Telecommunication Standard Version F6© and above Editorial and Best Practices

DOCUMENTATION

December 2025

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Version 01

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1. PURPOSE OF THIS DOCUMENT

This document provides a consolidated reference point for questions that have been posed based on the review and implementation of the NCPDP Telecommunication Standard Implementation Guide Version F6© and above, the Data Dictionary©, and the External Code List©. This document also addresses editorial changes made to these documents.

As stakeholders reviewed the documents, questions arose which were not specifically addressed in the guides or could be clarified further. These questions were addressed in the Work Group 1 Telecommunication meetings.

Editorial corrections include typographical errors, comments that do not match a field value or a reference pointer in error. Clarifications that affect implementation of the Telecommunication Standard Implementation Guide Version F6© will be cited in this document.

NCPDP Telecommunication Standard Implementation Guide Version F6© was named in Final Rule published December 13, 2024 for the Health Insurance Portability and Accountability Act (HIPAA).

It should be noted that values may be added/changed/deleted in the External Code List© on a quarterly basis. This allows the industry to adapt to business needs when values are needed.

The document is split into three sections – Editorial, Best Practices and General. Questions and the associated answers in the Editorial section must be implemented. Questions and answers in the Best Practices section are generally accepted guidelines. The General section contains questions and answers which are applicable to the Editorial section and the Best Practices section. Topics are in categories which provide a high-level reference. For example, a category may be a Segment in the format, with a subcategory of a field in that segment. The question and answer is then posed for that field found in that segment. Where appropriate, the question may be the actual heading in the index for ease of research.

This document will continue to be updated as questions and answers or editorial changes are necessary.

Note: within the guide, when dollar fields and amounts are discussed, all digits may be seen for readability. When actually using the field, rules should be followed for the overpunch character, as applicable.

1.1 Use Of This Document

This document should be used as a reference for the Telecommunication Standard Implementation Guide Version F6© and above, the Batch Standard Implementation Guide Version 15© and the Batch Standard Subrogation Implementation Guide Version 10© as applicable. In the Batch Standard© and the Batch Standard Subrogation Implementation Guide© (when used in batch mode), the Detail Data Record consists of the NCPDP Data Record, which consists of the Telecommunication Standard© record format. Therefore, references in these documents apply to all three standards as applicable.

1.1.1 Supporting This Document

Question:

Once the Telecommunication Standard Version F6© and Above Editorial and Best Practices (Version F6 Editorial) is published, how soon do implementers need to support it?

Answer:
When the Version F6 Editorial is published, it is effective for use *immediately unless the specific section or response lists an effective date*.

1.2 External Code List© (ECL) Information

Please review the *Overview External Code List© (ECL) Process and Telecom Emergency/Script and Specialized Expedited ECL Processes* document at https://standards.ncpdp.org/Standards/media/pdf/ECLProcessOverview.pdf

This document provides the process to request additions, modifications, and deletions to the data element values existing in the External Code List© (ECL). It provides the rules governing the procedures and steps for this process and maintenance of the ECL as approved by the NCPDP Board of Trustees. In addition, this document outlines the Telecommunication ECL implementation timetable used to facilitate consistency across the industry.

This document contains an ECL Publication and Implementation Chart to provide key dates in which full ECL Publications and ECL Emergency Values should be implemented across all industry participants supporting the NCPDP Telecommunication Standard©.

The *Emergency Telecommunication External Code List© Value Addendum* located at https://stds.ncpdp.org/ExternalCodeList/ provides a list of values approved for emergency implementation.

1.3 NCPDP Emergency Preparedness Resource

The *NCPDP Emergency Preparedness Guidance* document provides guidance for the pharmacy industry for resources available during a declared emergency. The intended audience is healthcare industry providers who would need resource information for eligibility and claims processing affecting displaced individuals. It is available at https://ncpdp.org/Resources under the Emergency Preparedness Topic.

2. EDITORIAL CORRECTIONS

2.1 Telecommunication Standard Version F6©

- Section 35.61 - *VERSION F6 JULY 2024 REPUBLICATION:* the field identifier for Other Payer Adjudicated Program Type should be C47-9T. The reference to Other Payer Adjudicated Type should be Other Payer Adjudicated Program Type with a field identifier of C47-9T.

- Even though the field Patient ID Associated State/Province Address (A22-YR) appears in the implementation guide as Not Used, the field should have been deleted from the implementation guide. Refer to DERF 1854.

- Formulary Alternative Required Therapy Indicator Count (D44-P0) does not repeat. The field should be listed in the implementation guide as Q, not Q***R***, N, not N***R*** or S***R***. This correction applies to the following sections:

10.5.1.2.6	10.5.2.2.6	10.5.3.2.6	12.4.1.2.6	12.4.2.2.6	12.4.3.2.6
13.5.1.2.4	13.5.2.2.4	13.5.3.2.4	13.8.1.2.4	13.8.2.2.4	13.8.3.2.4
14.4.1.2.6	14.4.2.2.6	14.4.3.2.6	14.7.1.2.6	14.7.2.2.6	14.7.3.2.6
16.3.1.2.6	16.3.2.2.6	16.3.3.2.6	16.3.4.2.6	18.3.1.2.6	18.3.3.2.5
18.3.4.2.5	18.3.5.2.5	19.3.1.2.5	19.3.2.2.5	19.3.3.2.5	19.3.4.2.5
21.4.1.2.6	21.4.2.2.6	21.4.3.2.6	22.5.1.2.4	22.5.2.2.4	22.5.3.2.4
23.4.1.2.6	23.4.2.2.6	23.4.3.2.6	25.2.2		

- Subrogation Requestors Reconciliation ID (D15-KY) is required for subrogation. It should be listed as RM, not QM. This correction applies to the following sections:
    - 10.5.1.2.6.1 Response Claim Segment (Subrogation Standard Claim Billing or Encounter) (Transmission Accepted/Transaction Paid)
    - 10.5.3.2.6.1 Response Claim Segment (Subrogation Standard Claim Billing or Encounter) (Transmission Accepted/Transaction Rejected)
    - 14.4.1.2.6.1 Response Claim Segment (Subrogation Standard Claim Rebill) (Transmission Accepted/Transaction Paid)

- Section 7.13.1.1 – Count Fields
    - Other Payer Reconciliation ID: The Other Payer Reconciliation ID (C49-9V) would not be reported when the COB occurrence is reporting a rejected response from the previous payer, represented by the values submitted in the Other Payer Reject Code (472-6E) field.

2.2 Batch Standard Version 15©

- The field File Type was incorrectly labeled as field ID 702 instead of 702-MC. Any instance of File Type (702) should be File Type (702-MC).

3. EDITORIAL SECTION

3.1 Transmission Level Segments

Question: Do any segments other than the respective headers belong to the transmission level, not the transaction level? If all segments other than the respective headers belong to the transaction level, how should Section 25 be understood? How do statements like that found in 22.5.4 which state there are "no situational transaction-level segments" be applied?

Answer: In the Implementation Guide, discussion of transmission level and transaction level has no significant meaning to how transactions are structured, and any actual or perceived contradictions can be effectively ignored.

Added May 2024

3.2 Order of Fields in a Segment

Question: Most of the time Mandatory fields are presented at the beginning of the segment within the Implementation Guide segment charts and in the F6 Matrices, but there are several examples where Mandatory fields are listed after other Situational fields in request or response segment charts. Is it correct to interpret that these Mandatory (M) fields are expected to be sent prior to any Required (R), Situational (Q), Optional (O), or Informational (I) fields within the segment as used within a specific transaction?

Answer: Yes, Mandatory fields are expected to be reported before any Situational (Q), Optional (O), or Informational (I) fields. Refer to "Section 5.1.2.1 – Segments" in the Telecommunication Standard Implementation Guide Version F6©.

In general, the Telecommunication Implementation Guide vF6© segment charts and matrices display Mandatory (M) fields before non-mandatory fields within the segment. There are however, several Mandatory (M) fields displayed after non-mandatory fields. This is a display issue only. The following lists the affected segments with Mandatory fields displayed after Required (R), Situational (S), Optional (O), or Informational (I) fields and provides the expected order of Mandatory (M) fields for each segment.

Compound Segment:

- Compound Ingredient Component Count (447-EC), Compound Product ID Qualifier (488-RE), Compound Product ID (489-TE), Compound Ingredient Quantity (448-ED) are Mandatory that are expected to be sent after all previous Mandatory (M) fields in the segment (versus after Situational (Q) fields in the segment as currently displayed in the vF6 Implementation Guide).
- All fields within the Compound Ingredient field grouping, regardless of their Situational (Q) status, would follow the logical grouping field order.
- Based on the rules for the ordering of Mandatory (M) fields as well as requirements for the logical grouping of sets of fields, the fields in the Compound segment would be ordered as follows (note: the qualified fields would only be sent when applicable):

Field			Field Name	Mandatory or Situational
111-AM	Segment Identification			M
450-EF	Compound Dosage Form Description Code			M
451-EG	Compound Dispensing Unit Form Indicator			M
447-EC	Compound Ingredient Component Count			M
	488-RE	Compound Product ID Qualifier		M***R***
	489-TE	Compound Product ID		M***R***
	448-ED	Compound Ingredient Quantity		M***R***
	449-EE	Compound Ingredient Drug Cost		Q***R***
	490-UE	Compound Ingredient Basis of Cost Determination		Q***R***
	362-2G	Compound Ingredient Modifier Code Count		Q
		363-2H	Compound Ingredient Modifier Code	Q***R***
C60-AG	Compound Level of Complexity			Q

Note: Payers should not reject claims where the Mandatory (M) fields may be submitted out of order.

Response Status Segment:

- Help Desk Support Type Count (C72-BH) and Help Desk Support Type (C71-BG) are Mandatory (M) fields that are expected to be sent after all previous Mandatory (M) fields in the segment (versus after Situational (Q) fields in the segment as currently displayed in the vF6 Implementation Guide).
- All fields within the Help Desk field grouping, regardless of their Situational (Q) status, would follow the logical grouping field order.
- Based on the rules for the ordering of Mandatory (M) fields as well as requirements for the logical grouping of sets of fields, the following fields must be sent at the start of the Response Status Segment (note: the qualified fields would only be sent when applicable).

Field			Field Name	Mandatory or Situational
111-AM	Segment Identification			M
112-AN	Transaction Response Status			M
C72-BH	Help Desk Support Type Count			M
	C71-BG	Help Desk Support Type		M***R***
	C67-BB	Help Desk Business Unit Type Count		R
		C66-BA	Help Desk Business Unit Type	Q***R***
		C70-BF	Help Desk Contact Information Qualifier	Q***R***
		C68-BC	Help Desk Contact Information	Q***R***
		C69-BD	Help Desk Contact Information Extension	Q***R***
Any remaining Response Status segment fields applicable to the response can be returned after this.				

Response Intermediary Segment:

- Intermediary Help Desk Support Type Count (C86-KC), and Intermediary Help Desk Support Type (C85-KB) are Mandatory (M) fields that are expected to be sent after all previous Mandatory (M) fields in the segment (versus after Situational (Q) fields in the segment as currently displayed in the vF6 Implementation Guide).
- All fields within the Intermediary Help Desk field grouping, regardless of their Situational (Q) status, would follow the logical grouping field order.
- Based on the rules for the ordering of Mandatory (M) fields as well as requirements for the logical grouping of sets of fields, the fields of the Response Intermediary Segment would be ordered as follows (note: the qualified fields would only be sent when applicable):

Field			Field Name	Mandatory or Situational
111-AM	Segment Identification			M
C86-KC	Intermediary Help Desk Support Type Count			M
	C85-KB	Intermediary Help Desk Support Type		M***R***
	C81-G9	Intermediary Help Desk Business Unit Type Count		R
		C80-G8	Intermediary Help Desk Business Unit Type	Q***R***
		C84-KA	Intermediary Help Desk Contact Information Qualifier	Q***R***
		C82-JP	Intermediary Help Desk Contact Information	Q***R***
		C83-JR	Intermediary Help Desk Contact Information Extension	Q***R***
B52-8R	Response Intermediary Authorization Count			Q
	B53-8S	Response Intermediary Authorization Type ID		Q***R***
	B54-8T	Response Intermediary Authorization ID		Q***R***
	B51-8Q	Intermediary Message		Q***R***

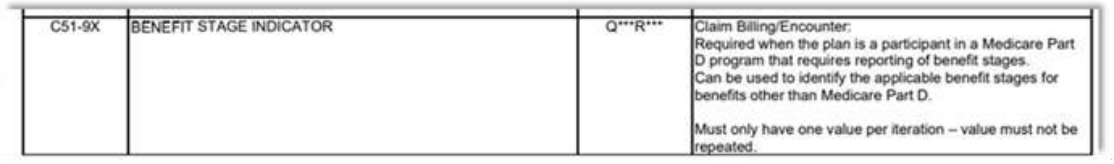
Added August 2024

3.3 ECL Values

Question: Can the same ECL value associated to a single field be sent multiple times within a distinct iteration of the field grouping for a single request or response transaction?

Answer: As of the Telecommunication Standard Implementation Guide vF6©, there is documentation in place for two specific fields that states the same ECL value cannot be repeated.

1. Benefit Stage Indicator (C51-9X)
   a. Telecommunication Standard Segment Diagrams, Situation of Use states *"Must only have one value per iteration, value must not be repeated"*



C51-9X	BENEFIT STAGE INDICATOR	Q***R***	Claim Billing/Encounter: Required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stages. Can be used to identify the applicable benefit stages for benefits other than Medicare Part D. Must only have one value per iteration – value must not be repeated.

2. Additional Message Information Qualifier (132-UH)
   a. Data Dictionary© description states *"Each value may only occur once per transaction…"*

After a comprehensive review, it was determined there are additional fields where the same value should not repeat within a distinct iteration of the field grouping for a single request or response transaction. The below table lists the Count/Counter fields and the associated Max count within the Telecommunication Standard vF6©. The associated fields with ECL values within the field grouping are also listed. The recommendation as to whether the same ECL value can repeat or not repeat is listed in the last column to the right.

Telecommunication Standard Implementation Guide vF6© Count/Counter Field Max Counts and Associated Repeating Fields with ECL Values

Request or Response Transaction	Count /Counter Field	Max Count	Repeating Field ID	Repeating Field Name	Can the same ECL value repeat?
Request	Clinical Information Counter (493-XE)	5	496-H2 497-H3	Measurement Dimension Measurement Unit	Yes
Request	DUR/PPS Code Counter (473-7E)	9	439-E4 440-E5 441-E6 474-8E 475-J9 476-H6	Reason For Service Code Professional Service Code Result of Service Code DUR/PPS Level of Effort DUR/DUE Co-Agent ID Qualifier DUR/DUE Co-Agent ID	Yes
Request	Procedure Modifier Code Count (458-SE)	10	459-ER	Procedure Modifier Code	Yes
Request	Submission Clarification Code Count (354-NX)	5	420-DK	Submission Clarification Code	No
Request	Submission Type Code Count (D16-KZ)	5	D17-K8	Submission Type Code	No
Request	Patient ID Count (618-RR)	9	331-CX	Patient ID Qualifier	Yes
Request	Diagnosis Code Count (491-VE)	5	424-DO	Diagnosis Code	No
Request	Compound Ingredient Component Count (447-EC)	25	488-RE 490-UE	Compound Product ID Qualifier Compound Ingredient BOC	Yes

Request or Response Transaction	Count /Counter Field	Max Count	Repeating Field ID	Repeating Field Name	Can the same ECL value repeat?
Request	Compound Ingredient Modifier Code Count (362-2G)	10	363-2H	Compound Ingredient Modifier Code	Yes
Request	Other Amount Claimed Submitted Count (478-H7)	3	479-H8	Other Amount Claimed Submitted Qualifier	No
Request	Regulatory Fee Count (D60-RK)	3	D61-RL	D61-RL Regulatory Fee Type Code	Yes
Request	Coordination of Benefits/Other Payments Count (337-4C)	3	338-5C 339-6C C47-9T	338-5C Other Payer Coverage Type* 339-6C Other Payer ID Qualifier C47-9T Other Payer Adjudicated Program Type	*Other Payer Coverage Type (338-5C) should not repeat for the request. 339-6C and C47-9T can repeat.
Request	Other Payer Reject Count (471-5E)	5	472-6E	Other Payer Reject Code	Yes
Request	Other Payer Amount Paid Count (341-HB)	9	342-HC	Other Payer Amount Paid Qualifier	No
Request	Other Payer-Patient Responsibility Amount Count (353-NR) *Note the occurrences are dependent upon the number of component parts returned from a previous payer.*	25	351-NP	Other Payer-Patient Responsibility Amount Qualifier	No
Request	Benefit Stage Indicator Count (C50-9W)	4	C51-9X	Benefit Stage Indicator	No
Request	Other Payer Regulatory Fee Type Count (D53-P9)	3	D63-RN D52-P8	Other Payer Regulatory Fee Type Code Other Payer Regulatory Fee Exempt Indicator	Yes
Request	Intermediary ID Count (B44-8G)	5	B45-8H B46-8J B47-8K B49-8N B55-8U	Intermediary ID Type Code Intermediary ID Type Entity Intermediary ID Qualifier Intermediary ID State/Province Address Intermediary ID Country Code	Yes

Request or Response Transaction	Count /Counter Field	Max Count	Repeating Field ID	Repeating Field Name	Can the same ECL value repeat?
Response	DUR/PPS Response Code Counter (567-J6)	9	439-E4 528-FS 475-J9 529-FT E95-Z9 E94-ZA 532-FW 533-FX F01-Z4 F05-Z0 F07-YL F09-YI	Reason for Service Code Clinical Significance Code DUR/DUE Co-Agent ID Qualifier Other Pharmacy Indicator Other Pharmacy ID Qualifier Unit of Measure for Previous Disp Qty Database Indicator Other Prescriber Indicator Other Prescriber ID Qualifier DUR/DUE Compound Product ID Qualifier DUR/DUE Maximum Daily Dose UoM DUR/DUE Minimum Daily Dose UoM	Yes
Response	Reject Count (510-FA)	5	511-FB	Reject Code	A reject code may be repeated if a field repeats (e.g., ingredients in a compound). The Reject Field Occurrence Indicator (546-4F) field should be used to identify the specific repeating field associated to the reject code. Reject Field Occurrence Indicator (546-4F) - Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.
Response	Approved Message Code Count (547-5F)	5	548-6F	Approved Message Code	No
Response	Additional Message Information Count (130-UF)	25	132-UH	Additional Message Information Qualifier	No

Request or Response Transaction	Count /Counter Field	Max Count	Repeating Field ID	Repeating Field Name	Can the same ECL value repeat?
Response	Formulary Alternative Product Count (551-9F)	6	D42-PV D43-PZ 552-AP	Formulary Alternative Plan Benefit Tier Formulary Alternative Reason Code Formulary Alternative ID Qualifier	Yes
Response	Formulary Alternative Required Therapy Indicator Count (D44-P0)	6	D45-P1 D46-P2	Formulary Alternative Req Therapy Indicator Formulary Alternative Required Therapy Time Period Qualifier	Yes
Response	Help Desk Support Type Count (C72-BH)	5	C71-BG	Help Desk Support Type	Yes
Response	Help Desk Business Unit Type Count (C67-BB)	5	C66-BA C70-BF	Help Desk Business Unit Type Help Desk Contact Information Qualifier	Yes
Response	Payer/Health Plan ID Count (C96-KR)	3	568-J7	Payer/Health Plan ID Qualifier	Yes
Response	Patient Pay Component Count (C94-KP)	25	C95-KQ	Patient Pay Component Qualifier	No
Response	Regulatory Fee Count (D60-RK)	3	D61-RL D62-RM	Regulatory Fee Type Code Regulatory Fee Exempt Indicator	Yes
Response	Other Amount Paid Count (563-J2)	9	564-J3	Other Amount Paid Qualifier	No
Response	Other Benefit Count (D26-M8)	9	D40-PN	Other Benefit Type Code	No
Response	Other Benefit Detail Information Count (D37-N8)	9	D32-MS	Other Benefit Detail Information Indicator	No
Response	Other Payer ID Count (355-NT) *Maximum count of 4 for claim, service and prior authorization response transactions. Maximum count of 9 for eligibility response transactions.*	4, 9	338-5C D41-PQ D50-P6 C47-9T 339-6C 143-UW	Other Payer Coverage Type Other Payer Relationship Type Other Payer Benefit Classification Other Payer Adjudicated Program Type Other Payer ID Qualifier Other Payer Patient Relationship Code	Yes
Response	Benefit Stage Indicator Count (C50-9W)	4	C51-9X	Benefit Stage Indicator	No
Response	Benefit Type Opportunity Count (C59-AF)	9	C58-AE	Benefit Type Opportunity	No
Response	Patient ID Count (618-RR)	9	331-CX	Patient ID Qualifier	Yes
Response	Intermediary ID Count (B44-8G)	5	B53-8S	Response Intermediary Auth Type ID	Yes
Response	Intermediary Help Desk Support Type Count (C86-KC)	5	C85-KB	Intermediary Help Desk Support Type	Yes

Request or Response Transaction	Count /Counter Field	Max Count	Repeating Field ID	Repeating Field Name	Can the same ECL value repeat?
Response	Intermediary Help Desk Business Unit Type Count (C81-G9)	5	C80-G8 C84-KA	Intermediary Help Desk Business Unit Type Intermediary Help Desk Contact Info Qual	Yes

Added November 2024

3.4 Request Transaction Header Segment

3.4.1 Transaction Count

Question: "As of Version E7, a transmission contains only one request transaction. The processor/PBM must respond to each request. The Transaction Count in the response must match the Transaction Count in the request. The Response Status Segment will have response information for each request transaction. Each transaction response will contain its own Transaction Response Status." Refer to Section 26.2 of the Telecommunication Standard Version F6© document.

Understanding that many errors at the syntactical level will have been made/encountered in order to participate in such an exchange, what is the proper response to a Version E7 or above transmission that has a Transaction Count greater than 1?

Answer: The Header Response Status (501-F1) and the Transaction Response Status (112-AN) must contain the value of "R". Use Reject Code of A9 – Missing/Invalid Transaction Count in the Reject Code (511-FB). The Transaction Count (109-A9) must be "1".

Added November 2023

3.5 Request Patient Segment (01)

3.6 Request Insurance Segment (04)

3.7 Request Claim Segment (07)

3.7.1 Days Supply (405-D5)

Question: How do you set the days supply for a recurring medication that has a long period between dosing or administering (such as once every 120 days, 180 days, etc…) that is dispensed as a single dose? How do you keep a long days supply from causing a misrepresentation of the claim as mail order?

Answer: The actual days supply (in this case days between dosing) is to be sent in order to properly apply DUR edits. The pharmacy system vendor and the processor must be able to support 3 digits in the Days Supply as the standard supports 3 digits. Days Supply should not be used as a determination for the type of pharmacy setting. Pharmacy Service Type (147-U7) is used for identifying the type of pharmacy submitting the claim.

3.7.2 Long Term and Post Acute Care (LTPAC) Qualified Environment

Three new fields were added to address the claim requirements in the Long Term and Post Acute Care (LTPAC) qualified environment. The LTPAC Billing Methodology (C90-KH) field was created to identify the type of billing that the date of service represents. The Number of LTPAC Dispensing Events (C92-KM) field was created to indicate the count of dispensing events that comprise the claim for the days supply

being submitted. The LTPAC Dispense Frequency (C91-KK) field was created to identify the typical interval pattern of a dispensing or resupply by the LTC pharmacy.

LTPAC Billing Methodology (C90-KH)
LTPAC Billing Methodology (C90-KH) in the claim segment indicates the billing methodology used for the claim submission. Below are example billing methodologies. Refer to the ECL for current values.

Billing full quantity as dispensed on date of dispensing.

- The quantity and days supply of product or service on the claim have been provided in full on the date of service stated on the claim.

Post- consumption billing

- Popular in the LTPAC Qualified setting, this refers to the practice of aggregating quantities of dispensed product or service that occurs over some period of elapsed days. One or more dispensings occurred over those days, most typically within a monthly period. The date of service on the claim represents either the billing date or the first date that the product or service was dispensed during the days supply for the entire claim.

Pre-consumption billing

- This refers to the practice of billing for a claim using a date of service that is the first date of one or more dispensings, but the subsequent dispensings of product or service that make up the full claim may not have yet occurred.

Number Of LTPAC Dispensing Events (C92-KM)
Number of LTPAC Dispensing Events (C92-KM) in the claim segment provides the total number of pharmacy dispensings to help trading partner agreements be more straightforward to administer. The field will indicate the count of dispensing events that comprise the claim for the days supply being submitted.

For example, if a 26-day supply claim consists of three 7-day resupplies and one 5-day initial fill then the Number of LTPAC Dispensing Events (C92-KM) is four. If the medication is dispensed using in-facility technology that is managed via pharmacy system integration and the medication is given three times daily for a 30-day supply, then the Number of LTPAC Dispensing Events (C92-KM) is 90.

The value should be assessed in context with the value of the LTPAC Billing Methodology (C90-KH) and Special Package Indicator (429-DT).

LTPAC Dispense Frequency (C91-KK)
LTPAC Dispense Frequency (C91-KK) in the claim segment represents the dispensing frequency which refers to the *typical interval pattern* of dispensing or resupply by the pharmacy that occurred for the claim being submitted. Refer to the ECL for current values.

For example, if a claim is submitted for a 30-day supply and the dispensing occurred as 2 initial days, followed by four 7-day resupplies, then the pharmacy is going to be indicating that the resident is being dispensed on a 7-day dispensing interval resupply pattern (or cycle).

Reject Code (511-FB) values appropriate for LTC Short Cycle:
Below are the reject codes related to LTC Short Cycle and examples of when the values should be used.

Value	Description	Use Cases
597	LTC Dispensing Type Does Not Support The Packaging Type	Value is N on the Validity Matrix*
613	The Packaging Methodology Or Dispensing Frequency Is Missing Or Inappropriate For LTC Short Cycle	SCC 16, 21 or 36 is submitted with LTPAC Dispense Frequency values 2-15
DF4	Invalid LTPAC Dispense Frequency and Submission Clarification Code (SCC) Combination	Value is N on the SCC and Dispense Frequency Combo Spreadsheet*

*Documents are located on the WG14 Member Home Page

SPLIT BILLING IN LONG TERM CARE
Below is an update to Section 28.6.3 Split Billing in Long Term Care of the Telecommunication F6 Implementation Guide to provide clarification related to the dispensing fee. The reference to MDS and RUGS score has also been removed in favor of more general terminology.

A skilled nursing facility is reimbursed for Medicare Part A based on a per-diem reimbursement system that focuses on time-and-motion of a nurse's attention to the resident. The medications that a patient receives during that stay are also paid for using the same Medicare Part A funds. Part A reimbursement ceases as of the Part A benefit expiration date for the resident. When applicable, the next covering business entity (insurance, PDP, family, estate) is billed for the rest of the medication days supply.

> Scenario: A Medicare Part A resident is dispensed a 30 day supply of medications on September 6th. Eleven days into that 30-day supply, the resident's Part A benefit no longer applies. Rather than return the unused medications to the pharmacy, and then redispense a fresh supply to the resident, the resident keeps the medication. After reversing the original 30 day claim, the 11 days supply is billed to the Part A stay. The 19 days supply is then billed to the next payer using a Date of Service (401-D1) of September 17th for a 19 days supply of ingredient cost and no dispensing fee.

The scenario mentions that no dispensing fee should be submitted. The recommendation is the submitted amount of the dispensing fee for the second days supply interval of a split bill must = "$0.00". If a non-zero dispensing fee is submitted by the pharmacy and accepted by the payer, the payer should return a Dispensing Fee Paid (507-F7) amount of $0.00.

Added May 2024

3.7.3 Route of Administration (995-E2) and SNOMED CT Codes

The Telecommunication Standard Version D.0 and above uses the Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) terminology for the Route of Administration (995-E2). NCPDP's External Code List© (ECL) entry for Route of Administration (995-E2) points to the National Library of Medicine (NLM)'s Value Set Authority Center (VSAC) for the list of values and includes a link with instructions for how to download the data. To ensure consistent values and processes across trading partners, NCPDP recommends using the downloadable list of codes published biannually by NLM.

Please see "*Appendix B. Route of Administration Questions*" for specific FAQs on Route of Administration (995-E2) and SNOMED CT values.

Added August 2024

3.8 Request Pharmacy Provider Segment (02)

3.9 Request Prescriber Segment (03)

3.9.1 No Prescriber Prescription

Question: What should be submitted on a Version D.0 claim to indicate the claim is not associated with a patient specific prescription/standing order (i.e., there is no prescriber)? What should be submitted on a Version F6 claim?

Answer: In order to support recent regulatory changes that support coverage for products without a prescription, updates were made to the External Code List© (ECL) to distinctly identify a claim is not associated with a patient specific prescription/standing order. The ECL changes will not be available until the October 2025 Annual ECL implementation.

It is recommended to use the following fields and associated ECL values to support this business need prior to and as of October 2025. This recommendation supersedes any prior FAQ on what value to submit as the Prescriber ID (411-DB) for products without a prescription.

- Time period – Prior to October 2025:
  - Prescriber ID Qualifier (466-EZ) value 01 (NPI)
  - Prescriber ID (411-DB) = Pharmacy NPI (Type 2 NPI)
  - When necessary, Submission Clarification Code (SCC) (420-DK) value 42 (Prescriber ID Submitted is valid and prescribing requirements have been validated)
  - Prescription Origin Code (419-DJ) value 5 (Pharmacy)
- Time period – As of October 2025:
  - Prescriber ID Qualifier (466-EZ) value 18 (No Prescriber ID, No Prescription Associated to the transaction) will be available for use within Version D.0 and Version F6 transactions (if applicable).
  - Prescriber ID (411-DB) = 0 (as directed by the Prescriber ID Qualifier (466-EZ) value 18 limitation).
  - Prescription Origin Code (419-DJ) value 6 (No Associated Prescription) will be available for use within version D.0 and version F6 transactions (if applicable).

- When the above values are submitted and the payer determines a prescription is required, the claim should reject with new Reject Code (511-FB) DO6 - Prescription Required. Claim without an associated prescription is not covered.

Added November 2024

3.10 Request Coordination of Benefits/Other Payments Segment (05)

3.10.1 Other Payer Adjudicated Program Type (C47-9T)

Question: How should the Other Payer Adjudicated Program Type (C47-9T) be populated in the Coordination of Benefits/Other Payments Segment of the claim billing transaction?

Answer: The pharmacy should populate the Other Payer Adjudicated Program Type (C47-9T) with the value returned by each of the previous payers in the Adjudicated Program Type (A28-ZR) field in their respective transactions. See section 28.3 of the *NCPDP Telecommunication Standard Version F6 Implementation Guide©*.

Added May 2025

Question: If the downstream payer does not coordinate benefits with the program type submitted in the Other Payer Adjudicated Program Type (C47-9T), can the payer reject the claim?

Answer: Yes, the payer should reject the claim with the most appropriate Reject Code (511-FB). Some possibilities include:

- DI8: Other Payer Adjudicated Program Type Value Not Supported (C47-9T)
- 887: A Previous Payer(s) Is An Excluded Federal Health Care Program Copay Assistance Is Not Allowed
- 888: Beneficiary Is Enrolled In Excluded Federal Health Care Program

Added May 2025

3.10.2 Populating Other Payer Date

Question: Does the Other Payer Date (443-E8) have to match the Date of Service (401-D1)?

Answer: No, the Other Payer Date (443-E8) does not have to match the Date of Service (401-D1).

The definition of Other Payer Date (443-E8) is, “Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.”

The definition of Date of Service (401-D1) is, “Identifies date the prescription was filled or professional service rendered or subsequent payer began coverage following Part A expiration in a long-term care setting only.” In the retail pharmacy setting, the Date of Service (401-D1) represents the date the prescription was filled or administered in the case of vaccines.

When additional coverage is known at the time the prescription is filled, the Other Payer Date (443-E8) will typically match the Date of Service (401-D1) as the COB claim will process immediately after the primary is billed. When additional coverage is identified after the prescription is picked up (or

administered), the pharmacy protocol may require the reversal and resubmission of the original claim in order to process the COB claim.

For example, the claim was filled on 9/2/2025 and the COB coverage was identified on 9/4/2025. The two fields in the COB transaction would be populated as follows:

Date of Service	401-D1	20250902
Other Payer Date	443-E8	20250904

The Other Payer Date (443-E8) is based on the last adjudication for this fill to the previous payer. Because this was billed to the primary payer again on 9/4/2025, the Other Payer Date (443-E8) is 9/4/2025, which is different from the Date of Service (401-D1).

Added December 2025

3.11 Request Workers' Compensation Segment (06)

3.12 Request DUR/PPS Segment (08)

3.13 Request Pricing Segment (11)

3.14 Request Compound Segment (10)

3.15 Request Prior Authorization Segment (12)

3.16 Request Clinical Segment (13)

3.17 Request Additional Documentation Segment (14)

3.18 Request Facility Segment (15)

3.19 Request Narrative Segment (16)

3.20 Request Intermediary Segment (19)

3.20.1 Segment Not Used

Question: What should processors do when they receive an Intermediary Segment on Telecommunication VF6 transactions, such as B1 and B3, and the processor does not use the Intermediary Segment?

Answer: F6 Implementation Guide Section 8.3 states, "Note, if the sender chooses to send in more fields than are required or situational by the receiver, but which the sender needs for their business, the receiver is to ignore these fields or segments."

As a result:

- Processors should not reject a transmission with an Intermediary Segment, solely based on the presence of that segment.
- Processors should always include the Intermediary Segment on their payer sheets. If segment is not used for processing, processors should select "Not used by processor/may be (situationally) required by intermediary" in the dropdown box on the payer sheet template.

- Processors do not need to but may validate the individual Intermediary Segment fields when not used for processing.
- Intermediaries and/or processors should include a fully detailed Intermediary Segment on their payer sheets if using the Intermediary Segment for processing.

Added December 2025

3.21 Request Last Known 4Rx Segment (37)

3.22 Request N Transaction Payer Identification Segment (38)

3.23 Response Header Segment

3.24 Response Message Segment (20)

3.25 Response Insurance Segment (25)

3.26 Response Insurance Additional Information Segment (27)

3.27 Response Patient Segment (29)

3.27.1 Patient ID (332-CY)

Question: What is expected to be returned by the PBM/processor in Patient ID (332-CY) on the response?

Answer: The Response Patient ID (332-CY) field allows PBMs/processors to share patient identifiers with pharmacies to:

- Improve the accuracy of patient data exchange
- Support care coordination and benefit alignment

This field was introduced so stakeholders could communicate in standard transactions a patient identifier either issued by a government agency (such as Social Security Number, State-issued, Indian Tribal), private entity (such as NCPDP's UPI) or others.

The field supports up to nine entries, enabling the PBM/processor to return multiple identifiers if needed.

Scenario-Based Guidance

Scenario 1: Mismatched UPIs from the Same Enumerator

- **Situation:** Both the pharmacy and PBM have UPIs from NCPDP, but the UPI submitted by the pharmacy does not match the PBM's record
- **PBM/Processor Options:**
    1. Return the UPI on file with qualifier (331-CX) = 15 (NCPDP UPI)
    2. Return nothing/blank
- **Purpose:** To inform the pharmacy that the PBM has a different UPI from the same source.

Option	Submitted Qualifier	Submitted Patient ID	Response Qualifier(s)	Response Patient ID(s)
1	15 (NCPDP Universal Patient Identifier (UPI))	ABC12345	15 (NCPDP Universal Patient Identifier (UPI))	ABC13345

2	15 (NCPDP Universal Patient Identifier (UPI))	ABC12345		

Scenario 2: Different UPI Enumerators

- **Situation:** Both the pharmacy and PBM have UPIs for the patient, but from different enumerating entities
- **PBM/Processor Options:**
    1. Return their UPI with the appropriate qualifier (331-CX) for their enumerator
    2. Return nothing/blank
- **Purpose:** To indicate that the patient has a UPI from a different source.

Option	Submitted Qualifier	Submitted Patient ID	Response Qualifier(s)	Response Patient ID(s)
1	16 (LexID) Universal Patient Identifier (UPI))	ABC123XYZ	18 (Evernorth) Universal Patient Identifier (UPI))	XYZ789ABC
2	16 (LexID Universal Patient Identifier (UPI))	ABC123XYZ		

Scenario 3: Submitted Patient ID Does Not Match PBM Records

- **Situation:** The pharmacy submits a patient ID (e.g., SSN) that does not match the PBM's records
- **PBM/Processor Options:**
    1. Return the ID they have on file, even if it doesn't match the submitted one
    2. If multiple IDs are on file, return any acceptable value
    3. Return nothing/blank
- **Purpose:** To provide the pharmacy with the PBM's known identifiers for potential reconciliation.

Option	Submitted Qualifier	Submitted Patient ID	Response Qualifier(s)	Response Patient ID(s)
1	01 (SSN)	999-99-9999	01 (SSN)	888-88-8888
2	01 (SSN)	999-99-9999	18 (Evernorth Universal Patient Identifier (UPI))	ABC123
			09 (Medicare Beneficiary ID)	XYZ789
3	01 (SSN)	999-99-9999		

Additional Resources:

For more detailed use cases and recommendations, refer to the Universal Patient Identifier Guidance Document.

Added August 2025

3.28 Response Status Segment (21)

3.28.1 N Transaction – Medicare Part D Payer to Payer

Question: What values should be provided in the Response Status Segment for a Medicare Part D Payer to Payer response when the help desk support type is not needed in the N Transaction?

Answer:

- In the Mandatory Help Desk Support Type Count (C72-BH) provide a default value of 1.
- In the Mandatory Help Desk Support Type (C71-BG) provide a default value of 4 (Other Payer - N1 Reporting).
- In the Required Help Desk Business Unit Type Count (C67-BB) provide a default value of 1.
- In the Situational Help Desk Business Unit Type (C66-BA) provide a default value of 1 (Pharmacy Help Desk).
- In the Situational Help Desk Contact Information Qualifier (C70-BF) provide a default value of 1 (Telephone Number).
- In the Situational Help Desk Contact Information (C68-BC) provide a default value of 9999999999 or put your help desk phone number here.

Added February 2023

3.28.2 Reconciliation ID

Question: What should a pharmacy do if a Reconciliation ID (B98-34) is not returned on an F6 claim response and the pharmacy needs to submit a related reversal or COB claim?

Answer: The Reconciliation ID (B98-34) field in the Claim Segment of a reversal (B2) and the Other Payer Reconciliation ID (C49-9V) field on a COB transaction are intended to report the Reconciliation ID (B98-34) value from the related Claim Billing response. If the pharmacy does not receive the Reconciliation ID from a processor/payer on an F6 claim response, the pharmacy should populate a value of "NOTAVAILABLE" for any subsequent related transactions.

Payers/processors must be prepared to recognize a value of "NOTAVAILABLE" as a valid value, since a more specific value may not always be available for the pharmacy to submit on Telecommunication Standard VF6© transactions. Reject Code (511-FB) values DB1 (M/I Reconciliation ID) and DH6 (M/I Other Payer Reconciliation ID) should not be used when the valid value of "NOTAVAILABLE" is submitted.

The Reconciliation ID (B98-34) field in the Claim Segment of a reversal (B2) is required, and a pharmacy must submit the field: if the field is missing, the payer/processor should reject with Reject Code (511-FB) value DB1 (M/I Reconciliation ID). As outlined in the Telecommunication Standard Implementation Guide VF6© (section 30.1.3), when the processor is unable to locate the original approved transaction using the Reconciliation ID (B98-34) and Service Provider ID (201-B1), it is recommended that the secondary match criteria using legacy reversal matching fields be used.

Payers/processors who receive "NOTAVAILABLE" on a reversal of an F6 claim should check their claim responses to ensure that the Reconciliation ID field is being populated appropriately.

The Other Payer Reconciliation ID (C49-9V) field is situational, and a payer/processor may reject with Reject Code (511-FB) value DH6 (M/I Other Payer Reconciliation ID) if it is not submitted and the payer/processor requires the field to be sent.

Added December 2025

3.28.3 Reject Code

Question: What reject code should be used when a field from Version D.0, such as the Home Plan field (314-CE), is submitted on a Version F6 transaction where the field is no longer available?

Answer: Payers/processors should return **Reject Code R8 – Syntax Error** to indicate the submitted field is not available as part of Version F6. Payers/processors should also include the field in error in the Additional Message Information field (526-FQ) to help the submitter identify and correct the issue. For example:

- Reject Code: R8
- Secondary Message Field: Field xxx-yy (field name, if known) is not a valid Version F6 field. The value of xxx, is optional. For example, "Field 314-CE (Home Plan) is not a valid Version F6 field" or "Field 99 is not a valid Version F6 field"

While reject codes like 239 (Home Plan Is Not Used For This Transaction Code) or CE (M/I Home Plan) are appropriate for a field not used in a specific transaction type (e.g., E1) or a value being submitted in the field is missing or invalid as defined by NCPDP guidance, R8 is preferred when the field is no longer defined in the F6 implementation guide for any transactions and its presence constitutes a syntax violation, not a semantic one.

Note: This guidance should be agnostic to the presence of a value in the field. Whether the field is populated or blank, its inclusion in a version F6 transaction is inappropriate.

Added December 2025

3.29 Response Claim Segment (22)

3.30 Response Other Payers Segment (28)

3.30.1 Other Payer Names

Question: What payer name information should be returned in the Other Payer ID (340-7C) and Other Payer Name (D23-M5) fields within the Response Other Payers Segment and when should these fields be populated?

Answer: When only the payer name of the other payer is known, the payer name should be returned in at least the Other Payer ID (340-7C) field. This field supports up to 30 characters. Return the defined short name or abbreviated name where applicable, to support the field length. When the payer name is returned as the Other Payer ID (340-7C), the Other Payer ID Qualifier (339-6C) must be returned with the value of 10 – Payer Name. Returning the applicable values in these fields allows the receiving system to initiate other coverage technical and operational workflows.

The payer name can also be returned in the **Other Payer Name (D23-M5**) field. This field supports up to 70 characters. Return the defined full payer name, up to the first 70 characters, abbreviating when

necessary. When the Other Payer Name (D23-M50) is returned, the Other Payer ID (340-7C) should also be returned. The Other Payer ID (340-7C) may be the short payer name with Other Payer ID Qualifier (339-6C) value 10, the IIN with qualifier value 03 or any other valid Other Payer ID (340-7C) and Other Payer ID Qualifier (339-6C) combination. Returning other payer name information in Other Payer Name (D23-M5) supports any necessary discussion between the pharmacy and the patient.

Example 1: The known information about the other payer includes the payer name and cardholder ID

- The PBM/processor does not cover the product, and it is known to be covered under the medical benefit.
- PBM/processor returns the name of the medical benefit plan in the Other Payer ID (340-7C) and Other Payer Name (D23-M5) fields.

Excerpt from rejected response transaction:

RESPONSE STATUS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	M	*R*	Rejected
510-FA	REJECT COUNT	R	*1*	
511-FB	REJECT CODE	R	*817*	Pharmacy Benefit Exclusion, Covered Under Patient's Medical Benefit

RESPONSE OTHER PAYERS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*28*	RESPONSE OTHER PAYERS SEGMENT
355-NR	OTHER PAYER ID COUNT	M	*1*	One occurrence
338-5C	OTHER PAYER COVERAGE TYPE	M	*01*	Primary
D41-PQ	OTHER PAYER RELATIONSHIP TYPE	M	*MX*	Mutually Exclusive Benefits
D50-P6	OTHER PAYER BENEFIT CLASSIFICATION TYPE	M	*MEDICAL*	Medical Benefit
C47-9T	OTHER PAYER ADJUDICATED PROGRAM TYPE	M	*99*	Other
339-6C	OTHER PAYER ID QUALIFIER	Q	*10*	Payer Name – *Name of other payer*
340-7C	OTHER PAYER ID	Q	*ABC HEALTH PLAN*	Return up to 30 characters of the Payer

RESPONSE OTHER PAYERS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
				Name, this may be a defined short name or abbreviated name
D23-M5	OTHER PAYER NAME	Q	*ABC HEALTH PLAN OF XX STATE, COUNTY AND CITY IN YOUR NEIGHBORHOOD*	Return up to 70 characters of the full payer name
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	Q		
356-NU	OTHER PAYER CARDHOLDER ID	Q	ABC123456789	
992-MJ	OTHER PAYER GROUP ID	Q		

Example 2: PBM/processor has other payer IIN/PCN and other payer name information

- Patient's prescription benefits were transitioned to a new health plan, requiring new 4RX processing information.
- The PBM/processor rejects the claim and provides new 4RX information and the name of the new plan within the Response Other Payers Segment.

Excerpt from rejected response transaction:

RESPONSE STATUS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	M	*R*	Rejected
510-FA	REJECT COUNT	R	*1*	
511-FB	REJECT CODE	R	*69*	Date of Service After Coverage Terminated

RESPONSE OTHER PAYERS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*28*	RESPONSE OTHER PAYERS SEGMENT
355-NR	OTHER PAYER ID COUNT	M	*1*	One occurrence

RESPONSE OTHER PAYERS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
338-5C	OTHER PAYER COVERAGE TYPE	M	*01*	Primary
D41-PQ	OTHER PAYER RELATIONSHIP TYPE	M	*CC*	Change in Coverage
D50-P6	OTHER PAYER BENEFIT CLASSIFICATION TYPE	M	*RX*	Prescription Benefit
C47-9T	OTHER PAYER ADJUDICATED PROGRAM TYPE	M	*3*	Commercial
339-6C	OTHER PAYER ID QUALIFIER	R	*03*	BIN/IIN
340-7C	OTHER PAYER ID	R	*12345600*	
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	Q	*OTHERPCN*	
356-NU	OTHER PAYER CARDHOLDER ID	Q	*19896351981*	
992-MJ	OTHER PAYER GROUP ID	Q	*HVE1835*	
D23-M5	OTHER PAYER NAME	Q	*HEALTH VALUE EQUITY PLAN*	This is the name of the other payer (up to 70 characters).

Added February 2024

3.30.2 Adjudicated Program Type (A28-ZR)

Question: Which Adjudicated Program Type value(s) should a pet insurance or pet discount program return on a claim response?

Answer: If the claim processes under an insurance policy meeting the definition of pet insurance provided by the National Association of Insurance Commissioners (NAIC), then an adjudicated program type of "42 – Pet Insurance" should be returned. If the claim processes under a discount program, then an adjudicated program type of "5 – Self-Pay: Discount Program" should be returned.

Added August 2024

Question: When is it appropriate to return the Adjudicated Program Type (A28-ZR) value of "Unknown" on a claim response?

Answer: The Adjudicated Program Type (A28-ZR) field is required on paid, duplicate paid, captured, and duplicate captured responses. The Adjudicated Program Type value of 9 – "Unknown" can only be returned on a rejected response transaction when the reject occurs before the Adjudicated Program Type value can be determined (refer to ECL value limitation). The following are examples where the claim may reject prior to program type evaluation:

1. 05 – M/I Service Provider Number (this refers to the Service Provider ID (201-B1) in the header segment)
2. 07 – M/I Cardholder ID

In the following examples, it would **NOT** be appropriate to return an Adjudicated Program Type (A28-ZR) of Unknown as the program type should have been determined:

1. 75 – Prior Authorization Required
2. 76 – Plan Limitations Exceeded

Added August 2024; Updated May 2025

Question: How and when should the following adjudicated program type fields be used in the Telecommunication Standard Version F6© transactions?

- ADJUDICATED PROGRAM TYPE (A28-ZR)
- REPORTED ADJUDICATED PROGRAM TYPE (A29-ZS)
- OTHER PAYER ADJUDICATED PROGRAM TYPE (C47-9T)
- N PAYER ADJUDICATED PROGRAM TYPE (C48-9U)

Answer: The Adjudicated Program Type fields are used in both transaction requests and responses to describe the type of program that has or would adjudicate the claim transaction if submitted. The following tables and additional details list the use of these distinct fields by Transaction Code (103-A3) within the Telecommunication Standard vF6© request and response transactions.

Transaction Requests

The following fields are used in transaction requests, and the associated values are listed under the "Adjudicated Program Type" ECL Shared Code List.

Segment	Field	Field Name	Field Definition	Eligibility **(E1)**	Claim/Service Billing **(B1/S1)**	Information Reporting (Claim/Service) **(N1)**	Information Reporting Reversal (Claim/Service) **(N2)**
Claim	A29-ZS	Reported Adjudicated Program Type	The type of prescription benefit plan/program under which the reported claim adjudicated.		RM		
Coordination of Benefits/Other Payments	C47-9T	Other Payer Adjudicated Program Type	The type of prescription benefit plan/program associated with the Other Payer.		Q	Q	

N Transaction Payer Identification	C48-9U	N Payer Adjudicated Program Type	The type of prescription benefit plan/program under which the claim was adjudicated.			Q	Q

Additional Details for Adjudicated Program Type Request Fields:

- **REPORTED ADJUDICATED PROGRAM TYPE (A29-ZS)**
  - **Required for subrogation claims only**
  - Contains the value returned in Adjudicated Program Type (A28-ZR) of the original payer's response

- **OTHER PAYER ADJUDICATED PROGRAM TYPE (C47-9T)**
  - This field may be sent to a *downstream* payer in the COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT based on what a primary payer has returned in the ADJUDICATED PROGRAM TYPE field as part of the response transaction

- **N PAYER ADJUDICATED PROGRAM TYPE (C48-9U)**
  - This field may be sent in the N TRANSACTION PAYER IDENTIFICATION SEGMENT to report the Adjudicated Program Type of the initial payer

Transaction Responses

The following fields are used in response transactions, and the associated values are listed under the "Adjudicated Program Type Shared Code List".

Segment	Field	Field Name	Field Definition	Eligibility **(E1)**	Claim/Service Billing **(B1/S1)**	Information Reporting (Claim/Service) **(N1)**	Information Reporting Reversal (Claim/Service) **(N2)**
Response Status	A28-ZR	Adjudicated Program Type	The type of prescription benefit plan/program under which the claim was adjudicated.	N	R	N	
Response Other Payers	C47-9T	Other Payer Adjudicated Program	The type of prescription benefit	M	M		

		Type	plan/program associated with the Other Payer.				

Additional Details for the Adjudicated Program Type Response Fields:

- **ADJUDICATED PROGRAM TYPE (A28-ZR)**
  - **Required** to be returned by a payer/processor in the RESPONSE STATUS segment on all claim/service billing transaction (B1/S1) responses.
  - The most descriptive program type value must be returned when known by the responding entity.

    Ex: The value of "Medicare" should not be returned if the responding entity knows that the prescription benefit plan under which the claim was adjudicated is a Medicare Part D PDP plan.
  - On Paid, Duplicate Paid, and Captured responses, "UNKNOWN" or "OTHER" must not be used for federal programs as defined in Section 1128B(B) of the Social Security Act.

    The value of "UNKNOWN" may be returned on a rejected response when the actual Adjudicated Program Type could not yet be determined.

- **OTHER PAYER ADJUDICATED PROGRAM TYPE (C47-9T)**
  - When the RESPONSE OTHER PAYERS SEGMENT is sent, this field is ***mandatory*** on all eligibility (E1) and claim/service billing transaction (B1/S1) responses.

    The Response Other Payers Segment is situational for an Eligibility Verification, Claim Billing, and Service Billing response when other insurance information is available and when the Header Response Status (501-F1) of "A" (Accepted) and Transaction Response Status (112-AN) of "A" (Approved) or "R" (Rejected) is returned.
  - The Other Payer Adjudicated Program Type (C47-9T) may be repeated:
    - Nine times in the E1
    - Four times in the B1 and S1

Added August 2024; Updated May 2025

3.30.3 Other Coverage Information is Known

Question: How should a payer populate the Response Other Payers segment when other coverage information is known?

Answer: A payer should include information regarding other payers that will assist the pharmacy in submitting the claim to all coverages. In the scenario where the responding payer is rejecting the claim with Reject Code 41 (Submit Bill To Other Processor Or Primary Payer) because of known other coverage, the payer should populate all available information for the previous payer. The responding payer should also include any known information for additional payers.

The following shows the Response Other Payers Segment and how it may be populated to identify the primary coverage that must be submitted as well as supplemental coverage that may be available.

Excerpt from Rejected Response

RESPONSE STATUS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*21*	RESPONSE STATUS SEGMENT
112-AN	TRANSACTION RESPONSE STATUS	M	*R*	Reject
510-FA	REJECT COUNT	R	*1*	One Occurrence
511-FB	REJECT CODE	R	*41*	Submit Bill to Other Processor or Primary Payer
C72-BH	HELP DESK SUPPORT TYPE COUNT	M	*1*	One Occurrence
C71-BG	HELP DESK SUPPORT TYPE	M	*1*	Pharmacy
C67-BB	HELP DESK BUSINESS UNIT TYPE COUNT	R	*1*	One Occurrence
C66-BA	HELP DESK BUSINESS UNIT TYPE	Q	*1*	Pharmacy Help Desk
C70-BF	HELP DESK CONTACT INFORMATION QUALIFIER	Q	*1*	Phone Number
C68-BC	HELP DESK CONTACT INFORMATION	Q	*5558176543*	
A28-ZR	ADJUDICATED PROGRAM TYPE	R	*3*	Commercial

RESPONSE OTHER PAYERS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
111-AM	SEGMENT IDENTIFICATION	M	*28*	RESPONSE OTHER PAYERS SEGMENT
355-NT	OTHER PAYER ID COUNT	M	*3*	Three occurrences
338-5C	OTHER PAYER COVERAGE TYPE	M	*01*	Primary
D41-PQ	OTHER PAYER RELATIONSHIP TYPE	M	*CP*	COB Coverage Prior To Responding Payer

RESPONSE OTHER PAYERS SEGMENT				
FIELD	**FIELD NAME**	**CAT**	**VALUE**	**COMMENTS**
D50-P6	OTHER PAYER BENEFIT CLASSIFICATION TYPE	M	*RX*	Prescription Benefit
C47-9T	OTHER PAYER ADJUDICATED PROGRAM TYPE	M	*3*	Commercial
339-6C	OTHER PAYER ID QUALIFIER	R	*03*	BIN/IIN for first occurrence
340-7C	OTHER PAYER ID	Q	*99999900*	Primary Payer's IIN
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	Q	*ABC123*	Primary Payer's PCN
356-NU	OTHER PAYER CARDHOLDER ID	Q	*998877665*	Known ID for Cardholder for the primary payer.
338-5C	OTHER PAYER COVERAGE TYPE	M	*02*	Secondary
D41-PQ	OTHER PAYER RELATIONSHIP TYPE	M	*RP*	Responding Payer
D50-P6	OTHER PAYER BENEFIT CLASSIFICATION TYPE	M	*RX*	Prescription Benefit
C47-9T	OTHER PAYER ADJUDICATED PROGRAM TYPE	M	*3*	Commercial
339-6C	OTHER PAYER ID QUALIFIER	R	*03*	BIN/IIN for first occurrence
340-7C	OTHER PAYER ID	Q	*12345600*	Responding Payer's IIN
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	Q	*ZYX456*	Responding Payer's PCN
356-NU	OTHER PAYER CARDHOLDER ID	Q	*51681591069*	Responding payer's cardholder ID
992-MJ	OTHER PAYER GROUP ID	Q	*543210*	Responding Payer's Group ID
338-5C	OTHER PAYER COVERAGE TYPE	M	*03*	Tertiary
D41-PQ	OTHER PAYER RELATIONSHIP TYPE	M	*CS*	COB Coverage Subsequent To Responding Payer
D50-P6	OTHER PAYER BENEFIT CLASSIFICATION TYPE	M	*RX*	Prescription Benefit

RESPONSE OTHER PAYERS SEGMENT				
FIELD	FIELD NAME	CAT	VALUE	COMMENTS
C47-9T	OTHER PAYER ADJUDICATED PROGRAM TYPE	M	*6*	Manufacturer Sponsored Patient Pay Reduction Program
339-6C	OTHER PAYER ID QUALIFIER	R	*10*	Payer Name for subsequent coverage
340-7C	OTHER PAYER ID	Q	*XYZ MFR COPAY CARD*	Payer Name

Note:

- Responding payer information may be omitted from the Response Other Payers Segment as the pharmacy already has the information on file.
- Responding payer is aware of an existing copay assistance program for the drug being billed but does not have the specific information.

Added November 2024

3.31 Response Pricing Segment (23)

3.31.1 Regulatory Fee Exempt Indicator (D62-RM)

Question: If there is a value populated in Regulatory Fee Exempt Indicator (D62-RM), is the expectation that the payer would send a $0 amount in the Regulatory Fee Amount Paid (558-AW)?

Answer: Per the Telecommunication Standard Implementation Guide Version F6©, Section 29 Pricing Guidelines (Claim/Service), if a value greater than zero is submitted in the Regulatory Fee Amount Submitted (481-HA) field, then a value must be returned in the Regulatory Fee Amount Paid (558-AW) field. In the situation where a value is returned in the Regulatory Fee Exempt Indicator (D62-RM) field indicating the claim is regulatory fee exempt, zero would be returned as the Regulatory Fee Amount Paid (558-AW).

Added November 2024

3.31.2 Regulatory Fee Amount Paid (558-AW)

Question: If a value greater than $0 is returned in the Regulatory Fee Amount Paid (558-AW) and the Regulatory Fee Exempt Indicator (D62-RM) is populated, should the value in the Regulatory Fee Amount Paid (558-AW) be ignored and the Regulatory Fee Exempt Indicator (D62-RM) value take precedence?

Answer: If a value greater than zero is returned in Regulatory Fee Amount Paid (558-AW), this amount would be included in the final reimbursement as reflected in the Response Pricing Formula. Any conflict in values returned in the Regulatory Fee Amount Paid (558-AW) and Regulatory Fee Exempt Indicator (D62-RM) should be addressed through Trading Partner Agreements.

Added November 2024

3.31.3 Benefit Stage Indicator (C51-9X)

Question: Under the descriptions for Benefit Stage Indicator (C51-9X) values 50 and 51, does the term "Medicare health plans" apply to all Medicare programs that offer Part B benefits?

- Benefit Stage Indicator value 50: Paid under the Part B benefit of the Medicare health plan
- Benefit Stage Indicator value 51: Paid under the Part B benefit of the Medicare health plan for a QMB dual eligible beneficiary. Pharmacy should not attempt to collect cost-share but instead should attempt to bill COB to Medicaid coverage.

Answer: Yes, the term "Medicare health plans" apply to all Medicare programs that offer Part B benefits. The descriptions for Benefit Stage Indicator (C51-9X) values 50 and 51 are intended to apply to Managed Medicare health plans (e.g., MA (Medicare Advantage), MAPD (Medicare Advantage Prescription Drug plan)). However, when applicable, Medicare Part B Fee-for-Service (FFS) processors using NCPDP Telecommunication claims may also return these values to alert the pharmacy when an NCPDP COB claim should be submitted to the Medicaid plan, due to the Medicaid plan not supporting cross-over claims.

Added May 2025

3.32 Response DUR/PPS Segment (24)

3.32.1 DUR/DUE Free Text Message (544-FY)

Question: For the Response DUR/PPS Segment on a Claim Billing or Encounter transaction (B1), is the field DUR/DUE Free Text Message (544-FY) allowed to be sent without a Reason For Service Code (439-E4) or any other associated fields in the initial loop of a DUR/PPS Response?"

Answer: No, the DUR/DUE Free Text Message (544-FY) must be sent with a Reason for Service Code (439-E4). Refer to the NCPDP Telecommunication Standard Version F6© which lists the Reason for Service Code (439-E4) as a required field in the Response DUR/PPS Segment if a utilization conflict is detected.

Added August 2025

Question: Does the DUR/DUE Free Text Message (544-FY) field allow for 9 repetitions of 360 bytes each, or is it 9 repetitions for 360 bytes total?

Answer: In the NCPDP Telecommunication Standard Version F6©, the DUR/DUE Free Text Message (544-FY) field is a component of a logical grouping which supports up to nine repetitions. Within each of these repetitions, 544-FY allows up to 360 bytes of messaging. This structure is designed to accommodate multiple Drug Utilization Review (DUR) occurrences within a single claim response.

In total, this could theoretically result in up to 3,240 bytes of free text messaging if all nine repetitions are utilized at their maximum length. While this capacity allows for detailed messaging, it also introduces potential challenges for processors, pharmacy systems, and downstream entities in terms of data storage, display, and user accessibility. Some pharmacy systems may truncate messages, require additional navigation to view full content, or may not display all messages in a user-friendly manner.

To improve clarity and streamline processing, processors are encouraged to minimize the use of free-text messaging whenever possible. Instead, processors should utilize the new structured fields available within the DUR/PPS Response Segment in the Telecommunication Standard Version F6©, which clearly

organizes alert information, making it easier for pharmacy systems and staff to quickly understand and act on the data. These fields include, but are not limited to:

- DUR/DUE Co-Agent ID Qualifier (475-J9)
- DUR/DUE Co-Agent ID (476-H6)
- DUR/DUE Co-Agent Description (E93-ZC)
- Other Prescriber & Pharmacy Information (various fields)
- Minimum/Maximum Limitations (various fields)

Additionally, it is recommended that processors optimize and streamline DUR messaging to ensure clarity and usability. Specifically, refer to Section *27.1.8.2.1, "The Problem of Noise"* in the NCPDP Telecommunication Standard VF6©, which provides best practices for maintaining relevant and concise messaging.

Key recommendations include:
- Prioritize and return the **most clinically significant alerts** in order of importance.
- **Minimize duplication** of DUR alerts.
- **Reduce false positives** where possible.

Ensure that free text messages are **clear, concise, and easily interpretable**, avoiding overly cryptic language.

Added December 2025

3.32.2 DUR Alerts

Question: How can a payer communicate to a pharmacy that more than 9 DUR alerts apply to a claim, what should be considered and how can the pharmacy resolve the alerts?

Answer: Per the Telecommunication Standard VF6©, "If more than nine Reasons for Service occur, it is recommended the ninth repetition of the Reason for Service Code (439-E4) and all repeating fields that follow be used to notify the provider to Call Help Desk ("CH")."

Considerations:
Payers should consider the following to ensure simplicity and timely patient access to care:

- Select the most appropriate Reject Code (511-FB) based on the availability of an override at point-of-sale.
  - Overridable at POS
    - DO5 – DUR Conflict. Limited override allowed at pharmacy. Thereafter, a prior authorization may be required
    - 88 – DUR Reject Error
  - Not Overridable at POS. PA Required
    - 943 – DUR Reject - Pharmacy Override Using DUR/PPS Not Allowed
    - 75 – *Prior Authorization Required*, in lieu of a DUR-related Reject Code (511-FB) value

Note: Reject code 943 may also be returned with the relevant Reason for Service Code values as additional information that can be provided to the prescriber when completing the prior authorization.

- Reason for Service Code (439-E4) values should be returned in rank order based on the Clinical Significance Code (528-FS) with the highest clinical significance being returned first.
- Payers may opt to avoid using Reason for Service Code (439-E4) value CH – *Call Help Desk* by:
  - Limiting their systems to return no more than 9 DUR alerts, particularly if alerts beyond the 9th are of low clinical significance.
  - Returning the first 9 Reason for Service codes for resolution, then returning additional Reason for Service codes on subsequent claim attempts (assuming prior codes were resolved) until all Reason for Service codes have been resolved. *Note: it is recommended that only high clinical significance codes be returned if this option is leveraged.*
- Review relevant sections of the Telecommunication Standard Version F6©
  - Section 27.1.8.2 "*The Problem of Noise*" for additional information on effective communication of DUR alerts, which indicates a multitude of ways to reduce the number of alerts, thereby reducing the likelihood of more than nine DUR alerts being applicable.
  - Section 6.26 Coverage of a Duplicate Therapy Interaction

Resolving Reject Code (511-FB) values DO5 or 88 when Reason for Service Code (439-E4) value CH is also returned

When the pharmacy receives Reason for Service Code (439-E4) value CH – *Call Help Desk*, the pharmacy should call the payer/processor help desk to identify the remaining Reason for Service Codes and descriptions. Using this information, the pharmacist can determine how best to address all DUR alerts applicable to the claim. If the pharmacist determines that dispensing the product is appropriate, the payer/processor help desk will communicate how to resolve the DUR conflict at POS. *Note: How the payer arrives at this decision is up to their own internal processes but should be looking at all the alerts/factors to arrive at that decision. Override of the DUR rejection does not require the payer to return a paid response, other rejections may still apply.* These could include:

- Payer-side resolution: After discussion with the Pharmacist, the Payer Help Desk may apply a POS override, allowing the claim to pass the DUR validation step. The pharmacy would then need to resubmit the claim.

- Pharmacy-side resolution: After discussion with the Pharmacist, the Payer Help Desk may provide an authorization number to the Pharmacist, allowing the claim to pass the DUR validation step. The pharmacy would need to resubmit the claim with this authorization number in the Prior Authorization ID Submitted (462-EV) field.

The pharmacy should not be required to override the Reason for Service Code (439-E4) value CH – *Call Help Desk*. This value is an administrative code and is used to communicate that additional Reason for Service Code values apply. However, the payer or processor should not reject a subsequent claim submission solely because it includes or omits Reason for Service Code CH and/or the associated Professional Service Code and Result of Service code.

Added December 2025

3.33 Response Prior Authorization Segment (26)

3.34 Response Intermediary Segment (36)

3.35 Response Other Related Benefit Detail Segment (39)

3.36 Response Provider Segment (40)

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3.37 Coordination of Benefits Information

3.37.1 Other Payer Amount Paid Qualifiers (342-HC) For S1 (Service Billing) COB

Question: How should the pharmacy populate the Other Payer Amount Paid (431-DV) field for Other Payer Amount Paid Qualifier (342-HC) value = 06 – Cognitive/Professional Service for the S1 transaction?

Answer: There is no direct mapping from an S1 response pricing field to report the Other Payer Amount Paid Qualifier (342-HC) value of 06 - Cognitive/Professional Service. The Other Payer Amount Paid (431-DV) price for Cognitive/Professional Service is a calculated amount, similar to how Drug Benefit is calculated for a COB B1 claim request.

To accurately report the amounts paid in the Other Payer Amount Paid field (431-DV) in a COB Other Payer Coverage Type occurrence for S1 service billing, a specific order of Other Payer Amount Paid Qualifiers (342-HC) must be followed.

- Order is based on the payment being associated to provider versus state revenue, the professional service (e.g., cognitive service) and any value-added services (i.e., delivery, administrative).
- Cognitive/Professional Service (Other Payer Amount Paid Qualifier (342-HC) value 06) is the end result, after all Other Payer Amount Paid values are subtracted from Total Amount Paid (509-F9).
- Note: The following Other Payer Amount Paid Qualifier (342-HC) values are not applicable to S1 COB billing, as the associated response pricing fields are not used in the S1 transaction, and 07-Drug Benefit is a calculated amount specific to B1 claim billing transaction.
    - 02: Shipping
    - 03: Postage
    - 05: Incentive
    - 07: Drug Benefit

OTHER PAYER AMOUNT PAID QUALIFIER (342-HC) VALUE 06 = COGNITIVE/PROFESSIONAL SERVICE CALCULATION

Total Amount Paid (509-F9)

- Percentage Tax Amount Paid (559-AX)
- Regulatory Fee Amount Paid (558-AW)
- Other Amount Paid (565-J4), Other Amount Paid Qualifier (564-J3) value 01 = Delivery Cost
- Other Amount Paid (565-J4), Other Amount Paid Qualifier (564-J3) value 04 = Administrative Cost

= Cognitive/Professional Service

The following table reflects the specific vF6 fields from the prior payer claim response that would be used to populate the applicable Other Payer Amount Paid Qualifier (342-HC) values in the vF6 S1 COB service billing request transaction.

vF6 S1 Response Field	**vF6 S1 Response Field Qualifier**	**vF6 S1 COB Request Other Payer Amount Paid Qualifier (342-HC) value reported with the associated Other Payer Amount Paid (341-DV) dollar amount**
509-F9 Total Amount Paid		
- (559-AX Percentage Tax Amount Paid – C93-KN Patient Pay Component Amount)	C95-KQ Patient Pay Component Qualifier (03) Percentage Tax	342-HC OPAP Qualifier = (15) Percentage Tax
- (558-AW Regulatory Fee Amount Paid – C93-KN Patient Pay Component Amount)	C95-KQ Patient Pay Component Qualifier (17) Regulatory Fee	342-HC OPAP Qualifier = (12) Regulatory Fee
- 565-J4 Other Amount Paid	564-J3 Other Amount Paid Qualifier (01) Delivery Cost	342-HC OPAP Qualifier = (01) Delivery Cost
- 565-J4 Other Amount Paid	564-J3 Other Amount Paid Qualifier (04) Administrative Cost	342-HC OPAP Qualifier = (04) Administrative Cost
= Cognitive Service		342-HC OPAP Qualifier = (06) Cognitive/Professional Service

Added August 2025

3.37.2 Payer-to-Payer COB

Question: What is payer-to-payer coordination of benefits?

Answer: Payer-to-payer coordination of benefits is described in the NCPDP Telecommunication Standard© Section 3.2.2 as the two-way communication between adjudicators. There are two examples of payer-to-payer scenarios mentioned:

- Medicare Crossover – Medicare crossover process does not utilize NCPDP transactions to bill downstream payers.
- Information Reporting Transactions – Information Reporting is an NCPDP-defined transaction that may be payer-to-payer.

Other examples of payer-to-payer coordination of benefits include:

- Subrogation, a process with its own implementation guide using the NCPDP Telecommunication Standard© detail transaction and the NCPDP Batch Standard©
- Financial information reporting, a process with its own implementation guide, NCPDP Financial Information Reporting Standard©

Added December 2025

3.38 Insulin Administration – Delivery Device

Question: What claim billing data elements can be used to communicate the delivery device method for rapid-acting insulin claims and assist in determining the appropriate Medicare benefit under which the claim should adjudicate?

Answer: The External Code List© (ECL) values below have been created for use with existing ECL values to support a standardized point of service process to communicate insulin delivery device method information when necessary.

Reason for Service Code (439-E4):

One new Reason for Service Code (439-E4) has been created for the payer to return on a rejected response, indicating the insulin delivery device method is needed.

- MD - Medication Delivery Device Method Required
  Code indicating that a payer/processor requested information related to the delivery device method of the dispensed drug
  Value Limitation: Not Used in Real Time Prescription Benefit Standard

Professional Service Code (440-E5):

One new Professional Service Code (440-E5) value has been created to support emergency situations when the insulin delivery device method cannot be confirmed.

- UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access
  Code indicating the delay to confirm the medication delivery device method would compromise patient therapy.

Note, there are other existing Professional Service Code (440-E5) values that can be used for the pharmacy to indicate the source of the insulin delivery method information.

Result of Service Code (441-E6):

Three new Result of Service Code (441-E6) values have been created for the pharmacy to communicate the insulin delivery device method of the dispensed insulin product.

- 5A – DME Pump Delivery Device Method
  Dispensed drug is being administered via durable medical equipment (DME) pump. DME is defined by Medicare as medically necessary, reusable medical equipment
- 5B - Non-DME or Disposable Delivery Device Method
  Dispensed drug is being administered via non-durable medical equipment (DME) pump or some other disposable mechanism. Examples of these products may include disposable pumps, pens, needles/syringes.
- 5C – Unknown Delivery Device Method and Immediate Access Required
  Medication delivery device method of dispensed drug is unknown, not defined on the prescription. Patient requires immediate access to medication.

Approved Message Code (548-6F):

One new Approved Message Code (548-6F) value has been created for the payer to communicate on a Paid claim response when the Result of Service Code value for Unknown Delivery Device Method and Immediate Access Required has been accepted under an exception.

- 062 - Submitted claim indicates Unknown Delivery Device Method; may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills.

Pharmacies could pro-actively submit an applicable Result of Service Code (441-E6) value to identify the insulin delivery device method, as the information may be mapped from an e-prescription to the B1 claim request. Refer to the SCRIPT Implementation Recommendations document for more information about how prescribers can communicate the insulin delivery device method information on an eRX using the current and future versions of the SCRIPT Standard.

If the information is not on the submitted claim and is necessary for the payer to complete the claim adjudication process, payers can initiate the point of service communication process using the specified ECL values as outlined below.

Refer to the Insulin Delivery Device Method DUR Code Set Sample Matrices at the end of this FAQ for a combination of Reason for Service (439-E4), Professional Service (440-E5) and Result of Service Code (441-E6) code values that could be submitted on the request.

POINT OF SERVICE CLAIMS PROCESSING GUIDANCE BASED ON MEDICARE PLAN TYPE

PDP - Prescription Drug Plan (Part D Benefit ONLY, No Part B)

1. Rapid-acting insulin claim submitted
2. If Patient Residence Code = 3 (Nursing Facility) or 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities), regardless of the insulin delivery device method, claim continues to adjudicate under the PDP benefit.
3. All other Patient Residence Codes, or Patient Residence Code not submitted, and the Result of Service Code (441-E6) field does not contain one of the new insulin delivery device method values, the claim may reject as follows:
    i. Reject Code (511-FB): 88 – *DUR Reject Error*
    ii. Reason For Service Code (439-E4): MD - *Medication Delivery Device Method Required*
    iii. Additional Message Information (526-FQ) indicating claim should be submitted with an appropriate Result of Service Code (441-E6) value to identify the insulin delivery device method
4. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of MD – *Medication Delivery Device Method Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
    i. 5A - *DME Pump Delivery Device Method*
        - Payer Response: Claim rejects with Reject Code (511-FB): A6 – *This Product/Service May Be Covered Under Medicare Part B*
    ii. 5B- *Non-DME or Disposable Delivery Device Method*

- Payer Response: Claim continues to adjudicate under the PDP benefit

iii. 5C - *Unknown Delivery Device Method and Immediate Access Required*

- Payer Response: Claim continues to adjudicate under the PDP benefit
  - If final status is a Paid claim, plan to return Approved Message *Code* (548-6F) *062 - Submitted claim indicates Unknown Delivery Device Method; may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills*

5. If required, Pharmacy includes one of the below Professional Service Code (440-E5) values:
   i. M0 - Prescriber consulted
   Communication with prescriber related to collection of information or clarification of a drug therapy concern
   ii. P0 - Patient consulted
   Consultation with the patient to clarify or collect additional information
   iii. R0 - Pharmacist consulted other source
   Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern
   iv. UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access
   Code indicating the delay to confirm the medication delivery device method would compromise patient therapy

MA Only - Medicare Advantage (Part B Benefit ONLY, No Part D)

1. Rapid-acting insulin claim submitted
2. If Patient Residence Code = 3 (Nursing Facility) or 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities), regardless of the insulin delivery device method, claim rejects with Reject Code (511-FB) value 620 – *This Product/Service May Be Covered Under Medicare Part D*
3. All other Patient Residence Codes, or Patient Residence Code not submitted, and the Result of Service Code (441-E6) field does not contain one of the new insulin delivery device method values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*
   ii. Reason For Service Code (439-E4): MD - *Medication Delivery Device Method Required*
   iii. Additional Message Information (526-FQ) indicating claim should be submitted with an appropriate Result of Service Code (441-E6) value to identify the insulin delivery device method.
4. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of MD – *Medication Delivery Device Method Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
   i. 5A - *DME Pump Delivery Device Method*
   - Payer Response: Claim continues to adjudicate under the MA Only benefit

ii. 5B - *Non-DME or Disposable Delivery Device Method*
- Payer response: Claim rejects with Reject Code (511-FB): 620 – *This Product/Service May Be Covered Under Medicare Part D*

iii. 5C - *Unknown Delivery Device Method and Immediate Access Required*
- Payer Response: Claim continues to adjudicate under the MA Only benefit
  - If final status is a Paid claim, plan to return Approved Message Code (548-6F): 062 - *Submitted claim indicates Unknown Delivery Device Method; may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills.*

5. If required, Pharmacy includes one of the below Professional Service Code (440-E5) values:
   i. M0 - Prescriber consulted
   Communication with prescriber related to collection of information or clarification of a drug therapy concern
   ii. P0 - Patient consulted
   Consultation with the patient to clarify or collect additional information
   iii. R0 - Pharmacist consulted other source
   Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern
   iv. UA- Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access.
   Code indicating the delay to confirm the medication delivery device method would compromise patient therapy

MAPD – Medicare Advantage Prescription Drug (Part B+D BENEFITS)

1. Rapid-acting insulin claim submitted
2. If Patient Residence Code = 3 (Nursing Facility) or 9 (Intermediate Care Facility/Individuals with Intellectual Disabilities), the claim should continue to adjudicate under the Part D benefit regardless of the insulin delivery device method
3. All other Patient Residence Codes, or Patient Residence Code not submitted, and the Result of Service Code (441-E6) field does not contain one of the new insulin delivery device method values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*
   ii. Reason For Service Code (439-E4): MD - *Medication Delivery Device Method Required*
   iii. Additional Message Information (526-FQ) indicating claim should be submitted with an appropriate Result of Service Code (441-E6) value to identify the insulin delivery device method.
4. Pharmacy resubmits claim with one of the below Result of Service Code values:
   i. 5A - *DME Pump Delivery Device Method*
      - Payer Response: Claim continues to adjudicate under the MAPD Part B benefit

ii. 5B - *Non-DME or Disposable Delivery Device Method*
   - Payer Response: Claim continues to adjudicate under the MAPD Part D benefit

iii. 5C - *Unknown Delivery Device Method and Immediate Access Required*
   - Claim routed to applicable plan benefit based on plan setup
     - If final status is a Paid claim, plan to return Approved Message Code 062 - *Submitted claim indicates Unknown Delivery Device Method; may be flagged for retrospective review. Result of Service Code (441-E6) value of 'Unknown Delivery Device Method and Immediate Access Required' may not be supported on future fills.*

5. If required, Pharmacy resubmits claim with one of the below Professional Service Code (440-E5) values:
   i. M0 - Prescriber consulted
   Communication with prescriber related to collection of information or clarification of a drug therapy concern
   ii. P0 - Patient consulted
   Consultation with the patient to clarify or collect additional information
   iii. R0 - Pharmacist consulted other source
   Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern
   iv. UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access
   Code indicating the delay to confirm the medication delivery device method would compromise patient therapy

Insulin Delivery Device Method DUR Code Set Sample Claim Request Matrices

Scenario	Request: Reason for Service Code (439-E4)	Professional Service Code (440-E5)	Result of Service Code (441-E6)
Pharmacy Proactively Submits Medication Delivery Device Method	–	M0 - Prescriber Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Pharmacy Proactively Submits Medication Delivery Device Method	–	P0 - Patient Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Pharmacy Proactively Submits Medication Delivery Device Method	–	R0 - Pharmacist Consulted Other Source	5A - DME Pump Delivery Device Method, or 5B- Non-DME or Disposable Delivery Device Method
Pharmacy Proactively Submits Medication Delivery Device Method	–	UA - Unable to Confirm Medication Delivery Device	5C - Unknown Delivery Device Method and Immediate Access Required

		Method and Patient Requires Immediate Access	
Pharmacy Proactively Submits Medication Delivery Device Method	MD - Medication Delivery Device Method Required	M0 - Prescriber Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Pharmacy Proactively Submits Medication Delivery Device Method	MD - Medication Delivery Device Method Required	P0 - Patient Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Pharmacy Proactively Submits Medication Delivery Device Method	MD- Medication Delivery Device Method Required	R0 - Pharmacist Consulted Other Source	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Pharmacy Proactively Submits Medication Delivery Device Method	MD - Medication Delivery Device Method Required	UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access	5C - Unknown Delivery Device Method and Immediate Access Required
Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required	MD - Medication Delivery Device Method Required	M0 - Prescriber Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required	MD - Medication Delivery Device Method Required	P0 - Patient Consulted	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required	MD - Medication Delivery Device Method Required	R0 - Pharmacist Consulted Other Source	5A - DME Pump Delivery Device Method, or 5B - Non-DME or Disposable Delivery Device Method
Plan Returns Reject 88 - DUR Error with Reason for Service Code XX - Medication Delivery Device Method Required	MD - Medication Delivery Device Method Required	UA - Unable to Confirm Medication Delivery Device Method and Patient Requires Immediate Access	5C - Unknown Delivery Device Method and Immediate Access Required

Added August 2024

4. BEST PRACTICES SECTION

4.1. COB Section

4.1.1. Patient Pay Component Qualifier when Patient Pay Amount is Zero

Question: Because the Patient Pay Component fields are required in a paid response transaction, when the Patient Pay Amount (505-F5) being returned is zero what Patient Pay Component Qualifier (C95-KQ) should be sent?

Answer: In the situation where the Patient Pay Amount (505-F5) being returned is zero, the payer/processor should return the Patient Pay Component Qualifiers (C95-KQ) that best reflect the plan benefit design. For example, if the standard benefit utilizes copay, then the Patient Pay Component Qualifier (C95-KQ) returned in the response transaction should be '05 – Amount of Copay'. If the plan design contains multiple components, the payer may return all applicable component qualifiers. See examples below:

Plan Benefit Design	Patient Pay Component Qualifier Values	Patient Pay Component Amount (Sum of components = 0)
Flat Copay	05 – Amount of Copay	$0.00
Percentage Coinsurance	07 – Amount of Coinsurance	$0.00
Deductible Plus Coinsurance	01 – Amount Applied to Periodic Deductible 07 – Amount of Coinsurance	$0.00 $0.00
Deductible Plus Coinsurance Plus Health Plan Funded Assistance – Health Reimbursement Account (HRA)	01 – Amount Applied to Periodic Deductible 07 – Amount of Coinsurance 09 – Amount Attributed to Health Plan Assistance Amount	$50.00 $22.21 -$72.21

5. GENERAL SECTION ON FIELDS

5.1 Dollar Amounts

Question: Does a payer/processor have to accept a dollar amount up to $999,999,999.99?

Answer: A receiver must be able to accept field values up to the limit defined by the standard. Significant digits of submitted values should not be truncated; see section 7.7.3 and section 7.7.3.1 of the Telecommunication Implementation Guide. If the processor cannot support a dollar amount up to the defined limit, the processor should reject the claim with reject code 945 - High Dollar Amount Is Not Supported. Additionally, the processor should return a message to the pharmacy identifying the field in error and provide further guidance to the pharmacy of alternate methods of submitting the claim.

6. BATCH STANDARD SUBROGATION IMPLEMENTATION GUIDE

6.1 Cardholder ID (302-C2) and Medicaid ID Number (115N5) use in Subrogation

Question: How are Cardholder ID (302-C2) and Medicaid ID Number (115-N5) used within the Batch Standard Subrogation detail transaction?

Answer: Medicaid ID Number (115-N5) is only used when Medicaid is the original adjudicator seeking subrogation per section 4.1.1 of the *Batch Standard Subrogation Implementation Guide*. In the Request Insurance Segment, the Medicaid ID Number (115-N5) contains the member's ID used by Medicaid while the Cardholder ID (302-C2) represents the member's ID for the additional adjudicator.

In the Response Insurance Segment for Medicaid Subrogation claims, the Medicaid ID Number (115-N5) echoes the value submitted on the request. The Cardholder ID (302-C2) is situational, and when returned, the Cardholder ID (302-C2) would reflect the ID used by the additional adjudicator.

Added November 2023

6.2 When is Medicaid Agency Number (116-N6) used in Subrogation

Question: When is Medicaid Agency Number (116-N6) used in Batch Standard Subrogation transactions?

Answer: Medicaid Agency Number (116-N6) is only used when Medicaid is the original adjudicator seeking subrogation per section 4.1.1 of the *Batch Standard Subrogation Implementation Guide*. In the Request Insurance Segment, the Medicaid Agency Number (116-N6) is used to report the Medicaid Agency Number as known to the additional adjudicator. In the Response Insurance Segment for Medicaid Subrogation claims, the Medicaid Agency Number (116-N6) echoes the value submitted on the request.

Medicaid Agency Number (116-N6) would not be used in any situation where Medicaid is not the original adjudicator.

Added November 2023

6.3 Reported Adjudicated Program Type

Question: How is Reported Adjudicated Program Type (A29-ZS) used in subrogation?

Answer: Reported Adjudicated Program Type (A29-ZS) is used by the original adjudicator to report their Adjudicated Program Type (A28-ZR). It is a required field for subrogation as indicated by the "RM" designation in the *NCPDP Telecommunication Standard Version F6©.*The original adjudicator should select the most specific ECL value that reflects the type of program the claim adjudicated under. For example, a Children's Health Insurance Program (CHIP) should use the applicable value for Children's Health Insurance Program (CHIP) rather than the value for Medicaid, which is a more general program.

Added December 2025

APPENDIX A – MODIFICATIONS TO THIS DOCUMENT

Version 01

Original Version

APPENDIX B – ROUTE OF ADMINISTRATION QUESTIONS

BEST PRACTICES FOR USE OF SNOMED CT ROUTE OF ADMINISTRATION VALUES

1. **Question:** Which "edition" of SNOMED CT Route of Administration data should be used and where can it be located?

   Answer: The Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) United States (US) Edition is the official source of SNOMED CT for use in US healthcare systems, as referenced by United States Core Data for Interoperability (USCDI) and the Interoperability Standards Advisory (ISA).

   The National Library of Medicine (NLM) distributes the US Edition of SNOMED CT, which is a standalone release that combines the content of both the US Extension and the International releases of SNOMED CT.

   The SNOMED CT Route of Administration subset is publicly available on the NLM Value Set Authority Center (VSAC) web site Value Set Authority Center (nih.gov).

   NCPDP's External Code List© (ECL) entry for Route of Administration (995-E2) points to NLM's VSAC for the list of values and includes a link with instructions for how to download the data. To ensure consistent values and processes across trading partners, NCPDP recommends using the downloadable list of codes published by NLM.

   NLM has a website which addresses some frequently asked questions: http://www.nlm.nih.gov/research/umls/Snomed/snomed_faq.html

2. **Question**: If a SNOMED CT Route of Administration code is listed on the NLM VSAC site, a payer/processor choose to not support the code and reject the claim?

   Answer: NCPDP does not dictate business requirements. If their business warrants it, the payer/processor may choose to not cover or support a code and deny a claim with Reject Code (511-FB) values such as 552 (Route of Administration Value Not Supported), 9Q (Route of Administration Submitted Not Covered) or other applicable values.

   However, Reject Code value E2 (M/I Route of Administration) should not be used to communicate that the code is not supported or covered.

3. **Question:** If a processor does not recognize a value being submitted in Route of Administration (995-E2) because they are using a different version of NLM's SNOMED CT ROA subset than the pharmacy, what is the appropriate reject code?

   Answer: When an unrecognized value is submitted in field Route of Administration (995-E2) and the processor is requiring the field data, the reject code E2 (M/I Route of Administration) should be used.

   To minimize the potential for unrecognized values due to trading partners referencing different versions of the published SNOMED CT Route of Administration codes, it is recommended that all industry participants regularly update their internal databases with the biannually published list from NLM.

   Note: Please reference FAQ #2 above.

TIMING CONSIDERATIONS

1. **Question:** How should the industry support the changes within the SNOMED CT vocabulary which occurs outside the NCPDP ECL timelines?
   Answer: The NCPDP External Code List© timelines were developed and approved by the NCPDP membership for values that occur **within** the NCPDP External Code List© publications. The vocabulary owners (FDA for NDC, HHS for ICD, NLM for SNOMED, NCI for FMT DoseForm, etc.) are based on the schedule established by these entities for their products. As the industry implements, for example NDC or ICD-9 updates outside of the NCPDP External Code List© timeline, implementation of SNOMED is based on NLM's publication dates.

2. **Question:** How often is a version of SNOMED released?
   Answer: The US Edition of SNOMED CT is released bi-annually in the months of March and September. Trading partners should make every effort to ensure the latest code sets have been downloaded and integrated into their systems.

   Trading partners are strongly encouraged to not use retired and/or ambiguous codes that are not valid Route of Administration codes per SNOMED CT guidance.

   As stated in the Quick Reference Chart in the *NCPDP Use of External Code Lists© and Vocabularies* for code set updates that do not require immediate use, it is recommended external code set updates be implemented within 180 days of their publication.

ROUTE OF ADMINISTRATION IN THE NCPDP TELECOMMUNICATION STANDARD

1. **Question:** Is Route of Administration (995-E2) required in NCPDP transactions?
   Answer: No. The Route of Administration (995-E2) is not mandatory or required in NCPDP transactions. The field is situational. Entities that wish to receive the field are to denote the situation when the field is required. The submission of Route of Administration (995-E2) in transactions helps to further clarify the compound being submitted or to override a default route referenced for the product.

2. **Question:** In the Telecommunication Standards lower than Version F8, the field length for Route of Administration (995-E2) is 11 characters, however some values within the SNOMED CT Route of Administration Code set are greater than 11 characters. Is there guidance on how to transmit and process values greater than 11 characters in the Telecommunication Standards lower than Version F8?
   Answer: We recommend using the first 11 digits and truncating the remaining digits as applicable. This recommendation is based on the February 2022 analysis of the code set which indicates truncation would not create duplicates. In Versions F8 and greater, the field length is 20 characters.

Entire Appendix Added August 2024

APPENDIX C – MEDICARE PART D TOPICS

Hepatitis B Vaccine Billing

Question: Hepatitis B vaccine can be covered under either Medicare Part B or Part D depending on the patient's risk of contracting the infection. What information should the pharmacy submit on the claim to allow the payer to make the payment determination?

Answer: The new External Code List (ECL) values below have been created for use with existing ECL values to support a standardized point of service process to communicate whether the patient is at low risk or moderate to high risk of becoming infected with the hepatitis B virus to determine Medicare Part B or Part D coverage.

Reason for Service Code (439-E4):
One new Reason for Service Code (439-E4) value has been created for the payer to return on a rejected response, indicating more information is needed to complete vaccine billing.

- UE – Hepatitis B Risk Determination Required
  Code indicating that risk of contracting Hepatitis B is needed to determine Medicare Part B or Medicare Part D coverage for Hepatitis B vaccination.

Result of Service Code (441-E6):

Three new Result of Service Code (441-E6) values have been created for the pharmacy to communicate the patient's risk of contracting the hepatitis B virus.

- 5D – Low Risk of Hepatitis B
  Low risk of contracting hepatitis B as defined by CMS guidelines.
- 5E – Medium/High Risk of Hepatitis B
  Medium to high risk of contracting Hepatitis B includes vaccine status unknown by patient, no prior vaccination, and/or other risk factors as defined by CMS guidelines.
- 5H - Unknown Exposure/Risk
  Exposure or risk to determine vaccine coverage is unknown to pharmacy.

Pharmacies could proactively submit an applicable Result of Service Code (441-E6) value to identify the patient's risk of contracting the hepatitis B virus.

If the information is not on the submitted claim and is necessary for the payer to complete the claim adjudication process, payers can initiate the point of service communication process using the specified ECL values as outlined below.

Refer to the Vaccine Billing DUR Code Set Sample Matrices at the end of this FAQ for a combination of Reason for Service (439-E4) and Result of Service Code (441-E6) code values that could be submitted on the request.

POINT OF SERVICE CLAIMS PROCESSING GUIDANCE BASED ON MEDICARE PLAN TYPE
PDP - Prescription Drug Plan (Part D Benefit ONLY, No Part B) for Hepatitis B Vaccine

1. Hepatitis B vaccine claim submitted
2. If the Result of Service Code (441-E6) field does not contain one of the new risk values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*
   ii. Reason For Service Code (439-E4): UE - *Hepatitis B Risk Determination Required*
3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of EU – *Hepatitis B Risk Determination Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
   i. 5D – Low Risk of Hepatitis B
      - Payer Response: Claim continues to adjudicate under the PDP benefit
   ii. 5E – *Medium/High Risk of Hepatitis B*
      - Payer Response: Claim rejects with Reject Code (511-FB): A6 – *This Product/Service May Be Covered Under Medicare Part B*
   iii. 5H - Unknown Exposure/Risk

- Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights

4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    Consultation with the patient to clarify or collect additional information
    ii. M0 - Prescriber consulted
    Communication with prescriber related to collection of information or clarification of a drug therapy concern.
    iii. R0 - Pharmacist consulted other source
    Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

MA Only - Medicare Advantage (Part B Benefit ONLY, No Part D) for Hepatitis B Vaccine

1. Hepatitis B vaccine claim submitted
2. If the Result of Service Code (441-E6) field does not contain one of the new risk values, the claim may reject as follows:
    i. Reject Code (511-FB): 88 – DUR Reject Error
    ii. Reason For Service Code (439-E4): UE - Hepatitis B Risk Determination Required
3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of XX – *Hepatitis B Risk Determination Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
    iii. 5D – *Low Risk of Hepatitis B*
        a. Payer Response: Claim rejects with Reject Code (511-FB): 620 – *This Product/Service May Be Covered Under Medicare Part D*
    iv. 5E – *Medium/High Risk of Hepatitis B*
        a. Claim continues to adjudicate under the MA Only benefit
    v. 5H - Unknown Exposure/Risk
        a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    Consultation with the patient to clarify or collect additional information
    ii. M0 - Prescriber consulted
    Communication with prescriber related to collection of information or clarification of a drug therapy concern.
    iii. R0 - Pharmacist consulted other source
    Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

MAPD – Medicare Advantage Prescription Drug (Part B+D BENEFITS) for Hepatitis B Vaccine

1. Hepatitis B vaccine claim submitted
2. If the Result of Service Code (441-E6) field does not contain one of the new risk values, the claim may reject as follows:
    i. Reject Code (511-FB): 88 – DUR Reject Error
    ii. Reason For Service Code (439-E4): UE - *Hepatitis B Risk Determination Required*
3. Pharmacy resubmits claim with one of the below Result of Service Code values:
    i. 5D – *Low Risk of Hepatitis B*
    Payer Response: Claim continues to adjudicate under the MAPD Part D benefit
    ii. 5E – *Medium/High Risk of Hepatitis B*
    Payer Response: Claim continues to adjudicate under the MAPD Part B benefit
    iii. 5H - Unknown Exposure/Risk
    Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    Consultation with the patient to clarify or collect additional information
    ii. M0 - Prescriber consulted
    Communication with prescriber related to collection of information or clarification of a drug therapy concern.
    iii. R0 - Pharmacist consulted other source
    Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

Vaccine Billing DUR Code Set Sample Claim Request Matrices

Scenario	**Request: Reason for Service Code (439-E4)**	**Professional Service Code (440-E5)** ***Only submitted if specified in trading partner agreement***	**Result of Service Code (441-E6)**
Pharmacy Proactively Submits Hepatitis B Risk Determination	UE – Hepatitis B Risk Determination Required	P0 - Patient Consulted M0 – Prescriber Consulted R0 – Pharmacy Consulted Other Sources	5D- Low Risk of Hepatitis B, or 5E – Medium/High Risk of Hepatitis B 5H - Unknown Exposure/Risk
Plan Returns Reject 88 - DUR Error with Reason for Service Code EU – Hepatitis B Risk Determination Required	UE – Hepatitis B Risk Determination Required	P0 - Patient Consulted M0 – Prescriber Consulted R0 – Pharmacy Consulted Other Sources	5D- Low Risk of Hepatitis B, or 5E – Medium/High Risk of Hepatitis B 5H - Unknown Exposure/Risk

Added December 2025

Medicare Part B vs Medicare Part D Vaccine Billing

Question: For vaccines that can be covered under either Medicare Part B or Part D depending on the patient's circumstances, what information should the pharmacy submit on the claim to allow the payer to make the payment determination?

Answer: The new External Code List (ECL) values below have been created for use with existing ECL values to support a standardized point of service process to communicate information about Part B vs Part D vaccines. For selected vaccines, such as tetanus and rabies, the pharmacy will indicate whether the patient is getting the vaccine due to possible exposure due to illness or injury (i.e., post-exposure, such as a puncture wound or animal bite) or whether it's needed for general prevention or upcoming travel (i.e., pre-exposure).

Reason for Service Code (439-E4):
One new Reason for Service Code (439-E4) value has been created for the payer to return on a rejected response, indicating more information is needed to complete vaccine billing.

- UF – Pre- vs Post-Exposure Vaccine Information Required
  Code indicating the reason for the vaccine administration is needed to determine coverage.

Result of Service Code (441-E6):
Three new Result of Service Code (441-E6) values have been created for the pharmacy to communicate whether the vaccine is being administered pre- or post-exposure.

- 5F – Maintenance/Travel Vaccine
  Vaccine is administered as part of maintenance/routine vaccine schedule or in preparation for travel.
- 5G – Post-Exposure Vaccine
  Vaccine is administered in response to an injury or direct exposure to a disease or condition.
- 5H - Unknown Exposure/Risk
  Exposure or risk to determine vaccine coverage is unknown to pharmacy.

Pharmacies could proactively submit an applicable Result of Service Code (441-E6) value to identify the reason for vaccine.

If the information is not on the submitted claim and is necessary for the payer to complete the claim adjudication process, payers can initiate the point of service communication process using the specified ECL values as outlined below.

Refer to the Vaccine Billing DUR Code Set Sample Matrices at the end of this FAQ for a combination of Reason for Service (439-E4) and Result of Service Code (441-E6) code values that could be submitted on the request.

POINT OF SERVICE CLAIMS PROCESSING GUIDANCE BASED ON MEDICARE PLAN TYPE
PDP - Prescription Drug Plan (Part D Benefit ONLY, No Part B) for Pre- vs Post-Exposure Vaccine

1. Claim submitted for a vaccine covered by Part D for general prevention/ travel.
2. If the Result of Service Code (441-E6) field does not contain one of the new reason for vaccine values, the claim may reject as follows:
   i. Reject Code (511-FB): 88 – *DUR Reject Error*
   ii. Reason For Service Code (439-E4): UF – *Pre- or Post-Exposure Vaccine Information Required*

3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of UF – *Pre- or Post-Exposure Vaccine Information Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
    i. 5F – *Maintenance/Travel Vaccine*
        a. Payer Response: Claim continues to adjudicate under the PDP benefit
    ii. 5G – *Post-Exposure Vaccine*
        a. Payer Response: Claim rejects with Reject Code (511-FB): A6 – *This Product/Service May Be Covered Under Medicare Part B*
    iii. 5H - Unknown Exposure/Risk
        a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    Consultation with the patient to clarify or collect additional information
    ii. M0 - Prescriber consulted
    Communication with prescriber related to collection of information or clarification of a drug therapy concern.
    iii. R0 - Pharmacist consulted other source
    Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

MA Only - Medicare Advantage (Part B Benefit ONLY, No Part D) for Pre- vs Post-Exposure Vaccine

1. Claim submitted under Part B for post-exposure prevention (ex: tetanus, rabies, hepatitis A)
2. If the Result of Service Code (441-E6) field does not contain one of the new reason for vaccine values, the claim may reject as follows:
    i. Reject Code (511-FB): 88 – *DUR Reject Error*
    ii. Reason For Service Code (439-E4): UF - *Pre- or Post-Exposure Vaccine Information Required*
3. Pharmacy resubmits rejected claim with the Reason for Service Code (439-E4) of UF – *Pre- or Post-Exposure Vaccine Information Required* to respond to the alert and one of the below Result of Service Code (441-E6) values:
    i. 5F – *Maintenance/Travel Vaccine*
        a. Payer Response: Claim rejects with Reject Code (511-FB): 620 – *This Product/Service May Be Covered Under Medicare Part D*
    ii. 5G – *Post-Exposure Vaccine*
        a. Claim continues to adjudicate under the MA Only benefit
    iii. 5H - *Unknown Exposure/Risk*
        a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights

4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    Consultation with the patient to clarify or collect additional information
    ii. M0 - Prescriber consulted
    Communication with prescriber related to collection of information or clarification of a drug therapy concern.
    iii. R0 - Pharmacist consulted other source
    Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

MAPD – Medicare Advantage Prescription Drug (Part B+D BENEFITS) for Pre- vs Post-Exposure Vaccine

1. Claim submitted for a vaccine covered by Part D for general prevention/travel and under Part B for post-exposure prevention (ex: tetanus, rabies, hepatitis A)
2. If the Result of Service Code (441-E6) field does not contain one of the new reason for vaccine values, the claim may reject as follows:
    i. Reject Code (511-FB): 88 – *DUR Reject Error*
    ii. Reason For Service Code (439-E4): UF - *Pre- or Post-Exposure Vaccine Information Required*
3. Pharmacy resubmits claim with one of the below Result of Service Code values:
    i. 5F – *Maintenance/Travel Vaccine*
        a. Payer Response: Claim continues to adjudicate under the MAPD Part D benefit
    ii. 5G – *Post-Exposure Vaccine*
        a. Payer Response: Claim continues to adjudicate under the MAPD Part B benefit
    iii. 5H - *Unknown Exposure/Risk*
        a. Payer Response: Claim rejects with Reject Code (511-FB): 75 – Prior Authorization Required and 569 - Provide Notice: Medicare Prescription Drug Coverage And Your Rights
4. If specified in the trading partner agreement, the pharmacy should select the appropriate Professional Service Code (440-E5), such as the examples listed below. Please note that additional codes may also be applicable depending on the specific circumstances.
    i. P0 - Patient consulted
    Consultation with the patient to clarify or collect additional information
    ii. M0 - Prescriber consulted
    Communication with prescriber related to collection of information or clarification of a drug therapy concern.
    iii. R0 - Pharmacist consulted other source
    Pharmacist referenced a source other than the patient or prescriber to collect information or clarification regarding a drug therapy concern.

Vaccine Billing DUR Code Set Sample Claim Request Matrices

Scenario	Request: Reason for Service Code (439-E4)	Professional Service Code (440-E5) *Only submitted if specified in trading partner agreement*	Result of Service Code (441-E6)
Pharmacy Proactively Submits Vaccine Purpose	UF – Pre- or Post-Exposure Vaccine Information Required	P0 - Patient Consulted M0 – Prescriber Consulted R0 – Pharmacy Consulted Other Sources	5F- Maintenance/Travel Vaccine, or 5G – Post-Exposure Vaccine 5H - Unknown Exposure/Risk
Plan Returns Reject 88 - DUR Error with Reason for Service Code UF – Pre- or Post-Exposure Vaccine	UF – Pre- or Post-Exposure Vaccine Information Required	P0 - Patient Consulted M0 – Prescriber Consulted R0 – Pharmacy Consulted Other Sources	5F- Maintenance/Travel Vaccine, or 5G – Post-Exposure Vaccine 5H - Unknown Exposure/Risk

Added December 2025