COMMONWEALTH OF VIRGINIA

Encounter Processing Solution (EPS)

Medicaid Enterprise System (MES)

Companion Guide

For NCPDP Batch Version 1.2 Encounter Transactions

December 11 2020

Document Version 2.2

Department of Medical Assistance Services (DMAS)

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Publication Version Change Summary

Version	Date	Revision Description	Prepared By:
1.0	13MAR2017	DMAS MES 5010 Original Implementation	DMAS
1.1	09MAY2017	Page 4 – Updated 88Ø-K1 SENDER ID to show Service Center and Subcontractor IDs with values and examples. Page 7 - Changed UNIQUE to SUBMITTER for 332-CY.	DMAS
1.2	13JUN2017	1- All items with API were reviewed and removed as needed. 2- Page 12- Field 337-4C, changed maximum count from 9 to 3 for EPS processing. 3- Page 12- Field 338-5C, removed BLANK = MCO Payment Only. MCO Payment Only will be have a value Ø1 (Primary). 3- Page 12- Field 341-HB, comment added 'Is mandatory for MCO Medicaid payment.' 4- Page 12- Field 342-HC, comment added 'Is mandatory for MCO Medicaid payment.' 5- Page 13- Field 431-DV, comment added 'Is mandatory for MCO Medicaid payment.'	DMAS

Version	Date	Revision Description	Prepared By:
1.3	25AUG2017	1- Remove several fields from Companion Guide as they are redundant with the NCPDP Implementation Guide (IG). HIPAA Core standards requires companion guides to not show redundencies if fields are not changed from the IG. The elements removed form the companion guide are: 305-C5, 307-C7, 335-2C, 309-C9, 455-EM, 402-D2, 436-E1, 407-D7, 456-EN, 457-EP, 442-E7, 405-D5, and 408-D8. Future updates may include removal of additional data elements from the companion guide if redundent with the IG. 1- Page 12- Field 337-4C, changed maximum count from 3 to 9 to be consistent with the NCPDP Implementation Guide. 2- Page 12- Field 338-5C, changed the maximum of values from 3 to 9 to be consistent with the NCPDP Implementation Guide. 3- Page 12- Field 339-6C, changed Qualifier to have a value of 99. 4- Page 13- Field 340-7C, added additional verbiage for the values to be entered. 5- Page 13- Field 443-E8, added additional verbiage to clarify information needed. 6- Page 13- Field 341-HB, added additional verbiage to clarify information needed. 7- Page 13- Field 993-A7 Internal Control Number added with verbiage to clarify information needed.	DMAS
1.4	01SEP2017	1- Page 8- Field 308-C8, modified Virginia Medicaid Notes that this field is always required for all submitters for the Medicaid related payment amount. Also added additional verbiage for value 02 as to being required for all submitters for the Medicaid related payment amount. 2- Page 12- modified Section 7.7 COB/Other Payers Segment to be Mandatory all submitters for the Medicaid related payment amount. 3- Page 13- Field 340-7C, modified verbiage to specify that only the 4-digit EPS Service Center is to be entered in this field.	DMAS

Version	Date	Revision Description	Prepared By:
1.5	20OCT2017	1- Page 10- Fields 427-DR, 498-PM, 364-2J, 365-2K, 366-2M, 367-2N, and 368-2P (Prescriber Name, Phone, and Address information) were change from REQUIRED to OPTIONAL as are not required to be submitted for VA EPS processing.	DMAS
1.6	16MAR2018	Page 12- Added additional clarifying information to COB/Other Payments Segment field Other Payer ID Qualifier (339-6C)	DMAS
2.0	06APRIL2018	Revised for Medallion 4.0 Implementation: Page 4 - Added example pertaining to Medallion 4 to 88Ø-K1 SENDER ID.	DMAS
2.1	27AUG2018	Page 13- Field 431-DV, comment added 'Value in field must be zero or greater than zero. Negative amounts are not valid.'	DMAS
2.2	11DEC2020	Page 8- Field 420-DK, changed Max # of occurrences from 1 to 3 per NCPDP IG standard. Page 12- Field 423-DN row removed from Pricing Segment as field is no longer required if Field 420-DK equals 20 (340B).	DMAS

TABLE OF CONTENTS

1 INTRODUCTION

The NCPDP Batch Transaction document defines the record for batch prescription encounter transactions between the Managed Care MCOs and the Virginia Medicaid administered by DMAS. This guide provides the basic requirements for implementation of the NCPDP Version 1.2 transaction.

This Companion Guide is to be used by Managed Care Organizations for the programming of the file that is required to electronically submit encounter data.

The National Council for Prescription Drug Programs (NCPDP) is a non-profit organization formed in 1976. It is dedicated to the development and dissemination of voluntary consensus standards that are necessary to transfer information that is used to administer the prescription drug benefit program.

To request a copy of the Telecommunication Batch Standard Formats or for more information contact the National Council for Prescription Drug Programs, Inc. The HIPAA implementation guide can be accessed at the NCPDP website: www.ncpdp.org

Table 1: NCPDP.ORG Contact Information

Contact information for NCPDP.org	
Address:	National Council for Prescription Drug Programs, Inc. 4201 North 24th Street Suite 365 Phoenix, Arizona 85016
Telephone:	(602) 957-9105

2 PURPOSE

This guide is concerned with the processing of batch encounters and responses submitted to DMAS for Virginia Medicaid. DMAS adheres to all HIPAA standards and this guide contains clarifications and requirements that are specific to transactions and data elements contained in various segments.

This NCPDP implementation companion guide will provide assistance in the development and execution of the electronic transfer of pharmacy batch encounter transaction data.

All specifications in this document conform to NCPDP Version D.Ø Telecommunications Standards and NCPDP Version 1.2 Batch Standards, adopted for use by the Virginia Medicaid. These specifications are designed to be compatible with currently existing communications networks.

3 SPECIAL NOTES

NCPDP Encounters may be sent at any time 24 hours a day, 7 days a week; however encounters should be submitted on their scheduled submission date based on the agreement established with DMAS. Contact the MCO/Contract Encounter Analyst if a scheduled submission is delayed and needs to be rescheduled.

The 999, 999HR, and NCPERROR response files will normally be available for pickup 1 hour after file submission unless there are unforeseen technical difficulties. The TA1, TA1HR, ACK, and RESP (XML and HTML formats) response files will available as soon as the file submission process has completed.

All references to Medicaid are used for simplicity, but other programs supported by DMAS are also included, such as FAMIS.

All encounters received will be processed using the NPI assigned to the pharmacy or the prescriber as assigned from the NPPES process.

DMAS uses a Managed File Transfer (MFT) application to securely transmit/receive batch EDI data into the Virginia Medicaid system. Approved EDI Submitters can upload and retrieve batch files via the MFT application, using Secure File Transfer Protocol (SFTP). All Service Centers must have applied and been authorized by the Virginia EDI Coordinators office before using MFT/SFTP to transmit files. Please refer to the EDI Procedures Manual for additional information related to the MFT.

4 GENERAL INFORMATION

Table 2: General Information

Payer Name: Virginia Medicaid		**Date:** 04/02/2017		
Processor: DMAS EPS	**Information Source:** DMAS EDI Help Desk	**BIN:** 010900	**Receiver ID:** 5148010900	**PCN:** DRVAPROD
Effective as of: 7/1/2017		**NCPDP Telecommunication Standard Version:** D.Ø		
Contact/Information Source: **General website:** www.virginiamedicaid.dmas.virginia.gov				
Certification Testing Window: Monday-Friday 8 am ET – 5 pm ET				
EDI Help Desk Info: 866-352-0766				
Email: DMASEDISupport@dmas.virginia.gov				

5 TRANSACTION FORMAT INFORMATION

Virginia Medicaid will accept Batch Standard Format Version 1.2. Version 1.2 allows for Telecommunications 5.1 transactions and higher, yet to be HIPAA compliant, the batch transaction must include NCPDP version D.Ø transactions. The batch transaction must be submitted using the NCPDP Telecommunications Standard Format Version D.Ø transactions within the NCPDP Batch Standard Format Version 1.2.

Field format values will follow the NCPDP standards for Version D.Ø. The following definitions will apply to the data element descriptions for all transaction formats:

Table 3: Definitions and Data Element Descriptions

Element	Description
M	*Mandatory*: as defined by NCPDP
R	*Required*: as defined by this Program
RW	*Required when*: defined by this Program
O	*Not Required*: as defined by this Program

5.1 Supported Transactions

Other valid transaction codes are available, Virginia Medicaid supports the following:

Table 4: Other Valid Transaction Codes Accepted by Virginia Medicaid

Transaction Code	Transaction Type
B1	Prescription Billing
B2	Prescription Reversal

6 BATCH SUBMISSION STANDARDS

6.1 Data Element Definitions

All data elements used in the Virginia Medicaid batch transaction submission system adhere to industry standards as defined by NCPDP.

6.2 Batch Standard Format

In order to submit Pharmacy batch transactions using the NCPDP Batch Standard, you must include a transmission header, transaction detail and a transmission trailer.

6.2.1 Transaction Header Definition

NCPDP Field Number	NCPDP Field Name	Type	Length	START	END	Virginia Medicaid Notes
88Ø-K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'Ø2'
7Ø1	SEGMENT IDENTIFIER	AN	2	2	3	ØØ-FILE CONTROL (HEADER)
88Ø-K6	TRANSMISSION TYPE	AN	1	4	4	T=TRANSACTION R=RESPONSE E=ERROR

NCPDP Field Number	NCPDP Field Name	Type	Length	START	END	Virginia Medicaid Notes
88Ø-K1	SENDER ID	AN	24	5	28	USE 4-CHARACTER SERVICE CENTER ID ASSIGNED BY DMAS VIRGINIA MEDICAID + 3-CHARACTER SUBCONTRACTOR NUMBER ASSIGNED BY DMAS. IF NO SUBCONTRACTOR NUMBER IS ASSIGNED, VALUE WILL BE ZEROS. VALUES CURRENTLY IN USE: CP14 – CP19 FOR CCC PLUS M444 – M449 FOR MEDALLION 4 EXAMPLES ARE: CP14000 IF NO ASSOCIATED SUBCONTRACTOR CP14001 IF ASSOCIATED SUBCONTRACTOR. M444000 IF NO ASSOCIATED SUBCONTRACTOR M444001 IF ASSOCIATED SUBCONTRACTOR.
8Ø6-5C	BATCH NUMBER	N	7	29	35	ASSIGNED BY SENDER. MATCHES TRAILER. TO BE RETURNED IN RESPONSE OR ERROR FILE FROM PROCESSOR.
88Ø-K2	CREATION DATE	N	8	36	43	FORMAT=CCYYMMDD
88Ø-K3	CREATION TIME	N	4	44	47	FORMAT=HHMM
7Ø2	FILE TYPE	AN	1	48	48	P=PRODUCTION T=TEST
1Ø2-A2	VERSION/RELEASE NUMBER	AN	2	49	5Ø	VERSION 1.2 “12” – VERSION/RELEASE FOR BATCH STANDARD
88Ø-K7	RECEIVER ID	AN	24	51	74	5148Ø1Ø9ØØ
88Ø-K4	TEXT INDICATOR	AN	1	75	75	END OF TEXT (ETX)=X’Ø3 ’

Transmission Header Notes:

1. Only one Header record per file.
2. Transmission Type "T" is required when the pharmacy is submitting a batch. Transmission Type "E" is required when the entire batch has been rejected by the processor or switch. Transmission Type "R" is returned to the pharmacy to denote the file contains responses to claims.
3. Sender ID - assigned by Virginia MES. This ID reflects valid enrollment between trading partners for batch file submission and consists of up to 4 bytes Virginia MMIS assigned service center.
4. Receiver ID - assigned by Virginia MES. This ID reflects valid enrollment between trading partners for batch file submission.
5. Batch Number is assigned by the sender and must match the trailer Batch Number field.
6. The Batch Number on the Response file should be the same Batch Number from the Request file.

6.2.2 Transaction Detail Definition

NCPDP Field Number	NCPDP Field Name	Type	Length	START	END	Virginia Medicaid Notes
88Ø-K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'Ø2'.
7Ø1	SEGMENT	AN	2	2	3	G1=DETAIL DATA RECORD.
88Ø-K5	TRANSACTION REFERENCE NUMBER	AN	1Ø	4	13	SEE TRANSACTION DETAIL NOTES BELOW
	NCPDP DATA RECORD		VARIES	14	VARIES	REFER TO THE FOLLOWING PAGES.
88Ø-K4	TEXT INDICATOR	AN	1	VARIES	VARIES	END OF TEXT (ETX)=X'Ø3 '

Transaction Detail Notes:

1. The NCPDP Data Record to be transmitted in this batch standard will follow NCPDP Telecommunication Standard Version D.Ø.
2. The Transaction Reference Number is a unique number assigned by the encounter submitter to identify an individual pharmacy encounter record in the batch. When the processor receives the file and begins processing the encounters, the Transaction Reference Number is returned with the response generated by Virginia Medicaid. The Transaction Reference Number is used to explicitly tie a response back to the original encounter.

6.2.3 Transmission Trailer Definition

NCPDP Field Number	NCPDP Field Name	Type	Length	START	END	Virginia Medicaid Notes
88Ø-K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'Ø2"
7Ø1	SEGMENT IDENTIFIER	AN	2	2	3	99=FILE TRAILER
8Ø6-5C	BATCH NUMBER	N	7	4	1Ø	ASSIGNED BY SENDER. MATCHES HEADER
751	RECORD COUNT	N	1Ø	11	2Ø	
5Ø4-F4	MESSAGE	AN	35	21	55	
88Ø-K4	TEXT INDICATOR	AN	1	56	56	END OF TEXT (ETX)=X"Ø3"

Transmission Trailer Notes:

1. Only one Trailer Record per file.
2. Batch number must match the Batch number field in the header record.
3. The record count field includes the total number of records in the batch, including the header and trailer records.
4. The message field can be used for information about testing or any other information that needs to be sent regarding the batch. This field should only contain informational data and should not contain required data D.Ø.
5. The maximum number of records in a file 5,000, including Transaction Header and Transaction Trailer.

7 NCPDP PRESCRIPTION BILLING (B1) DATA SPECIFICATIONS

7.1 Transaction Header Segment (Mandatory)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
1Ø1-A1	Bin Number	M	9(6)	Ø1Ø9ØØ
1Ø2-A2	Version Release Number	M	X(2)	DØ
1Ø3-A3	Transaction Code	M	X(2)	B1 = Prescription Billing
1Ø4-A4	Processor Control Number	M	X(1Ø)	DRVAPROD
1Ø9-A9	Transaction Count	M	X(1)	1 = One occurrence
2Ø2-B2	Service Provider ID Qualifier	M	X(2)	Ø1 = NPI
2Ø1-B1	Service Provider ID	M	X(15)	Pharmacy NPI
4Ø1-D1	Date of Service	M	9(8)	FORMAT=CCYYMMDD
11Ø-AK	Software Vendor/Certification ID	M	X(1Ø)	BLANKS are accepted. DMAS does not require this field.

7.2 Patient Segment (Mandatory)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
111-AM	Segment Identification	M	X(2)	Ø1
3Ø4-C4	Date of Birth	R	9(8)	REQUIRED Format = CCYYMMDD
331-CX	Patient ID Qualifier	R	X(2)	REQUIRED 99 = Other
332-CY	Patient ID	R	X(2Ø)	REQUIRED This will be the SUBMITTER CLAIM ID from the submitter (up to 2Ø characters)
35Ø-HN	Patient E-Mail Address	R	X(8Ø)	REQUIRED This field will be used to convey the encounter date received by the encounter submitter, the date adjudicated by the encounter submitter, the date paid by the encounter submitter, the date for resubmissions from the encounter submitter (if appropriate), and the payment status (Paid/Denied) of the encounter. The format for 35Ø-HN: DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD DRES-CCYYMMDD PYMS-P (Paid) or PYMS-D (Denied) Examples are as follows: DREC-2Ø17Ø1Ø1 DADJ-2Ø17Ø1Ø5 DPYM-2Ø17Ø111 PYMS-P for a paid encounter. DREC-2Ø17Ø1Ø1 DADJ-2Ø17Ø1Ø5 DPYM-2Ø17Ø111 PYMS-D for a denied encounter. DREC-2Ø17Ø1Ø1 DADJ-2Ø17Ø1Ø5 DPYM-2Ø17Ø111 DRES-2Ø17Ø115 PYMS-P for a resubmission paid encounter. DREC-2Ø17Ø1Ø1 DADJ-2Ø17Ø1Ø5 DPYM-2Ø17Ø111 DRES-2Ø17Ø115 PYMS-D for a resubmission denied encounter.
384-4X	Patient Residence	O	9(2)	OPTIONAL

7.3 Insurance Segment (Mandatory)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
111-AM	Segment Identification	M	X(2)	Ø4
3Ø2-C2	Cardholder ID	M	X(2Ø)	Medicaid ID – 12 Positions Numeric

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
312-CC	Cardholder First Name	R	X(12)	REQUIRED; Cardholder is Patient
313-CD	Cardholder Last Name	R	X(15)	REQUIRED; Cardholder is Patient

7.4 Claim Segment (Mandatory)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
111-AM	Segment Identification	M	X(2)	Ø7
4Ø3-D3	Fill Number	R	9(2)	REQUIRED ØØ = Original dispensing Ø1-99 = Refill number
4Ø6-D6	Compound Code	R	9(1)	REQUIRED Ø = Not Specified 1 = Not a compound 2 = Compound
414-DE	Date Prescription Written	R	9(8)	REQUIRED Format = CCYYMMDD
354-NX	Submission Clarification Code Count	RW	9(1)	REQUIRED WHEN 42Ø-DK is submitted on the claim
42Ø-DK	Submission Clarification Code	RW	9(2)	REQUIRED WHEN 340B Product is Dispensed Max # of occurrences supported = 3 If Value 20 submitted, this equates to 340B
3Ø8-C8	Other Coverage Code	RW	9(2)	REQUIRED WHEN Other payer information is sent in COB/Other Payments Segment. Is REQUIRED for all submitters for the Medicaid related payment amount. ØØ = Not Specified Ø1 = No Other Coverage Ø2 = Other coverage exists – payment collected. Must be used for the Medicaid related payment amount. Ø3 = Other coverage exists – claim not covered Ø4 = Other coverage exists – payment not collected Ø8 = Claim is billing for copay.
429-DT	Unit Dose Indicator	RW	9(1)	REQUIRED WHEN dispensing Manufacturer Unit Dose 2 = Manufacturer Unit Dose

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
418-DI	Level of Service	RW	9(2)	REQUIRED WHEN identifying emergency conditions (dispensing). Ø3 = Emergency
461-EU	Prior Auth Type Code	RW	9(2)	REQUIRED WHEN overriding the "Dosage Limit Exemption" for Anti-Ulcer medication. Ø5 = Exemption from RX.
462-EV	Prior Auth Number Submitted	RW	9(11)	REQUIRED WHEN overriding the "Dosage Limit Exemption" for Anti-Ulcer medications.
343-HD	Dispensing Status	RW	X(1)	REQUIRED WHEN "Partial Fill" situation. P = Partial Fill C = Completion of Partial Fill
344-HF	Quantity Intended to be Dispensed	RW	9(7)v999	REQUIRED WHEN "Partial Fill" situation. This is the Metric Decimal Quantity of medication that would be dispensed if inventory were available. It is used in association with a "P" or "C" in DISPENSING STATUS field.
345-HG	Days Supply Intended to be Dispensed	RW	9(3)	REQUIRED WHEN "Partial Fill" situation. This is the Days Supply for the Metric Decimal Quantity of medication that would be dispensed if inventory were available. It is used in association with a "P" or "C" in DISPENSING STATUS field.
995-E2	Route Of Administration	RW	X(11)	REQUIRED WHEN – Only required for Compound transactions (field 406-D6 = 2).
996-G1	Compound Type	O	X(2)	OPTIONAL Clarifies the type of Compound.

7.5 Prescriber Segment (Mandatory)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
111-AM	Segment Identification	M	X(2)	Ø3
466-EZ	Prescriber Id Qualifier	R	X(2)	REQUIRED Ø1 = NPI
411-DB	Prescriber ID	R	X(15)	REQUIRED Prescribing Provider NPI
427-DR	Prescriber Last Name	R	X(15)	OPTIONAL
498-PM	Prescriber Phone Number	R	9(1Ø)	OPTIONAL
364-2J	Prescriber First Name	R	X(12)	OPTIONAL
365-2K	Prescriber Street Address	R	X(3Ø)	OPTIONAL
366-2M	Prescriber City	R	X(2Ø)	OPTIONAL
367-2N	Prescriber State	R	X(2)	OPTIONAL
368-2P	Prescriber Zip	R	X(15)	OPTIONAL

7.6 Pricing Segment (Mandatory)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
111-AM	Segment Identification	M	X(2)	11
4Ø9-D9	Ingredient Cost Submitted	R	s9(6)v99	REQUIRED This is the actual Ingredient Cost paid to the pharmacy provider
412-DC	Dispense Fee Submitted	R	s9(6)v99	REQUIRED This is the actual Dispense Fee paid to the pharmacy provider
433-DX	Patient Paid Amount Submitted	R	s9(6)v99	REQUIRED This is the amount that was the Medicaid member's responsibility (copayment, co-insurance, patient payment, etc.) charged to the member as their portion of the final amount(s) paid to the pharmacy.
478-H7	Other Amount Claimed Submitted Count	RW	9(1)	REQUIRED WHEN Other Amount Claimed Submitted Qualifier (479-H8) is used. Max count = 3
479-H8	Other Amount Claimed Submitted Qualifier	RW***R***	X(2)	REQUIRED WHEN Other Amount Claimed Submitted (480-H9) is used. Ø1 = Delivery Cost. An indicator which signifies the amount claimed for the costs related to the delivery of a product or service. Ø2 = Shipping Costs. The amount claimed for transportation of an item. Ø3 = Postage Costs. The amount claimed for the mailing of an item. Ø4 = Administrative Costs. An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collections, claims processing, quality assurance, and risk management for purposes of insurance. Ø9 = Compound Preparation Cost Submitted. The amount claimed for the preparation of the compound.

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
480-H9	Other Amount Claimed Submitted	RW***R***	s9(6)v99	REQUIRED WHEN its value has an effect on the total amount reported as paid by the MCO in field 431-DV. This could be administrative fees or other contractual amounts applied to the MCO reported paid amount for the claim.
426-DQ	Usual and Customary Charge	R	s9(6)v99	REQUIRED Total Charges submitted for payment
43Ø-DU	Gross Amount Due	R	s9(6)v99	REQUIRED Total Price claimed from all sources.

7.7 COB/Other Payments Segment (Mandatory)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
111-AM	Segment Identification	M	X(2)	Ø5
337-4C	Coordination of Benefits/ Other Payments Count	M	9(1)	Defined as Count of other payment Occurrences including MCO Payment. For EPS processing, maximum count = 9.
338-5C	Other Payer Coverage Type	M***R***	X(2)	Ø1 = Primary Ø2 = Secondary Ø3 = Tertiary Ø4 = Forth Ø5 = Fifth Ø6 = Sixth Ø7 = Seventh Ø8 = Eighth Ø9 = Ninth If there is only the MCO Medicaid Payment, value Ø1 will be used. If there are other payments in addition to the MCO Medicaid Payment, the MCO Medicaid Payment occurrence must be last.
339-6C	Other Payer ID Qualifier	RW***R***	X(2)	REQUIRED WHEN Other Coverage Code (3Ø8-C8) is present. Value must be 99 when Other Payer ID (340-7C) is not a BIN ID.

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
34Ø-7C	Other Payer ID	RW***R***	X(1Ø)	REQUIRED WHEN other coverage code = Ø2 or Ø8 (From Claim Segment). The Other Payer ID value for the MCO Medicaid Payment must be the same as the Sender ID 4-digit registered Service Center without the 3-digit sub-contractor suffix. All Other Payer IDs may be the associated Bin Number or any ID in the submitter's system associated with the other payers for non-MCO Medicaid payments.
443-E8	Other Payer Date	RW***R***	9(8)	REQUIRED WHEN other coverage code = Ø2 or Ø8 (From Claim Segment). This will be the paid date associated to the Other Payer Amount Paid.
341-HB	Other Payer Amount Paid Count	RW	9(1)	REQUIRED WHEN amount collected from other payer. Is mandatory for MCO Medicaid payment. Value will be 1 for all Other Payments.
342-HC	Other Payer Amount Paid Qualifier	RW***R***	X(2)	REQUIRED WHEN Other Payer Amount Paid Count and Other Payer Amount Paid are used. Is mandatory for MCO Medicaid payment. Use Ø7 for all payment amounts.
431-DV	Other Payer Amount Paid	RW***R***	s9(6)v99	REQUIRED WHEN Other Payer Amount Paid and Other Payer Amount Paid Qualifier are used. Is mandatory for MCO Medicaid payment. Value in field must be zero or greater than zero. Negative amounts are not valid. Max # of occurrences supported = 1
471-5E	Other Payer Reject Count	RW	9(2)	REQUIRED WHEN Other Coverage Code = 3 Other Coverage Billed – claim not covered.
472-6E	Other Payer Reject Code	RW	X(3)	REQUIRED WHEN Other Coverage Code = 3 Other Coverage Billed – claim not covered. Max # of occurrences supported = 5
993-A7	Internal Control Number	RW	X(30)	REQUIRED WHEN Other Payer Amount Paid Count and Other Payer Amount Paid are used. Value is other payer's (Including the MCO Medicaid related payment) Claim ID/TCN/ICN.

7.8 DUR/PPS Segment (Situational)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
111-AM	Segment Identification	M	X(2)	Ø8
473-7E	DUR/PPS Code Counter	RW***R*** (Max = 2)	9(1)	REQUIRED WHEN identifying a drug utilization review. Max # of occurrences supported = 2
439-E4	Reason for Service Code	RW***R*** (Max = 2)	X(2)	REQUIRED WHEN identifying the type of utilization conflict detected. Max # of occurrences supported = 2
44Ø-E5	Professional Service Code	RW***R*** (Max = 2)	X(2)	REQUIRED WHEN identifying the pharmacist intervention when a conflict code has been identified. Max # of occurrences supported = 2
441-E6	Result of Service Code	RW***R*** (Max = 2)	X(2)	REQUIRED WHEN describing action taken by a pharmacist in response to a conflict. Max # of occurrences supported = 2
				NOTE: When the DUR/PPS Segment is submitted, all associated fields for each segment must be sent in sequence.

7.9 Clinical Segment (Situational)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
111-AM	Segment Identification	M	X(2)	13
491-VE	Diagnosis Code Count	RW	9(1)	Maximum count of 5
492-WE	Diagnosis Code Qualifier	RW	X(2)	Required When Diagnosis Code (424-DO) is used.
424-DO	Diagnosis Code	RW	X(15)	Required if present on the provider submitted claim as obtained or communicated by the prescriber or authorized representative.

7.10 Compound Segment (Situational)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
111-AM	Segment Identification	M	X(2)	1Ø
450-EF	Compound Dosage Form Description Code	M	X(2)	Max # of occurrences supported = 13
451-EG	Compound Dispensing Unit Form Indicator	M	9(1)	Max # of occurrences supported = 13
447-EC	Compound Ingredient Component Count	M	9(2)	Count of Compound Product IDs Max # of occurrences supported = 13
488-RE	Compound Product id Qualifier	M	X(2)	Max # of occurrences supported = 13 Ø3 = NDC
489-TE	Compound Product Id	M	X(19)	Max # of occurrences supported = 13
448-ED	Compound Ingredient Quantity	M	9(7)v999	Max # of occurrences supported = 13
449-EE	Compound Ingredient Drug Cost	M	S9(6)v2	

Compound Segment (Situational) Notes

1. When the Compound Segment is submitted, all associated fields for each segment must be sent in sequence.

8 NCPDP PRESCRIPTION REVERSAL (B2) DATA SPECIFICATIONS

8.1 Transaction Header Segment (Mandatory)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
1Ø1-A1	Bin Number	M	9(6)	Ø1Ø9ØØ
1Ø2-A2	Version Release Number	M	X(2)	DØ
1Ø3-A3	Transaction Code	M	X(2)	B2 = Prescription Reversal
1Ø4-A4	Processor Control Number	M	X(1Ø)	DRVAPROD
1Ø9-A9	Transaction Count	M	X(1)	1 = One occurrence
2Ø2-B2	Service Provider Id Qualifier	M	X(2)	Ø1 = NPI
2Ø1-B1	Service Provider Id	M	X(15)	Pharmacy NPI
4Ø1-D1	Date of Service	M	9(8)	FORMAT=CCYYMMDD
11Ø-AK	Software Vendor/Certification ID	M	X(1Ø)	BLANKS are accepted

8.2 Claim Segment (Mandatory)

NCPDP Field Number	NCPDP Field Name	VAMMIS Usage	Format	Virginia Medicaid Notes
111-AM	Segment Identification	M	X(2)	Ø7
455-EM	Prescription/ Service Reference # Qualifier	M	X(1)	1 = Prescription Billing
4Ø2-D2	Prescription/ Service Reference #	M	9(12)	
436-E1	Product/ Service Id Qualifier	M	X(2)	Ø3 = National Drug Code
4Ø7-D7	Product/ Service Id	M	X(19)	REQUIRED

9 BATCH RESPONSE FORMAT

9.1 Introduction

A Batch Response file is returned for every Batch Claim file received. The Batch Response will indicate whether the entire Batch Claim file is rejected ("batch error response") or accepted. When the Batch Claim file is accepted, the Batch Response file ("standard response") will contain individual accept/reject responses for each claim. Response Reject Codes indicate errors for NCPDP defined syntax, required fields, or valid codes only. Claims that are accepted will be submitted for adjudication processing.

A "batch error response" is returned when there is a problem with the Batch Transaction Header, Batch Transaction Detail (but not the NCPDP Data Record), or Batch Transaction Trailer. In this situation, the entire batch is rejected and the Batch Error Response file contains only Batch Response Header and Batch Response Trailer. Field 88Ø-K6 in the Header contains "E" (Error). Field 5Ø4-F4 in the Trailer contains the RESPONSE REJECT MESSAGE, which is a free text description of the error.

A "standard response" is returned for each transmitted claim and reversal when the entire batch is not rejected. In this situation, the Batch Error Response file contains a Batch Response Header, multiple Batch Response Detail records (one for each claim or reversal in the original Batch Transaction Request), and a Batch Response Trailer. Field 88Ø-K6 in the Header contains "R" (Response).

9.2 Batch Response Detail Records

Encounter Captured Response acknowledges receipt of an encounter that has all data fields with correct syntax. It will be processed further in MES EPS processing.

Encounter Rejected Response reports an encounter that has one or more data fields with incorrect data and the encounter will not be processed further. The Encounter Rejected Response will report up to 99 Reject Codes. Reject Codes identify the field in error but do not identify the type of error.

9.3 Response Reject Codes

Response Reject Codes are generated when a field has wrong format, is too long, is required but not present, or has an invalid code. Examples of these edits are based on the NCPDP Data Specifications, and may include:

- Field format is Numeric, data contains non-numeric characters
- Fields that exceed the maximum defined data length
- A field which does not contain any value
- A mandatory or required field is not sent
- A field has an incorrect or invalid code value

9.4 Response Status Codes

A Response contains two Status Codes: a Response Status (Header) which applies to fields in the Header Sections, and a Response Status (Prescription) which applies to fields in the Claim Sections.

9.5 Batch Standard Response Format

9.5.1 Batch Transmission Header

NCPDP Field Number	NCPDP Field Name	Type	Length	START	END	Virginia Medicaid Notes
88Ø-K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'Ø2'
7Ø1	SEGMENT IDENTIFIER	AN	2	2	3	ØØ-FILE CONTROL (HEADER)
88Ø-K6	TRANSMISSION TYPE	AN	1	4	4	R=RESPONSE E=ERROR (ENTIRE BATCH REJECTED)
88Ø-K1	SENDER ID	AN	24	5	28	DRVAPROD
8Ø6-5C	BATCH NUMBER	N	7	29	35	ASSIGNED BY SENDER. MATCHES TRAILER. TO BE RETURNED IN RESPONSE OR ERROR FILE FROM PROCESSOR.
88Ø-K2	CREATION DATE	N	8	36	43	FORMAT=CCYYMMDD
88Ø-K3	CREATION TIME	N	4	44	47	FORMAT=HHMM
7Ø2	FILE TYPE	AN	1	48	48	P=PRODUCTION T=TEST
1Ø2-A2	VERSION/RELEASE NUMBER	AN	2	49	5Ø	VERSION 1.2 "12" VERSION/ RELEASE OF BATCH STANDERD
88Ø-K7	RECEIVER ID	AN	24	51	74	VIRGINIA MMIS SUBMITTER ID SERVICE CENTER CODE, UP TO 4 ALPHA-NUMERIC CODE. REMAINING FIELD SPACE FILLED.
88Ø-K4	TEXT INDICATOR	AN	1	75	75	END OF TEXT (ETX)=X'Ø3'

9.5.2 Response Detail

NCPDP Field Number	NCPDP Field Name	Type	Length	START	END	Virginia Medicaid Notes
88Ø-K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'Ø2'.
7Ø1	SEGMENT	AN	2	2	3	G1=DETAIL DATA RECORD.
88Ø-K5	TRANSACTION REFERENCE NUMBER	AN	1Ø	4	13	A TEN DIGIT NUMBER THAT IS UNIQUE AND IDENTIFIES THE INDIVIDUAL PRESCRIPTION CLAIM. SAME VALUE AS THAT SUBMITTED IN THE CLAIM FILE.
	NCPDP DATA RECORD		VARIES	14	VARIES	REFER TO THE FOLLOWING PAGES.
88Ø-K4	TEXT INDICATOR	AN	1	VARIES	VARIES	END OF TEXT (ETX)=X"Ø3"

9.5.3 Response Transmission Trailer

NCPDP Field Number	NCPDP Field Name	Type	Length	START	END	Virginia Medicaid Notes
88Ø-K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'Ø2"
7Ø1	SEGMENT IDENTIFIER	AN	2	2	3	99=FILE TRAILER
8Ø6-5C	BATCH NUMBER	N	7	4	1Ø	MATCHES HEADER
751	RECORD COUNT	N	1Ø	11	2Ø	INCLUDES HEADER AND TRAILER.
5Ø4-F4	MESSAGE	AN	35	21	55	IF ENTIRE BATCH REJECTED, FREE-TEXT DESCRIPTION OF REASON.
88Ø-K4	TEXT INDICATOR	AN	1	56	56	END OF TEXT (ETX)=X"Ø3"

9.6 Telecommunication Standard D.Ø Response Format

9.6.1 Transmission Level Definition

NCPDP Field Number	NCPDP Field Name	Type	Length	START	END	Virginia Medicaid Notes
1Ø2-A2	VERSION/RELEASE	AN	2	1	2	"DØ"
1Ø3-A3	TRANSACTION CODE	AN	2	3	4	"B1" – Prescription Billing, "B2" – Prescription Reversal
1Ø9-A9	TRANSACTION COUNT	AN	1	5	5	1 – One Occurrence. Returned from the Request Transaction Header Segment
5Ø1-F1	HEADER RESPONSE STATUS	AN	1	6	6	"A" – Accepted, "R" - Rejected
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	AN	2	7	8	Returned from the Request Transaction Header Segment
2Ø1-B1	SERVICE PROVIDER ID	AN	15	9	23	Returned from the Request Transaction Header Segment
4Ø1-D1	DATE OF SERVICE	D	8	24	31	Returned from the Request Transaction Header Segment

9.6.2 Transaction Level Definition

Response Status Segment						
NCPDP Field Number	**NCPDP Field Name**	**Type**	**Length**	**START**	**END**	**Virginia Medicaid Notes**
	GROUP SEPARATOR		1	1	1	
	SEGMENT SEPARATOR		1	2	2	
111-AM	SEGMENT IDENTIFICATION	AN	2	3	4	"21" – Response Status Segment
112-AN	TRANSACTION RESPONSE STATUS	AN	1	5	5	"C" – Captured, "R" - Rejected
5Ø3-F3	AUTHORIZATION NUMBER	AN	2Ø	6	25	Number to identify an authorized transaction.
51Ø-FA	REJECT COUNT	AN	2	26	27	Count of "Reject Code" (511-FB) Occurrences. This field is only populated when field 112-AN is a "R" (Rejected).
511-FB	REJECT CODE	N	2	28	29	Code indicating the error encountered. This field is only populated when field 112-AN is a "R" (Rejected).
546-4F	REJECT FIELD OCCURRENCE INDICATOR	N	2	3Ø	31	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields. This field is only populated when field 112-AN is a "R" (Rejected).
Response Claim Segment						
	SEGMENT SEPARATOR		1			
111-AM	SEGMENT IDENTIFICATION	AN	2			"22" – Response Claim Segment
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	AN	1			Prescription/Service Reference Number Qualifier returned from the Request Transaction Claim Segment
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	N	12			Prescription/Service Number returned from the Request Transaction Claim Segment