STATE OF NEW YORK
DEPARTMENT OF HEALTH

CSC

eMedNY
Prospective Drug Utilization Review/
Electronic Claim Capture and Adjudication
ProDUR/ECCA Standards

July 21, 2004
Version 1.13

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1.0 <u>INTRODUCTION</u> (Rev. 09/03)

The New York State Department of Health (NYSDOH) is pleased to introduce a method for the pharmacy community to submit Electronic Medicaid Eligibility Verification System (MEVS) transactions in an on-line, real-time environment. This method includes the mandatory Prospective Drug Utilization Review (Pro-DUR) program in compliance with OBRA'90 requirements. ProDUR will alert pharmacists to possible medical problems associated with the dispensing of the drug to the recipient. In addition, the new system will allow pharmacies the option of having the claim captured for adjudication by the NYSDOH Fiscal Agent. The Electronic Claims Capture and Adjudication (ECCA), ProDUR and MEVS submission are all accomplished via the same transaction, with the system providing an immediate response for each program.

The telecommunication standards chosen for the system are the same as those recommended by the National Council for Prescription Drug Program, Inc., (NCPDP) and named under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Only the NCPDP Version 5.1 variable format and the Batch 1.1 format will be supported.

This document was developed to assist pharmacy providers and their system vendors in supporting the telecommunication standards. Format specifications were developed using the September 1999 Official Release of the NCPDP Telecommunication Standard Version 5 Release 1 standard as well as the September 1999 Data Dictionary Official Release provided to support this standard. If you do not have this information, it is available from:

<div align="center">

National Council for Prescription Drug Programs Inc.
9240 East Raintree Drive
Scottsdale, AZ 85260
Phone: (480) 477-1000
Fax: (480) 767-1042

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This document is divided into sections. The first section contains general background information provided to facilitate the programming necessary to support the telecommunication standard. Subsequent sections contain the NCPDP layouts, NCPDP Reject codes and MEVS codes.

2.0 <u>**GENERAL INFORMATION**</u> (Rev. 09/03)

2.1 <u>**Access Methods**</u> (Rev. 11/02)

The MEVS/ProDUR/ECCA system requires the use of the NCPDP transaction formats. The NCPDP formats will only be accepted via a PC-HOST Link (dial-up on the New York MEVS Network) or CPU-CPU link (direct connect to the eMedNY contractor). A provider may also choose to develop a connection through a telecommunication switch or a billing service. Providers using a switching company or billing service will be classified as a CPU-CPU provider, since the switching company or billing service will be connected to the eMedNY contractor as a CPU-CPU connection.

Once a provider has selected an access method, a certification process by the eMedNY contractor must occur. For more information on these access methods or certification process, please contact the Provider Services department at 1-800-343-9000.

Note: Submission via PC-Host or CPU-CPU allows up to four (4) claims per transaction. Submission via a switching company or billing service is limited to what the company allows, up to a maximum of four (4) claims per transaction.

2.2 <u>Communication Protocol</u> (Rev. 11/02)

Pharmacy providers will receive details concerning the correct communication protocol to use after notifying the eMedNY contractor of the access method the provider is selecting. Details will then be provided under a separate document.

2.3 <u>**Card Swipe**</u> (Rev. 09/03)

The card swipe function will still be available on the OMNI 3750 terminal for pharmacy providers who are designated by NYSDOH Quality Assurance and Audit Office as card swipe providers. Designated pharmacies must swipe the recipient's card on the OMNI 3750 POS VeriFone Terminal using transaction type 5, prior to entering the on-line DUR transaction. No **data** should be entered on the POS terminal. The eMedNY contractor will match the transactions to ensure that a swipe was performed. Only transaction type 5 will register the DUR transaction as a swipe. The card swipe only has to be performed once for each recipient per date of service, regardless of the number of prescriptions being filled that day for that recipient.

2.4 <u>Dispensing Validation System</u> (Rev. 09/03)

This function enables suppliers of prescription footwear items, specified drugs, certain medical surgical supplies and durable medical equipment to receive a prior approval number (DVS number) through an automated electronic MEVS system. The DVS transaction can be submitted through the NCPDP variable 5.1 format. The DUR program has been modified to recognize an item or NDC code requiring a DVS number and will process the transaction through all required editing. If approved, and if the item or NDC code is reimbursable under category of service 0441, the DVS number will be returned in response field 526-FQ and the claim will be processed for adjudication (if ECCA is requested). If ECCA is not requested, be sure to record the DVS number for submission on your paper or magnetic media claim. Item codes reimbursable under category of service 0442 cannot be submitted through NCPDP Version 5.1.

2.5 <u>Transaction Format</u> (Rev. 09/03)

The transaction formats in this document are divided into two parts, Request and Response. Each part is displayed in table format. The tables consist of columns. The columns include the NCPDP assigned "Field Number," "Field Identifier," "Field Name," "Format," "Length" and "Position" and contain strictly NCPDP information. Additional information about these columns can be found in the NCPDP manual. The final two columns include the "Req" (required) and "Value/Comments" columns and are described in the following paragraphs.

For the data in the "Value/Comments" column, a definition of the Values shown in the formats can either be found in the NCPDP Data Dictionary or listed as a comment.

Note: In the POSITION Column, the word "variable" indicates the position of the field in the format can vary depending on the presence or absence of any preceding field.

The "Req" (required) column indicates if the field is required to successfully execute a transaction. The values found in the column include:

R = Completion (or inclusion) of this field is required to successfully complete the transaction. The requirement may be due to the NCPDP format or a MEVS Program (Utilization Threshold, Post & Clear, Electronic Claims Capture and Adjudication, etc.). The entered data in some of the required fields will not be used in the execution of the transactions. These fields are so indicated in the comments column.

O = This field is optional. It is not needed to successfully complete all transactions, but is needed for most transactions.

<u>Request Format</u> (Rev. 09/03)

The NCPDP input format allowed for MEVS/ProDUR/ECCA transactions will consist of the variable "5.1".

The variable "5.1" format is made up of segments. The segments include the Transaction Header Segment, Patient Segment, Insurance Segment, Claim Segment, Prescriber Segment, COB/Other Payments Segment, DUR/PPS Segment, Pricing Segment, and Prior Authorization Segment. For multiple claims, all segments repeat for each claim up to a maximum of four claims except for the Transaction Header Segment, Patient Segment and Insurance Segment. EMedNY will not process the following segments if they are transmitted: Pharmacy Provider Segment, Workers' Compensation Segment, Coupon Segment, Compound Segment, and the Clinical Segment. These segments will be ignored if sent.

<u>Response Formats</u> (Rev. 09/03)

Responses will be returned via the same method of input, immediately following the completion of the processing of the transaction. The variable "5.1" format will contain response status codes in the Response Header Segment and for each prescription in the Response Status Segment.

If the header status code indicates the header is acceptable (A), then no errors were detected in the header data. If the header status code indicates the header is unacceptable (R), all prescriptions (claims) submitted are also in error and the response status code for the prescription will be "R". Reject codes applicable to the header will be present in the first claim reject code list in addition to any reject codes specific to the first claim.

If the header data is acceptable (A) and the prescription (claim) data has passed all edits and is accepted, a "C" will be returned in the prescription (claim) response status code. A "C" will also be returned for acceptable claims for which the Electronic Claims Capture and Adjudication option was selected. Each prescription segment submitted will receive an individual response status code. A single transaction with four (4) claim submissions could have a mixture of prescription (claim) response status codes. The first claim could be "R", the second claim "C", etc.

For each transaction, error codes will be returned, if applicable. NCPDP reject codes will be returned in Field 511-FB. MEVS Accepted and Denial Codes listed in Table 1 (page 8.0.1) and Table 2 (page 8.0.2), Rx Denial codes listed in Table 7 (page 8.0.5), UT/PC Codes listed in Table 8 (page 8.0.6), DVS codes listed in Table 9 (page 8.0.7), and the Pend Reason Codes listed in Table 10 (page 8.0.8) will be returned in Field 526-FQ, the additional message field. An NCPDP reject code will always be returned in Field 511-FB and may have a corresponding MEVS code placed in Field 526-FQ to clarify the error. Both Fields should always be reviewed. The valid MEVS and NCPDP codes can be found in Sections 8.0 (page 8.0.1) and 9.0 (page 9.0.1) of this document.

For ProDUR editing, denials will be returned via the rejected response format and can be found in the Response DUR/PPS Segment. DUR warnings will be returned via the approved claim response "C" format. Each submitted claim could have three (3) possible DUR responses. If a claim has three (3) denial responses and also has warnings, only the denials will be returned.

2.6 <u>Electronic Claims Capture and Adjudication</u> (Rev. 09/03)

The Electronic Claims Capture and Adjudication feature is optional. If a pharmacy chooses to have their original or rebill NCPDP claim transaction captured for online adjudication, the Processor Control Number, Field 104-A4, must be completed. Captured claims will be fully edited for completeness and validity of the format of the entered data. There is a possibility that claims captured by the eMedNY contractor for final adjudication may be pended and eventually denied. All claim processing edits are performed during the DUR process. An advantage of ECCA is that it saves the pharmacy from having to file the claims separately.

Proper completion of the Processor Control Number Field requires the provider to certify and attest to the statement made in the Certification Statement. An original signed and notarized Certification Statement must be on file with the eMedNY contractor and renewed annually. The pharmacy must also enter a Personal Identification Number (PIN) and Electronic Transmitter Identification Number (ETIN) in Field 104-A4. The Certification Statement and PIN Selection Form can be found in Section 7.0 (page 7.0.1) of this manual. To obtain an Electronic Transmission Identification Number (ETIN), call (518) 447-9256. Remittances for claims submitted via ECCA will be returned to the pharmacy via the media the pharmacy selects for that ETIN unless the claims are submitted under a vendor's ETIN, in which case paper remittances will be issued. Further details on Field 104-A4 can be found in the Unique Treatment of Fields Section.

If a Pharmacy chooses ECCA and the claim is approved, an invoice number will be returned in the Response Status segment in the Authorization Number, Field 503-F3. The invoice number can be used for tracking the claim with the eMedNY contractor and will appear on the remittance statement. Only **one** invoice number will be issued per transaction, which could include up to four claims.

Note: If the Processor Control Number Field is not completed, the claim will not be captured for payment but will be processed through all the claim edits. If the claim is approved, the response "NO CLAIM TO FA" will be returned in Field 503-F3.

In any case, the following types of claims **<u>can not</u>** be submitted via ECCA:

1.   An Rx billing claim (Transaction Code (B1)) with a date of service more than ninety (90) days old.

2.   Adjustments/Rebills with a fill date over two years old.

3.   Voids/Reversals with a fill date over two years old.

4.   Durable Medical Equipment (DME) claims. DME includes any claim identified by specialty code 307 or Category of Service 0442.
Note: DME does not include the product supply codes (1 alpha 4 numeric) found in the MMIS Pharmacy Provider Manual in sections 4.2 and 4.3.

5.   A Dispensing Validation System (DVS) transaction for an item that is only reimbursable under Category of Service 0442 (DME). Items reimbursable under Category of Service 0441 (RX) will be processed for ECCA.

2.7 <u>Transaction Overrides</u> (Rev. 09/03)

For a transaction rejected after the first submission, the provider may wish to resubmit the transaction with an override. There are four possible overrides. The first is a UT override, the second is a DUR override, the third is an excess income/spenddown override, and the fourth is a Nursing Home Override.

To submit a UT override, the provider must resubmit the original transaction with an entry in the Submission Clarification Code (420-DK) field. Details concerning the field can be found on page 2.10.7.

For submission of a DUR override, the provider must resubmit the original transaction with the DUR/PPS Segment completed. An entry must be made in Reason for Service Code (439-E4) field and Result of Service Code (441-E6) field. Details concerning these fields can be found on page 2.10.8.

For submission of an excess income/spenddown override, the provider must resubmit the original transaction with an entry in the Eligibility Clarification Code (309-C9) field on the Insurance Segment and the Patient Paid Amount (433-DX) field on the Pricing Segment. Details concerning these fields can be found on page 2.10.6.

For submission of a Nursing Home Override the provider must resubmit the original transaction with an entry in the Eligibility Clarification Code (309-C9) field on the Insurance Segment. The claim will be in a pend status, giving the local district time to update the Client's file. If the file update is not received in a timely manner, the claim will deny.

2.8 <u>MEVS Program Information</u> (Rev. 11/02)

The following bullets highlight items a provider should be aware of when submitting DUR transactions:

- Service Authorizations (MEVS transaction type 1) are only allowed via PC or CPU access method using the NCPDP format.

- Each claim (prescription) submitted equates to **one** MEVS service unit.

- If a claim (prescription) is denied for UT and/or Post & Clear, the claim will not be processed through DUR.

2.9 <u>NCPDP/MEVS Transaction Types</u> (Rev. 02/04)

NCPDP Field 103-A3, Transaction Code will be used to identify the type of MEVS/ProDUR transaction being submitted.

Eligibility Transactions

- Use NCPDP Field 103-A3 value E1 to submit.

- The variable eligibility format layout can be found in a subsequent section of this document.

- Pharmacy DME (specialty code 307) can NOT be submitted using an eligibility transaction.

Service Authorizations – Prescription Billing Transactions

- Use NCPDP Field 103-A3 value B1.

- Prescriptions require a service authorization.

- All Compounds require a service authorization.

- All Product Supply Codes require a service authorization. A Product Supply Code is a code that could normally be submitted on the pharmacy claim form and not the DME claim form C. These codes are in the MMIS Pharmacy Provider Manual in sections 4.2 and 4.3.

- ECCA is allowed for Compounds.

- Pharmacy DME transactions require a service authorization. A pharmacy DME supply is identified by specialty code 307 or category of service 0442. These types of transactions must be submitted using the 837 Professional ASC X12N.

- ECCA is **not** allowed for pharmacy DME, but is billed on the DME Claim Form C.

Dispensing Validation System Transactions

- Use NCPDP Field 103-A3, value B1. Although multiple line transactions (Transaction Count 2 – 4; Field 109-A9) can be submitted, only one DVS line item can be submitted per transaction and the DVS line must be the first line item within the transaction.

- Only items reimbursable under Category of Service 0288, 0161, and 0441 (RX) will be processed through ECCA. Items which are only reimbursable under Category of Service 0442 (DME) must be billed on DME Claim Form C or 837 Professional ASC X12N. Be sure to put the DVS number on the claim form. For ECCA claims, the DVS number will remain with the claim for adjudication purposes. Pharmacies should record the DVS number that is returned in the response.

Note: There may be some non-drug items where you are specifically instructed by New York State to use the 11 digit National Drug Code. If this occurs, use field 407-D7 (Product/Service ID) to enter the NDC and field 436-E1 to enter the Qualifier of 03. Field 406-D6 value should then be 1. The New York State Department of Health has also designated certain prescription drugs as requiring a DVS number. Field 407-D7 is used to enter these drugs.

- No UT, Post and Clear or DUR processing will occur for DVS item/HCPCS transactions. Prescription Drugs requiring a DVS number will be processed through the UT, Post and Clear and DUR programs.

- Only Current Dates of Service will be accepted for DVS Transactions.

Reversal/Cancel Transactions

- Use NCPDP Field 103-A3 value B2.

- Reversals can be submitted for service dates up to two years old if the original transaction was submitted directly to the eMedNY contractor. This includes paper and magnetic media, as well as online claim submissions.

- If the reversal is negating a paid claim, the reversal will appear on your remittance statement.

- If the reversal is negating a paid claim, you must complete the Processor Control Number field.

- If the reversal is negating a non-ECCA transaction, the reversal will not appear on your remittance statement.

Rebill/Adjustment Transactions

- Use NCPDP Field 103-A3 value B3. Data field requirements are otherwise identical to Prescription Billing requirements (B1).

- Rebill transactions can be submitted for service dates up to two years old if the original transaction was submitted directly to the eMedNY contractor. This includes paper and magnetic media, as well as online claim submissions.

- If the rebill is adjusting a paid claim, the rebill will appear on your remittance statement.

- If the rebill is adjusting a paid claim, you must complete the Processor Control Number field.

- You cannot adjust a non-ECCA claim to become an ECCA claim. The adjustment will apply any updated information, but the adjustment claim will remain a non-ECCA claim.

- If the rebill is adjusting a non-ECCA transaction, the rebill will not appear on your remittance statement.

- Rebills will not affect previously established service authorization limits.

- Rebills will not be allowed for original claims that generated a DVS prior approval. If a change is needed to a paid DVS claim, then you can submit the adjustment on paper or magnetic media. You may also reverse the original claim and then submit another original transaction with the corrected information.

Duplicate Claim Transactions

When an online claim transaction is sent to the MEVS, it will be matched against previously captured (approved) claims. If the transaction is determined to be an exact duplicate of a previously approved claim, the MEVS will return a "C" in the **Transaction Response Status** (112-AN) field. The remaining response fields will contain the data that was returned in the original response. The following fields will be examined to determine if the original captured response will be issued:

- Service Provider Number (201-B1 positions 21-28 on Transaction Header Segment)
- Cardholder ID Number (302-C2 on Insurance Segment)
- Date of Service (401-D1 positions 39-46 on Transaction Header Segment)
- Prescription/Service Reference # (402-D2 on Claim Segment)
- Fill Number (403-D3 on Claim Segment)
- Prior Auth Number Submitted (462-EV on Claim Segment)
- Product/Service ID (4Ø7-D7 on Claim Segment)

If identical data exists only in certain subsets of the above fields, your claim will be rejected for NCPDP Reject Code 83 "Duplicate Paid/Captured Claim" unless prior approval was obtained for one of the two conflicting transactions (meaning Prior Auth Number Submitted (462-EV) would need to contain a PA Number on one claim, and no PA Number for the other claim.)

For example, a NCPDP Reject Code of 83 "Duplicate Paid/Captured Claim" is returned when a claim is submitted and the Service Provider Number, Cardholder ID, and Prior Approval Number fields match a previous paid claim and one of the following conditions also exists:
- Prescription Service Reference Number matches, but NDC/HCPCS is different.
- NDC/HCPCS matches, but Prescription Service Reference Number is different.
- Prescription Service Reference Number and Fill Number are the same, but the Date of Service is different.

If the original transaction was non-ECCA and the duplicate transaction is ECCA, the transaction response will be the original non-ECCA response. No adjudication process will occur.

2.10 <u>Unique Treatment of Fields</u> (Rev. 02/04)

General Edits
The following edits apply to all transactions:

1. The Date of Service (Date Filled) **cannot** be in the future.

2. The Date of Service (Date Filled) **cannot** be more than two years old. For an original ECCA transaction, if the date filled is over 90 days old, the transaction will be processed but will not be captured for adjudication. If all other editing is passed, "NO CLAIM TO FA" will be returned in the response. This 90-day rule does not apply to rebills or reversals.

3. The Date of Service **cannot** be prior to the Date Prescription Written or more than 60 calendar days from the Date Prescription Written.

4. DUR editing will **not** be performed for NDCs with a Date of Service more than 90 days old.

5. The Fill Number and the Number of Refills Authorized **may not** exceed five.

6. The Fill Number **cannot** be greater than the Number of Refills Authorized.

Processor Control Number – (Transaction Header Segment) Field 104-A4
This is a ten (10) position field located in positions 11-20 on the Transaction Header segment. If a Pharmacy selects the Electronic Claims Capture and Adjudication option, this field must be completed and will be part of the claim record. It is required by New York State that the Certification Statement (Section 7.0 on page 7.0.4), must be read prior to entering data in this field. The field entry consists of:

Position 1   Y or N. Y means the provider has read and attests to the facts in the Certification statement (Section 7.0 on page 7.0.4) for this claim. N means the provider has not read and is not attesting to the statement.

Positions 2-3   The pharmacist must enter their first and last initials.

Positions 4-7   The Pharmacy's PIN must be entered here.

Positions 8-10   The Pharmacy's ETIN must be entered here.

If you normally receive remittance statements on tape, you must complete the Processor Control Number field in order for a reversal or rebill to appear on your tape remittance. If the Processor Control Number field is not sent, the reversal or rebill will appear on a paper remittance. Reversals and rebills will only appear on a remittance statement if the original transaction resulted in a paid claim. A reversal or rebill of a non-ECCA transaction will not appear on a remittance statement.

Service Provider ID Qualifier – (Transaction Header Segment) Field 202-B2

This is a two (2) position field located in positions 22-23 on the Transaction Header segment. This should always contain the value 05 to indicate Medicaid.

Service Provider ID – (Transaction Header Segment) Field 201-B1

This is a fifteen (15) position field located in positions 21-28 on the Transaction Header segments. The first eight positions of this field will always contain the eight digit MMIS assigned Provider Identification Number. The remaining seven positions will contain spaces.

Cardholder ID Number – (Insurance Segment) Field 302-C2

This is a twenty (20) position field. The only valid field entries are:

a. The eight (8) character ID number assigned by New York State which identifies each individual Medicaid Recipient. This number begins with two (2) alpha characters, followed by five (5) numeric digits and then one (1) alpha character. This is the Client Identification Number found on the recipient's benefit card.

<div align="center">or</div>

b. The thirteen (13) digit numeric access number found on the recipient's benefit card under Access Number. The ISO # and SEQ # should **not** be entered in this field.

Person Code – (Insurance Segment) Field 303-C3

This field must contain the two (2) character field found on the recipient's benefit card under SEQ #.

Other Coverage Code – (Claim Segment) Field 308-C8

This field will be used in conjunction with Field 431-DV, Other Payor Amount, to allow pharmacies to have their claims electronically captured and adjudicated when the recipient has other third party insurance. The field values are:

0= Not Specified

1= No Other coverage Identified

2= Other Coverage Exists – Payment Collected

3= Other Coverage Exists – This Claim Not Covered

4= Other Coverage Exists – Payment Not Collected (This value is only valid with non-ECCA transactions).

5= Managed Care Plan Denial (This functions the same as Coverage Code 3)

6=   Other Coverage Denied – Not a participating provider (This functions the same as Coverage Code 3)

7=   No Other coverage Identified (This functions the same as Coverage Code 1)

8=   Other Coverage Exists – Payment Collected (This functions the same as Coverage Code 2)

There are several edits in place to ensure that logical entries are made in both field 308-C8 and 431-DV. The following two charts describe what the status of the claim will be based on the field entries. The edits on Chart 1 (page 2.10.4) will occur when the recipient has MEVS Insurance Coverage Codes H, K, M, O or ALL on file at the eMedNY contractor. Chart 2 (page 2.10.5) will occur when no MEVS Insurance Coverage Codes indicating Pharmacy coverage for the recipient are on file.

Chart 1 – Recipient with Coverage Codes H, K, M, O or ALL on file

Field 308-C8 Value	Field 431-DV Value	NCPDP Format Version	Field 104-A4 Value	Claim Status
0, 1, 2, 3, 4, 5, 6, 7, 8	431-DV is Not sent	51	Non-ECCA (Processor Control Number not sent) or ECCA (Processor Control Number sent)	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. ("C - capture" (field 112-AN) and "NO CLAIM TO FA" (field 503-F3) will be returned).
0, 1, 4 or 7	Zeros or greater	51	ECCA or Non-ECCA	The transaction will be rejected. NCPDP Reject Code: 13 "M/I Other Coverage Code" and Response Code: 717 "Client Has Other Insurance" will be returned online.
2 or 8	Zeros	51	ECCA or Non-ECCA	The transaction will be rejected. NCPDP Reject Code 13 "M/I Other Coverage Code" and Response Code 715 'Other Payor Amount Must Be Greater Than 0' will be returned.
2 or 8	Greater than Zero	51	ECCA	If all other edits are passed, the claim will be approved for payment. ("C - capture" (field 112-AN) and an invoice number (field 503-F3) will be returned). Other payor amount will be subtracted from the claim's payment amount.
2 or 8	Greater than Zero	51	Non-ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. ("C - capture" (field 112-AN) and "NO CLAIM TO FA" (field 503-F3) will be returned).
3, 5 or 6	Zeros, blank or not sent	51	ECCA	If all other edits are passed, the claim will be approved for payment. ("C - capture" (field 112-AN) and an invoice number (field 503-F3) will be returned).
3, 5 or 6	Zeros	51	Non-ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. ("C - capture" (field 112-AN) and "NO CLAIM TO FA" (field 503-F3) will be returned).
3, 5 or 6	Greater than Zero	51	ECCA or Non-ECCA	The transaction will be rejected. NCPDP Reject Code "13 M/I Other Coverage Code" and Response Code "716 ' Other Payor Amount Must Be Equal to 0" will be returned.

Chart 2 – Recipient without Coverage Codes on file

Field 308-C8 Value	Field 431-DV Value	NCPDP Format Version	Field 104-A4 Value	Claim Status
0, 1, 2, 3, 5, 6, 7 or 8	Not sent	51	Non-ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. ("C - capture" (field 112-AN) and "NO CLAIM TO FA" (field 503-F3) will be returned).
0, 1 or 7	Not sent	51	ECCA	If all other edits are passed, the claim will be approved for payment. ("C - capture" (field 112-AN) and an invoice number (field 503-F3) will be returned).
0, 1, 3, 5, 6 or 7	Zeros	51	Non-ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. ("C - capture" (field 112-AN) and "NO CLAIM TO FA" (field 503-F3) will be returned).
0, 1or 7	Zeros	51	ECCA	If all other edits are passed, the claim will be approved for payment. ("C - capture" (field 112-AN) and an invoice number (field 503-F3) will be returned).
3, 5 or 6	Zeros, blank or not sent	51	ECCA	If all other edits are passed, the claim will be approved for payment. ("C - capture" (field 112-AN) and an invoice number (field 503-F3) will be returned).
0, 1, 3, 4, 5, 6 or 7	Greater than Zero	51	Non-ECCA or ECCA	The transaction will be rejected. NCPDP Reject Code "DV - M/I Other Payor Amount" and Response Code "510 – Other Insurance Information Inconsistent" will be returned.
2, 3, 5, 6, or 8	Not sent	51	Non-ECCA or ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. ("C - capture" (field 112-AN) and "NO CLAIM TO FA" (field 503-F3) will be returned).
4	Not sent or zeros	51	Non-ECCA or ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. ("C - capture" (field 112-AN) and "NO CLAIM TO FA" (field 503-F3) will be returned).
2 or 8	Greater than Zero	51	Non-ECCA	If all other edits are passed, the transaction will be accepted for issuing service authorizations and/or DVS prior authorizations. ("C - capture" (field 112-AN) and "NO CLAIM TO FA" (field 503-F3) will be returned).

Field 308-C8 Value	Field 431-DV Value	NCPDP Format Version	Field 104-A4 Value	Claim Status
2 or 8	Greater than Zero	51	ECCA	If all other edits are passed, the transaction will be accepted for payment. ("C - capture" (field 112-AN) and an invoice number (field 503-F3) will be returned).
2 or 8	Zeros	51	Non-ECCA or ECCA	The claim will reject. NCPDP Reject Code "13 M/I Other Coverage Code" and Response Code "715 Other Payor Amount Must Be Greater Than 0" will be returned.

Eligibility Clarification Code – (Insurance Segment) Field 309-C9

This field is used to submit overrides for Excess Income/Spenddown or Nursing Home Resident denials.

This field will be used in conjunction with Field 433-DX, Patient Paid Amount (Pricing Segment), to allow pharmacies to have their claims electronically captured and adjudicated for Excess Income/Spenddown recipients. This field is used when the recipient's eligibility has not yet been updated on file at the eMedNY contractor.

Only recognized entry is:

> 2 = Override (replaces SA Exception Code M – Temporary Medicaid Authorization/Excess Income - Spenddown) or Nursing Home Override

Note: The eMedNY will allow all NCPDP identified values (0 through 6). However, "2" is the only value utilized by the NYS Medicaid.

If field 309-C9 contains a value of "2" (to override Excess Income/ Spenddown) Field 433-DX must contain zeros or a dollar amount. Field 433-DX should only contain zeros when the recipient has already met their spenddown but eligibility has not yet been updated on the file at the eMedNY contractor. In all other cases, Field 433-DX should contain the dollar amount incurred or paid to the pharmacy by the recipient.

Excess Income claims will bypass eligibility editing but will be processed through the DUR edits. If the claim passes all edits, the recipient's DUR drug profile will be updated and the entry in Field 433-DX will be included in the Other Insurance Paid field on your remittance statement.

Note: An approved Excess Income override claim will pend for thirty days waiting for the eligibility update to occur. The online response will be Table 10 response code 317 (Claim Pending: Excess Income/Spenddown). If the necessary update does not occur within the thirty-day period, your claim will be denied. More information on Table 10 Pend Response codes can be found under the Additional Message Field 526-FQ in this section.

The **Eligibility Clarification Code** (309-C9) field may also be used to report a Nursing Home Override in those instances where the Client's file shows residency within an In-State Skilled Nursing Facility that covers pharmacy services. The override procedure may be used to resubmit a previously denied claim. If the Client has been discharged but the eMedNY Contractors' file shows that the Client still resides in the Skilled Nursing Facility,

you may submit an override. This will result in a pend status which will give the local districts time to update the Client's file. If the update is not received within 30 days, the claim will deny.

Compound Code – (Claim Segment) Field 406-D6

This is a one (1) position field and will be used to alert the system as to the type of editing to perform. The allowable values are:

0 = Should be entered when dispensing any five (5) character alpha numeric Product Supply Code from sections 4.2 and 4.3 in the MMIS Pharmacy Provider Manual. Claim can be captured for adjudication and will be considered as **one** unit for UT and P & C. No DUR processing will occur. This value should also be used for DVS transactions.

1 = Should be entered when dispensing a prescription with an NDC code. Claim can be captured for adjudication and all processing will occur. May also be entered when dispensing a Product Supply Code as described above.

2 = Should be entered when dispensing a compound drug code. Claim will be considered as one unit for UT and P & C. No DUR processing will occur.

Prior Auth Type Code – (Claim Segment) Field 461-EU

This field is a two (2) position numeric field. There are three possible values for this field:

00 = Not specified

01 = Prior Authorization/Prior Approval. If this value is used, field 462-EV must contain the prior approval number.

04 = Exemption from co-pay. Use to indicate the recipient is exempt.

Prior Auth Number Submitted – (Claim Segment) Field 462-EV

This field is an eleven (11) position numeric field. This field should be filled with the Prior Approval Number followed by three zeros.

If a claim requires prior approval and the recipient is also exempt from co-pay, use a value of four (4) in Field 461-EU and the Prior Authorization Number in Field 462-EV. If submitting a **DVS transaction** and the recipient is also exempt from co-pay, use a value of four (4) Field 461-EU and do not submit anything in Prior Authorization Number in Field 462-EV All possible entry combinations are listed in the "Value/Comments" column of the formats.

Submission Clarification Code (Claim Segment) Field 420-DK

This is a two (2) position field and will be used to replace the SA (Service Authorization) Exception Code Field currently being used for UT overrides. This field must contain the

same value for each claim submitted in the same transaction for the recipient. The recognized values are:

00 = Not Specified (NCPDP default value)

01 = No Override (No SA Exception Code)

02 = Other Override (use in place of SA Exception Code P – pending an override)

07 = Medically Necessary (use in place of SA Exception Codes J & L – Immediate Urgent Care & Emergency)

Reason for Service Code (DUR/PPS Segment) Field 439-E4

For a rejected transaction, the response may contain a DUR Conflict Code for a DUR edit that failed. If this is the case, an override may be submitted. To override a DUR reject, the DUR Conflict Code received in the response of the original transaction must be submitted with the transaction attempting the override. The DUR Conflict Code being sent in the override must match the DUR Conflict Code received in the response of the original transaction. A corresponding entry must also be entered in the DUR Outcome Code.

Result of Service Code – (DUR/PPS Segment) Field 441-E6

If a DUR override is being submitted, an entry in Field 441-E6, DUR Outcome Code, is required. The authorized values are detailed in each format and reflect the action taken by the pharmacist.

Authorization Number – (Response Status Segment) Field 503-F3

This field will contain a nine (9) digit invoice number assigned to the transaction (up to four claims) if the provider has elected to have the claim captured and adjudicated. The invoice number can be used to track the claim at the eMedNY contractor. If a claim will not be captured for adjudication by the system because it is too old or for other reasons, this field will contain "NO CLAIM TO FA", meaning a claim has **not** been captured for adjudication. These claims need to be submitted to the eMedNY contractor via paper, magnetic media or Batch Pharmacy Dial-Up.

Message – (Response Message Segment) Field 504-F4 & Additional Message – (Response Status Segment) Field 526-FQ

Dependent on which NCPDP format was submitted, these fields will contain MEVS specific Eligibility, UT, Post & Clear, Co-pay, Denial responses, Pend responses, Drug Plan File price, DVS Number, Medicare, Restriction, Miscellaneous and other Insurance data. Refer to the formats for details concerning these fields.

Pend messages from Table 10 will be returned in Field 526-FQ, positions 1-3. These field positions normally contain the Eligibility Accepted Codes from Table 1. Table 1 codes will not be returned when a Table 10 response is necessary. Additionally, if a claim passes all other editing but requires pending for one of the reasons listed in Table 10, the:

- Header Response Status (Field 501-F1) will contain an 'A' (Accepted).

- Response Status (Field 112-AN) will contain a 'C' (Captured).

- Authorization Number (Field 503-F3) will contain an Invoice Number.

Note: Once a pend is resolved, the results can be found on the provider's remittance statement.

3.0 <u>VARIABLE "5.1" TRANSACTION</u> (REV. 12/03)

3.1 <u>Request Segment Usage Matrix</u> (Rev. 12/03)

SEGMENT	ID	ELIG	Billing	Rev	Rebill	P/A Req & Billing	P/A Rev	P/A Req Only	Info Rptg	Info Rptg Rev	Info Rptg Rebill
Transaction Code	AM	E1	B1	B2	B3	P1	P2	P4	N1	N2	N3
Header	--	M	M	M	M	M	M	M	M	M	M
Patient	01	O	O_{NY}	O	O_{NY}	O_{NY}	O	O_{NY}	O_{NY}	O	O_{NY}
Insurance	04	M	M	O	M	M	O	M	M	O	M
Claim	07	N	M	M	M	M	M	M	M	M	M
Prescriber	03	N	O_{NY}	N	O_{NY}	O_{NY}	O	O_{NY}	O_{NY}	N	O_{NY}
COB/Other Payments	05	N	O_{NY}	N	O_{NY}	O_{NY}	N	O_{NY}	O	N	O
Pricing	11	N	M	O	M	M	O	O	O	O	O
Prior Authorization	12	N	O	N	O	M	O	M	N	N	N
DUR/PPS	08	N	O	O	O	O	O	O	O	O	O

M   = mandatory
O   = optional; conditional based on data content
O_{NY}   = optional; NYS data content required
N   = Not sent

3.2 <u>Variable "5.1" Request Format</u> (Rev. 09/03)

3.2.1 <u>Transaction Header Segment</u> (Rev. 09/03)

Required Transaction Header Segment Information

This segment is fixed in length (56 positions) and must always be submitted with all transactions.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
101		BIN Number	N	6	1-6	R	004740 = New York's Assigned Number
102		Version/Release Number	A/N	2	7-8	R	51 = Variable Format
103		Transaction Code	A/N	2	9-10	R	*This field identifies the type of transaction and number of prescriptions being submitted. Acceptable* TRANSACTION TYPES*:* E1 = Eligibility Verification *Format described in Section 4.0 on page 4.0.1.* B1 = 1-4 Rx Billings *Used for original claim billings and for pharmacists' responses (overrides) to Drug Conflict Alerts.* B2 = 1 Rx Reversal. *Used to cancel a previous transaction. Format described in Section 6.0 on page6.0.1.* B3 = 1-4 Rx Rebillings *Used to adjust a previously paid claim. Format is otherwise identical to an Rx Billing.* P1 = 1-4 PA Requests and Rx Billings *Used for original claim billings where a Prior Approval number is being requested and for pharmacists' responses (overrides) to Drug Conflict Alerts* P2 = 1 Prior Authorization Reversal *Used to cancel a previous transaction. Format described in Section 6.0 on page6.0.1.* P4 = 1-4 PA Requests Only (non-ECCA claims requesting PA)

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
							Used for original claim billings requiring Prior Authorization and for pharmacists' responses (overrides) to Drug Conflict Alerts N1 = 1 –4 Rx DURs *Used to supply DUR information <u>only </u>for purposes of updating recipient's drug history file when no claim submission or reimbursement is allowed or expected. At a minimum the reject code "84" (Claim not Paid/Captured) will be returned. For example: A pharmacist may wish to update a recipient's DUR history file even though the drug is not reimbursable by New York State.* N2 = 1 Rx DUR Reversal. *Used to cancel a previous DUR transaction. Format described in Section 6.0 on page6.0.1.* N3 = 1-4 Rx DUR Rebillings *Used to adjust a previously paid DUR claim. Format is otherwise identical to an Rx Billing.*
104		Processor Control Number	A/N	10	11-20	R	If using Electronic Claims Capture and Adjudication, field entry consists of:
				1	11-11		Y (yes) or N (no) – indicates whether the provider has read and attests to the data in the certification statement found in Section 7.0 on page 7.0.1.
				2	12-13		*Submitter's Initial*s – the first and last initial of the pharmacist submitting the claim (2 alpha characters.
				4	14-17		*PIN* – The four digit numeric *Personal Identification Number* previously selected by the provider and submitted to the Dept. of Health.
				3	18-20		*ETIN* – The three character (alpha, numeric or alphanumeric) *Electronic Transmission Identification Number* previously assigned to the provider by eMedNY contractor. For non-ECCA, the field must contain spaces.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
109		Transaction Count	N	1	21	R	Blank=Not Specified 1=One Occurrence 2=Two Occurrences 3=Three Occurrences 4=Four Occurrences
202		Service Provider ID Qualifier	N	2	22-23	R	Ø5=Medicaid
201		Service Provider ID	A/N	15	21-38	R	Field Entry consists of: The eight digit *Medicaid Provider Identification Number* assigned to the Pharmacy by the Dept. of Health. Must left justify, space fill.
401		Date of Service	N	8	39-46	R	The *date of service* the prescription was filled. Format = CCYYMMDD. *DVS transactions require a <u>current date</u> entry*.
110		Software Vendor/Certification ID	A/N	10	47-56	R	This field must be space filled.

3.2.2 <u>Insurance Segment</u> (Rev. 09/03)

Required Insurance Segment Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	Ø4=Insurance
FS	C2			3	*variable*	R	x'1C' C2
302		Cardholder ID Number	A/N	20	*variable*	R	The eight character alpha numeric *Medicaid Recipient Number (CIN)*. Left justify and space fill.

Optional Insurance Segment Information

Any fields entered in the Optional Insurance Segment Information section will be ignored by MEVS except the following, which are required by NYSDOH for processing:

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
FS	C3			3	*variable*	R	x'1C' C3
303		Person Code	A/N	3	*variable*	R	The 2 digit numeric Medicaid Card Sequence Number (SEQ). Left justify and space fill.
FS	C9			3	*variable*	O	x'1C' C9
309		Eligibility Clarification Code	N	1	*variable*	O	Use for Excess Income/ Spenddown recipients or for Nursing Home Override. Recognized value is: **2** = Override **Note:** Any other value from 0 to 6 will be ignored. For further explanation see page 2.10.6

3.2.3 Patient Segment (Rev. 09/03)

Required Patient Segment Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E'
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	Ø1=Patient

Optional Patient Segment Information

Any fields entered in the Optional Patient Segment Information section will be ignored by MEVS except the following, which are required by NYSDOH for processing:

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
FS	C4			3	*variable*	R	x'1C' C4
304		Date of Birth	N	8	*variable*	R	The Recipient's birth date. Format = **CCYYMMDD**.
FS	C5			3	*variable*	R	x'1C' C5
305		Patient Gender Code	N	1	*variable*	R	The Recipient's *gender*. Acceptable values are: **1** = Male **2** = Female
FS	2C			3	*variable*	O	x'1C' 2C
335		Pregnancy Indicator	A/N	1	*variable*	O	Used to indicate whether the client is pregnant or not. Acceptable values are: Blank = not specified 1 = not pregnant 2 = pregnant

3.2.4 <u>Claim Segment</u> (Rev. 02/04)

Note: This group separator must appear prior to each group of segments pertaining to a single claim line. From 1 to 4 claim segments with the other associated corresponding segments comprise a group. Only one of each of the associated segments may appear in a group. The Transaction Count field (109-A9) on the Transaction Header Segment indicates the number of claim line groups that will occur within a transaction.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	R	x'1D'

Required Claim Segment Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	Ø7=Claim
FS	EM			3	*variable*	R	X'1C' EM
455		Prescription/Service Reference Number Qualifier	A/N	1	*variable*	R	Use this field to identify the type of billing submitted. Acceptable value: 1 = Rx Billing
FS	D2			3	*variable*	R	x'1C' D2
402		Prescription/Service Reference Number	N	7	*variable*	R	The prescription number assigned by the pharmacy. Right justify and zero fill.
FS	E1			3	*variable*	R	x'1C' E1
436		Product/Service ID Qualifier	A/N	2	*variable*	R	Use this field to identify the *Product Type* dispensed. This field is used when the item dispensed is a product supply item (section 4.2 and 4.3 of MMIS Pharmacy Provider Manual), when an NDC code is submitted or for a **DVS transaction**. Acceptable values are: **03 =** NDC **09 =** HCPCS
FS	D7			3	*variable*	R	x'1C' D7

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
407		Product/Service ID	A/N	19	*variable*	R	Use this field to enter either the NDC code or the HCPCS Code. When entering the *National Drug Code* identifying the dispensed drug, only an 11 digit numeric entry is acceptable. When billing compounds use code 99999999999 when billing multiple ingredients where the most costly element is not covered by Medicaid. Otherwise compounds must be billed by individual components using the appropriate NDC code. Regulated drug components such as narcotics and other Schedule class drugs must be billed as separate components using a valid NDC code with a valid quantity which requires the use of multiple claim lines for each of the billed components. When submitting HCPCS codes, enter a 7 character field (beginning with an alpha and ending with 2 blanks). A two position modifier can replace the 2 blanks if it applies, e.g. **BO**. If a HCPCS code is entered, Field 436-E1 must be equal to 09.

Optional Claim Segment Information

Any fields entered in the Optional Claim Segment Information section will be ignored by MEVS except the following, which are required by NYSDOH for processing:

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
FS	C8			3	*variable*	O	x'1C' C8

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
308		Other Coverage Code	N	2	*variable*	O	Code indicating whether or not the Patient (Recipient) has other insurance coverage. Acceptable values are:
							00 Not Specified – Use for Medicare
							01/07 No Other Coverage identified
							02/08 Other Coverage Exists – Payment Collected
							03/05/06 Other Coverage Exists – This Claim Not Covered
							04 Other Coverage Exists – Payment Not Collected (ECCA not allowed)
							Note: For further explanation see page 2.10.2
FS	D5			3	*variable*	R	x'1C' D5
405		Days Supply	N	3	*variable*	R	Estimated number of *days* that the prescription will last. Maximum allowed is 366. Right justify and zero fill.
							Note: When prescription's directions state, "take as directed" (PRN), it is strongly advised "180" be entered.
FS	D6			3	*variable*	R	x'1C' D6

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
406		Compound Code	N	1	*variable*	R	Acceptable values are: **0** = Not specified. This is also the value to use for **DVS transactions**. **1** = Not a compound – *use when dispensing any prescription drug with an 11 digit NDC code.* **2** = Compound – *use when dispensing a compound drug code.* **Note:**"**0**" *or* "**1**" *may be used for sickroom supplies, etc.*, when dispensing any 5 character alpha numeric supply code contained in sections 4.2 and 4.3 of the MMIS Pharmacy Provider Manual. **Example:** Sickroom Supply Code Z2500 (gauze pads)
FS	D8			3	*variable*	R	x'1C' D8
408		Dispense As Written (DAW)/Product Selection Code	A/N	1	*variable*	R	Acceptable values are: **0** = No Product Selection Indicated. **1** = Substitution not allowed by Prescriber. **4** = Substitution allowed – Generic Drug not in stock. **5** = Substitution allowed – Brand Drug dispensed as a Generic. **7** = Substitution not allowed – Brand Drug mandated by Law. **8** = Substitution allowed – Generic Drug not available in Marketplace.
FS	DE			3	*variable*	R	x'1C' DE
414		Date Prescription Written	N	8	*variable*	R	Format = **CCYYMMDD**
FS	DF			3	*variable*	R	x'1C' DF
415		Number of Refills Authorized	N	2	*variable*	R	Acceptable values are: **00** = No Refills Authorized **01** = 1 Refill **02** = 2 Refills **03** = 3 Refills **04** = 4 Refills **05** = 5 Refills New York State only allows a maximum of 5 refills. The value in this field must be greater or equal to the Fill Number (field 403-D3).
FS	DK			3	*variable*	O	x'1C' DK

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
420		Submission Clarification Code	N	2	*variable*	O	This field is used to indicate an Utilization Threshold override and replaces the use of the *SA Exception Code*. Acceptable values are: **00** = Not Specified **01** = No Override **02** = Other Override – *use to replace SA Exception Code P (pending an override)* **07** = Medically Necessary – *use to replace SA Exception Code J & L (Immediate Urgent Care & Emergency)* **Note**: These are the only values accepted for UT Override by NYSDOH when using the NCPDP format. Any other value entered in this field will be ignored.
FS	E7			3	*variable*	R	x'1C' E7
442		Quantity Dispensed	D	10	*variable*	R	The total number of *Decimal Units* dispensed for the prescription. Right justify and zero fill. This is a required field for **DVS transactions**. For enteral products, enter caloric units. For example, a prescription is for Regular Ensure 1-8oz. Can daily, 30 cans with five refills. There are 75 caloric units per 30 cans (one month supply). The correct entry for current date of service is 0000075000. *Do not include refills.*
FS	D3			3	*variable*	R	x'1C' D3
403		Fill Number	N	2	*variable*	R	Acceptable values are: **00** = New Prescription **01** = First Refill **02** = Second Refill **03** = Third Refill **04** = Fourth Refill **05** = Fifth Refill *The maximum number of refills allowed = 5.*
FS	EU			3	*variable*	O	x'1C' EU
461		Prior Auth Type Code	N	2	*variable*	O	Acceptable values are: **00** = Not Specified **01** = Prior Authorization (use if no Copay exemption exists) **04** = Exemption from copay
FS	EV			3	*variable*	O	x'1C' EV

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
462		Prior Auth Number Submitted	N	11	*variable*	O	Use this field to indicate *prior approval.* Format = NNNNNNNNZZZ
				8	1-8		NNNNNNNN = Prior Approval Number
				3	9-11		ZZZ = zero fill

3.2.5 Prescriber Segment (Rev. 12/03)

Required Prescriber Segment Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	Ø3=Prescriber

Optional Prescriber Segment Information

Any fields entered in the Optional Prescriber Segment Information section will be ignored by MEVS except the following, which are required by NYSDOH for processing:

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
FS	DL			3	*variable*	O	x'1C' DL
421		Primary Care Provider ID	A/N	10	*variable*	O	Use to enter the 8 digit MMIS Provider ID Number of the Referring Provider. Left justify, space fill. If the claim is for a restricted recipient, the primary provider's provider number must be entered.
FS	2E			3	*variable*	O	x'1C' 2E
468		Primary Care Provider ID Qualifier	A/N	2	*variable*	O	Blank=Not Specified Ø5=Medicaid
FS	EZ			3	*variable*	R	x'1C' EZ
466		Prescriber ID Qualifier	A/N	2	*variable*	R	Ø5=Medicaid Ø8=State License
FS	DB			3	*variable*	R	x'1C' DB

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
411		Prescriber ID	A/N	15	*variable*	R	The ***Ordering Provider*** who wrote the prescription. Either the Ordering Provider's MMIS Provider ID number or license type and license number must be entered. If entering the 8 digit numeric Provider ID number, left justify; space fill. If entering the license type and number, enter: License Type in field position 1 & 2 (see Provider Manual for list of valid License Types). Zeros in position 3 & 4. Six digit license number in Position 5 – 10. If entering an _Out of State_ license number, replace the two zeros in position 3 & 4 with the two character alpha state code. NYS Nurse Practitioners who are allowed to prescribe will have an F preceding their license number. NYS Optometrists who are allowed to prescribe will have a U or V preceding their license numbers. When entering their license numbers, enter the license type followed by a zero, the alpha character and the six-digit license number. **Note**: When entering a license number, the last six positions of the entry should be the actual numeric license number. If the license number does not contain six numbers, zero fill the appropriate positions preceding the actual license number. For example, an entry for an Optometrist whose license number is U867 would be: 250U000867. **Examples:** **MMIS Provider Id** # 01234567 **New York license** # 0100987654 **Out of State license** # 11NJ345678 **Nurse Practitioner** # 290F121212 **Optometrist** # 250U343434 This is a required field for all NCPDP **transactions except eligibility**.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
FS	DL			3	*variable*	O	x'1C' DL
421		Primary Prescriber	A/N	10	*variable*	O	Use to enter the 8 digit MMIS Provider ID Number of the Referring Provider. Left justify, space fill. If the claim is for a restricted recipient, the primary provider's provider number must be entered.
FS	EZ			3	*variable*	R	x'1C' EZ
466		Prescriber ID Qualifier	A/N	2	*variable*	R	Ø5=Medicaid Ø8=State License
FS	2E			3	*variable*	O	x'1C' 2E
468		Primary Care Provider ID Qualifier	A/N	2	*variable*	O	Blank=Not Specified Ø5=Medicaid

3.2.6 <u>Pricing Segment</u> (Rev. 09/03)

Required Pricing Segment Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	11=Pricing

Optional Pricing Segment Information

Any fields entered in the Optional Pricing Segment Information section will be ignored by MEVS except the following, which are required by NYSDOH for processing:

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
FS	DQ			3	*variable*	R	x'1C' DQ
426		Usual and Customary Charge	D	8	*variable*	R	Entry Required for *Electronic Claims Capture and Adjudication*. Enter amount charged for the prescription. Right justify and zero fill.
FS	DX			3	*variable*	O	x'1C' DX
433		Patient Paid Amount Submitted	D	8	*variable*	O	Amount received from the Excess Income/Spenddown recipient for the prescription dispensed. **Note**: Must have numeric value (zero or greater) if Field 309 has value of "**2**".

3.2.7 **DUR/PPS Segment** (Rev. 09/03)

Required DUR/PPS Segment Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	Ø8=DUR/PPS

Optional DUR/PPS Segment Information

This portion of the segment is repeatable up to 9 times. However, only one DUR Conflict and Outcome code is captured and processed. Therefore, only 1 occurrence should be transmitted. Any fields entered in the Optional DUR/PPS Segment Information section will be ignored by MEVS except the following, which are required by NYSDOH for processing:

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
FS	7E			3	*variable*	O	x'1C' 7E
473		DUR/PPS Code Counter	N	1	*variable*	O	This will be a counter of each repeatable segment entered.
FS	E4			3	*variable*	O	x'1C' E4
439		Reason for Service Code	A/N	2	*variable*	O	This code identifies the *type of conflict*. One of the following codes is required to **override** a DUR reject. Acceptable values are: **TD** = Therapeutic Duplication **DD** = Drug-Drug Interactions
FS	E6			3	*variable*	O	x'1C' E6
441		Result of Service Code	A/N	2	*variable*	O	Action taken by pharmacist. Required if *Field 439-E4* is used. Acceptable values are: **1A** = Filled as is, false positive **1B** = Filled, Prescription as is **1C** = Filled with Different Dose **1D** = Filled with Different Directions **1E** = Filled with Different Drug **1F** = Filled with Different Quantity **1G** = Filled with Prescriber Approval

3.2.8 Coordination of Benefits/Other Payments Segment (Rev. 04/04)

Required Coordination of Benefits/Other Payments Segment Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	05=COB/Other Payments
FS	4C			3	*variable*	R	x'1C'4C
337		COB/Other Payments Count	N	1	*variable*	R	Enter the number of Other Payer occurrences.
The following fields (both required and optional can occur as a group up to 9 times:							
							338-5C 339-6C 340-7C 341-HB 443-E8
The following fields can occur up to 9 times for each of the 9 occurrences listed above:							
							342-HC 431-DV 471-5E 472-6E
FS	5C			3	*Variable*	R	x'1C'5C
338		Other Payer Coverage Type	A/N	2	*variable*	R	Enter one of the following values: Blank = not specified 01 = Primary 02 = Secondary 03 = Tertiary

Optional Coordination of Benefits/Other Payments Segment Information

Any fields entered in the Optional Coordination of Benefits/Other Payments Segment Information section will be ignored by MEVS except the following, which are required by NYSDOH for processing:

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
FS	6C			3	*variable*	O	x'1C' 6C

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
339		Other Payer ID Qualifier	A/N	2	*variable*	O	Enter any valid code qualifiying the Other Payer Id. Examples would be, but not limited to the following: 01 = National Payer Id 02 = Health Industry Number (HIN) 03 = Bin Number (BIN) 99 = Other For Medicare Claims a value of "99" must be used.
FS	7C			3	*variable*	O	x'1C' 7C
340		Other Payer ID	A/N	10	*variable*	O	Enter any valid value that identifies the Third Party Payer. For Medicare Claims enter a value of 13 (Medicare Part B)
FS	HB			3	*variable*	O	x'1C' HB
341		Other Payer Amount Paid Count	N	1	*variable*	O	Enter the count of the payer amount paid occurrences. (342-HC/431-DV)
FS	E8			3	*variable*	O	x'1C' E8
443		Other Payer Date	N	8	*variable*	O	Enter the date the payment was made or denied. Format=CCYYMMDD
The following two fields can occur up to 9 times with the above segment.							
FS	HC			3	*variable*	O	x'1C' HC
342		Other Payer Amount Paid Qualifier	A/N	2	*variable*	O	Enter the following value to report Third Party Information. 07=Drug Benefit If reporting Medicare Approved and paid amounts, the following values must be entered: 07=Medicare Approved 08=Medicare Paid 99=(1st Occurrence) Deductible Amount 99=(2nd Occurrence) Coinsurance Amount 99=(3rd Occurrence) Co-Payment Amount
Enter the following field if payment was made by Third Party payer.							
FS	DV			3	*variable*	O	x'1C' DV

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
431		Other Payer Amount Paid	D	8	*variable*	O	Enter the dollar amount of payment known by the pharmacy from other sources. The dollar amount should reflect the amount identified by field 342-HC. For example, if a third party amount is being reported, Field 342-HC will have a value of 07 (Drug Benefit) and field 431-DV will have the amount paid by the Third Party Insurance. If a rejection from the primary payer has been received, either zeros or blanks may be entered in this field. You may also choose not to send the Other Payer Amount Paid field 431-DV, if the Other Coverage Code field 308-C8, contains a "3", and the third party insurance has denied the claim. **Note**: When reporting payment from Third Party Insurance payer field 308-C8 must also be populated. Refer to page 2.10.2.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
Enter the following two fields if a Third Party denial was made. Field 472-6E can be repeated if more than one reject code was reported by the Third Party payer.
FS	5E			3	*variable*	O	x'1C' 5E
471		Other Payer Reject Code	N	2	*variable*	O	Enter the total count of the Other Payer Reject codes reported below.
FS	6E			3	*variable*	O	x'1C' 6E
472		Other Payer Reject Code	A/N	3	*variable*	O	Enter the Reject code received from Third Party Payer.

3.2.9 Prior Authorization Segment (Rev. 09/03)

Required Prior Authorization Segment Information

Note: This segment is only required when billing P1 (PA Requests and Rx Billings) and P4 (PA requests Only) Transactions.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	12=Prior Authorization
FS	PA			3	*variable*	R	x'1C'PA
498		Request Type	A/N	1	*variable*		Code Identifying type of Prior Authorization Request. Acceptable value is: 1 = Initial
FS	PB			3	*variable*	R	x'1C'PB
498		Request Period Date-Begin	N	8	*variable*	R	Enter the Date of Service. Format: CCYYMMDD
FS	PC			3	*variable*	R	x'1C'PC
498		Request Period Date-End	N	8	*variable*	R	Enter the Date of Service. Format: CCYYMMDD
FS	PD			3	*variable*	R	x'1C'PD
498		Basis of Request	A/N	2	*variable*	R	Describes the reason for Prior Authorization. Acceptable value is: PR = Plan Requirement

3.2.10 Second Claim Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	O	x'1D'
		2nd Prescription – Required and Optional Segments as per claim requirements: • Claim Segment • Prescriber Segment • COB/Other Payments Segment • DUR/PPS Segment • Pricing Segment • Prior Authorization Segment		*variable*	*variable*	O	Fields and format are the same as described on previous pages.

3.2.11 Third Claim Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	O	x'1D'
		3rd Prescription – Required and Optional Segments as per claim requirements: • Claim Segment • Prescriber Segment • COB/Other Payments Segment • DUR/PPS Segment • Pricing Segment • Prior Authorization Segment		*variable*	*variable*	O	Fields and format are the same as described on previous pages.

3.2.12 Fourth Claim Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	O	x'1D'
		4th Prescription – Required and Optional Segments as per claim requirements: • Claim Segment • Prescriber Segment • COB/Other Payments Segment • DUR/PPS Segment • Pricing Segment • Prior Authorization Segment		*variable*	*variable*	O	Fields and format are the same as described on previous pages.

3.3 <u>Variable "5.1" Response Overview</u> (Rev. 09/03)

Responses for transactions in a variable format will be returned in the rejected format or in the approved Claim Captured transaction format. Each of the formats will contain the MEVS response data in field 526-FQ, Additional Message. Data in the Additional Message field will be returned for each claim.

3.4   Claim Capture Response Format (Rev. 07/04)

Response Header Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
102		Version/Release Number	A/N	2	1-2	R	**51** (same as input)
103		Transaction Code	N	2	3-4	R	**B1, B3, P1, P4, N1, or N3** (same as input)
109		Transaction Count	A/N	1	5-5	R	1 = 1 Rx Response 2 = 2 Rx Responses 3 = 3 Rx Responses 4 = 4 Rx Responses
501		Header Response Status	A/N	1	6-6	R	**A** = Acceptable
202		Service Provider ID Qualifier	A/N	2	7-8	R	Returns the same value that was entered.
201		Service Provider ID	A/N	15	9-23	R	Returns the same value that was entered.
401		Date of Service	N	8	24-31	R	Returns the same value that was entered.

Response Message Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	20=Response Message
FS	F4			3	*variable*	R	x'1C'F4
504		Message	A/N	37	*variable*	R	***Will be in the following format***:
				8	1-8		Recipient's Medicaid Number (CIN)
				1	9-9		space
				2	10-11		Recipient's County Code
				1	12-12		value = * *(Used to separate fields)*
				2	13-14		Anniversary Month (values: 01-12)
				1	15-15		space
				1	16-16		Sex Code (values: M or F)
				3	17-19		Date of Birth (Format = CYY)
				1	20-20		space
				1	21-21		Category of Assistance
				1	22-22		space
				2	23-24		Re-certification Month (values: 01-12)
				1	25-25		space
				3	26-28		Office Number
				1	29-29		value = **&** *(Used to separate fields)*
				8	30-37		Service Date "ccyymmdd"

Response Status Segment

Note: This group separator must appear prior to each group of segments pertaining to a single response status.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	R	x'1D'

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	21=Response Status
FS	AN			3	*variable*	R	x'1C'AN
112		Transaction Response Status	A/N	1		R	**C** = Claim Captured. This response value means the claim has been accepted. If *Electronic Claims Capture and Adjudication* was selected, this field is used in conjunction with the Authorization Number field to indicate whether the claim has been captured for adjudication. **Note: A** for Approved is returned on a **P4.**
FS	F3			3	*variable*	R	x'1C'F3
503		Authorization Number	A/N	20	*variable*	R	If *Electronic Claims Capture and Adjudication* was selected, a nine digit invoice number will be returned in the first nine positions of this field. Only one invoice number will be issued per transaction, which can include up to four NDC claim segments. This field will contain the message "**NO CLAIM TO FA**" if ECCA was requested but the claim was not captured for Adjudication.
FS	FQ			3	variable	R	x'1C' FQ
526		Additional Message Information	A/N	108	variable	R	***Will be in the following format:***
				3	1-3		MEVS Accepted or Pend Codes *(see Section 8.0, Table 1 on page 8.0.1 and Table 10 on page 8.0.8, for values)*
				1	4-4		Space used to separate fields
				2	5-6		Utilization Threshold/Post & Clear Code *(see Section 8.0, Table 8 on page 8.0.6 for values)*
				1	7-7		value = **$** *(Used to separate fields)*

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
				9	8-16		Maximum Per Unit Price. This is a 9 digit field with a floating decimal. Examples are as follows: "999.99999" "9999.9999"
				1	17-17		value = **%** *(Used to separate fields)*
				3	18-20		Co-Payment Code *(see Section 8.0, Table 6 on page 8.0.4 for values)* or spaces
				1	21-21		Space used to separate fields
				8	22-29		Co-Pay Met Date "ccyymmdd" or spaces
				3	30-32		DVS Reason Code
				1	33-33		Value of **=** *(Used to separate fields)*
				2	34-35		Medicare Coverage
				1	36-36		Space used to separate fields
				12	37-48		HIC Number
				1	49-49		value = **#** *(Used to separate fields)*
				2	50-51		First Insurance Carrier Code
				1	52-52		value = **I** *(Used to separate fields)*
				14	53-66		First Insurance Coverage Codes
				1	67-67		value = **@** *(Used to separate fields)*
				2	68-69		Second Insurance Carrier Code
				1	70-70		value = **I** *(Used to separate fields)*
				14	71-84		Second Insurance Coverage Codes
				1	85-85		value = **+** *(Used to separate fields)*
				2	86-87		Indication of Additional Coverage
				1	88-88		value = ***** *(Used to separate fields)*
				11	89-99		Restriction Information - Exception Codes: "xx xx xx xx"
				1	100-100		value = } *(Used to separate fields)*
				8	101-108		DVS Number. This number will be entered on your ECCA claim. If billing manually, this number must be put on your claim form.

Response Claim Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C' AM
111		Segment Identification	N	2	*variable*	R	22 = Response Claim
FS	EM			3	*variable*	R	x'1C' EM
455		Prescription/Service Reference Number Qualifier	A/N	1	*variable*	R	Returns the same value that was entered.
FS	D2			3	*variable*	R	x'1C' D2
402		Prescription/Service Reference Number	A/N	7	*variable*	R	The Prescription Number that was entered will be returned in this field.

Response Pricing Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C' AM
111		Segment Identification	N	2	*variable*	R	23 = Response Pricing
FS	FI			3	*variable*	O	x'1C' FI
518		Amount of Copay/co-Insurance	D	8	*variable*	O	The amount of copay that should be taken will be reported back in this field.
FS	F5			3	*variable*	O	x'1C' F5
505		Patient Pay Amount	D	8	*variable*	O	The amount of copay that should be taken will be reported back in this field.

Response DUR/PPS Segment

Refer to for a description of this segment.

Response Prior Authorization Segment

This segment will only be sent when a **P4** Prior Authorization Request is submitted.
Only a single activity line can be processed within a **P4** Prior Authorization transaction.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C' AM
111		Segment Identification	N	2	*variable*	R	26 = Response Prior Authorization
FS	PY			3	*variable*	O	x'1C' PY
498		Prior Authorization Number - Assigned	N	11	*variable*	O	Unique number identifying the prior authorization assigned by the processor.

Second Response Claim Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	O	x'1D'
		2nd Prescription – Required and Optional Segments as per claim requirements: • Response Status Segment • Response Claim Segment • Response Pricing Segment • Response DUR/PPS Segment		*variable*	*variable*	O	Fields and format are the same as described on previous pages.

Third Response Claim Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	O	x'1D'
		3rd Prescription – Required and Optional Segments as per claim requirements: • Response Status Segment • Response Claim Segment • Response Pricing Segment • Response DUR/PPS Segment		*variable*	*variable*	O	Fields and format are the same as described on previous pages.

Fourth Response Claim Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	O	x'1D'
		4th Prescription – Required and Optional Segments as per claim requirements: • Response Status Segment • Response Claim Segment • Response Pricing Segment • Response DUR/PPS Segment		*variable*	*variable*	O	Fields and format are the same as described on previous pages.

3.5 <u>Rejected Response Format</u> (Rev. 12/03)

Response Header Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
102		Version/Release Number	A/N	2	1-2	R	**51** (same as input)
103		Transaction Code	N	2	3-4	R	**B1, B3, P1, P4, N1, or N3** (same as input)
109		Transaction Count	A/N	1	5-5	R	1 = 1 Rx Response 2 = 2 Rx Responses 3 = 3 Rx Responses 4 = 4 Rx Responses
501		Header Response Status	A/N	1	6-6	R	**A** = Acceptable **R** = Rejected
202		Service Provider ID Qualifier	A/N	2	7-8	R	Returns the same value that was entered.
201		Service Provider ID	A/N	15	9-23	R	Returns the same value that was entered.
401		Date of Service	N	8	24-31	R	Returns the same value that was entered.

Response Status Segment

Note: This group separator will appear prior to each group of segments pertaining to a single response status.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	R	x'1D'

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C' AM
111		Segment Identification	N	2	*variable*	R	21 = Response Status
FS	AN			3	*variable*	R	x'1C' AN
112		Transaction Response Status	A/N	1	*variable*	R	**R** = Rejected or Unacceptable.
The following Four fields can be repeated up to 20 times:							
FS	FA			3	*variable*	R	x'1C' FA
510		Reject Count	N	2	*variable*	R	Will contain the number of NCPDP Reject Codes listed in the following fields.
FS	FB			3	*variable*	R	x'1C' FB
511		Reject Code	A/N	2	*variable*	R	Will contain the NCPDP Reject Code applicable to the error. See Section 9.0 on page 9.0.1, for values.
FS	FQ			3	*variable*	R	x'1C' FQ
526		Additional Message Information	A/N	14	*variable*	R	
				3	1-3	R	**MEVS** error codes will be returned here. See Table 2 (page 8.0.2), Table 7 (page 8.0.5) and Table 8 (page 8.0.6) in Section 8.0 for values. **Note:** Both Field 504 and 511 should always be reviewed in order to ascertain all applicable reject reasons. *Field will be in the following format:*
				1	4-4		Space used to separate fields
				3	5-7		Rx Denial Code (*see Section 8.0, Table 7 on page 8.0.5, for values*)
				1	8-8		Space used to separate fields
				2	9-10		Utilization Threshold/Post & Clear Code (*see Section 8.0, Table 8 on page 8.0.6, for values*)
				1	11-11		Space used to separate fields

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
				3	12-14		DVS Reason Code *(see Section 8.0, Table 9 on page 8.0.7, for values)*

Response Claim Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C' AM
111		Segment Identification	N	2	*variable*	R	22 = Response Claim
FS	EM			3	*variable*	R	x'1C' EM
455		Prescription/Service Reference Number Qualifier	A/N	1	*variable*	R	Returns the same value that was entered.
FS	D2			3	*variable*	R	x'1C' D2
402		Prescription/Service Reference Number	A/N	7	*variable*	R	The Prescription Number that was entered will be returned in this field.

Response DUR/PPS Segment
Refer to Section 5.0 on page 5.0.1, for a description of this segment.

Second Response Claim Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	O	x'1D'
		2nd Prescription – Required and Optional Segments as per claim requirements: • Response Status Segment • Response Claim Segment • Response DUR/PPS Segment		*variable*	*variable*	O	Fields and format are the same as described on previous pages.

<u>Third</u> Response Claim Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	O	x'1D'
		3rd Prescription – Required and Optional Segments as per claim requirements: • Response Status Segment • Response Claim Segment • Response DUR/PPS Segment		*variable*	*variable*	O	Fields and format are the same as described on previous pages.

<u>Fourth</u> Response Claim Information

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	O	x'1D'
		4th Prescription – Required and Optional Segments as per claim requirements: • Response Status Segment • Response Claim Segment • Response DUR/PPS Segment		*variable*	*variable*	O	Fields and format are the same as described on previous pages.

4.0 **ELIGIBILITY VERIFICATION TRANSACTION** (REV. 09/03)

The Eligibility Verification or Inquiry transaction can only be submitted using the variable "5.1" format. The input and response formats are described on the following pages. Any other transaction must use another format. Refer to the other areas within this document for the proper format for the other transactions. An Eligibility Verification transaction does not include any claim or NDC information and therefore only header sections are included in the input and response formats.

Refer to Section 3.1 (page 3.0.1) "Request Segment Usage Matrix" for a quick synopsis of which segments are mandatory, optional, optional but required by NYS, or Not Sent.

4.1 <u>**Variable "5.1" Eligibility Verification Request**</u> (Rev. 09/03)

There are only two segments that are required in order to process an Eligibility Transaction. They are the Transaction Header Segment and the Insurance Segment.

Transaction Header Segment

Required Transaction Header Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
101		BIN Number	N	6	1-6	R	**004740** = New York's Assigned Number
102		Version/Release Number	A/N	2	7-8	R	**51** = Variable Format
103		Transaction Code	N	2	9-10	R	*This field identifies the type of transaction and number of prescriptions being submitted. Acceptable* TRANSACTION TYPES*:* **E1** = Eligibility Verification
104		Processor Control Number	A/N	10	11-20	R	NCPDP required field. Any data entered will be ignored.
109		Transaction Count	N	1	21	R	Blank=Not Specified 1=One Occurrence
202		Service Provider ID Qualifier	N	2	22-23	R	Ø5=Medicaid
201		Service Provider ID	A/N	15	21-38	R	Field Entry consists of: The eight digit *Medicaid Provider Identification Number* assigned to the Pharmacy by the Dept. of Health. Must left justify, space fill.
401		Date of Service	N	8	39-46	R	The *date of service* the prescription was filled. Format = **CCYYMMDD**.
110		Software Vendor/Certification ID	A/N	10	47-56	R	Leave this field blank.

Insurance Segment

Required Insurance Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	Ø4=Insurance
FS	C2			3	*variable*	R	x'1C' C2
302		Cardholder ID Number	A/N	20	*variable*	R	The eight character alpha numeric *Medicaid Recipient Number (CIN)*. Left justify and space fill.

Optional Insurance Segment
Any fields entered in the Optional Insurance Segment Information section will be ignored by MEVS except the following, which are required by NYSDOH for processing:

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
FS	C3			3	*variable*	O	x'1C' C3
303		Person Code	A/N	3	*variable*	O	The 2 digit numeric Medicaid Card Sequence Number (SEQ). Left justify and space fill.

4.2 <u>Eligibility Verification Accepted Response Format</u> (Rev. 02/04)

Response Header Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
102		Version/Release Number	A/N	2	1-2	R	**51** (same as input)
103		Transaction Code	N	2	3-4	R	**E1** (same as input)
109		Transaction Count	A/N	1	5-5	R	1 = 1 Eligibility Response
501		Header Response Status	A/N	1	6-6	R	**A** = Acceptable
202		Service Provider ID Qualifier	A/N	2	7-8	R	Returns the same value that was entered.
201		Service Provider ID	A/N	15	9-23	R	Returns the same value that was entered.
401		Date of Service	N	8	24-31	R	Returns the same value that was entered.

Response Message Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	20=Response Message
FS	F4			3	*variable*	R	x'1C'F4
504		Message	A/N	37	*variable*	R	***Will be in the following format**:*
				8	1-8		Recipient's Medicaid Number (CIN)
				1	9-9		Space used to separate fields
				2	10-11		Recipient's County Code
				1	12-12		Value = * *(Used to separate fields)*
				2	13-14		Anniversary Month (values: 01-12)
				1	15-15		Space used to separate fields
				1	16-16		Sex Code (values: M or F)
				3	17-19		Date of Birth (Format = CYY)
				1	20-20		Space used to separate fields
				1	21-21		Category of Assistance
				1	22-22		Space used to separate fields
				2	23-24		Re-certification Month (values: 01-12)
				1	25-25		Space used to separate fields
				3	26-28		Office Number
				1	29-29		Value = **&** *(Used to separate fields)*
				8	30-37		Service Date "ccyymmdd"

Response Status Segment

Note: This group separator must appear prior to each group of segments pertaining to a single response status.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	R	x'1D'

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	21=Response Status
FS	AN			3	*variable*	R	x'1C'AN
112		Transaction Response Status	A/N	1		R	**A** = Acceptable
FS	FQ			3	*variable*	R	x'1C'FQ
526		Additional Message Information	A/N	96	*variable*	R	***Will be in the following format***:
				3	1-3		MEVS Eligibility Codes *(see Section 8.0, Table 1)*
				1	4-4		Space field separator
				2	5-6		Utilization Threshold/Post & Clear Code *(see Section 8.0, Table 8 on page 8.0.6, for values)*
				1	7-7		Value = **$** *(Used to separate fields)*
				9	8-16		Maximum Per Unit Price "999.99999"
				1	17-17		Value = **%** *(Used to separate fields)*
				3	18-20		Co-Payment Code *(see Section 8.0, Table 6 on page 8.0.4, for values)* or spaces
				1	21-21		Space field separator
				8	22-29		Copay Met Date
				1	30-30		Value of **(=)** equal sign *(Used to separate fields)*
				2	31-32		Medicare Coverage Code
				1	33-33		Space field separator
				12	34-45		HIC Number
				1	46-46		Value = **#** *(Used to separate fields)*
				2	47-48		First Insurance Carrier Code
				1	49-49		Value = **/** *(Used to separate fields)*
				14	50-63		First Insurance Coverage Codes
				1	64-64		Value = **@** *(Used to separate fields)*

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
				2	65-66		Second Insurance Carrier Code
				1	67-67		Value = **/** *(Used to separate fields)*
				14	68-81		Second Insurance Coverage Codes
				1	82-82		Value = **+** *(Used to separate fields)*
				2	83-84		Indication of Additional Coverage
				1	85-85		Value = ***** *(Used to separate fields)*
				11	86-96		Restriction Information - Exception Codes: "xx xx xx xx"

4.3   Eligibility Verification Rejected Response Format (Rev. 12/03)

Response Header Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
102		Version/Release Number	A/N	2	1-2	R	**51** (same as input)
103		Transaction Code	N	2	3-4	R	**E1** (same as input)
109		Transaction Count	A/N	1	5-5	R	1 = 1 Eligibility Response
501		Header Response Status	A/N	1	6-6	R	**R** = Rejected
202		Service Provider ID Qualifier	A/N	2	7-8	R	Returns the same value that was entered.
201		Service Provider ID	A/N	15	9-23	R	Returns the same value that was entered.
401		Date of Service	N	8	24-31	R	Returns the same value that was entered.

Response Status Segment
Note: This group separator will appear prior to each group of segments pertaining to a single response status.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	R	x'1D'

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	21=Response Status
FS	AN			3	*variable*	R	x'1C'AN
112		Transaction Response Status	A/N	1	*variable*	R	**R** = Rejected
The following fields can be repeated up to 20 times:							
FS	FA			3	*variable*	R	x'1C' FA
510		Reject Count	N	2	*variable*	R	Will contain the number of NCPDP Reject Codes listed in the following fields.
FS	FB			3	*variable*	R	x'1C' FB
511		Reject Code	A/N	2	*variable*	R	Will contain the NCPDP Reject Code applicable to the error. See Section 9.0 on page 9.0.1, for values.
FS	FQ			3	*variable*	R	x'1C'FQ
526		Additional Message Information	A/N	3	*variable*	R	***Will be in the following format***:
				3	*1-3*		MEVS Denial Code *(see Section 8.0, Table 2 on page 8.0.2, for values)*

5.0 DUR/PPS RESPONSE SEGMENT (REV. 02/04)

The DUR Response Data contains various data elements which facilitate the communication of clinical drug therapy information. Some of the responses (those with a Reason for Service Code of PG, PA, LD, and HD) will not return fields 529-FT, 530-FU or 531-FV.

The positions shown on the following pages are relative to the location of the DUR/PPS Response Segment in the transaction format. Refer to the transaction format to determine actual field positions.

Required Response DUR/PPS Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	24=Response DUR/PPS
The following fields can be repeated up to 3 times depending on the number of DUR Rejects and/or Warnings issued:							
FS	J6			3	*variable*	O	x'1C' J6
567		DUR/PPS Response Code Counter	N	1	*variable*	O	Indicates the number of DUR messages.
FS	E4			3	*variable*	O	x'1C' E4
439		Reason for Service Code	A/N	3	*variable*	O	The source code that will be generated and sent back to the pharmacy when a conflict is detected. Acceptable values are: **TD** = Therapeutic Duplication **DD** = Drug-Drug Interactions **DC** = Inferred Drug Disease Precaution **PG** = Drug Pregnancy Alert **PA** = Drug Age Precaution **LD** = Low Dose Alert **HD** = High Dose Alert
FS	FS			3	*variable*	O	x'1C' FS
528		Clinical Significance Code	A/N	1	*variable*	O	Indicates how critical the conflict is. This field reflects the severity the originating database has assigned to an interaction.
FS	FT			3	*variable*	O	x'1C' FT
529		Other Pharmacy Indicator	A/N	1	*variable*	O	Indicates the source of the previous prescription that forms the basis for the conflict with the present prescription. Acceptable values are: **0** = Not Specified **1** = Your Pharmacy **3** = Other Pharmacy
FS	FU			3	*variable*	O	x'1C' FU

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
530		Previous Date of Fill	N	8	*variable*	O	Previous date prescription was filled. Format = **CCYYMMDD**
FS	FV			3	*variable*	O	x'1C' FV
531		Quantity of Previous Fill	D	10	*variable*	O	Indicates the quantity of the conflicting agent that was previously filled.
FS	FW			3	*variable*	O	x'1C' FW
532		Database Indicator	A/N	1	*variable*	O	Identifies the source of the message. Acceptable value is: **1** = First DataBank
FS	FX			3	*variable*	O	x'1C' FX
533		Other Prescriber Indicator	N	1	*variable*	O	Compares the prescriber of the current prescriptions to the prescriber of the previously filled conflicting prescription. Acceptable values are: **0** = Not Specified **1** = Same prescriber **2** = Other Prescriber
FS	FY			3	*variable*	O	x'1C' FY
544		DUR Free Text Message	A/ N	30	*variable*	O	Will contain data to assist the pharmacist in further identifying the DUR Conflict.

6.0 <u>**REVERSAL TRANSACTION**</u> (REV. 09/03)

A reversal transaction is needed to cancel or reverse a previously submitted transaction.

Only one claim or service authorization can be reversed at a time.

NCPDP Reversals can be submitted for service dates up to two years old as long as the previous transaction was submitted directly to the eMedNY contractor, or the transaction was submitted to eFunds no longer than 90 days prior to the eMedNY contractor takeover of the MEVS system.

By submitting a reversal via NCPDP format, you can either: reverse a previous NCPDP transaction, or the NCPDP reversal can be used to void a claim sent via paper or magnetic media. If a non-capture transaction (NO CLAIM TO FA) is being reversed, the action taken by the claims processing system is contingent on if the subsequent paper or magnetic media claim was approved during the interim.

If a paper or magnetic media claim was approved for payment during the interim, the paper or magnetic media claim will be voided, and any units used by the claim will be restored to its applicable service authorization or prior approval. The service authorization and prior approval will remain available for future use until the record becomes inactive.

If a subsequent paper or magnetic media claim has not been approved for payment during the interim, the non-capture transaction will be reversed, and any applicable service authorization or DVS prior approval generated as a result of submitting the non-capture transaction will be cancelled. When cancelled, the authorizations and approvals previously generated are no longer useable.

When reversing a previously submitted ECCA transaction that was captured for payment, if approved, the reversal will cancel any service authorization units used and cancel any DVS prior approval generated by the original transaction.

If a reversal transaction for a previously paid claim is approved, the remittance statement will show a new invoice number for the reversal transaction, and the information from the original claim that was reversed/voided on the subsequent line of the remittance.

Refer to <u>Section 3.1</u> (page 3.0.1) "Request Segment Usage Matrix" for a quick synopsis of which segments are mandatory, optional, optional but required by NYS, or Not Sent.

6.1 <u>Reversal Transaction Request Format</u> (Rev. 02/04)

Transaction Header Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
101		BIN Number	N	6	1-6	R	**004740** = New York's Assigned Number
102		Version/Release Number	A/N	2	7-8	R	**51** = Variable Format
103		Transaction Code	N	2	9-10	R	*This field identifies the type of transaction and number of prescriptions being submitted. Acceptable* TRANSACTION TYPES*:* **B2 = Reversal** **N2 = DUR Reversal** **P2 = Prior Authorization Reversal**
104		Processor Control Number	A/N	10	11-20	R	Required for a reversal for a paid captured claim. Will be ignored for a non-captured claim.
109		Transaction Count	N	1	21	R	Blank=Not Specified 1=One Occurrence
202		Service Provider ID Qualifier	N	2	22-23	R	Ø5=Medicaid
201		Service Provider ID	A/N	15	21-38	R	Field Entry consists of: The eight digit *Medicaid Provider Identification Number* assigned to the Pharmacy by the Dept. of Health. Must left justify, space fill.
401		Date of Service	N	8	39-46	R	The *date of service* the prescription was filled. Format = **CCYYMMDD**.
110		Software Vendor/Certification ID	A/N	10	47-56	R	Leave this field blank.

Claim Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	Ø7=Claim
FS	EM			3	*variable*	R	X'1C' EM
455		Prescription/Service Reference Number Qualifier	N	1	*variable*	R	1 = RX Billing.
FS	D2			3	*variable*	R	x'1C' D2
402		Prescription/Service Reference Number	N	7	*variable*	R	The prescription number assigned by the pharmacy. Right justify and zero fill.
FS	E1			3	*variable*	R	x'1C' E1
436		Product/Service ID Qualifier	A/N	2	*variable*	R	Use this field to identify the *Product Type* dispensed. This field is used when the item dispensed is a product supply item (section 4.2 and 4.3 of MMIS Pharmacy Provider Manual), when an NDC code is submitted or for a **DVS transaction**. Acceptable values are: **03 =** NDC **09 =** HCPCS
FS	D7			3	*variable*	R	x'1C' D7

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
407		Product/Service ID	N	19	*variable*	R	Use this field to enter either the NDC code or the HCPCS Code. When entering a *National Drug Code* identifying the dispensed drug, only an 11 digit numeric entry is acceptable. When billing compounds use code 99999999999 when billing multiple ingredients where the most costly element is not covered by Medicaid. Otherwise compounds must be billed by individual components using the appropriate NDC code. Regulated drug components such as narcotics and other Schedule class drugs must be billed as separate components using a valid NDC code with a valid quantity which requires the use of multiple claim lines for each of the billed components. When submitting HCPCS codes, enter a 7character field (beginning with an alpha and ending with 2 blanks). A two position modifier can replace the 2 blanks if it applies, e.g. **BO**. If a HCPCS code is entered, Field 436-E1 must be equal to 09.

6.2 <u>**Reversal Response Overview**</u> (Rev. 09/03)

Two types of response formats can be expected for a reversal transaction. The first is the accepted response and the second is the rejected response. The transaction response status code is limited to an "A" for "transaction acceptable" or an "R" for "transaction unacceptable" or rejected.

For each transaction, error codes will be returned if applicable. NCPDP format errors will be returned in the reject code fields (511-FB). MEVS denial codes will be part of the message field (504-F4) in the first three bytes. See the layouts that follow for details.

6.3 <u>Reversal Response Accepted Format</u> (Rev. 12/03)

Response Header Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
102		Version/Release Number	A/N	2	1-2	R	**51** (same as input)
103		Transaction Code	N	2	3-4	R	**B2, N2, or P2** (same as input)
109		Transaction Count	A/N	1	5-5	R	1 = 1 Reversal Response
501		Header Response Status	A/N	1	6-6	R	**A** = Accepted This response value means the reversal has been accepted.
202		Service Provider ID Qualifier	A/N	2	7-8	R	Returns the same value that was entered.
201		Service Provider ID	A/N	15	9-23	R	Returns the same value that was entered.
401		Date of Service	N	8	24-31	R	Returns the same value that was entered.

Response Status Segment

Note: This group separator will appear prior to each group of segments pertaining to a single response status.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	R	x'1D'

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C'AM
111		Segment Identification	N	2	*variable*	R	21=Response Status
FS	AN			3	*variable*	R	x'1C'AN
112		Transaction Response Status	A/N	1		R	**A** = Acceptable
FS	F3			3	*variable*	O	x'1C'F3
503		Authorization Number	A/N	20	*variable*	O	The nine digit invoice number assigned to the reversal will be returned in this field.
FS	FQ			3	*variable*	R	x'1C'FQ
526		Additional Message Information	A/N	3	*variable* 1-3	R	***Will be in the following format***: MEVS Accepted Codes (*see Section 8.0, Table 1 on page 8.0.2 for values*)

Response Claim Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C' AM
111		Segment Identification	N	2	*variable*	R	22 = Response Claim
FS	EM			3	*variable*	R	x'1C' EM
455		Prescription/Service Reference Number Qualifier	A/N	1	*variable*	R	Returns the same value that was entered.
FS	D2			3	*variable*	R	x'1C' D2
402		Prescription/Service Reference Number	A/N	7	*variable*	R	The Prescription Number that was entered will be returned in this field.

6.4   Reversal Response Rejected Format (Rev. 12/03)

Response Header Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
102		Version/Release Number	A/N	2	1-2	R	**51** (same as input)
103		Transaction Code	N	2	3-4	R	**B2, N2, or P2** (same as input)
109		Transaction Count	A/N	1	5-5	R	1 = 1 Reversal Response
501		Header Response Status	A/N	1	6-6	R	**R** = Rejected or Unacceptable
202		Service Provider ID Qualifier	A/N	2	7-8	R	Returns the same value that was entered.
201		Service Provider ID	A/N	15	9-23	R	Returns the same value that was entered.
401		Date of Service	N	8	24-31	R	Returns the same value that was entered.

Response Status Segment

Note: This group separator will appear prior to each group of segments pertaining to a single response status.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
GS				1	*variable*	R	x'1D'

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C' AM
111		Segment Identification	N	2	*variable*	R	21 = Response Status
FS	AN			3	*variable*	R	x'1C' AN
112		Transaction Response Status	A/N	1	*variable*	R	**R** = Rejected or Unacceptable.
The following fields can be repeated up to 20 times:							
FS	FA			3	*variable*	O	x'1C' FA
510		Reject Count	N	2	*variable*	O	Will contain the number of NCPDP Reject Codes listed in the following fields.
FS	FB			3	*variable*	O	x'1C' FB
511		Reject Code	A/N	2	*variable*	O	Will contain the NCPDP Reject Code applicable to the error. See Section 9.0, on page 9.0.1, for values.
FS	FQ			3	*variable*	O	x'1C' FQ
526		Additional Message Information	A/N	3-15	*variable*	O	
					1-3	O	MEVS Denial Code (*see Section 8.0, Table 2 on page 8.0.2, for values*)

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
					1-51	O	If more than 1 reversal transaction is submitted, the message "Resubmit Additional Reversal Transaction separately" is displayed.

Response Claim Segment

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
SS				1	*variable*	R	x'1E' segment separator
FS	AM			3	*variable*	R	x'1C' AM
111		Segment Identification	N	2	*variable*	R	22 = Response Claim
FS	EM			3	*variable*	R	x'1C' EM
455		Prescription/Service Reference Number Qualifier	A/N	1	*variable*	R	Returns the same value that was entered.
FS	D2			3	*variable*	R	x'1C' D2
402		Prescription/Service Reference Number	A/N	7	*variable*	R	The Prescription Number that was entered will be returned in this field.

7.0 **FORMS** (REV. 06/04)

The following forms are included in the manual:
Personal Identification Number Request
Certification Statement For Provider Utilizing Electronic Billing

PERSONAL IDENTIFICATION NUMBER REQUEST

Provider Number _____

Provider Name _____

Provider Address _____

_____

_____

_____

Pin Number ____ ____ ____ ____
(Any four (4) digits)

Name _____
(Print or Type)

Signature _____ Date _____

Telephone Number ( ) _____

Return To:

New York State Department of Health
Suite 608
99 Washington Avenue
Albany, NY 12210
Attn: Diane Sumell

Electronic Billing Certification Statement Instructions

Field (1): ETIN (Magnetic Supplier Number)

Please indicate the ETIN under which the claims are being transmitted.

Field (2): BILLING SERVICE NAME

If applicable, enter the name of the billing service that the provider is enrolled with. If not using a billing service, leave this field blank.

Field (3): DATE

Enter the date the Certification Statement is signed and notarized (same date as Field 7).

Field (4): PROVIDER NAME

Enter the name of the provider whose signature is being notarized.

Field (5): PROVIDER NUMBER

Enter the 8-digit Medicaid provider ID number which was assigned by the Department of Health at the time of the provider's enrollment. This must be the individual provider number, not a group number or license number.

Field (6): SIGNATURE

Enter the signature of the individual indicated in Field 4. The signature must be original.

Field (7): DATE

Enter the date the Certification Statement is signed and notarized.

Field (8): NAME AND TITLE

Print the name and the title of the individual whose signature appears in Field 6.

Field (9): NOTARY PUBLIC

To be completed and signed by the Notary Public. Certification Statements that are not notarized cannot be accepted by the fiscal agent.

PLEASE NOTE:

Electronic Billing Certification must be renewed annually. Renewal documents will be provided prior to certification expiration.

ETIN_____(1)_____BILLING SERVICE NAME (IF APPLICABLE_____(2)_____
MEDICAID MANAGEMENT INFORMATION SYSTEM

CERTIFICATION STATEMENT FOR PROVIDER UTILIZING ELECTRONIC BILLING
(Rev. 06/04)

As of (date)_____(3)_____and for one year after this date all claims electronically submitted to the State's Medicaid fiscal agent, for services or supplies furnished by (provider name) _____(4)_____(provider number) ___(5)_____will be subject to the following certification.

I am (or the business entity named on this form of which I am a partner, officer or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim; the person(s) providing services, care or supplies have the required licensing, certification and training. I have reviewed this form; I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized and I or the entity make this claim in accordance with applicable federal and state laws and regulations. I certify that the services were rendered at the location listed in the "place of service field" and that such location has been entered on the claim. I HAVE READ THE MEDICAID MANAGEMENT INFORMATION SYSTEMS PROVIDER MANUAL AS IT RELATES TO THE CLAIM FORM, AND ALL REVISIONS AND UPDATES THERETO; ALL CLAIMS ARE MADE IN FULL COMPLIANCE WITH THE PERTINENT PROVISIONS OF THE MANUAL, REVISIONS AND UPDATES; ALL CLAIMS FOR CARE SERVICES AND SUPPLIES PROVIDED AT THE ORDER OF ANOTHER PROFESSIONAL HAVE TO THE BEST OF MY KNOWLEDGE BEEN ORDERED BY THAT PROFESSIONAL IN BONA FIDE COMPLIANCE WITH THE PROCEDURES SET FORTH IN THE MANUAL, REVISIONS, OR UPDATES AND ALL FEDERAL AND STATE LAWS AND REGULATIONS. ALL CARE, SERVICES, AND SUPPLIES FOR WHICH CLAIM IS MADE ARE MEDICALLY NECESSARY FOR THE TREATMENT OF THE NAMED RECIPIENT. The amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than, the Medical Assistance Program; payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid; ALL. STATEMENTS MADE HEREON ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM; I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT; taxes from which the State is exempt are excluded; all records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding this claim and payment therefor shall be promptly furnished upon request to the local social services district or the New York State Department of Health, the State Medicaid Fraud Control Unit or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion; I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to this claim to enable its automated processing subject to reversal by provider, and (2) accept the claim data on this form as original evidence of care, services and supplies furnished.

By making this claim I understand and agree that I (or the entity) shall be subject to and bound by all laws, rules, regulations, policies, standards, fee codes and procedures of the United States Department of Health and Human Services, the New York State Department of Health (Department) and other publications of the Department, including Medicaid Management Information System Provider Manuals and other official bulletins of the Department or any other law, rule, regulation, policy, procedures of any other state agency which governs the provision of or billing for care, services or supplies which are reimbursed under the Medical Assistance Program for the State of New York. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, present or future status in the Medicaid program and/or imposing any duly considered sanction or penalty. I further certify that I have complied with the billing requirements of the United States Department of Health and Human Services and the Department including but not limited to the following: If I am billing as an individual provider (individual practitioner or business entity which is not required to enroll as a group), I certify that the care, services or supplies were provided by me except in situations where care, services or supplies were provided: (a) under a locum tenens agreement or (b) by a physician's assistant or certified social worker who was under my supervision, and that my provider identification number is being used on the claim for payment. If I am required to bill as a group provider, I certify that the care, services or supplies were provided by the group, that the provider identification number of the group is being used on the claim for payment, and that the provider identification number of the individual who provided the service has been entered on the claim.

I UNDERSTAND THAT MY SIGNATURE HEREON GUARANTEES THE ABOVE CERTIFICATION WILL APPLY TO ALL ELECTRONIC CLAIMS SUBMITTED, USING MY (OR THE ENTITY'S) MEDICAID PROVIDER IDENTIFICATION NUMBER.

(Signature)_____(6)_____(Date)_____(7)_____

(Typed Name and Title)_____(8)_____

STATE OF NEW YORK
COUNTY OF   (9)

On this day of   , 20   ,before me personally came   , to me known and known to me to be the individual described in and who executed the foregoing instrument, and (s)he acknowledged to me that (s)he executed the same.
(SEAL)

_____
NOTARY PUBLIC

ETIN_____BILLING SERVICE NAME (IF APPLICABLE_____
MEDICAID MANAGEMENT INFORMATION SYSTEM

CERTIFICATION STATEMENT FOR PROVIDER UTILIZING ELECTRONIC BILLING
(Rev. 06/04)

As of (date)_____and for one year after this date all claims electronically submitted to the State's Medicaid fiscal agent, for services or supplies furnished by (provider name) _____(provider number) _____ will be subject to the following certification.

I am (or the business entity named on this form of which I am a partner, officer or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim; the person(s) providing services, care or supplies have the required licensing, certification and training. I have reviewed this form; I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized and I or the entity make this claim in accordance with applicable federal and state laws and regulations. I certify that the services were rendered at the location listed in the "place of service field" and that such location has been entered on the claim. I HAVE READ THE MEDICAID MANAGEMENT INFORMATION SYSTEMS PROVIDER MANUAL AS IT RELATES TO THE CLAIM FORM, AND ALL REVISIONS AND UPDATES THERETO; ALL CLAIMS ARE MADE IN FULL COMPLIANCE WITH THE PERTINENT PROVISIONS OF THE MANUAL, REVISIONS AND UPDATES; ALL CLAIMS FOR CARE SERVICES AND SUPPLIES PROVIDED AT THE ORDER OF ANOTHER PROFESSIONAL HAVE TO THE BEST OF MY KNOWLEDGE BEEN ORDERED BY THAT PROFESSIONAL IN BONA FIDE COMPLIANCE WITH THE PROCEDURES SET FORTH IN THE MANUAL, REVISIONS, OR UPDATES AND ALL FEDERAL AND STATE LAWS AND REGULATIONS. ALL CARE, SERVICES, AND SUPPLIES FOR WHICH CLAIM IS MADE ARE MEDICALLY NECESSARY FOR THE TREATMENT OF THE NAMED RECIPIENT. The amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than, the Medical Assistance Program; payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid; ALL. STATEMENTS MADE HEREON ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM; I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT; taxes from which the State is exempt are excluded; all records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding this claim and payment therefor shall be promptly furnished upon request to the local social services district or the New York State Department of Health, the State Medicaid Fraud Control Unit or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion; I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to this claim to enable its automated processing subject to reversal by provider, and (2) accept the claim data on this form as original evidence of care, services and supplies furnished.

By making this claim I understand and agree that I (or the entity) shall be subject to and bound by all laws, rules, regulations, policies, standards, fee codes and procedures of the United States Department of Health and Human Services, the New York State Department of Health (Department) and other publications of the Department, including Medicaid Management Information System Provider Manuals and other official bulletins of the Department or any other law, rule, regulation, policy, procedures of any other state agency which governs the provision of or billing for care, services or supplies which are reimbursed under the Medical Assistance Program for the State of New York. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, present or future status in the Medicaid program and/or imposing any duly considered sanction or penalty. I further certify that I have complied with the billing requirements of the United States Department of Health and Human Services and the Department including but not limited to the following: If I am billing as an individual provider (individual practitioner or business entity which is not required to enroll as a group), I certify that the care, services or supplies were provided by me except in situations where care, services or supplies were provided: (a) under a locum tenens agreement or (b) by a physician's assistant or certified social worker who was under my supervision, and that my provider identification number is being used on the claim for payment. If I am required to bill as a group provider, I certify that the care, services or supplies were provided by the group, that the provider identification number of the group is being used on the claim for payment, and that the provider identification number of the individual who provided the service has been entered on the claim.

I UNDERSTAND THAT MY SIGNATURE HEREON GUARANTEES THE ABOVE CERTIFICATION WILL APPLY TO ALL ELECTRONIC CLAIMS SUBMITTED, USING MY (OR THE ENTITY'S) MEDICAID PROVIDER IDENTIFICATION NUMBER.

(Signature)_____ (Date)_____

(Typed Name and Title)_____

STATE OF NEW YORK
COUNTY OF

On this day of   , 20   ,before me personally came   , to me known and known to me to be the individual described in and who executed the foregoing instrument, and (s)he acknowledged to me that (s)he executed the same.
(SEAL)

_____
NOTARY PUBLIC

8.0 <u>**MEVS CODES**</u> (REV. 07/04)

<u>**MEVS Accepted Codes – Table 1**</u>

Code	Description
002	MA Eligible
003	Eligible Only Outpatient Care
005	Eligible Capitation Guarantee Only
006	Eligible PCP
007	Emergency Services Only
008	Presumptive Eligible Long-Term/Hospice
009	Medicare Coinsurance Deductible Only
010	Eligible Except Nursing Facility Services
013	Presumptive Eligibility Prenatal A
014	Presumptive Eligibility Prenatal B
015	Perinatal Family
016	MA Eligible-HR-Utilization Threshold
017	Family Health Plus Services Only
018	Family Planning Services Only
021	Record Canceled – Cancels a Previously Accepted Claim
034	Community Coverage With Community Based Long Term Care
035	Community Coverage without Long Term Care
036	Outpatient Coverage with Community Based Long Term Care
037	Outpatient Coverage without Long Term Care
038	Outpatient Coverage with No Nursing Facility Services

Note: If code is received and not found in tables, call the Provider Services Department at 1-800-343-9000.

MEVS Denial Codes – Table 2 (Rev. 11/02)

Code	Description
001	Not MA Eligible
030	Expired Temporary Card
031	Invalid Plastic Card Status
033	Non-current Card
045	No Authorization Found
050	Alternate Access Not Allowed
051	Invalid Provider Number
052	Provider Not on File
053	SSN Access Not Allowed
054	Provider Cannot Access by Account Type
055	Provider Not Eligible
056	Reenter Ordering Provider Number
059	Invalid License Type
061	Invalid Access Number
062	Invalid Medicaid Number
063	Invalid Sequence Number
065	Recipient Not on File
066	Disqualified Ordering Provider
067	Deceased Ordering Provider
068	Invalid Ordering Provider
071	Invalid Date
092	Invalid Specialty Code
100	Invalid Referring Provider Number
101	Restricted Recipient No Auth
103	No Coverage: Pending Family Health Plus
104	No Coverage-Excess Income
105	QMB Requires Medicare Approval
118	MCCP Recipient No Auth
300	Service Date Prior to Birth Date
302	Provider Ineligible Service on Date Performed
303	Prior Approval Indicated Denied/Rejected by NYS
304	Recipient ID Unequal to Prior Approval File
305	Child Care Recipient - Bill Agency

Code	Description
307	Prior Approval Units or Payment Amount Exceeded
308	Service Date Not Within Prior Approval Range
309	Claim Type Unequal to Prior Approval Record Class
312	Pregnancy Indicated – Invalid for Recipient Sex or Age
313	Provider Reimbursed for Medicare Only
314	Recipient Not QMB, Services Not Reimbursable
315	Recipient Not Medicare, Services Not Reimbursable
316	Claim Previously Paid Using Another Provider Number
318	Prescribing Provider License not in Active Status
320	Other Insurance Information Inconsistent
321	Pharmacy Service Included in Out-of-State Facility Rate
322	Online Adjustments/Rebills Not Allowed For DVS Items/Drugs
323	Processor Control Number Needed for Rebill/Reversal of Paid Claim
324	The system or file necessary to process the transaction is currently unavailable. Please call Provider Services at 800-343-9000 for system status or resubmit the transaction at a later time
325	Pharmacy Service Included in In-State Facility Rate
700	Year of Birth Not Equal to File
701	Sex Not Equal to File
702	ECCA Not Allowed
703	Invalid PIN
704	Invalid ETIN
999	Header Field Error

Note: If code is received and not found in tables, call the Provider Services Department at 1-800-343-9000.

<u>Co-payment Codes – Table 6</u> (Rev. 11/02)

Code	Description
127	Co-payment Requirements Have Been Met
128	No Co-payment Required – Recipient Under Age 21 or Exempt

Note: If code is received and not found in tables, call the Provider Services Department at 1-800-343-9000.

Rx Denial Codes – Table 7 (Rev. 12/03)

Code	Description
132	Missing/Invalid item/NDC code
133	Item not covered for patient gender
134	Patient age exceeds maximum age
135	Patient age precedes minimum age
136	Requested item exceeds frequency limitation
137	Missing/Invalid quantity dispensed
140	Category of service not valid for item / NDC code
142	Missing/Invalid category of service
705	NDC/HCPCS Not Covered
706	Refill Code Exceeds Number of Refills Authorized
707	Previously Filled Refill
708	Exceeds NY Allowable Refill Maximum
709	Maximum Days Supply Exceeded
710	Maximum Quantity Exceeded
711	Date Filled Prior to Date Rx Written
712	Override Denied-UT not at limit
713	Refill over 180 days old from date Rx Written
714	Date Filled More than 60 days from Date Rx Written
715	Other Insurance Amount must be greater than Zero
716	Other Insurance Amount must be equal to Zero
717	Recipient has Other Insurance
718	HR Recipient-No Rebate Agreement
719	MA Only Covers Family Planning
720	Days Supply is less than Minimum Required
722	Family Health Plus Denial

Note: If code is received and not found in tables, call the Provider Services Department at 1-800-343-9000.

Pharmacy UT & P & C Codes – Table 8 (Rev. 11/02)

Code	Description
AA	UT Approved P&C Approved
AD	UT Approved, Services Not Ordered
AN	UT Approved, P&C Not Invoked
DA	UT At Service Limit, P&C Approved
DD	UT At Service Limit, Services Not Ordered
DN	UT at Service Limit, P&C Not Invoked
LA	UT Approved Near Limit, P&C Approved
LD	UT Approved Near Limit, Services Not Ordered
LN	UT Approved Near Limit, P&C Not Invoked
NA	UT Not Invoked, P&C Approved
ND	UT Not Invoked, Services Not Ordered
NN	UT Not Invoked, P&C Not Invoked
PA	UT Override Denied, P&C Approved
PD	UT Override Denied, Services Not Ordered
PN	UT Override Denied, P&C Not Invoked
XX	DUR Denial

Note: If code is received and not found in tables, call the Provider Services Department at 1-800-343-9000.

Dispensing Validation System Reason Codes - Table 9 (Rev. 12/03)

Code	Description
129	Duplicate/Redundant DVS request
130	DVS process was not invoked
131	Item approved/DVS number Issued
132	Missing/Invalid item/NDC code
133	Item not covered for patient gender
134	Patient age exceeds maximum age
135	Patient age precedes minimum age
136	Requested item exceeds frequency limitation
137	Missing/Invalid quantity dispensed
139	DVS requires current date entry
140	Category of service not valid for item/NDC code
142	Missing/Invalid Category of Service
705	NDC/HCPCS not Covered
710	Maximum Order Quantity Exceeded

Note: If code is received and not found in tables, call the Provider Services Department at 1-800-343-9000.

Pend Reason Codes – Table 10 (Rev. 11/02)

Code	Description
301	Pending for Manual Pricing (NDC requires Manual Review and pricing)
306	Item Requires Manual Review (NDC requires Manual Review prior to payment)
310	Pharmacy Service Included in In-State Facility Rate
311	PCP Plan Code Not on Contract File – Call Provider Services 800-343-9000
317	Claim Pending: Excess Income/Spenddown
319	Prior Approval Not on or Removed From File

Note: These codes may appear in the Table 2 response area for non-ECCA and in some eligibility transactions since both transaction types will not be held in a pending status. They will be rejected if the conditions for these reason codes exist.

9.0 **NCPDP REJECT CODES** (REV. 09/03)

Code	Description
	M/I=Missing Invalid
01	M/I BIN
04	M/I Processor Control Number
05	M/I Pharmacy Number
07	M/I Cardholder ID Number
08	M/I Person Code
09	M/I Birth Date
10	M/I Patient Gender Code
13	M/I Other Coverage Code
14	M/I Eligibility Override Code
15	M/I Date of Service
16	M/I Prescription/Service Reference Number
17	M/I Fill Number
19	M/I Days Supply
20	M/I Compound Code
21	M/I Product/Service ID
22	M/I Dispense as Written (DAW)/Product Selection Code
25	M/I Prescriber Id
28	M/I Date Prescription Written
29	M/I Number Refills Authorized
34	M/I Submission Clarification Code
35	M/I Primary Care Provider ID
50	Non-Matched Pharmacy Number
52	Non-Matched Cardholder Id
61	Product/Service Not Covered for Patient Gender
65	Patient is Not Covered
66	Patient Age Exceeds Maximum Age
70	Product/Service Not Covered
75	Prior Authorization Required
76	Plan Limitations Exceeded
77	Discontinued Product/Service ID Number
81	Claim Too Old

Code	Description
82	Claim Is Post Dated
83	Duplicate Paid/Captured Claim
84	Claim Has Not Paid/Captured
85	Claim Not Processed
87	Reversal Not Processed
88	DUR Reject Error
92	System Unavailable
DQ	M/I Usual and Customary Charge
DV	M/I Other Payor Amount Paid
DX	M/I Patient Paid Amount Submitted
EV	M/I Prior Authorization Number Submitted
E1	M/I Product/Service ID Qualifier
E4	M/I Reason For Service Code
E6	M/I Result of Service Code
E7	M/I Quantity Dispensed
E9	M/I Provider ID
MZ	Error Overflow

Note: If code is received and not found in tables, call the Provider Services Department at 1-800-343-9000

10.0 <u>NCPDP 1.1 BATCH TRANSACTION RECORD STRUCTURE</u> (Rev. 02/04)

Note: The following pages are only required for providers and vendors that will submit batch transactions via magnetic media (tape / diskette) or Electronic Batch Dial-up. If your organization will not submit NCPDP 1.1 transactions, please ignore all pages beyond this point. Please refer to the NYSDOH Technical Supplementary Companion Guide and/or the NCPDP Batch Pharmacy Dial-Up User Manual for further formatting information and submission requirements.

Special Considerations for NCPDP Batch 1.1

System Availability

The NYS Medicaid batch transaction submission system is available to providers 24 hours a day, seven days a week. Transactions sent in after 5 PM will be processed in the following daily cycle.

Notification of Errors and Problems

If a provider has any questions, they may contact the Help Desk personnel who can assist with problem resolution. The Help Desk Unit will be available to answer questions and to address any problems that may occur during normal business hours. Please contact the Help Desk at (866) 840-3445.

<u>Transaction Format Information</u>

The NYS Medicaid will accept Batch Standard Format Version 1.1. Version 1.1 is the envelope structure used to transmit Version 5.1 transactions as described in this document within a batch mode. Each batch transmission must contain a Batch Header Record, one or many Transaction Detail Data Records which contain the NCPCP 5.1 information, and a Batch Trailer Record.

Batch Header Record (Request File)

The required batch header record is a fixed length record 75 bytes long.

The following is the layout for submitting the batch header record.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
880	K4	Text Indicator	A/N	1	1-1	R	Enter a value of **x'02'** to indicate the Start of the text.
701		Segment Identifier	A/N	2	2-3	R	**00** = File Control (header)
880	K6	Transmission Type	A/N	1	4-4	R	**T** = Transaction
880	K1	Sender ID	A/N	24	5-28	R	The first three positions must be the ETIN (formerly the Tape Supplier Number) followed by an eight digit Medicaid Provider ID. The remaining field positions must be space filled.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
806	5C	Batch Number	N	7	29-35	R	Enter the date the batch was created in Julian Date Format. **Format=CCYYDDD** CC= Century YY = Year DDD = Julian Date i.e. 2003230 = August 18, 2003 This number must match the Batch Number in the Trailer Record.
880	K2	Creation Date	N	8	36-43	R	Enter date file created in **CCYYMMDD** format
880	K3	Creation Time	N	4	44-47	R	Enter time file created in **HHMM** format.
702		File Type	A/N	1	48-48	R	**P** = Production **T** = Test
102	A2	Version/Release Number	A/N	2	49-50	R	**11** = Version 1.1
880	K7	Receiver ID	A/N	24	51-74	R	Enter **EMEDNYBAT** in this field followed by space fill to end.
880	K4	Text Indicator	A/N	1	75-75	R	Enter a value of **x'03'** to indicate the End of the text.

Transaction Detail Header

The transaction detail header record is a 13 byte fixed length record, which identifies and prefixes each 5.1 variable transaction detail record in the batch. Each detail record is terminated with the End of Text indicator x'03'.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
880	K4	Text Indicator	A/N	1	1-1	R	Enter a value of **x'02'** to indicate the Start of the text.
701		Segment Identifier	A/N	2	2-3	R	**G1** = Detail Data Record
880	K5	Transaction Reference Number	A/N	10	4-13	R	This number is assigned by the Pharmacy. This number uniquely identifies each claim within the submission.
		NCPDP Data Record	varies	14	variable	R	The NCPDP 5.1 Standard data stream is inserted here starting with the 5.1 Transaction Header Segment as defined in Section 3.0 on page 3.0.1.
880	K4	Text Indicator	A/N	1	variable	R	Enter a value of **x'03'** to indicate the End of the text.

Batch Trailer Record

The required batch trailer record is a fixed length record 56 bytes long.

The following is the layout for submitting the batch trailer record.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
880	K4	Text Indicator	A/N	1	1-1	R	Enter a value of **x'02'** to indicate the Start of the text.
701		Segment Identifier	A/N	2	2-3	R	**99** = File Trailer
806	5C	Batch Number	N	7	4-10	R	Enter the same Batch Number that is on the Batch Header Record. **Format=CCYYDDD** CC= Century YY = Year DDD = Julian Date i.e.2003230 = August 18, 2003
751		Record Count	N	10	11-20	R	Enter the total number of records within the batch, including the batch header and trailer records.
504	F4	Message	A/N	35	21-55	R	Free form text or blank fill for 35 positions.
880	K4	Text Indicator	A/N	1	56-56	R	Enter a value of **x'03'** to indicate the End of the text.

Batch Header Record (Response file)

The required batch header response record is a fixed length record 75 bytes long.

The following is the layout for the batch header response record.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
880	K4	Text Indicator	A/N	1	1-1	R	Enter a Value of **x'02'** to indicate the Start of the text.
701		Segment Identifier	A/N	2	2-3	R	**00** = File Control (header)
880	K6	Transmission Type	A/N	1	4-4	R	**R** = Response
880	K1	Sender ID	A/N	24	5-28	R	Returns **EMEDNYBAT** in this field followed by space filler to end.
806	5C	Batch Number	N	7	29-35	R	Returns the same batch number as submitted from the inbound batch. This number will match the batch number in the Trailer Record.
880	K2	Creation Date	N	8	36-43	R	Enter Date file created in **CCYYMMDD** format
880	K3	Creation Time	N	4	44-47	R	Enter Time file created in **HHMM** format.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
702		File Type	A/N	1	48-48	R	**P** = Production **T**= Test
102	A2	Version/Release Number	A/N	2	49-50	R	**11** = Version 1.1
880	K7	Receiver ID	A/N	24	51-74	R	Returns the number submitted from the Sender ID field with the outbound responses.
880	K4	Text Indicator	A/N	1	75-75	R	Value of **x'03'** to indicate the End of the text.

Transaction Detail Header

The transaction detail header record is a 13 byte fixed length record, which identifies and prefixes each 5.1 variable transaction response detail record in the batch. Each detail record is terminated with the End of Text indicator x'03'.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
880	K4	Text Indicator	A/N	1	1-1	R	Value of **x'02'** to indicate the Start of the text.
701		Segment Identifier	A/N	2	2-3	R	**G1** = Detail Data Record
880	K5	Transaction Reference Number	A/N	10	4-13	R	The number assigned by the provider to uniquely identify each claim transaction within the batch will be returned with the correlated response to the transaction submitted.
		NCPDP Transaction Data Record	varies	14	variable	R	The NCPDP 5.1 Standard data stream response is inserted here starting with the 5.1 Response Header Segment as defined in Section 3.4
880	K4	Text Indicator	A/N	1	variable	R	Value of **x'03'** to indicate the End of the text.

Batch Trailer Record

The required batch trailer record is a fixed length record 56 bytes long.

The following is the layout for the batch trailer record.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
880	K4	Text Indicator	A/N	1	1-1	R	Value of **x'02'** to indicate the Start of the text.
701		Segment Identifier	A/N	2	2-3	R	**99** = File Trailer
806	5C	Batch Number	N	7	4-10	R	Returns the same batch number as submitted from the inbound batch. This number will match the batch number in the Header Record.

Fld#	Id	Field Name	Format	Length	Position	Req	Value/Comments
751		Record Count	N	10	11-20	R	The total number of response records within the batch, including the batch header and trailer records.
504	F4	Message	A/N	35	21-55	R	Free form text or blank fill for 35 positions.
880	K4	Text Indicator	A/N	1	56-56	R	Value of **x'03'** to indicate the End of the text.