

The logo for the state of Ohio, featuring the word "Ohio" in a bold, sans-serif font. The letter "O" is a red outline, while the letters "hio" are a dark red color.

Department of  
Job and Family Services

**Ohio Companion Guide  
NCPDP D.0 Pharmacy Encounter**

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## Document Information

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## Amendment History

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1.0		HP EDI Team	DRAFT Version
2.0		HP EDI Team	Initial Production version
2.1		OHP	Modification of language

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## **EDI SUPPORT INFORMATION**

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## DISCLOSURE STATEMENT

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

MCP's, Providers and Trading Partners are responsible for periodically checking for Companion Guide updates on the ODJFS Trading Partner website. <http://jfs.ohio.gov/OHP/tradingpartners/info.stm>

Encounter Transactions are not HIPAA Mandated and can therefore be customized to suit the needs of ODJFS to receive Encounters from MCP's.

## 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 is a registered trademark of the National Council for Prescription Drug Programs (NCPDP), Inc., Versions 1.2 and D.0, and their predecessors include proprietary material that is protected under the U.S. Copyright Law, and all rights remain with NCPDP.

- 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 ODJFS.

The objectives of this document are:

- To point out preferred selections for data elements where multiple alternatives exist.

Since this is not a HIPAA Mandated Transaction ODJFS has the option to customize this Transaction to suit the needs of the ODJFS Adjudication process for Encounters.

## 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 ODJFS Companion Guides.

### American Standard Code for Information Exchange Formatting

ODJFS does not accept EBCDIC files. All data transfers are expected to be in the American Standard Code for Information Exchange (ASCII) format.

For additional information, see the EDI Trading Partner Information Guide found on the ODJFS Trading Partner web site [http://jfs.ohio.gov/OHP/tradingpartners/atp\\_lists.stm](http://jfs.ohio.gov/OHP/tradingpartners/atp_lists.stm).

## 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.

## 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

## 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. Compound billing transactions (B1, B2,) may only contain one transaction.
- Alphanumeric fields should be uppercase when alpha and always left justified.
- Leading zeros 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.

## 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 zeros
2. Alphanumeric (A): Remove trailing spaces

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

DRAFT

## PAYMENT ARRANGEMENT INFORMATION

ODJFS 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 per 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).

## SEGMENT INFORMATION

### Billing/Rebill Claim Request (B1/B2 Transactions)

Transaction Header Segment: Mandatory

NOTE: This is a fixed length segment and all 56 bytes are required. If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
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	Billing 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	One occurrence Two occurrences Three occurrences

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
					4	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 (Billing Provider NPI)
401-D1	Date of Service	M	9(8)	N		CCYYMMDD CC – Century YY – Year MM – Month DD – Day This is the date when pharmacy filled the prescription.
110-AK	Software Vendor/ Certification ID	M	x(10)	A		Required when known

### Patient Segment: Required

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

## Insurance Segment: Mandatory

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
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 (Recipient ID)
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.

## Claim Segment: Mandatory

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
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	Compound: Use 00 to designate multi-ingredient product. National Drug Code (NDC)
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 (Format: 9999999.999)  Enter the 10-digit metric decimal quantity of the drug dispensed. 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

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
406-D6	Compound Code	R	9(1)	N	0 1 2	Not specified Not a compound Compound (For a compound Claim atleast 2 NDC's are required)
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 This is the date that the prescriber wrote the prescription.
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

## Prescriber Segment: Required

NOTE: If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.

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

## Coordination Of Benefits (COB) And Other Payments Segment: Required

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
						<b>This iteration of the COB Segment should contain the MCP payment information. The first occurrence is required.</b>
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.(First occurrence is always MCP payment details)
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 MCP.(Ex: SBR segment of 837's)
993-A7	Internal Control Number		X(30)	A		TCN (MCP Claim Number)
338-5C	Other Payer Coverage	R	x(2)	A	01	Primary

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
	Type					This iteration of the COB Segment should contain the MCP payment information. The first occurrence is required.
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. This data element must contain the date that the pharmacy was paid.
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. This data element must contain what the MCP paid the pharmacy

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
						<p>This iteration of the COB Segment should contain the MCP payment information. The first occurrence is required.</p> <p>(or shadow priced).</p> <p><b>For capitated claims (qualifier=04) the value CANNOT be zero "0". The MCP must shadow price capitated encounters by placing the total payment amount at the claim level based on how the MCP's system adjudicated the claim from the provider.</b></p>



### Coordination Of Benefits (COB) And Other Payments Segment: Optional

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
						<b>This iteration of the COB segment should contain any other payment information available.</b>
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 (Claim number for COB payer)
338-5C	Other Payer Coverage Type	S	x(2)	A	Blank 01	Not specified Primary

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
					02 03 99	This iteration of the COB segment should contain any other payment information available.  Secondary Tertiary Composite
443-E8	Other Payer Date	S	9(8)			CCYYMMDD CC – Century YY – Year MM – Month DD – Day TPL paid date
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 (for COB occurrences [not the first occurrence] this is the only valid option).
431-DV	Other Payer Amount Paid	S	s9(6).9(2)	D	s\$\$\$\$\$\$cc s9(6)v99	

## Pricing Segment: Mandatory

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
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.(Total Billed amount)

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

Total Billed amount >= MCP paid amount + TPL paid amounts.

### Compound Segment: Optional

If Field 406-D6 in the Claim Segment = 2, then at least two line level items containing NDC information for the compound must be submitted, or a threshold error will occur.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
111-AM	Segment Identification	M	x(2)	A	10	Compound Element is mandatory when segment is present and Field 406-D6 in the Claim Segment = 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

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
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 Count	M	9(2)	N	01 – 40	Element is mandatory when segment is present
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.

## Claim Reversal (B2 Transactions)

### Transaction Header Segment: Mandatory

For Voiding the claim the most important 3 fields that are used to identify the mother claim are: Billing provider ID, Prescription Number, Dispense Date.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
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
401-D1	Date of Service	M	9(8)	N		CCYYMMDD

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
						CC – Century YY – Year MM – Month DD – Day This is the date when pharmacy filled the prescription.
110-AK	Software Vendor/Certification ID	M	x(10)	A		Spaces

## Claim Segment: Mandatory

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
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	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 <a href="http://www.snomeD.Org/">http://www.snomeD.Org/</a>  Note: New element - replaces 452-EH

## Billing/Rebill Paid Response

### Response Header Segment: Mandatory

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
102-A2	Version/Release Number	M	x(2)	A	D0	Version D.0
103-A3	Transaction Code	M	x(2)	A	B1 B2	Billing 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		Provider ID is returned from the ID received on the request. Note: If the service provider is also enrolled in

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

## Response Message Segment: Optional

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

## Response Status Segment: Mandatory

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

## Response Claim Segment: Mandatory

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

**Response Pricing Segment: Mandatory**

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

## Billing/Rebill Reject Response

### Response Header Segment: Mandatory

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
102-A2	Version/Release Number	M	x(2)	A	D0	Version D.0
103-A3	Transaction Code	M	x(2)	A	B1 B2	Billing 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

## Response Message Segment: Optional

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

## Response Status Segment: Mandatory

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

## Response Claim Segment: Mandatory

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

## Reversal Approved Response

### Response Header Segment: Mandatory

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

		ATTRIBUTES			Comments	
						CC – Century YY – Year MM – Month DD – Day

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## Response Message Segment: Optional

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

## Response Status Segment: Mandatory

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
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 TCN assigned by the MCP.

## Response Claim Segment: Mandatory

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

## Reversal Rejected Response

### Response Header Segment: Mandatory

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

## Response Message Segment: Optional

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

## Response Status Segment: Mandatory

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
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		This field contains the TCN assigned by the MCP.

## Response Claim Segment: Mandatory

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

## Transmission Rejected: Transaction Rejected Response

### Response Header Segment: Mandatory

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

## Response Message Segment: Optional

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

## Response Status Segment: Mandatory

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

## Header Record Definition: Mandatory

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

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
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 <b>An error is indicated if one of the following three scenarios occur:</b> <ol style="list-style-type: none"> <li>1. Transaction Header Record per batch transmission file is not of fixed length.</li> <li>2. Transaction Trailer Record per batch transmission file is not of fixed length.</li> <li>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.</li> </ol>
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

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
						Format – CCYYMMDD CC – Century YY – Year MM – Month DD – Day
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)

**Detail Data Record Definition: Required****Note: This is a Fixed Length record.**

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

## Batch Transaction Trailer Definition: Required

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

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
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		<p>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).</p> <p>The record count field includes the total number of Version 1.2 records in the batch, including the header and trailer records.</p> <p>The maximum number of records in a file is 9,999,999,999 including one Transaction Header and one Transaction Trailer.</p>
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.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
880-K4	Text Indicator	M	X(1)	A	x03	End of text (ETX)