Nevada Medicaid

National Council for Prescription Drug Program (NCPDP) Encounter Claims Companion Guide

The information in this Companion Guide is valid to use for the certification/testing to transition to the modernized MMIS and upon implementation of the MMIS Modernization Project

June 18, 2018

Medicaid Management Information System (MMIS)

Department of Health and Human Services (DHHS)

Division of Health Care Financing and Policy (DHCFP)

Disclosure Statement

The information contained in this companion guide is subject to change. Managed Care Organizations (MCOs) are advised to check the Nevada Medicaid website at http://www.medicaid.nv.gov/providers/edi.aspx regularly for the latest updates.

DXC Technology is the fiscal agent for Nevada Medicaid and is referred to as Nevada Medicaid throughout this document.

About DHCFP

The Nevada Department of Health and Human Services' Division of Health Care Financing and Policy (DHCFP) works in partnership with the Centers for Medicare & Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources. The medical programs are known as Medicaid and Nevada Check Up.

DHCFP website: Medicaid Services Manual, rates, policy updates, public notices: http://dhcfp.nv.gov.

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1 Introduction

1.1 NCPDP Batch Transaction Standard Version 1.2 and Telecommunication Standard Version D.0

These supplemental instructions are issued to help contractors submit pharmacy encounter data to Nevada Medicaid.

Every effort has been made to prevent errors in this document. However, if there is a discrepancy between this document and the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide Version D.0 and the Telecomm Implementation Guide Version 1.2, the Implementation Guides are the final authority.

Nevada Medicaid supports the B1 = Billing NCPDP transaction for Pharmacy Encounters:

These specifications cover the required fields per the NCPDP Batch Transaction Standard Implementation Guide Version 1.2 and NCPDP Telecommunication Standard Implementation Guide Version D.0, as well as the required fields needed for encounter claims processing by Nevada Medicaid.

When additional segments and/or fields that are allowed within the supported NCPDP versions are provided, Nevada Medicaid will accept the transaction, but only those segments and fields pertinent to encounter claims processing will be utilized.

Any NCPDP transaction that is not supported by Nevada Medicaid will be rejected.

2 Getting Started

This section describes how to interact with Nevada Medicaid's EDI department.

The Nevada Medicaid EDI Department or Helpdesk can be contacted at (877) 638-3472 options 2, 0, and then 3, Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Time, with the exception of Nevada State holidays. You can also send an email to nvmmis.edisupport@dxc.com.

2.1 Trading Partner Registration

This section describes how to register as an encounter Trading Partner with Nevada Medicaid.

In order to submit and/or receive transactions with Nevada Medicaid, Trading Partners must complete a Trading Partner Profile (TPP) agreement, establish connectivity and certify transactions.

- A Trading Partner is any entity (provider, billing service, clearinghouse, software vendor, etc.) that transmits electronic data to and receives electronic data from another entity. Nevada Medicaid requires all Trading Partners to complete a TPP agreement regardless of the Trading Partner type listed below.
- Vendor is an entity that provides hardware, software and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing or network service vendor or clearinghouse.
    - Software vendor is an entity that creates software used by billing services, clearinghouses and providers/suppliers to conduct the exchange of electronic transactions.
    - Billing service is a third party that prepares and/or submits claims for a provider.
    - Clearinghouse is a third party that submits and/or exchanges electronic transactions on behalf of a provider.

Establishing a Trading Partner Profile (TPP) agreement is a simple process which the Trading Partner completes using the Nevada Medicaid Provider Web Portal link at https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx.

Trading Partners must agree to the Nevada Medicaid Trading Partner Agreement at the end of the Trading Partner Profile enrollment process. Once the TPP application is completed, an 8-digit Trading Partner ID will be assigned.

After the TPP Agreement has been completed, the Trading Partner must submit a Secure Shell (SSH) public key file to Nevada Medicaid to complete their enrollment. Once the SSH key is received, you will be contacted to initiate the process to exchange the directory structure and authorization access on the Nevada Medicaid external SFTP servers.

Failure to provide the SSH key file to Nevada Medicaid will result in your TPP application request being rejected and you will be unable to submit transactions electronically to Nevada Medicaid. Please submit your SSH public key via email within five business days of completing the TPP application. Should you require additional assistance with information on SSH keys, please contact the Nevada EDI Helpdesk at (877) 638-3472 options 2, 0, and then 3.

2.2 Certification and Testing Overview

This section provides a general overview of what to expect during certification and testing phases.

All Trading Partners who submit electronic transactions with Nevada Medicaid will be certified through the completion of Trading Partner testing. This includes Clearinghouses, Software Vendors, Provider Groups and Managed Care Organizations (MCOs).

Providers who use a billing agent, clearinghouse or software vendor will not need to test for those electronic transactions that their entity submits on their behalf.

3 Testing with Nevada Medicaid

This section contains a detailed description of the testing phase.

Testing data such as provider IDs and recipient IDs will not be provided. Users should submit recipient information and provider information as done for production as the test environment is continually updated with production information.

There is no limit to the number of files that may be submitted. Results of the system's processing of your transactions are reviewed and communicated back via email. Once the test file(s) passes validation edits, a production URL and Production Authorization letter will be sent confirming certification.

The following Encounter transactions are available for testing:

- 837D Encounter Dental Claim
- 837P Encounter Professional (CMS-1500) Claim
- 837P NET Encounter Professional (CMS-1500) Claim
- 837I Encounter Institutional (UB-04) Claim
- NCPDP Batch Transaction Standard Version 1.2 and Telecommunication Standard Version D.0

3.1 Testing Process

The following points are actions that a Trading Partner will need to take before submitting production files to Nevada Medicaid:

- Enroll by using the Trading Partner Enrollment Application on the Nevada Medicaid Provider Web Portal to obtain a new Trading Partner ID
- Register on the Nevada Medicaid Provider Web Portal (optional unless submitting files via the Web Portal)
- Receive EDI Trading Partner Welcome Letter indicating Trading Partner Profile (TPP) has been approved for testing
- Submit test files using SFTP until transaction sets pass compliance testing
- Receive Production Authorization letter containing the list of approved transactions that could be submitted to the production environment along with the connection information
- Upon completion of the testing process, you may begin submitting production files for all approved transactions via the Nevada Medicaid Provider Web Portal or SFTP

To begin the testing process, please review the Nevada Medicaid Trading Partner User Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx.

3.2 File Naming Standard

Use the following naming standards when submitting encounter files to Nevada Medicaid.

- Trading Partner ID_Encounters_filetype_Environment_DateTime.dat or .txt

Examples are as follows:

- 01234567_ENCOUNTERS_NCPDP_PROD_201808301140512.dat
- 01234567_ENCOUNTERS_NCPDP_PROD_201808301140512.txt

The preferred extension is .dat; however, .txt is also allowed. Zip files (.zip) may also be submitted, but each zip file can contain only one encounter file, either .dat or .txt. Both the zip file and the encounter file it contains must meet the file naming standards.

If the file does not meet the file naming standard, the file will not be processed. In this instance, the Nevada Medicaid EDI Helpdesk will notify the submitter of the issue and request correction and resubmittal. You will need to correct the file name and resubmit the file in order for it to process.

3.3 Duplicate Pharmacy Logic

Pharmacy Logic

Logic will consider each Detail on the incoming claim.

Logic will consider history claims.

If a detail is Denied, do not check it for duplicate.

Since we do not reject pharmacy claims for lacking a NDC code, check if we do not have one. If we don't, do not check the detail for duplicate claims.

Since we do not reject claims for a provider that is not enrolled with NV Medicaid, check if we do not have a valid enrolled one. If we don't, do not check for duplicate claims.

Considering the 'dispense date' as the Date of first service.

Check current pharm detail against history claim details.

If an Encounter claim detail is found on history where, compared to current claim detail:

- recipients are equal
- providers are equal
- DOS (dates dispensed) are equal,
- NDC's are equal, and
- Trading partners are equal

Then set ENC DUP PHARM

Note: When referring to the 'history claims' used in the duplicate logic against the current incoming claims:

- If a claim is denied at the Header level, it does not get added to the audit history table

- If a Paid claim at the Header level has details that were denied, those denied details do not get added to the history table
- Thus, only paid details will be found on the audit history table for comparison

4 Connectivity with Nevada Medicaid/ Communications

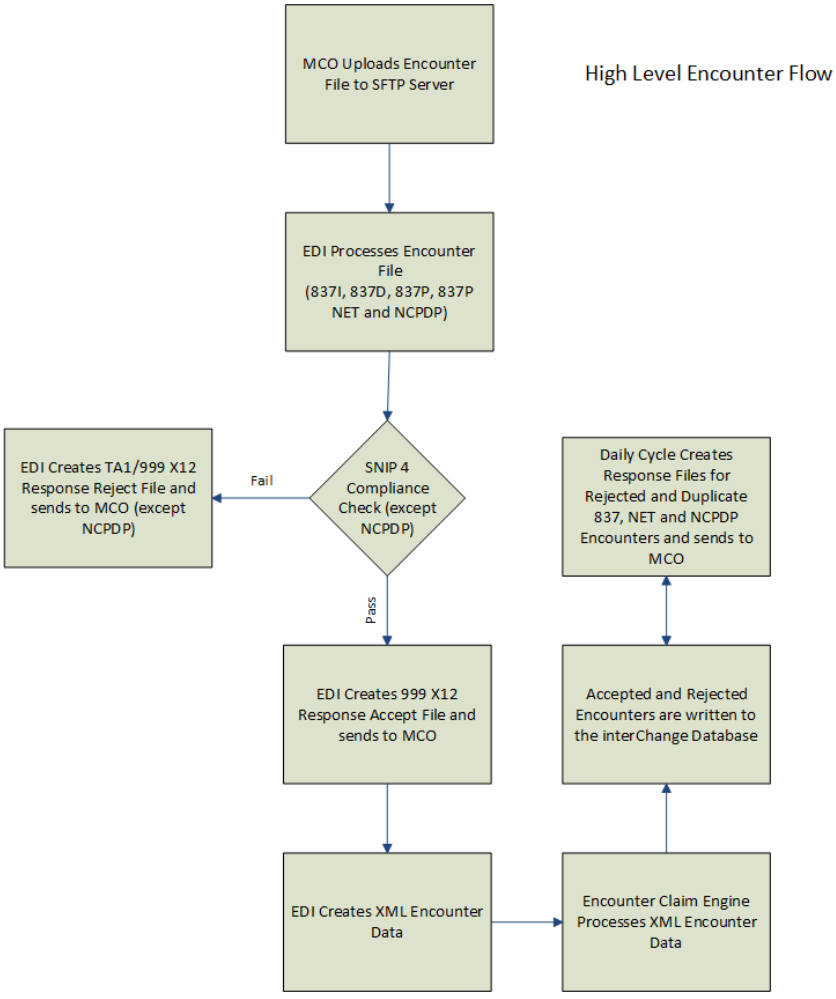
This section describes the process to submit NCPDP Encounter transactions, along with submission methods, security requirements, and exception handling procedures.

Nevada Medicaid supports multiple methods for exchanging electronic healthcare transactions depending on the Trading Partner's needs. For NCPDP Batch Encounter transactions, the following can be used:

- Secure File Transfer Protocol (SFTP) (this only applies to batch transactions)
- The Nevada Medicaid Provider Web Portal (not recommended for Encounter claims due to the size limitations)

4.1 Process Flows

This section contains a process flow diagram and appropriate text.



4.2 Encounter Response Files

1. The Trading Partner submits a batch of encounter claims to the Nevada Medicaid SFTP server.
2. EDI processes the batch.

   Note: With an NCPDP transaction, the TA1 and 999 responses are not available. If an error is detected with a batch/file, the Trading Partner will be contacted via email from the EDI Helpdesk. The email will contain the reason why the file rejected.
3. When the batch successfully processes through EDI, the encounter claims are transformed into XML records and submitted to the interChange Encounter Claim engine for further validation and processing. At this stage, individual encounter claims are inspected and if necessary rejected and sent back to the submitter for correction. (When resubmitting a rejected encounter claim, the same MCO ICN/TCN must be used on the corrected encounter claim). The submitter can expect two different response files as follows:

   - The proprietary encounter NCPDP response report will be generated daily once the translated file has processed. This report will contain the status of each encounter claim within the transaction. The Encounter Engine contains informational and threshold edits. Both types of edits are reported on the response file; however, only threshold edits will reject a claim. A claim with no edits or informational edits will be accepted. Claims can have both threshold and informational edits, but only the information pertaining to the threshold edit will need to be corrected and resubmitted for the claim to be accepted. If a claim within the batch is rejected due to duplicate, then an Encounter Claim Duplicate file will also be generated. This file provides information on the current claim that is being rejected and the related claim in the Encounter Claim Engine.

4.3 Transmission Administrative Procedures

This section provides Nevada Medicaid's specific transmission administrative procedures.

For details about available Nevada Medicaid Access Methods, refer to the Communication Protocol Specifications section below.

Nevada Medicaid is only available to authorized users. The submitter/receiver must be a Nevada Medicaid Trading Partner. Each submitter/receiver is authenticated using the Username and private SSH key provided by the Trading Partner as part of the enrollment process.

4.4 System Availability

The system is typically available 24X7 with the exception of scheduled maintenance windows as noted on the Nevada Medicaid Provider Web Portal at https://www.medicaid.nv.gov/.

4.5 Transmission File Size

Transactions	Submission Method	File Size Limit	Other Conditions
NCPDP	SFTP	200 MB per batch	
NCPDP	Web Portal	4 MB	

4.6 Re-transmission Procedure

Nevada Medicaid does not require any identification of a previous transmission of a file with the Note exception listed below. All files sent should be marked as original transmissions.

Nevada Medicaid does identify duplicate files based on content of the file before it reaches the MMIS system. The duplicate check algorithm only checks for file content. It does not check for filename or file size.

The submitter must correct and resubmit a disputed encounter file or claim within sixty (60) calendar days of receipt of rejection.

> Note: If the same file was resubmitted using SFTP and the data content is the same content of another file, this file will be detected as a duplicate file. The EDI Helpdesk will contact the EDI contact listed on file to see if the file was meant to be reprocessed.

4.7 Communication Protocol Specifications

This section describes Nevada Medicaid's communication protocol(s).

- **Secure File Transfer Protocol (SFTP)**: Nevada Medicaid allows Trading Partners to connect to the Nevada Medicaid SFTP server using the SSH private key and assigned user name. There is no password for the connection.
- **Nevada Medicaid Provider Web Portal**: Nevada Medicaid allows Trading Partners to connect to the Nevada Medicaid Provider Web Portal. Refer to the Trading Partner User Guide for instructions.

4.8 Passwords

Trading Partners must adhere to Nevada Medicaid's use of passwords. Trading Partners are responsible for managing their own data. Each Trading Partner must take all necessary precautions to ensure that they are safeguarding their information and sharing their data (e.g., granting access) only with users and entities who meet the required privacy standards. It is equally important that Trading Partners know who on their staff is linked to other providers or entities, in order to notify those entities whenever they remove access for that person in your organization(s).

4.9 NCPDP Batch Transaction Standard Version 1.2

The batch specifications contained in this document include the header, data and trailer. Batch files should contain one header record, one trailer record, and a maximum of 5,000 transaction details.

- Header (1 per file)
- Transaction Detail (can include 1 transaction)
- Trailer (1 per file)

Values in the header and trailer will be edited to verify that they contain appropriate values. Carriage returns/line feeds are not allowed within the batch file. If a file is received with carriage returns/line feeds, the file will be rejected.

4.10 Separator Characters

Segment Separator (hex character 1E, decimal 3Ø) delineates each segment within the transaction.

A Group Separator (hex character 1D, decimal 29) denotes the start of each transaction in the transmission.

A Field Separator (hex character 1C, decimal 28) separates each field in a transaction's segments.

Each field has a unique identifier code that, when used in conjunction with the Field Separator, shows the start of a new field in the record (for example, FB refers to Field 511-FB, Reject Code).

5 NCPDP Batch Transaction Standard Version 1.2 File Information and Telecommunication Standard Version D.0 Transaction Set Specifications

Following is a list of the field, use, field name and values/comments for Nevada Medicaid using the batch NCPDP Batch Transaction Standard Version v1.2 and Telecommunication Standard Version vD.0.

The following definitions are given to ensure consistency of interpretation:

- Field: The NCPDP Batch Transaction Standard v1.2 or NCPDP Telecommunication Standard vD.0 data element identifier for a given transaction.
- Field Name: The short definition, name, or literal constant of the data located within the transaction at the positions indicated.
- Format: Defines the field as alpha/numeric or numeric.
- Length: Defines the length the Nevada Medicaid allows.
- Values/Comments: If a particular value is expected, that value is given within single quotes. NCPCP Telecommunication Standard vD.0 is a variable length format. Therefore, with the exception of the header fields (which are always required), a transaction will contain only those elements that are necessary.

5.1 Transmission Header (Required/1 per file)

Field	Use	Field Name	Format	Length	Values/Comments
880-K4	M	Text Indicator	A/N	1	Start of Text (STX) = X'02'
701	M	Segment Identifier	A/N	2	00 = File Control Header
880-K6	M	Transmission Type	A/N	1	T = Transaction
880-K1	M	Sender ID	A/N	24	Trading Partner ID assigned by Nevada Medicaid.
806-5C	M	Batch Number	N	7	Assigned by the sender and must match the Transaction Trailer Batch Number field.
880-K2	M	Creation Date	N	8	Create Date = CCYYMMDD
880-K3	M	Creation Time	N	4	Create Time = HHMM
702	M	File Type	A/N	1	P = Production T = Test

Field	Use	Field Name	Format	Length	Values/Comments
102-A2	M	Version/ Release Number	A/N	2	12 = Version 1.2
880-K7	M	Receiver ID	A/N	24	NVMED
880-K4	M	Text Indicator	A/N	1	End of Text (ETX) = X'03'

6 NCPDP Version 1.2

6.1 Transaction Detail (Required/1 per transaction)

Field	Use	Field Name	Format	Length	Values/Comments
880-K4	M	Text Indicator	A/N	1	Start of Text (STX) = X'02'
701	M	Segment Identifier	A/N	2	G1 = Detail data record
880-K5	M	MCO Transaction Control Number (MCO TCN)	A/N	10	A reference number assigned by the provider to each of the data records in the batch. WHEN RE-SUBMITTING A REJECTED ENCOUNTER CLAIM, THIS FIELD NEEDS TO CONTAIN THE SAME TCN AS ON THE ORIGINAL ENCOUNTER CLAIM

6.2 NCPDP D.0 Billing Request (Required)

Field	Field Name	Format	Length	Values/Comments
101-A1	BIN Number	N	6	Use "999999"
102-A2	Version/Release Number	A/N	2	D0 = Version D.0
103-A3	Transaction Code	A/N	2	B1 = Billing
104-A4	Processor Control Number	A/N	10	Audit Number assigned at point of adjudication. Number assigned by processor. Suggestion: Populate unique characters in the first nine bytes to prevent processing number duplication. MCO Internal Control Number
109-A9	Transaction Count	X	1	1 = One occurrence
202-B2	Service Provider ID Qualifier	A/N	2	01 = NPI/API 05 = Medicaid Note: 05 is only valid for "Atypical" Providers - all other providers must submit their NPI (Value = 01), File will be rejected if value other than 01 or 05 is submitted.
201-B1	Service Provider ID	A/N	15	Billing Provider NPI Note: In the current NV Medicaid Encounter System, this value is sent in field 444-E9,

Field	Field Name	Format	Length	Values/Comments
				PROVIDER ID.
401-D1	Date of Service	N	8	Date Format CCYYMMDD
110-AK	Software Vendor/ Certification ID	A/N	10	The 8-digit Trading Partner ID assigned by Nevada Medicaid left justified and space filled.

6.3 Insurance Segment (Required)

Field	Field Name	Format	Length	Values/Comments
111-AM	Segment Identification	N	2	04 = Insurance
302-C2	Cardholder ID	A/N	20	Nevada Medicaid Member or Recipient ID
301-C1	GROUP ID	A/N	15	CMO Medicaid ID Number and Record ID XXXXXXXXXXB X= CMO Regional Medicaid ID B= Record ID 0= Denied Claim 1= Original Claim 2= Voided Claim 1st- 10th Byte will be equal to the CMO Medicaid ID, 11th byte will be equal to the Record ID to illustrate a voided, original or denied claim. Note: In the current NV Medicaid Encounter System, the value is sent in 201-B1, SERVICE PROVIDER ID
115-N5	MEDICAID ID NUMBER	A/N	15	NEVADA Medicaid ICN/Encounter ICN. Note: In the current NV Medicaid Encounter System, this value is sent in the field 330-CW, Alternate ID

6.4 Patient Segment (Situational)

Field	Field Name	Format	Length	Values/Comments
111-AM	Segment Identification	N	2	01= Patient
304-C4	Date of Birth	N	8	Format: CCYYMMDD

Field	Field Name	Format	Length	Values/Comments
305-C5	Patient Gender Code	N	1	0 = Not Specified 1 = Male 2 = Female
310-CA	Patient First Name	A/N	12	
311-CB	Patient Last Name	A/N	15	
326-CQ	Patient Phone	N	10	
307-C7	Place of Service	N	2	00 = Not Specified 01 = Home 02 = Inter-Care 03 = Nursing Home 04 = Long Term/Extended Care 05 = Rest Home 06 = Boarding Home 07 = Skilled Care Facility 08 = Sub-Acute Care Facility 09 = Acute Care Facility 10 = Outpatient 11 = Hospice

6.5 Claim Segment (Required)

Field	Field Name	Format	Length	Values/Comments
111-AM	Segment Identification	N	2	07 = Claim
455-EM	Prescription/ Service Reference Number Qualifier	N	1	1 = Rx Billing Notes: "1" is the only value accepted. All other values will reject the file.
402-D2	Prescription/ Service Reference Number	N	12	Prescription Number Note: When prescription number is less than the required length, leading zeroes are not required, may use spaces to make max length but this is not required.
436-E1	Product/Service ID Qualifier	A/N	2	03 = NDC

Field	Field Name	Format	Length	Values/Comments
407-D7	Product/Service ID	A/N	11	NDC MMMMMNNNNPP M = NDC Mfg Code N = NDC Nbr P = NDC Pkg Code
457-EP	Associated Prescription/ Service Date	A/N	8	Date Format CCYYMMDD
442-E7	Quantity Dispensed	9(7)v999	10	10 Digit Metric decimal quantity of drug dispensed. Format = 9999999.999
403-D3	Fill Number	A/N	2	00 - New (original dispensing) 01 to 99 = Refill Number
405-D5	Days' Supply	N	3	Estimated number of days the prescription will last. Note: When days' supplied are less than the required length, leading zeroes are not required, may use spaces to make max length but this is not required.
406-D6	Compound Code	N	1	1 = Not a Compound 2 = Compound
408-D8	Dispense As Written (DAW)/Product Selection Code	N	1	See Appendix A
414-DE	Date Prescription Written	N	8	Date Format CCYYMMDD
419-DJ	Prescription Origin Code	N	1	0 = Not Known 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile 5 = Pharmacy
308-C8	Other Coverage Code	N	2	See Appendix B
461-EU	Prior Authorization Type Code	N	2	Must be submitted when 462-EV is present.

Field	Field Name	Format	Length	Values/Comments
462-EV	Prior Authorization Number Submitted	N	11	Prior Authorization Number This would be the PA number for the member.
345-HG	Days' Supply Intended To Be Dispensed	N	3	Days' supply intended to be dispensed.

6.6 Pricing Segment (Required)

Field	Field Name	Format	Length	Values/Comments
111-AM	Segment Identification	N	2	11 = Pricing
409-D9	Ingredient Cost Submitted	s9(6)v99	8	Submitted product component cost of the dispensed prescription.
412-DC	Dispensing Fee Submitted	s9(6)v99	8	Dispensing fee submitted by the pharmacy.
433-DX	Patient Paid Amount Submitted	s9(6)v99	8	Amount of co-pay the pharmacy received for the prescription dispensed.
478-H7	Other Amount Claimed Submitted Count	N	1	A valid value will be required.
479-H8	Other Amount Claimed	A/N	2	99 = Other Only to be reported once.
480-H9	Other Amount Claimed Submitted	s9(6)v99	8	Total Amount Paid (MCO Paid Amount) This is the Amount that the PBM is paying the pharmacy. Only to be reported once.
426-DQ	Usual and Customary Charge	s9(6)v99	8	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.
430-DU	Gross Amount Due	s9(6)v99	8	Total price claimed from all sources.
423-DN	Basis of Cost Determination	A/N	2	Valid values: See Appendix H. Note: In the current NV Medicaid Encounter System, this value is sent in field 490-UE, COMPOUND INGREDIENT BASIS OF COST DETERMINATION

6.7 Provider Segment (Required)

Field	Field Name	Format	Length	Values/Comments
111-AM	Segment Identification	N	2	02 = Provider
465-EY	Provider ID Qualifier	N	2	05 = NPI
444-E9	Provider ID	A/N	15	Rendering Pharmacy NPI ID Note: In the current NV Medicaid Encounter System, this value is sent in field 301-C1, Group ID.

6.8 Prescriber Segment (Required)

Field	Field Name	Format	Length	Values/Comments
111-AM	Segment Identification	N	2	03 = Prescriber
466-EZ	Prescriber ID Qualifier	N	2	01 = NPI
411-DB	Prescriber ID	A/N	15	Prescriber NPI ID

6.9 COB/Other Payments Segment (Situational)

Field	Field Name	Format	Length	Values/Comments
111-AM	Segment Identification	N	2	05 = COB/Other Payer
337-4C	Coordination of Benefits/Other Payments Count	N	1	1 = If, 1 COB 2 = If, 2 COBs 3 = If, 3 COBs This is required if submitting other coverage/payment information. (Maximum count of 9).
338-5C	Other Payer Coverage Type	N	2	01 = Primary Payer (MCO) 02 = Secondary Payer 03 = Tertiary Payer Required if the patient has other coverage.
339-6C	Other Payer ID Qualifier	N	2	Required if Other Payer ID (Field # 34Ø-7C) is used.
340-7C	Other Payer ID	N	10	Required if COB segment is used.
341-HB	Other Payer Amount Paid Count	N	1	Required if Other Payer Amount Paid Qualifier (342-HC) is used. (Maximum count of 9).
342-HC	Other Payer Amount	A/N	2	Required on all COB claims with Other

Field	Field Name	Format	Length	Values/Comments
	Paid Qualifier			Coverage Code of 2 "Ø7" is the only accepted value
431-DV	Other Payer Amount Paid	9(6)v99	8	Amount of any payment known by the pharmacy from other sources.

6.10 DUR/PPS Segment (Situational)

Field	Field Name	Format	Length	Values/Comments
111-AM	Segment Identification	N	2	08 = DUR/PPS
473-7E	DUR/PPS Code Counter	N	1	Counter number for each DUR/PPS set/logical grouping.
439-E4	Reason for Service Code	A/N	2	See Appendix D
440-E5	Professional Service Code	A/N	2	See Appendix E
441-E6	Result of Service Code	A/N	2	See Appendix F

6.11 Compound Segment (Situational)

Field	Field Name	Format	Length	Values/Comments
111-AM	Segment Identification	N	2	10 = Compound
450-EF	Compound Dosage Form Description Code	A/N	2	See Appendix G
451-EG	Compound Dispensing Unit Form Indicator	N	1	1 = Each 2 = Grams 3 = Milliliters
447-EC	Compound Ingredient Component Count	N	2	Count of compound product IDs (both active and inactive) in the compound mixture submitted.
488-RE	Compound Product ID Qualifier	A/N	2	03 = NDC 99 = Other (Container Count) Must be accompanied with all 9's and a 7 (99999999997) in field 489-TE. When a product ID of all 9's and a 7 (99999999997) is submitted then the quantity in field 448-ED will be considered the Container Count. Repeating field depending on count found in

Field	Field Name	Format	Length	Values/Comments
				field 447-EC.
489-TE	Compound Product ID	A/N	19	National Drug Code (NDC)
448-ED	Compound Ingredient Quantity	9(7)v999	10	Compound Ingredient Quantity. Amount expressed in metric decimal units of the product included in the compound mixture. Implied decimal, no overpunch required
490-UE	Compound Ingredient Basis of Cost Determination	A/N	2	

6.12 Clinical Segment (Required for Encounter)

Field	Field Name	Format	Length	Values/Comments
111-AM	Segment Identification	N	2	13 = Clinical
491-VE	Diagnosis Code Count	N	1	1 = First entry
493-XE	Clinical Information Counter	N	1	1 = Received Date NOTE: The two occurrences of the 493-XE and 494-ZE must occur in the following sequence and both are REQUIRED.
494-ZE	Received Date	N	8	Date Encounter claim was received by MCO
493-XE	Clinical Information Counter	N	1	2 = Paid Date
494-ZE	Paid Date	N	8	Date Encounter claim was paid by MCO. (This is the date paid by the MCO, not the date the check was mailed).

6.13 Transmission Trailer (1 per file required)

Field	Use	Field Name	Format	Length	Values/Comments
880-K4	M	Text Indicator	A/N	1	Start of Text (STX) = X'02'
701	M	Segment Identifier	A/N	2	99 = File Trailer Record
806-5C	M	Batch Number	N	7	Assigned by the sender and must match the Transaction Header Batch Number field.
751	M	Record Count	N	10	Count of detail records, including header and trailer. A transaction detail can contain up to four transactions. The transaction detail would be counted only once.

Field	Use	Field Name	Format	Length	Values/Comments
504-F4	M	Message	A/N	35	The message field can be used to further explain the reasons why the entire batch is in error or any other information that needs to be sent regarding the batch. This field should only contain informational data and should not contain required data.
880-K4	M	Text Indicator	A/N	1	End of Text (ETX) = X'03'

7 The NCPDP Encounter Response File

If all encounter claims within the file pass format compliance, then the encounter claims will be processed by the backend Encounter Claim Engine and the NCPDP Encounter Response File will be sent to the submitter. The response file will be available one business day after the file was received.

The response file contains the status of each encounter claim that was processed. One response file will be sent for each batch file received. Each edit/audit on an encounter claim is a record in the response file. If there are multiple edits/audits on the encounter claim, then an encounter claim will be in the file more than once. The Encounter Engine contains informational and threshold edits. Both types of edits are reported on the response file; however, only threshold edits will cause encounter claim rejections. An encounter claim with no edits or only informational edits will be accepted. Encounter claims can have both threshold and informational edits, but only the information pertaining to the threshold edit will need to be corrected and resubmitted for the encounter claim to be accepted. DHCFP reserves the right to change the edit type (informational and threshold) at any time.

7.1 File layout of the NCPDP Encounter Response File

Field Name	Format	Length	Description
INTERCHANGE_ICN	A/N	13	ICN if accepted, "REJECTED" if not accepted
MCO_AUDIT NUMBER	A/N	10	MCO Audit Number from the Process Control Number Field 104-A4.
ID_MEDICAID	A/N	12	Recipient's Medicaid ID
PHARM_PROVIDER_NUMBER	A/N	15	Dispensing Provider Number submitted
PRESCRIPTION_NUMBER	A/N	12	Prescription Number submitted
DISPENSE_DATE	A/N	8	Dispense Date – CCYYMMDD submitted
NDC_CODE	A/N	11	National Drug Code submitted
IND_VOID	A/N	1	Y/N – Submitted as a Void
INTERCHANGE_EDIT	A/N	4	Interchange Edit on this Encounter claim submitted
INTERCHANGE_EDIT_DESC	A/N	50	Interchange Edit Description
Filler – line feed	A/N	1	This is one character of filler – for Nevada Medicaid use. It will contain a line feed character.

NOTE: There will be a possibility of more than one record for each encounter claim since Nevada Medicaid is reporting back all the edits set on the encounter claim.

8 Encounter Claim Duplicate File

The duplicate file contains information about the encounter claim rejected as a duplicate and the related encounter claim within the Encounter Claim Engine.

Field Name	Format	Length	Information
NUM_PAT_ACCT	Char	38	MCO Submitted Patient Account Number with the MCO TCN
ID_MEDICAID	Char	12	Recipient Medicaid ID
DUPE_CLAIM_TYPE	Char	1	Encounter claim Type of the duplicate encounter claim
DUPE_SVC_LINE	Char	3	This is the detail number of the encounter the failed as a duplicate. Zero indicates that header of the encounter.
INTERCHANGE_AUDIT_NBR	Char	4	Interchange Audit Duplicate Error number
RELATED_DXC_ICN	Char	13	This is the encounter claim Nevada Medicaid ICN on file.
RELATED_NUM_PAT_ACCT	Char	38	MCO Submitted Patient Account Number
RELATED_CLAIM_TYPE	Char	1	Encounter claim Type of the duplicate claim
RELATED_SVC_LINE	Char	3	This is the detail number of the encounter the failed as a duplicate. Zero indicates that header of the encounter.
Filler - line feed	Char	1	This is one character of filler - for Nevada Medicaid use. It will contain a line feed character.

NOTE: There will be a possibility of more than one record for each encounter claim since there are multiple reasons for duplicates and all reasons are reported to support resolution.

9 Contact Information

Refer to this companion guide with questions and use the contact information below for questions not answered by this guide.

9.1 EDI Customer Service

This section contains detailed information concerning EDI Customer Service, especially contact numbers.

MCOs should send an email to nvmmis.edisupport@dxc.com with any encounter claims status inquiries or questions regarding how an encounter claim was processed. The email should contain enough information to research the question. The following is a list of information that would be helpful in answering most questions:

- Trading Partner ID
- Contact Name
- Contact Phone Number
- Question
- Encounter Claim Identifying Information (TCN or Processor Control Number)
- Original File Name
- Response File Name
- Duplicate File Name

9.2 EDI Technical Assistance

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

Nevada Medicaid EDI Helpdesk can help with connectivity issues or transaction formatting issues at (877) 638-3472 options 2, 0, then 3, Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Time, with the exception of Nevada State holidays.

The 8-digit Trading Partner ID is Nevada Medicaid's key to accessing Trading Partner information. Trading Partners should have this number available each time they contact the Nevada Medicaid EDI Helpdesk.

For written correspondence:

Nevada Medicaid

PO Box 30042

Reno, Nevada 89520-3042

9.3 Applicable Websites/Email

This section contains detailed information about useful websites.

- Accredited Standards Committee (ASC X12): ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org.
- Accredited Standards Committee (ASC X12N): ASC X12N develops and maintains X12 EDI and XML standards, standards interpretations, and guidelines as they relate to all aspects of insurance and insurance-related business processes. www.x12.org.
- American Dental Association (ADA): Develops and maintains a standardized data set for use by dental organizations to transmit claims and encounter information. www.ada.org.
- American Hospital Association Central Office on ICD-10-CM/ICD-10-PCS (AHA): This site is a resource for the International Classifications of Diseases, 10th edition, Clinical Modification (ICD-10-CM) codes, used for reporting patient diagnoses and (ICD-10-PCS) for reporting hospital inpatient procedures. www.ahacentraloffice.org.
- American Medical Association (AMA): This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org.
- Centers for Medicare & Medicaid Services (CMS): CMS is the unit within HHS that administers the Medicare and Medicaid programs. Information related to the Medicaid HIPAA Administrative Simplification provision, along with the Electronic Health-Care Transactions and Code Sets, can be found at http://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA.

  This site is the resource for information related to the Healthcare Common Procedure Coding System (HCPCS): www.cms.hhs.gov/HCPCSReleaseCodeSets.
- Committee on Operating Rules for Information Exchange (CORE): A multi-phase initiative of Council for Affordable Quality Healthcare, CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care. www.caqh.org/CORE_overview.php.
- Council for Affordable Quality Healthcare (CAQH): A nonprofit alliance of health plans and trade associations, working to simplify healthcare administration through industry collaboration on public-private initiatives. Through two initiatives – the Committee on Operating Rules for Information Exchange and Universal Provider Datasource – CAQH aims to reduce administrative burden for providers and health plans. www.caqh.org.
- Designated Standard Maintenance Organizations (DSMO): This site is a resource for information about the standard-setting organizations and transaction change request system: www.hipaa-dsmo.org.
- Health Level Seven (HL7): HL7 is one of several ANSI-accredited Standards Development Organizations (SDOs), and is responsible for clinical and administrative data standards. www.hl7.org.

- Healthcare Information and Management Systems (HIMSS): An organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care. www.himss.org.
- National Committee on Vital and Health Statistics (NCVHS): The National Committee on Vital and Health Statistics was established by Congress to serve as an advisory body to the Department of Health and Human Services on health data, statistics and national health information policy. www.ncvhs.hhs.gov.
- National Council of Prescription Drug Programs (NCPDP): The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org.
- National Uniform Billing Committee (NUBC): NUBC is affiliated with the American Hospital Association. It develops and maintains a national uniform billing instrument for use by the institutional health-care community to transmit claims and encounter information. www.nubc.org.
- National Uniform Claim Committee (NUCC): NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org.
- Nevada Department of Health and Human Services (DHHS) Division of Health Care Financing and Policy (DHCFP): The DHCFP website assists policy questions: http://dhcfp.nv.gov and this website assists providers with billing and enrollment support. www.medicaid.nv.gov/.
- Office for Civil Rights (OCR): OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa.
- United States Department of Health and Human Services (HHS): The DHHS website is a resource for the Notice of Proposed Rule Making, rules, and their information about HIPAA. www.aspe.hhs.gov/admnsimp.
- Washington Publishing Company (WPC): WPC is a resource for HIPAA-required transaction technical report type 3 documents and code sets. www.wpc-edi.com.
- Workgroup for Electronic Data Interchange (WEDI): WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org.

Appendix A: Dispense as Written (DAW) Product Selection Code

Definition of Field	Field Format
Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	x(1)

Values:

Code	Description
0	No Product Selection Indicated - This is the field default value that is appropriately used for prescriptions where product selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed.
1	Substitution Not Allowed by Prescriber - This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written.
2	Substitution Allowed - Patient Requested Product Dispensed - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.
3	Substitution Allowed - Pharmacist Selected Product Dispensed - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.
4	Substitution Allowed - Generic Drug Not in Stock - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.
5	Substitution Allowed - Brand Drug Dispensed as a Generic - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the Pharmacist is utilizing the brand product as the generic entity.
6	Override - This value is used by various claims processors in very specific instances as defined by that claims processor and/or its client(s).
7	Substitution Not Allowed - Brand Drug Mandated by Law - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a

Code	Description
	brand product even though generic versions of the product may be available in the marketplace.
8	Substitution Allowed - Generic Drug Not available in Marketplace - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed or is temporarily unavailable.
9	Other - This value is reserved and currently not in use. NCPDP does not recommend use of this value at the present time. Please contact NCPDP if you intend to use this value and document how it will be utilized by your organization.

Appendix B: Other Coverage Code

Definition of Field	Field Format
Code indicating whether or not the patient has other insurance coverage.	9(2)

Values:

Code	Description
0	Not Specified
1	No other coverage identified
2	Other coverage exists, payment collected
3	Other coverage exists, this claim not covered
4	Other coverage exists, payment not collected
8	Claim is a billing for a copay

Appendix C: Other Payer Amount Paid Qualifier

Definition of Field	Field Format
Code qualifying the 'Other Payer Amount Paid' (431-DV).	x(2)

Values:

Code	Description
01	Delivery – An indicator which signifies the amount paid for the costs related to the delivery of a product or service.
02	Shipping – The amount paid for transportation of an item.
03	Postage – The amount paid for the mailing of an item
04	Administrative – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance.
05	Incentive – Used to indicate an additional fee or compensation paid to the provider by another payer as an inducement for an action taken by the provider; this might be a collection of survey data or counseling to plan enrollees.
06	Cognitive Service – Used to indicate pharmacist interaction with patient or caregiver beyond the traditional dispensing/patient instruction activity. For example, therapeutic regimen review, recommendation for additional, fewer, or different therapeutic choices.
07	Drug Benefit – An indicator which signifies when the dollar amount paid by the other payer has been paid as part of the drug benefit plan.
09	Compound Preparation Cost – the amount paid for the preparation of the compound

Appendix D: Reason for Service Code

Definition of Field	Field Format
Code identifying the type of utilization	x(2)

Values:

Code	Description
AR	Adverse Drug Reaction – Code indicating an adverse reaction by a patient to a drug.
AT	Additive Toxicity – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself.
CD	Chronic Disease Management – The patient is participating in a coordinated health care intervention program.
CH	Call Helpdesk – Processor message to recommend the receiver contact the processor/plan.
CS	Patient Complaint/Symptom – Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment.
DA	Drug-Allergy – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question.
DC	Drug-Disease (Inferred) – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history.
DD	Drug-Drug Interaction – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately.
DF	Drug-Food interaction – Indicates interactions between a drug and certain foods.
DI	Drug Incompatibility – Indicates physical and chemical incompatibilities between two or more drugs.
DL	Drug-Lab Conflict – Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value.
DM	Apparent Drug Misuse – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber.
DR	Dose Range Conflict – Code indicating that the prescription does not follow recommended medication dosage.
DS	Tobacco Use – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products.

Code	Description
ED	Patient Education/Instruction – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient beyond the simple task of explaining the prescriber's instructions on the prescription.
ER	Overuse – Code indicating that the current prescription refill is occurring before the days' supply of the previous filling should have been exhausted.
EX	Excessive Quantity – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed.
HD	High Dose – Detects drug doses that fall above the standard dosing range.
IC	Iatrogenic Condition – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected.
ID	Ingredient Duplication – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected.
LD	Low Dose – Code indicating that the submitted drug doses fall below the standard dosing range.
LK	Lock In Recipient – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type; hence the member is "locked in" to using only those providers or pharmacies.
LR	Underuse – Code indicating that a prescription refill that occurred after the days' supply of the previous filling should have been exhausted.
MC	Drug-Disease (Reported) – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist.
MN	Insufficient Duration – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product's common uses, has been detected.
MS	Missing Information/Clarification – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information.
MX	Excessive Duration – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses.
NA	Drug Not Available – Indicates the drug is not currently available from any source.
NC	Non-covered Drug Purchase – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted and a claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug.
ND	New Disease/Diagnosis – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease.

Code	Description
NF	Non-Formulary Drug – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan.
NN	Unnecessary Drug – Code indicating that the drug is no longer needed by the patient.
NP	New Patient Processing – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient.
NR	Lactation/Nursing Interaction – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant.
NS	Insufficient Quantity – Code indicating that the quantity of dosage units prescribed is insufficient.
OH	Alcohol Conflict – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages.
PA	Drug-Age – Indicates age-dependent drug problems.
PC	Patient Question/Concern – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care.
PG	Drug-Pregnancy – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus.
PH	Preventive Health Care – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems.
PN	Prescriber Consultation – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient.
PP	Plan Protocol – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided.
PR	Prior Adverse Reaction – Code identifying the patient has had a previous atypical reaction to drugs.
PS	Product Selection Opportunity – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists.
RE	Suspected Environmental Risk – Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors.
RF	Health Provider Referral – Patient referred to the pharmacist by another health care provider for disease specific or general purposes.

Code	Description
SC	Suboptimal Compliance – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of noncompliance.
SD	Suboptimal Drug/Indication – Code indicating incorrect, inappropriate or less than optimal drug prescribed for the patient's condition.
SE	Side Effect – Code reporting possible major side effects of the prescribed drug.
SF	Suboptimal Dosage Form – Code indicating incorrect, inappropriate or less than optimal dosage form for the drug.
SR	Suboptimal Regimen – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question.
SX	Drug-Gender – Indicates the therapy is inappropriate or contraindicated in either males or females.
TD	Therapeutic – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected.
TN	Laboratory Test Needed – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy.
TP	Payer/Processor Question – Code indicating that a payer or processor requested information related to the care of a patient.
UD	Duplicate Drug – Code indicating that multiple prescriptions of the same drug formulation are present in the patient's current medication profile.

Appendix E: Professional Service Code

Definition of Field	Field Format
Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	x(2)

Values:

Code	Description
00	No intervention
AS	Patient assessment – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan.
CC	Coordination of care – Case management activities of a pharmacist related to the care being delivered by multiple providers.
DE	Dosing evaluation/determination – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation.
DP	Dosage evaluated – Code indicating that dosage has been evaluated with respect to risk for the patient.
FE	Formulary enforcement – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange.
GP	Generic product selection – The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer.
M0	Prescriber consulted – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem.
MA	Medication administration – Code indicating an action of supplying a medication to a patient through any of several routes — oral, topical, intravenous, intramuscular, intranasal, etc.
MB	Overriding benefit – Benefits of the prescribed medication outweigh the risks.
MP	Patient will be monitored – Prescriber is aware of the risk and will be monitoring the patient.
MR	Medication review – Code indicating comprehensive review and evaluation of a patient's entire medication regimen.
PA	Previous patient tolerance – Patient has taken medication previously without issue.
PE	Patient education/instruction – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management.

Code	Description
PH	Patient medication history – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile.
PM	Patient monitoring – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered.
P0	Patient consulted – Code indicating patient communication related to collection of information or clarification of a specific limited problem.
PT	Perform laboratory test – Code indicating that the pharmacist performed a clinical laboratory test on a patient.
R0	Pharmacist consulted other source – Code indicating communication related to collection of information or clarification of a specific limited problem.
RT	Recommend laboratory test – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient.
SC	Self-care consultation – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment.
SW	Literature search/review – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.
TC	Payer/processor consulted – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient.
TH	Therapeutic product interchange – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer.
ZZ	Other Acknowledgement. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.

Appendix F: Result of Service Code

Definition of Field	Field Format
Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	x(2)

Values:

Code	Description
00	Not specified
1A	Filled as is, false positive
1B	Filled prescription as is
1C	Filled with different dose
1D	Filled with different directions
1E	Filled with different drug
1F	Filled with different quantity
1G	Filled with prescription approval
1H	Brand – To – generic change
1J	RY – to – OTC change
1K	Filled with different dosage form
2A	Prescription not filled
2B	Not filled, directions clarified
3A	Recommendation accepted
3B	Recommendation not accepted
3C	Discontinued drug
3D	Regimen changed
3E	Therapy changed
3F	Therapy changed – cost increased acknowledged
3G	Drug therapy unchanged
3H	Follow-up/report
3J	Patient referral
3K	Instructions understood
3M	Compliance aid provided
3N	Medication Administered

Code	Description
4N	Prescribed with acknowledgments

Appendix G: Compound Dosage Form Description Code

Definition of Field	Field Format
Dosage form of the complete compound mixture.	x(2)

Values:

Code	Description
Blank	Not Specified
01	Capsule – a soluble dispensable unit enclosing a single dose of a medication or combination of medications
02	Ointment – a semisolid preparation, used as a vehicle for medication and applied externally to the body
03	Cream -- a soft solid or thick liquid containing medication, applied externally for a prophylactic, therapeutic or cosmetic purpose
04	Suppository – a dispensable unit containing a single dose of medication or combination of medications to be introduced into a body orifice, such as the rectum, urethra or vagina
05	Powder – finely ground particles of a solid medication
06	Emulsion – a mixture of two immiscible liquids, one being dispersed throughout the other in small droplets
07	Liquid – a substance that flows readily in its natural state
10	Tablet – a single dispensable unit containing one or more medications, with or without a suitable diluent
11	Solution – a homogeneous mixture of one or more liquids
12	Suspension – a preparation of a powdered form of a drug incorporated into a suitable liquid vehicle
13	Lotion – a liquid suspension for external application to the body
14	Shampoo – a liquid preparation (solution, suspension, emulsion) for external application to the scalp
15	Elixir – a clear, sweetened, usually hydro alcoholic liquid containing flavoring substance and one or more medications
16	Syrup – a concentrated solution of a sugar in water or other aqueous liquid and one or more medications
17	Lozenge – a solid, single dispensable unit containing one or more medications intended for dissolution in the mouth
18	Enema – a liquid preparation intended for introduction into the rectum containing one or more medications

Appendix H: Compound Ingredient Bases of Cost Determination

Definition of Field	Field Format
Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.	x(2)

Values:

Code	Description
00	Default
01	AWP (Average Wholesale Price)
02	Local Wholesaler
03	Direct
04	EAC (Estimated Acquisition Cost)
05	Acquisition
06	MAC (Maximum Allowable Cost)
07	Usual and Customary
08	340B/Disproportionate Share Pricing/Public Health Service
09	Other – Different from those implied or specific
10	ASP (Average Sales Price)
11	AMP (Average Manufacturer Price)
12	WAC (Wholesale Acquisition Cost)
13	Special Patient Pricing

Appendix I: Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to encounter claims submitted to Nevada Medicaid.

Q: As a Trading Partner or clearinghouse, who should I contact if I have questions about testing, specifications, Trading Partner enrollment or if I need technical assistance with electronic submission?

A: EDI testing and Trading Partner enrollment support is available Monday through Friday 8 a.m.-5 p.m. Pacific Time by calling toll-free at (877) 638-3472 option 2, 0, and then 3 or send an email to: nvmmis.edisupport@dxc.com.

Q: Who should I contact if I have questions regarding how an encounter claim was processed or to check on the status of a submitted encounter claim?

A: MCOs should send an email to nvmmis.edisupport@hdxc.com with any encounter claims status inquiries or questions regarding how an encounter claim was processed. The email should contain enough information to research the question. The following is a list of information that would be helpful in answering most questions:

- Trading Partner ID
- Contact Name
- Contact Phone Number
- Question
- Encounter Claim Identifying Information (TCN or Processor Control Number)
- Original File Name
- Response File Name
- Duplicate File Name

Q: How do I request and submit EDI files through the secure Nevada Medicaid SFTP server in production?

A: Once you have satisfied testing, you will receive an approval letter via email, which will contain the URL to connect to production.

Q: What types of acknowledgment reports will Nevada Medicaid return following EDI submission?

A: An NCPDP Encounter response file will be returned for all encounter claims stating each encounter claims' errors and disposition. An encounter claim duplicate file will be returned if duplicate encounter claims rejected within the Encounter Claims Engine.

Q: What transaction type should a corrected encounter record be submitted as (PAID, REPLACEMENT)? B1 OR B3?

A: We only allow B1 transactions. Encounters doesn't currently have replacement or resubmission processing. Adjustments can be sent and the instructions are in Companion Guide.

Q: Are there any requirements to submit separate files based on membership , plan, etc.?

A: No.

Q: Is there any requirement noted that certain transactions cannot go on the same file (i.e. PAID, VOID/REVERSAL, and/or correction records on separate files)?

A: No.

Q: Will response files be generated for full file rejections?

A: All files are currently full rejections.

Q: Can multiple NCPDP encounter files be submitted in a single day?

A: You can submit multiple files per day and per week.

Q: Will the response file be sent with line-feed or single string of data?

A: It is a file with end of record.

Q: Is a response returned for each record? Would an NCPDP Encounter claim be suspended for later processing?

A: Yes, and it's at the level of the batch. It'll list multiple edits, whether informational or threshold. The response record, once accepted, will receive an Encounter ICN. The word 'rejected' denotes reject.

Q: When can we expect the response file to be returned after the NCPDP file is submitted?

A: You will see it first thing the following morning.

Q: If we submit multiple files in a day, how are the response files returned?

A: One response file per submission file will be returned.