



Newsletter

*Published by the
N.J. Dept. of Human Services,
Div. of Medical Assistance & Health Services
and the N.J. Dept. of Health & Senior Services
Div. of Senior Benefits
and Utilization Management*

Volume 13 No. 15

April 2003

TO: Providers of Pharmaceutical Services – **For Action**
Health Maintenance Organizations – **For Information**

SUBJECT: Implementation of the new National Council for Prescription Drug Programs, Inc. (NCPDP) Version 5.1 and Version 1.1 Electronic Claim Formats

EFFECTIVE: Claims with service dates on or after July 1, 2003 and prior to October 1, 2003 for pharmaceutical services

PURPOSE: 1. To notify providers of pharmaceutical services of decisions by the New Jersey Division of Medical Assistance and Health Services (DMAHS) and the New Jersey Department of Health and Senior Services (DHSS) to accept, on a voluntary basis:

- The new National Council for Prescription Drug Programs, Inc. (NCPDP), version 5.1 electronic claim format for point-of-sale (POS) claims with service dates on or after July 1, 2003 and prior to October 1, 2003;
- The new NCPDP version 1.1 electronic claim format for Electronic Media Claims (EMC) with service dates on or after July 1, 2003 and prior to October 1, 2003; and
- The new NCPDP version 1.1 claim format for health maintenance organization (HMO) encounter claims with service dates on or after July 1, 2002 and prior to October 16, 2003.

2. To notify providers of pharmaceutical services that the NCPDP version 5.1 and version 1.1 electronic formats will be mandatory on and after October 1, 2003 for POS and EMC claims. Further information regarding mandatory compliance will be issued to providers in a future DMAHS/DHSS newsletter.

BACKGROUND: The National Council for Prescription Drug Programs, Inc. (NCPDP), version Medicaid 3C fixed format, is the current electronic claim format used by the New Jersey Medicaid Management Information System (NJMMIS) to process pharmacy claims through the State's point-of-sale (POS) claims processing system. Unisys proprietary formats are currently used by providers submitting EMC and HMO pharmacy encounter claims to the State.

As providers of pharmaceutical services and HMOs are aware, the national Health Insurance Portability and Accountability Act (HIPAA) establishes new standards for processing electronic pharmacy transactions. New Jersey Healthcare Information Networks and Technology (HINT) legislation, P.L. 1999, Chapter 154, also requires similar standards for third party health plans. While the New Jersey Medicaid program does not meet the definition of a third party plan, as defined by HINT, the State of New Jersey intends to voluntarily comply with the New Jersey HINT legislation.

The State intends to develop the capability to accept HIPAA-compliant electronic pharmacy claim transactions in the NCPDP version 5.1 and version 1.1 claim format with service dates on or after July 1, 2003 and prior to October 1, 2003. This capability is in preparation for mandatory compliance using the NCPDP version 5.1 and version 1.1 formats for electronic claims with service dates on or after October 1, 2003. **Use of these new claim formats will apply to all electronic State pharmacy benefit claims.**

The NJMMIS will accept the NCPDP version Medicaid 3C fixed format, the NCPDP version 5.1 claim format or the NCPDP version 1.1 claim format for electronic claims with service dates on or after July 1, 2003 and prior to October 1, 2003. Providers will be notified further concerning mandatory compliance in a future Medicaid/DHSS Newsletter.

This Newsletter announces DMAHS and DHSS' intentions to accept NCPDP version 5.1 and version 1.1 formats and to explain new billing and adjudication policies as a result of these new electronic claim formats. In addition, this Newsletter will delineate differences between the existing NCPDP version Medicaid 3C fixed format currently in use and the new NCPDP version 5.1 and version 1.1 claim formats.

The decision to accept the new format will have no impact on the coverage and reimbursement for the Medicaid, Work First New Jersey/General Assistance (WFNJ/GA), Pharmaceutical Assistance to the Aged and Disabled, Senior Gold, and AIDS Drug Distribution (ADD) programs.

ACTION: Effective for POS pharmacy claims and EMC with service dates on or after July 1, 2003 and prior to October 1, 2003, the NJMMIS (Unisys, fiscal agent) will accept the new NCPDP version 5.1 and version 1.1 claim formats for processing electronic POS, EMC and encounter pharmacy claims.

This Newsletter is divided **into three (3) sections and includes an Appendix A for software vendor use.** Each section discusses the impact of changes in the NCPDP format on processing pharmacy claims through the State's point-of-sale (POS) claims processing system and for submitting EMC and encounter claims.

- **Section I** compares the claim information currently required in the existing NCPDP version Medicaid 3C fixed format to that which will be required under the new NCPDP version 5.1 and version 1.1 electronic claim formats.
- **Section II** discusses the requirements established by the DMAHS and DHSS regarding acceptance of the old and new NCPDP formats.
- **Section III** discusses additional billing procedures resulting from the new NCPDP version 5.1 and version 1.1 electronic claim formats.
- **Appendix A** is intended for use by software vendors and provides further technical details concerning these changes.

If you have any questions concerning this Newsletter, please do not hesitate to contact the Chief Pharmaceutical Consultant, DMAHS, at (609) 588-2721.

**RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB
(BLUE TAB MARKED "5")**

Section I: Claim Format

Section I compares the claim information currently required in the existing NCPDP version Medicaid 3C fixed format to that which will be required under the new NCPDP version 5.1 and version 1.1 claim formats.

The following information is intended to describe differences between the current NCPDP version Medicaid 3C fixed format and the NCPDP version 5.1 and version 1.1 claim formats. *Unless otherwise indicated*, providers of pharmaceutical services will continue to report accepted values for claim fields currently reported in the NCPDP Medicaid 3C fixed format when transmitting the new NCPDP version 5.1 and version 1.1 claim formats to Unisys. HMOs are encouraged to reference the current EMC encounter format and the table below to better understand differences between the formats.

Table 1 describes mandatory information for submitting claims using the new NCPDP version 5.1 and version 1.1 claim formats. *Table 1 is limited to that information which the pharmacist must enter when submitting a pharmacy claim.* Additional details concerning this information follow in Sections II and III of this Newsletter.

DMAHS will publish an NCPDP Companion Guide in April 2003 that will provide comprehensive technical requirements concerning these new claim formats. Providers or their software vendor should consult Appendix A and/or the NCPDP Companion Guide for any additional information required for claim submission purposes.

Table 1

Field Description	NCPDP Version 3C	NCPDP Version 5.1 NCPDP Version 1.1
BIN Number	610515	610515
Service Provider ID Number	7-character Medicaid provider number	7-character Medicaid provider number
Date of Service	YYYYMMDD	YYYYMMDD
Date of Birth	YYYYMMDD	YYYYMMDD
Patient Gender Code	Not Applicable	1 = Male 2 = Female
Patient First Name	Enter full first name of beneficiary	Enter full first name of beneficiary
Patient Last Name	Enter full last name of beneficiary	Enter full last name of beneficiary
Patient Location Code	Referred to as Customer Location Code, values accepted: 01 = Home 02 = Intermediate Care Facility 03 = Nursing Facility 04 = Long Term/Extended Care 05 = Rest Home 06 = Boarding Home 07 = Skilled Nursing Facility 08 = ALRs & CPCHs 10 = Outpatient 11 = Hospice	Referred to as Patient Location Code, values accepted: 01 = Home 02 = Intermediate Care Facility 03 = Nursing Facility 04 = Long Term/Extended Care 05 = Rest Home 06 = Boarding Home 07 = Skilled Nursing Facility 08 = ALRs & CPCHs 10 = Outpatient 11 = Hospice
Smoker/Non-Smoker Code	Not Applicable	1 = Non-Smoker 2 = Smoker
Pregnancy indicator	Not Applicable	1 = Non Pregnant 2 = Pregnant
Prescriber ID	7 characters of Prescriber Service Number (PSN)	7 characters of Prescriber Service Number (PSN)
Cardholder ID	12 character Medicaid Beneficiary ID Number	First 10 characters of Medicaid Beneficiary ID or the number reported on the plastic ID card (to be issued).
Person Code	Included in Cardholder ID Field	Last 2 characters of Medicaid Beneficiary ID or the number reported on the plastic ID card (to be issued).
Other Payer ID (Identity of other insurance carrier that may have provided prescription coverage)	Not Required	Required for claims with other insurance; <u>Claim will deny</u> if Other Payer ID on file is not reported on pharmacy claim. Other Payer ID is <u>3-character code</u> identifying the other insurance Pharmacy Benefit Manager (PBM). (See Section III for Accepted Other Payer IDs)

Other Coverage Code (Currently used to override availability of other coverage, when appropriate)	00 = Pharmacist unaware of insurance coverage 01 = Claim previously denied for Edit 893 02 = TPL payment reported on claim 03 = Other coverage exists; drug product not covered by carrier 04 = Other coverage exists but other insurance claim cannot be processed electronically or payment reflects 100% copayment	00 or 01 = Pharmacist unaware of insurance coverage 02 = TPL payment reported on claim 03 = Other coverage exists; drug product not covered by carrier 04 = Other coverage exists but other insurance claim cannot be processed electronically 05 = Not applicable; if reported claim will deny 06 = Not applicable; if reported claim will deny 07 = Claim previously denied for Edit 893 08 = Payment reflects 100% copayment
Prescription/Service Reference Number	7 character prescription number	7 character prescription number
Product/Service ID	11 character NDC number	Enter 11 character NDC number
Quantity Dispensed	No decimal accepted; up to 5 characters	Decimal accepted; enter up to 7 characters to the left and 3 characters to the right of the decimal as needed
Fill Number	Not Applicable	0 = Original 1 through 99 = Refill number
Days Supply	Up to 3 characters	Up to 3 characters
Compound Code	0 = not specified 1 = not compound 2 = compound	0 or 1 = not compound 2 = compound
Dispense as written (DAW)/Product Selection Code	Blank = Not dispensed as written 1 = Dispense as written	Blank = Not dispensed as written 1 = Dispense as written
Date Prescription Written	Not Applicable	YYYYMMDD
Number of refills authorized	Not Applicable	Up to 2 characters indicating number of refills authorized by prescriber
Unit of Measure	Not Applicable	EA = Each GM = Gram ML = Milliliter
Prior authorization type code	0 = No PA number 1 = PA number entered 5 = Nonparticipating pharmacy in other insurance provider network	0 = No PA number 1 = PA number entered 5 = Nonparticipating pharmacy in other insurance provider network
Prior authorization number submitted	0, 1, or 5 in first position of PA number field	Enter 10-character PA number in 11 character field Enter '0' in first field position
Result of Service Code	Not Applicable	Not Applicable
Compound dispensing unit form indicator	Not Applicable	1 = Each 2 = Gram 3 = Milliliter

Compound ingredient component count	Not Applicable	1, 2, 3, 4, etc. Identifies the ingredient 'count' within a compound (i.e. ingredient No.1, 2, 3, etc) Up to 25 ingredients by NDC may be reported
Compound product ID	Not Applicable	11 character NDC number; up to 25 ingredients by NDC may be reported
Compound ingredient quantity	Not Applicable	Enter up to 7 characters to the left and 3 characters to the right of the decimal
Compound ingredient drug cost	Not applicable	Report usual and customary charge for <i>each</i> compound ingredient; enter 6 characters to the left and 2 characters to the right of the decimal
Ingredient cost submitted	Entered 4 characters to the left and 2 characters to the right of the decimal	Report usual and customary charge. For compounds, report usual and customary charge for <i>entire</i> compound. Enter 6 characters to the left and 2 characters to the right of the decimal
Dispensing fee submitted	Not Applicable	Enter 6 characters to the left and 2 characters to the right of the decimal
Usual and Customary charge	Entered 4 characters to the left and 2 characters to the right of the decimal	Enter 6 characters to the left and 2 characters to the right of the decimal
Diagnosis code count	Not applicable	1, 2, 3, 4, or 5
Diagnosis code	Not applicable	Enter 5 character ICD-9 diagnosis code Note: This field <i>shall</i> be used to report ICD-9 diagnostic codes on PAAD claims for Medicare-covered drugs. Prior authorization from First Health Services not required for pharmacies submitting NCPDP version 5.1 claim format.

Section II: Requirements

Section II discusses the requirements established by DMAHS and DHSS for processing electronic pharmacy claims in the new NCPDP version 5.1 or version 1.1 claim formats.

1. All electronic POS pharmacy claims submitted to Unisys with service dates **on or after July 1, 2003 and prior to October 1, 2003** may be submitted to Unisys using either the current NCPDP version 3C Medicaid fixed format or the new NCPDP version 5.1 claim format.
2. All electronic pharmacy claims submitted to Unisys with service **dates on or after October 1, 2003** must be submitted using the new NCPDP version 5.1 claim format. The NCPDP version 3C Medicaid fixed format will no longer be accepted by Unisys for service dates **on or after October 1, 2003**.
3. Pharmacies submitting electronic media claims (EMC) on diskette or tape with service dates **on or after July 1, 2003 and prior to October 1, 2003** have the option of using the new NCPDP version 1.1 claim format. During this period, Unisys will accept the existing Unisys proprietary format or the new NCPDP Version 1.1 claim format.
4. DMAHS and DHSS will only accept the new NCPDP version 1.1 claim format from pharmacies for EMC claims with service dates **on or after October 1, 2003**.
5. The new NCPDP version 5.1 claim format will only apply to electronic (POS) claims. **Billing Procedures for completion of hard-copy (paper) pharmacy claims (i.e. MC-6) shall remain the same, except as noted in No. 9 below for compound drug claims.**
6. **Reporting of Service Units or Metric Quantity on Pharmacy Claims**

The new NCPDP version 5.1 and version 1.1 claim formats change the way pharmacies report service units or metric quantities on pharmacy claims.

The new NCPDP version 5.1 and version 1.1 claim formats require pharmacies to report the ACTUAL METRIC QUANTITY of the drug dispensed on pharmacy claims.

THIS IS A CRITICAL CLAIMS PROCESSING CHANGE. Pharmacies using the new NCPDP claim formats shall discontinue any and all reporting practices that change the actual metric quantity of a prescription dispensed.

a. The NCPDP versions 5.1 and 1.1 claim formats require pharmacists to report actual fractional package size. For example, an ophthalmic ointment must be reported as 3.5 Grams and not rounded up to 4 Grams, as is current practice with the NCPDP version 3C Medicaid fixed format.

b. The NCPDP version 5.1 and version 1.1 claim formats require pharmacists to report the actual number of drug units dispensed. The new format expands the metric quantity field to allow the reporting of seven (7) characters to the left of the decimal and three (3) characters to the right of the decimal.

- i. Reducing the number of units for hemophiliac drugs to 1/10 the number of units dispensed will no longer be required. The new NCPDP version 5.1 and version 1.1 claim formats will accommodate the reporting of units as six (6) characters to the left of the decimal and two (2) characters to the right of the decimal.
- ii. Reporting bulk solutions, defined as any product with a metric quantity greater than 100 milliliters, as one (1) unit will no longer be required. Therefore, a 1000 milliliter Normal Saline solution would be reported as 1000 milliliters, instead of one (1) unit.

7. Reporting of Compound Drug Claims

THIS IS A CRITICAL CLAIMS PROCESSING CHANGE. The new NCPDP version 5.1 and version 1.1 claim formats change the way pharmacies report claims for compound drug prescriptions.

a. The new NCPDP version 5.1 and version 1.1 claim formats require pharmacies to report compound drugs claims in the manner described below. **Pharmacies using the new NCPDP version 5.1 and version 1.1 claim formats must discontinue the practice of reporting the most expensive National Drug Code (NDC), the compound drug quantity and total cost on pharmacy claims.**

- i. The **Compound Code** field must continue to be valued with a '2' to indicate the claim is a compound prescription claim.
- ii. A **Compound Product ID** field shall be used to report individual NDCs for compound drug ingredients (up to 25 ingredients).
- iii. A **Compound Ingredient Quantity** field shall be provided for reporting the actual quantity of each ingredient NDC included in the compound (up to 25 ingredients).
- iv. A **Compound Ingredient Drug Cost** field shall be used to report a provider's usual and customary charge for each individual ingredient used in the compound (up to 25 ingredients).
- v. An **Ingredient Cost Submitted** field shall be used to report a provider's usual and customary charge for all ingredients used in a compound (i.e. the sum total of usual and customary charges for all ingredients).

- vi. A **Compound Dispensing Unit Form Indicator** field must be valued to indicate the metric quantity description of each compound ingredient (i.e. '1' = Each; '2' = Gram; and '3' = Milliliter).
 - vii. A **Compound Ingredient Component Count** field must be valued to identify the ingredient count within a compound (i.e. No. 1, 2, 3, 4, etc.).
 - viii. **Compound drug claim payments** shall be reported on the Remittance Advice (RA) statement with all '9s' in the NDC field.
 - ix. If **prior authorization** is required for a compound drug claim, the authorization number shall be requested for the entire compound, not for individual ingredients that make-up the compound.
- b. **Between July 1, 2003 and October 1, 2003**, Unisys will continue to accept and process paper compound drug claims. **On or after October 1, 2003, paper compound drug claims will no longer be accepted and processed by Unisys.** These claims must be submitted in the NCPDP version 5.1 or version 1.1 claim format through the POS claims processing system.
- c. For electronic compound drug claims submitted to Unisys using the NCPDP version 5.1 or NCPDP version 1.1 claim format, the cost of inert ingredients commonly used in compound drug prescriptions will not be covered by DMAHS and DHSS. This decision is based on electronic compound drug processing limitations inherent to the new NCPDP Formats. This decision may be subject to change based on future decisions of the NCPDP.
- d. For compound drugs requiring prior authorization, the quantity of drug to be authorized is based on the total quantity of the compound, not only the quantity of the compound drug ingredient (reported by NDC) requiring prior authorization.
8. **Regardless of the Format used, POS responses received from Unisys will include both the 2-character NCPDP Rejection codes, commonly used by commercial insurers, and the current Unisys 3-character Error Codes. It is anticipated that future changes to the RA statement will limit reporting of Error Codes to the commercially accepted 2-character NCPDP Rejection Codes.**
9. **Between July 1, 2003 and October 1, 2003**, Unisys will process claims in accordance with the claim format received. Thus, claims received with a service date prior to October 1, 2003 using the existing NCPDP version 3C Medicaid fixed format will be processed in accordance with existing requirements.
- For example, pharmacies currently report a fractional package size of 3.5 grams as 4.0 grams. The new NCPDP version 5.1 or version 1.1 claim formats will require pharmacies to report this quantity as a metric quantity of 3.5 grams.
10. **Prior Authorization Requests (not applicable to HMO pharmacy encounter claims):**

a. **Between July 1, 2003 and October 1, 2003**, First Health Services will ask pharmacists what claim format was used to process a claim. First Health will prior authorize service units or metric quantity based on the response received.

Thus, if prior authorization is requested for a claim submitted to Unisys in the current NCPDP version 3C Medicaid fixed format, the number of service units or metric quantity authorized will be consistent with current requirements.

- i. For example, the current claim format requires pharmacists to report a fractional package size of 3.5 grams as 4 grams. In this example, 4 grams will be authorized by First Health Services.
- ii. For example, if authorization were requested for this same package in the NCPDP version 5.1 or version 1.1 claim formats, 3.5 grams would be authorized by First Health Services.

b. Pharmacists may continue to request prior authorization from First Health Services by telephone after a claim is denied by the POS system because authorization is required. Information regarding electronic submission of Prior Authorizations (PAs) will be addressed in a future newsletter.

c. If prior authorizations are requested before claims have been processed by the POS system, these requests may be made by telephone or may be received by First Health Services as an electronic file transmitted via diskette, tape or some other means to be identified by First Health Services. This information will follow in a future Newsletter.

11. The new NCPDP version 5.1 and version 1.1 claim formats allow pharmacists to report whether a prescription is 'partial' or 'complete'. In other words, the new Format allows pharmacies to report when a partial prescription has been dispensed because a drug is not available in their inventory. Payment would then be limited to the actual quantity of drug dispensed. When the remainder of the prescription becomes available and is dispensed, the claim would be identified as a complete prescription and the claims processing system would perform the necessary adjustments to ensure that the payment for the prior partial prescription was reversed and the payment for the complete prescription represented payment for the entire prescription.

DMAHS and DHSS are not implementing this optional NCPDP capability. In situations involving partial prescriptions, pharmacies must continue to process claims for the actual drug quantity dispensed. According to existing requirements, the initial prescription for the partial fill will be reversed when a claim is subsequently billed for the complete prescription.

12. Pharmacies using the NCPDP version 5.1 and version 1.1 claim formats for processing Pharmaceutical Assistance to the Aged and Disabled (PAAD) claims for Medicare-covered drugs identified by the State must report the appropriate ICD-9 diagnosis code in the Diagnosis Code field. Claims reporting the ICD-9 diagnosis code shall not require prior authorization from First Health Services. Pharmacies using the NCPDP version 3C Medicaid fixed format must continue to

request prior authorization from First Health Services for Medicare-covered drugs.

13. **Remittance Advice Statement**

a. Regardless of the claim format used to submit claims, drug quantity information reported on the Unisys Remittance Advice (RA) statement will remain unchanged (i.e. the drug quantity reported on the RA will be the same as that currently reported under the NCPDP Version 3C Medicaid Fixed Format).

b. It is anticipated that future changes to the RA statement may limit reporting of Error Codes to the commercially-accepted 2-character NCPDP Rejection Codes.

Section III: Additional Billing Procedures

Section III discusses additional billing procedures resulting from the new NCPDP version 5.1 and version 1.1 claim formats.

1. Pharmacies are required to report the **Smoker Status** of State beneficiaries. Report a value of '1' for non-smokers and a value of '2' for smokers.
2. Pharmacies are required to report the **Pregnancy Status** of State beneficiaries. Report a value of '1' for non-pregnant and a value of '2' for pregnant.
3. Pharmacies are required to report the **Date the Prescription is Written** in the year, month, day format (i.e. YYYYMMDD).
4. Pharmacies are required to report the **Number of Refills Authorized** (i.e. 01, 02, 03, 04, 05, etc.).
5. Pharmacies are required to report the **Unit of Measure** for the drug reported on a pharmacy claim (i.e. **Each, Gram, or Milliliters**).
6. **For Pharmaceutical Assistance to the Aged and Disabled (PAAD) claims submitted only in the NCPDP version 5.1 or version 1.1 claim formats**, pharmacists must report the ICD-9 diagnosis code for Medicare-covered drug identified by the State (see DHSS Newsletter Volume 6, No. 2, dated March 2002). Prior authorization will not be required for processing these PAAD claims.
7. Values for **Patient Location (v 5.1)** and **Customer Location (v3C)** are the same for the NCPDP version 3C Medicaid fixed format and the NCPDP version 5.1 claim format.
8. Pharmacists are required to report up to three (3) **Other Payer ID Codes** for the other insurers that may have provided payment(s) for a pharmacy claim. Currently, pharmacies are not required to report Other Payer ID codes and must only report the payment received for a claim in the Other Payment Amount Field.

9. DMAHS and DHSS have identified the following **Other Payer ID Codes** to be reported when payments are received from other insurance carriers. Additional Other Payer ID Codes may be assigned by DMAHS and DHSS in the future:

Pharmacy Benefit Manager	Accepted Other Payer ID Codes
Advance PCS	ADV
Aetna/USHC	AET
CareMark	CAR
Cigna	CIG
Express Scripts	EXP
FirstHealth	FIR
Merck-Medco (PAID)	PAI
NPA	NPA
PCS	PCS
ProServ	PRO
TriCare	TRI
Restat	RES
United Health Services	UHS
Well Point	WEL
Other	OTH

10. Pharmacists are required to report the following **Other Coverage Codes** when overriding the availability of prescription payments by other insurers.

Other Coverage Codes
00 or 01 = Pharmacist unaware of insurance coverage
02 = TPL payment reported on claim
03 = Other coverage exists; drug product not covered by carrier
04 = Other coverage exists but other insurance claim cannot be processed electronically
05 = Not applicable; if reported claim will deny
06 = Not applicable; if reported claim will deny
07 = Claim previously denied for Edit 893
08 = Payment reflects 100% copayment

11. The new NCPDP version 5.1 and version 1.1 claim formats provide a separate claim field for reporting the reason for including a prior authorization number in an electronic pharmacy claim.

Currently, providers report a value of '1' in the first position of the existing prior authorization field on a claim. This value is followed by a value of '0' as a placeholder.

The new NCPDP version 5.1 and version 1.1 claim formats provide a separate claim field to identify the reason for a prior authorization number. The values for this new field include the following:

Type of Prior Authorization
0 = No PA number
1 = PA number entered
5 = Nonparticipating pharmacy in other insurance provider network

12. The NCPDP version 5.1 and version 1.1 claim formats, as mentioned in Section II (13), provide optional opportunities for pharmacies to report partial and complete prescriptions. In Section II (13), DMAHS and DHSS indicated the State would not proceed with this option. Therefore, pharmacies must leave the **Dispensing Status** blank.
13. See Section II (8) for information concerning changes in how service units or metric quantity is reported in the new NCPDP version 5.1 and version 1.1 claim formats.
14. See Section II (9) for information concerning changes in how compound drug claims are reported in the new NCPDP version 5.1 and version 1.1 claim formats.

APPENDIX A

Appendix A is intended to advise software vendors regarding mandatory fields and values required by the New Jersey Division of Medical Assistance and Health Services and the New Jersey Department of Health and Senior Services for pharmacy claims submitted to Unisys in the new NCPDP version 5.1 and version 1.1 claim formats. For additional information, please consult the NCPDP Companion Guide, anticipated to be available in March 2003.

The NCPDP version 5.1 and version 1.1 claim formats shall be optional for claims with service dates on or after July 1, 2003 and prior to October 1, 2003. These formats shall be mandatory for claims with service dates on or after October 1, 2003.

This Table compares current requirements for the NCPDP version 3C Medicaid fixed claim format to the new NCPDP version 5.1 and version 1.1 claim formats. All fields and values listed under NCPDP version 5.1/version 1.1 are mandatory. HMOs are encouraged to reference other materials to compare the current proprietary encounter EMC format to the NCPDP version 1.1 format.

Field Description	NCPDP Version 3C	NCPDP Version 5.1 NCPDP Version 1.1
BIN Number	610515	610515
Version/Release Number	3C	51
Transaction Code	01 or 02	B1 or B2
Processor Control Number	NJP followed by Unisys 7-character Submitter ID Number	NJP followed by Unisys 7-character Submitter ID Number
Service Provider ID Qualifier	Not Applicable	05
Service Provider ID Number	7-character Medicaid provider number entered into first 7 positions of a 15 character field	7-character Medicaid provider number entered into first 7 positions of a 15 character field
Date of Service	YYYYMMDD	YYYYMMDD
Date of Birth	YYYYMMDD	YYYYMMDD
Patient Gender Code	Not Applicable	1 = Male 2 = Female
Patient First Name	Enter full first name; Unisys edits against first character of first name in 12 character field	Enter full first name; Unisys will edit against first character of first name in 12 character field
Patient Last Name	Enter full last name; Unisys edits against first 5 characters of last name in 15 character field	Enter full last name; Unisys will edit against first 5 characters of last name in 15 character field
Patient Location Code	Referred to as Customer Location Code, values accepted: 01 = Home 02 = Intermediate Care Facility 03 = Nursing Facility 04 = Long Term/Extended Care 05 = Rest Home 06 = Boarding Home 07 = Skilled Nursing Facility 08 = ALRs & CPCHs 10 = Outpatient 11 = Hospice	Referred to as Patient Location Code, values accepted: 01 = Home 02 = Intermediate Care Facility 03 = Nursing Facility 04 = Long Term/Extended Care 05 = Rest Home 06 = Boarding Home 07 = Skilled Nursing Facility 08 = ALRs & CPCHs 10 = Outpatient 11 = Hospice
Smoker/Non-Smoker Code	Not Applicable	1 = Non-Smoker 2 = Smoker
Pregnancy indicator	Not Applicable	1 = Non Pregnant 2 = Pregnant
Prescriber ID Qualifier	Not Applicable	05
Prescriber ID	Enter first 7 characters of Prescriber Service Number (PSN) in 15 character field	Enter the 7 characters Prescriber Service Number (PSN) in 15 character field
Cardholder ID	12 character Medicaid Beneficiary ID Number entered in a 12 character field	Enter first 10 characters of Medicaid Beneficiary ID or the number reported on the plastic ID card in the 12 character field

Person Code	Included in Cardholder ID Field	Enter last 2 characters of Medicaid Beneficiary ID or the number reported on the plastic ID card (to be issued) in the 2 character field
Other Payer ID Qualifier	Not Applicable	99
Other Payer ID (Identity of other insurance carrier that may have provided prescription coverage)	Not Required	<p>Required for claims with other insurance; Claim will deny if Other Payer ID on file is not reported on pharmacy claim. Other Payer ID is 3-character code identifying the other insurance Pharmacy Benefit Manager (PBM).</p> <p>Other Payer ID Codes:</p> <p>Advance PCS _____ ADV Aetna/USHC _____ AET CareMark _____ CAR Cigna _____ CIG Express Scripts _____ EXP FirstHealth _____ FIR PAID _____ PAI NPA _____ NPA PCS _____ PCS ProServ _____ PRO TriCare _____ TRI Restat _____ RES United Health _____ UHS Well Point _____ WEL Other _____ OTH</p>
Other Coverage Code (Currently used to override availability of other coverage, when appropriate)	00 = Pharmacist unaware of insurance coverage 01 = Claim previously denied for Edit 893 02 = TPL payment reported on claim 03 = Other coverage exists; drug product not covered by carrier 04 = Other coverage exists but other insurance claim cannot be processed electronically or payment reflects 100% copayment	00 or 01 = Pharmacist unaware of insurance coverage 02 = TPL payment reported on claim 03 = Other coverage exists; drug product not covered by carrier 04 = Other coverage exists but other insurance claim cannot be processed electronically 05 = Not applicable; if reported claim will deny 06 = Not applicable; if reported claim will deny 07 = Claim previously denied for Edit 893 08 = Payment reflects 100% copayment

Prescription/Service Reference Number Qualifier	Not Applicable	1
Prescription/Service Reference Number	Enter 7 character prescription number in 7 character field	Enter 7 character prescription number in 7 character field
Product/Service ID Qualifier	Not Applicable	03
Product/Service ID	Enter 11 characters of NDC in first 11 positions of 11 character field	Enter 11 characters of NDC in first 11 positions of 19 character field
Quantity Dispensed	No decimal accepted; up to 5 characters	Decimal accepted; enter up to 7 characters to the left and 3 characters to the right of the decimal as needed
Fill Number	Not Applicable	0 = Original 1 through 99 = Refill Number
Days Supply	Up to 3 characters	Up to 3 characters
Compound Code	0 = not specified 1 = not compound 2 = compound	0 or 1 = not compound 2 = compound
Dispense as written (DAW)/Product Selection Code	Blank = not dispense as written 1 = dispense as written	Blank = not dispense as written 1 = dispense as written 2 to 99 = Not Applicable
Date Prescription Written	Not Applicable	YYYYMMDD
Number of refills authorized	Not Applicable	Enter up to 2 characters in 2 character field reflecting number of refills authorized by prescriber
Unit of Measure	Not Applicable	EA = Each GM = Gram ML = Milliliter
Prior authorization type code	0 = No PA number 1 = PA number entered 5 = Nonparticipating pharmacy in other insurance provider network	0 =No PA number 1 = PA number entered 5 = Nonparticipating pharmacy in other insurance provider network
Prior authorization number submitted	0, 1, or 5 in first position of PA number field	Enter 10-character PA number in 11 character field Enter '0' in first field position
Dispensing Status	Not Applicable	Partial fill not currently supported
Quantity intended to be dispensed	Not Applicable	Partial fill not currently supported
Days supply intended to be dispensed	Not Applicable	Partial fill not currently supported
Reason for Service Code	Not Applicable	Not Applicable
Professional Service Code	Not Applicable	Not Applicable
Result of Service Code	Not Applicable	Not Applicable
Compound dispensing unit form indicator	Not Applicable	1 = Each 2 = Gram 3 = Milliliter Up to 25 segments may be reported

Compound ingredient component count	Not Applicable	1, 2, 3, 4, etc. Identifies the ingredient 'count' within a compound (i.e. ingredient No.1, 2, 3, etc) Up to 25 segments may be reported
Compound product ID	Not Applicable	Enter 11 character NDC in 19 character field Up to 25 segments may be reported
Compound ingredient quantity	Not Applicable	Enter up to 7 characters to the left and 3 characters to the right of the decimal Up to 25 segments may be reported
Compound ingredient drug cost	Not applicable	Provider usual and customary charge for each compound ingredient; enter 6 characters to the left and 2 characters to the right of the decimal Up to 25 segments may be reported
Ingredient cost submitted	Entered 4 characters to the left and 2 characters to the right of the decimal	Report usual and customary charge. For compounds, report usual and customary charge for <i>entire</i> compound. Enter 6 characters to the left and 2 characters to the right of the decimal.
Dispensing fee submitted	Not Applicable	Enter 6 characters to the left and 2 characters to the right of the decimal
Usual and Customary charge	Entered 4 characters to the left and 2 characters to the right of the decimal	Enter 6 characters to the left and 2 characters to the right of the decimal
Diagnosis code count	Not applicable	1, 2, 3, 4, or 5
Diagnosis code qualifier	Not applicable	01
Diagnosis code	Not applicable	Enter 5 character ICD-9 diagnosis code in 15 character field Note: This field shall be used to report ICD-9 diagnostic code on PAAD claims (cardholder ID with the value of '6' in first position) only for Medicare-covered drugs