NCPDP PAYER SHEET

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

GENERAL INFORMATION

Payer Name: Montana Medicaid	Date: June 1, 2017	
Plan Name/Group Name: Montana Medicaid/ Montana Mental Health Services (MHSP)/ Healthy Montana Kids (HMK)/ Montana Health and Economic Livelihood Partnership (HELP)	BIN: 610084	PCN: DRMTPROD = Production
Plan Name/Group Name: Montana Medicaid/ Montana Mental Health Services (MHSP)/ Healthy Montana Kids (HMK)/ Health and Economic Livelihood Partnership (HELP) (test)	BIN: 610084	PCN: DRMTUA01 = Test (after 1/1/2012)
Processor: Conduent		
Effective as of: June 1, 2017	NCPDP Telecommunication Standard Version/Release D.0	
NCPDP Data Dictionary Version Date: April 2017	NCPDP External Code List Version Date: April 2017	
Updated: February 7, 2024		
Provider Relations: (800) 365-4944		

OTHER TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name
B1	Billing Transaction
B2	Reversal
B3	Rebill

FIELD LEGEND FOR COLUMNS

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

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

CLAIM BILLING/CLAIM REBILL TRANSACTION

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

Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent.	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued.		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN Issued.		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not Used.		

Transaction Header Segment				**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
101-A1	BIN NUMBER	610084	M	
102-A2	VERSION/RELEASE NUMBER	D.0	M	Version Supported
103-A3	TRANSACTION CODE	B1, B2, B3	M	What type of transaction is being sent
104-A4	PROCESSOR CONTROL NUMBER	DRMTPROD = Production DRMTUA01= Test	M	
109-A9	TRANSACTION COUNT	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	Count of transactions in the transmission.
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider Identifier (NPI)	M	NPI mandatory 05/23/2008
201-B1	SERVICE PROVIDER ID	NPI Number	M	NPI mandatory 05/23/2008
401-D1	DATE OF SERVICE	CCYYMMDD	M	CC = Century YY = Year MM = Month DD = Day
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	This will be provided by the provider's software vendor.	M	If no number is supplied, populate with zeros.

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

	Insurance Segment **Segment Identification** **(111-AM) = "04"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
302-C2	CARDHOLDER ID	Use client's 7-digit ID number, 9-digit SSN, or 9-digit HMK number.	M	
301-C1	GROUP ID	For Medicaid, HELP or Healthy Montana Kids (HMK) use 1509040. For MHSP use 0064206420 .	R	

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

	Patient Segment **Segment Identification** **(111-AM) = "01"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
304-C4	DATE OF BIRTH	CCYYMMDD	R	CC = Century YY = Year MM = Month DD = Day
305-C5	PATIENT GENDER CODE	1 = Male 2 = Female	R	
311-CB	PATIENT LAST NAME		R	
335-2C	PREGNANCY INDICATOR	Blank = Not Specified 1 = Not pregnant 2 = Pregnant	RW	Required when submitting a claim for a pregnant member.

Claim Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent.	X	
This payer supports partial fills.	X	

	Claim Segment Segment Identification (111-AM) = "07"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Up to 12 numbers	M	Number assigned by the pharmacy
419-DJ	PRESCRIPTION ORIGIN CODE	0 = Not Known 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile 5 = Pharmacy (transfer)	M	Code indicating the origin of the prescription
436-E1	PRODUCT/SERVICE ID QUALIFIER	03 = National Drug Code	M	
407-D7	PRODUCT/SERVICE ID	NDC Number	M	Use 11-digit NDC.
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER		RW	Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription.

	Claim Segment Segment Identification (111-AM) = "07"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	CCYYMMDD	RW	Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if Associated Prescription/Service Reference Number (456-EN) is used. Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. CC = Century YY = Year MM = Month DD = Day
442-E7	QUANTITY DISPENSED	Metric Decimal Quantity	R	Format = 9999999.999
403-D3	FILL NUMBER	0 = Original Dispensing 1-99 = Number of refills	R	
405-D5	DAYS SUPPLY		R	There is a maximum 34-day supply allowed for Montana providers, or 90 days for maintenance medications approved by the Department.
406-D6	COMPOUND CODE	0 = Not specified 1 = Not a compound 2 = Compound	R	
474-8E	DUR/PPS Level of Effort	0 = Not specified **11 = Level 1 (Lowest)** **12 = Level 2** **13 = Level 3** 14 = Level 4 15 = Level 5 (Highest)	RW	Used by Montana Medicaid to indicate level of effort for compound claims. Valid Values are 11, 12, and 13.

	Claim Segment Segment Identification (111-AM) = "07"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	1 = Substitution Not Allowed by Prescriber 5 = Substitution Allowed – Brand Drug Dispensed as a Generic 7 = Substitution Not Allowed, Brand Drug Mandated by Law 9 = Substitution Allowed by Prescriber but Plan Requests Brand – Patient's Plan Requested Brand Product to be Dispensed	R	DAWs 1 and 5 require a prior authorization.
414-DE	DATE PRESCRIPTION WRITTEN	CCYYMMDD	R	CC = Century YY = Year MM = Month DD = Day
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	Required if Submission Clarification Code (420-DK) is used.
420-DK	SUBMISSION CLARIFICATION CODE	2 = Other Override. To be used to indicate the first dose of the COVID-19 vaccine. 6 = Starter Dose. To be used to indicate the second dose of the COVID-19 vaccine. No SCC code is required for single dose COVID-19 vaccines. 8 = Process compound for Approved Ingredients 10= Meets Plan Limitations- to be used only when billing non-psychotropic medications for members currently residing in a Psychiatric Residential Treatment Facility	RW	Provider may submit when submitting a claim for a multi-line compound that includes a non-covered ingredient. Montana only uses Valid Values 2, 6, 8, 10, and 20.

	Claim Segment Segment Identification (111-AM) = "07"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		20 = Indicates that, prior to providing service, the product being billed is purchased pursuant to rights available under Section 340B of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 340B (a)(10) and those made through the Prime Vendor Program (Section 340B(a)(8)).		
460-ET	QUANTITY PRESCRIBED	Amount expressed in metric decimal units.	RW	Required when the transmission is for a Schedule II drug as defined in 21 CFR 1308.12 and per CMS-0055-F (Compliance Date 9/21/2020. Refer to the Version D.0 Editorial Document). Format = 9999999.999
308-C8	OTHER COVERAGE CODE	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	R	Values 5, 6, 7 and 8 are not allowed in D.0.
429-DT	SPECIAL PACKAGING INDICATOR	0 = Not specified 1 = Not Unit Dose 2 = Manufacturer Unit Dose 3 = Pharmacy Unit Dose	RW	Value 3 required when in-house unit dose.

	Claim Segment Segment Identification (111-AM) = "07"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
461-EU	PRIOR AUTHORIZATION TYPE CODE	4 = Exemption from Co-pay 8 = Payer Defined Exemption	RW	Value 4 is used for copay exemptions: pregnancy and long-term care. Value 8 can be used for up to a 3-day emergency supply.
343-HD	DISPENSING STATUS	P = Partial Fill C = Completion Fill	RW	Required for the partial fill or the completion fill of a prescription.
344-HF	QUANTITY INTENDED TO BE DISPENSED	Metric Decimal Quantity	RW	Required for the partial fill or the completion fill of a prescription. Format = 9999999.999
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	Required for the partial fill or the completion fill of a prescription.
995-E2	ROUTE OF ADMINISTRATION	SNOMED CT Value	RW	Required when the Rx is a compound. See Provider Notice for SNOMED CT Values required for D.0.

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

	Pricing Segment Segment Identification (111-AM) = "11"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
409-D9	INGREDIENT COST SUBMITTED	Format = s$$$$$$cc	R	Required in D.0. For example: If the gross amount due is

	Pricing Segment Segment Identification (111-AM) = "11"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				$14.95, this field would reflect: 149E.

412-DC	DISPENSING FEE SUBMITTED	Format = s$$$$$$cc	RW	Required if needed to balance claim
426-DQ	USUAL AND CUSTOMARY CHARGE	Format = s$$$$$$cc	R	
430-DU	GROSS AMOUNT DUE	Format = s$$$$$$cc	R	Required in D. 0

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

	Prescriber Segment **Segment Identification (111-AM) = "03"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	01 = National Provider Identifier	R	Required if Prescriber Identifier (411-DB) is used.
411-DB	PRESCRIBER IDENTIFIER	NPI	R	
427-DR	PRESCRIBER LAST NAME	Individual last name	R	**Example**: BROWN
498-PM	PRESCRIBER PHONE NUMBER	10 -digit telephone number of the prescriber	R	Format = AAAEEENNN AAA = Area Code EEE = Exchange Code NNNN = Number **Example**: This field would reflect the telephone number (414) 555-1212 as 4145551212.

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "05"**			**Claim Billing/Claim Rebill Scenario 1 – Other Payer Amount, Paid Repetitions Only**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "05"**			**Claim Billing/Claim Rebill Scenario 1 – Other Payer Amount, Paid Repetitions Only**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*

339-6C	OTHER PAYER ID QUALIFIER		RW	Required if Other Payer ID (340-7C) is used.
340-7C	OTHER PAYER ID		RW	Required if identification of the Other Payer is necessary for claim/encounter adjudication.
443-E8	OTHER PAYER DATE		RW	Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	Required if Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER		RW	Required if Other Payer Amount Paid (431-DV) is used.
431-DV	OTHER PAYER AMOUNT PAID		RW	Required if Other Payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer – Patient Responsibility Amount (352-NQ) is submitted.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	Required if Other Payer Reject Code (472-6E) is used.
472-6E	OTHER PAYER REJECT CODE		RW	Required when the Other Payer has denied the payment for the billing, designated with Other Coverage Code (308-C8) = 3 (Other Coverage Billed – claim not covered).
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	Required when Other Payer-Patient Responsibility Amount Qualifier (351-NP) and/or Other Payer-Patient Responsibility Amount (352-NQ) is used.

351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	See attached list of valid values.	RW	Required when reported by previous payer and Other Payer-Patient Responsibility Amount Count (353-NR) is used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	Required when reported by previous payer and Other Payer-Patient Responsibility Amount Count (353-NR) is used.

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

	DUR/PPS Segment **Segment Identification** **(111-AM) = "08"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	M	Required when submitting this segment.
439-E4	REASON FOR SERVICE CODE	See attached list of valid values.	RW	Required when there is a conflict to resolve or reason for service to be explained.
438-E3	INCENTIVE AMOUNT SUBMITTED	See attached list of valid values.	RW	Required when there is an incentive amount to be submitted.
440-E5	PROFESSIONAL SERVICE CODE	See attached list of valid values.	RW	Required when there is a professional service to be identified.
441-E6	RESULT OF SERVICE CODE	See attached list of valid values.	RW	Required when there is a result of service to be submitted.

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

	Clinical Segment Segment Identification (111-AM) = "13"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	Required when Diagnosis Code (424-DO) and/or Diagnosis Code Qualifier (492-WE) is used.
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the diagnosis code (424-DO). **Valid Value '01' ICD-9** **Valid Value '02' ICD-10**	RW	Required for billing Plan First prescriptions.
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient. ICD-9 format (XXX.XX) ICD-10 format (XXXXX)	RW	Needed for billing Plan First prescriptions. Note: No decimal is needed when submitting ICD-10 codes.

Compound Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is situational.	X	

	Compound Segment Segment Identification (111-AM) = "10"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	01 = Capsule 02 = Ointment 03 = Cream 04 = Suppository 05 = Powder 06 = Emulsion 07 = Liquid 10 = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup	M	Dosage form of the complete compound mixture.

	Compound Segment Segment Identification (111-AM) = "10"			**Claim Billing/Claim Rebill**

Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
		17 = Lozenge 18 = Enema		
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	1 = Each 2 = Grams 3 = Milliliters	M	NCPDP standard product billing codes
449-EE	COMPOUND INGREDIENT DRUG COST	Format=s$$$$$$cc	M	Required when billing a compound claim Example: If the amount is $5.50 this field would reflect: 55
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 Ingredients	M (Repeating)	Count of compound product IDs (both active and inactive) in the compound mixture submitted.
488-RE	COMPOUND PRODUCT ID QUALIFIER	03 = National Drug Code	M (Repeating)	
489-TE	COMPOUND PRODUCT ID	11-digit NDC	M (Repeating)	
448-ED	COMPOUND INGREDIENT QUANTITY	Metric Decimal Quantity	M (Repeating)	Format = 9999999.999

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

Additional Claim Information
DUR Codes
DUE Reason for Service Code Values (DUR Conflict Codes)

AD Additional Drug Needed – Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy.

AN Prescription Authentication – Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription.

AR Adverse Drug Reaction – Code indicating an adverse reaction by a patient to a drug.

AT Additive Toxicity – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself.

CD Chronic Disease Management – The patient is participating in a coordinated health care intervention program.

CH Call Help Desk – Processor message to recommend the receiver contact the processor/plan.

CS Patient Complaint/Symptom – Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment.

DA Drug-Allergy – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question.

DC Drug-Disease (Inferred) – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history.

DD Drug-Drug Interaction – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately.

DF Drug-Food interaction – Indicates interactions between a drug and certain foods.

DI Drug Incompatibility – Indicates physical and chemical incompatibilities between two or more drugs.

DL Drug-Lab Conflict – Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value.

DM Apparent Drug Misuse – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber.

DR Dose Range Conflict – Code indicating that the prescription does not follow recommended medication dosage.

DS Tobacco Use – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products.

DUE Reason for Service Code Values (cont'd)

ED Patient Education/Instruction – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient beyond the simple task of explaining the prescriber's instructions on the prescription.

ER Overuse – Code indicating that the current prescription refill is occurring before the days' supply of the previous filling should have been exhausted.

EX Excessive Quantity – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed.

HD High Dose – Detects drug doses that fall above the standard dosing range.

IC Iatrogenic Condition – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected.

ID Ingredient Duplication – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected.

LD Low Dose – Code indicating that the submitted drug doses fall below the standard dosing range.

LK Lock In Recipient – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is "locked in" to using only those providers or pharmacies.

LR Underuse – Code indicating that a prescription refill that occurred after the days' supply of the previous filling should have been exhausted.

MC - Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient, or pharmacist. specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient, or pharmacist.

MN Insufficient Duration – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product's common uses, has been detected.

MS Missing Information/Clarification – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information.

MX Excessive Duration – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses.

NA Drug Not Available-Indicates the drug is not currently available from any source.

NC Non-Covered Drug Purchase – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted, and a claim is submitted to the processor requesting.

ND New Disease/Diagnosis – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease.

DUE Reason for Service Code Values (cont'd)

NF Non-Formulary Drug – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan.

NN Unnecessary Drug – Code indicating that the drug is no longer needed by the patient.

NP New Patient Processing-Code indicating that a pharmacist has performed the initial interview and medication history of a new patient.

NR Lactation/Nursing Interaction – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant.

NS Insufficient Quantity – Code indicating that the quantity of dosage units prescribed is insufficient.

OH Alcohol Conflict – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages.

PA Drug-Age – Indicates age-dependent drug problems.

PC Patient Question/Concern – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care.

PG Drug-Pregnancy – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus.

PH Preventive Health Care – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems.

PN Prescriber Consultation – Code indicating that a prescriber has requested information, or a recommendation related to the care of a patient.

PP Plan Protocol – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided.

PR Prior Adverse Reaction – Code identifying the patient has had a previous atypical reaction to drugs.

PS Product Selection Opportunity – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists.

RE Suspected Environmental Risk- – Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors.

RF Health Provider Referral – Patient referred to the pharmacist by another health care provider for disease specific or general purposes.

DUE Reason for Service Code Values (cont'd)

SC Suboptimal Compliance – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance.

SD Suboptimal Drug/Indication – Code indicating incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition.

SE Side Effect – Code reporting possible major side effects of the prescribed drug.

SF Suboptimal Dosage Form – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug.

SR Suboptimal Regimen – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question.

SX Drug-Gender- Indicates the therapy is inappropriate or contraindicated in either males or females.

TD Therapeutic – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected.

TN Laboratory Test Needed – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy.

TP Payer/Processor Question – Code indicating that a payer or processor requested information related to the care of a patient.

UD Duplicate Drug – Code indicating that multiple prescriptions of the same drug formulation are present in the patient's current medication profile.

DUE Result of Service Code Values

00 Not Specified

1A Filled As Is, False Positive – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and determines the alert is incorrect for that prescription for that patient and fills the prescription as originally written.

1B Filled Prescription As Is – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and determines the alert is not relevant for that prescription for that patient and fills the prescription as originally written.

1C Filled, With Different Dose – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dose than was originally prescribed.

1D Filled, With Different Directions – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with different directions than were originally prescribed.

1E Filled, With Different Drug – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different drug than was originally prescribed.

1F Filled, With Different Quantity – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different quantity than was originally prescribed.

1G Filled, With Prescriber Approval – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription after consulting with or obtaining approval from the prescriber.

1H Brand-to-Generic Change – Action whereby a pharmacist dispenses the generic formulation of an originally prescribed branded product. Allowed, often mandated, unless the prescriber indicates “Do Not Substitute” on the prescription

1J Rx-to-OTC Change – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) fills the prescription with an over-the-counter product in lieu of the originally prescribed prescription-only product

1K Filled with Different Dosage Form – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed.

2A Prescription Not Filled – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written.

2B Not Filled, Directions Clarified – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber’s instructions.

DUE Result of Service Code Values (cont'd)

3A Recommendation Accepted – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber.

3B Recommendation Not Accepted – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur.

3C Discontinued Drug – Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen.

3D Regimen Changed – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the recommended medication(s) after consultation with the prescriber.

3E Therapy Changed – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber.

3F Therapy Changed – Cost Increased Acknowledged – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber.

3G Drug Therapy Unchanged- – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written.

3H Follow-Up/Report – Code indicating that additional follow through by the pharmacist is required.

3J Patient Referral – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist.

3K Instructions Understood – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed.

3M Compliance Aid Provided – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications.

3N Medication Administered – Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication.

4A Prescribed With Acknowledgements – Physician is prescribing this medication with knowledge of the potential conflict.

DUR Professional Service Code Values

00 No intervention.

AS Patient assessment – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan.

CC Coordination of care – Case management activities of a pharmacist related to the care being delivered by multiple providers.

DE Dosing evaluation/determination – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency, and/or formulation.

DP Dosage evaluated – Code indicating that dosage has been evaluated with respect to risk for the patient.

FE Formulary enforcement – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange.

GP Generic product selection– The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer.

M0 Prescriber consulted – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem.

MA Medication administration – Code indicating an action of supplying a medication to a patient through any of several routes—oral, topical, intravenous, intramuscular, intranasal, etc.

MB Overriding benefit – Benefits of the prescribed medication outweigh the risks.

MP Patient will be monitored – Prescriber is aware of the risk and will be monitoring the patient.

MR Medication review – Code indicating comprehensive review and evaluation of a patient's entire medication regimen.

PA Previous patient tolerance – Patient has taken medication previously without issue.

PE Patient education/instruction – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management.

PH Patient medication history – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile.

PM Patient monitoring – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered.

DUR Professional Service Code Values

P0 Patient consulted – Code indicating patient communication related to collection of information or clarification of a specific limited problem.

PT Perform laboratory test – Code indicating that the pharmacist performed a clinical laboratory test on a patient.

R0 Pharmacist consulted other source – Code indicating communication related to collection of information or clarification of a specific limited problem.

RT Recommend laboratory test – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient.

SC Self-care consultation – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment.

SW Literature search/review – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.

TC Payer/processor consulted – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient.

TH Therapeutic product interchange – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer.

ZZ Other Acknowledgement. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.

Additional Claim Information

Other Payer-Patient Responsibility Amount Qualifier Codes

CODE	DESCRIPTION
Blank	Not Specified
01	Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability.
02	Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.
03	Amount Attributed to Sales Tax (523-FN) as reported by previous payer. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription.
04	Amount Exceeding Periodic Benefit Maximum (520-FK) as reported by previous payer. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded.
05	Amount of Copay (518-FI) as reported by previous payer. Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer.
06	Patient Pay Amount (505-F5) as reported by previous payer. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility.
07	Amount of Coinsurance (572-4U) as reported by previous payer. Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection.
08	Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer
09	Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer
10	Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.
11	Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.
12	Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.
13	Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.