Pharmacy Billing – Request (Section 1.2.5)

Page last updated: August 2020

Copyright Notice

Pharmacy Billing – Request

The NCPDP (Batch Standard Implementation Guide Version 1.2) transaction is to be used by Providers, Clearinghouses, and all Covered Entities for programming of the NCPDP Batch 1.2 Standard transaction that will be submitted to Medi-Cal.

The structure and format for NCPDP Batch 1.2 Standard transaction should be as per NCPDP (Batch Standard Implementation Guide Version 1.2) published January 2006. Please refer to this publication for detailed programming requirements.

The NCPDP (Batch Standard Implementation Guide Version 1.2) requires a Transmission Header record, a Transaction Detail Data record (which contains the NCPDP D.Ø data records) and the Transmission Trailer record.

NCPDP (Batch Standard Implementation Guide Version 1.2) transactions must include one or more NCPDP Telecommunication Standard Version D.Ø claim record. Each claim record must contain at least one claim detail and a maximum of four claim details.

Within the Transmission Header record, the Sender ID field must be specified as “610442”, which is the same number that is specified for the BIN number in the NCPDP D.Ø Header record.

Medi-Cal accepts only B1 Claim Billing Transaction for NCPDP Batch 1.2 Standard transactions.

Medi-Cal does not accept Compound Drug Claims Transaction for NCPDP Batch 1.2 Standard transactions.

The B1 Claim Billing transmission will include the Header Segment, Insurance Segment, Patient Segment, Claim Segment, Pricing Segment, Prescriber Segment, COB/OPS Segment and Clinical Segment.

B1 – Claim Billing – Request – Data Record

	Transaction Header Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	Bin Number	61Ø442	M	
1Ø2-A2	Version/Release Number	DØ	M	
1Ø3-A3	Transaction Code	B1	M	
1Ø4-A4	Processor Control Number	Fill with Spaces	M	
1Ø9-A9	Transaction Count	1 through 4	M	
2Ø2-B2	Service Provider ID Qualifier	Ø1 = NPI	M	
2Ø1-B1	Service Provider ID		M	NPI of Submitting Pharmacy
4Ø1-D1	Date of Service		M	
11Ø-AK	Software Vendor/Certification ID	PC/POS Version Number - 7 Bytes and Submitter ID - 3 Bytes	M	

B1 – Claim Billing – Request – Data Record (Continued)

	Insurance Segment Segment Identification (111-AM) = "Ø4"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	Cardholder Identification Number	Must be one of the following formats: • CIN (9 characters) plus the BIC Issue Date (YYMMDD) • MEDS ID (9 characters) plus the BIC Issue Date (YYMMDD) • BID (14 characters) plus the BIC Issue Date (YYMMDD) • BIC ID (14 characters) plus the BIC Issue Date (YYMMDD) • BIC ID (14 characters)		3Ø2-C2

B1 – Claim Billing – Request – Data Record (Continued)

	Patient Segment Segment Identification (111-AM) = "Ø1"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø4-C4	Date of Birth		R	
3Ø5-C5	Patient Gender Code		R	
311-CB	Patient Last Name		R	
3Ø7-C7	Place of Service		RW	*Imp Guide*: Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Medi-Cal requires a valid POS as defined by ECL.

B1 – Claim Billing – Request – Data Record (Continued)

	Claim Segment Segment Identification (111-AM) = "Ø7"			**Claim Billing**
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 NDC	M	
4Ø7-D7	Product/Service ID		M	
442-E7	Quantity Dispensed		R	
4Ø3-D3	Fill Number		M	
4Ø5-D5	Days Supply		R	
4Ø6-D6	Compound Code	1 = Not Compound	4Ø6-D6	Compound Code
4Ø8-D8	Dispense as Written (DAW)/Product Selection Code		R	
414-DE	Date Prescription Written		R	

B1 – Claim Billing – Request – Data Record (Continued)

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
419-DJ	Prescription Origin Code		RW	*Imp Guide*: Required if necessary for plan benefit administration *Payer Requirement:* Medi-Cal requires this field.
354-NX	Submission Clarification Code Count	Only 1 allowed	RW	*Imp Guide*: Required if Submission Clarification Code (42Ø-DK) is used. Payer Requirement: Medi-Cal only allows 1 repetition at this time. Please review available values in Submission Clarification Code (42Ø-DK).
42Ø-DK	Submission Clarification Code	7 = Medically Necessary (indicates that Code 1 Restrictions have been met)	RW	*Imp Guide*: Required if clarification is needed and value submitted is greater than zero (Ø).
3Ø8-C8	Other Coverage Code	1 = No other coverage identified 2 = Other coverage exists-payment collected 3 = Other coverage exists-this claim not covered 4 = Other coverage exists-payment not collected	3Ø8-C8	*Imp Guide:* Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers. *Payer Requirement:* Required if Beneficiary has other coverage.

B1 – Claim Billing – Request – Data Record (Continued)

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
461-EU	Prior Authorization Type Code	1 = Prior Authorization	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Required when the claim requires Prior Authorization/ Approval, Medi-Cal will process values 1 in the system. **Note:** The Prior Authorization Number (field 462-EV) will be mapped as a TAR number if the Prior Authorization Type Code is one of the above values.
462-EV	Prior Authorization Number Submitted		RW	462-EV Prior Authorization Number Submitted RW

B1 – Claim Billing – Request – Data Record (Continued)

	Pricing Segment Identification (111-AM) = "11"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	Ingredient Cost Submitted		R	
412-DC	Dispensing Fee Submitted'		RW	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation Zero (Ø) is a valid value. *Payer Requirement:* Same as Imp Guide.
433-DX	Patient Paid Amount		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* Required when Medi-Cal share of cost is collected by Pharmacy.
438-E3	Incentive Amount Submitted		RW	*Imp Guide*: Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation
43Ø-DU	Gross Amount Due		R	*Payer Requirement:* Total price claimed from all sources.
423-DN	Basis of Cost Determination	Submit Ø8 for Disproportionate Share/Public Health Service	R	

B1 – Claim Billing – Request – Data Record (Continued)

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	Prescriber ID Qualifier	Ø1= NPI	RW	*Imp Guide*: Required if Prescriber ID (411-DB) is used. *Payer Requirement:* Medi-Cal requires this field.
466-EZ	Prescriber ID Qualifier	Ø1= NPI	RW	*Imp Guide:* Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/ regulatory agency programs. *Payer Requirement:* Medi-Cal requires NPI of the prescriber.

B1 – Claim Billing – Request – Data Record (Continued)

	COB/OP Segment Identification (111-AM) = "Ø5"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	Coordination of Benefits/Other Payments Count		M	
338-5C	Other Payer Coverage Type		M	
341-HB	Other Payer Amount Paid Count	Maximum count of 9	RW	*Imp Guide:* Required if Other Payer Amount Paid Qualifier (342-HC) is used. *Payer Requirement:* Same as Imp Guide.
342-HC	Other Payer Amount Paid Qualifier		RW	*Imp Guide:* Required if Other Payer Amount Paid (431-DV) is used. *Payer Requirement*: Same as Imp Guide.

B1 – Claim Billing – Request – Data Record (Continued)

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
431-DV	Other Payer Amount Paid		RW	*Imp Guide:* Required if other payer has approved payment for some/all of the billing. Zero (Ø) is a valid value. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. *Payer Requirement:* Field should contain the individual amount of all reimbursement received from all other coverage payers. Occurrence depending on count in field 341-HB.
491-VE	Diagnosis Code Count	Medi-Cal supports one or two diagnosis codes	RW	*Imp Guide:* Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. *Payer Requirement:* Same as Imp Guide.

B1 – Claim Billing – Request – Data Record (Continued)

	Clinical Segment Segment Identification (111-AM) = "13"			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
492-WE	Diagnosis Code Qualifier	Ø1= International Classification of Diseases (ICD-9-CM) Ø2= International Classification of Diseases (ICD-10-CM)	RW	*Imp Guide:* Required if Diagnosis Code (424-DO) is used. *Payer Requirement:* Same as Imp Guide.
424-DO	Diagnosis Code		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/ regulatory agency programs. *Payer Requirement:* Same as Imp Guide

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.