Program Memorandum Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal B-03-024 **DATE: APRIL 11, 2003**

CHANGE REQUEST 2581

SUBJECT: Follow up to Implementation of the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard Version 5.1 and the Equivalent Batch Standard Version 1.1 for Retail Pharmacy Drug Transactions

This Program Memorandum (PM) is to supply instructions regarding the completion of the implementation of the NCPDP standards by Durable Medicare Equipment Regional Carriers (DMERCs) for retail pharmacy transactions. The information contained in this PM supplements the information initially distributed in CR 2255, CR 2455 and CR 2339. This PM provides answers and clarification to issues that have been raised, and changes the implementation date of this transaction.

CR 2339 – Change

The CR 2339 requirement for reporting the National Drug Codes (NDC) on all retail pharmacy claims applied to both electronic and paper claims. This CR changes that requirement by eliminating the requirement that paper claims would need to include the NDC. The NDC will be required on all electronic retail pharmacy claims.

Narrative Information

Several situations have been identified where Medicare requires narrative information for processing certain National Drug Codes (NDCs). The NCPDP standard contains a 500-position field in the Prior Authorization segment that supports one occurrence of narrative information. Retail pharmacists will be required to use this field to submit formatted information relating to a Certificate of Medical Necessity (CMN) to the DMERCs. Retail pharmacies will also use this narrative field to submit formatted facility name and address information. The attached spreadsheet (B03_024a.xls) will apply when the narrative field is being used and additional narrative information is needed to support the claim. The information contained in this spreadsheet will be included in the NCPDP companion document.

Compound Drugs

Compounded drugs will be billed using the Compound Segment in the NCPDP standard. For Nebulizer drugs, providers must send the following information in the Compound segment of the inbound NCPDP claim:

1. The KP modifier will be assigned to one of the compound ingredients.
2. The Compound Ingredient Basis of Cost Determination field (490-UE), will equal “09” (Other) to identify the ingredient that has been assigned the KP modifier.
3. All other ingredients in the Compound Segment will be assigned the KQ modifier.
4. The Compound Route of Administration field (452-EH) will be used to distinguish the Nebulizer Drug Compounds from Other Drug Compounds. This field is the route of administration of the complete compound mixture. The valid values for this field are:
   a. 3 - Nebulizer Compounds; and
   b. 11- Immunosuppressive Compounds.

5. If an ingredient in the compound is not found in the CMS NDC file, the claim will not reject for invalid NDC. In this case, the DMERCs will crosswalk this NDC compound ingredient to HCPCS code A9270 (Non covered item or service).
6. The Compound Ingredient Drug Cost field (449-EE) will equal the Amount Submitted for each claim line.

Each Compound Drug must be sent in a separate transmission. Mapping one compound drug per transmission is a complicated task and should not be attempted with more than one drug per transmission.

Parenteral Nutrition Products and Associated Supplies

Parenteral nutrition claims will be billed on the X12N 837 using HCPCS codes.

Enteral Nutrition Products

Enteral nutrition claims will be billed on the X12N 837 using HCPCS codes.

End Stage Renal Disease (ESRD)

ESRD claims will be billed on the X12N 837 using HCPCS codes.

Claims Submitted by Home Infusion Pharmacies

Home infusion pharmacies are professional pharmacies and must bill on the X12N 837. Home infusion drugs and associated supplies submitted by these pharmacies must be billed on the X12N 837 using the HCPCS codes to identify the drug and related supply.

NDC/HCPCS Crosswalk

1. Refer to CR 2339 for specific instructions for using the NDC/HCPCS crosswalk.
2. For situations where one NDC could crosswalk to many HCPCS codes, VIPS will match the NDC on the claim to the first HCPCS code on the crosswalk that correlates to that NDC. This is an interim solution in order that the DMERCs will be able to do internal testing and beta test with a few providers by July 7, 2003. The final crosswalk will be complete and available by May 1, 2003. VIPS will update the crosswalk logic based on the final crosswalk.
3. Instructions for maintaining the crosswalk will be issued in a future PM.

Mapping Metric Decimal Quantities to the X12N 835 and 277

For the July, 2003 release, the Units fields in the X12N 835 and 277 transactions do not accommodate a field size of s9(7)v999 for the Metric Decimal Quantity field in the NCPDP. When this field is transferred from an NCPDP claim to an X12N 835 or 277 outbound transactions, data in this field will be truncated. Any providers testing or in production between July and October 2003 must be notified that an X12N 835 or 277 received in response to an NCPDP claim will contain invalid data in the Units field. This problem will be corrected in the October, 2003 release of the X12N 835 and 277 flat files.

Generating a Batch Response

DMERCs will return the NCPCP batch response for all NCPDP transmissions received. The NCPDP term transaction is equivalent to a Medicare line item and the NCPDP term transmission is equivalent to a Medicare claim.

The NCPDP implementation guide allows for up to 4 transactions (line items) per transmission (claim). This means that each claim can have up to 4 line items. Therefore, if one transaction (line item) rejects, the entire transmission (claim) will be returned. Each NCPDP batch can have up to

9,999,999,997 transmissions (claims). All transactions (up to 4) in the transmission will be treated as one claim, while each transmission is treated as a separate claim in the batch. For a transmission (claim) where one or more claim transactions (lines) have errors, the following will occur:

1. DMERCs will reject all claim transactions (line items) in the transmission (claim) if any one claim (transmission) has detail errors.
2. The response status for all transactions will equal R (rejected).
3. The DMERCs will send up to 5 reject codes for claim transactions (line items) that have detail errors.
4. For the claim transactions (line items) that have no errors but are not being processed because of errors in other claim transactions (line items), the response status will equal R and the reject code will equal 84 (claim has not been paid/captured.)
5. Only the claim that rejected will have the reject codes other than 84. The other claims will have an 84 reject code indicating the claims were not paid/captured.

Coding changes for generating the batch response will be included in the July 2003 release.

Medicare Secondary Payer (MSP)

For processing MSP claim transactions, providers must send the following segments and data elements in the inbound NCPDP claim:

1. Submitted amount will be sent in Gross Amount Due (430-DU) on the Pricing Segment.
2. All other data needed for MSP will be sent in the COB segment.
3. MSP will use the following values in Other Payer Amount Paid Qualifier (342-HC):
   a. 07 (Drug Benefit) - Contract amount will be sent in Other Payer Amount Paid (432-DV);
   b. 08 (Sum of All Reimbursement) - Primary paid amount will be sent in 432-DV; and
   c. 99 (Other) - Primary allowed amount will be sent in 432-DV.

These changes will require Test Tool and VMS Edit changes.

Medigap

The following instructions for processing Medigap claims will be included in the NCPDP Companion Document: These data elements are required in the inbound NCPDP for processing Medigap claims:

1. The Medicare HICN will be submitted in the Cardholder ID field (302-C2).
2. Medigap Plan ID (or OCNA) will be submitted in the Group ID field (301-C1).
3. Medigap Policy Number will be submitted in the Alternate ID field (330-CW).

Partial Fills

Partial fills and completion of partial fills are not current DMERC functions. The DMERCs will treat partial fill information as a full claim and pay only for the quantity dispensed. The DMERCs will not add the functionality to begin processing claims as partial fills in NCPDP standard.

Medicare Part B Claims

Claims for vaccines and other drugs currently billed to Medicare Part B carriers will not be submitted in the NCPDP format. These claims will be submitted using the X12N 837 format or on paper.

Coordination of Benefits (COB)

For paper claims submitted by providers, the DMERCs will use the ASC X12N 837 to transmit these claims for COB.

Testing

1. DMERC internal testing of all NCPDP functions will begin by June 1, 2003.
2. DMERCs are to begin beta testing with at least one provider and COB trading partner (if requested by a COB trading partner) by July 7, 2003.
3. DMERCs must be ready to test with all providers and requesting COB trading partners by August 1, 2003, allowing those who tested successfully to go into production on the NCPDP.

Provider Education or Notification

By June 1, 2003, DMERCs must notify their providers, third party provider billing agents, provider clearinghouses, and the COB trading partners with whom they interact electronically for Medicare of/that:

- Each provider that submits retail pharmacy drug claims electronically must submit all of their retail pharmacy drug claims in compliance with the requirements in the NCPDP format (online version 5.1 or batch version 1.1);

- Each trading partner that has elected to exchange COB electronically must accept NCPDP format for retail pharmacy drug claims originally sent in this format by providers;

- Include the NCPDP Companion Document that will be made available by May 1, 2003. Instructions for accessing this document will be issued in a separate program memorandum.

- If an EDI submitter is using a vendor, clearinghouse, or billing service to generate a certain transaction and that entity has passed testing requirements for the NCPDP transaction and is using the same program to generate the transaction for all of their clients, then all clients of the vendor/clearinghouse/billing service will not be required to test prior to DMERC acceptance of production data. EDI submitters should request a testing appointment as soon as possible to be assured they can complete testing and correct any detected system problems prior to Medicare's full implementation of the NCPDP format. Appointment slots will be assigned on a first come basis. DMERCs will perform limited provider beta testing in July 2003. DMERCs will be ready for full provider testing on August 1, 2003;

- COB trading partners must either request system compatibility testing for use of the NCPDP COB format prior to Medicare's full implementation, or be confident that they have completed system changes as required to accept production NCPDP COB transactions. Any trading partner that prefers to have COB testing conducted prior to transmission of production data must schedule testing with you as soon as possible to assure testing will be completed before Medicare's full implementation; and

- There is no Medicare charge for this system testing.

DMERCs must be pro-active to assure that providers, agents, clearinghouses, and trading partners are furnished adequate information for them to understand the impact of the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification requirements, as implemented by Medicare, on their operations. DMERCs are not expected to furnish providers or others with in-depth training on use and interpretation of the NCPDP format for incoming claims and COB. However, they must furnish appropriate information in regularly scheduled provider bulletins/newsletters, in other provider educational publications during their regularly scheduled provider educational seminars, and in correspondence with COB trading partners to enable those individuals and entities to make educated and timely decisions to plan their reaction to the NCPDP format as implemented by Medicare.

Cost Issues

Refer to CR 2255 for cost instructions. You must notify CMS by April 15, 2003 of any revisions to the SBR for these activities.

The *effective date* for this PM is April 11, 2003.

The implementation date for this PM is July 1, 2003.

DMERCs should be ready to test with all providers by August 1, 2003.

See the section titled "Cost Issues" for detailed information on SBR submission for costs related to implementation of requirements in this PM.

This PM may be discarded after July 1, 2004.

If you have any questions, contact Marilyn Abramovitz, 410-786-5939 or E-mail mabramovitz1@cms.hhs.gov

Attachment (1)

	Element Attributes					
Description	**ID**	**R/S**	**Start**	**Length**	**Values**	**Comments**
498-PP Prior Auth Supporting Document			**1**	**500**		
Authorization Information Qualifier	AN	R	1	3	CMN - Medicare Certificate of Medical Necessity CNA - Medicare CMN and Narrative CFA - Medicare CMN and Facility Name and Address CNF - Medicare CMN, Narrative, and Facility Name and Address FAC - Facility Name and Address FAN - Facility Name and Address and Narrative NAR - Narrative for Medicare claim	CMN - Indicates that the Supporting documentation that follows is Medicare required CMN information CNA - Indicates that the Supporting documentation that follows is both Medicare required CMN and narrative information CFA - Indicates that the Supporting documentation that follows is both Medicare required CMN and Facility Name and address information CNF - Indicates that the Supporting documentation that follows is Medicare required CMN information, narrative information, and Facility Name and address information FAC - Indicates that the Supporting documentation that follows is Medicare required Facility Name and address information FAN - Indicates that the Supporting documentation that follows is both Medicare required Facility Name and address information and narrative information NAR - Indicates that the Supporting documentation that follows is Medicare required Narrative Information
Data Elements for Medicare CMN/DIF Form 08.02 Only						
Form Identifier	AN	R	4	6	08.02 - Immunosuppressive Drug CMN	
Ordering Physician First Name	AN	R	10	12		
Ordering Physician Address	AN	R	22	30		
Ordering Physician City	AN	R	52	20		
Ordering Physician State	AN	R	72	2		
Ordering Physician Zip	AN	R	74	15		

	Element Attributes					
Description	**ID**	**R/S**	**Start**	**Length**	**Values**	**Comments**
Certificate on File Ind	AN	R	89	1	Y or N	This certifies that the supplier has a paper copy of the CMN on file available for the DMERC to review if necessary
Signature Date	DT	R	90	8	CCYYMMDD	Date the Physician signed the CMN for form 10.02A & 10.02B Date the Supplier signed the CMN form for 08.02
Question 01A - HCPCS	AN	R	98	11	valid drug HCPCS code	Drug prescribed
Question 01B - MG	N0	R	109	4	0001 thru 9999	Dosage in Milligrams of the Drug prescribed in question 01A
Question 01C - Times Per Day	N0	R	113	2	01 - 99	Frequesncy of administration of Drug Prescribed in question 01A
Question 02A - HCPCS	AN	S	115	11	valid drug HCPCS code spaces are valid	Drug prescribed Required if more than one drug prescribed
Question 02B - MG	N0	S	126	4	0000 thru 9999	Dosage in Milligrams of the Drug prescribed in question 02A Required if question 02A is answered
Question 02C - Times Per Day	N0	S	130	2	00 - 99	Frequency of administration of Drug Prescribed in question 02A Required if question 02A is answered
Question 03A - HCPCS	AN	S	132	11	valid drug HCPCS code spaces are valid	Drug prescribed
Question 03B - MG	N0	S	143	4	0000 thru 9999	Dosage in Milligrams of the Drug prescribed in question 03A Required if question 03A is answered
Question 03C - Times Per Day	N0	S	147	2	00 - 99	Frequency of administration of Drug Prescribed in question 03A Required if question 03A is answered
Question 04	AN	R	149	1	Y or N	Has the Patient had an organ transplant that was covered by Medicare?
Question 05A	AN	S	150	1	spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted? (List most recent transplant) Required if the answer to question 4 is Y

	Element Attributes					
Description	**ID**	**R/S**	**Start**	**Length**	**Values**	**Comments**
Question 05B	AN	S	151	1	spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted? (List most recent transplant)
Question 05C	AN	S	152	1	spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted? (List most recent transplant)
Question 11	DT	R	153	8	CCYYMMDD	Date Patient was discharged from the hospital following this transplant surgery
Question 12	AN	R	161	1	Y or N	Was there a prior transplant failure of this same organ?
Filler	AN	S	162	19		space for possible expansion of data required for Immunosuppressive DIF/CMN
Data Elements for Medicare Required Narrative Data						
Narrative	AN	S	181	80	Free Form Text	
Data Elements for Medicare Required Facility name and Address Data						**Required when Patient Location is not 01 - home**

	Element Attributes					
Description	**ID**	**R/S**	**Start**	**Length**	**Values**	**Comments**
Facility Name	AN	R	261	27		
Facility Address	AN	R	288	30		
Facility City	AN	R	318	20		
Facility State	AN	R	338	2		
Facility Zip	AN	R	340	15		
Filler	AN	S	355	146		space for possible expansion of data required for Medicare processing