

New Mexico Medicaid

D.0 FFS Payer Sheet B1-B3

Expert Mode (EM)

Project Management Methodology

February 3, 2021

Version 1.0



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## Revision History

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| --- | --- | --- | --- |
| **Version Number**  | **Date**  | **Description**  | **Author**  |
| 1.0  | 10/01/14  | Initial document with the incentive amount included for Naloxone (438E3 and 440-E5 updated)  | Christine Marshall  |
|  2.0 | 09/10/20 | Added notes to 440-E5 for opioid prescriptions |  Barb Sullivan |
|  3.0 | 02/04/21 | Updated for Covid Vaccine  | Barbara Sullivan |
|   |   |   |   |
|   |   |   |   |

## Configuration of This Document

This document is under full configuration management. See Configuration Items List.

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# 1.0 Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet

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

**GENERAL INFORMATION**

|  |  |
| --- | --- |
| Payer Name: New Mexico Medicaid  |   |
| Plan Name/Group Name: NM Medicaid Fee For Service  | BIN: 610084  | PCN: DRNMPROD  |
| Plan Name/Group Name: NM Medicaid Fee For Service (test)  | BIN: 610084  | PCN: DRNMACCP (after 1/1/2012) PCN: DRNMDV5S (thru 12/31/2011 for D.Ø testing)  |
| Processor: Conduent  |
| Effective as of: 02/11/21  | NCPDP Telecommunication Standard Version/Release #: D.0  |
| NCPDP Data Dictionary Version Date: October, 2007  | NCPDP External Code List Version Date: March, 2010  |
| Contact/Information Source: Other references such as Provider Manuals, Payer phone number, web site, etc.  |
| Certification Testing Window: Certification is not required  |
| Certification Contact Information: Certification phone number and information  |
| Provider Relations Help Desk Info: 8ØØ-365-4944  |
| Other versions supported: 5.1 supported through 12/31/2011  |

**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  |
| B3  | Rebilling  |

**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.Ø*.

|  |  |  |
| --- | --- | --- |
| **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 (11Ø-AK) is Not used  | X  |   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Transaction Header Segment**  |  |  | **Claim Billing/Claim Rebill**  |
| *Field #*  | *NCPDP Field Name*  | *Value*  | *Payer Usage*  | *Payer Situation*  |
| 1Ø1-A1  | BIN NUMBER  | 610084  | M  |   |
| 1Ø2-A2  | VERSION/RELEASE NUMBER  | DØ  | M  |   |
| 1Ø3-A3  | TRANSACTION CODE  | B1, B3  | M  | Claim Billing, Claim Rebill  |
| 1Ø4-A4  | PROCESSOR CONTROL NUMBER  | DRNMPROD = Production DRNMDV5S = D.Ø test DRNMACCP = Test  | M  | Use DRNMDV5S for D.Ø testing through 12/31/2011   |
| 1Ø9-A9  | TRANSACTION COUNT  | 1. = One

Occurrence 1. = Two

Occurrences 1. = Three

Occurrences 1. = Four

Occurrences  | M  |   |
| 2Ø2-B2  | SERVICE PROVIDER ID QUALIFIER  | Ø1 – National Provider Identifier  | M  | NPI mandated Ø2/Ø1/2ØØ8  |
| 2Ø1-B1  | SERVICE PROVIDER ID  | National Provider Identifier (NPI)  | M  | NPI mandated Ø2/Ø1/2ØØ8  |
| 4Ø1-D1  | DATE OF SERVICE  | CCYYMMDD  | M  |   |
| 11Ø-AK  | SOFTWARE VENDOR/CERTIFICATION ID  | ØØØØØØØØØØ  | M  | 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) = “Ø4”**  |  |  | **Claim Billing/Claim Rebill**  |
| *Field #*  | *NCPDP Field Name*  | *Value*  | *Payer Usage*  | *Payer Situation*  |
| 3Ø2-C2  | CARDHOLDER ID  |   | M  |   |
| 312-CC  | CARDHOLDER FIRST NAME  | 12 characters  | R  |   |
| 313-CD  | CARDHOLDER LAST NAME | 15 Characters  | R  |  |
| 3Ø9-C9  | ELIGIBILITY CLARIFICATION CODE  | Ø=Not specified 1=No Override 2=Override  | RW  | Enter ‘2’ when the claim has been denied for eligibility but the provider has documentation showing eligibility has recently been determined. Claim will be held for up to 40 days for eligibility to be updated.  |
| 3Ø1-C1  | GROUP ID  | NEWMEXMED  | R  |   |
| 3Ø6-C6  | PATIENT RELATIONSHIP CODE  | 1 = Cardholder  | 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) = “Ø1”**  |  |  | **Claim Billing/Claim Rebill**  |
| *Field*  | *NCPDP Field Name*  | *Value*  | *Payer Usage*  | *Payer Situation*  |
| 3Ø4-C4  | DATE OF BIRTH  | CCYYMMDD  | R  |   |
| 3Ø5-C5  | PATIENT GENDER CODE  | Ø=Not specified 1=Male 2=Female  | R  |   |
| 335-2C  | PREGNANCY INDICATOR  | Blank=Not Specified 1=Not pregnant 2=Pregnant  | RW  | Required if pregnant  |
| 384-4X  | PATIENT RESIDENCE  | Ø=Not specified 3=Nursing Facility 9=Intermediate Care Facility/Mentally Retarded 11=Hospice 15=Correctional Institution  | RW  | Required to indicate patient residence in any of the facilities indicated   |

|  |  |  |
| --- | --- | --- |
| **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 (111AM) = “Ø7”**  |  |  | **Claim Billing/Claim Rebill**  |
| *Field #*  | *NCPDP Field Name*  | *Value*  | *Payer Usage*  | *Payer Situation*  |
| 455-EM  | PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER  | 1 = Rx Billing  | M  |   |
| 4Ø2-D2  | PRESCRIPTION/SERVICE REFERENCE NUMBER  |   | M  |   |
| 436-E1  | PRODUCT/SERVICE ID QUALIFIER  | Ø3 = National Drug Code  | M  |   |
| 4Ø7-D7  | PRODUCT/SERVICE ID  | National Drug Code (NDC)  | M  |   |
| 456-EN  | ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER  | Rx number of the associated partial fill claim  | RW  | Required for the “completion” transaction in a partial fill (Dispensing Status (343-HD) = “C”).  |
| 457-EP  | ASSOCIATED PRESCRIPTION/SERVIC E DATE  | Used when submitting a claim for a partial fill  | RW  | Date of the Associated Prescription/Service Reference Number.  |
| 442-E7  | QUANTITY DISPENSED  | Metric Decimal Quantity  | R  |   |
| 4Ø3-D3  | FILL NUMBER  | Ø = Original Dispensing 1-99 = Refill number  | R  |   |
| 4Ø5-D5  | DAYS SUPPLY  |   | R  |  ‘1’ |
| 4Ø6-D6  | COMPOUND CODE  | Ø = Not specified 1= Not a compound 2 = Compound  | R  |   |
| 4Ø8-D8  | DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE  | Ø=Default, no product selection indicated 1=Physician request 7=brand mandated by law  | R  | Code indicating whether or not the prescriber’s instructions regarding generic substitution were followed. Value ‘1’ may be used when physician requests meet the Medicaid Program standards for a brand being medically necessary.  |
| 414-DE  | DATE PRESCRIPTION WRITTEN  | CCYYMMDD  | R  |   |
| 419-DJ  | PRESCRIPTION ORIGIN CODE  | 1=Written 2=Telephone 3=Electronic 4=Facsimile 5=Transfer  | R  | Required effective Ø9/Ø1/2ØØ9 Value Ø (not specified) will not be accepted by NM. |
| 354-NX  | SUBMISSION CLARIFICATION CODE COUNT  | Maximum count of 3.  | RW  | Required if Submission Clarification Code (42Ø-DK) is used. |
| 42Ø-DK  | SUBMISSION CLARIFICATION CODE  | 02 = Initial Dose06 = Second Dose  | R | Required when submitting a claim for a multi-dose Covid Vaccine. |
|  |  |  |  |  |
|  |  |  |  |  |
| 3Ø8-C8  | OTHER COVERAGE CODE  | Ø=Not Specified 1=No other Coverage 2=Other coverage exists - payment collected 3=Other coverage billed - claim not covered 4=Other coverage exists - payment not collected  | RW  | Required when other coverage exists    |
|  | **Claim Segment** **Segment** **Identification (111AM) = “Ø7”**  |  |  | **Claim Billing/Claim Rebill**  |
| *Field #*  | *NCPDP Field Name*  | *Value*  | *Payer Usage*  | *Payer Situation*  |
| 445-EA  | ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE  |   | RW  | Code of the initially prescribed product or service. Effective 07/01/2010 used to indicate when Product Selection has occurred. See notes regarding Product Selection on page 1Ø.  |
| 461-EU  | PRIOR AUTHORIZATION TYPE CODE  | Ø=Not Specified 1=Prior Authorization 2=Medical Certification   | RW  | Use ‘1’ in this field when submitting claims for Children’s Medical Services Use ‘2’ in this field for early Refill override – when authorized by the POS help desk  |
| 462-EV  | PRIOR AUTHORIZATION NUMBER SUBMITTED  |   | RW  | Required if valid value in Field 461-EU is ‘1’ and a number is required to be submitted  |
| 343-HD  | DISPENSING STATUS  | P = Initial Fill C = Completion Fill  | RW  | Required for the partial fill or the completion fill of a prescription. |
| 344-HF  | QUANTITY INTENDED TO BE DISPENSED  |   | RW  | Required when submitting a claim for a partial fill  |
| 345-HG  | DAYS SUPPLY INTENDED TO BE DISPENSED  |   | RW  | Required when submitting a claim for a partial fill  |
| 995-E2  | ROUTE OF ADMINISTRATION  | SNOMED Values Required  | RW  | Required when submitting compounds  |

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

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| --- | --- | --- | --- | --- |
|  | **Pricing Segment** **Segment** **Identification (111AM) = “11”**  |  |  | **Claim Billing/Claim Rebill**  |
| *Field #*  | *NCPDP Field Name*  | *Value*  | *Payer Usage*  | *Payer Situation*  |
| 4Ø9-D9  | INGREDIENT COST SUBMITTED  |  $0.01 | R  |  |
| 412-DC  | DISPENSING FEE SUBMITTED  |   | RW  | Required if necessary as component part of Gross Amount Due  |
| 438-E3  | INCENTIVE AMOUNT SUBMITTED  |   | R  | 16.49 for Initial dose28.39 for second dose / single dose vaccine  |
| 478-H7  | OTHER AMOUNT CLAIMED SUBMITTED COUNT  | Maximum count of 3.  | RW  | Imp Guide: Required if Other Amount Claimed Submitted Qualifier (479H8) is used.   |
| 479-H8  | OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER  | Ø9=Compound Preparation Cost Submitted  | RW  | If a compounding fee is being requested in addition to the dispensing fee enter Ø9. New qualifier value added in D.0  |
| 48Ø-H9  | OTHER AMOUNT CLAIMED SUBMITTED  |   | RW  | NM providers enter compound fee in this field.  |
| 426-DQ  | USUAL AND CUSTOMARY CHARGE  |   | R  | Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.  |
| 43Ø-DU  | GROSS AMOUNT DUE  |   | R  | This field is required to be submitted in D.0 which is a change from 5.1  |
| 423-DN  | BASIS OF COST DETERMINATION  | 15 = Free Product  | R | Required for COVID Vaccine submission during the EUA  |

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

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| --- | --- | --- | --- | --- |
|  | **Prescriber Segment** **Segment Identification (111-AM) = “Ø3”**  |  |  | **Claim Billing/Claim Rebill**  |
| *Field #*  | *NCPDP Field Name*  | *Value*  | *Payer Usage*  | *Payer Situation*  |
| 466-EZ  | PRESCRIBER ID QUALIFIER  | Ø1=National Provider Identifier (NPI)  | R  | Prescriber NPI is required effective 05/23/2008.   |
| 411-DB  | PRESCRIBER ID  | National Provider Identifier (NPI)  |   | Pharmacist or Pharmacy ID if not prescribed by a physician |

|  |  |  |
| --- | --- | --- |
| **Coordination of Benefits/Other Payments Segment Questions**  | **Check**  | **Claim Billing/Claim Rebill** If Situational, *Payer Situation* |
| This Segment is situational  | X  | Required only for secondary, tertiary, etc claims.  |
|   |   |   |
| Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)  | X  |   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Coordination of** **Benefits/Other** **Payments Segment** **Segment** **Identification (111AM) = “Ø5”**  |  |  | **Claim Billing/Claim Rebill**  Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)  |
| *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  | Blank=Not Specified Ø1=Primary Ø2=Secondary - Second Ø3=Tertiary - Third Ø4=Quaternary - Fourth Ø5=Quinary - Fifth  | M  |   |
| 339-6C  | OTHER PAYER ID QUALIFIER  | Ø3=Bank Information Number (BIN) 99=Other  | RW  | Submit value “99” and NM Carrier code in 340-7C if known. Otherwise use “03” and submit BIN of previous payer in 340-7C. |
| 34Ø-7C  | OTHER PAYER ID  |   | RW  | Submit NM Carrier Code if known, otherwise submit BIN of previous payer  |
| 443-E8  | OTHER PAYER DATE  | CCYYMMDD  | RW  | Required when there is payment or denial from another source  |
| 341-HB  | OTHER PAYER AMOUNT PAID COUNT  | Maximum count of 9.  | RW  | Required if Other Payer Amount Paid Qualifier (342HC) is used.  |
| 342-HC  | OTHER PAYER AMOUNT PAID QUALIFIER  | Ø1=Delivery Ø2=Shipping Ø3=Postage Ø4=Administrative Ø5=Incentive Ø6=Cognitive Service Ø7=Drug Benefit Ø9=Compound  | RW  | Required when there is payment from another source *Payer Requirement:* Required when 308-C8 = ‘2’   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Coordination of** **Benefits/Other** **Payments Segment** **Segment** **Identification (111AM) = “Ø5”**  |  |  | **Claim Billing/Claim Rebill**  Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)  |
| *Field #*  | *NCPDP Field Name*  | *Value*  | *Payer Usage*  | *Payer Situation*  |
|  |  | Preparation Cost 1Ø=Sales Tax  |  |  |
| 431-DV  | OTHER PAYER AMOUNT PAID  |   | RW  | Required if other payer has approved payment for some/all of the billing.   |
| 471-5E  | OTHER PAYER REJECT COUNT  | Maximum count of 5.  | RW  | Required if Other Payer Reject Code (472-6E) is used. *Payer Requirement*: Requiredif OCC = 3  |
| 472-6E  | OTHER PAYER REJECT CODE  |   | RW  | Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8C8) = 3 (Other Coverage Billed – claim not covered).  |
| 353-NR  | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT  | Maximum count of 25.   | RW  | Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.   |
| 351-NP  | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER  | Ø1=Amt Applied to Periodic Deductible Ø2=Amt Attributed to Product Selection/Brand Drug Ø3=Amt Attributed to Sales Tax Ø4=Amt Exceeding Periodic Benefit Maximum Ø5=Amount of Copay Ø6=Patient Pay Amount Ø7=Amount of Coinsurance Ø8=Amt Attributed to Product Selection/Non-Pref Formulary Ø9=Amt Attributed to Health Plan Funded Assistance Amount 1Ø= Amt Attributed to Provider Network Selection 11=Amt Attributed to Product Selection/Brand Non-Preferred  | RW  | Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. Use to indicate patient responsibility amount when 308-C8 = ‘2’ or ‘4’  Submission of Ø3, 09, 13 will result in a Denial  Submission of 02, 08, 11 will pay only if DAW=1  Submission of 12 will deny if Medicare Part D, pay if other non-Medicare insurer  Submission of 10 will return to patient for payment  |
|  |  | Formulary Selection 12=Amt Attributed to Coverage Gap 13=Amt Attributed to Processor Fee  |  |  |
| 352-NQ  | OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT  |   | RW  | Required when Other Coverage Code 308-C8 = ‘2’ or ‘4’   |

|  |  |  |
| --- | --- | --- |
| **DUR/PPS Segment Questions**  | **Check**  | **Claim Billing/Claim Rebill** If Situational, *Payer Situation* |
| This Segment is always sent  |   |   |
| This Segment is situational  | X  |   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **DUR/PPS Segment** **Segment Identification (111-AM) = “Ø8”**  |  |  | **Claim Billing/Claim Rebill**  |
| *Field #*  | *NCPDP Field Name*  | *Value*  | *Payer Usage*  | *Payer Situation*  |
| 473-7E  | DUR/PPS CODE COUNTER  | Maximum of 9 occurrences.  | RW  | Required if DUR/PPS Segment is used.  |
| 439-E4  | REASON FOR SERVICE CODE  |   | O | Code identifying the type of utilization conflict detected or the reason for the pharmacist’s professional service.   |
| 44Ø-E5  | PROFESSIONAL SERVICE CODE  | MA = Medication administration  Use ‘MA’ for vaccine administration  | RW  | Must equal a value of MA (Medication Administered) when Incentive Amount Submitted (438-E3) is greater than zero (Ø).  *Payer Requirement:* Enter one professional service code only, indicating the type of service. NM Medicaid Valid Values: **MA = Medication** Administration For Covid Vaccines |
| 441-E6  | RESULT OF SERVICE CODE  |   | O | Action taken by a pharmacist in response to a conflict or the result of a pharmacist’s professional service.  |
| 474-8E  | DUR/PPS LEVEL OF EFFORT  | Ø=Not Specified 11=Level 1 (Lowest) 12=Level 2 13=Level 3 14=Level 4 15=Level 5  | RW  | Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.  |
| 475-J9  | DUR CO-AGENT ID QUALIFIER  |   | RW  | Required if DUR Co-Agent ID (476-H6) is used. |
| 476-H6  | DUR CO-AGENT ID  |   | RW   | Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).  |

**/Claim Rebill (B1/B3) Payer Sheet**

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