

# OHIO BUREAU FOR CHILDREN WITH MEDICAL HANDICAPS

## B1-B3 REQUEST PAYER SHEET

### Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet

#### GENERAL INFORMATION

Payer Name: Ohio Bureau for Children with Medical Handicaps		Date: January 01, 2012	
Plan Name/Group Name: BCMH		BIN: 610084	PCN: DRBCPROD = Production
Plan Name/Group Name: BCMH (test)		BIN: 610084	PCN: DRBCACCP = Test
Processor: ACS, A Xerox Company			
Effective as of: January 01, 2012		NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: Date of Publication		NCPDP External Code List Version Date: Date of Publication	
Contact/Information Source: Other references such as Provider Manuals, Payer phone number, web site, etc.			
Certification Testing Window: Certification Testing Dates			
Certification Contact Information: Certification phone number and information			
Provider Relations Help Desk Info: 800-365-4944			
Other versions supported: 5.1 supported through 12/31/2011			

#### OTHER TRANSACTIONS SUPPORTED

**Payer:** Please list each transaction supported with the segments, fields, and pertinent information on each transaction.

Transaction Code	Transaction Name
B1	Billing
B3	Rebilling

#### FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	<b>M</b>	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	<b>R</b>	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	<b>RW</b>	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

**Fields that are not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the template.**

#### CLAIM BILLING/CLAIM REBILL TRANSACTION

The following lists the segments and fields in a Claim Billing or Claim Rebill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used	X	

Transaction Header Segment	NCPDP Field Name	Value	Payer Usage	Claim Billing/Claim Rebill <i>Payer Situation</i>
101-A1	BIN NUMBER	610084	M	
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1 = Billing B3 = Rebill	M	Claim Billing, Claim Rebill
104-A4	PROCESSOR CONTROL NUMBER	DRBCPROD = Production DRBCACCP = Test	M	
109-A9	TRANSACTION COUNT	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01 – National Provider Identifier (NPI)	M	
201-B1	SERVICE PROVIDER ID	NPI Number	M	

Transaction Header Segment			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
401-D1	DATE OF SERVICE	CCYYMMDD	M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	This will be provided by the provider's software vender	M	If no number is supplied, populate with zeros

Insurance Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	

Insurance Segment Segment Identification (111-AM) = "04"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	CARDHOLDER ID	12 digit OH BCMH ID	M	Member's OH BCMH ID Number
301-C1	GROUP ID	OHCHILDREN	R	

Patient Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	

Patient Segment Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill	
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
304-C4	DATE OF BIRTH	CCYYMMDD	R	
305-C5	PATIENT GENDER CODE	0=Not Specified 1=Male 2=Female	R	
<b>311-CB</b>	<b>PATIENT LAST NAME</b>		<b>R</b>	<b>Required field in D.0</b>
384-4X	PATIENT RESIDENCE	0=Not specified 01=Home 03=Skilled Nursing Facility 06=Group Home 11=Hospice	R	Use this for old "Patient Location" field 307-C7 5.1 Payer Sheet shows Patient Location as NA for BCMH

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	
This payer supports partial fills	X	

Claim Segment Segment Identification (111-AM) = "07"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Number Assigned by the Pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	03 = National Drug Code	M	
407-D7	PRODUCT/SERVICE ID	National Drug Code (NDC)	M	
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER		RW	Required for the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C").
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE		RW	Required when submitting a claim for a completion fill  Date of the Associated Prescription/Service Reference Number.
442-E7	QUANTITY DISPENSED	Metric Decimal Quantity	R	
403-D3	FILL NUMBER	0 = Original Dispensing 1-99 = Refill number	R	
405-D5	DAYS SUPPLY		R	
406-D6	COMPOUND CODE	0 = Not specified 1 = Not a compound 2 = Compound	R	Value '0' not allowed in D.0

Claim Segment Segment Identification (111-AM) = "07"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	Required in D.0
414-DE	DATE PRESCRIPTION WRITTEN	CCYYMMDD	R	
415-DF	NUMBER OF REFILLS AUTHORIZED	0 = Not specified 1-99=number of refill	R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	Required if Submission Clarification Code (420-DK) is used.
420-DK	SUBMISSION CLARIFICATION CODE	8=Process Compound for Approved Ingredients	RW	Required when needed to provide additional information for compound coverage purposes.
308-C8	OTHER COVERAGE CODE	0=Not Specified 1=No other Coverage Identified 2=Other coverage exists-payment collected 3=Other coverage exists-this claim not covered 4=Other coverage exists-payment not collected	RW	Required when submitting a claim for a recipient who has other coverage.  Values 5, 6 and 7 are not allowed in D.0 If using Govt. COB, value 8 also not used
418-DI	LEVEL OF SERVICE	3 = Emergency	RW	Required when submitting a claim for an emergency fill.
461-EU	PRIOR AUTHORIZATION TYPE CODE	5=Exemption from Rx	RW	Required for billing COB (5 must be used with the submission of OCC '2') Internal – we need to verify if still needed???
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility.  Internal Question - Payer Requirement: What needs to be submitted here?????
343-HD	DISPENSING STATUS	P = Initial Fill C = Completion Fill	RW	Required for the partial fill or the completion of a partial fill.
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	Required when submitting a partial fill or the completion of a partial fill.
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	Required when submitting a partial fill or the completion of a partial fill.
995-E2	ROUTE OF ADMINISTRATION	Buccal = 54471007 Dental = 372449004 Inhalation = 112239003 Injection = 385218009 Intraperitoneal = 38239002 Irrigation = 47056001 Mouth/Throat = 26643008 Mucous Membrane = 419874009 Nasal = 46713006 Ophthalmic = 54485002 Oral = 26643006 Otic = 10547007 Perfusion = C444364 Rectal = 37161004 Sublingual = 37839007 Topical = 419464001 Transdermal = 372464004 Translingual = 37839007 Vaginal = 16857009 Enteral = 417985001 Urethral = 90028008	RW	Required when the Rx is a compound  New Field - replaces 452-EH from 5.1 Compound Segment  SNOMED CT Values required for D.0 Do we need to list the mapped values on the left or just indicate that SNOMED values are now required?

Pricing Segment Questions	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	If Situational, Payer Situation

Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	INGREDIENT COST SUBMITTED		R	Format=s\$\$\$\$\$cc Zero is not a valid value.
<b>412-DC</b>	<b>DISPENSING FEE SUBMITTED</b>		<b>RW</b>	<b>Imp Guide: Required if its value has an effect on the Gross Amount Due (430-DU) calculation.</b>
438-E3	INCENTIVE AMOUNT SUBMITTED	Vaccine administration charge	RW	Required when submitting for vaccine administration.  Format=s\$\$\$\$\$cc Examples: If the incentive amount submitted is \$4.50, this field would reflect: 45.
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3. No longer required – now available in updated COB segment for Pt Responsibility	RW	Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.  Used with Other Coverage code '8'.
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	Now in COB segment	RW	Required if Other Amount Claimed Submitted (480-H9) is used.
480-H9	OTHER AMOUNT CLAIMED SUBMITTED	Now in COB segment	RW	Required if its value has an effect on the Gross Amount Due (430-DU) calculation.
430-DU	GROSS AMOUNT DUE		R	Format=s\$\$\$\$\$cc <b>Will now be standard use – must balance</b> Must be submitted with co-pay only claims. The amount in this field must equal the amount submitted in Field 480-H9.

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	

Prescriber Segment Segment Identification (111-AM) = "03"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	01 = NPI 05 = Medicaid Number	R	NPI mandatory 05/23/2007
411-DB	PRESCRIBER ID	NPI Number Medicaid Number	R	NPI mandatory 05/23/2007

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	X	<b>Need to confirm that Ohio BCMH can and/or wants to use Govt COB</b>

If the Payer supports the Coordination of Benefits/Other Payments Segment, only one scenario method shown above may be supported per template. The template shows the Coordination of Benefits/Other Payments Segment that must be used for each scenario method. The Payer must choose the appropriate scenario method with the segment chart, and delete the other scenario methods with their segment charts. See section [Coordination of Benefits \(COB\) Processing](#) for more information.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"				Claim Billing/Claim Rebill Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
338-5C	OTHER PAYER COVERAGE TYPE	Blank=Not Specified Ø1=Primary Ø2=Secondary Ø3=Tertiary	M	Code identifying the type of 'Other payer ID' (340-7C)
443-E8	OTHER PAYER DATE	CCYYMMDD	RW	Required when there is payment from another source
341-HB	OTHER PAYER AMOUNT PAID COUNT		RW	Required if Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø1=Delivery Ø2=Shipping Ø3=Postage Ø4=Administrative Ø5=Incentive Ø6=Cognitive Service Ø7=Drug Benefit Ø9=Compound Preparation Cost 1Ø=Sales Tax	RW	Required when there is payment from another source  Valid values Blank, Ø8, 98 and 99 are not allowed values in D.Ø
431-DV	OTHER PAYER AMOUNT PAID	S\$\$\$\$\$cc	RW	Required if other payer has approved payment for some/all of the billing.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	Required if Other Payer Reject Code (472-6E) is used. Previously not used by OH BCMH
472-6E	OTHER PAYER REJECT CODE		RW	Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered).
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	Payer Requirement: Required if OCC=2 or 4
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		RW	Payer Requirement: Required if OCC=2 or 4
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	Payer Requirement: Required if OCC=2 or 4
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	RW	Imp Guide: Required if Benefit Stage Amount (394-MW) is used.  Does OH BCMH want to receive these if Med D?
393-MV	BENEFIT STAGE QUALIFIER		RW	Imp Guide: Required if Benefit Stage Amount (394-MW) is used.  Does OH BCMH want to receive these if Med D?
394-MW	BENEFIT STAGE AMOUNT		RW	Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts.

DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is situational	X	

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	Required if DUR/PPS Segment is used.
439-E4	REASON FOR SERVICE CODE	See Attached list of valid	RW	Required when there is a conflict to resolve or

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		Values		reason for service to be explained (Max 9)  Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.
44Ø-E5	PROFESSIONAL SERVICE CODE	See Attached list of valid Values  <b>NEW: Use MA for vaccine administration</b> <b>Does this apply for BCMH?</b>	RW	Required when there is a professional service to be identified (Max 9)  Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.
441-E6	RESULT OF SERVICE CODE	See Attached list of valid Values	RW	Required when There is a result of service to be Submitted (Max = 9).  Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.

Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is situational	X	Required when billing for a compound

Compound Segment Segment Identification (111-AM) = "1Ø"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	Ø1=Capsule Ø2=Ointment Ø3=Cream Ø4=Suppository Ø5=Powder Ø6=Emulsion Ø7=Liquid 1Ø=Tablet 11=Solution 12=Suspension 13=Lotion 14=Shampoo 15=Elixir 16=Syrup 17=Lozenge 18=Enema	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	1=Each 2=Grams 3=Milliliters	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3= National Drug Code (NDC)	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		R	

Clinical Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is situational	X	Required when a DX is used to determine coverage

Clinical Segment Segment Identification (111-AM) = "13"			Claim Billing/Claim Rebill	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.
492-WE	DIAGNOSIS CODE QUALIFIER		RW	Required if Diagnosis Code (424-DO) is used.

424-DO	DIAGNOSIS CODE		RW	Need to define the circumstance for requiring submission
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\*\* End of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template\*\*

### Additional Claim Information

- **M = Mandatory per the NCPDP Version D.0 Claim Format Standard. These fields must be populated in order for the claim to be processed.**
- **R = Required above the Standard. These data fields must also be populated in order to have the claim processed.**
- **RW = Required When. These fields depend on other claim information or eligibility information to determine if they are required.**
- **ACS POS Help Desk: 1-877-518-1545**

### DUR Codes

#### Reason for Service Codes (439-E4): DUR Conflict Codes

Code	Meaning	Code	Meaning
AT	Additive Toxicity	LD	Low Dose Alert
CH	Call Help Desk	LR	Under Use Precaution
DA	Drug Allergy Alert	MC	Drug Disease Precaution
DC	Inferred Drug Disease Precaution	MN	Insufficient Duration Alert
DD	Drug-Drug Interaction	MX	Excessive Duration Alert
DF	Drug Food Interaction	OH	Alcohol Precaution
DI	Drug Incombatability	PA	Drug Age Precaution
DL	Drug Lab Conflict	PG	Drug Pregnancy Alert
DS	Tobacco Use Precaution	PR	Prior Adverse Drug Reaction
ER	Over Use Conflict	SE	Side Effect Alert
HD	High Dose Alert	SX	Drug Gender Alert
IC	Iatrogenic Condition Alert	TD	Therapeutic Duplication
ID	Ingredient Duplication		

#### Professional Service Codes (440-E5): Intervention Codes

Code	Meaning	Code	Meaning
MA	<b>Medication Administration – use for Vaccine Administration</b>	PØ	Patient Consulted - patient interaction
MØ	Prescriber Consulted - MD Interface	RØ	Pharmacist Consulted Other Source - Pharmacist reviewed

#### Result of Service Codes (441-E6): Intervention Codes

Code	Meaning	Code	Meaning
1A	Filled As Is – False Positive	1F	Filled – Different Quantity
1B	Filled Prescription As Is	1G	Filled after prescriber approval
1C	Filled With Different Dose	2A	Prescription Not Filled
1D	Filled With Different Directions	2B	Not Filled – Directions Clarified