Ohio | Department of Medicaid

NCPDP D.0 Pharmacy Encounter

Version 3.2

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Document Information

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Amendment History

Version	Date	Modified By	Modifications
1.0		HP EDI Team	DRAFT Version
2.0		HP EDI Team	Initial Production version
2.1	04/30/2012	HP EDI Team	Made the following changes: 406-D6: removed value of 0: Not Specified 402-D2, 401-D1, and 201-B1: for Reversals, all were specified to require the same values as came in with the claim being reversed.
3.0	03/14/2014	ODM & HP EDI Team	Updates related to Agency Name Change
3.1	06/02/2016	ODM & HPE Team	Updates to 526-FQ - for Reversal Approved Response and Reversal Rejected Response
3.2	03/22/2017	ODM & HPE Team	Updated the contact information.

Disclosure Statement

The ODM Companion Guides are subject to change without prior notice.

Managed Care Plans, Providers and Trading Partners are responsible for periodically checking for Companion Guide updates on the ODM Trading Partner website - http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx.

EDI Support Information

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1 INTRODUCTION

This Companion Guide contains the format and establishes the data contents of the NCPDP Versions 1.2 and D.0 Transaction for use within the context of an Electronic Data Interchange (EDI) environment from MCP's.

NCPDP Version 1.2 defines the data structure and content of Batch Retail Pharmacy transmissions only.

NCPDP Version D.0 defines the data structure and content of Single Retail Pharmacy Place of Service (POS) transmissions only.

General Information

This EDI Companion Guide was based on the NCPDP Version 1.2 and updated with D.0 Guide for ODM.

The objective of this document is to point out preferred selections for data elements where multiple alternatives exist.

2 DATA FORMATTING

The NCPDP Version 1.2 Header and Trailer records are in a fixed-format standard. Therefore, all of these segments and fields are required.

The Detail Data Record is in a variable-format standard, with the exception of the Header Segment. Use the Ohio MCP Version D.0 Payer Sheet for the Detail Data Record instructions.

The NCPDP Version D.0 transaction is a variable length format standard. Therefore, with the exception of the header fields (which are always required), a transaction will contain only those elements that are necessary.

NCPDP Formatting

The EDI objects must strictly adhere to the structure, syntax, and semantic requirements as specified in the NCPDP Telecommunication Standard Implementation Guides Version 1.2 and D.0 and as provided in the ODM Companion Guides.

3 NCPDP GENERAL TRANSACTION FORMATTING INFORMATION

The first segment of every transmission (request or response) is the Header Segment. This is the only segment that does not have a Segment Identification because it is a fixed field and length segment. After the Header Segment, other segments are included, according to the particular transaction type. Every other segment has an identifier to denote the particular segment for parsing. Segments may appear in any order after the Header Segment, according to whether the segment occurs at the transmission or transaction level. Segments are not allowed to repeat within a transaction. Segments may occur more than once only in a multi-transaction transmission.

In the Header Segment, all fields are required positional and filled to their maximum designation. This is a fixed segment. If a mandatory field is not used, it must be filled with spaces or zeroes, as appropriate. The fields within the Header Segment do not use field separators.

Other segments may have both mandatory and required fields. Required fields in a segment are submitted after the mandatory fields. A field separator and the field's identifier must precede both types of fields. Required fields may appear in any order except for those designated with a qualifier or in a repeating group. The mandatory and required fields may be truncated to the actual size used.

Parsing is accomplished with the use of separators. Version D.0 uses the following three separators:

- Segment separator Hex 1E (Dec 30)
- Group separator Hex 1D (Dec 29)
- Field separator Hex 1C (Dec 28)

A transmission consists of one or more transactions separated by group separators. All transmissions, whether for one, two, three, or four transactions, use group separators to denote the start of a transaction.

Within a transaction, appropriate segments are included. Segments are delineated with the use of Segment separators. Segments are also identified with the use of a Segment Identification in the first position of each segment. One or many segments may be included in each transaction. Field separators are used to delineate fields in the segments.

4 GENERAL SYNTAX

The general syntax of a transmission request and response appears as follows:

Table 1. Syntax of Transmission Request and Response

Header Segment
Header Segment Fields
Segment Separator
Required Fields within Segment as appropriate, with field separators
Optional Segment Fields with field separators
Segment Separator
Required Fields within Segment as appropriate, with field separators
Optional Segment Fields with field separators
Group Separator
Segment Separator
Required Fields within Segment as appropriate, with field separators
Optional Segment Fields with field separators
Segment Separator
Required Fields within Segment as appropriate, with field separators
Optional Segment Fields with field separators

5 VARIABLE USAGE GUIDELINES

The following variable usage guidelines apply to Version D.0:

- Version D.0 allows variable length transactions only.
- Version D.0 supports up to four transactions per transmission for transaction codes B1, B2, and B3. Compound billing transactions (B1, B2, and B3) may only contain one transaction.
- Alphanumeric fields should be uppercase when alpha and always left justified.
- Leading zeroes and trailing blanks may be omitted from some data fields.
- Alphanumeric fields default to spaces, not null characters, when empty.
- Numeric fields default to zeroes.
- Dollar fields default to zeroes; however, dollar fields are always signed. The least significant digit of a dollar field must always be an Overpunch Sign, not a digit.

6 OVERPUNCH SIGN

The purpose of using Overpunch signs in dollar fields is to allow the representation of positive and negative dollar amounts without expanding the size of the field (for example, to hold the plus or minus character).

The Overpunch sign replaces the right most character in a dollar field. The signed value designates the positive or negative status of the numeric value. The dollar field of $99.95 would be represented as 999E with truncation. A negative dollar amount of $2.50 would be represented as 25} with truncation. The following information is used for Version D.0:

Table 2. Overpunch Sign

Unit	Signed Positive				Signed Negative			
	Graphic	Oct	Dec	Hex	Graphic	Oct	Dec	Hex
0	{	173	123	7B	}	175	125	7D
1	A	101	65	41	J	112	74	4A
2	B	102	66	42	K	113	75	4B
3	C	103	67	43	L	114	76	4C
4	D	104	68	44	M	115	77	4D
5	E	105	69	45	N	116	78	4E
6	F	106	70	46	O	117	79	4F
7	G	107	71	47	P	1250	80	50
8	H	110	72	48	Q	121	81	51
9	I	111	73	49	R	122	82	52

Table values show ASCII values.

Implied Decimal Points: In the Version D.0 standard, only patient clinical value fields contain decimal points. All other decimal points are implied. For example, patient diagnosis codes must be formatted with explicit decimal points.

Note: Decimal points in dollar fields are implied.

Truncation: To truncate a field using Version D.0 perform the following steps:

1. Numeric (N or D): Remove leading zeroes

2. Alphanumeric (A): Remove trailing spaces

Note: Do not truncate or eliminate any fields in the required header segments.

7 PAYMENT ARRANGEMENT INFORMATION

ODM considers a capitation payment arrangement to include those arrangements for which a sub-contracted entity to the MCP assumes a risk. If any part of the encounter is part of capitation payment arrangement, the 342-HC should reflect whether the service is part of a capitation payment. For encounters which have a capitation payment arrangement, the MCP must provide approximate payment information as follows:

1. For sub-contracted payment arrangements in which a vendor directly pays particular claims (e.g., an MCP's sub-contractor pays all claims to vision providers), the MCP must submit the amounts paid by to the provider at the claim-level.
2. For payments arrangements for which the MCP pays a member per month rate to a provider or group of providers, the MCP must shadow price the encounter to be the amount that the MCP would have paid to the provider if the capitation arrangement did not exist.
    a. If the MCP has also maintains a contractual arrangement on a fee-for-service basis with the provider, the MCP must submit the amount that the MCP's claims system would have priced the claim at the claim - level per the adjudication process specific to that provider.
    b. If the MCP does not maintain a contractual arrangement on a fee-for-service basis with the provider, the MCP must submit the amount that the MCP's claims system would have priced the claim at the claim-level per the adjudication process that is for the same provider type and specialty (if appropriate) which is within the either county, region, and/or state (prioritized in this order per the information that is available).

8 SEGMENT INFORMATION

8.1 Billing/Rebill Claim Request (B1/B3 Transactions)

8.1.1 Transaction Header Segment: Mandatory

NOTE: This is a fixed length segment and all 56 bytes are required.

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
101-A1	BIN Number	M	9(6)	N		610084 - OH Medicaid
102-A2	Version/Release Number	M	x(2)	A	D0	Version D.0
103-A3	Transaction Code	M	x(2)	A	B1 B2 B3	Billing Reversal Rebill
104-A4	Processor Control Number	M	x(10)	A	DROHPROD DROHACCP	Production Test As the value entered is 8 characters in length, it must be followed by 2 spaces
109-A9	Transaction Count	M	x(1)	A	1 2 3 4	One occurrence Two occurrences Three occurrences Four occurrences Maximum of one allowed for compound transactions
202-B2	Service Provider ID Qualifier	M	x(2)	A	01	National Provider Identifier (NPI)
201-B1	Service Provider ID	M	x(15)	A		Pharmacy Provider 10-digit NPI
401-D1	Date of Service	M	9(8)	N		CCYYMMDD CC – Century YY – Year MM – Month DD – Day
110-AK	Software Vendor/	M	x(10)	A		Required when known

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
	Certification ID					

8.1.2 Patient Segment: Required

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	01 05	Patient Coordination of Payments/Other Benefits
310-CA	Patient First Name	R	x(12)	A		Patient first name
311-CB	Patient Last Name	R	x(15)	A		Patient last name
307-C7	Place of Service	R	9(2)	N	00 01 02 03 04 05 06 07 08 09 10 11	Not specified Home Inter-Care Nursing home Long term/extended care Rest Home Boarding Home Skilled Care Facility Sub-Acute Care Facility Acute Care Facility Outpatient Hospice
335-2C	Pregnancy Indicator	R	x(1)	A	1 2 Blank	Not Pregnant Pregnant Not Specified

8.1.3 Insurance Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	04	Insurance
302-C2	Cardholder ID	M	x(20)	A		12-digit Ohio Medicaid recipient Billing number
301-C1	Group ID	R	x(15)	A		For managed care plan (MCP) encounter claims: Same 10-digit NPI ID as that entered for the Service Provider ID (201-B1) in the Transaction Header.

8.1.4 Claim Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	07	Claim
455-EM	Prescription/Service Reference Number Qualifier	M	x(1)	A	1	Rx billing
402-D2	Prescription/Service Reference Number	M	9(12)	N		Prescription number (expanded from 7 digits to 12 digits)
436-E1	Product/Service ID Qualifier	M	x(2)	A	00 03	Not specified National Drug Code (NDC) Compound: Use 00 to designate multi-ingredient product.
407-D7	Product/Service ID	M	x(19)	A		NDC (Drug Code) 11 characters
442-E7	Quantity Dispensed	R	9(7).9(3)	D		Maximum of 9999999.999 Enter the 10-digit metric decimal quantity of the drug dispensed.

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
						Compound: Enter the quantity of entire multi-ingredient product
403-D3	Fill Number	R	9(2)	N	00 01-99	Original dispensing Refill number
405-D5	Days Supply	R	9(3)	N		Estimated number of days the prescription will last
406-D6	Compound Code	R	9(1)	N	1 2	Not a compound Compound
408-D8	Dispense as Written Code (DAW)/Product Selection Code	R	x(1)	A	0 5 6 8	No product selection indicated Substitution allowed-brand drug dispensed as a generic Override Substitution allowed-generic drug not available in marketplace Code indicating the prescriber's instructions regarding substitution. Other values sent treated as 0.
414-DE	Date Prescription Written	R	9(8)	N		CCYYMMDD CC – Century YY – Year MM – Month DD – Day
420-DK	Submission Clarification Code	S	9(2)	N	08	Process compound for approved ingredients
418-DI	Level of Service	R	9(2)	N	00 03	Not specified Emergency Required when known

8.1.5 Prescriber Segment: Required

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	03	Prescriber
466-EZ	Prescriber ID Qualifier	R	x(2)	A	01	National Provider (Prescriber) Identifier (NPI)
411-DB	Prescriber ID	R	x(15)	A		Ten-digit national provider identifier of the prescribing practitioner.

8.1.6 Coordination of Benefits (COB) and Other Payments Segment: Required

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	**This iteration of the COB Segment should contain the MCP payment information.**
111-AM	Segment Identification	M	x(2)	A	05	Coordination of benefits/other payments Element is mandatory when segment is present
337-4C	Coordination of Benefits/Other Payments Count	M	9(1)	N	1-9	Maximum of nine allowed National Council for Prescription Drug Programs (NCPDP) recommends limiting the number of payers to three in the COB segment. Mandatory when segment is present
339-6C	Other Payer ID Qualifier	R	x(2)	A	99	MCP 7 digit Provider ID. Element is mandatory when segment is present.
340-7C	Other Payer ID	R	x(10)	A		MCP information is always Primary payer. MCP information should always be included in the first occurrence of the Primary payer. This should be the 7-digit region/program specific Medicaid provider number of the

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	**This iteration of the COB Segment should contain the MCP payment information.**
						MCP.
338-5C	Other Payer Coverage Type	R	x(2)	A	01	Primary
443-E8	Other Payer Date	R	9(8)			CCYYMMDD CC – Century YY – Year MM – Month DD – Day One occurrence of this element is required and should contain the MCP information. First occurrence should be the MCP Paid Date. MCP information should always be included in the first occurrence of the Other Payer Date.
341-HB	Other Payer Amount Paid Count	R	9(1)	N	1-9	Maximum of nine allowed Required when known
342-HC	Other Payer Amount Paid Qualifier	R	x(2)	A	(blank) 04 07	blank: indicates MCP paid amount in 431-DV '04': indicates capitated amount in 431-DV '07': indicates TPL information in 431-DV
431-DV	Other Payer Amount Paid	R	s9(6).9(2)	D	s$$$$$$cc s9(6)v99	Refer to 342-HC for a description of this amount field. MCP information should always be included in the first occurrence of the Other Payer Amount Paid. **For capitated claims (qualifier=04) the value CANNOT be zero "0". The MCP must shadow price capitated encounters by placing the total**

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	**This iteration of the COB Segment should contain the MCP payment information.**
						payment amount at the claim level based on how the MCP's system adjudicated the claim from the provider.

8.1.7 Coordination of Benefits (COB) and Other Payments Segment: Optional

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	**This iteration of the COB segment should contain any other payment information available.**
111-AM	Segment Identification	M	x(2)	A	05	Coordination of benefits/other payments Element is mandatory when segment is present
337-4C	Coordination of Benefits/ Other Payments Count	M	9(1)	N	1-9	Maximum of nine allowed National Council for Prescription Drug Programs (NCPDP) recommends limiting the number of payers to three in the COB segment. Mandatory when segment is present
339-6C	Other Payer ID Qualifier	M	x(2)	A	01 02 03 04 99	National Payer ID Health Industry Number (HIN) Bank Information Number (BIN) National Association of Insurance Commissioners (NAIC) Other Element is mandatory when segment is present.
340-7C	Other Payer ID	S	x(10)	A		
993-A7	Internal Control Number		X(30)	A		TCN (MCP Claim Number) Note: New element, replaces

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	**This iteration of the COB segment should contain any other payment information available.**
						Alternate ID (330-CW) MCPs need to send ICN for the reversals.
338-5C	Other Payer Coverage Type	S	x(2)	A	Blank 01 02 03 99	Not specified Primary Secondary Tertiary Composite
443-E8	Other Payer Date	S	9(8)			CCYYMMDD CC – Century YY – Year MM – Month DD – Day
341-HB	Other Payer Amount Paid Count	S	9(1)	N	1-9	Maximum of nine allowed Required when known
342-HC Other Occurrences	Other Payer Amount Paid Qualifier	S	x(2)	A	(blank) 04 07	blank: indicates MCP paid amount in 431-DV '04': indicates capitated amount in 431-DV '07': indicates TPL information in 431-DV
431-DV	Other Payer Amount Paid	S	s9(6).9(2)	D	s$$$$$$cc s9(6)v99	

8.1.8 Pricing Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	11	Pricing
409-D9	Ingredient Cost Submitted	S	s9(6).9(2)	D	s$$$$$$cc s9(6)v99	Submitted product component cost of the dispensed prescription. Included in the Gross Amount Due.
412-DC	Dispensing Fee Submitted	S	s9(6).9(2)	D	s$$$$$$cc s9(6)v99	Dispensing fee submitted by pharmacy. Included in the Gross Amount Due.
426-DQ	Usual and Customary Charge	R	s9(6).9(2)	D	s$$$$$$cc s9(6)v99	The total billed amount that the pharmacy billed to the MCP.

Submitted product component cost of the dispensed prescription. Included in the Gross Amount Due.

8.1.9 Compound Segment: Optional

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	10	Compound Element is mandatory when segment is present. Field 406-D6 in the Claim Segment must = 2
450-EF	Compound Dosage Form Description Code	M	x(2)	A	Blank 01 02 03 04 05 06 07 10 11 12 13 14 15 16 17 18	Not Specified Capsule Ointment Cream Suppository Powder Emulsion Liquid Tablet Solution Suspension Lotion Shampoo Elixir Syrup Lozenge Enema Element is mandatory when segment is present
451-EG	Compound Dispensing Unit Form Indicator	M	9(1)	N	1 2 3	Each Grams Milliliters Element is mandatory when segment is present
447-EC	Compound Ingredient Component	M	9(2)	N	01 – 40	Element is mandatory when segment is present

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
	Count					
488-RE	Compound Product ID Qualifier	M	x(2)	A	03	NDC Code Element is mandatory when segment is present. Subsequent occurrences should be filled in as appropriate.
489-TE	Compound Product ID	M	X(19)	A		NDC (Drug Code) 11 characters Element is mandatory when segment is present. Subsequent occurrences should be filled in as appropriate.
448-ED	Compound Ingredient Quantity	M	9(7).9(3)	D		Compound Ingredient Quantity 9999999.999 Element is mandatory when segment is present. Subsequent occurrences should be filled in as appropriate.

8.2 Claim Reversal (B2 Transactions)

8.2.1 Transaction Header Segment: Mandatory

NOTE: 4/6/12 – added conditions for 201-B1 and 401-D1 that they must equal the values provided on the Claim being reversed.

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
101-A1	BIN Number	M	9(6)	N		610084 - OH Medicaid
102-A2	Version/Release Number	M	x(2)	A	D0	Version D.0
103-A3	Transaction Code	M	x(2)	A	B2	Reversal
104-A4	Processor Control Number	M	x(10)	A	DROHPROD DROHACCP	Production Test As the value entered is 8 characters in length, it must be followed by 2 spaces
109-A9	Transaction Count	M	x(1)	A	1 2 3 4	One occurrence Two occurrences Three occurrences Four occurrences
202-B2	Service Provider ID Qualifier	M	x(2)	A	01	National Provider Identifier (NPI)
201-B1	Service Provider ID	M	x(15)	A		Pharmacy Provider, 10-digit NPI; must match the NPI provided on the Claim being reversed.
401-D1	Date of Service	M	9(8)	N		CCYYMMDD CC – Century YY – Year MM – Month DD – Day Must match the Date provided on the Claim being reversed.

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
110-AK	Software Vendor/Certification ID	M	x(10)	A		Spaces

8.2.2 Claim Segment: Mandatory

NOTE: 4/6/12 – added conditions for **402-D2** that it must equal the Prescription Number provided on the Claim being reversed.

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	07	Claim
455-EM	Prescription/Service Reference Number Qualifier	M	x(1)	A	1	Rx billing
402-D2	Prescription/Service Reference Number	M	9(12)	N		Prescription number (expanded from 7 digits to 12 digits); must match the Prescription Number provided on the Claim being reversed.
436-E1	Product/Service ID Qualifier	M	x(2)	A	03	National Drug Code (NDC)
407-D7	Product/Service ID	M	x(19)	A		NDC (Drug Code) 11 characters
995-E2	Route of Administration	S	x(11)			Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the College of American Pathologists, Northfield, Illinois http://www.snomeD.0rg/ Note: New element - replaces 452-EH

8.3 Billing/Rebill Paid Response

8.3.1 Response Header Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
102-A2	Version/Release Number	M	x(2)	A	D0	Version D.0
103-A3	Transaction Code	M	x(2)	A	B1 B3	Billing Re-bill
109-A9	Transaction Count	M	x(1)	A	1 2 3 4	One occurrence Two occurrences Three occurrences Four occurrences
501-F1	Header Response Status	M	x(1)	A	A	Accepted
202-B2	Service Provider ID Qualifier	M	x(2)	A	01	National Provider Identifier (NPI)
201-B1	Service Provider ID	M	x(15)	A		Provider ID is returned from the ID received on the request. Note: If the service provider is also enrolled in Ohio MCP, this is the same provider number.
401-D1	Date of Service	M	9(8)	N		CCYYMMDD CC – Century YY – Year MM – Month DD – Day

8.3.2 Response Message Segment: Optional

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	20	Response Message Element is mandatory when segment is present
504-F4	Message	R	x(200)	A		This field contains the TCN assigned by the MCP. Required if additional message is needed

8.3.3 Response Status Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	21	Response status
112-AN	Transaction Response Status	M	x(1)	A	P D R	Paid Duplicate of paid Rejected
503-F3	Authorization Number	R	x(20)	A		13-character Internal Control Number (ICN) for original claim
526-FQ	Additional Message Information	R	x(200)	A		This field contains the TCN assigned by the MCP.

8.3.4 Response Claim Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	22	Response claim
455-EM	Prescription/Service Reference Number Qualifier	M	x(1)	A	1	Rx billing
402-D2	Prescription/Service Reference Number	M	9(12)	N		Prescription number (expanded from 7 digits to 12 digits)

8.3.5 Response Pricing Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	23	Response pricing
505-F5	Patient Pay Amount	R	s9(6).9(2)	D	s$$$$$$cc s9(6)v99	For encounters, this will be 0
507-F7	Dispensing Fee Paid	R	s9(6).9(2) s9(6)V99	D	s$$$$$$cc s9(6)v99	For encounters, this will be 0
509-F9	Total Amount Paid	R	s9(6).9(2) s9(6)V99	D	s$$$$$$cc s9(6)v99	For encounters, this will be 0
518-FI	Amount of Copay/Co-insurance	R	s9(6).9(2) s9(6)V99	D	s$$$$$$cc s9(6)v99	For encounters, this will be 0

8.4 Billing/Rebill Reject Response

8.4.1 Response Header Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
102-A2	Version/Release Number	M	x(2)	A	D0	Version D.0
103-A3	Transaction Code	M	x(2)	A	B1 B3	Billing Rebill
109-A9	Transaction Count	M	x(1)	A	1 2 3 4	One occurrence Two occurrences Three occurrences Four occurrences
501-F1	Header Response Status	M	x(1)	A	A	Accepted
202-B2	Service Provider ID Qualifier	M	x(2)	A	01	National Provider Identifier (NPI)
201-B1	Service Provider ID	M	x(15)	A		Pharmacy Provider 10-digit NPI
401-D1	Date of Service	M	9(8)	N		CCYYMMDD CC – Century YY – Year MM – Month DD – Day

8.4.2 Response Message Segment: Optional

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	20	Response message Element is mandatory when segment is present
504-F4	Message	M	x(200)	A		This field contains the TCN assigned by the MCP. Required if additional message is needed

8.4.3 Response Status Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	21	Response Status
112-AN	Transaction Response Status	M	x(1)	A	R	Rejected
503-F3	Authorization Number	R	x(20)	A		13-character Internal Control Number (ICN) for original claim
510-FA	Reject Count	R	9(2)	N		Reject count
511-FB	Reject Code	R	x(3)	A		See National Council on Prescription Drug Programs (NCPDP) Data Dictionary, Appendix F - Reject Codes.
526-FQ	Additional Message Information	R	x(200)	A		This field contains the TCN assigned by the MCP.

8.4.4 Response Claim Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	22	Response claim

		ATTRIBUTES				Comments
455-EM	Prescription/Service Reference Number Qualifier	M	x(1)	A	1	Rx billing
402-D2	Prescription/Service Reference Number	M	9(12)	N		Prescription number (expanded from 7 digits to 12 digits)

8.5 Reversal Approved Response

8.5.1 Response Header Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
102-A2	Version/Release Number	M	x(2)	A	D0	Version D.0
103-A3	Transaction Code	M	x(2)	A	B2	Reversal
109-A9	Transaction Count	M	x(1)	A	1 2 3 4	One occurrence Two occurrences Three occurrences Four occurrences
501-F1	Header Response Status	M	x(1)	A	A	Accepted
202-B2	Service Provider ID Qualifier	M	x(2)	A	01 05	National Provider Identifier (NPI) Medicaid Note: This qualifier does not guarantee Ohio MCP enrollment, unless the provider is currently enrolled.
201-B1	Service Provider ID	M	x(15)	A		Provider ID is returned from the ID received on the request Note: If the service provider is also enrolled in Ohio MCP, this is the same provider number.
401-D1	Date of Service	M	9(8)	N		CCYYMMDD CC – Century YY – Year MM – Month DD – Day

8.5.2 Response Message Segment: Optional

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	

		ATTRIBUTES				Comments
111-AM	Segment Identification	M	x(2)	A	20	Response Message
504-F4	Message	R	x(200)	A		This field contains the TCN assigned by the MCP. Required if additional message is needed

8.5.3 Response Status Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	21	Response Status
112-AN	Transaction Response Status	M	x(1)	A	A R	Approved Rejected
503-F3	Authorization Number	R	x(20)	A		13-character Internal Control Number (ICN) for reversal claim
526-FQ	Additional Message Information	R	x(200)	A		This field contains the message 'Reversal Processed'.

8.5.4 Response Claim Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	22	Response Claim
455-EM	Prescription/Service Reference Number Qualifier	M	x(1)	A	1	Rx billing
402-D2	Prescription/Service Reference Number	M	9(12)	N		Prescription number (expanded from 7 digits to 12 digits)

8.6 Reversal Rejected Response

8.6.1 Response Header Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
102-A2	Version/Release Number	M	x(2)	A	D0	Version D.0
103-A3	Transaction Code	M	x(2)	A	B2	Reversal
109-A9	Transaction Count	M	x(1)	A	1 2 3 4	One occurrence Two occurrences Three occurrences Four occurrences
501-F1	Header Response Status	M	x(1)	A	A	Accepted
202-B2	Service Provider ID Qualifier	M	x(2)	A	01	National Provider Identifier (NPI)
201-B1	Service Provider ID	M	x(15)	A		Pharmacy Provider 10-digit NPI
401-D1	Date of Service	M	9(8)	N		CCYYMMDD CC – Century YY – Year MM – Month DD – Day

8.6.2 Response Message Segment: Optional

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	20	Response Message Element is mandatory when segment is present
504-F4	Message	R	x(200)	A		This field contains the TCN assigned by the MCP. Required if additional message is needed

8.6.3 Response Status Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	21	Response Status
112-AN	Transaction Response Status	M	x(1)	A	R	Rejected
503-F3	Authorization Number	R	x(20)	A		13-character Internal Control Number (ICN) for reversal claim
510-FA	Reject Count	R	9(2)	N		Reject Count
511-FB	Reject Code	R	x(3)	A		See NCPDP Data Dictionary, Appendix F - Reject Codes
526-FQ	Additional Message Information	R	x(200)	A		Any of the following messages will appear: Invalid dispense date Adjudication date older than 30 days + days supply Invalid provider number Cannot find claim Missing/Invalid original ICN Cannot find original ICN Claim already reversed Multiple claims found System Error

8.6.4 Response Claim Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	M	x(2)	A	22	Response Claim
455-EM	Prescription/Service Reference Number	M	x(1)	A	1	Rx Billing

		ATTRIBUTES				Comments
	Qualifier					
402-D2	Prescription/Service Reference Number	M	9(12)	N		Prescription number (expanded from 7 digits to 12 digits)

8.7 Transmission Rejected: Transaction Rejected Response

8.7.1 Response Header Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/ Max**	**Data Type**	**Codes/ Values**	
102-A2	Version/Release Number	M	X(2)	A		Same value as in request
103-A3	Transaction Code	M	X(2)	A		Same value as in request
109-A9	Transaction Count	M	X(1)	A		Same value as in request
501-F1	Header Response Status	M	X(1)	A	R	Rejected
202-B2	Service Provider ID Qualifier	M	X(2)	A		Same value as in request
201-B1	Service Provider ID	M	X(15)	A		Same value as in request
401-D1	Date of Service	M	9(8)	N		Same value as in request

8.7.2 Response Message Segment: Optional

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment Identification	R	X(2)	A	20	Response Message Required when segment is present
504-F4	Message	R	X(200)	A		This field contains the TCN assigned by the MCP. Required If additional message is needed

8.7.3 Response Status Segment: Mandatory

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
111-AM	Segment	M	X(2)	A	21	Response Status

		ATTRIBUTES				Comments
	Identification					
112-AN	Transaction Response Status	M	X(1)	A	R	Rejected One per transaction
510-FA	Reject Count	R	9(2)	N		Reject Count
511-FB	Reject Code	R	X(3)	A		See NCPDP Data Dictionary, Appendix F - Reject Codes
526-FQ	Additional Message Information	R	X(200)	A		This field contains the TCN assigned by the MCP.

8.8 Header Record Definition: Mandatory

Note: Only one Version 1.2 Transaction Header Record per batch transmission file.

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
880-K4	Text Indicator	M	X(1)	A	X02	Start of Text (STX)
701	Segment Identifier	M	X(2)	A	00	File header
880-K6	Transmission Type	M	X(1)	A	T R E	Transaction Response Error An error is indicated if one of the following three scenarios occur: 1. Transaction Header Record per batch transmission file is not of fixed length. 2. Transaction Trailer Record per batch transmission file is not of fixed length. 3. On Transaction Trailer Record, Element 751 - Record Count. If the count in this field does not match with the Total Record Count in the file including one Transaction Header and one Transaction Trailer.
880-K1	Sender ID	M	X(24)	A		This is the seven-digit number assigned to the Medicaid Trading Partner.
806-5C	Batch Number	M	9(7)	N		Assigned by the sender and must match the Transaction Trailer Batch Number field
880-K2	Creation Date	M	9(8)	N		Date Filled Format – CCYYMMDD CC – Century YY – Year MM – Month DD – Day

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
880-K3	Creation Time	M	9(4)	N		Time Filled Format – HHMM HH – Hour MM – Minute
702	File Type	M	X(1)	A	P T	Production Test
102-A2	Version/Release Number	M	X(2)	A	12	Version 1.2
880-K7	Receiver ID	M	X(24)	A	610084	Ohio Medicaid BIN #
880-K4	Text Indicator	M	X(1)	A	X03	End of text (ETX)

8.9 Detail Data Record Definition: Required

Note: This is a Fixed Length record.

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
880-K4	Text Indicator	M	X(1)	A	X02	Start of text (STX)
701	Segment Identifier	M	X(2)	A	G1	Detail data record
880-K5	Transaction Control Number	M	X(10)	A		A reference number assigned by the MCP to each of the data records in the batch. The purpose of this number is to facilitate the process of matching the claim response to the claim. The transaction reference number assigned to the claim is to be returned with the claim's corresponding reference number. The number should be unique for each claim in the batch.
	NCPDP Version D.0 Data Record					The data record to be transmitted in this batch standard follows the National Council on Prescription Drug Programs (NCPDP) Telecommunication Standard Version D.0 Length varies
880-K4	Text Indicator	M	X(1)	A	X03	End of text (ETX)

8.10 Batch Transaction Trailer Definition: Required

Note: Only one Version 1.2 Transaction Trailer Record per batch transmission file.

		ATTRIBUTES				Comments
Element	**Name**	**Use**	**Min/Max**	**Data Type**	**Codes/ Values**	
880-K4	Text Indicator	M	X(1)	A	x02	Start of text (STX)
701	Segment Identifier	M	X(2)	A	99	File Trailer
806-5C	Batch Number	M	9(7)	N		Assigned by the sender and must match the Transaction Header Batch Number field.
751	Record Count	M	9(10)	N		Count of Version 1.2 Batch records (one Version 1.2 Batch Transaction Header, One or many Version 1.2 Batch Transaction Detail Data Records, and one Version 1.2 Batch Transaction Trailer). The record count field includes the total number of Version 1.2 records in the batch, including the header and trailer records. The maximum number of records in a file is 9,999,999,999 including one Transaction Header and one Transaction Trailer.
504-F4	Message	S	X(35)	A		The message field can be used to further explain the reasons why the entire batch is in error 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.
880-K4	Text Indicator	M	X(1)	A	x03	End of text (ETX)