

Medicaid Encounter Data System Pharmacy Claims Companion Guide

Accompanies and clarifies the following NCPDP Guides:

- The Telecommunication Standard Implementation Guide (5.1)
- The Batch Standard Implementation Guide (1.1)
- The Specifications Guide (1.1)

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Revision History

Date	Version	Change Description
04/29/ 09	1.0	First Version
05/18/09	1.1	<p>Editorial and stylistic changes to document that altered pagination from prior version (throughout document)</p> <p>Additions:</p> <ul style="list-style-type: none"> • Table containing fields for Transmission Header Segment (see page 14) • Table containing fields for Trailer Segment (see page 16) • Encounter Data Submission Certification Requirements (see pages 5-12) <p>Changes:</p> <ul style="list-style-type: none"> • Field 880-K5 (TRANSACTION REFERENCE NUMBER) in the G1 Detail Data Record “must contain a unique identifier” (see page 15) • Fields 202-B2 (SERVICE PROVIDER ID QUALIFIER) and 201-B1 (SERVICE PROVIDER ID): for claims with a service date after 05/23/2008 these fields should contain the NPI for Pharmacy encounter claims (see page 15) • Field 304-C4 (DATE OF BIRTH): as of 05/20/2009 this is a MANDATORY field. Field remains SITUATIONAL for claims with a service date prior to 05/20/2009 (see page 16) • “COB/Other Payments” in Request Segment Matrix changed from REQUIRED to NOT REQUIRED (see page 11) • Field 420-DK (SUBMISSION CLARIFICATION CODE) changed to REQUIRED (9 = Encounters) (see page 19)
05/18/09	1.2	Recipient (Member) ID, Edit Disposition changed from REPORT to REJECT (see page 33)

Date	Version	Change Description
06/30/09	1.3	<p>Editorial and stylistic changes to document that altered pagination from prior version (throughout document)</p> <p>Addition:</p> <ul style="list-style-type: none"> Appendix A: NCPDP Transactions Dispositions & Errors (see pp 36-37) <p>Change:</p> <ul style="list-style-type: none"> Field 449-EE (COMPOUND INGREDIENT DRUG COST) changed to S***R*** (see page 24)
07/24/09	1.4	<p>Significant editorial and stylistic changes to document that altered pagination from prior version (throughout document)</p> <p>Deletion:</p> <ul style="list-style-type: none"> Appendix A: NCPDP Transactions Dispositions & Errors <p>Change:</p> <ul style="list-style-type: none"> The Agency has limited the size of the batch to a maximum of 8,000 transactions (see page 11)
10/02/09	1.5	<p>Additions:</p> <ul style="list-style-type: none"> Note on “reject codes” (see page 22) Note on Pricing Segment, “<i>As an amount, zero should be indicated with the character “{” (positive overstrike character).</i>” (see page 18) <p>Deletions:</p> <ul style="list-style-type: none"> Duplicate Logic Error Code 16 Florida Medicaid value of “14” from the PRESCRIBER ID QUALIFIER, PRESCRIBER SEGMENT (466-EZ)
11/05/09	1.6	<p>Revised the Encounter Data Submission Certification requirements and form</p>

Date	Version	Change Description
12/18/09	1.7	<p>Editorial and stylistic changes to document that altered pagination from prior version (throughout document)</p> <p>Addition:</p> <ul style="list-style-type: none"> • “A Note Regarding Sorting Submissions” (see page 8)
02/23/10	1.8	<p>Editorial and stylistic changes to document that altered pagination from prior version (throughout document).</p> <p>Addition:</p> <ul style="list-style-type: none"> • Caveat regarding NCPDP file submission (see page 9) <p>Change:</p> <ul style="list-style-type: none"> • Certification form: link and instructions (see page 11:12)
04/14/10	1.9	<p>Addition:</p> <ul style="list-style-type: none"> • “Coordination of Benefits Segment” (see page 21) <p>Change:</p> <ul style="list-style-type: none"> • Page numbers have adjusted for the addition; please refer to the Table of Contents (see page 2)
05/12/10	2.0	<p>Change:</p> <ul style="list-style-type: none"> • Pricing Segment (Additional “required” fields): <ul style="list-style-type: none"> ○ Dispensing Fee Submitted (409-D9) ○ Incentive Amount Submitted (438-E3) ○ Other Amount Claimed Submitted (480-H9) ○ Flat Sales Tax Amount Submitted (481-HA) ○ Percentage Sales Tax Amount Submitted (482-GE) <p>Addition:</p> <ul style="list-style-type: none"> • Claims Segment (Additional “required when” fields): <ul style="list-style-type: none"> ○ Other Coverage Code (308-C8) ○ Dispensing Status (343-HD) ○ Quantity Intended to be Dispensed (344-HF) ○ Days Supply Intended to be Dispensed (345-HG) ○ Added values to Other Coverage Code (308-C8).

Date	Version	Change Description
05/17/10	2.1	Addition: <ul style="list-style-type: none"> • Claims segment: <ul style="list-style-type: none"> ○ 3Ø8-C8 – Other Coverage Code; value 8 (see page 20) • Coordination of Benefits segment: <ul style="list-style-type: none"> ○ 339-6C - Other Payer ID Qualifier; multiple values (see page 23) ○ 342-HC – Other Payer Amount Paid Qualifier; multiple values (see page 24)
05/27/10	2.2	Change: <ul style="list-style-type: none"> • Medicaid Data Certification information section updated regarding delegation instruction (see page 11) • Certification Link update (see page 12)
06/22/10	2.3	Addition: <ul style="list-style-type: none"> • Compound Segment: 449-EE – Compound Ingredient Drug Cost (see page 25)
07/14/2010	2.4	Addition: <ul style="list-style-type: none"> • Missing/Invalid and Non-Matched Prescriber ID edit added to NCPDP Transactions: Dispositions and Errors.
11/17/2010	2.5	Addition: <ul style="list-style-type: none"> • Rebills (Voids) Segment • Change MEDS Team references to Program Oversight Unit • Change PBM name from First Health Services, Inc. to Magellan Medicaid Administration, Inc. (Magellan).
02/01/2011	2.6	Change: <ul style="list-style-type: none"> • Medicaid Data Certification information section updated regarding delegation instruction (see page 12,13)

Florida Medicaid and Encounter Data: Overview

The Agency for Health Care Administration (AHCA or the Agency) is committed to better health care for all Floridians. AHCA is the state agency responsible for the administration and oversight of the Florida Medicaid Program.

Medicaid is the state and federal partnership that provides health coverage for selected categories of people with low incomes. Its purpose is to improve the health of those who might otherwise go without medical care for themselves and their children.

Florida implemented the Medicaid program on January 1, 1970 to provide medical services to low-income people. Over the years, the Florida Legislature has authorized changes in the scope of Medicaid services covered, as well as changes to Medicaid reimbursement for additional services. A major expansion occurred in 1989, when the United States Congress mandated that states provide all Medicaid services allowable under the Social Security Act to children 20 years of age or younger.

Florida's Medicaid Encounter Data System

The Agency is required to capture medical services encounter data for all Medicaid-covered services in compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, Florida Statutes.

Encounter data can be broadly defined as electronic records of Medicaid-covered services provided to enrollees of a health plan. More specifically, encounter data are components of a record that capture and describe the interaction(s) between a patient and a provider.

Encounters consist of many types of services, some of which include:

- Anesthesia Services
- Behavioral Health Care
- Dental
- Dialysis Center Services
- Durable Medical Equipment
- EPDST
- Hospital Services
- Laboratory Tests
- Long-Term Care Services
- Nursing Home Services
- Nursing Visits
- Outpatient
- Pharmacy
- Physician Services
- Radiology Services
- Surgical Services

Florida's Medicaid Encounter Data System (MEDS) is the name given to the statewide operation of processing, receiving, validating, and storing encounter data in a centralized location. Rather than describing particular software and the hardware that runs it, "system" describes the complex interconnection between the Agency and Managed Care Organizations.

The ultimate goal for MEDS is simple: ready access to managed care encounter data in the same way that Agency staff access and analyze fee-for-service (FFS) claims data today.

Data will be used for reports regarding service activities and prescription drug utilization for all Medicaid capitated health care plans, and to support specific information requests and ad hoc reporting (e.g., service utilization trends, quality of care, access to care, cost models, targeted studies). In addition, MEDS will also support the risk model computations that set capitated payments for managed health care entities as defined in the Florida Medicaid Reform contracts.

Intent of the MEDS Pharmacy Companion Guide

The MEDS Pharmacy Companion Guide provides specific information on the fields and values required for pharmacy encounter data transactions that are submitted to the Florida Medicaid Pharmacy Benefits Manager, Magellan Medicaid Administration, Inc. (Magellan). The intent of the Companion Guide is to serve as a supplement to the National Council for Prescription Drug Program's (NCPDP) implementation guides. **The MEDS Pharmacy Companion Guide is for clarification purposes only and is not intended to be a substitute for the implementation guides.**

For specific information regarding nationally accepted standards, please refer to the *NCPDP Batch Standard Implementation Guide, version 1.1*, *NCPDP Telecommunications Standard Implementation Guide v5.1*; the *Specifications Guide, version 5.1*, the *Compound Implementation Guide v2.0*, the *External Code List (2008)*, the *Data Dictionary (2008)*, and the *NCPDP Telecommunication Version 5 Questions, Answers, and Editorial Updates (2008)*.

NCPDP membership is required to obtain a copy of the implementation guides. For information on becoming a NCPDP member, please visit their website (www.ncdp.org) or call 480.477.1000.

Please note that the NCPDP formats are copyrighted material of the National Council for Prescription Drug Programs. Information provided in this document is provided with the permission of NCPDP.

Steps in the Pharmacy Encounter Submission Process:

1. Registering

The first step to encounter submission involves registering for an encounter Trading Partner Identification Number (TPID) by completing the *Electronic Data Interchange Agreement-Encounter* form and obtaining an encounter Florida Medicaid Encounter Provider Identification Number by completing the Managed Care Treating Provider Registration form. These forms can be obtained by sending a request via email to medsmailbox@ahca.myflorida.com.

2. Getting Connected

The next step in the encounter submission process is to test connectivity of a Secure File Transfer Protocol (SFTP) site account with the Program Oversight Unit and with Magellan Medicaid Administration, Inc. (Magellan), the Agency's Pharmacy Benefits Manager (PBM).

3. Program Oversight Unit Format/Compliance Testing

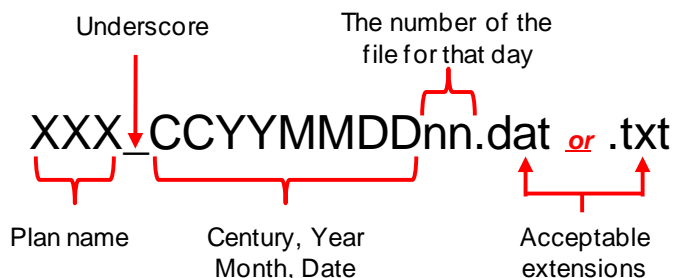
Upon completion of steps 1 & 2 above, each MCO must create and submit (via FTP to the Program Oversight Unit) a test file that includes each transaction type the MCO expects to submit in the production environment. The Program Oversight Unit will review test files for proper formatting of each transaction type.

All MCOs are required to submit B1 and B2 transactions at a minimum. MCOs using (or anticipating future use of) B3 transactions, partial fill fields, compound segments, and coordination of benefits segments must submit these transactions as well. In the event the plan does not utilize B3 transactions, partial fill fields, or compound segments, an email to the Program Oversight Unit identifying transaction types the MCO will not submit is required to exempt that component of testing. If a health plan decides to submit a new segment and/or transaction type, the plan is required to submit a new test file including the new segment/transaction type for compliance testing purposes prior to submission in production data files.

Test Submission Volumes by Transaction Type

- a. During the initial testing phase with a new health plan, the test file should contain 1,000 NCPDP transactions total that includes each transaction type the plan expects to submit in the production environment. Exceptions to the file size may be considered for small or new plans.

Please use the following file naming convention established by Magellan when submitting test files during the testing phase:

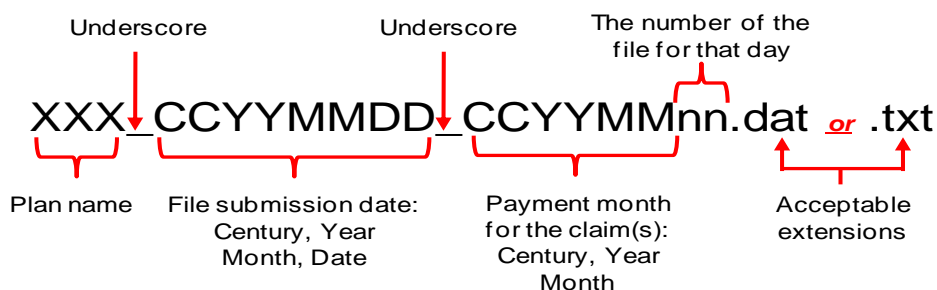


- b. The test file should also contain at least five of each additional transaction type and segment the health plan expects to submit in the production environment (i.e., B2 transactions, B3 transactions, compound segments, coordination of benefits (COB) segments and partial fills, if applicable. Reversal transactions (B3) reverse or replace the related B1 transactions discussed in (3a.). **Note:** Please be sure to submit B1, B2, and B3 transactions *in sequential order within the file* or the file will reject.
- c. For partial fill testing, one or more B1 transactions that complete the prescribed “fill” amount should be submitted to demonstrate the ability to complete the transaction set. Please follow *the Florida-specific encounter specifications* for NCPDP transactions found in this guide.

4. Magellan Certification

Once the Program Oversight Unit has reviewed the file format for compliance and has ensured consistency with Florida pharmacy encounter data specifications, the test file will be forwarded to Magellan, for testing. Upon completion of threshold and repairable edit testing with Magellan, the MCO will be assigned a certification number which will allow them to submit in a production environment. *This number is to be included on all NCPDP transactions (see field 110 -AK of the ‘Transaction Header Segment’ below).*

Please use the following naming convention when submitting files during the production phase:



***Note – zip files and/or password protected files are not acceptable formats for NCPDP file submission.**

A Note Regarding Sorting Submissions

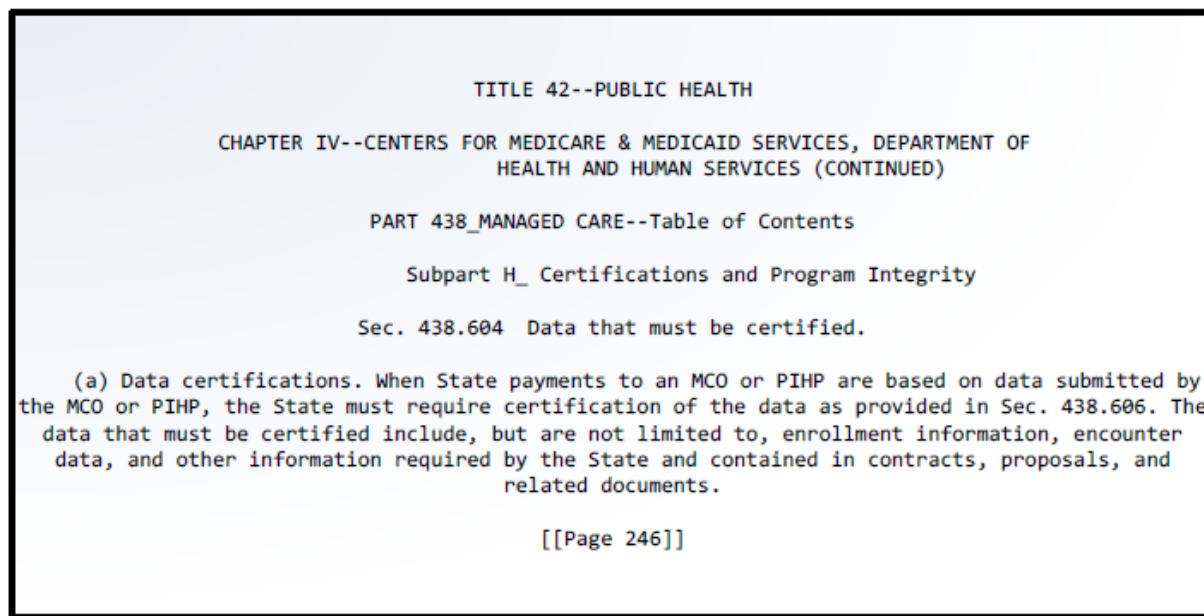
Please be sure to submit B1, B2, and B3 transactions *in sequential order within the file* or the file will reject.

Examples:

	Void	Void and Replace	Adjustment
Submission Order:	B1 (original) B2 (reversal/void)	B1 (original) B2 (reversal/void) B1 (Final)	B1 (original) B3 (adjustment/rebill)
Description:	Void transactions are a two-step process in which the B2 voids the original B1.	Void and Replace transactions are a three-step process in which the original B1 is voided by the B2 and replaced by a corrected/final B1.	Adjustment transactions are a two-step process in which the B3 serves as a void of and replacement for the original B1.

Submission Certification Requirements and Instructions

As stated in 42 CFR §438.604 (see below) when State payments to an MCO or Prepaid Inpatient Health Program (PIHP) are based on data submitted by the MCO or PIHP, the State must require attestation. As such, encounter data which is likely to be used for both rate setting and risk adjustment requires a procedure that fulfills the data certification requirements.



Medicaid Data Certification

To accomplish the data certification requirements, the Medicaid Data Certification Statement is required with each transmission of ANSI ASC X12 837 transactions (i.e., Institutional, Professional, and Dental), and NCPDP encounter claims submitted to the Agency for processing in a production environment. The Medicaid Data Certification Statement acknowledges that encounter data contained within the submission(s) are complete, accurate, and truthful.

Multiple forms may be submitted by an MCO daily. Each should contain the relevant information necessary to certify each submission, including the preparer's initials.

This certification must be signed by the Chief Executive Officer, Chief Financial Officer or Chief Medical Officer, or a direct report who has been delegated authority in writing to certify encounter data submitted to AHCA. The written delegation must be sent to the Agency (scanned and sent electronically is permissible). A new written delegation must be provided each time the delegate changes.

Please note that a copy of the written delegated authority must be provided with the certification, MCOs are also requested to retain the written delegation and make it available upon request.

The signed Medicaid Data Certification Statement may be scanned and emailed to the Program Oversight Unit. Printed or electronic copies of signed certification forms should be retained by the MCO for future reference.

The MEDS Data Certification can be accessed from the Agency's website at <http://ahca.myflorida.com>. Once you are on the site, click on the *Site Menu* tab and then on the *Medicaid Encounter Data Systems (MEDS)* link located under the **Division of Medicaid** column. Once the MEDS webpage appears, click on the *Current Information* link and then on the *Data Certification and Provider Registration*.

Procedures associated with completing the Medicaid Data Certification Statement are discussed below. Questions regarding the completion of this form should be forwarded to Medsmailbox@ahca.myflorida.com.

1. Enter the date.
2. Enter the MCO name (subject line).
3. Enter the MCO name (attestation statement).
4. Enter the file name(s); you may add rows if additional space is needed.
5. Enter the number of claims for each file.
6. Enter the New Day, Void and/or Replacement file designation(s) (i.e. N, V and/or R). Indicate all that apply for each file. For example, files containing only void claims should be marked with a 'V' only. Files containing only replacement claims should be designated 'R'. Files containing any combination of New Day, Replacement and/or Void claims should be designated with the appropriate letters.
7. Enter the plan payment date (i.e. the month and year the listed encounters were paid by the associated plan).
8. Enter the encounter claim type (i.e. 837I, 837P, 837D or NCPDP).
9. Enter the exact date (month/day/year) the file was uploaded to the HP or Magellan portal for processing.
10. Enter the name of the data source.
11. Enter the email address of the data source.
12. Enter the phone number of the data source.
13. Use this line for the signature of the CEO/CFO/CMO/or Delegate. (*Please note that the delegation must be written and a copy provided with the certification.)
14. Enter the full name for the signatory.
15. Enter the signatory's title (CEO, CFO, CMO or Delegate).

CERTIFICATION OF MEDICAID HMO ENCOUNTER DATA

1 Insert date

Medicaid Program Oversight
 Quality Management Bureau
 Agency for Health Care Administration
 2727 Mahan Drive, Building 3, MS #48
 Tallahassee, FL 32308

2 RE: <Type MCO name> Medicaid Managed Care Encounter Data Certification

3 On behalf of <Type MCO name> I attest, in accordance with 42 CFR 438.600 to 438.606, that, to the best of my knowledge, information and belief, all data submitted are complete, accurate and true and have been submitted in accordance with the contract between the MCO and the Florida Agency for Health Care Administration. I further attest that, to the best of my knowledge, no material fact has been omitted from the data form and acknowledge that the information described below may directly affect the reimbursement to the MCO that I represent. This statement applies to all documents and data submitted by the MCO to AHCA, including, but not limited to, the following information: encounter data, claims data, financial data, and other workbook files.

Instructions: List the file name and number of claims for each encounter data file submitted. Provide the Claim Type (837I, 837P, 837D, or NCPDP), New-Day (N), Voids (V) and/or Replacements (R), and Plan Payment Date (Month + Year) for each encounter data file submitted. Indicate the exact date the file was uploaded to the HP/Magellan portal for processing.

File Name	# Claims	N = New Day Claims V = Void Claims R = Replacement Claims (Indicate all that apply for each file)	Plan Payment Date (Month/Year)	Claim Type: 837I 837P 837D or NCPDP	Date File Uploaded to Portal (Month/Day/Year)
4	5	6	7	8	9

10 Provide the data source contact information: _____
 Name

11 _____
 Email

12 _____
 Phone number

Sincerely,

13 _____
 Signature (CEO/COO/CMO/Delegate)

14 _____
 Please print or enter name

15 _____
 Title (CEO/COO/CMO/Delegate)

NOTE: Delegation must be written and provided to the Agency. Delegate must be a direct report to the CEO/COO/CMO. Person signing certification must be named in the written delegation provided to the Agency.

Revision effective 2/01/2011

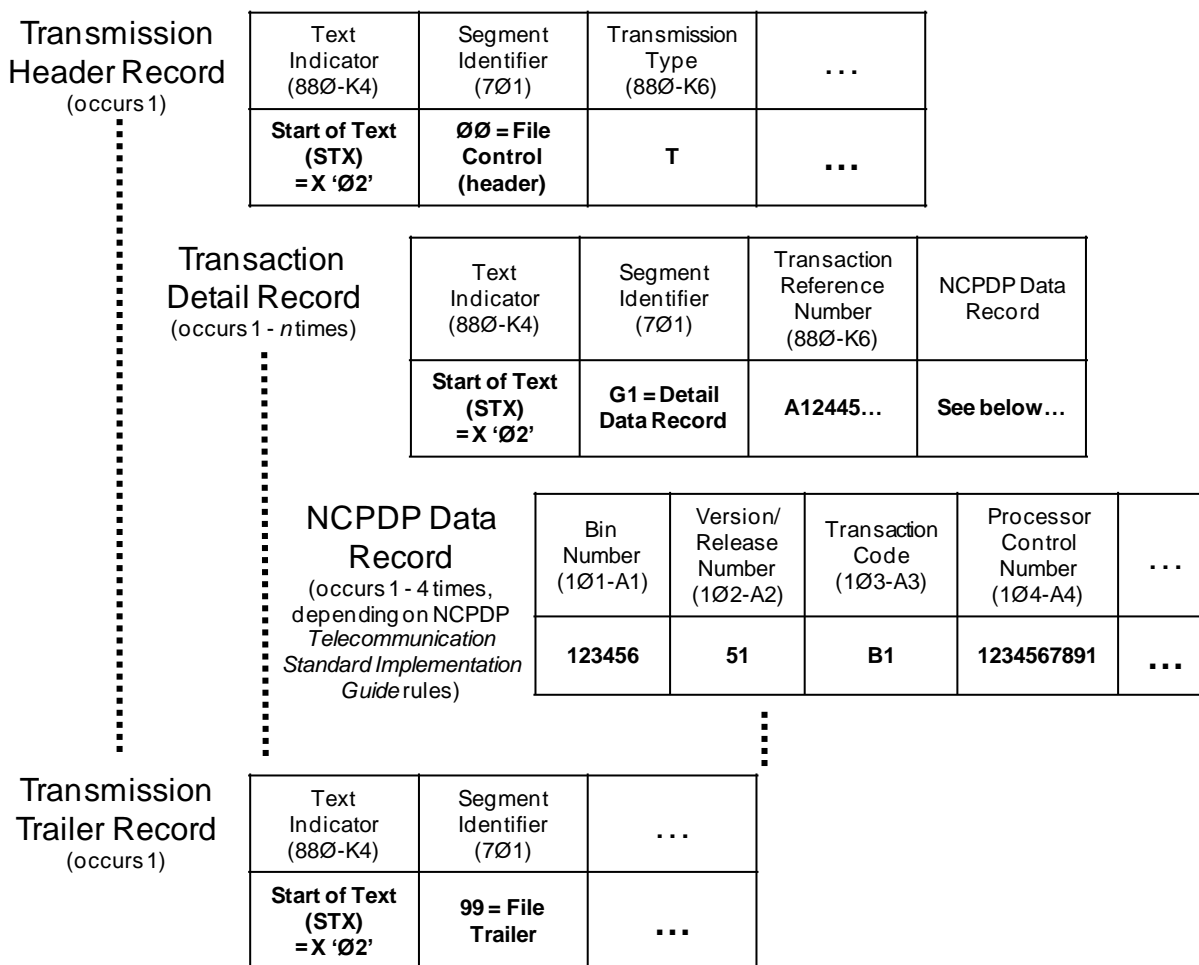
Data Transmission Schedules

The timing of historical submissions should be coordinated and approved by the Program Oversight Unit prior to any production submissions. The timing of current, ongoing submissions is set in the contract between the Agency and the submitting plan. This is done in an effort to ensure efficiency in processing of the encounters, as well as to accommodate the specific circumstances of the MCOs.

Data Transmission Methods/Problems

Encounter data submissions should be sent to the Agency’s PBM, Magellan Medicaid Administration, Inc. (Magellan), via the *Move-IT* Secure File Transfer Protocol (SFTP) site. The Agency has limited the size of the production batch file to **a maximum of 8,000 transactions**. For more information regarding data transmission including problems in transmitting or transmission tracking, please e-mail the MEDSmailbox@ahca.myflorida.com.

Figure 1: The diagram below shows a transmission construct (from the NCPDP Batch Standard Implementation Guide).



Specific Information for the NCPDP Pharmacy Format

The *NCPDP Telecommunication Standard, version 5.1* is the national standard for HIPAA-compliant pharmacy transactions. It provides formats for the standardization of pharmacy claims and encounter records. The *NCPDP Batch Standard Implementation Guide, version 1.1* is the standard “wrapper” for the *Telecommunications Standard* - the *Telecommunications Standard* must be “wrapped” in the *Batch Standard* format prior to being transmitted to Florida Medicaid’s Pharmacy Benefits Manager. Together, the NCPDP Implementation Guides and Specification Guides provide a reference for building the required dataset for Medicaid encounter data transmissions. This Companion Guide lists formats for billing transactions specific to Florida Medicaid.

Transactions consist of various fields that may or may not be required for submission. The following table defines codes used to describe field designations and requirements for NCPDP encounter data submission for Florida Medicaid.

Code	Description
M	Designated as MANDATORY in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. These fields must be sent if the segment is required for the transaction.
N	Designated as NOT USED . This single-letter designation can mean either NA (NOT USED BY FLORIDA) or NS (NOT SUPPORTED) .
R	Designated as REQUIRED in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. These fields must be sent if the segment is required for the transaction.
RW	Designated as REQUIRED WHEN in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. A field designated REQUIRED WHEN indicates that it is required in conjunction with the use of a SITUATIONAL field.
S	Designated as SITUATIONAL in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. It is necessary to send these fields in noted situations. SITUATIONAL fields are not required at this time. Use of SITUATIONAL fields may require use of attendant RW fields.
X***R***	The “R***” indicates that the field is repeating, whereas “X***” represents M, R, RW, or S codes.

NCPDP Lower Version Transaction Name	NCPDP V.5.1 Transaction Code	NCPDP V.5.1 Transaction Name	Transaction Support Requirements
Rx Billing	B1	Billing	Required
Rx Reversal	B2	Reversal	Required
Rx Re-billing	B3	Re-bill	Required

Florida's Medicaid Encounter Data System does not make use of all fields listed in the table below. The Program Oversight Unit strongly recommends **not** including segments designated as "Not Required" or "Situational" with your encounter data submissions.

CLINICAL SEGMENT	NOT REQUIRED
COUPON SEGMENT	NOT REQUIRED
PHARMACY PROVIDER SEGMENT	NOT REQUIRED
PRIOR AUTHORIZATION SEGMENT	NOT REQUIRED
RESPONSE CLAIM SEGMENT	SITUATIONAL
RESPONSE INSURANCE SEGMENT	SITUATIONAL
RESPONSE MESSAGE SEGMENT	SITUATIONAL
RESPONSE MESSAGE SEGMENT	OPTIONAL
RESPONSE PRICING SEGMENT	SITUATIONAL
RESPONSE PRIOR AUTHORIZATION SEGMENT	NOT REQUIRED
RESPONSE STATUS SEGMENT	SITUATIONAL
RESPONSE STATUS SEGMENT	OPTIONAL

Program Highlights

The software/certification ID will control whether 5.1 claims will be accepted by the production system. Your software vendor will receive a number upon certification with Magellan. This number must be included in the transaction header segment, field 11Ø-AK. Most national software vendors have previously certified with Magellan. If you have questions and/or if certification is required, please e-mail MEDSmailbox@ahca.myflorida.com.

Compounds can be processed online using the Compound Segment.

In cases where multiple iterations of a field ("repeating fields") are allowed, the maximum number of iterations supported has been indicated.

Partial fills will be supported.

Reversals will match on Provider Number, RX Number, DOS and Product (NDC).

All submitted data elements will be edited for valid format and values.

Provider software should support any/ all data elements on the required segments.

Florida NCPDP Encounter Specifications

The fields listed below represent only those fields that are required for Florida pharmacy batch file submissions. There are additional fields that are not required for Florida encounter data submissions and are thus not listed here. While submission of these non-required “situational” fields is permitted, if used, they must be formatted correctly to avoid errors. We recommend that Florida encounter data submissions use only those fields which are required/mandatory in an effort to minimize errors.

TRANSMISSION HEADER SEGMENT		MANDATORY for all transmissions.	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
880-K4	TEXT INDICATOR	M	Start of text (Stx) = X'02'
701	SEGMENT IDENTIFIER	M	00 = File Control (header)
880-K6	TRANSMISSION TYPE	M	T = Transaction
880-K1	SENDER ID	M	Submitting MCO's Encounter TPID.
806-5C	BATCH NUMBER	M	Matches Trailer
880-K2	CREATION DATE	M	Format = CCYYMMDD
880-K3	CREATION TIME	M	Format = HHMM
702	FILE TYPE	M	P = production T = test
102-A2	VERSION/RELEASE NUMBER	M	Version/Release of Header Data “11”
880-K7	RECEIVER ID	M	”FLMEDICAID”
880-K4	TEXT INDICATOR	M	End of Text (Etx) = X'03'

TRANSACTION HEADER SEGMENT		MANDATORY for all transactions.	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
880-K4	TEXT INDICATOR	M	Start of text (Stx) = X'02'
701	SEGMENT IDENTIFIER	M	G1 = Detail Data Record
880-K5	TRANSACTION REFERENCE NUMBER	M	To be determined by provider. Must contain a unique identifier.
101-A1	BIN NUMBER	M	013352
102-A2	VERSION/RELEASE NUMBER	M	51
103-A3	TRANSACTION CODE	M	B1, B2, B3
104-A4	PROCESSOR CONTROL NUMBER	M	P035013352
109-A9	TRANSACTION COUNT	M	B1 = 1-4 (except multi-ingredient compound <when implemented> = 1) B2 = 1-4 (except multi-ingredient compound <when implemented> = 1) B3 = 1-4 (except multi-ingredient compound <when implemented> = 1)
202-B2	SERVICE PROVIDER ID QUALIFIER	M	01 = NPI <i>or</i> 05 = Medicaid ID Number For claims with a service date after 05/23/2008, field should contain the NPI for Pharmacy encounter claims.
201-B1	SERVICE PROVIDER ID	M	National Provider Identifier <i>or</i> Medicaid Provider Number For claims with a service date after 05/23/2008, Field should contain the NPI for Pharmacy encounter claims.
401-D1	DATE OF SERVICE	M	Format = CCYYMMDD
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	M	Assigned when vendor is certified with Magellan; will reject if missing or not valid.

TRAILER SEGMENT		MANDATORY for all transactions.	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
880-K4	TEXT INDICATOR	M	Start of text (Stx) = X'02'
701	SEGMENT IDENTIFIER	M	99 = File Trailer
806-5C	BATCH NUMBER	M	Matches Header
752	RECORD COUNT	M	Includes Header and Trailer

504-F4	MESSAGE	M	
880-K4	TEXT INDICATOR	M	End of Text (Etx) = X'03'

PATIENT SEGMENT		MANDATORY for B1 and B3 transactions.	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	01 = Patient Segment
304-C4	DATE OF BIRTH	M	Format = CCYYMMDD. As of 05/20/2009 this is a REQUIRED field. Field remains SITUATIONAL for claims with a service date prior to (05/20/2009).
305-C5	PATIENT GENDER CODE	R	0= unspecified 1 = male 2 = female
310-CA	PATIENT FIRST NAME	R	
311-CB	PATIENT LAST NAME	R	

INSURANCE SEGMENT		MANDATORY for B1 and B3 transactions.	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	04 = Insurance Segment
302-C2	CARDHOLDER ID	M	Florida Medicaid ID Number
301-C1	GROUP ID	R	"FLMEDICAID" (Submit for all recipients)

CLAIM SEGMENT		MANDATORY for B1, B2*, and B3 transactions.	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	07 = Claim Segment
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	1 = Rx billing

CLAIM SEGMENT		MANDATORY for B1, B2*, and B3 transactions.	
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	00 = Default for Compounds 03 = NDC
407-D7	PRODUCT/SERVICE ID	M	NDC
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE #	RW	Required when the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed) and the Prescription/Service Reference Number (402-D2) changed from the "P" (Partial Fill). Required when the "P" (Partial Fill) is not the original fill and the Prescription/Service Reference Number (402-D2) has not changed.
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	RW	Required when the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required when Associated Prescription/Service Reference Number (456-EN) is used. Required when the "P" (Partial Fill) transaction is not the original fill.
442-E7	QUANTITY DISPENSED	R	
403-D3	FILL NUMBER	R	
405-D5	DAYS SUPPLY	R	
406-D6	COMPOUND CODE	R	1 = Not a Compound 2 = Compound
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	R	DAW = 7 will override payment (i.e., bypass FUL and SMAC) for certain brand name drugs
414-DE	DATE PRESCRIPTION WRITTEN	R	CCYYMMDD format
420-DK	SUBMISSION CLARIFICATION CODE	R	9 = Encounters
308-C8	OTHER COVERAGE CODE	RW	Required when COB/TPL claims are submitted. 0 = Not Specified by patient; 1 = No other coverage; 2 = Other coverage exists – payment collected; 3 = Other Coverage Billed – claims not covered; 4 = Other coverage exists – payment

CLAIM SEGMENT		MANDATORY for B1, B2*, and B3 transactions.	
			not collected. 8 = Claim is billing for Co-pay – Claim is billing for patient financial responsibility only
343-HD	DISPENSING STATUS	RW	Required when submitting a partial fill or the completion of a partial fill.
344-HF	QUANTITY INTENDED TO BE DISPENSED	RW	Required when submitting a partial fill or the completion of a partial fill.
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	RW	Required when submitting a partial fill or the completion of a partial fill.

*In accordance with the NCPDP Telecommunications Implementation Guide, B2 transactions only require the Transaction Header and the first five fields of the claim segment.

PRICING SEGMENT		MANDATORY for B1 and B3 transactions.	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	11 = Pricing Segment
409-D9	INGREDIENT COST SUBMITTED	R	Zero is a valid amount.*
412-DC	DISPENSING FEE SUBMITTED	R	
438-E3	INCENTIVE AMOUNT SUBMITTED	R	
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	R	Maximum of 9 iterations.
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	R	Valid Values: <ul style="list-style-type: none"> • 01 = Delivery Cost • 02 = Shipping cost • 03 = Postage Cost • 04 = Administrative Cost • 99 = Other NOTE: “Blank” is not a valid value.
480-H9	OTHER AMOUNT CLAIMED SUBMITTED	R	
481-HA	FLAT SALES TAX AMOUNT SUBMITTED	R	
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED	R	
426-DQ	USUAL AND CUSTOMARY CHARGE	R	The usual and customary charge “must” contain a valid value > zero. This may contain the amount paid by the MCO.

PRESCRIBER SEGMENT		REQUIRED for B1 and B3 transactions.	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	03 = Prescriber Segment
466-EZ	PRESCRIBER ID QUALIFIER	R	01 = NPI Number 08 = State License Number
411-DB	PRESCRIBER ID	R	NPI <i>or</i> State License Number <i>or</i> Plan Specific Number

COORDINATION OF BENEFITS SEGMENT		Segment REQUIRED for B1 and B3 transactions if there is OTHER PAYER information.	
Field	Field Name	Mandatory /Situational	Florida Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	05 = Coordination of Benefits/Other Payments Segment
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	M Max = 3	
338-5C	OTHER PAYER COVERAGE TYPE	M***R*** Max = 3	Valid Values: 01 = Primary (First) 02= Secondary (Second) 03 = Tertiary (Third) 04 = Quaternary (Fourth) 05 = Quinary (Fifth) 06 = Senary 07 = Septenary 08 = Octonary 09 = Nonary
339-6C	OTHER PAYER ID QUALIFIER	S***R*** Max = 3	Required if Other Payer ID is sent. Valid Values: 01 = National Payer ID 1C = Medicare Number 1D = Medicaid Number 02 = Health Industry Number (HIN) 03 = Bank Information Number (BIN) 04 = National Association of Insurance Commissioners (NAIC) 05 = Medicare Carrier Number 99 = Other
340-7C	OTHER PAYER ID	S***R*** Max = 3	

COORDINATION OF BENEFITS SEGMENT		Segment REQUIRED for B1 and B3 transactions if there is OTHER PAYER information.	
443-E8	OTHER PAYER DATE	R***R***	Required when submitting COB/TPL claims.
		Max = 3	
341-HB	OTHER PAYER AMOUNT PAID COUNT	RW	Required when submitting Other Payer Amount Paid.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	RW***R***	Required when submitting COB/TPL claims. Valid Values: 01 = Delivery 02 = Shipping 03 = Postage 04 = Administrative 05 = Incentive 06 = Cognitive Service 07 = Drug Benefit
		Max = 3	
431-DV	OTHER PAYER AMOUNT PAID	RW***R***	Required when submitting COB/TPL claims.
		Max=3	
471-5E	OTHER PAYER REJECT COUNT	RW	Not required at this time.
472-6E	OTHER PAYER REJECT CODE	RW	Not required at this time.

*As an amount, zero should be indicated with the character “{” (positive overstrike character).

COMPOUND SEGMENT		REQUIRED for B1 and B3 transactions, <i>if there is compound information.</i>	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	10 = Compound Segment
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	M	
452-EH	COMPOUND ROUTE OF ADMINISTRATION	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M	Maximum of 25 iterations.
488-RE	COMPOUND PRODUCT ID QUALIFIER	M***R***	
489-TE	COMPOUND PRODUCT ID	M***R***	
448-ED	COMPOUND INGREDIENT QUANTITY	M***R***	
449-EE	COMPOUND INGREDIENT DRUG COST	M***R***	

Reversal (B2) Transactions

Reversal transactions should be submitted using the entire transaction header segment and the following fields of the Claim Segment:

CLAIM SEGMENT		REQUIRED for B2 transactions	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	07 = CLAIMS SEGMENT
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	1 = Rx Billing
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	00 = Default for Compounds 03 = NDC
407-D7	PRODUCT/SERVICE ID	M	NDC

NOTE: The Program Oversight Unit suggests only sending the 'MANDATORY' fields when submitting Reversal (B2) Transactions. However, if additional fields within the 'Claim Segment' are submitted, please ensure that they are properly formatted to reduce the possibility of potential errors.

Rebill (B3) Transactions

Rebill transactions are submitted in the same manner as the B1 transactions with the exception of the transaction type located in the Transaction Detail Data Record (field 103-A3) and the required changes made to the following segments and/or fields, if applicable: Patient, Insurance, Claim, Pricing, COB, Compound, Prescriber Segments or Partial Fill fields. Should you have any questions regarding submission of B3 transactions, please send them to the MEDS Mailbox at medsmailbox@ahca.myflorida.com.

RESPONSE TRANSACTIONS

Response segment and field requirements:

PAID (or DUPLICATE OF PAID) Response:

TRANSACTION HEADER SEGMENT		MANDATORY for all transactions.	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
1Ø2-A2	VERSION/RELEASE NUMBER	M	Same value as in request billing
1Ø3-A3	Ø	M	Same value as in request billing
1Ø9-A9	TRANSACTION COUNT	M	Same value as in request billing
5Ø1-F1	HEADER RESPONSE STATUS	M	A = Accepted; R = Rejected
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Same value as in request billing
2Ø1-B1	SERVICE PROVIDER ID	M	Same value as in request billing
4Ø1-D1	DATE OF SERVICE	M	Same value as in request billing

Reject Response segment and field requirements:

TRANSACTION HEADER SEGMENT		MANDATORY for all transactions.	
Field	Field Name	Mandatory Required	Florida Medicaid Values Supported
1Ø2-A2	VERSION/RELEASE NUMBER	M	Same value as in request billing
1Ø3-A3	TRANSACTION CODE	M	Same value as in request billing
1Ø9-A9	TRANSACTION COUNT	M	Same value as in request billing
5Ø1-F1	HEADER RESPONSE STATUS	M	R
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Same value as in request billing
2Ø1-B 1	SERVICE PROVIDER ID	M	Same value as in request billing
4Ø1-D1	DATE OF SERVICE	M	Same value as in request billing

When a claim posts a **Denied** or **Rejection** status in the Transaction Response Status field (112-AN), the transaction is NOT required to be voided out of Magellan's processing system. However, if it is determined the transaction is required to be submitted, a new B1 transaction must be submitted correcting the issue(s) identified and provided within the response file.

All transactions posting an FB87 (Reversal Not Processed) reject code must be voided and resubmitted for correction. The B1 transaction must be successfully processed before the corresponding B2 transaction can be successfully processed.

In order to prevent out-of-sequence processing from occurring, we recommend that B2 transactions be submitted in a separate batch file.

NCPDP Transactions: Dispositions & Errors

Transaction Dispositions & Errors

NCPDP has three pharmacy transaction types which include B1 (initial billing), B2 (reversal/void), and B3 (re-bill/adjustment). There are three possible adjudication dispositions for each transaction type as provided in the table below:

B1 [†]		B3 [†]		B2*	
P	Pay	P	Pay	A	Approved
D	Duplicate	D	Duplicate	S	Duplicate of A
R	Reject/Deny	R	Reject/Deny	R	Reject/Deny

Transaction-level duplicates are based on matching:

- Service Provider ID^{†*}
- Date of Service^{†*}
- Prescription/Service Reference Number^{†*}
- NDC^{†*}
- Fill Number^{†*}
- Cardholder ID[†]

Syntax Errors (Formatting Errors)

Syntax errors at the transaction (claim) level post an error code of R8, 87, or 99, any of which prevent adjudication (processing) of the claim. Such errors are considered Repairable. Health plans are ultimately responsible for resubmitting all files posting syntax errors including host processing errors.

Repairable Errors

Repairable errors are those error codes that pertain to situations or information that are deemed essential for collection and require remediation. Claims with repairable errors must be remediated and resubmitted. Repairable errors are listed in the following tables.

Duplicate Logic Errors (Repairable)

Error Code	Description	Matched on:
83	Indicates that the claim, or portions thereof, duplicates a claim that has been paid or captured.	2Ø1-B1 (Service Provider ID*)
		4Ø1-D1 (Date of Service*)
		4Ø2-D2 (Prescription Reference Number*)
		4Ø3-D3 (Fill Number)
		4Ø7-D7 (NDC*)

Cardholder ID Errors (Repairable)

Error Code	Description	Probable Field in Error
Ø7	M/I Cardholder ID	3Ø2-C2 (Cardholder ID)
52	Non-Matched Cardholder ID	
MS	More than One Cardholder Found – Narrow Search Criteria	

NDC Errors (Repairable)

Error Code	Description	Probable Field in Error
21	M/I Product/Service ID	4Ø7-D7 (NDC)*
54	Non-Matched Product/Service ID Number	

Date of Service Errors (Repairable)

Error Code	Description	Probable Field in Error
15	M/I Date of Service	4Ø1-D1 (Date of Service)

NPI Errors (Repairable)

Error Code	Description	Probable Field in Error
5Ø	Non-Matched Service Provider (Pharmacy) ID	2Ø1-B1 (Service Provider ID)*

Prescriber ID

Error Code	Description	Probable Field in Error
25	M/I Prescriber ID	411-DB (Prescriber ID)
56	Non-Matched Prescriber ID	

Reversal Not Processed

Error Code	Description	Probable Field in Error
87	Reversal Not Processed	None

A Note on Reject Codes:

After Magellan has processed a plan's encounter data submission, the plan will receive two types of reports. Magellan will provide a response file reporting all errors contained in the file, and the Program Oversight Unit will provide the plan with exception reports that details errors that must be remediated as required by Florida Medicaid. Both reports utilize standard NCPDP "reject codes."

The tables above contain some common errors and their associated reject codes; however, these examples represent only a small number of possible reject codes. Fortunately, Appendix A of the *NCPDP External Code List (2008)* provides considerable guidance for remediating these errors, providing both a description of the error and the field likely in error. NCPDP membership is required to obtain a copy of the NCPDP implementation guides. For information on becoming a NCPDP member, please visit their website (www.ncdp.org) or call 480.477.1000.

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