Claim Level Correction

Record Indicator (398): Indicates transmission status at the record level. For record corrections, use the following values.

1 – Overwrite existing record

2 – Delete existing record

Otherwise, always use the following value for regular submissions.

0 – New Record

COORDINATION OF BENEFITS

COB Claims

The Coordination of Benefits (COB) Category groups fields are used to define information from primary or secondary payers. The primary payer is the payer associated with the main claim record itself. COB primary payer-based information must be populated for secondary claim when known. If reporting a tertiary claim, the secondary-based information must be present. MCE trading partners should report all instances of COB scenarios received by providers in their encounter submissions. Additional information such as co-pay, deductible, adjustments, etc. should be submitted as applicable. Appendices B and C provide business scenario examples for reporting COB.

DENIED CLAIMS

MassHealth requires denied claims to be submitted in a separate file from paid claims. Denied claims should be populated where Record Status Code (399) = 2 for all claims in that file. See Appendix C.2 for MassHealth expectations on how denied claims are populated.

As a reminder, denied encounters and lines follow similar expectations as paid encounters with some exceptions. MassHealth requires that denied claims conform to the rules in the implementation guide as well as this companion guide by submitting with complete and accurate data. Per situational and required field requirements, they should contain cardholder ID, service provider ID, and adjudication date.

NCPDP AMOUNTS MAPPING

This section **provides guidance to MCEs/PBMs on MassHealth's expectations when populating NCPDP Amounts and Quantity fields. Specifically, memo provides clarity and streamlines expectations when reporting and submitting encounters associated with some critical "amount" and "quantity" NCPDP EDI fields.**

For details on validations applied to each of these fields, see Section 9: Transaction-Specific Information.

MassHealth Amount Field	Description of use and mapping	Related NCPDP Field(s)
Invoice Amount	The amount the pharmacy submits as the charge for the product or service. Per NCPDP Data Dictionary, NCPDP Field 269 is defined as: Amount invoiced for this transaction. Determined by processor.	NCPDP Field 269 (Invoiced Amount)
Billed Amount	The original amount submitted by the pharmacy for reimbursement. Per NCPDP Data Dictionary, NCPDP Field 430-DU is defined as: Total price claimed from all sources. For	NCPDP Field 430-DU (Gross Amount Due)

MassHealth Amount Field	Description of use and mapping	Related NCPDP Field(s)
	prescription claim request, field represents a sum of Ingredient Cost Submitted (409-D9), Dispensing Fee Submitted (412-DC), Regulatory Fee Amount Submitted (481-HA), Percentage Tax Amount Submitted (482-GE), Incentive Amount Submitted (438-E3), Other Amount Claimed (480-H9). For service claim request, field represents a sum of Professional Services Fee Submitted (477-BE), Regulatory Fee Amount Submitted (481-HA), Percentage Tax Amount Submitted (482-GE), Other Amount Claimed (480-H9)	
Medicaid Paid Amount	The amount paid by the PBM or payer after adjudication and it's the Medicaid amount. Per NCPDP Data Dictionary, NCPDP Field 281 is defined as: Net amount paid to provider by the payer or net amount due from the client to the payer, determined by trading partner agreement.	NCPDP Field 281 (Net Amount Due)
Medicare Paid Amount	The portion of the claim paid by Medicare when coordination of benefits (COB) applies. Per NCPDP Data Dictionary, NCPDP Field 228 is defined as: Amount paid by primary payer for product or service.	NCPDP Field 228 (COB Primary Payer Amount Paid)
Total Paid Amount	Total amount paid by all sources including Medicaid, Medicare, and Third-Party Liability Per NCPDP Data Dictionary, NCPDP Field 894 is defined as: Total amount of the prescription regardless of party responsible for payment.	NCPDP Field 894 (Total Amount Paid by All Sources)
Ingredient Cost Paid	Per NCPDP Data Dictionary, NCPDP Field 506-F6 is defined as: Drug ingredient cost paid included in the Total Paid Amount.	NCPDP Field 506-F6 (Ingredient Cost Paid)
Ingredient Cost Submitted	Per NCPDP Data Dictionary, NCPDP Field 409-D9 is defined as: Submitted product component cost of the dispensed prescription. This amount is included in the Gross Amount Due (430-DU).	NCPDP Field 409-D9 (Ingredient Cost Submitted)

MassHealth Amount Field	Description of use and mapping	Related NCPDP Field(s)
Patient Pay Amount	Per NCPDP Data Dictionary, NCPDP Field 505-F5 is defined as: Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, etc.	NCPDP field 505-F5 (Patient Pay Amount)
Dispensing Fee Paid	Amount paid to the pharmacy for dispensing the medication Per NCPDP Data Dictionary, NCPDP Field 507-F7 is defined as: Dispensing fee paid included in the Total Amount Paid (509-F9).	NCPDP field 507-F7 (Dispensing Fee Paid)
Usual and Customary Charge	Per NCPDP Data Dictionary, NCPDP Field 426-DQ is defined as: Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.	NCPDP field 426-DQ (Usual and Customary Charge)
Compound Ingredient Drug Cost	Per NCPDP Data Dictionary, NCPDP Field 449-EE is defined as: Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in Compound Ingredient Quantity (Field 448-ED).	NCPDP field 449-EE (Compound Ingredient Drug Cost)
Quantity Dispensed	Per NCPDP Data Dictionary, NCPDP Field 442-E7 is defined as: Quantity dispensed expressed in metric decimal units.	NCPDP field 442-E7 (Quantity Dispensed)
Compound Ingredient Quantity	Per NCPDP Data Dictionary, NCPDP Field 448-ED is defined as: Amount expressed in metric decimal units of the product included in the compound mixture.	NCPDP field 448-ED (Compound Ingredient Quantity)
Unit of Measure	Per NCPDP Data Dictionary, NCPDP Field 600-28 is defined as: NCPDP standard product billing codes.	NCPDP field 600-28 (Unit of Measure)

MassHealth Amount Field	Description of use and mapping	Related NCPDP Field(s)
Client Specific Data	Trading partners mutually agreed upon specific data defined by client. This field should be populated with the amount paid by PBM to Pharmacy. For the Legacy Encounter flat file, this is field #232 (Provider Payment). This is defined as "The Gross Amount that the PBM paid to the pharmacy for the claim, excluding any amounts retained by the PBM." Also note that a negative amount of $53.01 should be populated as "-53.01". Per NCPDP Data Dictionary, NCPDP Field 224 is defined as: Trading partners mutually agreed upon specific data defined by client.	NCPDP field 224 (Client Specific Data)
Allowed Amount	The maximum amount the payer allows for reimbursement. Note that this represents allowable charges for covered services based on the specially negotiated fee between the provider and MCO.	MassHealth will Calculate Allowed Amount from [Net Amount Due (281)] + [Other Payer Amount Recognized (566-J5)] as "Allowed Amount" (MassHealth will determine allowed amount through this calculation). MCEs should just send NCPDP Fields 281 and 566-J5.

7. Acknowledgements and Reports

MassHealth has adopted two acknowledgement transactions with the NCPDP Post Adjudication Standard: a proprietary acknowledgement layout (JSON ACK) and the 277DRA. These acknowledgments will replace any/all proprietary reports issued by MassHealth in response to proprietary encounter data submissions.

THE PHARMACY (RX) PROPRIETARY ACKNOWLEDGMENT

The Rx Acknowledgment allows the receiver of a file to notify the sender when an invalid NCPDP layout was received or that problems were encountered during the processing of the NCPDP message. The pharmacy acknowledgement verifies the items listed below. If any errors are encountered, the Rx layout is generated with detail of the errors encountered.

- NCPDP Header, Detail, Compound, and Trailer records are well formed and NCPDP structure compliant.
- Correct sequencing of records within the NCPDP layout

- All NCPDP mandatory fields are present.
- Trailer record control sum checks
- Datatype violations

For general layout of this acknowledgement, see Appendix D: 999 JSON Scenarios.

THE 277 DATA REPORTING ACKNOWLEDGEMENT (277DRA)

This report acknowledges the validity and acceptability of data reporting claim submissions at the pre-processing stage and identifies claims that are accepted as well as those that are not accepted.

8. Trading Partner Agreements

MCEs that intend to conduct electronic transactions with MassHealth must sign the MassHealth Trading Partner Agreement (TPA). A copy of the agreement is available for download (www.mass.gov) or by contacting the Deloitte EDI Support at (email address TBD, targeting to be provided after Design phase) if you have any questions.

TRADING PARTNERS

MassHealth defines a Trading Partner as any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that exchanges electronic transactions with MassHealth. The Trading Partner and MassHealth acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Each party agrees to take all steps reasonably necessary to ensure that all electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder.

9. Transaction-Specific Information

FIELD LEGEND FOR USAGE:

M = Mandatory field

S = Situational field source

Allowable values are those defined by the NCPDP External Code List, unless otherwise specified.

The tables in sections 9.1, 9.2, and 9.3 reference columns from the published and corresponding NCPDP Implementation Guide. Each row provides additional information on MassHealth's specific business requirements and includes Usage/Requirement to clarify intent and usage.

9.1 POST ADJUDICATION HISTORY HEADER RECORD

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
601-04	Record Type	M	PA	Post Adjudication History Header Record
102-A2	Version/Release Number	M	51	
879-N2	Sending Entity Identifier	M	TPID	Trading Partner ID assigned by MassHealth (the 10-character MassHealth MMIS provider number, including service location)
806-5C	Batch Number	M		
880-K2	Creation Date	M	CCYYMMDD	Date the file was created
880-K3	Creation Time	M	HHMM	
880-K7	Receiver ID	M	DMA7384	
601-06	Reporting Period Start Date	M	CCYYMMDD	Should be a valid calendar date and cannot be a future date or prior to start date.
601-05	Reporting Period End Date	M	CCYYMMDD	
702-MC	File Type	M		Only defined values are accepted.
981-JV	Transmission Action	M	O - Original file C – Resubmission	MassHealth only accepts O and C.
888	Submission Number	M		MassHealth expects value of 00 when Transmission Action (981-JV) = O
	Filler	M		

9.2 POST ADJUDICATION HISTORY DETAIL RECORD

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
601-04	RECORD TYPE	M	DE	Post Adjudication History Detail Record
398	RECORD INDICATOR	M	Blank - Not Specified 0 - New record 1 - Overwrite existing record	When the Transmission Action is "O" (Original file), use Record Indicator "0" (New record) to indicate the creation of a new record or prescription. This is typically used for submitting new prescription requests. Record Indicator (398) choice is influenced by the nature of the action specified in the Transmission Action field (981-JV). Required if Transmission Action (981-JV) = "O"
SECTION DENOTES ELIGIBILITY CATEGORY				
248	ELIGIBLE COVERAGE CODE	S		Submit if used.
898	USER BENEFIT ID	S		Submit if used.
899	USER COVERAGE ID	S		Submit if used.
246	ELIGIBILITY GROUP ID	S		Submit if used.
270	LINE OF BUSINESS CODE	S		Submit if used.
267	INSURANCE CODE	S		Submit if used.
220	CLIENT ASSIGNED LOCATION CODE	S		Submit if used.
222	CLIENT PASS THROUGH	S		Submit if used.
SUBSECTION DENOTES CARDHOLDER INFORMATION				
302-C2	CARDHOLDER ID	M		12-digit MassHealth Member ID Number
716-SY	LAST NAME	M	Subscriber Name Last	
717-SX	FIRST NAME	M	Subscriber Name First	
718-SZ	MIDDLE INITIAL	S	Subscriber Name Middle	Submit if used.
280	NAME SUFFIX	S	Subscriber Name Suffix	Submit if used.
726-SR	ADDRESS LINE 1	S	Subscriber Street Address 1	Submit if used.
727-SS	ADDRESS LINE 2	S	Subscriber Street Address 1	Submit if used.
728-SU	CITY	S	Subscriber City	Submit if used.
729-TA	STATE/PROVINCE	S	Subscriber State/Province	Submit if used.
730-TC	ZIP/POSTAL CODE	S	Subscriber Zip code	Submit if used.
B36-1W	ENTITY COUNTRY CODE	S		Submit if used.
214	CARDHOLDER DATE OF BIRTH	M	Subscriber Date of Birth	
721-MD	GENDER CODE	M	Blank- Unknown 1 Male 2 Female	
274	MEDICARE PLAN CODE	S		Submit if used. MassHealth expects this field to be populated with "Z" when not

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
				applicable.
288	PAYROLL CLASS	S		Submit if used.
SUBSECTION DENOTES PATIENT INFORMATION				
331-CX	PATIENT ID QUALIFIER	S	EA	Must provide when available.
332-CY	PATIENT ID	S	Medical Record Number	Must provide when available.
716-SY	LAST NAME	S		Not currently utilized by MassHealth.
717-SX	FIRST NAME	S		Not currently utilized by MassHealth.
718 -SZ	MIDDLE INITIAL	S		Not currently utilized by MassHealth.
280	NAME SUFFIX	S		Not currently utilized by MassHealth.
726-SR	ADDRESS LINE 1	S		Not currently utilized by MassHealth.
727-SS	ADDRESS LINE 2	S		Not currently utilized by MassHealth.
728-SU	CITY	S		Not currently utilized by MassHealth.
729-TA	STATE/PROVINCE ADDRESS	S		Not currently utilized by MassHealth.
730 -TC	ZIP/POSTAL CODE	S		Not currently utilized by MassHealth.
A43-1K	PATIENT COUNTRY CODE	S		Not currently utilized by MassHealth.
304-C4	DATE OF BIRTH	S		Not currently utilized by MassHealth.
305-C5	PATIENT GENDER CODE	S		Not currently utilized by MassHealth.
247	ELIGIBILITY/PATIENT RELATIONSHIP CODE	S		Not currently utilized by MassHealth.
208	AGE	S	Calculated from Date of Birth (3Ø4-C4)	Not currently utilized by MassHealth.
303-C3	PERSON CODE	S		Not currently utilized by MassHealth.
306-C6	PATIENT RELATIONSHIP CODE	S		Not currently utilized by MassHealth.
309-C9	ELIGIBILITY CLARIFICATION CODE	S		Not currently utilized by MassHealth.
E06-S8	SPECIES	S		Not currently utilized by MassHealth.
336-8C	FACILITY ID	S		Not currently utilized by MassHealth.
SECTION DENOTES BENEFIT CATEGORY:				
301-C1	GROUP ID	M	Group ID	
215	CARRIER NUMBER	S		Submit if used.
757-U6	BENEFIT ID	S		Submit if used.
240 -U1	CONTRACT NUMBER	S		Submit if used.
212	BENEFIT TYPE	S		Submit if used.
279	MEMBER SUBMITTED CLAIM PROGRAM CODE	S		Submit if used.
282	NON-POS CLAIM OVERRIDE CODE	S		Submit if used.
282	NON-POS CLAIM OVERRIDE CODE	S		Submit if used.
282	NON-POS CLAIM OVERRIDE CODE	S		Submit if used.
241	COPAY MODIFIER ID	S		Submit if used.
292	PLAN CUTBACK REASON CODE	S		Submit if used.
293	PREFERRED	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	ALTERNATIVE FILE ID			
308-C8	OTHER COVERAGE CODE	S	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. 08=Patient financial responsibility	Submit if used.
291	PLAN BENEFIT CODE	S		Submit if used.
601-01	PLAN TYPE	S		Submit if used.
SECTION DENOTES PHARMACY CATEGORY:				
202-B2	SERVICE PROVIDER ID QUALIFIER	M	01	Pharmacy National Provider Identifier (NPI) Qualifier
201-B1	SERVICE PROVIDER ID	M		Pharmacy NPI
202-B2-alt	SERVICE PROVIDER ID QUALIFIER (ALTERNATE)	M	05	Alternate Pharmacy ID Qualifier
201-B1-alt	SERVICE PROVIDER ID (ALTERNATE)	M		Internal Provider ID lookup based on SENDING ENTITY IDENTIFIER (879-N2) and SUBMITTING ENTITY IDENTIFIER (filler)
886	SERVICE PROVIDER CHAIN CODE	S		Submit if used.
833-5P	PHARMACY NAME	S		Submit if used.
726-SR	ADDRESS LINE 1	S		Submit if used.
727-SS	ADDRESS LINE 2	S		Submit if used.
728-SU	CITY	S		Submit if used.
729-TA	STATE/PROVINCE ADDRESS	S		Submit if used.
730 -TC	ZIP/POSTAL CODE	S		Submit if used.
887	SERVICE PROVIDER COUNTY CODE	S		Submit if used.
A93	SERVICE PROVIDER COUNTRY CODE	S		Submit if used.
732 -TB	TELEPHONE NUMBER	S		Submit if used.
B10-8A	TELEPHONE NUMBER EXTENSION	S		Submit if used.
146	PHARMACY DISPENSER TYPE QUALIFIER	S		Submit if used.
290	PHARMACY DISPENSER TYPE	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
150	PHARMACY CLASS CODE QUALIFIER	S		Submit if used.
289	PHARMACY CLASS CODE	S		Submit if used.
266	IN NETWORK INDICATOR	M		Must submit the In Network Indicator.
545-2F	NETWORK REIMBURSEMENT ID	S		Submit if used.
SECTION DENOTE PRESCRIBER CATOGORY:				
466-EZ	PRESCRIBER ID QUALIFIER	M	01	Prescriber National Provider Identifier (NPI) Qualifier
411-DB	PRESCRIBER ID	M		Prescriber NPI
466-EZ	PRESCRIBER ID QUALIFIER (ALTERNATE)	M	05	Alternate Prescriber ID Qualifier
411-DB-alt	PRESCRIBER ID (ALTERNATE)	M		Internal Provider ID lookup based on SENDING ENTITY IDENTIFIER (879-N2) and SUBMITTING ENTITY IDENTIFIER (filler)
296	PRESCRIBER TAXONOMY	S		Submit if used.
295	PRESCRIBER CERTIFICATION STATUS	S		Submit if used.
716-SY	LAST NAME	S		Submit if used.
717-SX	FIRST NAME	S		Submit if used.
732 -TB	TELEPHONE NUMBER	S		Submit if used.
B10-8A	TELEPHONE NUMBER EXTENSION	S		Submit if used.
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	S		Submit if used.
421-DL	PRIMARY CARE PROVIDER ID	S		Submit if used.
716-SY	LAST NAME	S		Submit if used.
717-SX	FIRST NAME	S		Submit if used.
SUBSECTION DENOTES CLAIM CATEGORY				
399	RECORD STATUS CODE	M	1 Paid - Code indicating that the transaction was adjudicated using plan rules and was payable. 2 Rejected/Denied - Code indicating that the transaction was denied/rejected. 3 Reversed/Void - Code indicating that the paid transaction was cancelled. 4 Adjusted/Replacement - Code indicating that the	MassHealth only accepts the values 1, 2, 3, and 4. Other values will be rejected. Original claim ID of claim being voided/adjusted must be populated in TRANSACTION ID CROSS REFERENCE (897) when RECORD STATUS CODE (399) = 3 or 4.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
			previous transaction was changed.	
218	CLAIM MEDIA TYPE	M		Must provide the claim media type.
395	PROCESSOR PAYMENT CLARIFICATION CODE	M		Must provide the payment clarification code.
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	1: Rx Billing Transaction is a billing for a prescription or OTC drug product. 2: Service Billing Transaction is a billing for a professional service performed. 3: Non Prescription Product	Must provide a prescription/service qualifier.
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M		Must provide a prescription/service number.
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	00 - for multi-ingredient Prescription 01 – UPC Code 03 - NDC Code 07 - CPT-4 Code 08 - CPT-5 Code 09 - HCPCS	MassHealth expects a value 00 when there are compound ingredients.
407-D7	PRODUCT/SERVICE ID	M		Must provide value of 0 when PRODUCT/SERVICE ID QUALIFIER = 00. Must provide the 11-digit UPC Code when available and when PRODUCT/SERVICE ID QUALIFIER = 01. Must provide the 11-digit NDC Code when available and when PRODUCT/SERVICE ID QUALIFIER = 03. Must provide the 5-character CPT-4 Code when available and when PRODUCT/SERVICE ID QUALIFIER = 07. Must provide the 5-character CPT-5 Code when available and when PRODUCT/SERVICE ID QUALIFIER = 08. Must provide the 5-character HCPCS Code when available and when PRODUCT/SERVICE ID QUALIFIER = 09.
401-D1	DATE OF SERVICE	M		Must provide the service date.
578	ADJUDICATION DATE	M		Must provide the adjudication date.
203	ADJUDICATION TIME	S		Populate when known.
283	ORIGINAL CLAIM	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	RECEIVED DATE			
219	CLAIM SEQUENCE NUMBER	S		Submit if used.
213	BILLING CYCLE END DATE	S		Submit if used.
239	COMMUNICATION TYPE INDICATOR	S		Submit if used.
307-C7	PLACE OF SERVICE	S	01=Pharmacy 02=Unassigned 03=School 04=Homeless Shelter 05=Indian Health Service Free-standing Facility 06=Indian Health Service Provider-based Facility 07=Tribal 638 Free-standing Facility 08=Tribal 638 Provider-based Facility 09=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	Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
			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 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	
384-4X	PATIENT RESIDENCE	S		Submit if used.
419-DJ	PRESCRIPTION ORIGIN	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	CODE			
278	MEMBER SUBMITTED CLAIM PAYMENT RELEASE DATE	S		Submit if used.
217	CLAIM DATE RECEIVED IN THE MAIL	S		Submit if used.
268	INTERNAL MAIL ORDER PRESCRIPTION/SERVICE REFERENCE NUMBER	S		Submit if used.
102-A2	VERSION/RELEASE NUMBER (OF THE CLAIM)	S		Submit if used.
216	CHECK DATE	M		Must provide the Check Date.
287	PAYMENT/REFERENCE ID	M		Must provide the Payment/Reference ID.
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER	S		Submit if used.
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	S	CCYYMMDD	Populate when known.
442-E7	QUANTITY DISPENSED	M	Metric decimal quantity	Must provide the Quantity Dispensed.
403-D3	FILL NUMBER	M		Must provide the Fill Number.
405-D5	DAYS SUPPLY	M		Must provide the Days' Supply.
414-DE	DATE PRESCRIPTION WRITTEN	M	CCYYMMDD	Must provide the Date Prescription Written.
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	M		Must provide the DAW/Production Selection Code.
415-DF	NUMBER OF REFILLS AUTHORIZED	M		Must provide the Number of Authorized Refills.
429-DT	SPECIAL PACKAGING INDICATOR	S		Submit if used.
600-28	UNIT OF MEASURE	S		When COMPOUND CODE (406-D6) !=2 then UNIT OF MEASURE (600-28) will be required to be populated and should not be space-filled. On the other hand, if COMPOUND CODE (406-D6) = 2 then UNIT OF MEASURE (600-28) will remain situational and should be space-filled.
418-DI	LEVEL OF SERVICE	S		Submit if used.
343-HD	DISPENSING STATUS	S		Submit if used.
344-HF	QUANTITY INTENDED TO BE DISPENSED	S		Submit if used.
460-ET	QUANTITY PRESCRIBED	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	M		Must provide the Days' Supply Intended to be Dispensed.
254	FILL NUMBER CALCULATED	S		Submit if used.
406-D6	COMPOUND CODE	M	0 Not Specified 1 Not a Compound Medication that is available commercially as a dispensable product. 2 Compound Customized medication prepared in a pharmacy by combining, mixing, or altering of ingredients (but not reconstituting) for an individual patient in response to a licensed practitioner's prescription.	For Multi Ingredient Claim: PRODUCT/SERVICE ID QUALIFIER (436-E1) = 00 PRODUCT/SERVICE ID (407-D7) = 0 COMPOUND CODE (406-D6) = 2 Then the Compound Detail Record is used to capture the ingredient detail.
996-G1	COMPOUND TYPE	S		Must be populated when COMPOUND CODE (406-D6) = 2
452-EH	COMPOUND ROUTE OF ADMINISTRATION	S		Submit if used.
995-E2	ROUTE OF ADMINISTRATION	S	54471007=Buccal 372449004=Dental 417985001=Enteral 372454008=Gastro-enteral 421503006=Hemodialysis 424494006=Infusion 78421000=Intramuscular 72607000=Intrathecal 58100008=Intraarterial 112239003=Inhalation 424109004=Injection 372464004=Intradermal 38239002=Intra-peritoneal 47625008=Intravenous 404817000=Intravenous Piggyback 404816009=Intravenous	Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
			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	
C60-AG	COMPOUND LEVEL OF COMPLEXITY	S		Submit if used.
C99-KU	PREPARATION ENVIRONMENT TYPE	S		Submit if used.
C98-KT	PREPARATION ENVIRONMENT EVENT CODE	S		Submit if used.
492-WE	DIAGNOSIS CODE QUALIFIER	S	02	Submit ICD10 Code if available.
424-DO	DIAGNOSIS CODE	S		Submit ICD10 Code if available.
492-WE	DIAGNOSIS CODE QUALIFIER	S	02	Submit ICD10 Code if available.
424-DO	DIAGNOSIS CODE	S		Submit ICD10 Code if available.
492-WE	DIAGNOSIS CODE QUALIFIER	S	02	Submit ICD10 Code if available.
424-DO	DIAGNOSIS CODE	S		Submit ICD10 Code if available.
492-WE	DIAGNOSIS CODE QUALIFIER	S	02	Submit ICD10 Code if available.
424-DO	DIAGNOSIS CODE	S		Submit ICD10 Code if available.
492-WE	DIAGNOSIS CODE QUALIFIER	S	02	Submit ICD10 Code if available.
424-DO	DIAGNOSIS CODE	S		Submit ICD10 Code if available.
439-E4	REASON FOR SERVICE CODE	S		Submit if used.
440-E5	PROFESSIONAL SERVICE CODE	S		Submit if used.
441-E6	RESULT OF SERVICE CODE	S		Submit if used.
474-8E	DUR/PPS LEVEL OF EFFORT	S		Submit if used.
439-E4	REASON FOR SERVICE CODE	S		Submit if used.
440-E5	PROFESSIONAL SERVICE CODE	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
441-E6	RESULT OF SERVICE CODE	S		Submit if used.
474-8E	DUR/PPS LEVEL OF EFFORT	S		Submit if used.
439-E4	REASON FOR SERVICE CODE	S		Submit if used.
440-E5	PROFESSIONAL SERVICE CODE	S		Submit if used.
441-E6	RESULT OF SERVICE CODE	S		Submit if used.
474-8E	DUR/PPS LEVEL OF EFFORT	S		Submit if used.
439-E4	REASON FOR SERVICE CODE	S		Submit if used.
440-E5	PROFESSIONAL SERVICE CODE	S		Submit if used.
441-E6	RESULT OF SERVICE CODE	S		Submit if used.
474-8E	DUR/PPS LEVEL OF EFFORT	S		Submit if used.
439-E4	REASON FOR SERVICE CODE	S		Submit if used.
440-E5	PROFESSIONAL SERVICE CODE	S		Submit if used.
441-E6	RESULT OF SERVICE CODE	S		Submit if used.
474-8E	DUR/PPS LEVEL OF EFFORT	S		Submit if used.
439-E4	REASON FOR SERVICE CODE	S		Submit if used.
440-E5	PROFESSIONAL SERVICE CODE	S		Submit if used.
441-E6	RESULT OF SERVICE CODE	S		Submit if used.
474-8E	DUR/PPS LEVEL OF EFFORT	S		Submit if used.
439-E4	REASON FOR SERVICE CODE	S		Submit if used.
440-E5	PROFESSIONAL SERVICE CODE	S		Submit if used.
441-E6	RESULT OF SERVICE CODE	S		Submit if used.
474-8E	DUR/PPS LEVEL OF EFFORT	S		Submit if used.
439-E4	REASON FOR SERVICE CODE	S		Submit if used.
440-E5	PROFESSIONAL SERVICE CODE	S		Submit if used.
441-E6	RESULT OF SERVICE CODE	S		Submit if used.
474-8E	DUR/PPS LEVEL OF EFFORT	S		Submit if used.
439-E4	REASON FOR SERVICE CODE	S		Submit if used.
440-E5	PROFESSIONAL SERVICE CODE	S		Submit if used.
441-E6	RESULT OF SERVICE	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	CODE			
474-8E	DUR/PPS LEVEL OF EFFORT	S		Submit if used.
439-E4	REASON FOR SERVICE CODE	S		Submit if used.
440-E5	PROFESSIONAL SERVICE CODE	S		Submit if used.
441-E6	RESULT OF SERVICE CODE	S		Submit if used.
474-8E	DUR/PPS LEVEL OF EFFORT	S		Submit if used.
475-J9	DUR/DUE CO-AGENT ID QUALIFIER	S		Submit if used
476-H6	DUR/DUE CO-AGENT ID	S		Submit if used.
878	REJECT OVERRIDE CODE	S		Only populate the Reject Overrider Code when Record Status Code (399) = 1
511-FB	REJECT CODE	S		First occurrence of Reject Code must be populated when Record Status Code (399) = 2 This field is validated against total list of 1494 reject codes (all NCPDP reject codes are supported i.e. not just the Post Adjudicated NCPDP format related reject codes)
511-FB	REJECT CODE	S		See Reject Code (511-FB) above.
511-FB	REJECT CODE	S		See Reject Code (511-FB) above.
511-FB	REJECT CODE	S		See Reject Code (511-FB) above.
511-FB	REJECT CODE	S		See Reject Code (511-FB) above.
SECTION DENOTES WORKERS COMPENSATION CATEGORY:				
435-DZ	CLAIM/REFERENCE ID	S		Submit if used.
434-DY	DATE OF INJURY	S		Submit if used.
SECTION DENOTES PRODUCT CATEGORY:				
532-FW	DATABASE INDICATOR	S		Submit if used.
397	PRODUCT/SERVICE NAME	S		Submit if used.
261	GENERIC NAME	S		Submit if used.
601-24	PRODUCT STRENGTH	S		Submit if used.
243	DOSAGE FORM CODE	S		Submit if used.
FIL	FILLER	S		Spaces
425-DP	DRUG TYPE	M		Must provide the Drug Type.
273	MAINTENANCE DRUG INDICATOR	S		Submit if used.
244	DRUG CATEGORY CODE	S		Submit if used.
252	FEDERAL DEA SCHEDULE	S		Submit if used.
297	PRESCRIPTION OVER THE COUNTER	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	INDICATOR			
420-DK	SUBMISSION CLARIFICATION CODE	S	*Note that a submission Clarification code of 20 is required for all 340B claims.* *Note that NCPDP Guide v51 positions are incorrect; this field starts at 2242 and ends at 2244.*	Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2245 and ends at 2247.*	Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2248 and ends at 2250.*	Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2251 and ends at 2253.*	Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2254 and ends at 2256.*	Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2257 and ends at 2259.*	Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2260 and ends at 2262.*	Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2263 and ends at 2265.*	Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2266 and ends at 2268.*	Must be provided if there was an out-of-process submission.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
250	FDA DRUG EFFICACY CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts and ends at 2269.*	Submit if used.
601-19	PRODUCT CODE QUALIFIER	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts and ends at 2270.*	Submit if used.
601-18	PRODUCT CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2271 and ends at 2310.*	Submit if used.
601-19	PRODUCT CODE QUALIFIER	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts and ends at 2311.*	Submit if used.
601-18	PRODUCT CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2312 and ends at 2351.*	Submit if used.
601-19	PRODUCT CODE QUALIFIER	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts and ends at 2352.*	Submit if used.
601-18	PRODUCT CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2353 and ends at 2392.*	Submit if used.
251	FEDERAL UPPER LIMIT INDICATOR	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts and ends at 2393.*	Submit if used.
294	PRESCRIBED DAYS SUPPLY	M	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2394 and ends at 2396.*	Must provide the Prescribed Days' Supply.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts and ends at 2397.*	Submit if used.
601-25	THERAPEUTIC CLASS CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2398 and ends at 2414.*	Submit if used.
601-26	THERAPEUTIC CLASS	S	*Note that NCPDP Guide*	Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	CODE QUALIFIER		*v51 positions are incorrect; this field starts and ends at 2415.*	
601-25	THERAPEUTIC CLASS CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2416 and ends at 2432*	Submit if used.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts and ends at 2433.*	Submit if used.
601-25	THERAPEUTIC CLASS CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2434 and ends at 2450.*	Submit if used.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts and ends at 2451.*	Submit if used.
601-25	THERAPEUTIC CLASS CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2452 and ends at 2468.*	Submit if used.
D17-K8	SUBMISSION TYPE CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2469 and ends at 2470.*	Submit if used.
D17-K8	SUBMISSION TYPE CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2471 and ends at 2472.*	Submit if used.
D17-K8	SUBMISSION TYPE CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2473 and ends at 2474.*	Submit if used.
D17-K8	SUBMISSION TYPE CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2475 and ends at 2476.*	Submit if used.
D17-K8	SUBMISSION TYPE CODE	S	*Note that NCPDP Guide v51 positions are incorrect; this field starts at 2477 and ends at 2478.*	Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
SECTION DENOTES FORMULARY CATEGORY:				
257	FORMULARY STATUS	S		Submit if used.
221	CLIENT FORMULARY FLAG	S		Submit if used.
889	THERAPEUTIC CHAPTER	S		Submit if used.
256	FORMULARY FILE ID	S		Submit if used.
255	FORMULARY CODE TYPE	S		Submit if used.
SECTION DENOTES PRICING CATEGORY:				
506-F6	INGREDIENT COST PAID	M		Must provide the Ingredient Cost.
507-F7	DISPENSING FEE PAID	M		Must provide the Dispensing Fee Paid.
894	TOTAL AMOUNT PAID BY ALL SOURCES	M		Must provide the Total Amount Paid.
523-FN	AMOUNT ATTRIBUTED TO SALES TAX	S		Submit if used.
505-F5	PATIENT PAY AMOUNT	M		Must provide the Patient Pay Amount.
518-FI	AMOUNT OF COPAY	S		Submit if used.
572-4U	AMOUNT OF COINSURANCE	S		Submit if used.
519-FJ	AMOUNT ATTRIBUTED TO PRODUCT SELECTION	S		Submit if used.
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	S		Submit if used.
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE	S		Submit if used.
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION	S		Submit if used.
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG	S		Submit if used.
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION	S		Submit if used.
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION	S		Submit if used.
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP	S		Submit if used.
272	MAC REDUCED	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	INDICATOR			
223	CLIENT PRICING BASIS OF COST	S		Submit if used.
260	GENERIC INDICATOR	S	B - Branded G - Generic	Submit if used.
284	OUT OF POCKET APPLY AMOUNT	S		Submit if used.
209	AVERAGE COST PER QUANTITY UNIT PRICE	S		Submit if used.
210	AVERAGE GENERIC UNIT PRICE	S		Submit if used.
211	AVERAGE WHOLESALE UNIT PRICE	S		Submit if used.
253	FEDERAL UPPER LIMIT UNIT PRICE	S		Submit if used.
430-DU	GROSS AMOUNT DUE	M		Must provide the Gross Amount Due.
271	MAC PRICE	S		Submit if used.
409-D9	INGREDIENT COST SUBMITTED	M		Must provide the Ingredient Cost Submitted.
426-DQ	USUAL AND CUSTOMARY CHARGE	M		Must provide the Usual and Customary Charge.
558-AW	REGULATORY FEE AMOUNT PAID	S		Submit if used.
559-AX	PERCENTAGE TAX AMOUNT PAID	S		Submit if used.
560-AY	PERCENTAGE TAX RATE PAID	S		Submit if used.
561-AZ	PERCENTAGE TAX BASIS PAID	S		Submit if used.
521-FL	INCENTIVE AMOUNT PAID	S		Submit if used.
562-J1	PROFESSIONAL SERVICE FEE PAID	S		Submit if used.
564-J3	OTHER AMOUNT PAID QUALIFIER	S		Submit if used.
565-J4	OTHER AMOUNT PAID	S		Submit if used.
564-J3	OTHER AMOUNT PAID QUALIFIER	S		Submit if used.
565-J4	OTHER AMOUNT PAID	S		Submit if used.
564-J3	OTHER AMOUNT PAID QUALIFIER	S		Submit if used.
565-J4	OTHER AMOUNT PAID	S		Submit if used.
566-J5	OTHER PAYER AMOUNT RECOGNIZED	S		Submit if used.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	S		Submit if used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	AMOUNT			
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	S		Submit if used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	S		Submit if used.
281	NET AMOUNT DUE	M		Must provide the Net Amount Due.
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	M		Must provide the Basis of Reimbursement Determination.
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT	S		Submit if used.
513-FD	REMAINING DEDUCTIBLE AMOUNT	S		Submit if used.
514-FE	REMAINING BENEFIT AMOUNT	S		Submit if used.
242	COST DIFFERENCE AMOUNT	S		Submit if used.
249	EXCESS COPAY AMOUNT	S		Submit if used.
277	MEMBER SUBMIT AMOUNT	S		Submit if used.
265	HOLD HARMLESS AMOUNT	S		Submit if used.
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM	S		Submit if used.
346-HH	BASIS OF CALCULATION – DISPENSING FEE	S		Submit if used.
347-HJ	BASIS OF CALCULATION – COPAY	S		Submit if used.
348-HK	BASIS OF CALCULATION – REGULATORY FEE	S		Submit if used.
349-HM	BASIS OF CALCULATION – PERCENTAGE TAX	S		Submit if used.
573-4V	BASIS OF CALCULATION – COINSURANCE	S		Submit if used.
557-AV	PERCENTAGE TAX EXEMPT INDICATOR	S		Submit if used.
285	PATIENT FORMULARY REBATE AMOUNT	S		Submit if used.
276	MEDICARE RECOVERY INDICATOR	S		Submit if used.
275	MEDICARE RECOVERY	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	DISPENSING INDICATOR			
286	PATIENT SPEND DOWN AMOUNT	S		Submit if used.
263	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT APPLIED	S		Submit if used.
264	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT REMAINING	S		Submit if used.
207	ADMINISTRATIVE FEE EFFECT INDICATOR	S		Submit if used.
206	ADMINISTRATIVE FEE AMOUNT	S		Submit if used.
269	INVOICED AMOUNT	S		Submit if used.
FIL	FILLER	S		Spaces
128-UC	SPENDING ACCOUNT AMOUNT REMAINING	S		Submit if used.
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT	S		Submit if used.
C95-KQ	PATIENT PAY COMPONENT QUALIFIER	S		Submit if used.
C93-KN	PATIENT PAY COMPONENT AMOUNT	S		Submit if used.
C95-KQ	PATIENT PAY COMPONENT QUALIFIER	S		Submit if used.
C93-KN	PATIENT PAY COMPONENT AMOUNT	S		Submit if used.
C95-KQ	PATIENT PAY COMPONENT QUALIFIER	S		Submit if used.
C93-KN	PATIENT PAY COMPONENT AMOUNT	S		Submit if used.
C95-KQ	PATIENT PAY COMPONENT QUALIFIER	S		Submit if used.
C93-KN	PATIENT PAY COMPONENT AMOUNT	S		Submit if used.
C95-KQ	PATIENT PAY COMPONENT QUALIFIER	S		Submit if used.
C93-KN	PATIENT PAY COMPONENT AMOUNT	S		Submit if used.
C95-KQ	PATIENT PAY COMPONENT	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	QUALIFIER			
C93-KN	PATIENT PAY COMPONENT AMOUNT	S		Submit if used.
C95-KQ	PATIENT PAY COMPONENT QUALIFIER	S		Submit if used.
C93-KN	PATIENT PAY COMPONENT AMOUNT	S		Submit if used.
C95-KQ	PATIENT PAY COMPONENT QUALIFIER	S		Submit if used.
C93-KN	PATIENT PAY COMPONENT AMOUNT	S		Submit if used.
C95-KQ	PATIENT PAY COMPONENT QUALIFIER	S		Submit if used.
C93-KN	PATIENT PAY COMPONENT AMOUNT	S		Submit if used.
C95-KQ	PATIENT PAY COMPONENT QUALIFIER	S		Submit if used.
C93-KN	PATIENT PAY COMPONENT AMOUNT	S		Submit if used.
C95-KQ	PATIENT PAY COMPONENT QUALIFIER	S		Submit if used.
SECTION DENOTES PRIOR AUTHORIZATION CATEGORY:				
461-EU	PRIOR AUTHORIZATION TYPE CODE	S	0-8	Must provide if there was a prior authorization.
462-EV	PRIOR AUTHORIZATION ID SUBMITTED	S		Must provide if there was a prior authorization.
498-PY	PRIOR AUTHORIZATION ID ASSIGNED	S		Submit if used.
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	S		Submit if used.
SECTION DENOTES ADJUSTMENT CATEGORY:				
204	ADJUSTMENT REASON CODE	S		Must be provided if there was an adjustment RECORD STATUS CODE (399) = 4
205	ADJUSTMENT TYPE	S		Must be provided if there was an adjustment RECORD STATUS CODE (399) = 4
897	TRANSACTION ID	M		Original Claim ID of claim being

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	CROSS REFERENCE			voided/adjusted. Must always be provided for voids and adjustments.
SECTION DENOTES COORDINATION OF BENEFITS CATEGORY:				
225	COB CARRIER SUBMIT AMOUNT	S		Submit if used.
245	ELIGIBILITY COB INDICATOR	S		Submit if used.
226	COB PRIMARY CLAIM TYPE	S		Submit if used.
232	COB PRIMARY PAYER ID	S		Submit if used.
FIL	FILLER	S		Spaces
228	COB PRIMARY PAYER AMOUNT PAID	S		Submit if used.
231	COB PRIMARY PAYER DEDUCTIBLE	S		Submit if used.
229	COB PRIMARY PAYER COINSURANCE	S		Submit if used.
230	COB PRIMARY PAYER COPAY	S		Submit if used.
238	COB SECONDARY PAYER ID	S		Submit if used.
FIL	FILLER	S		Spaces
234	COB SECONDARY PAYER AMOUNT PAID	S		Submit if used.
237	COB SECONDARY PAYER DEDUCTIBLE	S		Submit if used.
235	COB SECONDARY PAYER COINSURANCE	S		Submit if used.
236	COB SECONDARY PAYER COPAY	S		Submit if used.
SECTION DENOTES REFERENCE CATEGORY:				
896	TRANSACTION ID	M		Unique Claim ID. Must always be provided.
503-F3	AUTHORIZATION NUMBER	S		Submit if used.
224	CLIENT SPECIFIC DATA	M		Populate with Provider Payment Amount paid by PBM to Provider. For example, the amount of negative $53.01 should be populated as "-53.01"
396	PROCESSOR SPECIFIC DATA	S		Submit if used.
997-G2	CMS PART D DEFINED QUALIFIED FACILITY	S		Submit if used.
SECTION DENOTES FIELDS ADDED IN VERSIONS CATEGORY:				
393-MV	BENEFIT STAGE QUALIFIER	S		Submit if used.
394-MW	BENEFIT STAGE AMOUNT	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
393-MV	BENEFIT STAGE QUALIFIER	S		Submit if used.
394-MW	BENEFIT STAGE AMOUNT	S		Submit if used.
393-MV	BENEFIT STAGE QUALIFIER	S		Submit if used.
394-MW	BENEFIT STAGE AMOUNT	S		Submit if used.
393-MV	BENEFIT STAGE QUALIFIER	S		Submit if used.
394-MW	BENEFIT STAGE AMOUNT	S		Submit if used.
C51-9X	BENEFIT STAGE INDICATOR	S		Submit if used.
C51-9X	BENEFIT STAGE INDICATOR	S		Submit if used.
C51-9X	BENEFIT STAGE INDICATOR	S		Submit if used.
C51-9X	BENEFIT STAGE INDICATOR	S		Submit if used.
690-ZG	INVOICED DATE	S		Submit if used.
691-ZH	OUT OF POCKET REMAINING AMOUNT	S		Submit if used.
302-C2 - alt	CARDHOLDER ID (ALTERNATE)	S		Submit if used.
692-ZJ	NUMBER OF GENERIC MANUFACTURERS	S		Submit if used.
475-J9	DUR/DUE CO-AGENT ID QUALIFIER	S		Submit if used.
476-H6	DUR/DUE CO-AGENT ID	S		Submit if used.
475-J9	DUR/DUE CO-AGENT ID QUALIFIER	S		Submit if used.
476-H6	DUR/DUE CO-AGENT ID	S		Submit if used.
475-J9	DUR/DUE CO-AGENT ID QUALIFIER	S		Submit if used.
476-H6	DUR/DUE CO-AGENT ID	S		Submit if used.
475-J9	DUR/DUE CO-AGENT ID QUALIFIER	S		Submit if used.
476-H6	DUR/DUE CO-AGENT ID	S		Submit if used.
475-J9	DUR/DUE CO-AGENT ID QUALIFIER	S		Submit if used.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	S		Submit if used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	S		Submit if used.
A37	SPECIALTY CLAIM INDICATOR	S		Submit if used.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
A38	MEMBER SUBMITTED CLAIM REJECT CODE	S		Submit if used.
A38	MEMBER SUBMITTED CLAIM REJECT CODE	S		Submit if used.
A38	MEMBER SUBMITTED CLAIM REJECT CODE	S		Submit if used.
A38	MEMBER SUBMITTED CLAIM REJECT CODE	S		Submit if used.
A38	MEMBER SUBMITTED CLAIM REJECT CODE	S		Submit if used.
A39	COPAY WAIVER AMOUNT	S		Submit if used.
A33-ZX	CMS PART D CONTRACT ID	S		Submit if used.
A34-ZY	MEDICARE PART D PLAN BENEFIT PACKAGE (PBP)	S		Submit if used.
A73	MEDICARE DRUG COVERAGE CODE	S		Submit if used.
	PRESCRIBER PIDSL	S	Use filler position 4400 – 4409	Prescriber PID/SL; this field has a max length of 10 digits and must be populated when information is available.
	PRESCRIBER LOCATION ID	M	Use filler position 4410 – 4429	Prescriber Internal Provider Location ID; this ID is related to PRESCRIBER ID (ALTERNATE) (411-DB-alt) and can have a max length of 20 digits. Internal Provider ID lookup based on SENDING ENTITY IDENTIFIER (879-N2) and SUBMITTING ENTITY IDENTIFIER (filler)
	SERVICE PROVIDER PIDSL	S	Use filler position 4430 – 4439	Pharmacy PID/SL; this field can have a max length of 10 digits.
	SERVICE PROVIDER LOCATION ID	M	Use filler position 4440 – 4459	Pharmacy Internal Provider Location ID; this ID is related to SERVICE PROVIDER ID (ALTERNATE) (201-B1-alt) and can have a max length of 20 digits. Lookup to MH_INT.ID_PROVIDER_LOCATION, based on SENDING ENTITY IDENTIFIER (879-N2) lookup to MH_INT.CLAIM_PAYER_PIDSL And Lookup MH_INT.ID_PROVIDER_LOCATION, based on SUBMITTING ENTITY IDENTIFIER (filler) lookup to MH_INT.ENT_PIDSL
	SUBMITTER ENTITY	M	Use filler position 4460 –	Submitter Entity PIDSL; this field has a

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	PIDSL		4469	max length of 10 digits and must be populated when information is available.
FIL	FILLER			Spaces

9.2.1 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD1

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
601-04	RECORD TYPE	M	CD	Must be populated if COMPOUND CODE (406-D6) = 2 Must not be populated if COMPOUND CODE (406-D6) != 2
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M		Must be populated if COMPOUND CODE (406-D6) = 2
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M		Must be populated if COMPOUND CODE (406-D6) = 2
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M		Must be populated if COMPOUND CODE (406-D6) = 2
SECTION DENOTES FIRST INGREDIENT				
488-RE	COMPOUND PRODUCT ID QUALIFIER	M	03 National Drug Code (NDC)	Product ID Qualifier
489-TE	COMPOUND PRODUCT ID	M	NDC Code	NCPDP Formatted 11 digits (N)
448-ED	COMPOUND INGREDIENT QUANTITY	M		Quantity must be >0 for each ingredient, when COMPOUND CODE (406-D6) = 2
449-EE	COMPOUND INGREDIENT DRUG COST	M		Submit if available.
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	S		Submit if available.
221	CLIENT FORMULARY FLAG	S		Submit if available.
397	PRODUCT/SERVICE NAME	S		Submit if available.
261	GENERIC NAME	S		Submit if available.
601-24	PRODUCT STRENGTH	S		Submit if available.
243	DOSAGE FORM CODE	S		Submit if available.
532-FW	DATABASE INDICATOR	S		Submit if available.
425-DP	DRUG TYPE	S		Submit if available.
257	FORMULARY STATUS	S		Submit if available.
244	DRUG CATEGORY CODE	S		Submit if available.
252	FEDERAL DEA SCHEDULE	S		Submit if available.
250	FDA DRUG EFFICACY CODE	S		Submit if available.
601-19	PRODUCT CODE QUALIFIER	S		Submit if available.
601-18	PRODUCT CODE	S		Submit if available.
601-19	PRODUCT CODE QUALIFIER	S		Submit if available.
601-18	PRODUCT CODE	S		Submit if available.
601-19	PRODUCT CODE QUALIFIER	S		Submit if available.

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
601-18	PRODUCT CODE	S		Submit if available.
251	FEDERAL UPPER LIMIT INDICATOR	S		Submit if available.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	S		Submit if available.
601-25	Therapeutic Class Code	S		Submit if available.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	S		Submit if available.
601-25	Therapeutic Class Code	S		Submit if available.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	S		Submit if available.
601-25	Therapeutic Class Code	S		Submit if available.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	S		Submit if available.
601-25	Therapeutic Class Code	S		Submit if available.
429-DT	SPECIAL PACKAGING INDICATOR	S		Submit if available.
600-28	UNIT OF MEASURE	M		Submit if available.
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	S		Submit if available.
272	MAC REDUCED INDICATOR	S		Submit if available.
223	CLIENT PRICING BASIS OF COST	S		Submit if available.
475-J9	DUR/DUE CO-AGENT ID QUALIFIER	S		Submit if available.
476-H6	DUR/DUE CO-AGENT ID	S		Submit if available.
260	GENERIC INDICATOR	S	B - Branded G - Generic	Submit if available.
292	PLAN CUTBACK REASON CODE	S		Submit if available.
889	THERAPEUTIC CHAPTER	S		Submit if available.
209	AVERAGE COST PER QUANTITY UNIT PRICE	S		Submit if available.
210	AVERAGE GENERIC UNIT PRICE	S		Submit if available.
211	AVERAGE WHOLESALE UNIT PRICE	S		Submit if available.
253	FEDERAL UPPER LIMIT UNIT PRICE	S		Submit if available.
271	MAC PRICE	S		Submit if available.
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	S		Submit if available.
285	PATIENT FORMULARY REBATE AMOUNT	S		Submit if available.
	SECTION DENOTES SECOND INGREDIENT	**S**	**Same detail as first ingredient**	
	SECTION DENOTES THIRD INGREDIENT	**S**	**Same detail as first ingredient**	
	SECTION DENOTES	**S**	**Same detail as first**	

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
	FOURTH INGREDIENT		**ingredient**	
	SECTION DENOTES FIFTH INGREDIENT	**S**	**Same detail as first ingredient**	
	SECTION DENOTES SIXTH INGREDIENT	**S**	**Same detail as first ingredient**	
	SECTION DENOTES SEVENTH INGREDIENT	**S**	**Same detail as first ingredient**	
	SECTION DENOTES EIGHTH INGREDIENT	**S**	**Same detail as first ingredient**	
	FILLER	M		Spaces

9.2.2 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD2

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
601-04	RECORD TYPE	M	CE	Must be value "CE" when record is created, and the previous record must have a Record Type of “CD.”
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M		Must be provided if Compound Record 2 is formed.
402-DC	PRESCRIPTION/SERVICE REFERENCE NUMBER	M		Must be provided if Compound Record 2 is formed.
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M		Must be provided if Compound Record 2 is formed.
	SECTION DENOTES NINTH INGREDIENT	**S**	**Same detail as first ingredient**	
	SECTION DENOTES TENTH INGREDIENT	**S**	**Same detail as first ingredient**	
	SECTION DENOTES ELEVENTH INGREDIENT	**S**	**Same detail as first ingredient**	
	SECTION DENOTES TWELFTH INGREDIENT	**S**	**Same detail as first ingredient**	
	SECTION DENOTES THIRTEENTH INGREDIENT	**S**	**Same detail as first ingredient**	
	SECTION DENOTES FOURTEENTH INGREDIENT	**S**	**Same detail as first ingredient**	
	SECTION DENOTES FIFTEENTH INGREDIENT	**S**	**Same detail as first ingredient**	
	Filler	M		Spaces

9.3 POST ADJUDICATION HISTORY TRAILER RECORD

Field	Field Name	Mandatory or Situational	Values	Usage/Requirement
601-04	RECORD TYPE	M	PT	Post Adjudication History Trailer Record
601-09	TOTAL RECORD COUNT	M		Total number of records, including the header and trailer
895	TOTAL NET AMOUNT DUE	M		Sum of NET AMOUNT DUE (281) in the file
693	TOTAL GROSS AMOUNT DUE	M		Sum of GROSS AMOUNT DUE (430-DU) in the file
694	TOTAL PATIENT AMOUNT	M		Sum of PATIENT PAY AMOUNT (505-F5) in the file
	FILLER	M		Spaces

APPENDICES

Appendix A. Implementation Checklist

This appendix contains all necessary steps for implementing the transactions with MassHealth. More details are defined in the MCE User Guide.

- Develop your system to comply with ACS X12N v5010 Technical Reports 3/Implementation Guides.
    - Develop your system to comply with X12 837 Post Adjudicated Claims Data Reporting (PACDR) Technical Reports 3/Implementation Guide
- Review MassHealth SENDPro Companion Guides to identify and implement necessary changes to your system.
    - Develop your system to comply with additional requirements as defined in this guide.
- Complete the SENDPro onboarding activities. A summary is listed below:
    - Complete MOVEit service account setup to exchange EDI files with MassHealth.
    - Complete MOVEit user account setup to exchange EDI files with MassHealth.
    - Complete setup of encryption keys to securely exchange EDI files with MassHealth.
    - Complete VG account setup to access the SENDPro Portal and reports.
- Test connectivity.
    - Perform a connectivity test with MassHealth to confirm EDI files are able to be securely sent to MassHealth and securely received by MCEs.
- Participate in all trading partner testing activities.
    - Successfully complete testing activities based on testing scenarios provided by MassHealth.
- Utilize various and real case business scenarios during testing.
    - Successfully complete testing of MassHealth-defined business scenarios as part of testing activities.

Appendix B. Business Scenarios

This appendix contains typical business scenarios. The actual data streams linked to these scenarios are included in Appendix C.

1. Parent/Child Submissions
2. NCPDP Original, Adjustment, and Void
3. NCPDP Denied Encounter
4. NCPDP Initial Denied Encounter then Subsequently Paid in MCE Claims System
5. Coordination of Benefit where Medicare is the COB Payer

Appendix C. Transmission Examples

Below are examples of how MCEs should submit NCPDP files as described in Appendix B.

1. Parent/Child Submissions

The table below provides details for Sending and Submitting entities, and includes examples for a file submitted by Parent-Tufts Health Together TPID/PIDSL = 110088791A and with claims from Affiliate Tuft's Health Together with CHA: TPID/PIDSL = 110088791E.

SECTION DENOTES HEADER RECORD:		
Field	**Field Name**	**Field Details**
879-N2	SENDING ENTITY IDENTIFIER	MCE PID/SL Example: 110088791A
Filler position 4460 - 4469	SUBMITTER ENTITY PIDSL	MCE PID/SL of affiliate if different from parent MCE; MCE PID/SL if claims are not associated with an affiliate Example: 110088791E

2. NCPDP Original, Adjustment, and Void

MCE Submission to Medicaid	Value	Description	SENDPro to MCE	Value
Original Claim				
TRANSACTION ID (896)	C1	Unique Claim ID	2200D TNR02	C1
TRANSACTION ID CROSS REFERENCE (897)		Original Claim ID (Applicable for Adjustment claims)		
RECORD STATUS CODE (399)	1			
RECORD INDICATOR (398)	0			
Adjustment Claim				
TRANSACTION ID (896)	C2	Unique Claim ID (New unique claim ID)	2200D TNR02	C2
TRANSACTION ID CROSS REFERENCE (897)	C1	Original Claim ID (Refer back to claim being adjusted - C1 in this example)		
RECORD STATUS CODE (399)	4			
RECORD INDICATOR (398)	0			
Void Claim				
TRANSACTION ID (896)	C3	Unique Claim ID (New unique claim ID)	2200D TNR02	C3
TRANSACTION ID CROSS REFERENCE (897)	C2	Original Claim ID (Refer back to claim being voided - C2 in this example)		
RECORD STATUS CODE (399)	3			
RECORD INDICATOR (398)	0			

3. NCPDP Denied Encounter

MCE Submission to Medicaid	Value	Description	SENDPro to	Value

			MCE	
TRANSACTION ID (896)	C4	Unique Claim ID (New unique claim ID)	2200D TNR02	C4
TRANSACTION ID CROSS REFERENCE (897)		Original Claim ID (This should always be null for denied claims)		
RECORD STATUS CODE (399)	2			
RECORD INDICATOR (398)	0			

4. NCPDP Initial Denied Encounter then Subsequently Paid in MCE Claims System

A denied claim can subsequently be submitted as either adjusted (Example A) or paid (Example B). Claims submitted as shown below would be accepted by MassHealth using either scenario.

Example A – Adjusted Scenario

MCE Submission to Medicaid	Value	Description
Original Denied Claim		
TRANSACTION ID (896)	C4	Unique Claim ID (New unique claim ID)
TRANSACTION ID CROSS REFERENCE (897)		Original Claim ID (This should always be null for denied claims)
RECORD STATUS CODE (399)	2	
RECORD INDICATOR (398)	0	
Subsequent Adjustment		
TRANSACTION ID (896)	C5	Unique Claim ID
TRANSACTION ID CROSS REFERENCE (897)	C4	Original Claim ID (Applicable for Adjustment claims)
RECORD STATUS CODE (399)	4	
RECORD INDICATOR (398)	0	

Example B – Paid Scenario

MCE Submission to Medicaid	Value	Description
Original Denied Claim		
TRANSACTION ID (896)	C4	Unique Claim ID (New unique claim ID)
TRANSACTION ID CROSS REFERENCE (897)		Original Claim ID (This should always be null for denied claims)
RECORD STATUS CODE (399)	2	
RECORD INDICATOR (398)	0	
Subsequent Original Paid Claim		
TRANSACTION ID (896)	C5	Unique Claim ID
TRANSACTION ID CROSS REFERENCE (897)		Original Claim ID (This should always be null for denied claims)
RECORD STATUS CODE (399)	1	
RECORD INDICATOR (398)	0	

5. Coordination of Benefit where Medicare is the COB Payer

Note: The below is an example of the minimum fields that should be populated where Medicare is a COB payer. It is not inclusive and not intended to be a fully formed NCPDP message. Additional information such as co-pay, deductible, adjustments, etc. should be submitted as applicable.

SECTION DENOTES UTILIZATION HEADER RECORD:		
Field	**Field Name**	
879-N2	SENDING ENTITY IDENTIFIER	*MCE PID/SL*

SECTION DENOTES BENEFIT CATEGORY:		
Field	**Field Name**	
308-C8	OTHER COVERAGE CODE*	*2 – Other coverage exists – payment indicated* *4 – Other coverage exists – no payment indicated*

*When populated with 2 and 4 this is interpreted to indicate COB; hence, the COB section has to be populated with the other payer information, including Medicare.

SECTION DENOTES PRICING CATEGORY:		
Field	**Field Name**	
281	NET AMOUNT DUE	*MCE paid amount*

SECTION DENOTES COORDINATION OF BENEFITS CATEGORY:		
Field	**Field Name**	
225	COB CARRIER SUBMIT AMOUNT	*The amount submitted by the Medicare*
245	ELIGIBILITY COB INDICATOR	*2 – Payer is secondary*
232	COB PRIMARY PAYER ID	*Medicare payer ID*
FILLER		
228	COB PRIMARY PAYER AMOUNT PAID	*Medicare paid amount*
238	COB SECONDARY PAYER ID	*Payer ID of the tertiary payer if applicable*

SECTION DENOTES FIELDS ADDED IN VERSIONS CATEGORY:		
Field	**Field Name**	
A73	MEDICARE DRUG COVERAGE CODE	*00 Does Not Apply (used when other values do not apply)* *01 Processed Under Part D* *02 Processed Under Part B*

Appendix D. NCPDP Acknowledgement JSON Scenarios

This section provides an overview of the NCPDP acknowledgement message along with some error scenarios

NCPDP acknowledgement response general layout

```
{
  "FileName": "string",
  "Version": "string",
  "Transaction": [
          {
            "Identifier": "string",
            "Errors": [
                    {
                      "Error Description": "string",
                      "Error Element": "string",
                      "Error Value": "string",
                      "Error Type": "string",
                      "Record Type": "string",
                      "Initial Position": "string",
                      "Final Position": "string"
                    }
            ],
            "Error_Count": "string"
          }
  ],
"File_Error": {
          "Errors": [
                  {
                    "Error Description": "string",
                    "Record Type": "string",
                    "Error Value": "string",
                    "Identifier": "string"
                  }
           ],
 "Error_Count": "string"
},
              "Total_Error_Count": "string"
}
```

Example of a JSON illustrating no errors in the Header and Trailer

```
{
       "FileName" : "111111111a_ncpdp_10242025001611_sit_pd.txt",
       "Version" : "51",
       "Transaction" : [
              {
                     "Identifier" : "1423001"
              }
],
              "Total_Error_Count" : "0"
}
```

Example of a JSON illustrating a header/trailer length validation error

```
{
"FileName" : "111111111a_ncpdp_10282025000712_sit_pd.txt",
"Version" : "51",
"File_Error" : {
       "Errors" : [
              {
              "Error Description" : "Length should be 4500",
```

```
                "Record Type" : "PA",
                "Error Value" : "4499"
                },
                {
                "Error Description" : "Length should be 4500",
                "Record Type" : "PT",
                "Error Value" : "4499"
                }
        ],
        "Error_Count" : "2"
},
        "Total_Error_Count" : "2"
}
```

Example of a JSON illustrating a header/trailer field validation error

```
{
"FileName" : "111111111a_ncpdp_10242025000711_sit_pd.edi",
"Version" : "51",
"Transaction" : [
        {
        "Identifier" : "1423001",
        "Errors" : [
                {
                "Error Description" : "Incorrect record count, Expected 5",
                "Error Element" : "Record Count",
                "Error Value" : "8",
                "Record Type" : "PT",
                "Initial Position" : "3",
                "Final Position" : "12"
                }
        ],
        "Error_Count" : "1"
}
],
        "Total_Error_Count" : "1"
}
```

Example of a JSON illustrating a length validation error with a DE-CD-CE record

```
{
"FileName" : "111111111a_ncpdp_05092025000205_sit_pd.edi",
"Version" : "51",
"File_Error" : {
        "Errors" : [ {
                "Error Description" : "Invalid Length it should of be length 4500",
                "Record Type" : "DE",
                "Error Value" : "4499",
                "Identifier" : "EMH8MKLM0300"
        } ],
        "Error_Count" : "1"
},
        "Total_Error_Count" : "1"
}
```

Example of a JSON illustrating a DE-CD-CE field validation error

```
{
"FileName" : "111111111a_ncpdp_04092025111214_sit_pd.txt",
"Version" : "51",
"Transaction" : [ {
"Identifier" : "DEMH8MKLM0303",
```

```
        "Errors" : [ {
                        "Error Description" : "Invalid Length",
                        "Error Element" : "claimServiceID",
                        "Error Value" : "",
                        "Record Type" : "DE",
                        "Initial Position" : "1634",
                        "Final Position" : "1673"
                    }, {
                        "Error Description" : "Invalid data it should be decimal",
                        "Error Element" : "ingredientCostPaid",
                        "Error Value" : "00000000500",
                        "Record Type" : "DE",
                        "Initial Position" : "2505",
                        "Final Position" : "2515"
                    } ],
                    "Error_Count" : "2"
                    }, {
                    "Identifier" : "DEMH8MKLM0301",
                    "Errors" : [ {
                        "Error Description" : "Verify FldAddVerInvoiceDate is not null
                        when InvoicedAmt not null",
                        "Error Element" : "FldAddVerInvoiceDate",
                        "Error Value" : "",
                        "Record Type" : "DE",
                        "Initial Position" : "3855",
                        "Final Position" : "3862"
                    } ],
                    "Error_Count" : "1"
                    }, {
                    "Identifier" : "DEMH8MKLM0302",
                    "Errors" : [ {
                        "Error Description" : "Verify NDCServ is valid 11 digit format
                        when NDCServQual is 03",
                        "Error Element" : "NDCServ",
                        "Error Value" : "YGTE67EKIYU",
                        "Record Type" : "DE",
                        "Initial Position" : "1634",
                        "Final Position" : "1673"
                    } ],
    "Error_Count" : "1"
    }, {
    "Identifier" : "DEMH8MKLM0304",
        "Errors" : [ {
                    "Error Description" : "Verify NDCServ is valid 11 digit format when
                    NDCServQual is 03",
                    "Error Element" : "NDCServ",
                    "Error Value" : "111363002518",
                    "Record Type" : "DE",
                    "Initial Position" : "1634",
                    "Final Position" : "1673"
        } ],
    "Error_Count" : "1"
    } ],
    "File_Error" : {
    "Errors" : null,
        "Error_Count" : "0"
    },
        "Total_Error_Count" : "5"
    }
```

Appendix E. Frequently Asked Questions

This appendix contains a link to the FAQ document published on mass.gov.

Appendix F. Change Summary

This version of the MassHealth Companion Guide follows the CAQH CORE V5010 Companion Guide template. All references to the ASCX12 Implementation Guide are necessary to convey MassHealth's specific usage of the data elements to support electronic processing of the transaction with its Trading Partners, including codes and specific program instructions. The following changes were made to this MassHealth Companion Guide.

Date	Page Number	Section	Notes/Comments
April 2024	4	Section 3: Testing with SENDPro	Updated document contents to include additional details.
April 2024	10	Section 6: MassHealth Specific Business Rules and Limitations	Updated document contents to include additional details.
April 2024	17	Section 9: Transaction-Specific Information	Updated Transmission Action (981-JV) to remove support for P = Replacement of previous batch as an acceptable value for this field.
April 2024	17	Section 9: Transaction-Specific Information	Updated Last Name (716-SY) to 'Mandatory'
April 2024	17	Section 9: Transaction-Specific Information	Updated First Name (716-SX) to 'Mandatory'
April 2024	17	Section 9: Transaction-Specific Information	Updated Cardholder Date of Birth (214) to 'Mandatory'
April 2024	17	Section 9: Transaction-Specific Information	Updated Gender Code (721-MD) to 'Mandatory'
November 2024	5 and 6	Section 4: Connectivity with SENDPro/Communications	Updated file naming convention and example.
November 2024	9	Section 6: MassHealth Specific Business Rules and Limitations	Updated submission frequency and file construction guidelines.
November 2024	10	Section 6: MassHealth Specific Business Rules and Limitations	Updated TMSIS providers.
November 2024	9-10	Section 6: MassHealth Specific Business Rules and Limitations	Updated Provider ID guidelines.
November 2024	10-11	Section 6: MassHealth Specific Business Rules and Limitations	Updated guidance on voids and adjustments.
November 2024	12	Section 6: MassHealth Specific Business Rules and Limitations	Updated guidance for denied claims submissions.
November 2024	13	Section 7: Acknowledgements and Reports	Updated with sample layout for Acknowledgement file.
November 2024	20 and 32	Section 9: Transaction-Specific Information	Updated guidance for populating former claim number based on Record Status Code.
November 2024	27	Section 9: Transaction-Specific Information	Updated with details of position for product codes and qualifiers.
November 2024	33	Section 9: Transaction-Specific Information	Updated expected use of Cardholder ID (Alternate).
November 2024	34	Section 9: Transaction-Specific Information	Updated with use of filler fields for provider IDs.

Date	Page Number	Section	Notes/Comments
February 2025	9	Section 6: MassHealth Specific Business Rules and Limitations	Updated guidance for Encounter Sender/Submitter IDs
February 2025	10	Section 6: MassHealth Specific Business Rules and Limitations	Updated Secondary Provider Identifiers Table
February 2025	10-12	Section 6: MassHealth Specific Business Rules and Limitations	Updated guidance for submission of voids and adjustments.
February 2025	19	Section 9: Transaction-Specific Information	Updated validation details for OTHER COVERAGE CODE (308-C8)
February 2025	35	Section 9: Transaction-Specific Information	Updated validation details for SUBMITTER ENTITY PIDSL
February 2025	36	Section 9: Transaction-Specific Information	Updated validation details for RECORD TYPE (601-04)
February 2025	36	Section 9: Transaction-Specific Information	Updated validation details for PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER (455-EM)
February 2025	36	Section 9: Transaction-Specific Information	Updated validation details for PRESCRIPTION/SERVICE REFERENCE NUMBER (402-D2)
February 2025	36	Section 9: Transaction-Specific Information	Updated validation details for COMPOUND INGREDIENT COMPONENT COUNT (477-EC)
February 2025	36	Section 9: Transaction-Specific Information	Updated validation details for COMPOUND INGREDIENT QUANTITY (448-ED)
February 2025	38	Section 9: Transaction-Specific Information	Updated validation details for COMPOUND INGREDIENT COMPONENT COUNT (477-EC)
February 2025	38	Section 9: Transaction-Specific Information	Updated validation details for TOTAL PATIENT AMOUNT (694)
February 2025	App-2	Appendix B: Business Scenarios	Added examples for submission of voids and adjustments
February 2025	App-4–5	Appendix C: Transmission Examples	Added examples for submission of voids and adjustments
August 2025	4-5	Section 3: Testing with SENDPro	Updated to include new Pre-Testing Activities and Trading Partner Test subsections
August 2025	11	Section 6: MassHealth Specific Business Rules and Limitations	Updated to add guidance about bi-weekly submission cadence

Date	Page Number	Section	Notes/Comments
August 2025	13	Section 6: MassHealth Specific Business Rules and Limitations	Updated to remove reference to CARCs which are not applicable for NCPDP
August 2025	19	Section 9: Transaction-Specific Information	Updated to clarify guidance for Field 274, Medicare Plan Code
August 2025	22	Section 9: Transaction-Specific Information	Updated to clarify guidance for Field 466-EZ Prescriber ID Qualifier Alternate
August 2025	29-31	Section 9: Transaction-Specific Information	Added guidance about incorrect start/end positions for Fields 420-DK, 250, 601-18, 601-19, 251, 294, 601-25, 601-26, D17-K8
August 2025	36	Section 9: Transaction-Specific Information	Updated to clarify guidance for Field 224, Client Specific Data
August 2025	48	Appendix D: Frequently Asked Questions	Updated to include link to a newly created external FAQ document
March 2026	4-5	Section 3: Testing with SENDPro	Updated to add guidance for Trading Partner Testing.
March 2026	6	Section 4: Connectivity with SENDPro/Communications	Added guidance from File Size Limitations Memo.
March 2026	7-8	Section 4: Connectivity with SENDPro/Communications	Added guidance on suffix and outbound file specifications.
March 2026	14	Section 6: MassHealth Specific Business Rules and Limitations	Updated to add guidance on Field 411-DB, PRESCRIBER ID validation relaxation for denied claims.
March 2026	14	Section 7: Acknowledgements and Reports	Updated to add guidance on code set history details.
March 2026	20-21	Section 6: MassHealth Specific Business Rules and Limitations	Updated to add NCPDP Mapping Guidance in alignment with NCPDP Amounts and Quantity Clarification Memo.
March 2026	20	Section 7:MassHealth-Specific Business Rules and Limitations	Added guidance on Error Threshold Specifications.
March 2026	24	Section 7: Acknowledgements and Reports	Updated add guidance from NCPDP Implementation Guide Field Positioning Alert Memo.
March 2026	26-27	Section 9: Transaction-Specific Information	Updated to add guidance on Fields 201-B1-Alt, SERVICE PROVIDER ID (ALTERNATE), position 4440 SERVICE PROVIDER LOCATION ID, 411-DB PRESCRIBER ID (ALTERNATE),

Date	Page Number	Section	Notes/Comments
			position 4410 PRESCRIBER LOCATION ID.
March 2026	28,32	Section 9: Transaction-Specific Information	Updated to add guidance on Fields 436-E1 PRODUCT/SERVICE ID QUALIFIER, 407-D7 PRODUCT/SERVICE ID.
March 2026	32	Section 9: Transaction-Specific Information	Updated guidance for valid values of 406-D6 COMPOUND CODE.
March 2026	29	Section 9: Transaction-Specific Information	Updated to add guidance on FILED 203, ADJUDICATION TIME.
March 2026	37	Section 9: Transaction-Specific Information	Updated to add guidance on FIELD 600-28 UNIT OF MEASURE.
March 2026	39	Section 9: Transaction-Specific Information	Updated to add guidance on Field 511-FB, REJECT CODE.
March 2026	40	Section 9: Transaction-Specific Information	Updated add guidance from NCPDP Implementation Guide Field Positioning Alert Memo.
March 2026	40	Section 9: Transaction-Specific Information	Updated to add guidance on Field 223, CLIENT PRICING BASIS OF COST.
March 2026	40	Section 9: Transaction-Specific Information	Updated guidance on Field 426-DQ USUAL AND CUSTOMARY CHARGE.
March 2026	40,50	Section 9: Transaction-Specific Information	Updated to add guidance on Field 260, GENERIC INDICATOR.
March 2026	47	Section 9: Transaction-Specific Information	Updated PIDSL guidance.
March 2026	App-3	Appendix C: Transmission Examples	Added additional table of examples
March 2026	App-5	Appendix C: Transmission Examples	Updated to reflect language in Medicare+Medicaid Split Expectations Memo and NCPDP Amounts and Quantity Mapping Memo.
March 2026	App-6-10	Appendix D: NCPDP Acknowledgement JSON Scenarios	Added general layout and examples for ACK JSON Acknowledgement.

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