Hawaii Medicaid

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

GENERAL INFORMATION

Payer Name: Hawaii Medicaid Fee for Service	Date: Date of Publication of this Template	
Plan Name/Group Name: Hawaii Medicaid	BIN: 61ØØ84	PCN: DRHIPROD = Production
Plan Name/Group Name: Hawaii Medicaid (test)	BIN: 61ØØ84	PCN: DRHIACCPDØ = D.Ø Testing PCN: DRHIACCP all testing after 1/1/2012
Processor: Conduent Healthcare, LLC		
Effective as of: October 1, 2020	NCPDP Telecommunication Standard Version/Release #: D.Ø	
NCPDP Data Dictionary Version Date: Current	NCPDP External Code List Version Date: June, 2010	
Contact/Information Source: Other references such as Provider Manuals, Payer phone number, web site, etc.		
Certification Testing Window: D.Ø Testing will be available beginning September 6, 2011		
Certification Contact Information: Certification phone number and information		
Provider Relations Help Desk Info: 877-439- Ø8Ø3		
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	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	**RW**	"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.Ø*.

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	61ØØ84	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1 = Billing B3 = Rebill	M	Claim Billing, Claim Rebill
1Ø4-A4	PROCESSOR CONTROL NUMBER	DRHIPROD = Production DRHIACCPDØ = Test DRHIACCP = Test	M	Use PCN = DRHIACCPDØ for D.Ø testing through 12/31/2011 After 1/1/2012 use DRHIACCP for all testing
1Ø9-A9	TRANSACTION COUNT	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider Identifier (NPI)	M	
2Ø1-B1	SERVICE PROVIDER ID	NPI Number	M	
4Ø1-D1	DATE OF SERVICE	CCYYMMDD	M	

	Transaction Header Segment			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
11Ø-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) = "Ø4"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID	1Ø digit Hawaii Medicaid ID Number	M	
3Ø1-C1	GROUP ID	HAWAII1ØØØ OYS members use HAWAII2ØØØ	R	
3Ø6-C6	Patient Relationship Code	1 = Cardholder 2 = Spouse 3 = Child 4 = Other	RW	*Imp Guide:* Required if needed to uniquely identify the relationship of the Patient to the Cardholder. Default to "1"

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

	Patient Segment Segment Identification (111-AM) = "Ø1"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø4-C4	DATE OF BIRTH	CCYYMMDD	R	
3Ø5-C5	PATIENT GENDER CODE	Ø = Not Specified 1 = Male 2 = Female	R	
311-CB	PATIENT LAST NAME		R	

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

	Claim Segment Segment Identification (111-AM) = "Ø7"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Rx Number assigned by the pharmacy	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code	M	
4Ø7-D7	PRODUCT/SERVICE ID	National Drug Code (NDC)	M	
460-ET	QUANTITY PRESCRIBED	Metric Decimal Quantity	RW	Required when Rx is a Schedule II drug. Quantity Prescribed must be greater than or equal to Quantity Dispensed.
442-E7	QUANTITY DISPENSED	Metric Decimal Quantity	R	
4Ø3-D3	FILL NUMBER	Ø = Original Dispensing 1-99 = Refill number	R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	1 = Not a compound 2 = Compound	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Ø = No Product Selection Indicated 1 = Substitution Not Allowed by Prescriber 5 = Substitution Allowed-Generic Drug Not in Stock 7 = Substitution Not Allowed-Brand Drug Mandated by Law	R	Allow 'Ø', '1', '5' or '7'

	Claim Segment Segment Identification (111-AM) = "Ø7"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
414-DE	DATE PRESCRIPTION WRITTEN	CCYYMMDD	R	
3Ø8-C8	OTHER COVERAGE CODE	Ø = 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	
461-EU	PRIOR AUTHORIZATION TYPE CODE	Ø = Not Specified 1 = Prior Authorization	R	"Enter '1' for prior authorization number obtained through ACS"
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		R	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. "Enter PA number"
995-E2	ROUTE OF ADMINISTRATION	SNOMED CT Values required for D.Ø	RW	Required when the Rx is a compound New Field - replaces 452-EH in 5.1 Compound Segment SNOMED CT Values required for D.Ø

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

	Pricing Segment Segment Identification (111-AM) = "11"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		RW	Required if necessary as part of Gross Amount Due (43Ø-DU) calculation.
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
43Ø-DU	GROSS AMOUNT DUE		R	Required field and must always reflect total amount of prescription (not copay). COB segment required for reporting copay information of previous payer(s)

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

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	Ø1=National Provider Identifier (NPI) Ø5 = Medicaid ID number 12 = Drug Enforcement Administration (DEA)	R	
411-DB	PRESCRIBER ID	NPI Number HPMMIS Medicaid provider ID DEA Number	R	

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	

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) = "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*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE	Blank=Not Specified Ø1=Primary Ø2=Secondary Ø3=Tertiary	M	
339-6C	OTHER PAYER ID QUALIFIER	~~Ø1=National Payer ID~~ ~~Ø2=Health Industry Number (HIN)~~ Ø3=Bank Information Number (BIN) ~~Ø4=National Association of Insurance Commissions (NAIC)~~ ~~Ø5=Medicare Carrier Number~~ ~~99=Other~~	R	Required if Other Payer ID (34Ø-7C) is used.
34Ø-7C	OTHER PAYER ID	BIN	R	Submit BIN of previous payer
443-E8	OTHER PAYER DATE	CCYYMMDD	R	Required when there is payment or denial from another source.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	Required if Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER		RW	Required if Other Payer Amount Paid (431-DV) is used.
431-DV	OTHER PAYER AMOUNT PAID		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.
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	Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		RW	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	Required if necessary for patient financial responsibility only billing. Used to report Patient Copay
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	RW	*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used.
393-MV	BENEFIT STAGE QUALIFIER	Ø1 = Deductible Ø2 = Initial Benefit	RW	*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used.

	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*
		Ø3 = Coverage Gap Ø4 = Catastrophic Coverage 5Ø = Not Part D – paid under Part C 6Ø = Not Part D – Supplemental 7Ø = Part D Drug not covered by plan – Pt pay is negotiated price 8Ø = Not Part D – Pt pay is negotiated price		
394-MW	BENEFIT STAGE AMOUNT		RW	*Imp Guide:* 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. Required if necessary for state/federal/regulatory agency programs.

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 Values	RW	Required when there is a conflict to resolve or 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	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. This Segment is required in D.Ø for compound claims – recommend allowing on-line compound submission

	Compound Segment **Segment Identification (111-AM) = "1Ø"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*

	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	

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

	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 when a DX is used to determine coverage. Always a '1'
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1 = ICD9 Ø2 = ICD1Ø (future)	RW	Required when a DX is used to determine coverage.
424-DO	DIAGNOSIS CODE		RW	Required when a DX is used to determine coverage. Used when known to bypass prior authorization rejections.

**** End of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template****

Additional Claim Information

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 (44Ø-E5): Intervention Codes

Code	Meaning	Code	Meaning
MØ	Prescriber Consulted - MD Interface	PE	Patient Education/Instruction
PØ	Patient Consulted - patient interaction	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	1D	Filled With Different Directions
1B	Filled Prescription As Is	1F	Filled – Different Quantity
1C	Filled With Different Dose	1G	Filled after prescriber approval