MassHealth

Standard Companion Guide

National Council of Prescription Drug Programs (NCPDP) Post-Adjudication V5.1

Refers to the Implementation Guide Based on NCPDP Post Adjudication Standard Version 5.1

April 2024

MassHealth

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 weekly basis through its SENDPro solution. 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 usages 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.

Contents

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 health care 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; and
- 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, health care 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 health care 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 health care transaction.

2. Getting Started

WORKING WITH MASSHEALTH

Managed Care Entity (MCE) Trading Partners can exchange electronic health care 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.

Please note: Additional information will be incorporated in future versions of the Companion Guide.

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. The size of each test file should be between 25 and 50 transactions.

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 277DRA reports for errors, make the appropriate corrections, and resubmit updated test files.

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 validation is complete, the Trading Partner may submit transactions to MassHealth's SENDPro for processing.

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

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 Monday 8 a.m. to Friday 6 p.m. ET. Files submitted after 6 a.m. EST Friday will undergo processing once SENDPro completes its maintenance window.

Transmission File Size

Transmission sizes are defined based on two factors:

- Number of Segments/Records allowed by HIPAA Standards
- File size limitations (File size limitations will be updated in the next iteration of the CG)

Please note that SENDPro does not unzip or decompress files. Transmit all files in an unzipped or uncompressed format.

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 1 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 the HIPAA standards.

Production File-naming Convention

For Inbound transactions, use the below naming convention:

submitterid_transactionid_transtype_datetime_env

For example, a production 837 D file submitted on January 4, 2024, at 2:30 p.m. ET, by a TP with a three-digit PID of “xyz” might be named:

xyz_pacdrd_010420241430_prod

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. In the case of this process, the naming convention is as follows:

submitterid_transactionid_transtype_datetime_env_xxx

The three-character alpha suffix *xxx* defines the exception when needed.

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 this method 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)
- SENDPro Web Portal (MFTP - MOVEit File Transfer protocol)

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 Support Services

Days Available: Monday through Friday

Time Available: TBD

Email: TBD

Phone: TBD

Fax: TBD

Please note: Further details will be included in future versions 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 health care 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. For example:

- Reporting specific scenarios, such as coordination of benefits (COB), amounts paid, durable medical equipment (DME), ambulance, home health services; and
- Communicating MassHealth-specific edits.

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

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

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.

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 table below:

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
201-B1-alt	SERVICE PROVIDER ID (ALTERNATE)	Alternate ID assigned to a pharmacy	Pharmacy Internal Provider Number<space>PID/SL
466-EZ	PRESCRIBER ID QUALIFIER (ALTERNATE)	Code qualifying the alternate Prescriber ID (411-DB-alt)	Prescriber Alternate ID Qualifier
411-DB-alt	PRESCRIBER ID (ALTERNATE)	Alternate ID assigned to a prescriber	Pharmacy Internal Provider Number<space>PID/SL

201-B1 Service Provider ID (alternate) field, should contain the MMIS ID linked to the NPI (National Provider Identifier) of the Servicing provider. 202-B2, the corresponding ID qualifier field should have a value of 05, indicating a Medicaid ID.

If the Massachusetts Medicaid ID is not available, please populate the field with the ID assigned by the plan, with a qualifier 14 to denote it as a unique number assigned by the plan.

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 a number of critical data elements that must be included in every relevant encounter when applicable. It's imperative that MCEs 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)	
Detail and Total Allowed Amounts	
Detail and Total Medicaid Paid Amounts	
Detail and Total Billed Amounts	
Medicare Paid, Deductible, Copay, and Coinsurance Amounts	
Present and Valid NPI values	

ORIGINAL, VOID, AND REPLACEMENT TRANSACTIONS

MassHealth strongly recommends that MCEs follow the approach below to report adjustments, overpayments, and recoveries.

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

- 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:

- 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 following:

- The adjustments/voids are linked to the original claim.

TRANSMISSION CORRECTION

Transmission Action (981-JV) and Record Indicator (398) are used to manage transmission correction of pharmacy claims.

File Level Correction

Transmission Action (981-JV): At the file level, specifies the action to be applied to all records contained within the file. Values to be used:

"O" for Original Submission
"C" for Correction/Adjustment to a previous batch

Claim Level Correction

Record Indicator (398): Indicates transmission status at the record level. Values to be used:

0 – New Record
1 – Overwrite existing record
2 – Delete existing record

COORDINATION OF BENEFITS

COB Claims

MCE trading partners should report all instances of COB scenarios received by providers in their encounter submissions. Information such as the other payer's adjudication amounts and details, subscriber/patient details, line item details, and adjustment reason codes (using standard claim adjustment reason codes – CARCs) must be reported in the appropriate data elements. 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.

7. Acknowledgements and Reports

MassHealth has adopted two acknowledgement transactions with the NCPDP Post Adjudication Standard: a proprietary acknowledgement layout 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

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.

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 not be a Future Date and cannot be prior to Start Date. Should be a valid calendar date and cannot be a future 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), then 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	SM	Subscriber Name First	
718-SZ	MIDDLE INITIAL	S	Subscriber Name ~~Last~~ 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	SM	Subscriber Date of Birth	
721-MD	GENDER CODE	SM	Blank- Unknown 1 Male 2 Female	

274	MEDICARE PLAN CODE	S		Submit if used.
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	S		Submit if used.

	CLAIM PROGRAM CODE			
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 ALTERNATIVE FILE ID	S		Submit if used.
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=429Other coverage exists; payment not collected	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	5	Alternate Pharmacy ID Qualifier
201-B1-alt	SERVICE PROVIDER ID (ALTERNATE)	M		Concatenation of Internal Provider ID <space) PID/SL
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.
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)	S	5	Alternate Prescriber ID Qualifier
411-DB - alt	PRESCRIBER ID (ALTERNATE)	S		Concatenation of Internal Provider ID <space) PID/SL
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 previous transaction was changed.	MassHealth only accepts the values 1,2,3, and 4. Other values will be rejected.
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 03 - NDC Code	MassHealth expects a value of 03 for NDC and 00 when there are compound ingredients.
407-D7	PRODUCT/SERVICE ID	M		Must provide the NDC Code 03 when available .
401-D1	DATE OF SERVICE	M		Must provide the service date.
578	ADJUDICATION DATE	M		Must provide the adjudication date.
203	ADJUDICATION TIME	S		Must provide the adjudication time.
283	ORIGINAL CLAIM RECEIVED DATE	S		Submit if used.
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	1=Pharmacy 2=Unassigned 3=School 4=Homeless Shelter 5=Indian Health Service Free-standing Facility 6=Indian Health Service Provider-based Facility 7=Tribal 638 Free-standing Facility 8=Tribal 638 Provider-based Facility 9=Prison/Correctional Facility 10=Unassigned 11=Office 12=Home 13=Assisted Living Facility 14=Group Home 15=Mobile Unit 16=Temporary Lodging 17=Walk-in Retail Health Clinic 18=Place of Employment-worksite- 19=Off Campus-Outpatient Hospital 20=Urgent Care Facility 21=Inpatient Hospital 22=On Campus-Outpatient Hospital 23=Emergency Room – Hospital 24=Ambulatory Surgical Center 25=Birthing Center	Submit if used.

			26=Military Treatment Facility 27-30=Unassigned 31=Skilled Nursing Facility 32=Nursing Facility 33=Custodial Care Facility 34=Hospice 35-40=Unassigned 41=Ambulance – Land 42=Ambulance – Air or Water 43-48=Unassigned 49=Independent Clinic 50=Federally Qualified Health Center 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 CODE	S		Submit if used.
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	M	CCYYMMDD	Must provide the Service Date.
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	M		Must provide Unit of Measure.
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.
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		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 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	Submit if used.
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	S	02	Submit ICD10 Code if

	QUALIFIER			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.
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 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
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 INDICATOR	S		Submit if used.
420-DK	SUBMISSION CLARIFICATION CODE	S	***Note: A submission Clarification code of 20 is required for all 340B claims.***	Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S		Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S		Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S		Must be provided if there was an out-of-process submission.
420-DK	SUBMISSION CLARIFICATION CODE	S		Must be provided if there was an out-of-process submission.
250	FDA DRUG EFFICACY CODE	S		Submit if used.

601-19	PRODUCT CODE QUALIFIER	S		Submit if used.
601-18	PRODUCT CODE	S		Submit if used.
601-19	PRODUCT CODE QUALIFIER	S		Submit if used.
601-18	PRODUCT CODE	S		Submit if used.
601-19	PRODUCT CODE QUALIFIER	S		Submit if used.
601-18	PRODUCT CODE	S		Submit if used.
251	FEDERAL UPPER LIMIT INDICATOR	S		Submit if used.
294	PRESCRIBED DAYS SUPPLY	M		Must Provide the Prescribed Days' Supply.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	S		Submit if used.
601-25	THERAPEUTIC CLASS CODE	S		Submit if used.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	S		Submit if used.
601-25	THERAPEUTIC CLASS CODE	S		Submit if used.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	S		Submit if used.
601-25	THERAPEUTIC CLASS CODE	S		Submit if used.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	S		Submit if used.
601-25	THERAPEUTIC CLASS CODE	S		Submit if used.
D17-K8	SUBMISSION TYPE CODE	S		Submit if used.
D17-K8	SUBMISSION TYPE CODE	S		Submit if used.
D17-K8	SUBMISSION TYPE CODE	S		Submit if used.
D17-K8	SUBMISSION TYPE CODE	S		Submit if used.
D17-K8	SUBMISSION TYPE CODE	S		Submit if used.
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	S		Submit if used.

	PROCESSOR FEE			
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 INDICATOR	S		Submit if used.
223	CLIENT PRICING BASIS OF COST	M		Must provide the Client Pricing Basis of Cost.
260	GENERIC INDICATOR	S		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		Submit if used.
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 AMOUNT	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.
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 DISPENSING INDICATOR	S		Submit if used.
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 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 QUALIFIER	S		Submit if used.
C93-KN	PATIENT PAY COMPONENT AMOUNT	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 CROSS REFERENCE	M		Original Claim ID. Must always be provided.
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.
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.
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)	M		Populate Plan ID.
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.
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.
FII	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 and this field is not equal to "CD"
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M		Must be populated if COMPOUND CODE (406-D6) = 2 and 455-EM is not provided (Null / Blank / Space Filled)
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M		Must be populated if COMPOUND CODE (406-D6) = 2 and 455-EM is not provided (Null / Blank / Space Filled)
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M		Must be populated if COMPOUND CODE (406-D6) = 2 and this field is not provided (Is Zero Filled). Cannot be greater than 8. Must always match the number of compound ingredients reported [COMPOUND INGREDIENT COMPONENT COUNT (447-EC) != Count of COMPOUND PRODUCT ID (489-TE)]
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	S		Submit if available.
449-EE	COMPOUND INGREDIENT DRUG COST	S		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.
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	S		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		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 1st Ingredient**	

	SECTION DENOTES THIRD INGREDIENT	S	Same detail as 1st Ingredient	
	SECTION DENOTES FOURTH INGREDIENT	S	Same detail as 1st Ingredient	
	SECTION DENOTES FIFTH INGREDIENT	S	Same detail as 1st Ingredient	
	SECTION DENOTES SIXTH INGREDIENT	S	Same detail as 1st Ingredient	
	SECTION DENOTES SEVENTH INGREDIENT	S	Same detail as 1st Ingredient	
	SECTION DENOTES EIGHTH INGREDIENT	S	Same detail as 1st 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. Value cannot be greater than 7. Must always match the number of compound ingredients reported [COMPOUND INGREDIENT COMPONENT COUNT (447-EC) != Count of COMPOUND PRODUCT ID (489-TE)]
	SECTION DENOTES NINTH INGREDIENT	S	Same detail as 1st Ingredient	
	SECTION DENOTES TENTH INGREDIENT	S	Same detail as 1st Ingredient	
	SECTION DENOTES ELEVENTH INGREDIENT	S	Same detail as 1st Ingredient	
	SECTION DENOTES TWELFTH INGREDIENT	S	Same detail as 1st Ingredient	
	SECTION DENOTES THIRTEENTH	S	Same detail as 1st Ingredient	

	INGREDIENT			
	SECTION DENOTES FOURTEENTH INGREDIENT	**S**	**Same detail as 1st Ingredient**	
	SECTION DENOTES FIFTEENTH INGREDIENT	**S**	**Same detail as 1st 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 (C93-KN) in the file
	FILLER	M		Spaces

APPENDICES

Appendix A. Implementation Checklist

This appendix contains all necessary steps for implementing the transactions with MassHealth.

- Develop your system to comply with Post Adjudication Standard Version 53 Technical Reports 3/Implementation Guides.
- Review MassHealth SENDPro Companion Guides to identify and implement necessary changes to your system.
- Complete the SENDPro Connectivity Form.
- Test connectivity.
- Participate in all trading partner testing activities.
- Utilize various real case business scenarios during testing.

Appendix B. Business Scenarios

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

Please note: This information will be included in future versions of the Companion Guide.

Appendix C. Transmission Examples

NCPDP Acknowledgement Response:


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

Appendix D. Frequently Asked Questions

This appendix contains a compilation of questions and answers related to MassHealth and its providers. Typical questions would involve a discussion about code sets and their effective dates.

Please note: This information will be included in future versions of the Companion Guide.

Appendix E. 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.

Field ID	Name	Codes	Notes/Comments
n/a	Section 3: Testing with SENDPro		Updated document contents to include additional details.
n/a	Section 6: MassHealth Specific Business Rules and Limitations		Updated document contents to include additional details.
981-JV	Transmission Action	O, C	Removed support for P = Replacement of previous batch as an acceptable value for this field.
716-SY	Last Name		Updated to 'Mandatory'
717-SX	First Name		Updated to 'Mandatory'
214	Cardholder Date of Birth		Updated to 'Mandatory'
721-MD	Gender Code		Updated to 'Mandatory'
n/a	Appendix C: Transmission Examples		Updated document contents to include additional details.