

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 |
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## 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 |  |

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| --- | --- | --- | --- | --- |
|  | **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/CERTIFICATIO  N ID | ØØØØØØØØØØ | M | Populate with zeros |

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

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| --- | --- | --- | --- | --- |
|  | **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 |  |

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

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| --- | --- | --- | --- | --- |
|  | **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 |  |

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| --- | --- | --- | --- | --- |
|  | **Claim Segment**  **Segment**  **Identification (111AM) = “Ø7”** |  |  | **Claim Billing/Claim Rebill** |
| *Field #* | *NCPDP Field Name* | *Value* | *Payer Usage* | *Payer Situation* |
| 455-EM | PRESCRIPTION/SERVI  CE REFERENCE  NUMBER QUALIFIER | 1 = Rx Billing | M |  |
| 4Ø2-D2 | PRESCRIPTION/SERVI  CE 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/SERVIC  E 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 Dose  06 = 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 dose  28.39 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 |

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| **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 |

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| --- | --- | --- |
| **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*: Required  if 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’ |

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| --- | --- | --- |
| **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\*\***