ADDENDUM 13

PRMMIS_PHASE_I_837D_Companion_Guide

PRMMIS_PHASE_I_837I_Companion_Guide

PRMMIS_PHASE_I_837P_Companion_Guide

PRMMIS_NCPDP_Post_Adjudication_
Companion_Guide

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GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3) Implementation Guides Based on ASC X12 Version 005010X222A1 Professional Health Care Claim/Encounter (837P)

Companion Guide Version Number: 7.1

November 2021

Puerto Rico Medicaid Management Information System Services Project

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Disclosure Statement

Companion guides may contain two types of data, instructions for electronic communications with the publishing entity (communications/connectivity instructions), and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 implementation guide (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every companion guide. The components may be published as separate documents or as a single document.

The communications/connectivity component is included in the companion guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The transaction instruction component is included in the companion guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12's copyrights and Fair Use statement.

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Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with the Puerto Rico Department of Health. Transmissions based on this companion guide, used in tandem with the TR3, also called the Health Care Professional Claim/Encounter ASC X12N version 005010X222A1 (837P), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. To access the HIPAA Implementation Guides, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

Disclaimer: The information contained in this Companion Guide is subject to change.

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1 INTRODUCTION

This section describes how TR3, also called 837P ASC X12N (version 005010X222A1), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Puerto Rico Department of Health has information additional to the TR3. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health's usage for composite and simple data elements, and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from Puerto Rico Department of Health for specific segments provided by the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 6: TRANSACTION-SPECIFIC INFORMATION.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Puerto Rico Department of Health.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value "N6" is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

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1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 837P (referred to as Professional Claim/Encounter in the rest of this document) for the purpose of submitting 837P electronically. This companion guide is not intended to replace the TR3. The TR3s define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this companion guide is to provide trading partners with a guide to communicate Puerto Rico Department of Health-specific information required to successfully exchange transactions electronically with Puerto Rico Department of Health. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

The information contained in this companion guide applies to Puerto Rico Department of Health for processing.

Puerto Rico Department of Health will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Puerto Rico Department of Health-specific information, though processed, may be denied. For example, a compliant 837P Claim/Encounter created with an invalid Puerto Rico Department of Health member identification number will be processed by Puerto Rico Department of Health, but will be denied. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the Puerto Rico Department of Health.

Refer to this companion guide first if there is a question about how Puerto Rico Department of Health processes a HIPAA transaction. For further information, contact **their policy-specific** area of the Puerto Rico Department of Health or PRMMIS MCO EDI (prmmis_edi_support@gainwelltechnologies.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCOs) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions. This document provides instructions for obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

Per HIPAA requirements, Puerto Rico Department of Health and all other covered entities must comply with the EDI standards for health care as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required under HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. Additionally, HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The HIPAA requirements serve to:

- Create better access to health insurance.
- Limit fraud and abuse.
- Reduce administrative costs.

This guide is designed to help those responsible for testing and setting up electronic Professional Claim/Encounter transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting, and identifies codes and data elements that do not apply to Puerto Rico Department of Health. This guide supplements (but does not contradict) requirements in the ASC X12N 837P (version 005010X222A1) Implementation Guide. This guide provides communications-related information that a trading partner needs to enroll as

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a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with Puerto Rico Department of Health.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic 837P transactions that meet Puerto Rico Department of Health processing standards by identifying pertinent structural and data-related requirements and recommendations.

1.3 References

For more information regarding the ASC X12 Standards for Electronic Data Interchange 837P Health Care Claim/Encounter (version 005010X222A1) and to purchase copies of the TR3 documents, consult the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that the provider's Information Technology (IT) staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Puerto Rico Department of Health.

To obtain the Provider taxonomy code set, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

1.4 Additional Information

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standard is recognized by the United States as the standard for North America. Electronic Data Interchange adoption has been proved to reduce the administrative burden on providers.

The intended audience for this document is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

National Provider Identifier

As a result of HIPAA, the federal HHS adopted a standard identifier for health care providers. The Final Rule published by the HHS adopted the National Provider Identifier (NPI) as the standard identifier.

The NPI replaces all payer-specific identification numbers (e.g., Medicaid provider numbers) on nationally recognized electronic transactions (also known as standard transactions); therefore, all health care providers are required to obtain an NPI to identify themselves on these transactions. The NPI is the only identification number that will be allowed on these transactions.

All providers, except those that the Puerto Rico Department of Health determined to not identify as a healthcare provider such as non-emergency transportation, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. Puerto Rico Department of Health requires all health care providers to submit their NPI on electronic transactions.

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Acceptable Characters

The HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. Puerto Rico Department of Health accepts the extended character set. Uppercase characters are recommended. Files should be less than 100 MB.

File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance to standard file naming conventions, including a valid three-character file extension. The following standards should be used:

- To avoid accidently overwriting files, do not send multiple files with the same name on the same day.
- File Names should not be longer than 45 characters.
- File Names should not contain spaces or special characters.
- File Names should contain a file extension such as .dat or .txt.
- Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file.
- Zip files must contain the extension .zip (not case sensitive).

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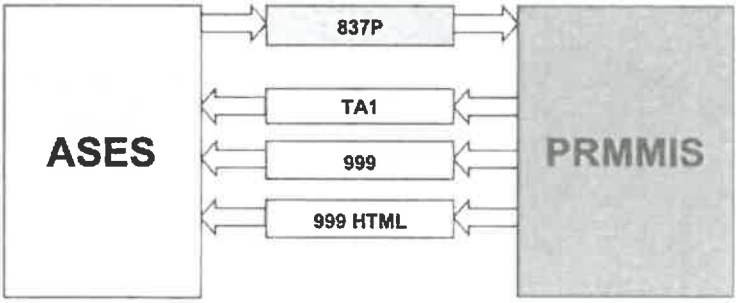
2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

This section describes the process to interactively submit HIPAA 837P transactions, along with various submission methods, security requirements, and exception handling procedures.

2.1 Process Flows

This section contains process flow diagrams and appropriate text.
Each transaction is validated to ensure that the 837P complies with the 005010X222A1 TR3.

Transactions that fail this compliance check will generate a "Rejected" 999 file back to the sender with an error message indicating the compliance error. Transactions that pass this compliance check will generate an "Accepted" 999 file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a "Partial" 999 file back to the sender with an error message indicating the compliance error (all claims/encounters in the ST/SE envelopes that pass compliance will be processed). Claims/Encounters that pass compliance checks but fail to process (e.g., due to member not being found) will be denied. Claims/Encounters that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the date(s) of service) will be classified as "paid."



2.2 Transmission Administrative Procedures

This section provides Puerto Rico Department of Health's-specific transmission administrative procedures.

The trading partner must determine if the transmission being sent is Test or Production and is using the appropriate indicator (ISA15). For details about available Puerto Rico Department of Health access methods, refer to the Communication Protocol Specifications section.

Puerto Rico Department of Health is available only to authorized users. Submitters must be Puerto Rico Department of Health trading partners. A submitter is authenticated using a username and password assigned by the trading partner.

2.3 Communication Protocol Specifications

This section describes Puerto Rico Department of Health's communication protocol(s).
The following communication methods are available to get a member's Eligibility and Benefits from Puerto Rico Department of Health:

Batch

Trading partners can submit all batch transactions to Puerto Rico Department of Health and download acknowledgements and response files. Access is free; however, the user must have his or her own internet connection to access the web application.

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3 CONTROL SEGMENTS / ENVELOPES

3.1 ISA-IEA

This section describes Puerto Rico Department of Health's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

Interchange Control Header (ISA)

To promote efficient, accurate electronic transaction processing, please note the following Puerto Rico Department of Health specifications:

- Each trading partner is assigned a Trading Partner ID.
- All dates are in the CCYYMMDD format. Except for ISA09.
- All dates/times are in the CCYYMMDDHHMM format.
- Payer IDs can be found in the companion guides.
- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Each Payer ID must be in its own file.
- No more than 999 claims/encounters per Transaction Set (ST-SE).
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted as a batch are identified by an ISA and trailer segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The table below represents only those fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction — the TR3 should be reviewed for that information.

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

Note: Puerto Rico Department of Health accepts files with one ISA/IEA loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	03	ENCOUNTER – "03" – Additional Data Identification
C.4		ISA02	Authorization Information		ENCOUNTER – MCO Medicaid ID + [space fill]
C.4		ISA03	Security Information Qualifier	00	00 = No Security Information Present
C.4		ISA04	Security Information		[space fill]
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	ZZ = Mutually defined
C.4		ISA06	Interchange Sender ID		Trading Partner ID supplied by Puerto Rico Department of Health, left-justified and space-filled.
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	ZZ = Mutually defined
C.5		ISA08	Interchange Receiver ID	PRMMIS	"PRMMIS" – left-justified and space-filled.
C.5		ISA09	Interchange Date		The date format is YYMMDD.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.5		ISA10	Interchange Time		The time format is HHMM.
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	00501 = Control Version Number
C.5		ISA13	Interchange Control Number		The interchange control number assigned in ISA13 must be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	0 = No interchange acknowledgment requested (TA1)
C.6		ISA15	Usage Identifier	P, T	Code indicating whether the data enclosed is Production or Test.
			Production Data	P	Enter value "P" to indicate that the file contains Production data.
			Test Data	T	Enter value "T" to indicate that the file contains Test data.
C.6		ISA16	Component Separator	:	A colon ":" is recommended.

IEA – Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.10	None	IEA	Interchange Control Trailer		
C.10		IEA01	Number of Included Functional Groups		Number of included Functional Groups
C.10		IEA02	Interchange Control Number		Must be identical to the value in ISA13

3.2 GS-GE

This section describes Puerto Rico Department of Health's use of the functional group control segments.

It includes a description of expected application sender and receiver codes.

Functional Group Header (GS)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

Note: Puerto Rico Department of Health only accepts files with one GS/GE loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	None	GS	Functional Group Header		
C.7		GS01	Functional ID Code	HC	"HC" – Health Care Professional Claim/Encounter (837P)

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7		GS02	Application Sender's Code		'Trading Partner ID' supplied by Puerto Rico Department of Health.
C.7		GS03	Application Receiver's Code	PRMMIS	'PRMMIS' Puerto Rico Department of Health Sender ID.
C.7		GS04	Date		The date format is CCYYMMDD.
C.8		GS05	Time		The time format is HHMM.
C.8		GS06	Group Control Number		Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	"X" – Responsible Agency Code
C.8		GS08	Version / Release / Industry Identifier Code	005010X222A1	Version / Release / Industry Identifier Code

Functional Group Trailer (GE)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	None	GE	Functional Group Trailer		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

3.3 ST-SE

This section describes Puerto Rico Department of Health's use of transaction set control numbers.

Puerto Rico Department of Health recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with "000000001" and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

TRANSACTION SET HEADER (ST)

The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	837	837 Health Care Claim
70		ST02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X222A1	This field contains the same value as GS08.

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TRANSACTION SET TRAILER (SE)

The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of transaction sets
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

3.4 Control Segment Notes

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

3.5 File Delimiters

Puerto Rico Department of Health requests that you use the following delimiters on your file. If used as delimiters, these characters must not be submitted within the data content of the transaction sets. Contact PRMMIS MCO EDI (prmmis_edi_support@gainwelltechnologies.com) if there is a need to use a delimiter other than the following:

- Segment Terminator = ~
- Element Separator = *
- Component Separator = :
- Repetition Separator = ^

Element Separator

Byte 4 in the ISA segment defines the element separator to be used throughout the entire transaction. The recommended element separator is an asterisk (*).

Repetition Separator

ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^).

Component Separator

ISA16 defines the component separator to be used throughout the entire transaction. The recommended component separator is a colon (:).

Segment Terminator

Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The recommended segment terminator is a tilde (~).

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4 PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS

4.1 Trading Partner Identification Number

In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS, the EDI team will create any needed Trading Partner Profiles.

4.2 Testing

Module One of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.

4.3 Terminology

The term "subscriber" will be used as a generic term throughout the companion guide.

4.4 Limits

File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including a Transaction ST segment and Transaction SE segment.

4.5 Scheduled Maintenance

Puerto Rico Department of Health schedules regular maintenance every Sunday from 01:00 a.m. to 05:00 a.m. EST.

4.6 Procedures for Voiding Encounters

PRMMIS requires that the MCO's internal Transaction Control Number (TCN) be sent for every claim:

Loop 2330B – Other Payer Name
REF – Other Payer Claim Control Number
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the claim being submitted

When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:

Loop: 2300 — CLAIM INFORMATION
REF – PAYER CLAIM CONTROL NUMBER
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the encounter being voided

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5 ACKNOWLEDGEMENTS AND/OR REPORTS

5.1 Acknowledgements

TA1 — Transaction Acknowledgement

Puerto Rico Department of Health will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced, then a 999 will not be sent. The submitted 837P will need to be corrected and resubmitted.

999 — Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file. Puerto Rico Department of Health will always respond with a 999 for a batch X12 file. If a "rejected" 999 is produced then claims/encounters will not be sent to the claims engine for adjudication. The submitted 837P will need to be corrected and resubmitted.

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6 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the implementation guides. That information can do the following:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health's usage for composite and simple data elements, and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the TR3s.

6.1 005010X222A1 — 837P Health Care Claim/Encounter

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
71	None	BHT	Beginning of Hierarchical Transaction		
71	None	BHT02	Transaction Set Purpose Code	00	"00" – Original
71	None	BHT06	Claim Identifier	CH, RP	CH = Claims — Chargeable. RP = Encounters — Reporting.
74	1000A	NM1	Submitter Name		
75	1000A	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
75	1000A	NM109	Submitter Identifier		Enter the same value as ISA06 'Trading Partner ID' supplied by Puerto Rico Department of Health.
76	1000A	PER	Submitter EDI Contact Information		This segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
77	1000A	PER01	Contact Function Code	IC	"IC" – Information Contact
77	1000A	PER02	Submitter Contact Name		This is required if it's different than the name contained in the Submitter Name (Loop 1000A, NM1 segment).
77	1000A	PER03	Communication Number Qualifier	EM, FX, TE	"EM" – Electronic Mail "FX" – Fax "TE" – Telephone
77	1000A	PER04	Communication Number		Email Address, Fax Number, or Telephone Number (including the area code)

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
79	1000B	NM1	Receiver Name		
80	1000B	NM103	Receiver Name	PUERTO RICO DEPARTMENT OF HEALTH	"PUERTO RICO DEPARTMENT OF HEALTH"
80	1000B	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
80	1000B	NM109	Receiver Primary Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
83	2000A	PRV	Billing Provider Specialty Information		ENCOUNTER – When required for NPI crosswalk, this loop should contain the Taxonomy Code for the Provider paid by the MCO (refer to 2010AA below).
83	2000A	PRV01	Provider Code	BI	"BI" – Billing
83	2000A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code *Note:* Taxonomy codes are only required if the National Provider Identifier (NPI) has multiple certifications and the taxonomy is necessary to determine the appropriate one.
83	2000A	PRV03	Provider Taxonomy Code		Enter the taxonomy that was reported to Puerto Rico Department of Health for the service you are billing. *Note:* The provider is required to use the appropriate taxonomy code that is associated to the provider type and specialty currently on file with Puerto Rico Department of Health.
88	2010AA	NM1	Billing Provider Name		ENCOUNTER – This loop should contain the NPI information for the Provider paid by the MCO. *Note:* For MCO Plan ID submission information, refer to ISA01 and ISA02.
88	2010AA	NM102	Entity Identifier Code	85	"85" – Billing Provider
89	2010AA	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
89	2010AA	NM109	Billing Provider Identifier		HIPAA National Provider Identifier
91	2010AA	N3	Billing Provider Address		Enter the address that is currently on file with Puerto Rico Department Of Health. *Note:* Do not enter a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-To Address loop.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
92	2010AA	N4	Geographic Location		Use the physical address as reported on the provider's Puerto Rico Department of Health certification.
93	2010AA	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department Of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
94	2010AA	REF	Billing Provider Tax Identification		
94	2010AA	REF01	Reference Identification Qualifier	EI	"EI" – Employer ID Number (EIN)
94	2010AA	REF02	Billing Provider Tax Identification Number		Valid nine-digit Employer ID number
101	2010AB	NM1	Pay-To Address Name		*Note:* This loop will not be used by Puerto Rico Department of Health's PRMMIS.
114	2000B	HL	Subscriber Hierarchical Level		*Note:* For Puerto Rico Department of Health, the insured and the patient are always the same person. Use this HL segment to identify the recipient and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.
115	2000B	HL03	Hierarchical Level Code	22	"22" – Subscriber
115	2000B	HL04	Hierarchical Child Code	0	"0" – No Subordinate HL Segment in this Hierarchical Structure.
116	2000B	SBR	Subscriber Information		
116	2000B	SBR01	Payer Responsibility Sequence Number Code		Refer to the 837 Professional Implementation Guide for valid values (page 296).
118	2000B	SBR09	Claim Filing Indicator Code	MC	"MC" – Medicaid
121	2010BA	NM1	Subscriber Name		Enter information about the subscriber/member in this loop.
122	2010BA	NM102	Entity Type Qualifier	1	Enter the value "1" to indicate that the member is a person.
122	2010BA	NM103	Subscriber Last Name		Enter the member's last name.
122	2010BA	NM104	Subscriber First Name		Enter the member's first name.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
122	2010BA	NM108	Identification Code Qualifier	MI	MI = Member Identification number.
123	2010BA	NM109	Subscriber Primary Identifier		PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
125	2010BA	N4	Subscriber City, State, Zip Code		
125	2010BA	N401	Subscriber City Name		Subscriber City
125	2010BA	N402	Subscriber State Code		Subscriber State
126	2010BA	N403	Subscriber Postal Zone or ZIP Code		Subscriber Zip Code
130	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department Of Health.
133	2010BB	NM1	Payer Name		
134	2010BB	NM103	Payer Name	PUERTO RICO DEPARTMENT OF HEALTH	Enter "PUERTO RICO DEPARTMENT OF HEALTH"
134	2010BB	NM108	Identification Code Qualifier	PI	"PI" – Payer Identification
134	2010BB	NM109	Payer Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
136	2010BB	N4	Payer City, State, Zip Code		
136	2010BB	N401	City Name	SAN JUAN	
137	2010BB	N402	Payer State Code	PR	
137	2010BB	N403	Payer Postal Zone or ZIP Code	00922	
140	2010BB	REF	Billing Provider Secondary Identification		*Note:* Non-healthcare (Atypical) providers are required to submit this segment.
140	2010BB	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Code *Note:* This qualifier may only be used by non-healthcare providers who do not possess an NPI ID (i.e., Med waivers).
141	2010BB	REF02	Billing Provider Secondary Identifier		Puerto Rico Department of Health Provider ID
157	2300	CLM	Claim Information		*Note:* Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, Puerto Rico Medicaid Program PRMMIS reserves the

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					partners to enter Patient Control Number (PCN) and Transaction Control Number (TCN) in CLM01 separated by a dash.
158	2300	CLM01	Patient Control Number		ENCOUNTER: Trading partners should enter the encounter's Patient Control Number (PCN) and Transaction Control Number (TCN) separated by a dash – all characters will be returned in the 835's CLP01 field.
159	2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter.
159	2300	CLM05-1	Facility Type Code		Value received is the first two positions of the Type of Bill (TOB). Enter the two-digit Place of Service Code at the claim header. Enter Place of Service code "99" for public transportation claims.
159	2300	CLM05-2	Facility Code Qualifier	B	"B" – Place of Service Codes for Professional or Dental Services
159	2300	CLM05-3	Claim Frequency Code	1, 7, 8	The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or if it is a replacement/void of a previously adjudicated and "paid" claim/encounter: "1" – Original Claim/encounter submitted to PRMMIS. "7" – Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" – Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. ENCOUNTER – Use "1" as a Frequency code when resubmitting a denied claim. *Note:* The use of values "7" and "8" can result in the previously submitted claim/encounter being adjusted. Include the Internal Control Number (ICN) from the previously submitted claim/encounter in the original

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					reference number segment in Loop 2300. The claim frequency code was switched to an external code source during the addenda process. See the NUBC Manual or Web site, www.nubc.org/. ENCOUNTER: Paper submissions/requests will not be supported for encounter processing. ENCOUNTER: MCOs are required to send their Claim ID (TCN) for each encounter submitted as well as their Claim ID (TCN) for an encounter being voided (refer to Section 4.6 – Procedures for Voiding Encounters).
161	2300	CLM11-1	Related Causes Code	AA, EM, OA	"AA" – Auto Accident "EM" – Employment "OA" – Other Accident If the services being rendered are the result of an injury or accident, enter one of the standard two-character injury codes listed above in each Data Element if they apply. Otherwise, this field may be left blank.
161	2300	CLM11-2	Related Causes Code	AA, EM, OA	"AA" – Auto Accident "EM" – Employment "OA" – Other Accident If the services being rendered are the result of an injury or accident, enter one of the standard two-character injury codes listed above in each Data Element, if they apply. Otherwise, this field may be left blank.
182	2300	PWK	Claim Supplemental Information		Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.
186	2300	CN1	Contract Information		ENCOUNTER – This is required when the encounter claim was paid at the header level. This refers to the contract between the plan and the provider paid by the plan.
186	2300	CN101	Contract Type Code		ENCOUNTER – Required "05" – If provider's services were provided under a capitation agreement, Fee For Service (FFS) encounter claims should indicate the appropriate value as listed in the TR3.
186	2300	CN102	Contract Amount		ENCOUNTER – Required If CN101 = "05", then amount is zero. For all other values of CN101, then the amount paid to the provider for service rendered

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					Note: The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 Loop) and CN102 contains the total monetary amount the health plan paid the provider.
193	2300	REF	Referral Number		
193	2300	REF01	Reference Identification Qualifier	9F	"9F" – Referral Number
193	2300	REF02	Referral Number		
194	2300	REF	Prior Authorization		
194	2300	REF01	Reference Identification Qualifier	G1	"G1" – Prior Authorization Number
195	2300	REF02	Prior Authorization Number		Enter the 10-digit Prior Authorization Number. Enter this number only if the services rendered required and received prior authorization. This number must be entered with the qualifier "G1" (Prior Authorization Number).
196	2300	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested). ENCOUNTER – MCOs are required to send their Claim ID (TCN) for an encounter being voided (refer to Section 4.6 – Procedures for Voiding Encounters).
196	2300	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number
196	2300	REF02	Payer Claim Control Number		The ID (TCN), in the MCO's system, of the encounter being voided.
211	2300	CR1	Ambulance Transport Information		
212	2300	CR104	Ambulance Transport Reason Code		Enter the Ambulance Transport Reason Code. *Note:* Refer to the 837 Professional Implementation Guide for the valid code values.
212	2300	CR105	Unit or Basis for Measurement Code	DH	"DH" – Miles
213	2300	CR106	Transport Distance		Puerto Rico Department of Health processes only the whole number when units are entered with decimals. Example: Units entered on the transaction, 3.75, are processed as 3 units.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
213	2300	CR109	Round Trip Purpose Description		Description/clarification of the Purpose of the ambulatory trip. *Note:* Only used on round-trip ambulatory claims.
214	2300	CR2	Spinal Manipulation Service Information		
215	2300	CR208	Patient Condition Code		Enter the corresponding Condition Code. *Note:* Refer to the 837 Professional Implementation Guide for the valid code values.
216	2300	CRC	EPSDT Referral		
216	2300	CRC01	Code Category	07, ZZ	"07" – Ambulance Certification "ZZ" – Mutually Defined Enter this for Child Health Check-Up Screening Referral Information.
217	2300	CRC02	Certification Condition Indicator	Y, N	"Y" – Yes "N" – No For Child Health Check-Up screenings, enter a "Y" if the patient is referred to another provider as a result of the screening. Enter "N" if no referral is made. If "N" is entered here, enter "NU".
217	2300	CRC03	Condition Code	AV, NU, S2, ST	Enter one of the following valid values. For Child Health Check-Up Exam Result: "AV" – Patient Refused Referral "NU" – Not Used (Patient Not Referred) "S2" – Under Treatment "ST" – New Services Requested
257	2310A	NM1	Referring Provider Name		
258	2310A	NM101	Entity Identifier Code	DN	"DN" – Referring Provider
258	2310A	NM102	Entity Type Qualifier	1	"1" – Person
259	2310A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
259	2310A	NM109	Referring Provider Identifier		
260	2310A	REF	Referring Provider Secondary Identification		
260	2310A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
262	2310B	NM1	Rendering Provider Name		*Note:* This is required when the Rendering Provider is different than

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					the Billing Provider reported in Loop 2010AA. *Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop (2310C – N403).
263	2310B	NM101	Entity Identifier Code	82	"82" – Rendering Provider
264	2310B	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
264	2310B	NM109	Rendering Provider Identifier		
265	2310B	PRV	Rendering Provider Specialty Information		
265	2310B	PRV01	Provider Code	PE	"PE" – Performing
265	2310B	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
265	2310B	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code that is used for claims submitted with NPI.
267	2310B	REF	Rendering Provider Secondary Identification		
267	2310B	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non-healthcare providers. This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.
269	2310C	NM1	Service Facility Name		*Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop (2310C – N403).
270	2310C	NM101	Entity Identifier Code	77	"77" – Service Location
270	2310A	NM102	Entity Type Qualifier	2	"2" – Non-Person Entity
270	2310A	NM103	Laboratory or Facility Name		
271	2310C	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
271	2310C	NM109	Laboratory or Facility Primary Identifier		
272	2310C	N3	Service Facility Location Address		

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
272	2310C	N301	Laboratory or Facility Address Line		
273	2310C	N4	Service Facility Location City, State, Zip Code		
273	2310C	N401	Laboratory or Facility City Name		
273	2310C	N402	Laboratory or Facility State or Province Code		
273	2310C	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
275	2310C	REF	Service Facility Location Secondary Information		
275	2310C	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
276	2310C	REF02	Laboratory or Facility Secondary Identifier		
285	2310E	NM1	Ambulance Pick-Up Location		*Note:* For Ambulatory claims only.
285	2310E	NM101	Entity Identifier Code	PW	"PW" – Pickup Address
286	2310E	NM102	Identification Code Qualifier	2	"2" – Non-Person Entity
287	2310E	N3	Ambulance Pick-Up Location Address		
287	2310E	N301	Ambulance Pick-up Address Line		*Note:* If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, 'crossroad of State Road 34 and 45' or 'Exit near Mile marker 265 on Interstate').
288	2310E	N4	Ambulance Pick-Up Location City, State, Zip Code		
288	2310E	N401	Ambulance Pick-up City Name		
289	2310E	N402	Ambulance Pick-up State or Province Code		
289	2310E	N403	Ambulance Pick-up Postal Zone or ZIP Code		
290	2310F	NM1	Ambulance Drop-Off Location		*Note:* For Ambulatory Claims Only
290	2310F	NM101	Entity Identifier Code	45	"45" – Drop-Off Location
291	2310F	NM102	Identification Code Qualifier	2	"2" – Non-Person Entity

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
292	2310F	N3	Ambulance Drop-Off Location Address		
292	2310F	N301	Ambulance Drop-off Address Line		*Note:* If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, 'crossroad of State Road 34 and 45' or 'Exit near Mile marker 265 on Interstate').
293	2310F	N4	Ambulance Drop-Off Location City, State and Zip Code		
293	2310F	N401	Ambulance Drop-off City Name		
294	2310F	N402	Ambulance Drop-off State or Province Code		
294	2310F	N403	Ambulance Drop-off Postal Zone or ZIP Code		
295	2320	SBR	Other Subscriber Information		ENCOUNTER – Loop 2320 (Other Subscriber Information) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
298	2320	SBR09	Claim Filing Indicator Code		ENCOUNTER – When the MCO is the payer, the value should be "HM". *Note:* All valid values will be accepted for other payer loops.
299	2320	CAS	Claim Level Adjustments		
301	2320	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO denied claim
305	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
305	2320	AMT01	Amount Qualifier Code	D	"D" – Payer Amount Paid
305	2320	AMT02	Payer Paid Amount		Other Payer Amount Paid (Third Party Liability or Managed Care Organization)
320	2330B	NM1	Other Payer Name		ENCOUNTER – Loop 2330B (Other Payer Name) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
321	2330B	NM109	Other Payer Primary Identifier		This number must be identical to at least one occurrence of the 2430-SVD01 to identify the other payer. Puerto Rico Department of Health captures Third Party Payment Amount(s) from the service line(s) in 2430-SVD02. *Note:* The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail. ENCOUNTER – This value should be the MCO's assigned Trading Partner ID.
258	2330B	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal Claim ID be entered here for every encounter.
258	2330B	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number
258	2330B	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted.
350	2400	LX	Service Line Number		
350	2400	LX01	Assigned Number		
351	2400	SV1	Professional Service		
351	2400	SV101	Service Line Revenue Code		*Note:* Nursing homes are not a covered service under the Puerto Rico Medicaid program.
352	2400	SV101-1	Product/Service ID Qualifier	HC	"HC" – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
353	2400	SV101-2	Procedure Code		Enter the procedure code for this Service line. For Child Health Check-up (CHCUP) claims, enter the screening procedure code on the first service line. Enter procedure code "99998" for Public Transportation Claims.
355	2400	SV104	Service Unit Count		
357	2400	SV109	Emergency Indicator	Y	"Y" – Yes Enter 'Y' if the services are known to be an emergency.
357	2400	SV111	EPSDT Indicator	Y	"Y" – Yes Enter 'Y' when the recipient was referred for services as the result of a Child Health Check-up screening.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
357	2400	SV112	Family Planning Indicator	Y	"Y" – Yes Enter 'Y' if the services relate to pregnancy or if the services were for Family Planning.
373	2400	CRC	Ambulance Certification		
374	2400	CRC03	Condition Code		Enter the Patient Condition Code. Use this Loop and Segment if Condition Code is different by detail line, otherwise use CRC03 in the 2300 Loop if the Condition Code applies to entire claim. Used only for Ambulance claims.
375	2400	CRC07	Condition Code		Enter the Patient Condition Code. Use this Loop and Segment if the Condition Code is different by detail line, otherwise use CRC03 in the 2300 Loop if the Condition Code applies to entire claim. Used only for Ambulance claims.
395	2400	CN1	Contract Information		ENCOUNTER – This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan.
395	2400	CN101	Contract Type Code		ENCOUNTER – Required "05" – If provider's services were provided under a capitation agreement, Fee For Service encounter claims should indicate the appropriate value as listed in the TR3.
395	2400	CN102	Contract Amount		ENCOUNTER – Required If CN101 = "05", then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (SVD02 in 2430 loop) and CN102 contains the amount that the health plan paid the provider for this detail.
423	2410	LIN	Drug Identification		
425	2410	LIN02	Product or Service ID Qualifier	N4	"N4" – National Drug Code
425	2410	LIN03	National Drug Code		Enter National Drug Code in 5-4-2 format.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
426	2410	CTP	Drug Quantity		
426	2410	CTP04	National Drug Unit Count		
427	2410	CTP05-1	Code Qualifier	UN	"UN" – Unit
430	2420A	NM1	Rendering Provider Name		*Note:* This is required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering Provider information is different than the Billing Provider (2010 AA). *Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop (2310C – N403).
432	2420A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
432	2420A	NM109	Rendering Provider Identifier		
433	2420A	PRV	Rendering Provider Specialty Information		
433	2420A	PRV01	Provider Code	PE	"PE" – Performing
433	2420A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
433	2420A	PRV03	Provider Taxonomy Code		Detail Level Rendering Provider Taxonomy Code
434	2420A	REF	Rendering Provider Secondary Identification		
434	2420A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* Non-healthcare providers must send this REF segment where REF01 = G2.
435	2420A	REF02	Rendering Provider Secondary Identifier		Enter Puerto Rico Medicaid Provider ID.
441	2420C	NM1	Service Facility Name		*Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop (2310C – N403).
442	2420C	NM101	Entity Identifier Code	77	"77" – Service Location
442	2420C	NM102	Entity Type Qualifier	2	"2" – Non-Person Entity
442	2420C	NM103	Laboratory or Facility Name		

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
442	2420C	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
442	2420C	NM109	Laboratory or Facility Primary Identifier		
444	2420C	N3	Service Facility Location Address		
444	2420C	N301	Laboratory or Facility Address Line		
445	2420C	N4	Service Facility Location City, State, Zip Code		
445	2420C	N401	Laboratory or Facility City Name		
446	2420C	N402	Laboratory or Facility State or Province Code		
446	2420C	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
447	2420C	REF	Service Facility Location Secondary Information		
447	2420C	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
448	2420C	REF02	Laboratory or Facility Secondary Identifier		
480	2430	SVD	Line Adjudication Information		ENCOUNTER – Loop 2430 is required on all encounter claims. *Note:* Other payer payment amounts are required to be entered at the detail level.
480	2430	SVD01	Other Payer Primary Identifier		This should match one occurrence of the 2330B-NM109 Identifying Other Payer.
480	2430	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount. ENCOUNTER – If CN101 = "05", SVD02 should be zero. If CN101 = "09", then SVD02 should be the detail other payer paid amount or amount health plan paid to provider.
484	2430	CAS	Line Adjustment		

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
486	2430	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO Denied detail
486	2430	CAS03	Adjustment Amount		

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A. APPENDIX A

A.1 Change Summary

Version 1.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Initial Submission

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A.2 Change Summary

Version 2.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2310B	24	NM1	Rendering Provider Name		*Note:* Required when the Rendering Provider is different than the Attending Provider reported in Loop ID-2310A of this claim. *Note:* If a zip code is required in the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C. **Changed to:** *Note:* Required when the Rendering Provider is different than the Billing Provider reported in Loop 2010AA.

A.3 Change Summary

Version 3.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	3		Introduction		The following is just an example of the type of information that would be spelled out or elaborated on in Section 6: TRANSACTION-SPECIFIC INFORMATION.
2300	19	CLM02	Total Claim Charge Amount		Remove Note – negative amount will fail compliance
2300	21	CN101	Contract Type Code		Modify test: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	21	CN102	Contract Amount		Change text to: ENCOUNTER - Required

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					If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	22	REF02	Value Added Network Trace Number		Modify text: Enter the 13-digit ICN or 17-digit TCN assigned to the original claim submission. (ICN/TCN to be credited/voided).
2310A	23	REF01	Reference Identification Qualifier	0B, G2	*Note:* The "G2" qualifier must be used for non-healthcare providers.
2310B	24	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers. This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.
2310C	25	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
2400	28	SV101-1	Product/Service ID Qualifier	HC	Element changed from SV102-1 to SV101-1.
2400	28	SV101-2	Procedure Code		Element changed from SV102-2 to SV101-2.
2400	29	CRC	Ambulance Certification		Loop corrected from 2410 to 2400
2400	29	CRC03	Condition Code		Loop corrected from 2410 to 2400
2400	29	CRC07	Condition Code		Loop corrected from 2410 to 2400

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2420C	31	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier must be used for non-healthcare providers.

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A.4 Change Summary

Version 3.1 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 09-09-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Section 1.1	8		Scope		Modify text: For further information, contact their policy-specific area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses
Section 1.2	8		Overview		Remove text: This information should be given to the provider's business area to ensure that Claim/Encounters are interpreted correctly.
Section 1.4	9		National Provider Identifier		Modify text: All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency transportation,
Section 1.4	10		File/System Specifications		Remove text: The recommended extension is .txt or .dat. EDI does not allow zipped files. Files will be submitted to EDI via STFP. Add text: The following standards should be used: To avoid accidently overwriting files, do not send multiple files with the same name on the same day. File Names should not be longer than 45 characters

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					File Names should not contain spaces or special characters File Names should contain a file extension such as .dat or .txt Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file Zip files must contain the extension .zip (not case sensitive)
Section 1.4	10		Negative Dollar Amounts		New Paragraph: Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
Section 2.1	11		Process Flows		Modify text: classified as "paid".
N/A	12	ISA01	Authorization Information Qualifier		Remove text: Claim - [space fill]
N/A	12	ISA02	Authorization Information		Remove text: "00" – No Authorization Information Present.
N/A	14	ISA14	Acknowledgement Requested	0	Remove code 1 & comment.
Section 4.1	16		Trading Partner Identification		Modify text: In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS the EDI team will create any needed Trading Partner Profiles
Section 4.2	16		Testing		Modify text: Module one of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.
Section 4.4	16		Limits		Modify text: File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including the Transaction ST segment and Transaction SE segment.
Section 4.6	16		Procedures for voiding encounters		Modify text:

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					When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:
1000B	18	NM1	Receiver Name		Correct the Loop number.
2010AB	20	NM1	Pay-to-Address		Modify text: *Note:* This loop will not be used by Puerto Rico Department of Health's PRMMIS.
2010BA	22	NM109	Subscriber Primary Identifier		Change text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. Remove Text: *Note:* Do not enter any other numbers or letters. Use the Puerto Rico Department of Health card or the EVS to obtain the correct identification number.
2300	23	CLM01	Patient Control Number		Modify text: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. Remove text: *Note:* Value received is returned on the 835 Remittance Advice. Add text: ENCOUNTERS: MCO should send the original PCN from the provider's original claim.
2300	23	CLM05-1	Facility Type Code		Remove text: *Note:* See the Medicaid Provider Reimbursement Handbook for a list of all of the valid values.
2300	23	CLM05-3	Claim Frequency Code		Remove text: Valid values are as follows: Modify text: The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or if it is a replacement/void of

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					a previously adjudicated and "paid" claim/encounter: "1" – Original claim/encounter submitted to PRMMIS. "7" – Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" – Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety.
2300		CN1			
2300	21	CN101	Contract Type Code		Modify test: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	21	CN102	Contract Amount		Change text to: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	23	PWK	Claim Supplemental Information		Remove text: ENCOUNTER - Attachments are not permitted for Encounter Claims Modify text: Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.

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2300	23	PWK01 thru PWK05			Delete rows.
2300	24	REF02	Referral Number		Remove text: Enter DS Waiver Coordinator Number with the REF01 = '9F'
2300	25	REF	Payer Claim Control Number		Add Note/Comment: ENCOUNTER: MCOs are required to send their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	25	REF02	Payer Claim Control Number		Modify Note/Comment: The ID (TCN), in the MCO's system, of the encounter being voided.
2300	25	REF	Claim Identifier for Transmission Intermediaries		Remove Segment
2300	26	REF01	Reference Identification Qualifier		Remove code and text: "0B" – State License Number
2310B	26	REF01	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2320	28	CAS02	Adjustment Reason Code	A1	Remove text: All values from code source 139 are allowed.
2320	28 thru 29	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.
2400	29	LX01	Assigned Number		Add text: Puerto Rico Department of Health accepts up to the HIPAA allowed 50 detail lines per claim/encounter. The claim/encounter would need to be split to submit more than 50 detail lines.
2400	30	SV101	Service Line Revenue Code		Remove text: Nursing home submitters must enter a revenue code. Enter Revenue Code "0101" and the per diem amount if no home days or hospital days need to be reported. Enter Revenue Code "0185" for days spent in hospital or Service Line Revenue Code "0182" for days spent at home. (Nursing Home only) Add text: *Note:* Nursing homes are not a covered service under the

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					Puerto Rico Medicaid program.
2430	33	SVD	Line Adjudication Information		Remove (name loop) from Notes/Comments
2430	34	SVD01	Other Payer Primary Identifier		Remove number from Notes/Comments
2430	34	SVD02	Service Line Paid Amount		Modify text: Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
2430	33	CAS02	Adjustment Reason Code		Remove code & text: "1" = Medicare Deductible Amount "2" = Medicare Coinsurance Amount "66" = Medicare Blood Deductible. Remove text: Other external code source values from code source 139 are allowed.
2430	33	CAS03	Adjustment Amount		Remove codes & text: "1" = Medicare Deductible Amount "2" = Medicare Coinsurance Amount "66" enter the Medicare Blood Deductible. ENCOUNTER: "A1" - MCO Denied detail Other external code source values from code source 139 are allowed.
2430	28 thru 29	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.

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A.5 Change History

Version 4.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 10-24-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	23	CN1	Contract Information		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
N/A	10	Section 1.4	Additional Information		Remove text: **Negative Dollar Amounts** Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
2010BA	20	NM109	Subscriber Primary Identifier		Add text: ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.
2320	28	SBR09	Claim Filing Indicator Code	16, CI, HM, MA, MB	Modify text: "16" – HMO Medicare Risk (required for Medicare Part C claims) "CI" – Commercial Insurance "HM" – Managed Care Organization "MA" – Medicare Part A "MB" – Medicare Part B
2330B	28	NM109	Other Payer Primary Identifier		Add text: ENCOUNTER – This value should be the MCO's assigned trading partner ID.
2330B	28	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
2400	30	CN1	Contract Information		Add text: ENCOUNTER - This information is required on all encounter claims. This refers to the contract between the plan and the provider paid by the plan.

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2400	30	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" -- If provider's services were provided under a capitation agreement. "09" - FFS
2400	30	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.

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A.6 Change History

Version 5.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-16-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	23	CN1	Contract Information		Modify the text: ENCOUNTER – Required:when the encounter claim was paid at the header level This refers to the contract between the plan and the provider paid by the plan.
2300	23	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement FFS encounter claims should indicate the appropriate value as listed in the TR3.
2300	22	CN102	Contract Amount		Modify the text: If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered.
2300	24	K3	File Information		Remove Segment
2300	24	K301	Fixed Format Information		Remove Line: MCO Receipt Date – Format: CCYYMMDD.
2320	28	SBR09	Claim Filing Indicator Code	~~16, CI, HM, MA, MB~~	Modify the text: ~~"16" – HMO Medicare Risk (required for Medicare Part C claims).~~ ~~"CI" – Commercial Insurance~~ ~~"HM" – Managed Care Organization~~ ~~"MA" – Medicare Part A~~ ~~"MB" – Medicare Part B~~ ENCOUNTER: When the MCO is the payer the value should be "HM" *NOTE:* All valid values will be accepted for other payer loops.
2330B	29	DTP	Claim Check or Remittance Date		Remove Segment

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2330B	29	DTP01	Date / Time Qualifier	573	Remove Line: "573" – Other Payer or MCO Claim Adjudication Date
2330B	29	DTP02	Date Time Period Format Qualifier	D8	Remove Line: "D8" – Date Expressed in Format CCYYMMDD
2330B	29	DTP03	Adjudication or Payment Date		Remove Line: TPL or MCO Adjudication Date (CCYYMMDD)
2400	30	CN1	Contract Information		Modify text: ENCOUNTER - This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan.
2400	30	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER "05" – If provider's services were provided under a capitation agreement. FFS encounter claims should indicate the appropriate value as listed in the TR3.
2400	30	CN102	Contract Amount		Modify the text: ENCOUNTER If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider..

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A.7 Change History

Version 6.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 04-01-19
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010BA	20	NM109	Subscriber Primary Identifier		Old text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID. New text: PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
2300	21	CLM	Claim Information		Add new text: NOTE: Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when one encounter is found to be non-compliant, the recommendation is to enter TCN in CLM02.

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A.8 Change History

Version 7.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 05-05-20
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	21	CLM	Claim Information		New text *Note:* Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, PRMP requires trading partners to enter PCN and TCN in CLM01 separated by a dash.
2300	21	CLM01	Patient Control Number		New text ENCOUNTER: Trading partners should enter encounter's PCN and TCN separated by a dash – all characters will be returned in the 835's CLP01 field.

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A.9 Change History

Version 7.1 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-10-21
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010AA	20	N403	Billing Provider Postal Zone or ZIP Code		New text: Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department Of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
2310C	27	N403	Laboratory or Facility Postal Zone or ZIP Code		New text: Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
2420C	32	N403	Laboratory or Facility Postal Zone or ZIP Code		New text: Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**

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GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3) Implementation Guides Based on ASC X12 Version 005010X224A2 Dental Health Care Claim/Encounter (837D)

Companion Guide Version Number: 7.1

November 2021

Puerto Rico Medicaid Management Information System Services Project

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X12_837D_005010X224A2

Disclosure Statement

Companion guides may contain two types of data, instructions for electronic communications with the publishing entity (communications/connectivity instructions), and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 implementation guide (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every companion guide. The components may be published as separate documents or as a single document.

The communications/connectivity component is included in the companion guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The transaction instruction component is included in the companion guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12's copyrights and Fair Use statement.

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Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with the Puerto Rico Department of Health. Transmissions based on this companion guide, used in tandem with the TR3, also called the Health Care Dental Claim/Encounter ASC X12N version 005010X224A2 (837D), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. To access the HIPAA Implementation Guides, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

Disclaimer: The information contained in this Companion Guide is subject to change.

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1 INTRODUCTION

This section describes how TR3, also called 837D ASC X12N (version 005010X224A2), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Puerto Rico Department of Health has information additional to the TR3. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health's usage for composite and simple data elements, and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from Puerto Rico Department of Health for specific segments provided by the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 6: TRANSACTION-SPECIFIC INFORMATION.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Puerto Rico Department of Health.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value "N6" is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and how to specify that only one code value is applicable.

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1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 837D (referred to as Dental Claim/Encounter in the rest of this document) for the purpose of submitting 837D electronically. This companion guide is not intended to replace the TR3. The TR3s define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this companion guide is to provide trading partners with a guide to communicate Puerto Rico Department of Health-specific information required to successfully exchange transactions electronically with Puerto Rico Department of Health. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

The information contained in this companion guide applies to Puerto Rico Department of Health for processing.

Puerto Rico Department of Health will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Puerto Rico Department of Health-specific information, though processed, may be denied. For example, a compliant 837D Claim/Encounter created with an invalid Puerto Rico Department of Health member identification number will be processed by Puerto Rico Department of Health, but will be denied. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the Puerto Rico Department of Health.

Refer to this companion guide first if there is a question about how Puerto Rico Department of Health processes a HIPAA transaction. For further information, contact **their policy-specific** area of the Puerto Rico Department of Health or PRMMIS MCO EDI (prmmis_edi_support@dxc.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCOs) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions. This document provides instructions for obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

Per HIPAA requirements, Puerto Rico Department of Health and all other covered entities must comply with the EDI standards for health care as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required under HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. Additionally, HIPAA directs the Secretary to adopt standards for transactions, to enable health information to be exchanged electronically, and to adopt specifications for implementing each standard.

The HIPAA requirements serve to:

- Create better access to health insurance.
- Limit fraud and abuse.
- Reduce administrative costs.

This guide is designed to help those responsible for testing and setting up electronic Dental Claim/Encounter transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting, and identifies codes and data elements that do not apply to Puerto Rico Department of Health. This guide supplements (but does not contradict) requirements in the ASC X12N 837D (version 005010X224A2) Implementation Guide. This guide provides communications-related information that a trading partner needs to enroll as

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a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with Puerto Rico Department of Health.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic 837D transactions that meet Puerto Rico Department of Health processing standards by identifying pertinent structural and data-related requirements and recommendations.

1.3 References

For more information regarding the ASC X12 Standards for Electronic Data Interchange 837D Health Care Claim/Encounter (version 005010X224A2) and to purchase copies of the TR3 documents, consult the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that the provider's Information Technology (IT) staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Puerto Rico Department of Health.

To obtain the Provider taxonomy code set, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

1.4 Additional Information

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standard is recognized by the United States as the standard for North America. Electronic Data Interchange adoption has been proved to reduce the administrative burden on providers.

The intended audience for this document is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

National Provider Identifier

As a result of HIPAA, the federal HHS adopted a standard identifier for health care providers. The Final Rule published by the HHS adopted the National Provider Identifier (NPI) as the standard identifier.

The NPI replaces all payer-specific identification numbers (e.g., Medicaid provider numbers) on nationally recognized electronic transactions (also known as standard transactions); therefore, all health care providers are required to obtain an NPI to identify themselves on these transactions. The NPI is the only identification number that will be allowed on these transactions.

All providers, except those that the Puerto Rico Department of Health determined to not identify as a healthcare provider such as non-emergency transportation, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. Puerto Rico Department of Health requires all health care providers to submit their NPI on electronic transactions.

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Acceptable Characters

The HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. Puerto Rico Department of Health accepts the extended character set. Uppercase characters are recommended. Files should be less than 100 MB.

File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance to standard file naming conventions, including a valid three-character file extension. The following standards should be used:

- To avoid accidently overwriting files, do not send multiple files with the same name on the same day.
- File Names should not be longer than 45 characters.
- File Names should not contain spaces or special characters.
- File Names should contain a file extension such as .dat or .txt.
- Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file.
- Zip files must contain the extension .zip (not case sensitive).

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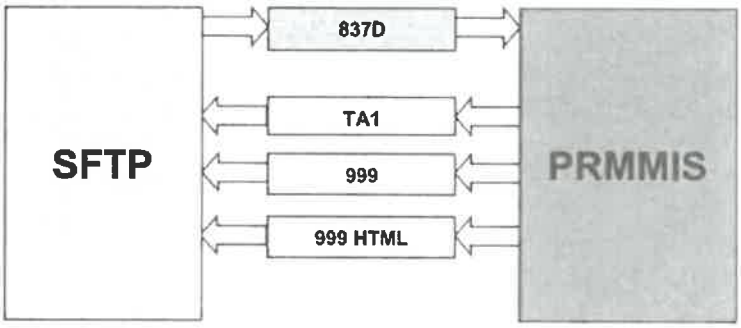
2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

This section describes the process to interactively submit HIPAA 837D transactions, along with various submission methods, security requirements, and exception handling procedures.

2.1 Process Flows

This section contains process flow diagrams and appropriate text.
Each transaction is validated to ensure that the 837D complies with the 005010X224A2 TR3.

Transactions that fail this compliance check will generate a "Rejected" 999 file back to the sender with an error message indicating the compliance error. Transactions that pass this compliance check will generate an "Accepted" 999 file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a "Partial" 999 file back to the sender with an error message indicating the compliance error (all claims/encounters in the ST/SE envelopes that pass compliance will be processed). Claims/Encounters that pass compliance checks but fail to process (e.g., due to member not being found) will be denied. Claims/Encounters that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the date(s) of service) will be classified as "paid."



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2.2 Transmission Administrative Procedures

This section provides Puerto Rico Department of Health's-specific transmission administrative procedures.

The trading partner must determine if the transmission being sent is Test or Production and is using the appropriate indicator (ISA15). For details about available Puerto Rico Department of Health access methods, refer to the Communication Protocol Specifications section.

Puerto Rico Department of Health is available only to authorized users. Submitters must be Puerto Rico Department of Health trading partners. A submitter is authenticated using a username and password assigned by the trading partner.

2.3 Communication Protocol Specifications

This section describes Puerto Rico Department of Health's communication protocol(s). The following communication methods are available to get a member's Eligibility and Benefits from Puerto Rico Department of Health:

Batch

Trading partners can submit all batch transactions to Puerto Rico Department of Health and download acknowledgements and response files. Access is free; however, the user must have his or her own internet connection to access the web application.

3 CONTROL SEGMENTS / ENVELOPES

3.1 ISA-IEA

This section describes Puerto Rico Department of Health's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

Interchange Control Header (ISA)

To promote efficient, accurate electronic transaction processing, please note the following Puerto Rico Department of Health specifications:

- Each trading partner is assigned a Trading Partner ID.
- All dates are in the CCYYMMDD format. Except for ISA09.
- All dates/times are in the CCYYMMDDHHMM format.
- Payer IDs can be found in the companion guides.
- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Each Payer ID must be in its own file.
- No more than 999 claims/encounters per Transaction Set (ST-SE).
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted as a batch are identified by an ISA and trailer segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The table below represents only those fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction — the TR3 should be reviewed for that information.

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

Note: Puerto Rico Department of Health accepts files with one ISA/IEA loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	03	ENCOUNTER – "03" – Additional Data Identification
C.4		ISA02	Authorization Information		ENCOUNTER – MCO Medicaid ID + [space fill]
C.4		ISA03	Security Information Qualifier	00	00 = No Security Information Present
C.4		ISA04	Security Information		[space fill]
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	ZZ = Mutually defined
C.4		ISA06	Interchange Sender ID		Trading Partner ID supplied by Puerto Rico Department of Health, left-justified and space-filled.
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	ZZ = Mutually defined
C.5		ISA08	Interchange Receiver ID	PRMMIS	"PRMMIS" – left-justified and space-filled.
C.5		ISA09	Interchange Date		The date format is YYMMDD.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.5		ISA10	Interchange Time		The time format is HHMM.
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	00501 = Control Version Number
C.5		ISA13	Interchange Control Number		The interchange control number assigned in ISA13 must be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	0 = No interchange acknowledgment requested (TA1)
C.6		ISA15	Usage Identifier	P, T	Code indicating whether the data enclosed is Production or Test.
			Production Data	P	Enter value "P" to indicate that the file contains Production data
			Test Data	T	Enter value "T" to indicate that the file contains Test data.
C.6		ISA16	Component Separator	:	A colon ":" is recommended.

IEA – Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.10	None	IEA	Interchange Control Trailer		
C.10		IEA01	Number of Included Functional Groups		Number of included Functional Groups
C.10		IEA02	Interchange Control Number		Must be identical to the value in ISA13

3.2 GS-GE

This section describes Puerto Rico Department of Health's use of the functional group control segments.

It includes a description of expected application sender and receiver codes.

Functional Group Header (GS)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

Note: Puerto Rico Department of Health only accepts files with one GS/GE loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	None	GS	Functional Group Header		
C.7		GS01	Functional ID Code	HC	"HC" – Health Care Dental Claim/Encounter (837D)

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7		GS02	Application Sender's Code		'Trading Partner ID' supplied by Puerto Rico Department of Health.
C.7		GS03	Application Receiver's Code	PRMMIS	'PRMMIS' Puerto Rico Department of Health Sender ID.
C.7		GS04	Date		The date format is CCYYMMDD.
C.8		GS05	Time		The time format is HHMM.
C.8		GS06	Group Control Number		Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	"X" – Responsible Agency Code
C.8		GS08	Version / Release / Industry Identifier Code	005010X224A2	Version / Release / Industry Identifier Code

Functional Group Trailer (GE)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	None	GE	Functional Group Trailer		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

3.3 ST-SE

This section describes Puerto Rico Department of Health's use of transaction set control numbers.

Puerto Rico Department of Health recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with "000000001" and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

TRANSACTION SET HEADER (ST)

The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	837	837 Health Care Claim
70		ST02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X224A2	This field contains the same value as GS08.

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TRANSACTION SET TRAILER (SE)

The TR3 should be reviewed for specific information.

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of transaction sets
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

3.4 Control Segment Notes

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

3.5 File Delimiters

Puerto Rico Department of Health requests that you use the following delimiters on your file. If used as delimiters, these characters must not be submitted within the data content of the transaction sets. Contact PRMMIS MCO EDI (prmmis_edi_support@dxc.com) if there is a need to use a delimiter other than the following:

- Segment Terminator = ~
- Element Separator = *
- Component Separator = :
- Repetition Separator = ^

Element Separator

Byte 4 in the ISA segment defines the element separator to be used throughout the entire transaction. The recommended element separator is an asterisk (*).

Repetition Separator

ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^).

Component Separator

ISA16 defines the component separator to be used throughout the entire transaction. The recommended component separator is a colon (:).

Segment Terminator

Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The recommended segment terminator is a tilde (~).

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4 PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS

4.1 Trading Partner Identification Number

In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS, the EDI team will create any needed Trading Partner Profiles.

4.2 Testing

Module One of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.

4.3 Terminology

The term "subscriber" will be used as a generic term throughout the companion guide.

4.4 Limits

File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including a Transaction ST segment and Transaction SE segment.

4.5 Scheduled Maintenance

Puerto Rico Department of Health schedules regular maintenance every Sunday from 01:00 a.m. to 05:00 a.m. EST.

4.6 Procedures for Voiding Encounters

PRMMIS requires that the MCO's internal Transaction Control Number (TCN) be sent for every claim:

Loop 2330B – Other Payer Name
REF – Other Payer Claim Control Number
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the claim being submitted

When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:

Loop: 2300 — CLAIM INFORMATION
REF – PAYER CLAIM CONTROL NUMBER
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the encounter being voided

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5 ACKNOWLEDGEMENTS AND/OR REPORTS

5.1 Acknowledgements

TA1 — Transaction Acknowledgement

Puerto Rico Department of Health will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced, then a 999 will be sent. The submitted 837D will need to be corrected and resubmitted.

999 — Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file. Puerto Rico Department of Health will always respond with a 999 for a batch X12 file. If a "rejected" 999 is produced, then claims/encounters will not be sent to the claims engine for adjudication. The submitted 837D will need to be corrected and resubmitted.

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6 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the implementation guides. That information can do the following:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health's usage for composite and simple data elements, and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the TR3s.

6.1 005010X224A2 — 837D Health Care Claim/Encounter

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
66	None	BHT	Beginning of Hierarchical Transaction		
66	None	BHT02	Transaction Set Purpose Code	00	"00" – Original
67	None	BHT06	Claim Identifier	CH, RP	CH = Claims — Chargeable RP = Encounters — Reporting
69	1000A	NM1	Submitter Name		
70	1000A	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
70	1000A	NM109	Submitter Identifier		Enter the same value as ISA06 'Trading Partner ID' supplied by Puerto Rico Department of Health.
71	1000A	PER	Submitter EDI Contact Information		This segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
71	1000A	PER01	Contact Function Code	IC	"IC" – Information Contact
71	1000A	PER02	Submitter Contact Name		This is required if it's different than the name contained in the Submitter Name (Loop 1000A, NM1 segment).
71	1000A	PER03	Communication Number Qualifier	EM, FX,TE	"EM" – Electronic Mail "FX" – Fax "TE" – Telephone
71	1000A	PER04	Communication Number		Email Address, Fax Number, or Telephone Number (including the area code)

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
74	2100A	NM1	Receiver Name		
75	1000B	NM103	Receiver Name	PUERTO RICO DEPARTMENT OF HEALTH	"PUERTO RICO DEPARTMENT OF HEALTH"
80	1000B	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
75	1000B	NM109	Receiver Primary Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
78	2000A	PRV	Billing Provider Specialty Information		ENCOUNTER – When required for NPI crosswalk, this loop should contain the Taxonomy Code for the Provider paid by the MCO (refer to 2010AA below).
78	2000A	PRV03	Reference Identification		Enter the taxonomy that was reported to Puerto Rico Department of Health for the service you are billing.
82	2010AA	NM1	Billing Provider Name		*Note:* Puerto Rico Department of Health only accepts the use of NPIs as identification for dental providers.
83	2010AA	NM102	Entity Type Qualifier	1, 2	Enter the "1" value to indicate that the biller is a person. Enter the "2" value to indicate that the biller is a non-person entity.
86	2010AA	N3	Billing Provider Address		Enter the address that is currently on file with Puerto Rico Department of Health. *Note:* Do not enter a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-To Address loop.
87	2010AA	N4	Geographic Location		Use the physical address as reported on the provider's Puerto Rico Department of Health certification.
88	2010AA	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
96	2010AB	NM1	Pay-To Address Name		This loop will not be used by Puerto Rico Department of Health's PRMMIS.
101	2010AC	NM1	Pay-to Plan Name		This loop will only be used for subrogation.
114	2010BA	NM1	Subscriber Name		Enter information about the subscriber/member in this loop.
115	2010BA	NM102	Entity Type Qualifier	1	Enter the value "1" to indicate that the member is a person.
115	2010BA	NM103	Subscriber Last Name		Enter the Last Name

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
115	2010BA	NM104	Subscriber First Name		Enter the member's first name.
115	2010BA	NM108	Identification Code Qualifier	MI	Enter the value "MI" for member identification number.
116	2010BA	NM109	Subscriber Primary Identifier		PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
123	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department of Health.
124	2010BB	NM1	Payer Name		
125	2010BB	NM103	Payer Name	PUERTO RICO DEPARTMENT OF HEALTH	Enter the value "PUERTO RICO DEPARTMENT OF HEALTH".
125	2010BB	NM108	Identification Code Qualifier	PI	"PI" – Payer Identification
125	2010BB	NM109	Payer Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
125	2010BB	N4	Payer City, State, Zip Code		
125	2010BB	N401	City Name	SAN JUAN	
125	2010BB	N402	Payer State Code	PR	
126	2010BB	N403	Payer Postal Zone or ZIP Code	009220000	
123	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department of Health.
145	2300	CLM	Claim Information		*Note:* Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, Puerto Rico Medicaid Program (PRMP) requires trading partners to enter Patient Control Number (PCN) and Transaction Control Number (TCN) in CLM01 separated by a dash.
146	2300	CLM01	Patient Control Number		ENCOUNTER – Trading partners should enter the encounter's Patient Control Number (PCN) and Transaction Control Number (TCN) separated by a dash – all characters will be returned in the 835's CLP01 field.
147	2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter.
147	2300	CLM05-3	Claim Frequency Code	1, 7 8	The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or it

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					is a replacement/void of a previously adjudicated and "paid" claim/encounter: "1" — Indicates that this is the first claim/encounter submitted to PRMMIS. "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" — Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. ENCOUNTER – Use "1" as a frequency code when resubmitting a denied claim. *Note:* The use of values "7" and "8" can result in the previously submitted claim/encounter being adjusted. Include the Internal Control Number (ICN) from the previously submitted claim/encounter in the original reference number segment in Loop 2300. The claim frequency code was switched to an external code source during the addenda process. See the NUBC Manual or Web site, www.nubc.org/. ENCOUNTER: Paper submissions/requests will not be supported for encounter processing. ENCOUNTER: MCOs are required to send their claim ID (TCN) for each encounter submitted as well as their claim ID (TCN) for an encounter being voided (refer to Section 4.6 – Procedures for Voiding Encounters).
148	2300	CLM19	Predetermination of Benefits Code		*Note:* Puerto Rico Department of Health does not support predetermination of benefits.
154	2300	**DTP**	Service Date		
154	2300	DTP01	Date / Time Qualifier	472	"472" – Service
154	2300	DTP02	Date Time Period Format Qualifier	D8, RD8	"D8" – Date expressed in format CCYYMMDD

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					"RD8" – Range of Dates expressed in format CCYYMMDD-CCYYMMDD (including dash).
154	2300	DTP03	Service Date		Service Date
166	2300	REF	Service Authorization Exception Code		*Note:* If all services were not the result of emergency care, submit multiple claims/encounters.
156	2300	DN1	Orthodontic Total Months of Treatment		
156	2300	DN101	Orthodontic Treatment Months Count		The estimated number of treatment months.
156	2300	DN102	Orthodontic Treatment Months Remaining Count		The number of treatment months remaining.
159	2300	PWK	Claim Supplemental Information		Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.
162	2300	CN1	Contract Information		ENCOUNTER – Required when the encounter claim was paid at the header level. This refers to the contract between the plan and the provider paid by the plan.
162	2300	CN101	Contract Type Code		ENCOUNTER – Required "05" – If provider's services were provided under a capitation agreement, Fee For Service (FFS) encounter claims should indicate the appropriate value as listed in the TR3.
162	2300	CN102	Contract Amount		ENCOUNTER – Required If CN101 = "05", then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
168	2300	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested). ENCOUNTER – MCOs are required to send their Claim ID (TCN) for an encounter being voided (refer to Section 4.6 – Procedures for Voiding Encounters).
168	2300	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
168	2300	REF02	Payer Claim Control Number		The ID (TCN), in the MCO's system, of the encounter being voided.
171	2300	REF	Prior Authorization		
172	2300	REF01	Reference Identification Qualifier	G1	"G1" – Prior Authorization Number
172	2300	REF02	Prior Authorization Number		Enter the 10-digit Prior Authorization Number. Enter this number only if the services rendered required and received prior authorization. This number must be entered with the qualifier "G1" (Prior Authorization Number).
190	2310A	NM1	Referring Provider Name		
191	2310A	NM101	Entity Identifier Code	DN, P3	"DN" – Referring Provider Use on the first iteration of this loop. Use if loop is used only once. "P3" – Primary Care Provider Use only if loop is used twice. Use only on second iteration of this loop.
192	2310A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
192	2310A	NM109	Referring Provider Identifier		
193	2310A	PRV	Referring Provider Specialty Information		
193	2310A	PRV01	Provider Code	RF	"RF" – Referring
193	2310A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
193	2310A	PRV03	Provider Taxonomy Code		Referring Provider Taxonomy Code that is used for claims submitted with NPI.
194	2310A	REF	Referring Provider Secondary Identification		
194	2310A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
196	2310B	NM1	Rendering Provider Name		*Note*: If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C N403.
197	2310B	NM101	Entity Identifier Code	82	"82" – Rendering Provider
198	2310B	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
198	2310B	NM109	Rendering Provider Identifier		

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
199	2310B	PRV	Rendering Provider Specialty Information		
199	2310B	PRV01	Provider Code	PE	"PE" – Performing
199	2310B	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
199	2310B	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code that is used for claims submitted with NPI.
200	2310B	REF	Rendering Provider Secondary Identification		
200	2310B	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
202	2310C	NM1	Service Facility Name		*Note:* Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider). *Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C N403.
203	2310C	NM101	Entity Identifier Code	77	"77" – Service Location
203	2310C	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
204	2310C	NM109	Laboratory or Facility Primary Identifier		
205	2310C	N3	Service Facility Location Address		
205	2310C	N301	Laboratory or Facility Address Line		Service Facility Location Address Line
206	2310C	N4	Service Facility Location City, State, Zip Code		
206	2310C	N401	Laboratory or Facility City Name		Service Facility Location City
207	2310C	N402	Laboratory or Facility State or Province Code		Service Facility Location State
207	2310C	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
221	2320	SBR	Other Subscriber Information		ENCOUNTER – Loop 2320 (Other Subscriber Information) is required on all encounter claims. *Note*: For encounter claims, the MCO should always be reported as one of the other payers. For example, when

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
224	2320	SBR09	Claim Filing Indicator Code		ENCOUNTER – When the MCO is the payer the value should be "HM". *Note:* All valid values will be accepted for other payer loops.
225	2320	CAS	Claim Level Adjustments		
227	2320	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO denied claim
227	2320	CAS03	Adjustment Amount		
231	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
231	2320	AMT01	Amount Qualifier Code	D	"D" – Payer Amount Paid
231	2320	AMT02	Payer Paid Amount		Other Payer Amount Paid (TPL or MCO)
246	2330B	NM1	Other Payer Name		ENCOUNTER – Loop 2330B (Other Payer Name) is required on all encounter claims. *Note*: For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
247	2330B	NM109	Other Payer Primary Identifier		This number must be identical to at least one occurrence of the 2430-SVD01 to identify the other payer. Puerto Rico Department of Health captures Third Party Payment Amount(s) from the service line(s) in 2430-SVD02. *Note*: The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail. ENCOUNTER – This value should be the MCO's assigned Trading Partner ID.
258	2330B	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal Claim ID be entered here for every encounter.
258	2330B	REF01	Reference Identification Qualifier	F8	Original Reference Number
258	2330B	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
281	2400	LX	Service Line Number		
281	2400	LX01	Assigned Number		Puerto Rico Department of Health accepts up to the HIPAA-allowed 50 detail lines per claim/encounter. The claim/encounter would need to be split to submit more than 50 detail lines.
282	2400	SV3	Dental Service		
282	2400	SV304-1	Oral Cavity Designation Code		Enter the appropriate Mouth Quadrant code for each procedure. Only the first value listed for each procedure is used to process the claim. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.
288	2400	TOO	Tooth Information		
288	2400	TOO01	Code List Qualifier Code	JP	"JP" – Universal National Tooth Designation System
288	2400	TOO02	Tooth Code		Enter the appropriate two-digit Tooth Number on the detail line for each procedure. Each line should contain only one Tooth Number (for permanent teeth) or Tooth Character (for primary teeth). Refer to the National Standards Tooth Numbering System for the appropriate Tooth Number or Tooth Letter for the procedure. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.
289	2400	TOO03-1	Tooth Surface Code		Enter the appropriate Tooth Surface code for each procedure. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.
290	2400	DTP	Service Date		
290	2400	DTP01	Date/ Time Qualifier	472	"472" – Service This DTP Segment is required if the Dates of Service are different than

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					those submitted within the 2300-DTP03, where DTP01 = 472.
290	2400	DTP02	Date Time Period Format Qualifier	D8	"D8" – Date expressed in format CCYYMMDD.
290	2400	DTP03	Service Date		
296	2400	CN1	Contract Information		ENCOUNTER – This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan.
296	2400	CN101	Contract Type Code		ENCOUNTER – Required "05" – If provider's services were provided under a capitation agreement, Fee For Service encounter claims should indicate the appropriate value as listed in the TR3.
296	2400	CN102	Contract Amount		ENCOUNTER – Required If CN101 = "05", then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (SVD02 in 2430 loop) and CN102 contains the amount that the health plan paid the provider for this detail.
316	2420A	NM1	Rendering Provider Name		*Note*: This is required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is different than the Billing/Pay-To Provider (2010AA\AB).
318	2420A	NM108	Identification Code Qualifier	XX	XX = Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers
318	2420A	NM109	Rendering Provider Identifier		National Provider Identifier (NPI)
319	2420A	PRV	Rendering Provider Specialty Information		Used for claims submitted with NPI.
319	2420A	PRV01	Provider Code	PE	"PE" – Performing
319	2420A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
319	2420A	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code
320	2420A	REF	Rendering Provider Secondary Identification		
320	2420A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number Non-healthcare providers must send this REF segment where REF01 = G2.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
333	2420D	NM1	Service Facility Name		*Note*: This is required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider).
334	2420D	NM101	Entity Identifier Code	77	"77" – Service Location
334	2420D	NM102	Entity Type Qualifier	2	"2" – Non-Person Entity
334	2420D	NM102	Laboratory or Facility Name		
334	2420D	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
334	2420D	NM109	Laboratory or Facility Primary Identifier		
336	2420D	N3	Service Facility Location Address		
336	2420D	N301	Laboratory or Facility Address Line		
337	2420D	N4	Service Facility Location City, State, Zip Code		
337	2420D	N401	Laboratory or Facility City Name		
338	2420D	N402	Laboratory or Facility State or Province Code		
338	2420D	N403	Laboratory or Facility Postal Zone or ZIP Code		Must be nine digits **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
339	2420D	REF	Service Facility Location Secondary Identification		
339	2420D	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note*: The "G2" qualifier should only be used for non-healthcare providers.
340	2420D	REF02	Service Facility Location Secondary Identifier		
341	2430	SVD	Line Adjudication Information		ENCOUNTER – Loop 2430 is required on all encounter claims. *Note*: Other payer payment amounts are required to be entered at the detail level.
341	2430	SVD01	Other Payer Primary Identifier		This should match one occurrence of the 2330B – NM109 identifying Other Payer.
342	2430	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					ENCOUNTER – If CN101 = "05", SVD02 should be zero. If CN101 = "09", then SVD02 should be the detail other payer paid amount or amount health plan paid to provider.
345	2430	CAS	Line Adjustment		
346	2430	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO denied claim
346	2430	CAS03	Adjustment Amount		
490	2430	DTP	Line Check or Remittance Date		ENCOUNTER – Claim will be denied if all the dates at the detail level are not the same date.

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A. APPENDIX A

A.1 Change History

Version 1.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Initial submission

A.2 Change History

Version 2.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	16		Specific business rules and limitations		Added new text for PRMMIS procedure for Voiding encounters
2300	23	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested).
2300	23	REF02	Payer Claim Control Number		The ID, in the MCO's system, of the encounter being voided
2330B	29	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal claim ID be entered here for every encounter.
2330B	29	REF01	Reference Identification Qualifier	F8	Original Reference Number
2330B	29	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted

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A.3 Change History

Version 3.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	7		Introduction		Change Section 10 to Section 6.
2300	20	CLM02	Total Claim Charge Amount		Remove Note: *"Note:* Puerto Rico Department of Health interChange will process claims/encounters submitted with a negative billed amount as if the provider submitted a zero billed amount."
2300	22	PWK06	Attachment Control Number		Remove text: Please see page 16, "Hard Copy Attachments."
2300	23	CN101	Contract Type Code	05,09	Replace text with: ENCOUNTER - Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	23	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	23	CN103	Contract Percentage		Remove row.
2300	24	HI	Health Care Diagnosis Code		Remove segment.
2310A	25	REF01	Reference Identification Qualifier	0B, G2G2	Modify text: "0B" – State License Number "G2" – Provider Commercial Number *Note:* This is not required for nursing homes.

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Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Note: The "G2" qualifier must be used for non-healthcare providers.
2310B	25	REF01	Reference Identification Qualifier	0B, G2G2	Modify text: "0B" – State License Number "G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers.
2310C	25	NM1	Service Facility Name		Remove text: NOTE: If a zip code is required in the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C.
2330B	27	NM1	Other Payer Name		Remove text: NOTE: If a zip code is required in the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C.
2420D	30	REF04-1	Reference Identification Qualifier		Remove row.

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A.4 Change History

Version 3.1 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 09-09-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Section 1.1	8		Scope		Modify text: For further information, contact **their policy-specific** area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses
Section 1.2	8		Overview		Remove text: This information should be given to the provider's business area to ensure that Claim/Encounters are interpreted correctly.
Section 1.4	9		National Provider Identifier		Modify text in third paragraph: All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency transportation
Section 1.4	9		File/System Specifications		Remove text: The recommended extension is .txt or .dat. EDI does not allow zipped files. Files will be submitted to EDI via STFP. Add text: The following standards should be used: To avoid accidently overwriting files, do not send multiple files with the same name on the same day. File Names should not be longer than 45 characters

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Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					File Names should not contain spaces or special characters File Names should contain a file extension such as .dat or .txt Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file Zip files must contain the extension .zip (not case sensitive)
Section 1.4	9		Negative Dollar Amounts		New Paragraph: Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
Section 2.1	11		Process Flow		Modify text: classified as "paid".
N/A	12	ISA01	Authorization Information Qualifier		Remove text: "00" – No Authorization Information Present.
N/A	12	ISA02	Authorization Information		Remove text: Claim - [space fill]
N/A	13	ISA14	Acknowledgement Requested	0	Remove code 1 & comment.
Section 4.1	16		Trading Partner Identification Number		Modify test: In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS the EDI team will create any needed Trading Partner Profiles.
Section 4.2	16		Testing		Modify Text: Module one of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.
Section 4.4	16		Limits		Modify text: File Size is restricted to 5,000 transactions (claims/encounters) per file
Section 4.6	16		Procedures for Voiding Encounters		Modify text: When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided.

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Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010AB	19	NM1	Pay-To Address Name		Modify text: This loop will not be used by Puerto Rico Department of Health's PRMMIS.
2010BA	20	NM109	Subscriber Primary Identifier		Change text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. Remove Text: *Note:* Do not enter any other numbers or letters. Use the Puerto Rico Department of Health card or the EVS to obtain the correct identification number.
2300	20	CLM01	Patient Control Number		Modify Note/Comment: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. Encounters: MCO should send the original PCN from the provider's original claim.
2300	21	CLM05-3	Claim Frequency Code		Modify Note/Comment: "1" — Indicates that this is the first claim/encounter submitted to the PRMMIS. "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" — Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. Encounter: Paper submissions/requests will not be supported for encounter processing. Remove Note/Comment:

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Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Electronic adjustments are subject to the same requirements as paper adjustments and therefore may result in a letter to the provider if the requirements are not met. Do not use adjustment values if reconsideration of the original payment is needed. All requests for reconsideration should be submitted on paper with supporting documentation. Add Note/Comment: Encounter: MCOs are required to send their claim ID (TCN) for each encounter submitted as well as their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	22	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" - FFS
2300	22	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	22	PWK	Claim Supplemental Information		Modify Note/Comment: Puerto Rico Department of Health PRMMIS does not use this field for processing of the claim/encounter
2300	22	PWK01 thru PWK05			Delete PRMMIS.

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Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	23	REF	Payer Claim Control Number		Add Note/Comment: Encounter: MCOs are required to send their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	25	REF02	Payer Claim Control Number		Add Note/Comment: The ID (TCN), in the MCO's system, of the encounter being voided.
2300	25	REF	Claim Identifier for Transmission Intermediaries		Remove Segment
2310A	25	REF01	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2310B	24	REF01	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2320	25	CAS02	Adjustment Reason Code	A1	Remove text: All external code source values from code source 139 are allowed.
2320	25	CAS05 thru CAS17	Adjustment Reason Code		Delete rows.
2400	26	LX01	Assigned Number		Add text: Puerto Rico Department of Health accepts up to the HIPAA allowed 50 detail lines per claim/encounter. The claim/encounter would need to be split to submit more than 50 detail lines.
2430	28	SVD	Line Adjudication Information		Change name of segment and remove (name loop) from Notes/Comments
2430	28	SVD01	Other Payer Primary Identifier		Remove number from Notes/Comments
2430	28	SVD02	Service Line Paid Amount		Modify text: Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other

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Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					payer paid amount OR amount health plan paid to provider.
2430	29	CAS02	Adjustment Reason Code	A1	Remove text: All external code source values from code source 139 are allowed.
2430	29	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.
N/A	34		Section 7 – Appendix A		Remove Section 7

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Contrato Número

A.5 Change History

Version 4.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 10-24-17

Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	10	Section 1.4	Additional Information		Remove text: **Negative Dollar Amounts** Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
2010BA	20	NM109	Subscriber Primary Identifier		Add text: ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.
2320	24	SBR09	Claim Filing Indicator Code	16, CI,HM, MA, MB	Modify text: "16" – HMO Medicare Risk (required for Medicare Part C claims) "CI" – Commercial Insurance "HM" – Managed Care Organization "MA" – Medicare Part A "MB" – Medicare Part B
2330B	25	NM109	Other Payer Primary Identifier		Add text: ENCOUNTER – This value should be the MCO's assigned trading partner ID.
2300	25	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
2330B	25	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
2400	27	CN1	Contract Information		Add text: ENCOUNTER - This information is required on all encounter claims. This refers to the contract between the plan and the provider paid by the plan.

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Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2400	27	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" - FFS
2400	27	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.

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Contrato Número

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A.6 Change History

Version 5.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-17-17
Approved by:
Name: _____ Designation: _____ Date: _____

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Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	22	CN1	Contract Information		Modify the text: ENCOUNTER – Required:when the encounter claim was paid at the header level This refers to the contract between the plan and the provider paid by the plan.
2300	22	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. And no other value applies. "09" – FFS
2300	22	CN102	Contract Amount		Modify the text: If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered.
2300	23	NTE	Claim Notes		Remove Segment
2300	23	NTE01	Note Reference Code	ADD	Remove line
2300	23	NTE02	Claim Note Text		Remove line
2320	25	SBR09	Claim Filing Indicator Code	~~16, CI, HM, MA, MB~~	Modify the text: ~~"16" – HMO Medicare Risk (required for Medicare Part C claims).~~ ~~"CI" – Commercial Insurance~~ ~~"HM" – Managed Care Organization~~ ~~"MA" – Medicare Part A~~ ~~"MB" – Medicare Part B~~ ENCOUNTER: When the MCO is the payer the value should be "HM" *NOTE:* All valid values will be accepted for other payer loops.
2330B	25	DTP	Claim Check or Remittance Date		Remove Segment

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2330B	25	DTP01	Date / Time Qualifier	573	Remove Line: "573" – Other Payer or MCO Claim Adjudication Date
2330B	25	DTP02	Date Time Period Format Qualifier	D8	Remove Line: "D8" – Date Expressed in Format CCYYMMDD
2330B	25	DTP03	Adjudication or Payment Date		Remove Line: TPL or MCO Adjudication Date (CCYYMMDD)
2400	27	CN1	Contract Information		Modify text: ENCOUNTER - This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan.
2400	27	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER "05" – If provider's services were provided under a capitation agreement. FFS encounter claims should indicate the appropriate value as listed in the TR3.
2400	27	CN102	Contract Amount		Modify the text: ENCOUNTER If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider..

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Contrato Número

A.7 Change History

Version 6.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 03-01-19
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010BA	20	NM109	Subscriber Primary Identifier		Old text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID. New text: PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
2300	20	CLM	Claim Information		Add text: NOTE: Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when one encounter is found to be non-compliant, the recommendation is to enter TCN in CLM02.
2430	28	DTP	Line Check or Remittance Date		Add new segment: ENCOUNTER – Claim will be denied if all the dates at the detail level are not the same date.

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A.8 Change History

Version 7.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 05-05-20
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	20	CLM	Claim Information		New text *Note:* Because duplicate CLM01 values within ST/SE

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, PRMP requires trading partners to enter PCN and TCN in CLM01 separated by a dash.
2300	20	CLM01	Patient Control Number		New text ENCOUNTER: Trading partners should enter encounter's PCN and TCN separated by a dash – all characters will be returned in the 835's CLP01 field.

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A.9 Change History

Version 7.1 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-10-21
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010AA	19	N403	Billing Provider Postal Zone or ZIP Code		New text Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
2310C	24	N403	Laboratory or Facility Postal Zone or ZIP Code		New text: Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
2420D	28	N403	Laboratory or Facility Postal Zone or ZIP Code		Must be nine digits **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**

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HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3)
Implementation Guides Based on ASC X12 Version
005010X223A2 Institutional Health Care Claim/Encounter (837I)

Companion Guide Version Number: 7.2

November 2021

Puerto Rico Medicaid Management Information System Services Project

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Disclosure Statement

Companion guides may contain two types of data, instructions for electronic communications with the publishing entity (communications/connectivity instructions), and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 implementation guide (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every companion guide. The components may be published as separate documents or as a single document.

The communications/connectivity component is included in the companion guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The transaction instruction component is included in the companion guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12's copyrights and Fair Use statement.

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Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with the Puerto Rico Department of Health. Transmissions based on this companion guide, used in tandem with the TR3, also called the Health Care Institutional Claim/Encounter ASC X12N version 005010X223A2 (837I), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. To access the HIPAA Implementation Guides, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

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Disclaimer: The information contained in this Companion Guide is subject to change.

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1 INTRODUCTION

This section describes how TR3, also called 837I ASC X12N (version 005010X223A2), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Puerto Rico Department of Health has information additional to the TR3. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health's usage for composite and simple data elements, and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from Puerto Rico Department of Health for specific segments provided by the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 6: TRANSACTION-SPECIFIC INFORMATION.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Puerto Rico Department of Health.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value "N6" is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and how to specify that only one code value is applicable.

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Contents

1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 837I (referred to as Institutional Claim/Encounter in the rest of this document) for the purpose of submitting 837I electronically. This companion guide is not intended to replace the TR3. The TR3s define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this companion guide is to provide trading partners with a guide to communicate Puerto Rico Department of Health-specific information required to successfully exchange transactions electronically with Puerto Rico Department of Health. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

The information contained in this companion guide applies to Puerto Rico Department of Health for processing.

Puerto Rico Department of Health will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Puerto Rico Department of Health-specific information, though processed, may be denied. For example, a compliant 837I Claim/Encounter created with an invalid Puerto Rico Department of Health member identification number will be processed by Puerto Rico Department of Health, but will be denied. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the Puerto Rico Department of Health.

Refer to this companion guide first if there is a question about how Puerto Rico Department of Health processes a HIPAA transaction. For further information, contact their policy-specific area of the Puerto Rico Department of Health or PRMMIS MCO EDI (prmmis_edi_support@gainwelltechnologies.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCOs) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions. This document provides instructions for obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

Per HIPAA requirements, Puerto Rico Department of Health and all other covered entities must comply with the EDI standards for health care as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required under HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. Additionally, HIPAA directs the Secretary to adopt standards for transactions, to enable health information to be exchanged electronically, and to adopt specifications for implementing each standard.

The HIPAA requirements serve to:

- Create better access to health insurance.
- Limit fraud and abuse.
- Reduce administrative costs.

This guide is designed to help those responsible for testing and setting up electronic Institutional Claim/Encounter transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting, and identifies codes and data elements that do not apply to Puerto Rico Department of Health. This guide supplements (but does not contradict) requirements in the ASC X12N 837I (version 005010X223A2) Implementation Guide. This guide provides communications-related information that a trading partner needs to enroll as

a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with Puerto Rico Department of Health.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic 837I transactions that meet Puerto Rico Department of Health processing standards by identifying pertinent structural and data-related requirements and recommendations.

1.3 References

For more information regarding the ASC X12 Standards for Electronic Data Interchange 837I Health Care Claim/Encounter (version 005010X223A2) and to purchase copies of the TR3 documents, consult the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that the provider's Information Technology (IT) staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Puerto Rico Department of Health.

To obtain the Provider taxonomy code set, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

1.4 Additional Information

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standard is recognized by the United States as the standard for North America. Electronic Data Interchange adoption has been proved to reduce the administrative burden on providers.

The intended audience for this document is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

National Provider Identifier

As a result of HIPAA, the federal HHS adopted a standard identifier for health care providers. The Final Rule published by the HHS adopted the National Provider Identifier (NPI) as the standard identifier.

The NPI replaces all payer-specific identification numbers (e.g., Medicaid provider numbers) on nationally recognized electronic transactions (also known as standard transactions); therefore, all health care providers are required to obtain an NPI to identify themselves on these transactions. The NPI is the only identification number that will be allowed on these transactions.

All providers, except those that the Puerto Rico Department of Health determined to not identify as a healthcare provider such as non-emergency transportation, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. Puerto Rico Department of Health requires all health care providers to submit NPI on electronic transactions.

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Acceptable Characters

The HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. Puerto Rico Department of Health accepts the extended character set. Uppercase characters are recommended. Files should be less than 100 MB.

File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance to standard file naming conventions, including a valid three-character file extension. The following standards should be used:

- To avoid accidently overwriting files, do not send multiple files with the same name on the same day.
- File Names should not be longer than 45 characters.
- File Names should not contain spaces or special characters.
- File Names should contain a file extension such as .dat or .txt.
- Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file.
- Zip files must contain the extension .zip (not case sensitive).

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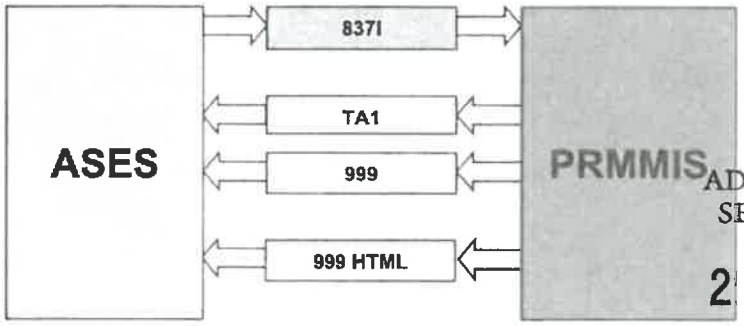
2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

This section describes the process to interactively submit HIPAA 837I transactions, along with various submission methods, security requirements, and exception handling procedures.

2.1 Process Flows

This section contains process flow diagrams and appropriate text.
Each transaction is validated to ensure that the 837I complies with the 005010X223A2 TR3.

Transactions that fail this compliance check will generate a "Rejected" 999 file back to the sender with an error message indicating the compliance error. Transactions that pass this compliance check will generate an "Accepted" 999 file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a "Partial" 999 file back to the sender with an error message indicating the compliance error (all claims/encounters in the ST/SE envelopes that pass compliance will be processed). Claims/Encounters that pass compliance checks but fail to process (e.g., due to member not being found) will be denied. Claims/Encounters that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the date(s) of service) will be classified as "paid."



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2.2 Transmission Administrative Procedures

This section provides Puerto Rico Department of Health's-specific transmission administrative procedures.

The trading partner must determine if the transmission being sent is Test or Production and is using the appropriate indicator (ISA15). For details about available Puerto Rico Department of Health access methods, refer to the Communication Protocol Specifications section.

Puerto Rico Department of Health is available only to authorized users. Submitters must be Puerto Rico Department of Health trading partners. A submitter is authenticated using a username and password assigned by the trading partner.

2.3 Communication Protocol Specifications

This section describes Puerto Rico Department of Health's communication protocol(s).
The following communication methods are available to get a member's Eligibility and Benefits from Puerto Rico Department of Health:

Batch

Trading partners can submit all batch transactions to Puerto Rico Department of Health and download acknowledgements and response files. Access is free; however, the user must have his or her own internet connection to access the web application.

3 CONTROL SEGMENTS / ENVELOPES

3.1 ISA-IEA

This section describes Puerto Rico Department of Health's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

Interchange Control Header (ISA)

To promote efficient, accurate electronic transaction processing, please note the following Puerto Rico Department of Health specifications:

- Each trading partner is assigned a Trading Partner ID.
- All dates are in the CCYYMMDD format. Except for ISA09.
- All dates/times are in the CCYYMMDDHHMM format.
- Payer IDs can be found in the companion guides.
- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Each Payer ID must be in its own file.
- No more than 999 claims/encounters per Transaction Set (ST-SE).
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted as a batch are identified by an ISA and trailer segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The table below represents only those fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction — the TR3 should be reviewed for that information.

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

Note: Puerto Rico Department of Health accepts files with one ISA/IEA loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	03	ENCOUNTER – "03" – Additional Data Identification
C.4		ISA02	Authorization Information		ENCOUNTER – MCO Medicaid ID + [space fill]
C.4		ISA03	Security Information Qualifier	00	00 = No Security Information Present
C.4		ISA04	Security Information		[space fill]
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	ZZ = Mutually defined
C.4		ISA06	Interchange Sender ID		Trading Partner ID supplied by Puerto Rico Department of Health, left-justified and space-filled.
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	ZZ = Mutually defined
C.5		ISA08	Interchange Receiver ID	PRMMIS	"PRMMIS" – left-justified and space-filled.
C.5		ISA09	Interchange Date		The date format is YYMMDD.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.5		ISA10	Interchange Time		The time format is HHMM.
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	00501 = Control Version Number
C.5		ISA13	Interchange Control Number		The interchange control number assigned in ISA13 must be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	0 = No interchange acknowledgment requested (TA1)
C.6		ISA15	Usage Identifier	P, T	Code indicating whether the data enclosed is Production or Test.
			Production Data	P	Enter value "P" to indicate that the file contains Production data.
			Test Data	T	Enter value "T" to indicate that the file contains Test data.
C.6		ISA16	Component Separator	:	A colon ":" is recommended.

IEA – Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.10	None	IEA	Interchange Control Trailer		
C.10		IEA01	Number of Included Functional Groups		Number of included Functional Groups
C.10		IEA02	Interchange Control Number		Must be identical to the value in ISA13

3.2 GS-GE

This section describes Puerto Rico Department of Health's use of the functional group control segments.

It includes a description of expected application sender and receiver codes.

Functional Group Header (GS)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

Note: Puerto Rico Department of Health only accepts files with one GS/GE loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	None	GS	Functional Group Header		
C.7		GS01	Functional ID Code	HC	"HC" – Health Care Institutional Claim/Encounter (837I)

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7		GS02	Application Sender's Code		'Trading Partner ID' supplied by Puerto Rico Department of Health.
C.7		GS03	Application Receiver's Code	PRMMIS	'PRMMIS' Puerto Rico Department of Health Sender ID.
C.7		GS04	Date		The date format is CCYYMMDD.
C.8		GS05	Time		The time format is HHMM.
C.8		GS06	Group Control Number		Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	"X" – Responsible Agency Code
C.8		GS08	Version / Release / Industry Identifier Code	005010X223A2	Version / Release / Industry Identifier Code

Functional Group Trailer (GE)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	None	GE	Functional Group Trailer		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

3.3 ST-SE

This section describes Puerto Rico Department of Health's use of transaction set control numbers.

Puerto Rico Department of Health recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with "000000001" and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

TRANSACTION SET HEADER (ST)

The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	837	837 Health Care Claim
70		ST02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X223A2	This field contains the same value as GS08.

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TRANSACTION SET TRAILER (SE)

The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of transaction sets
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

3.4 Control Segment Notes

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

3.5 File Delimiters

Puerto Rico Department of Health requests that you use the following delimiters on your file. If used as delimiters, these characters must not be submitted within the data content of the transaction sets. Contact PRMMIS MCO EDI (prmmis_edi_support@gainwelltechnologies.com) if there is a need to use a delimiter other than the following:

- Segment Terminator = ~
- Element Separator = *
- Component Separator = :
- Repetition Separator = ^

Element Separator

Byte 4 in the ISA segment defines the element separator to be used throughout the entire transaction. The recommended element separator is an asterisk (*).

Repetition Separator

ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^).

Component Separator

ISA16 defines the component separator to be used throughout the entire transaction. The recommended component separator is a colon (:).

Segment Terminator

Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The recommended segment terminator is a tilde (~).

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4 PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS

4.1 Trading Partner Identification Number

In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS, the EDI team will create any needed Trading Partner Profiles.

4.2 Testing

Module One of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.

4.3 Terminology

The term "subscriber" will be used as a generic term throughout the companion guide.

4.4 Limits

File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including a Transaction ST segment and Transaction SE segment.

4.5 Scheduled Maintenance

Puerto Rico Department of Health schedules regular maintenance every Sunday from 01:00 a.m. to 05:00 a.m. EST.

4.6 Procedures for Voiding Encounters

PRMMIS requires that the MCO's internal Transaction Control Number (TCN) be sent for every claim:

Loop 2330B – Other Payer Name
REF – Other Payer Claim Control Number
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the claim being submitted

When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:

Loop: 2300 — CLAIM INFORMATION
REF – PAYER CLAIM CONTROL NUMBER
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the encounter being voided

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5 ACKNOWLEDGEMENTS AND/OR REPORTS

5.1 Acknowledgements

TA1 — Transaction Acknowledgement

Puerto Rico Department of Health will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced, then a 999 will be sent. The submitted 837I will need to be corrected and resubmitted.

999 — Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file. Puerto Rico Department of Health will always respond with a 999 for a batch X12 file. If a "rejected" 999 is produced, then claims/encounters will not be sent to the claims engine for adjudication. The submitted 837I will need to be corrected and resubmitted.

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6 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the implementation guides. That information can do the following:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health's usage for composite and simple data elements, and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the TR3s.

6.1 005010X223A2 — 837I Health Care Claim/Encounter

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
66	None	BHT	Beginning of Hierarchical Transaction		
66	None	BHT02	Transaction Set Purpose Code	00	"00" – Original
67	None	BHT06	Claim Identifier	CH, RP	CH = Claims — Chargeable RP = Encounters — Reporting
69	1000A	NM1	Submitter Name		
70	1000A	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
70	1000A	NM109	Submitter Identifier		Enter the same value as ISA06 'Trading Partner ID' supplied by Puerto Rico Department of Health.
71	1000A	PER	Submitter EDI Contact Information		This segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
71	1000A	PER01	Contact Function Code	IC	"IC" – Information Contact
71	1000A	PER02	Submitter Contact Name		This is required if it's different than the name contained in the Submitter Name (Loop 1000A, NM1 segment).
71	1000A	PER03	Communication Number Qualifier	EM, FX, TE	"EM" – Electronic Mail "FX" – Fax "TE" – Telephone
71	1000A	PER04	Communication Number		Email Address, Fax Number, or Telephone Number (including the area code)

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
74	2100A	NM1	Receiver Name		
75	1000B	NM103	Receiver Name	PUERTO RICO DEPARTMENT OF HEALTH	"PUERTO RICO DEPARTMENT OF HEALTH"
75	1000B	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
75	1000B	NM109	Receiver Primary Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
80	2000A	PRV	Billing Provider Specialty Information		*Note:* Taxonomy codes are only required if the National Provider Identifier (NPI) has multiple certifications and the taxonomy is necessary to determine the appropriate one.
80	2000A	PRV01	Provider Code	BI	"BI" – Billing
80	2000A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
80	2000A	PRV03	Provider Taxonomy Code		Enter the taxonomy that was reported to Puerto Rico Department of Health for the service you are billing.
84	2010AA	NM1	Billing Provider Name		ENCOUNTER – This loop should contain the NPI information for the Provider paid by the MCO. *Note:* For MCO Plan ID submission information, refer to ISA01 and ISA02.
85	2010AA	NM102	Entity Identifier Code	85	"85" – Billing Provider
86	2010AA	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
86	2010AA	NM109	Billing Provider Identifier		HIPAA National Provider Identifier
87	2010AA	N3	Billing Provider Address		Enter the address that is currently on file with Puerto Rico Department of Health. *Note:* Do not enter a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-To Address loop.
88	2010AA	N4	Geographic Location		Use the physical address as reported on the provider's Puerto Rico Department of Health certification.
88	2010AA	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
90	2010AA	REF	Billing Provider Tax Identification		
90	2010AA	REF01	Reference Identification Qualifier	EI	"EI" – Employer ID Number (EIN)
90	2010AA	REF02	Billing Provider Tax Identification Number		Valid nine-digit Employer ID number
94	2010AB	NM1	Pay-To Address Name		This loop will not be used by Puerto Rico Department of Health's PRMMIS.
107	2000B	HL	Subscriber Hierarchical Level		*Note:* For Puerto Rico Department of Health, the insured and the patient are always the same person. Use this HL segment to identify the recipient and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.
108	2000B	HL03	Hierarchical Level Code	22	"22" – Subscriber
108	2000B	HL04	Hierarchical Child Code	0	"0" – No Subordinate HL Segment in this Hierarchical Structure.
109	2000B	SBR	Subscriber Information		
110	2000B	SBR09	Claim Filing Indicator Code	MC	"MC" = Medicaid
112	2010BA	NM1	Subscriber Name		Enter information about the subscriber/member in this loop.
113	2010BA	NM102	Entity Type Qualifier	1	Enter the value "1" to indicate that the member is a person.
113	2010BA	NM103	Subscriber Last Name		Enter the member's last name.
113	2010BA	NM104	Subscriber First Name		Enter the member's first name.
113	2010BA	NM108	Identification Code Qualifier	MI	"MI" – Member identification number.
114	2010BA	NM109	Subscriber Primary Identifier		PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
116	2010BA	N4	Subscriber City, State, Zip Code		
116	2010BA	N401	Subscriber City Name		Subscriber City
116	2010BA	N402	Subscriber State Code		Subscriber State
117	2010BA	N403	Subscriber Postal Zone or ZIP Code		Subscriber Zip Code

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
121	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department of Health.
122	2010BB	NM1	Payer Name		
122	2010BB	NM103	Payer Name	PUERTO RICO DEPARTMENT OF HEALTH	Enter "PUERTO RICO DEPARTMENT OF HEALTH"
123	2010BB	NM108	Identification Code Qualifier	PI	"PI" – Payer Identification
123	2010BB	NM109	Payer Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
125	2010BB	N4	Payer City, State, Zip Code		
125	2010BB	N401	City Name	SAN JUAN	
125	2010BB	N402	Payer State Code	PR	
126	2010BB	N403	Payer Postal Zone or ZIP Code	009220000	
129	2010BB	REF	Billing Provider Secondary Identification		
129	2010BB	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Code *Note:* The "G2" qualifier must be used for non-healthcare providers.
130	2010BB	REF02	Billing Provider Secondary Identifier		Puerto Rico Department of Health Provider ID
143	2300	CLM	Claim Information		*Note:* Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, PRMP requires trading partners to enter Patient Control Number (PCN) and Transaction Control Number (TCN) in CLM01 separated by a dash.
144	2300	CLM01	Patient Control Number		ENCOUNTER: Trading partners should enter the encounter's Patient Control Number (PCN) and Transaction Control Number (TCN) separated by a dash – all characters will be returned in the 835's CLP01 field.
145	2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter.
147	2300	CLM05-1	Facility Type Code		Value received is the first two positions of the Type of Bill (TOB).
147	2300	CLM05-2	Facility Code Qualifier	A	"A" – Uniform Billing Claim Form Bill Type

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
147	2300	CLM05-3	Claim Frequency Code	1, 3, 7, 8	The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or if it is a replacement/void of a previously adjudicated and "paid" claim/encounter: "1" — Indicates that this is the first claim/encounter submitted to PRMMIS. "3" — Hospice Only "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" — Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. ENCOUNTER – Use "1" as a frequency code when resubmitting a denied claim. *Note:* The use of values "7" and "8" can result in the previously submitted claim/encounter being adjusted. Include the Internal Control Number (ICN) from the previously submitted claim/encounter in the original reference number segment in Loop 2300. The claim frequency code was switched to an external code source during the addenda process. See the NUBC Manual or Web site, www.nubc.org/. ENCOUNTER: Paper submissions/requests will not be supported for encounter processing. ENCOUNTER: MCOs are required to send their Claim ID (TCN) for each encounter submitted as well as their Claim ID (TCN) for an encounter being voided (refer to Section 4.6 – Procedures for Voiding Encounters).
149	2300	DTP	Discharge Hour		

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
149	2300	DTP01	Date / Time Qualifier	096	"096" – Discharge
149	2300	DTP02	Date Time Period Format Qualifier	TM	"TM" – Time (HHMM)
149	2300	DTP03	Discharge Time		Bill the Discharge Hour on all claims involving final services rendered. When a Discharge Hour is submitted, the Discharge Date is populated with the Statement Last Date of Service. This field only applies for nursing home patients discharged prior to the end of the month.
150	2300	DTP	Statement Dates		
150	2300	DTP01	Date / Time Qualifier	434	"434" – Statement
150	2300	DTP02	Date Time Period Format Qualifier	RD8	"RD8" – Range of Dates expressed in format: CCYYMMDD-CCYYMMDD.
153	2300	CL1	Institutional Claim Code		
153	2300	CL103	Patient Status Code		*Note:* Nursing home claims/encounters are not a covered program for the Puerto Rico Department of Health.
154	2300	PWK	Claim Supplemental Information		Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.
158	2300	CN1	Contract Information		ENCOUNTER – This refers to the contract between the plan and the provider paid by the plan.
158	2300	CN101	Contract Type Code		ENCOUNTER – Required "05" – If provider's services were provided under a capitation agreement, Fee For Service (FFS) encounter claims should indicate the appropriate value as listed in the TR3.
158	2300	CN102	Contract Amount		ENCOUNTER – Required If CN101 = "05", then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount that the health plan paid the provider.
163	2300	REF	Referral Number		

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
163	2300	REF01	Reference Identification Qualifier	9F	"9F" – Referral Number
163	2300	REF02	Referral Number		
164	2300	REF	Prior Authorization		
164	2300	REF01	Reference Identification Qualifier	G1	"G1" – Prior Authorization Number
164	2300	REF02	Prior Authorization Number		Enter the 10-digit Prior Authorization Number. Enter this number only if the services rendered required and received prior authorization. This number must be entered with the qualifier "G1" (Prior Authorization Number).
166	2300	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested).
166	2300	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number
166	2300	REF02	Payer Claim Control Number		The ID (TCN), in the MCO's system, of the encounter being voided.
258	2300	HI	Occurrence Information		For those HI Segments (Page 184 through Page 304) within the 837I Implementation Guide that can repeat multiple times and allow up to 12 occurrences of information within each segment are captured and stored within the MMIS.
258	2300	HI01-1	Code List Qualifier Code	BH	"BH" – Occurrence
269	2300	HI12-1	Code List Qualifier Code	BH	"BH" – Occurrence
319	2310A	NM1	Attending Provider Name		This is required for Inpatient Services.
319	2310A	NM101	Entity Identifier Code	71	"71" – Attending Provider
321	2310A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
321	2310A	NM109	Attending Provider Primary Identifier		HIPAA National Provider Identifier
322	2310A	PRV	Attending Provider Specialty Information		
322	2310A	PRV01	Provider Code	AT	"AT" – Attending
322	2310A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
322	2310A	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code that is used for claims submitted with NPI.
324	2310A	REF	Attending Provider Secondary Identification		
324	2310A	REF01	Reference Identification Qualifier	0B, G2	"0B" – State License Number "G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
336	2310D	NM1	Rendering Provider Name		*Note:* This is required when the Rendering Provider is different than the Attending Provider reported in Loop ID-2310A of this claim.
337	2310D	NM101	Entity Identifier Code	82	"82" – Rendering Provider
338	2310D	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
338	2310D	NM109	Rendering Provider Identifier		HIPAA National Provider Identifier
339	2310D	REF	Rendering Provider Secondary Identification		
339	2310D	REF01	Reference Identification Qualifier	0B, G2	"0B" – State License Number "G2" – Provider Commercial Number *Note:* The "G2" qualifier should only be used for non-healthcare providers.
341	2310E	NM1	Service Facility Name		*Note:* This is required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider).
342	2310E	NM101	Entity Identifier Code	77	"77" – Service Location
342	2310E	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
342	2310E	NM109	Laboratory or Facility Primary Identifier		HIPAA National Provider Identifier
344	2310E	N3	Service Facility Location Address		
344	2310E	N301	Laboratory or Facility Address Line		Service Facility Location Address Line
345	2310E	N4	Service Facility Location City, State, Zip Code		
345	2310E	N401	Laboratory or Facility City Name		Service Facility Location City
346	2310E	N402	Laboratory or Facility State or Province Code		Service Facility Location State

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
346	2310E	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
339	2310E	REF	Rendering Provider Secondary Identification		
339	2310E	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier should only be used for non-healthcare providers.
349	2310F	NM1	Referring Provider Name		*Note:* This is required on an outpatient claim when the Referring Provider is different than the Attending Provider.
350	2310F	NM101	Entity Identifier Code	DN	"DN" – Referring Provider
351	2310F	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
351	2310F	NM109	Referring Provider Identifier		HIPAA National Provider Identifier
352	2310F	REF	Referring Provider Secondary Identification		
352	2310F	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier should only be used for non-healthcare providers.
354	2320	SBR	Other Subscriber Information		ENCOUNTER – Loop 2320 (Other Subscriber Information) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
355	2320	SBR01	Payer Responsibility Sequence Number Code		Enter the appropriate standard code. The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim, replaces the data supplied by the Financial Class Code.
356	2320	SBR09	Claim Filing Indicator Code		ENCOUNTER – When the MCO is the payer, the value should be "HM". *Note:* All valid values will be accepted for other payer loops.
358	2320	CAS	Claim Level Adjustments		

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
360	2320	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO Denied Claim
360	2320	CAS03	Adjustment Amount		
364	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
364	2320	AMT01	Amount Qualifier Code	D	"D" – Payer Amount Paid
364	2320	AMT02	Payer Paid Amount		Other Payer Amount Paid (Third Party Liability or Managed Care Organization)
364	2320	AMT	Remaining Patient Liability		
364	2320	AMT01	Amount Qualifier Code	EAF	"EAF" – Amount Owed
364	2320	AMT02	Remaining Patient Liability		
384	2330B	NM1	Other Payer Name		ENCOUNTER – Loop 2330B (Other Payer Name) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
385	2330B	NM108	Identification Code Qualifier	PI, XV	"PI" – Payer Identification "XV" – Centers for Medicare and Medicaid Services Plan ID
385	2330B	NM109	Other Payer Primary Identifier		This number must be identical to at least one occurrence of the 2430-SVD01 to identify the other payer. Puerto Rico Department of Health captures third party payment amount(s) from the service line(s) in 2430-SVD02. *Note:* The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail. ENCOUNTER – This value should be the MCO's assigned Trading Partner ID.
258	2330B	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal Claim ID be entered here for every encounter.
258	2330B	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number
258	2330B	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
423	2400	LX	Service Line Number		
423	2400	LX01	Assigned Number		Puerto Rico Department of Health accepts up to the HIPAA-allowed 999 detail lines per claim.
424	2400	SV2	Institutional Service Line		
424	2400	SV201	Service Line Revenue Code		*Note:* Nursing homes are not a covered service under the Puerto Rico Medicaid program.
425	2400	SV202-1	Product/Service ID Qualifier	HC	"HC" – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
428	2400	SV205	Service Unit Count		Enter the number of days spent in hospital or at home. Puerto Rico Department of Health processes only the whole number when units are entered with decimals. Example: Units entered on the transaction, 3.75, are processed as 3 units.
459	2410	LIN	Drug Identification		
451	2410	LIN02	Service ID Qualifier	N4	"N4" – National Drug Code
451	2410	LIN03	Drug Identification		Enter National Drug Code in 5-4-2 format.
451	2410	CTP	Drug Quantity		
452	2410	CTP04	National Drug Unit Count		National Drug Unit Count
452	2410	CTP05-1	Code Qualifier	UN	"UN" – Unit
476	2430	SVD	Line Adjudication Information		ENCOUNTER – Loop 2430 required on all encounter claims. *Note:* Other payer payment amounts are required to be entered at the detail level.
476	2430	SVD01	Other Payer Primary Identifier		This should match one occurrence of the 2330B-NM109 identifying Other Payer.
477	2430	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the line-item level only.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					This is also used for crossover detail paid amount. ENCOUNTER – If CN101 = "05", SVD02 should be zero. If CN101 = "09", then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
481	2430	CAS	Line Adjustment		
482	2430	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO Denied line item
482	2430	CAS03	Adjustment Amount		

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A. APPENDIX A

A.1 Change History

Version 1.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Initial Submission

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Contrato Número

A.2 Change History

Version 2.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	17		Specific business rules and limitations		Added new text for PRMMIS procedure for Voiding encounters
2300	27	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested).
2300	27	REF02	Payer Claim Control Number		The ID, in the MCO's system, of the encounter being voided
2330B	34	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal claim ID be entered here for every encounter.
2330B	34	REF01	Reference Identification Qualifier	F8	Original Reference Number
2330B	29	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted

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A.3 Change Summary

Version 3.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	7		Introduction		Change Section 10 to Section 6
2000B	21	SBR09	Claim Filing Indicator Code		Update text: See Comment on 2000B-SBR03
2300	22	CLM02	Total Claim Charge Amount		Remove Note – negative amount will fail compliance
2300	24	CL103	Patient Status Code		Changed the title of Section 9 to Nursing Home Termination Codes to Patient Status Codes Crosswalk.
2300	25	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	25	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	25	CN104	Contract Code		REMOVED THIS ROW
2310A	27	REF01	Reference Identification Qualifier	0B, G2	Modify text: "0B" – State License Number "G2" – Provider Commercial Number *Note:* This is not required for nursing homes.

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					Note: The "G2" qualifier must be used for non-healthcare providers.
2310A	27	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers.
2310D	27	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers.
2320	30	CAS03	Adjustment Amount		Remove Comment.
2320	30	CAS06	Adjustment Amount		Remove Comment.
2320	30	CAS09	Adjustment Amount		Remove Comment.
2320	30	CAS12	Adjustment Amount		Remove Comment.
2320	30	CAS15	Adjustment Amount		Remove Comment.
2320	31	CAS18	Adjustment Amount		Remove Comment.
2320	34	CAS03	Adjustment Amount		Remove Comment.
2320	34	CAS06	Adjustment Amount		Remove Comment.
2320	34	CAS09	Adjustment Amount		Remove Comment.
2320	34	CAS12	Adjustment Amount		Remove Comment.
2320	35	CAS15	Adjustment Amount		Remove Comment.
2320	35	CAS18	Adjustment Amount		Remove Comment.

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A.4 Change Summary

Version 3.1 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 09-09-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Section 1.1	7		Scope		Modify text: For further information, contact their policy-specific area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions.
Section 1.2	7		Overview		Remove text: This information should be given to the provider's business area to ensure that Claim/Encounters are interpreted correctly.
Section 1.4	9		National Provider NPI		Modify text: All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency *transportation*,
Section 1.4	10		File/System Specifications		Remove text: The recommended extension is .txt or .dat. EDI does not allow zipped files. Files will be submitted to EDI via STFP. Add text: The following standards should be used: To avoid accidently overwriting files, do not send

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					multiple files with the same name on the same day. File Names should not be longer than 45 characters File Names should not contain spaces or special characters File Names should contain a file extension such as .dat or .txt Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file Zip files must contain the extension .zip (not case sensitive)
Section 1.4	10		Negative Dollar Amounts		New Paragraph: Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
Section 2.1	11		Process Flows		Modify text: classified as "paid".
N/A	12	ISA01	Authorization Information Qualifier		Remove text: "00" – No Authorization Information Present.
N/A	12	ISA02	Authorization Information		Remove text: Claim - [space fill]
N/A	13	ISA14	Acknowledgement Requested	0	Remove code 1 & comment.
Section 4.1	16		Trading Partner Identification Number		Modify text: In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS the EDI team will create any needed Trading Partner Profiles.
Section 4.2	16		Testing		Module One of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.
Section 4.4	16		Limits		Modify text: File Size is restricted to 5,000 transactions (claims/encounters) per file.
Section 4.6	16		Procedures for Voiding Encounters		Modify text:

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					When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:
2010AB	20	NM1	Pay-To Address Name		Modify text: This loop will not be used by Puerto Rico Department of Health's PRMMIS.
2000B	20	SBR01	Payer Responsibility Sequence Number Code		The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim replaces the data supplied by the Financial Class Code. Remove Text: See Section 7 - Appendix A for a crosswalk of Financial Class Codes to the Claim Filing Indicator/Payer Responsibility Sequence.
2000B	21	SBR09	Claim Filing Indicator Code		Update text: See Comment on 2000B-SBR03
2010BA	20	NM109	Subscriber Primary Identifier		Change text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. Remove Text: *Note:* Do not enter any other numbers or letters. Use the Puerto Rico Department of Health card or the EVS to obtain the correct identification number.
2300	21	CLM01	Patient Control Number		Modify text: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. Remove text:

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					Note: Value received is returned on the 835 Remittance Advice. Add text: ENCOUNTERS: MCO should send the original PCN from the provider's original claim.
2300	21	CLM05-3	Claim Frequency Code		Modify text: "1" — Indicates that this is the first claim/encounter submitted to PRMMIS. "3" — Hospice Only "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" — Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. Remove text: Electronic adjustments are subject to the same requirements as paper adjustments and therefore may result in a letter to the provider if the requirements are not met. Do not use adjustment values if reconsideration of the original payment is needed. All requests for reconsideration should be submitted on paper with supporting documentation. Modify text: ENCOUNTER: Paper submissions/requests will not be supported for encounter processing. Add text: ENCOUNTER: MCOs are required to submit claim

					ID (TCN) for each encounter submitted as well as their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	25	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	25	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	23	PWK	Claim Supplemental Information		Modify text: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length.
2300	23	PWK01 thru PWK05			Remove rows.
2300	23				Modify text: Puerto Rico Department of Health's PRMMIS does not use this field for processing of the claim/encounter
2300	23	CL103	Patient Status Code		Remove text: The X12N 837I does not support the use of the Nursing Home Termination Codes currently billed on Nursing Home claims. Remove Text: The Termination Code is derived from the Patient Status Code. Remove Text: See Section 9 - Nursing Home Termination Codes to

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					Patient Status Codes Crosswalk. Add text: *Note:* Nursing home claims/encounters are not a covered program for the Puerto Rico Department of Health.
2300	24	REF	Payer Claim Control Number		Add Note/Comment: ENCOUNTER: MCOs are required to send their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	24	REF02	Payer Claim Control Number		Modify Note/Comment: The ID (TCN), in the MCO's system, of the encounter being voided.
2300	25	REF02	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2300	25	REF	Claim Identifier for Transmission Intermediaries		Remove Segment
2300	25	REF02	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2300	26	HI01-1	Code List Qualifier Code	BH	Modify Notes/Comments: "BH" – Occurrence Remove Text: See Appendix B for a list of current Puerto Rico-specific Occurrence Codes to replacement codes and their description.
2300	26	HI12-1	Code List Qualifier Code	BH	Modify Notes/Comments: "BH" – Occurrence Remove Text: See Appendix B for a list of current Puerto Rico-specific Occurrence Codes to replacement codes and their description.
2310F	26	REF02	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2320	27	SBR01	Payer Responsibility Sequence Number Code		Modify Notes/Comments: The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing

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					Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim replaces the data supplied by the Financial Class Code. Remove Text: See Section 7 - Appendix A for a crosswalk of Financial Class Codes to the Claim Filing Indicator/Payer Responsibility Sequence.
2320	27	CAS02	Adjustment Reason Code	A1	Remove text: For Inpatient: "1" - Deductible "2" - Coinsurance Other external code source values from code source 139 are allowed.
2320	27 thru 28	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.
2400	29	SV201	Service Line Revenue Code		Remove text: Nursing home submitters must enter a revenue code. Enter Revenue Code "0101" and the per diem amount if no home days or hospital days need to be reported. Enter Revenue Code "0185" for days spent in hospital or Service Line Revenue Code "0182" for days spent at home. (Nursing Home only) Add text: *Note:* Nursing homes are not a covered service under the Puerto Rico Medicaid program.
2430	30	SVD	Line Adjudication Information		Remove (name loop) from Notes/Comments
2430	30	SVD01	Other Payer Primary Identifier		Remove number from Notes/Comments
2430	30	SVD02	Service Line Paid Amount		Modify text: Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the line item level only.

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					This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
2430	31	CAS02	Adjustment Reason Code	A1	Remove text: For Inpatient: "1" - Deductible "2" - Coinsurance Other external code source values from code source 139 are allowed.
2430	31 thru 32	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.
N/A	36		Section 7 – Appendix A		Remove Section 7
N/A	36		Section 8 – Appendix B		Remove Section 8
N/A	36		Section 9 – Appendix C		Remove Section 9
N/A	37		Section 10 – Appendix D		Remove Section 10

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A.5 Change History

Version 4.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 10-24-17

Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	10	Section 1.4	Additional Information		Remove text: Negative Dollar Amounts Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
2010BA	20	NM109	Subscriber Primary Identifier		Add text: ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.
2320	26	SBR09	Claim Filing Indicator Code	16 CI, HM MA, MB	Modify text: "16" – HMO Medicare Risk (required for Medicare Part C claims) "CI" – Commercial Insurance "HM" – Managed Care Organization "MA" – Medicare Part A "MB" – Medicare Part B
2330B	27	NM109	Other Payer Primary Identifier		Add text: ENCOUNTER – This value should be the MCO's assigned trading partner ID.
2330B	27	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.

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A.6 Change History

Version 5.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-17-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	23	CN1	Contract Information		Modify the text: ENCOUNTER – This refers to the contract between the plan and the provider paid by the plan.
2300	23	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER - Required "05" – If provider's services were provided under a capitation agreement FFS encounter claims should indicate the appropriate value as listed in the TR3.
2300	22	CN102	Contract Amount		Modify the text: If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered.
2300	24	K3	File Information		Remove Segment
2300	24	K301	Fixed Format Information		Remove Line: MCO Receipt Date – Format: CCYYMMDD.
2320	26	SBR09	Claim Filing Indicator Code	~~16, CI, HM, MA, MB~~	Modify the text: ~~"16" – HMO Medicare Risk (required for Medicare Part C claims).~~ ~~"CI" – Commercial Insurance~~ ~~"HM" – Managed Care Organization~~ ~~"MA" – Medicare Part A~~ ~~"MB" – Medicare Part B~~ ENCOUNTER: When the MCO is the payer the value should be "HM" *NOTE:* All valid values will be accepted for other payer loops.
2330B	27	DTP	Claim Check or Remittance Date		Remove Segment
2330B	27	DTP01	Date / Time Qualifier	573	Remove Line: "573" – Other Payer or MCO Claim Adjudication Date

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2330B	27	DTP02	Date Time Period Format Qualifier	D8	Remove Line: "D8" – Date Expressed in Format CCYYMMDD
2330B	27	DTP03	Adjudication or Payment Date		Remove Line: TPL or MCO Adjudication Date (CCYYMMDD)

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A.7 Change History

Version 6.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 04-01-19
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010BA	20	NM109	Subscriber Primary Identifier		Old text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID. New text: PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
2300	21	CLM	Claim Information		New text: NOTE: Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when one encounter is found to be non-compliant, the recommendation is to enter TCN in CLM02.

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A.8 Change History

Version 7.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 05-05-20
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	21	CLM	Claim Information		New text *Note:* Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, PRMP requires trading partners to enter PCN and TCN in CLM01 separated by a dash.
2300	21	CLM01	Patient Control Number		New text ENCOUNTER: Trading partners should enter encounter's PCN and TCN separated by a dash – all characters will be returned in the 835's CLP01 field.

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A.9 Change History

Version 7.1 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-10-21
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010AA	19	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
2310E	26	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**

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A.10 Change History

Version 7.2 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-22-21
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2000B	20	SBR01	Payer Responsibility Sequence Number Code		Remove row
2000B	20	SBR09	Claim Filing Indicator Code	MC	Remove text: See Comment on 2000B-SBR01. Add text: "MC" = Medicaid

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GOVERNMENT OF PUERTO RICO
Department of Health
Medicaid Program

Puerto Rico Medicaid Management Information System Fiscal Agent Services

PRMMIS_NCPDP_Post_Adjudication_Companion_Guide

Puerto Rico Medicaid Program Post Adjudication Companion Guide

HIPAA Transaction Standard Companion Guide

Refers to the NCPDP Post Adjudication Standard V4.2

Companion Guide

Version 4.Ø – November 2Ø2Ø

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Disclosure Statement

This template is based on the CORE v5Ø1Ø Master Companion Guide Template and adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2ØØ3.

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Preface

This Companion Guide to the NCPDP Post Adjudication 4.2 Implementation Guide clarifies and specifies the data content when exchanging electronically with Puerto Rico Medicaid Program. Transmissions based on this Companion Guide, used in tandem with the Post Adjudication 4.2 Implementation Guides, are compliant with NCPDP. This Companion Guide is intended to convey information that is within the framework of the Post Adjudication 4.2 Implementation Guides. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

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Contents

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1 Introduction

NCPDP – NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and issuers. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The National Council for Prescription Drug Programs (NCPDP) is a non-profit organization formed in 1976. It is dedicated to the development and dissemination of voluntary consensus standards that are necessary to transfer information that is used to administer the prescription drug benefit program.

Refer to the NCPDP Post Adjudication Version 4.2 documents (NCPDP Post Adjudication Standard Implementation Guide (IG), Data Dictionary, and External Code List) for more detailed information on field values and segments.

The following information is intended to serve only as a Companion Guide to the aforementioned NCPDP Post Adjudication Standard Version 4.2 documents. The use of this Companion Guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This Companion Guide supplements, but does not contradict, any requirements in the NCPDP Post Adjudication Standard Version 4.2 Implementation Guide and related documents.

To request a copy of the NCPDP Standard Formats or for more information contact the National Council for Prescription Drug Programs, Inc. at www.ncpdp.org. The contact information is as follows:

National Council for Prescription Drug Programs
924Ø East Raintree Drive Scottsdale, AZ 8526Ø
Phone: (48Ø) 477-1ØØØ
Fax (48Ø) 767-1Ø42

This section describes how the NCPDP Post Adjudication (4.2) Implementation Guides (IGs) will be detailed with the use of a table. The table contains a row for each element/field of the NCPDP Post Adjudication V4.2 records.

Each row will indicate whether the element/field is required or is not required by PRMMIS.

The following table is an example:

Table 1 – Example NCPDP Post Adjudication 4.2 Implementation Guides Table

SHADED Rows represent "sections" in the NCPDP Post Adjudication Implementation Guide.
NON-SHADED Rows represent "data elements" in the NCPDP Post Adjudication Implementation Guide.

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	PA – Post Adjudication History Header Record	M	P	A	2	1	2	Required
6Ø1-Ø9	TOTAL RECORD COUNT	Total number of records being submitted, including header and trailer.		M	P	N	1Ø	3	12	Required
895	TOTAL NET AMOUNT DUE	Summarization of Net Amount Due (281).		M	P	D	12	13	24	Required

1.1 Scope

This Companion Guide is to be used in addition to the NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code List.

This Companion Guide contains supplemental information for creating transactions for PRMP while ensuring compliance with the associated Post Adjudication 4.2 Implementation Guide.

The Transaction Instruction component of this Companion Guide must be used in conjunction with an associated NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code List.

The instructions in this Companion Guide are not intended to be stand-alone requirements documents. This Companion Guide conforms to all the requirements of any associated NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code List, and is in conformance with NCPDP's Fair Use and Copyright statements.

2 NCPDP Post Adjudication Transaction Standard Version 4.2 File Information

The batch specifications contained in this document include the header, detail, compound, and trailer segments. Batch files should contain one header record, one trailer record, and a maximum of 2ØØ,ØØØ transaction details.

- Post Adjudication History Header (Occurs 1)
- Post Adjudication History Detail (Occurs 1 to 2ØØ,ØØØ)
- Post Adjudication History Compound Detail 1 (Occurs 1 as Applicable with Detail Record)
- Post Adjudication History Compound Detail 2 (Occurs 1 as Applicable with Detail Record)
- Post Adjudication History Trailer (Occurs 1)

Note: All ingredients in a Compound detail should be consecutive and contiguous to each other; gaps or holes in the sequence are not accepted. Also, only send a Compound Detail 2 record if and only if Compound Detail 1 has all 8 ingredients already set up, and more ingredients or components are required.

Batch files should have a creation date in the batch header that is valid and less than 3Ø days old from the submission date of the file, or the file will be rejected. Values in the header and trailer will be edited to verify that they contain appropriate values.

2.1 Record Delimiter

The V4.2 Post Adjudication V4.2 record is 3,7ØØ characters followed by a Carriage return only – UNIX-based system (record length n+1).

2.2 Over Punch Sign Requirements

Table 2 – Over Punch Sign Requirements

Positive Signed		Negative Signed	
Numeric	**Graphic**	**Numeric**	**Graphic**
Ø	{	Ø	}
1	A	1	J
2	B	2	K
3	C	3	L
4	D	4	M
5	E	5	N

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Positive Signed		Negative Signed	
Numeric	Graphic	Numeric	Graphic
6	F	6	O
7	G	7	P
8	H	8	Q
9	I	9	R

Examples:

1. 1Ø{ is 1ØØ
2. 45A is 451

Decimal points are usually implied, not explicit in the text. Using numbers with two decimal digits: 1ØØØØ{ is 1ØØ.ØØ.

2.3 Additional NCPDP Post Adjudication Transaction Standard Version 4.2 File Information

The following definitions are given to ensure consistency of interpretation:

- **Field** – The Post Adjudication Transaction Standard Version 4.2 field number
- **Field Name** – The Post Adjudication Transaction Standard Version 4.2 field name
- **Description** – A short description of field
- **Values** – Required or default value(s) for each field
- **Usage** – Field designation – indicates whether a field is mandatory, situational, or not used. Mandatory fields are made mandatory by the NCPCP Post Adjudication Transaction Standard Version 4.2 and/or required by the processor. If a field is situational and data does not exist for the field, the field MUST be populated with the appropriate padding (default value). If a field is not required, note that PRMMIS will not process any data submitted.
  - M – Mandatory field
  - S – Situational field
  - N/U – Not used (PRMMIS will not use information sent in this field)
- **Source** – Data source
  - C – Submitted Claim or the Processor's response to the Submitted Claim
  - P – Processor/Payer

- **Format** – Field format values
  - A – Alpha Numeric – upper case when alpha, always left justified, space filled, printable characters and **default values of spaces**
    - Example: X(14) represents "1234ABC44bbbbb"
  - N – Unsigned Numeric – always right justified, zero filled and **default values of zeros**
    - Example: 9(7)v999 represents "9999999999"
  - D – Signed Numeric – sign is internal and trailing (see Section **Over Punch Sign Requirements**), zero always positive, always right justified, zero filled dollar-cents amount with 2 positions to the right of the implied decimal point, all other positions to the left of the implied decimal point and **default values of positive zeros**
    - Example: "D" fields of length 8 represent $$$$$$cc
- **Size** – The field length
- **Start** – The starting position of the field in the record
- **End** – The ending position of the field in the record
- **PRMP Comment** – Notes/comments about specific fields

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3 Naming Convention Rules for NCPDP V4.2 Post Adjudication File:

Position 1 – 4 = 4 byte abbreviation of PBM/MAO's name
Position 5 – 6 = sequence number of file (each file limited to 2ØØ,ØØØ claims)
Position 7 = underscore
Position 8 – 2Ø = Always use PRM_ClaimData
Position 21 = underscore
Position 22 – 29 = Date file was created (YYYYMMDD format)
Position 3Ø – 33 = use .dat or .zip

Example #1:
Submission Date: 11/Ø1/2Ø19
Total Number of Claims: 3ØØ,ØØØ

ABRV01_ PRM_ClaimData_20191101.dat [First 2ØØ,ØØØ claims]
ABRV02_ PRM_ClaimData_20191101.dat [Last 1ØØ,ØØØ claims]

Example #2:
Submission Date: 11/15/2Ø19
Total No of Claims: 5ØØ,ØØØ

ABRV01_ PRM_ClaimData_20191115.dat [First 2ØØ,ØØØ claims]
ABRV02_ PRM_ClaimData_20191115.dat [Second 2ØØ,ØØØ claims]
ABRV03_ PRM_ClaimData_20191115.dat [Last 1ØØ,ØØØ claims]

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4 Transaction Specific Information

This section describes how the NCPDP Post Adjudication 4.2 Implementation Guide (IG), Data Dictionary, and the External Code List will be used. The tables contain a row for each data element that PRMP has something additional, over and above, the information in the IGs in addition to any other information tied directly to a data element pertinent to trading electronically with PRMP.

4.1 POST ADJUDICATION HISTORY HEADER RECORD

Table 3 – Post Adjudication History Header Record

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	PA – Post Adjudication History Header Record	M	P	A	2	1	2	Required
1Ø2-A2	VERSION/ RELEASE NUMBER	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	42 – Version 4.2	M	P	A	2	3	4	Required
879	SENDING ENTITY IDENTIFIER	Party creating the data enclosed or the entity for whom the data is being enclosed.	PRMP assigned six-digit trading partner ID	M	P	A	24	5	28	Required
8Ø6-5C	BATCH NUMBER	This number is assigned by the processor/sender. A number generated by the sender to uniquely identify this batch from others, especially when multiple batches may be sent in one day.		M	P	N	7	29	35	Required
88Ø-K2	CREATION DATE	Date that the file was created. Not older than 3Ø days from the actual submission date.	Format CCYYMMDD	M	P	N	8	36	43	Required
88Ø-K3	CREATION TIME	Time that the file was created.	Format HHMM	M	P	N	4	44	47	Required

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
88Ø-K7	RECEIVER ID	An identification number of the endpoint receiver of the data file.	PRMMIS	M	P	A	24	48	71	Required
6Ø1-Ø6	REPORTING PERIOD START DATE	The first day of the period being reported in the file.	Format CCYYMMDD	M	P	N	8	72	79	Required
6Ø1-Ø5	REPORTING PERIOD END DATE	The last day of the period being reported in the file.	Format CCYYMMDD	M	P	N	8	8Ø	87	Required
7Ø2-MC	FILE TYPE	Code identifying whether the file contained test or production data.	T – Test – In processing systems, the test environment P – Production – In processing systems, the live environment	M	P	A	1	88	88	Required
981-JV	TRANSMISSION ACTION	Indicates whether this is a replacement file, file updates, or a file delete.	O – Original Submission (New) – a new file	M	P	A	1	89	89	Required
888	SUBMISSION NUMBER	Indicates the number of times that a data set has been resent.	Blank – Not Specified ØØ – First Submission Ø1 – First Resubmission Ø2 – Second Resubmission Ø3 – 99 – Number of Resubmission	M	P	A	2	9Ø	91	Required
	FILLER			N/U	P	A	36Ø9	92	37ØØ	

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4.2 POST ADJUDICATION HISTORY DETAIL RECORD

Table 4 – Post Adjudication History Detail Record

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	DE – Post Adjudication History Detail Record	M	P	A	2	1	2	Required
398	RECORD INDICATOR	Action to be taken on the record.	Ø – New Record	S	P	A	1	3	3	Required
SECTION DENOTES ELIGIBILITY CATEGORY:										
248	ELIGIBLE COVERAGE CODE	Coverage Level Code. Code indicating the level of coverage being provided for the insured.	IND – Individual	S	P	A	3	4	6	Required
898	USER BENEFIT ID	Member's benefit ID based upon User Group Number from Eligibility when submitted by Client.		N/U	P	A	1Ø	7	16	
899	USER COVERAGE ID	Member's coverage ID based upon User Group Number submitted by Client on eligibilty data.		N/U	P	A	1Ø	17	26	
246	ELIGIBILITY GROUP ID	Identifier of the group that determines eligibility parameters for the member when submitted by the client.		N/U	P	A	15	27	41	
27Ø	LINE OF BUSINESS CODE	Line of Business Code from Client eligibility or as defined by trading partner agreement.		N/U	P	A	6	42	47	
267	INSURANCE CODE	Special group/member data as supplied on eligibility record when supplied by the client.		N/U	P	A	2Ø	48	67	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
22Ø	CLIENT ASSIGNED LOCATION CODE	The location of the member within the Client's Company from Client eligibility when submitted by the client.		N/U	P	A	2Ø	68	87	
222	CLIENT PASS THROUGH	Information from Client eligibility when submitted by the client.		N/U	P	A	2ØØ	88	287	
SUBSECTION DENOTES CARDHOLDER INFORMATION:										
3Ø2-C2	CARDHOLDER ID	Insurance ID assigned to the cardholder or identification number used by the plan.		M	C/P	A	2Ø	288	3Ø7	Required PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number.
716-SY	LAST NAME	Last name.		S	P	A	35	3Ø8	342	Required when available in the payer's adjudication system
717-SX	FIRST NAME	First name.		S	P	A	35	343	377	Required when available in the payer's adjudication system
718	MIDDLE INITIAL	Middle initial.		N/U	P	A	1	378	378	
28Ø	NAME SUFFIX	Individual name suffix.		N/U	P	A	1Ø	379	388	
726-SR	ADDRESS LINE 1	First line of address information.		N/U	P	A	4Ø	389	428	
727-SS	ADDRESS LINE 2	Second line of address information.		N/U	P	A	4Ø	429	468	
728	CITY	Free-form text for city name.		N/U	P	A	3Ø	469	498	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
729-TA	STATE/ PROVINCE ADDRESS	The State/Province Code of the address.		N/U	P	A	2	499	5ØØ	
73Ø	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.		N/U	P	A	15	5Ø1	515	
B36-1W	ENTITY COUNTRY CODE	Code of the country.		N/U	P	A	2	516	517	
214	CARDHOLDER DATE OF BIRTH	Date of Birth of Member.		N/U	P	N	8	518	525	
721-MD	GENDER CODE	Code identifying the gender of the individual.	Blank – Unknown or Unspecified 1 – Male 2 – Female	S	P	N	1	526	526	Required when available in the payer's adjudication system
274	MEDICARE PLAN CODE	This represents if the member is eligible for Medicare coverage as provided in eligibility data.		N/U	P	A	1	527	527	
288	PAYROLL CLASS	A field defined by the client indicating the payroll class of the member.		N/U	P	A	1	528	528	
SECTION DENOTES PATIENT INFORMATION:										
331-CX	PATIENT ID QUALIFIER	Code qualifying the 'Patient ID' (332-CY).	Ø6 – Medicaid ID – A number assigned by a state Medicaid agency	S	P	A	2	529	53Ø	Required
332-CY	PATIENT ID	ID assigned to the patient.		S	P	A	2Ø	531	55Ø	Required PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number.

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
716-SY	LAST NAME	Last name.		N/U	P	A	35	551	585	
717-SX	FIRST NAME	First name.		N/U	P	A	35	586	62Ø	
718	MIDDLE INITIAL	Middle initial.		N/U	P	A	1	621	621	
28Ø	NAME SUFFIX	Individual name suffix.		N/U	P	A	1Ø	622	631	
726-SR	ADDRESS LINE 1	First line of address information.		N/U	P	A	4Ø	632	671	
727-SS	ADDRESS LINE 2	Second line of address information.		N/U	P	A	4Ø	672	711	
728	CITY	Free-form text for city name.		N/U	P	A	3Ø	712	741	
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.		N/U	P	A	2	742	743	
73Ø	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.		N/U	P	A	15	744	758	
A43-1K	PATIENT COUNTRY CODE	Code of the country.		N/U	P	A	2	759	76Ø	
3Ø4-C4	DATE OF BIRTH	Date of Birth of Member.	Default ØØØØØØØØ	S	P	N	8	761	768	Required when available in the payer's adjudication system
3Ø5-C5	PATIENT GENDER CODE	Code identifying the gender of the patient.	Default Ø	N/U	P	N	1	769	769	
247	ELIGIBILITY/PATIENT RELATIONSHIP CODE	Individual Relationship Code. Code indicating the relationship between two individuals or entities.	ØØ – Not Applicable	N/U	P	N	2	77Ø	771	
2Ø8	AGE	Calculated from Date of Birth (3Ø4-C4).	Default ØØØ	N/U	P	N	3	772	774	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
3Ø3-C3	PERSON CODE	Code assigned to a specific person within a family.		N/U	P	A	3	775	777	
3Ø6-C6	PATIENT RELATIONSHIP CODE	Code indicating relationship of patient to cardholder.	Ø – Not Specified	N/U	C	N	1	778	778	
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE	Code indicating that the pharmacy is clarifying eligibility for a patient.		N/U	C	A	1	779	779	
336-8C	FACILITY ID	ID assigned to the patient's clinic/host party.		N/U	P	A	1Ø	78Ø	789	
SECTION DENOTES BENEFIT CATEGORY:										
3Ø1-C1	GROUP ID	ID assigned to the cardholder group or employer group.		N/U	P	A	15	79Ø	8Ø4	
215	CARRIER NUMBER	Account Number assigned during installation.		M	P	A	9	8Ø5	813	Required PRMP assigned trading partner ID of MCO/MAO.
757-U6	BENEFIT ID	Assigned by processor to identify a set of parameters, benefits, or coverage criteria used to adjudicate a claim.		N/U	P	A	15	814	828	
24Ø	CONTRACT NUMBER	Account Number assigned during installation for segments of business.		N/U	P	A	8	829	836	
212	BENEFIT TYPE	Indicates the type of acceptable claims for the group based on the Benefit setup.		N/U	P	A	1	837	837	
278	MEMBER SUBMITTED	A one-position field indicating the type of member submitted claim		N/U	P	A	1	838	838	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	CLAIM PROGRAM CODE	program used to process this claim.								
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.		N/U	P	A	1	839	839	
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.		N/U	P	A	1	84Ø	84Ø	
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.		N/U	P	A	1	841	841	
241	COPAY MODIFIER ID	Unique drug list ID that is coordinated for use with the clients copay setup. Processor defined codes.		N/U	P	A	1Ø	842	851	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.		N/U	P	A	1	852	852	
293	PREFERRED ALTERNATIVE FILE ID	Indicates the preferred alternative file ID number used to determine processing.		N/U	P	A	1Ø	853	862	
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no	S	C	N	2	863	864	If available, report the appropriate value that represents other coverage for the drug/product. COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other Coverage Billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed,							

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only. Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.							
291	PLAN BENEFIT CODE	Determines the method by which Insulin and OTC claims are paid. Defined by processor.		N/U	P	A	2	865	866	
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan.	192Ø – Medicaid 193Ø – Medicare If neither MAO nor Wraparound is the primary payer, enter four spaces.	M	P	A	4	867	87Ø	Use 193Ø (Medicare) when only MAO funding is used to pay the drug/product. Use 192Ø (Medicaid) when only Puerto Rico Medicaid funds are used to pay the drug/product. If neither, enter spaces. COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
SECTION DENOTES PHARMACY CATEGORY:										
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Code qualifying the 'Service Provider ID' (2Ø1-B1).	Ø1 – National Provider Identifier (NPI) Ø5 – Medicaid ID if atypical	M	C	A	2	871	872	Required
2Ø1-B1	SERVICE PROVIDER ID	ID assigned to a pharmacy or provider.		M	C	A	15	873	887	Required
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER (ALTERNATE)	Code qualifying the 'Service Provider ID' (2Ø1-B1).		N/U	P	A	2	888	889	
2Ø1-B1	SERVICE PROVIDER ID (ALTERNATE)	ID assigned to a pharmacy or provider.		N/U	P	A	15	89Ø	9Ø4	
886	SERVICE PROVIDER CHAIN CODE	Processor specific ID assigned to a chain by processor.		N/U	P	A	7	9Ø5	911	
833-5P	PHARMACY NAME	Pharmacy name.		M	P	A	7Ø	912	981	Required
726-SR	ADDRESS LINE 1	First line of address information.		M	P	A	4Ø	982	1Ø21	Required
727-SS	ADDRESS LINE 2	Second line of address information.		N/U	P	A	4Ø	1Ø22	1Ø61	
728	CITY	Free-form text for city name.		M	P	A	3Ø	1Ø62	1Ø91	Required
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.		M	P	A	2	1Ø92	1Ø93	Required
73Ø	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.		M	P	A	15	1Ø94	11Ø8	Required
887	SERVICE PROVIDER COUNTY CODE	Indicates the county of the pharmacy.		N/U	P	A	3	11Ø9	1111	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
A93	SERVICE PROVIDER COUNTRY CODE	Indicates the country code of the provider.		N/U	P	A	2	1112	1113	
732	TELEPHONE NUMBER	Telephone Number.		N/U	P	N	1Ø	1114	1123	
B1Ø -8A	TELEPHONE NUMBER EXTENSION	Extension of the telephone number.		N/U	P	N	8	1124	1131	
146	PHARMACY DISPENSER TYPE QUALIFIER	Code qualifying the 'Pharmacy Dispenser Type' (29Ø).		N/U	P	A	1	1132	1132	
29Ø	PHARMACY DISPENSER TYPE	Type of pharmacy dispensing product.		N/U	P	A	2	1133	1134	
15Ø	PHARMACY CLASS CODE QUALIFIER	Code qualifying the 'Pharmacy Class Code' (289).		N/U	P	A	1	1135	1135	
289	PHARMACY CLASS CODE	Indicates class of the pharmacy.		N/U	P	A	1	1136	1136	
266	IN NETWORK INDICATOR	Indicates if the pharmacy dispensing the prescription is considered in network.		N/U	P	A	1	1137	1137	
545-2F	NETWORK REIMBURSEMENT ID	Field defined by the processor. It identifies the network, for the covered member, used to calculate the reimbursement to the pharmacy.		N/U	P	A	1Ø	1138	1147	
SECTION DENOTES PRESCRIBER CATEGORY:										
466-EZ	PRESCRIBER ID QUALIFIER	Code qualifying the 'Prescriber ID' (411- DB).	Ø1 – National Provider Identifier (NPI) Ø5 – Medicaid ID if atypical	M	C	A	2	1148	1149	Required

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
411-DB	PRESCRIBER ID	ID assigned to the prescriber.		M	C	A	15	115Ø	1164	Required
466-EZ	PRESCRIBER ID QUALIFIER (ALTERNATE)	Code qualifying the 'Prescriber ID' (411- DB).		N/U	P	A	2	1165	1166	
411-DB	PRESCRIBER ID (ALTERNATE)	ID assigned to the prescriber.		N/U	P	A	15	1167	1181	
296	PRESCRIBER TAXONOMY	The taxonomy is defined as a classification scheme that codifies provider type and provider area of specialization.		S	P	A	1Ø	1182	1191	Required when available in the payer's adjudication system.
295	PRESCRIBER CERTIFICATION STATUS	Indicates a provider's certification in the health plan program.		N/U	P	A	2	1192	1193	
716-SY	LAST NAME	Last name.		M	P	A	35	1194	1228	Required
717-SX	FIRST NAME	First name.		M	P	A	35	1229	1263	Required
732	TELEPHONE NUMBER	Telephone Number.		M	P	N	1Ø	1264	1273	Required
B1Ø-8A	TELEPHONE NUMBER EXTENSION	Extension of the telephone number.		N/U	C/P	N	8	1274	1281	
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	Code qualifying the 'Primary Care Provider ID' (421-DL).		N/U	C/P	A	2	1282	1283	
421-DL	PRIMARY CARE PROVIDER ID	ID assigned to the primary care provider. Used when the patient is referred to a secondary care provider.		N/U	C/P	A	15	1284	1298	
716-SY	LAST NAME	Last name.		N/U	P	A	35	1299	1333	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
717-SX	FIRST NAME	First name.		N/U	P	A	35	1334	1368	
SECTION DENOTES CLAIM CATEGORY:										
399	RECORD STATUS CODE	Identifies the transaction status as assigned by the processor.	1 – Paid – Code indicating that the transaction was adjudicated using plan rules and was payable. 2 – Rejected – Code indicating that the transaction was denied/rejected. 3 – Reversed – Code indicating that the paid transaction was cancelled. 4 – Adjusted – Code indicating that the previous transaction was changed. 5 – Captured – Code indicating the receipt of the transaction, but no judgment has been made regarding eligibility of the patient or payment. 6 – Reverse – Captured – Code indicating that the captured transaction was cancelled.	M	P	A	1	1369	1369	Required

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
218	CLAIM MEDIA TYPE	Claim submission type code.	Blank – Not Specified 1 – POS Claim – A Point-Of-Sale transaction submitted in a real-time mode. 2 – Batch Claim – A non-real-time transaction submitted when an immediate response is not available or required. 3 – Pharmacy Submitted Paper Claim (UCF) – A non-electronic transaction submitted via an NCPDP-developed Universal Claim Form. 4 – Member Submitted Paper Claim (Direct Member Reimbursement (DMR)) – A claim submitted by the member requesting reimbursement. 5 – Other – Different from the codes already specified.	M	P	A	1	137Ø	137Ø	Required
395	PROCESSOR PAYMENT	Provides additional information of the status	Blank – Not Specified	M	P	A	2	1371	1372	PRMP requires "Blank" for this data element.

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	CLARIFICATION CODE	of the payment of the claim.								
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	Prescription/Service Reference Number Qualifier	1 – Rx Billing Transaction – A billing for a prescription or OTC drug product. 2 – Service Billing – Transaction is a billing for a professional service performed.	M	C	A	1	1373	1373	Required
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided.		M	C	N	12	1374	1385	Required
436-E1	PRODUCT/ SERVICE ID QUALIFIER	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	36 – NDC	M	C	A	2	1386	1387	Required
4Ø7-D7	PRODUCT/ SERVICE ID	ID of the product dispensed or service provided.		M	C	A	19	1388	14Ø6	Required NDC drug code if a compound drug is being reported; this field should be all zeros.
4Ø1-D1	DATE OF SERVICE	Identifies date that the prescription was filled or professional service rendered or subsequent payer began coverage following Part A expiration in a long-term care setting only.		M	C	N	8	14Ø7	1414	Required CCYYMMDD
578	ADJUDICATION DATE	Date that the claim or adjustment is processed.		M	P	N	8	1415	1422	Required

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
2Ø3	ADJUDICATION TIME	Time that the claim or adjustment is processed.		N/U	P	N	6	1423	1428	
283	ORIGINAL CLAIM RECEIVED DATE	The date that the pharmacy submitted the claim electronically for a paper claim-matching program.		N/U	P	N	8	1429	1436	
219	CLAIM SEQUENCE NUMBER	Indicates the sequence of this claim within the set of claims submitted.		N/U	P	N	5	1437	1441	
213	BILLING CYCLE END DATE	Cycle end date.		N/U	P	N	8	1442	1449	
239	COMMUNICATION TYPE INDICATOR	For Mail Service Claims Only – Identifies the type of communication used by either prescriber or patient to initiate the request for the fill.		N/U	P	A	2	145Ø	1451	
3Ø7-C7	PLACE OF SERVICE	Code identifying the place where a drug or service is dispensed or administered.		N/U	C	N	2	1452	1453	
384-4X	PATIENT RESIDENCE	Code identifying the patient's place of residence.	ØØ – Not Specified	N/U	C	N	2	1454	1455	
419-DJ	PRESCRIPTION ORIGIN CODE	Code indicating the origin of the prescription.	Ø – Not Known	N/U	C	N	1	1456	1456	
278	MEMBER SUBMITTED CLAIM PAYMENT RELEASE DATE	Indicates the date that the member-submitted claim became payable, which could differ from the check date.		N/U	P	N	8	1457	1464	
217	CLAIM DATE RECEIVED IN THE MAIL	Date that the paper claim was received in the mail.		N/U	P	N	8	1465	1472	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
268	INTERNAL MAIL ORDER PRESCRIPTION/ SERVICE REFERENCE NUMBER	Field designating the internal prescription number assigned by pharmacies.		N/U	P	A	15	1473	1487	
1Ø2-A2	VERSION/ RELEASE NUMBER (OF THE CLAIM)	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.		N/U	C	A	2	1488	1489	
216	CHECK DATE	Member Claims – Actual member check date. Nonmember Claims – Pharmacy check date.		N/U	P	N	8	149Ø	1497	
287	PAYMENT/ REFERENCE ID	Identifies ID assigned by sender to reference individual pharmacy and member reimbursement. Check or EFT trace number.		N/U	P	A	3Ø	1498	1527	
456-EN	ASSOCIATED PRESCRIPTION/ SERVICE REFERENCE NUMBER	Related 'Prescription/Service Reference Number' (4Ø2-D2) to which the service is associated.		N/U	C	N	12	1528	1539	
457-EP	ASSOCIATED PRESCRIPTION/ SERVICE DATE	Date of the 'Associated Prescription/Service Reference Number' (456-EN).		N/U	C	N	8	154Ø	1547	
442-E7	QUANTITY DISPENSED	Quantity dispensed, expressed in metric decimal units.		M	C	N	1Ø	1548	1557	Required Quantity dispensed – if a compound drug is being reported, this field should be all zeros.

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
4Ø3-D3	FILL NUMBER	The code indicating whether the prescription is an original or a refill.	ØØ – Original dispensing – The first dispensing Ø1 – 99 – Refill number – Number of the replenishment	M	C	N	2	1558	1559	Required Indicates new Rx (zero) or number of refills used.
4Ø5-D5	DAYS SUPPLY	Estimated number of days that the prescription will last.		M	C	N	3	156Ø	1562	Required
414-DE	DATE PRESCRIPTION WRITTEN	Date that the prescription was written.		M	C	N	8	1563	157Ø	Required CCYYMMDD
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	Ø – No Product Selection Indicated 1 – Substitution Not Allowed by Prescriber 2 – Substitution Allowed – Patient Requested Product Dispensed 3 – Substitution Allowed – Pharmacist Selected Product Dispensed 4 – Substitution Allowed – Generic Drug Not in Stock 5 – Substitution Allowed – Brand 6 – Override 7 – Substitution Not Allowed 8 – Substitution Allowed	M	C	A	1	1571	1571	Required

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			9 – Substitution Allowed By Prescriber, but Plan Requests Brand							
415-DF	NUMBER OF REFILLS AUTHORIZED	Number of refills authorized by the prescriber.	ØØ – No refills authorized Ø1 – 99 – Authorized Refill number – with '99' being refills unlimited	M	C	N	2	1572	1573	Required
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.		N/U	C	N	1	1574	1574	
6ØØ-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA – Each GM – Grams ML – Milliliters	M	C	A	2	1575	1576	Required
418-DI	LEVEL OF SERVICE	Coding indicating the type of service that the provider rendered.	ØØ – Not Specified Ø1 – Patient consultation Ø2 – Home delivery Ø3 – Emergency Ø4 – 24 hour service Ø5 – Patient consultation regarding generic product selection Ø6 – In-Home Service	M	C	N	2	1577	1578	Required
343-HD	DISPENSING STATUS	Code indicating that the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory	Blank – Not Specified P – Partial Fill C – Completion of Partial Fill	M	C	A	1	1579	1579	Required

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		shortages do not allow the full quantity to be dispensed.								
344-HF	QUANTITY INTENDED TO BE DISPENSED	Metric decimal quantity of medication that would be dispensed on original filling if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).		N/U	C	N	1Ø	158Ø	1589	
46Ø-ET	QUANTITY PRESCRIBED	Amount expressed in metric decimal units.		N/U	C	N	1Ø	159Ø	1599	
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	Days' supply for metric decimal quantity of medication that would be dispensed on original dispensing if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).		S	C	N	3	16ØØ	16Ø2	Required
254	FILL NUMBER CALCULATED	Code identifying whether the prescription is an original (ØØ) or by refill number (Ø1 – 99).		N/U	P	N	2	16Ø3	16Ø4	
4Ø6-D6	COMPOUND CODE	Code indicating whether or not the prescription is a compound.	Ø – Not Specified 1 – Not a Compound 2 – Compound	M	C	N	1	16Ø5	16Ø5	Required
996-G1	COMPOUND TYPE	Clarifies the type of compound.		N/U	C	A	2	16Ø6	16Ø7	
452-EH	COMPOUND ROUTE OF ADMINISTRATION	Code for the route of administration of the complete compound mixture.		N/U	C	N	2	16Ø8	16Ø9	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
995-E2	ROUTE OF ADMINISTRATION	This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture.		M	C	A	11	161Ø	162Ø	Required
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	ØØ – Not Specified Ø1 – International Classification of Diseases (ICD9) Ø2 – International Classification of Diseases-1Ø (ICD1Ø)	S	C	A	2	1621	1622	Required
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		S	C	A	15	1623	1637	Required
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		N/U	C	A	2	1638	1639	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	164Ø	1654	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		N/U	C	A	2	1655	1656	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	1657	1671	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		N/U	C	A	2	1672	1673	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	1674	1688	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		N/U	C	A	2	1689	169Ø	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	1691	17Ø5	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	17Ø6	17Ø7	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	17Ø8	17Ø9	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	171Ø	1711	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1712	1713	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1714	1715	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has		N/U	C	A	2	1716	1717	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		been identified or service has been rendered.								
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1718	1719	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	172Ø	1721	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1722	1723	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1724	1725	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1726	1727	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a		N/U	C	N	2	1728	1729	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		pharmacist to perform a professional service.								
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	173Ø	1731	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1732	1733	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1734	1735	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1736	1737	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1738	1739	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	174Ø	1741	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1742	1743	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1744	1745	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1746	1747	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1748	1749	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber In response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	175Ø	1751	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1752	1753	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1754	1755	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1756	1757	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1758	1759	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	176Ø	1761	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1762	1763	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1764	1765	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1766	1767	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1768	1769	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	177Ø	1771	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1772	1773	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1774	1775	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1776	1777	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	1778	1779	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	178Ø	1798	
878	REJECT OVERRIDE CODE	Indicates the reason for paying a claim when override is used.		N/U	P	A	1	1799	1799	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	18ØØ	18Ø2	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	18Ø3	18Ø5	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	18Ø6	18Ø8	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	18Ø9	1811	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	1812	1814	
SECTION DENOTES WORKER'S COMPENSATION CATEGORY:										
435-DZ	CLAIM/REFERENCE ID	Identifies the claim number assigned by Worker's Compensation Program.		N/U	C	A	3Ø	1815	1844	
434-DY	DATE OF INJURY	Date on which the injury occurred.		N/U	C	N	8	1845	1852	
SECTION DENOTES PRODUCT CATEGORY:										
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define		N/U	P	A	1	1853	1853	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		the database used for identifying the product.								
397	PRODUCT/ SERVICE NAME	Product or Service Description or Product Label Name.		N/U	P	A	3Ø	1854	1883	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.		N/U	P	A	3Ø	1884	1913	
6Ø1-24	PRODUCT STRENGTH	The strength of the product.		N/U	P	A	15	1914	1928	
243	DOSAGE FORM CODE	Dosage form code for product identified.		N/U	P	A	4	1929	1932	
	FILLER			N/U	P	A	8	1933	194Ø	
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.		N/U	P	N	1	1941	1941	
273	MAINTENANCE DRUG INDICATOR	Indicates if the drug is a maintenance drug under the client's benefit plan.		N/U	P	A	1	1942	1942	
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.		N/U	P	A	1	1943	1943	
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.		N/U	P	A	1	1944	1944	
297	PRESCRIPTION OVER THE COUNTER INDICATOR	The indicator that specifies this prescription is a federal/legend (Rx prescription only) or non-prescription drug (OTC).		N/U	P	A	1	1945	1945	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.	Ø9 – Encounters	M	C	N	2	1946	1947	Required
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.		N/U	C	N	2	1948	1949	
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.		N/U	C	N	2	195Ø	1951	
25Ø	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.		N/U	P	A	1	1952	1952	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.		N/U	P	A	1	1953	1953	
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		N/U	P	A	17	1954	197Ø	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.		N/U	P	A	1	1971	1971	
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		N/U	P	A	17	1972	1988	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.		N/U	P	A	1	1989	1989	
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		N/U	P	A	17	199Ø	2ØØ6	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.		N/U	P	A	1	2ØØ7	2ØØ7	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
294	PRESCRIBED DAYS SUPPLY	Indicates the original days' supply of the prescription. Applies to internal Mail Service only.		N/U	P	N	3	2Ø08	2Ø1Ø	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø11	2Ø11	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø12	2Ø28	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø29	2Ø29	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø3Ø	2Ø46	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø47	2Ø47	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø48	2Ø64	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø65	2Ø65	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø66	2Ø82	
SECTION DENOTES FORMULARY CATEGORY:										
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.		N/U	P	A	1	2Ø83	2Ø83	
221	CLIENT FORMULARY FLAG	Indicates that the client has a formulary.		N/U	P	A	1	2Ø84	2Ø84	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor.		N/U	P	A	8	2Ø85	2Ø92	
256	FORMULARY FILE ID	Identifies the formulary ID used during adjudication of the claim.		N/U	P	A	15	2Ø93	21Ø7	
255	FORMULARY CODE TYPE	Indicates how the Formulary Benefit is set up. As defined by processor.		N/U	P	A	1	21Ø8	21Ø8	
SECTION DENOTES PRICING CATEGORY:										
5Ø6-F6	INGREDIENT COST PAID	Drug ingredient cost paid included in the "Total Amount Paid" (5Ø9-F9).		M	C	D	8	21Ø9	2116	Required
5Ø7-F7	DISPENSING FEE PAID	Total amount to be paid by the claims processor.		M	C	D	8	2117	2124	Required
894	TOTAL AMOUNT PAID BY MCO or MAO	Total amount of the prescription regardless of party responsible for payment.		M	P	D	8	2125	2132	Required
523-FN	AMOUNT ATTRIBUTED TO SALES TAX	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to sales tax paid.		N/U	C	D	8	2133	214Ø	
5Ø5-F5	PATIENT PAY AMOUNT	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over		M	C	D	8	2141	2148	Required

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		maximum amounts, penalties, etc.								
518-FI	AMOUNT OF COPAY	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to per prescription coinsurance.		S	C	D	8	2149	2156	Required
572-4U	AMOUNT OF COINSURANCE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of a Brand product.		S	C	D	8	2157	2164	Required
519-FJ	AMOUNT ATTRIBUTED TO PRODUCT SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to per prescription copay.		N/U	C	D	8	2165	2172	
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to a periodic deductible.		N/U	C	D	8	2173	218Ø	
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the processing fee imposed by the processor.		N/U	C	D	8	2181	2188	
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's provider network selection.		N/U	C	D	8	2189	2196	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/ BRAND DRUG	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of Brand product.		N/U	C	D	8	2197	22Ø4	
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of Non-Preferred Formulary product.		N/U	C	D	8	22Ø5	2212	
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/ BRAND NON-PREFERRED FORMULARY SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of a Brand Non-Preferred Formulary product.		N/U	C	D	8	2213	222Ø	
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient being in the coverage gap (i.e., donut hole). A coverage gap is defined as the period or amount during which the previous coverage ends and before an additional coverage begins.		N/U	C	D	8	2221	2228	
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a Maximum Allowable Cost (MAC) program.		N/U	P	A	1	2229	2229	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.		N/U	P	A	2	223Ø	2231	
26Ø	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product, as defined by processor.		N/U	P	A	1	2232	2232	
284	OUT OF POCKET APPLY AMOUNT	Amount applied to the out of pocket expense.		N/U	P	D	8	2233	224Ø	
2Ø9	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.		N/U	P	D	9	2241	2249	
21Ø	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.		N/U	P	D	9	225Ø	2258	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.		N/U	P	D	9	2259	2267	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.		N/U	P	D	9	2268	2276	
43Ø-DU	GROSS AMOUNT DUE	Total price claimed from all sources.		M	C	D	8	2277	2284	Required Amount billed to the MCO (Amount being billed by the provider to the MCO). MASK 9999999V99 zero filled, no sign.
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.		N/U	P	D	9	2285	2293	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
4Ø9-D9	INGREDIENT COST SUBMITTED	Submitted product component cost of the dispensed prescription. This amount is included in the "Gross Amount Due (43Ø-DU).		S	C	D	8	2284	23Ø1	Send if Available
426-DQ	USUAL AND CUSTOMARY CHARGE	Amount charged to cash customers for the prescription exclusive of sales tax or other amounts claimed.		S	C	D	8	23Ø2	23Ø9	Send if Available
558-AW	FLAT SALES TAX AMOUNT PAID	Flat sales tax paid which is included in the "Total Amount Paid" (5Ø9-F9).		S	C	D	8	231Ø	2317	Send if Available
559-AX	PERCENTAGE SALES TAX AMOUNT PAID	Amount of percentage sales tax paid which is included in the "Total Amount Paid" (5Ø9- F9).		N/U	C	D	8	2318	2325	
56Ø-AY	PERCENTAGE SALES TAX RATE PAID	Percentage sales tax rate used to calculate "Percentage Sales Tax Amount Paid" (559-AX).		N/U	C	D	7	2326	2332	
561-AZ	PERCENTAGE SALES TAX BASIS PAID	Code indicating the percentage sales tax.		N/U	C	A	2	2333	2334	
521-FL	INCENTIVE AMOUNT PAID	Amount represents the contractually agreed upon incentive fee paid for specific services rendered. Amount is included in the "Total Amount Paid" (5Ø9-F9).		N/U	C	D	8	2335	2342	
562-J1	PROFESSIONAL SERVICE FEE PAID	Amount representing the contractually agreed upon fee for professional services rendered. This amount is included in the		N/U	C	D	8	2343	235Ø	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		"Total Amount Paid" (5Ø9-F9).								
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565- J4).	Ø1 – Delivery Cost Ø2 – Shipping Cost Ø3 – Postage Ø4 – Administrative Cost Ø5 – Incentive Ø6 – Cognitive Service Ø7 – Drug Benefit Ø8 – Compound Preparation Cost Submitted Ø9 – Sales Tax 1Ø – Medication Administration	M	C	A	2	2351	2352	Required
565-J4	OTHER AMOUNT PAID	Amount paid for additional costs claimed in 'Other Amount Claimed Submitted' (48Ø-H9).		S	C	D	8	2353	236Ø	Required
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565-J4).	See first occurrence of 564-J3 above.	S	C	A	2	2361	2362	Required
565-J4	OTHER AMOUNT PAID	Amount paid for additional costs claimed in 'Other Amount Claimed Submitted' (48Ø-H9).		S	C	D	8	2363	237Ø	Required
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565- J4).	See first occurrence of 564-J3 above.	S	C	A	2	2371	2372	Required
565-J4	OTHER AMOUNT PAID	Amount paid for additional costs claimed in 'Other Amount		S	C	D	8	2373	238Ø	Required

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Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		Claimed Submitted' (48Ø-H9).								
566-J5	OTHER PAYER AMOUNT RECOGNIZED	Total amount recognized by the processor of any payment from another source.		N/U	C	D	8	2381	2388	Not Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)"	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer.	S	C	A	2	2389	239Ø	Required COB/TPL

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Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer. Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. 11 – Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer. 12 – Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as							

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Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			reported by previous payer. 13 – Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	2391	24ØØ	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Same Values as Above.	S	C	A	2	24Ø1	24Ø2	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	24Ø3	2412	Required COB/TPL
281	NET AMOUNT DUE	Net amount paid to provider by the payer or net amount due from the client to the payer, determined by trading partner agreement.		M	P	D	8	2413	242Ø	Required
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).		N/U	C	N	2	2421	2422	
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT	Amount in dollars met by the patient/family in a deductible plan.		N/U	C	D	8	2423	243Ø	
513-FD	REMAINING DEDUCTIBLE AMOUNT	Amount not met by the patient/family in the deductible plan.		N/U	C	D	8	2431	2438	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
514-FE	REMAINING BENEFIT AMOUNT	Amount remaining in a patient/family plan with a periodic maximum benefit.		N/U	C	D	8	2439	2446	
242	COST DIFFERENCE AMOUNT	Difference between client contracted amount and the pharmacy or member submitted amount.		N/U	P	D	8	2447	2454	
249	EXCESS COPAY AMOUNT	Amount of the copay that exceeds the approved amount for this claim.		N/U	P	D	8	2455	2462	
277	MEMBER SUBMIT AMOUNT	Ingredient cost as submitted by member (paper claims only).		N/U	P	D	8	2463	247Ø	
265	HOLD HARMLESS AMOUNT	Amount payable to member when paper claims amount exceeds Pharmacy Network Reimbursement.		N/U	P	D	8	2471	2478	
52Ø-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM	Amount to be collected from the patient that is included in "Patient Pay Amount" (5Ø5-F5) that is due to the patient exceeding a periodic benefit maximum.		N/U	C	D	8	2479	2486	
346-HH	BASIS OF CALCULATION – DISPENSING FEE	Code indicating how the reimbursement amount was calculated for "Dispensing Fee Paid" (5Ø7-F7).		N/U	C	A	2	2487	2488	
347-HJ	BASIS OF CALCULATION – COPAY	Code indicating how the copay reimbursement amount was calculated for "Dispensing Fee Paid" (5Ø5-F5).		N/U	C	A	2	2489	249Ø	

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Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
348-HK	BASIS OF CALCULATION – FLAT SALES TAX	Code indicating how the reimbursement amount was calculated for "Flat Sales Tax Amount Paid" (558-AW).		N/U	C	A	2	2491	2492	
349-HM	BASIS OF CALCULATION – PERCENTAGE SALES TAX	Code indicating how the reimbursement amount was calculated for "Percentage Sales Tax Amount Paid" (559-AX).		N/U	C	A	2	2493	2494	
573-4V	BASIS OF CALCULATION – COINSURANCE	Code indicating how the coinsurance reimbursement amount was calculated for "Patient Pay Amount" (559-AX).		N/U	C	A	2	2495	2496	
557-AV	TAX EXEMPT INDICATOR	Code indicating that the payer and/or the patient is exempt from taxes.		N/U	C	A	1	2497	2497	
285	PATIENT FORMULARY REBATE AMOUNT	Credit that the patient receives on this claim from the drug manufacturer.		N/U	P	D	8	2498	25Ø5	
276	MEDICARE RECOVERY INDICATOR	Field to indicate if Medicare was billed in order to recover funds for current or previous claims billed to the client.		N/U	P	A	1	25Ø6	25Ø6	
275	MEDICARE RECOVERY DISPENSING INDICATOR	Field to indicate if days' supply on prescription was reduced due to plan limits.		N/U	P	A	1	25Ø7	25Ø7	
286	PATIENT SPEND DOWN AMOUNT	Claim dollars applied to patient's spend down account (example: Flexible Spending Account).		N/U	P	D	8	25Ø8	2515	

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Contrato Número

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
263	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT APPLIED	Health Care Reimbursement Account Amount Applied		N/U	P	D	8	2516	2523	
564-	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT REMAINING	Client-defined benefit that provides funds to patients that can be used to offset Out of Pocket expenses.		N/U	P	D	8	2524	2531	
2Ø7	ADMINISTRATIVE FEE EFFECT INDICATOR	Indicates how the transaction should be counted for administrative fee determination.		N/U	P	A	1	2532	2532	
2Ø6	ADMINISTRATIVE FEE AMOUNT	Administrative fee charge per claim.		N/U	P	D	4	2533	2536	
269	INVOICED AMOUNT	Amount invoiced for this transaction. Determined by Processor.		N/U	P	D	11	2537	2547	
	FILLER			N/U	P	A	1Ø	2548	2557	
128-UC	SPENDING ACCOUNT AMOUNT REMAINING	The balance from the patient's spending account after this transaction was applied.		N/U	C	D	8	2558	2565	
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT	The amount from the health plan-funded assistance account for the patient that was applied to reduce 'Patient Pay Amount' (5Ø5-F5). This amount is used in Healthcare Reimbursement Account (HRA) benefits only. This		N/U	C	D	8	2566	2573	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		field is always a negative amount or zero.								
SECTION DENOTES PRIOR AUTHORIZATION CATEGORY:										
461-EU	PRIOR AUTHORIZATION TYPE CODE	Code clarifying the 'Prior Authorization Number Submitted' (462-EV) or benefit/plan exemption.		N/U	C	N	2	2574	2575	
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Number submitted by the provider to identify the prior authorization.		N/U	C	N	11	2576	2586	
498-PY	PRIOR AUTHORIZATION NUMBER – ASSIGNED	Unique number identifying the prior authorization assigned by the processor.		N/U	P	N	11	2587	2597	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.		N/U	P	N	2	2598	2599	
SECTION DENOTES ADJUSTMENT CATEGORY:										
2Ø4	ADJUSTMENT REASON CODE	Reason for adjustment		N/U	P	N	3	26ØØ	26Ø2	
2Ø5	ADJUSTMENT TYPE	Type of adjustment.		N/U	P	A	1	26Ø3	26Ø3	
897	TRANSACTION ID CROSS REFERENCE	For reversals, ID associated with original claim.		M	P	A	3Ø	26Ø4	2633	Required The TCN of the encounter being voided by this reversal is entered here.
SECTION DENOTES COORDINATION OF BENEFITS CATEGORY:										
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.		S	P	D	8	2634	2641	If available in payer's system.

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
										COB/TPL
245	ELIGIBILITY COB INDICATOR	COB code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient. 2 – Payer is Secondary – Plan is second payer for patient. 3 – Payer is Tertiary – Plan is third payer for patient.	S	P	A	1	2642	2642	Required when available in the payer's adjudication system. COB/TPL
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB. M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed	S	P	A	1	2643	2643	If the MAO/MCO has COB Carrier Amount available. COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			out of a retail pharmacy.							
232	COB PRIMARY PAYER ID	ID assigned to primary payer.	**MAOSNP** = When MAO pays for a drug. **MEDICAID** = When PR Medicaid funding is used to pay for the drug. **MEDB** = Medicare Part B (in the event that Part D does not cover). **MEDD** = Medicare Part D. **MEDIGAP** = An insurance plan that covers only Medicare/MAO cost sharing. **COMMERCIAL** = When the MAO Member has a private health insurance plan that must consider payment of a drug before the MAO can consider payment of the drug/product. **TRICARE** = If the MAO Member is a veteran where TRICARE must pay or deny the pharmacy claim before the MAO can consider paying for the drug.	M	C/P	A	1Ø	2644	2653	Required COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	FILLER			N/U	P	A	8	2654	2661	
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		S	C/P	D	8	2662	2669	Required – report the payment associated to the primary payer. The MAO SNP would be considered the primary payer when the Platino Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibility). COB/TPL
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		S	C/P	D	8	267Ø	2677	Required COB/TPL
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		S	C/P	D	8	2678	2685	Required COB/TPL
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		S	C/P	D	8	2686	2693	Required COB/TPL
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	**MAOSNP** = When the MAO pays for a drug as a secondary payer to a Commercial insurance plan or TRICARE. **MEDIGAP** = When the MAO Member has a 'Medicare gap' insurance as a commercial	S	C/P	A	1Ø	2694	27Ø3	Required when the MAO/MCO and another insurance plan or Medicaid paid for the drug or cost sharing. COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			insurance plan that covers Medicare or MAO cost sharing. Medicare gap insurance is always secondary to Medicare or an MAO. **MEDICAID** = When the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product. The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** = When the Platino Member has a private health insurance plan that must consider payment of a drug/product, report							

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			'COMMERCIAL' as the Secondary Payer ID in Field #238. **TRICARE** = When the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim.							
	FILLER			N/U	P	A	8	27Ø4	2711	
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		S	C/P	D	8	2712	2719	Required when the Secondary Payer paid for the drug/product or the Platino Member's cost sharing. COB/TPL
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		S	C/P	D	8	272Ø	2727	Required when there is a Secondary Payer deductible that was assessed on the drug/product. COB/TPL
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		S	C/P	D	8	2728	2735	Required when there is a Secondary Payer coinsurance that was assessed on the drug/product. COB/TPL
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		S	C/P	D	8	2736	2743	Required when there is a Secondary Payer copayment

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
										that was assessed on the drug/product. COB/TPL
SECTION DENOTES REFERENCE CATEGORY:										
898	TRANSACTION ID	Internally assigned unique claim ID by the payer.		M	P	A	3Ø	2744	2773	Required Every claim in the file must contain the unique internal Transaction ID (TCN) assigned by PBM during adjudication.
5Ø3-F3	AUTHORIZATION NUMBER	Number assigned by the processor to identify an authorized transaction.		N/U	P	A	2Ø	2774	2793	
224	CLIENT SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by client.		N/U	P	A	5Ø	2794	2843	
396	PROCESSOR SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by processor.		N/U	P	A	5Ø	2844	2893	
997-G2	CMS PART D DEFINED QUALIFIED FACILITY	Indicates that the patient resides in a facility that qualifies for the CMS Part D benefit.		N/U	C	A	1	2894	2894	
SECTION DENOTES FIELDS ADDED IN VERSIONS CATEGORY:										
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	Ø1 – Deductible Ø2 – Initial Benefit Ø3 – Coverage Gap (donut hole) Ø4 – Catastrophic Coverage	M	C	A	2	2895	2896	Required COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan). 6Ø – Not paid under Part D. 61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only. 62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only. 63 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid under Medicaid benefit only of the Medicare/Medicaid (MMP) plan. 7Ø – Part D drug not paid by Part D plan benefit; paid by the beneficiary under plan-sponsored negotiated pricing. 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit							

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan.							
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).		M	C	D	8	2897	29Ø4	Required COB/TPL
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).		N/U	C	A	2	29Ø5	29Ø6	
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).		N/U	C	D	8	29Ø7	2914	
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).		N/U	C	A	2	2915	2916	
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).		N/U	C	D	8	2917	2924	
393-MV	BENEFIT STAGE QUALIFIER	The amount of claim allocated to the Medicare stage identified by the		N/U	C	A	2	2925	2926	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		'Benefit Stage Qualifier' (393-MV).								
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).		N/U	C	D	8	2927	2934	
69Ø-ZG	INVOICED DATE	The date that this claim was included on an invoice.		N/U	P	N	8	2935	2942	
691-ZH	OUT OF POCKET REMAINING AMOUNT	Dollars remaining until patient is totally in benefit, paying no out of pocket expenses.		N/U	P	D	8	2943	295Ø	
3Ø2-C2	CARDHOLDER ID (ALTERNATE)	Insurance ID assigned to the cardholder or identification number used by the plan.		N/U	P	A	2Ø	2951	297Ø	
692-ZJ	NUMBER OF GENERIC MANUFACTURERS	Number of manufacturers that produce this generic drug provided by drug compendium.		N/U	P	N	3	2971	2973	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	2974	2975	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	2976	2994	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	2995	2996	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	2997	3Ø15	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3Ø16	3Ø17	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	3Ø18	3Ø36	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co- Agent ID' (476-H6).		N/U	C	A	2	3Ø37	3Ø38	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	3Ø39	3Ø57	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co- Agent ID' (476-H6).		N/U	C	A	2	3Ø58	3Ø59	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	3Ø6Ø	3Ø78	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3Ø79	3Ø8Ø	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	3Ø81	3Ø99	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	31ØØ	31Ø1	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	31Ø2	312Ø	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3121	3122	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	3123	3141	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)"	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.	S	C	A	2	3142	3143	Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer. Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer. Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health							COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. 11 – Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer. 12 – Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer. 13 – Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3144	3153	Required COB/TPL
351-NP	OTHER PAYER-PATIENT	Code qualifying the "Other Payer-Patient	See 351-NP above for codes.	S	C	A	2	3154	3155	Required

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	RESPONSIBILITY AMOUNT QUALIFIER	Responsibility Amount (352-NQ)".								COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3156	3165	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3166	3167	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3168	3177	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3178	3179	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	318Ø	3189	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	319Ø	3191	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3192	32Ø1	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY	Code qualifying the "Other Payer-Patient	See 351-NP above for codes.	S	C	A	2	32Ø2	32Ø3	Required COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	AMOUNT QUALIFIER	Responsibility Amount (352-NQ)".								
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	32Ø4	3213	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3214	3215	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3216	3225	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3226	3227	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3228	3237	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3238	3239	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	324Ø	3249	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	325Ø	3251	Required COB/TPL

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	AMOUNT QUALIFIER									
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3252	3261	Required COB/TPL
A37	SPECIALTY CLAIM INDICATOR	Indicates whether a claim was filled by a specialty pharmacy or a specialty drug.		N/U	P	A	1	3262	3262	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		N/U	P	A	3	3263	3265	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		N/U	P	A	3	3266	3268	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		N/U	P	A	3	3269	3271	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		N/U	P	A	3	3272	3274	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		N/U	P	A	3	3275	3277	
A39	COPAY WAIVER AMOUNT	Dollar amount funded by third party for a copay waiver program where a client funds a portion of their copay amount if they select a certain drug.		N/U	P	D	8	3278	3285	

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Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
A33-ZX	CMS PART D CONTRACT ID	Designation assigned by CMS that identifies a specific Medicare Part D sponsor.		N/U	P	A	5	3286	329Ø	
A34-ZY	MEDICARE PART D PLAN BENEFIT PACKAGE (PBP)	Identifier assigned by CMS of a particular plan benefit package (Benefit Category) within a Medicare Part D contract.		N/U	P	N	3	3291	3293	
A73	MEDICARE DRUG COVERAGE CODE	Code to indicate if the claim was processed under the Part D Drug Benefit, the Part B Drug Benefit, or does not apply.		N/U	P	A	2	3294	3295	
	FILLER			N/U	P	A	423	3296	37ØØ	

Note: "COB/TPL" indicates that further directions can be found in Appendix A: Discussion of MAO COB/TPL Reporting.

4.2.1 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD1

Table 6 – Post Adjudication History Compound Detail Record1

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	CD – Post Adjudication History Compound Detail Record1.	M	P	A	2	1	2	Required
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	Prescription/Service Reference Number Qualifier	1 – Rx Billing Transaction- A billing for a prescription or OTC drug product.	M	C	A	1	3	3	Required

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			2 – Service Billing – Transaction is a billing for a professional service performed.							
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided.		M	C	N	12	4	15	Required
477-EC	COMPOUND INGREDIENT COMPONENT COUNT	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		M	C	N	2	16	17	Required
SECTION DENOTES FIRST INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank – Not Specified Ø1 – UPC Ø2 – HRI Ø3 – NDC Ø4 – HIBCC 11 – NAPPI 12 – GTIN 15 – GCN 28 – FDB Med Name ID 29 – FDB Routed Med ID 3Ø – FDB Routed Dosage Form Med ID 31 – FDB Med ID	M	C	A	2	18	19	Required

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			32 – GCN_SEQ_NO 33 – HICL_SEQ_NO 99 – Other							
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.		M	C	A	19	2Ø	38	Required If a compound drug is being reported, this is the NDC of the FIRST component of the compound drug.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.		S	C	N	14	39	52	Required Amount expressed in metric decimal units of the product included in the compound mixture. MASK 9(7)V999 zero filled, no sign.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448- ED).		S	C	D	8	53	6Ø	Required
49Ø-UE	COMPOUND INGREDIENT	Code indicating the method by which the drug cost of an ingredient	ØØ – Default	S	C	N	2	61	62	Required

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
	BASIS OF COST DETERMINATION	used in a compound was calculated.	Ø1 – AWP (Average Wholesale Price) Ø2 – Local Wholesaler Ø3 – Direct Ø4 – EAC (Estimated Acquisition Cost) Ø5 – Acquisition Ø6 – MAC (Maximum Allowable Cost) Ø7 – Usual & Customary Ø8 – 34ØB/ Disproportionate Share Pricing/Public Health Service Ø9 – Other – Different from those implied or specified. 1Ø – ASP (Average Sales Price) 11 – AMP (Average Manufacturer Price) 12 – WAC (Wholesale Acquisition Cost) 13 – Special Patient Pricing 14 – Cost basis on un-reportable quantities							

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			15 – Free product or no associated cost							
221	CLIENT FORMULARY FLAG	Indicates that the client has a formulary.	Blank – Not specified Y – Yes N – No	S	P	A	1	63	63	Indicates that the NDC for the FIRST component of the compound drug is not recognized by PRMP but the MCO covered the drug. Value 'Y'
397	PRODUCT/ SERVICE NAME	Product or Service Description or Product Label Name.		N/U	P	A	3Ø	64	93	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.		N/U	P	A	3Ø	94	123	
6Ø1-24	PRODUCT STRENGTH	The strength of the product.		N/U	P	A	1Ø	124	133	
243	DOSAGE FORM CODE	Dosage form code for product identified.		N/U	P	A	4	134	137	
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1 – First DataBank 2 – Medi-Span Product Line 3 – Micromedex/ Medical Economics 4 – Processor Developed 5 – Other 6 – Redbook 7 – Multum	S	P	N	1	138	138	Required

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	ØØ – Not specified 1 – Single Source 2 – Authorized Generic (aka "Branded Generic") 3 – Generic 4 – Over the Counter 5 – Multi-source Brand	S	P	N	1	139	139	
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank – Not Specified I – Drug on Formulary; Non-Preferred J – Drug not on Formulary; Non-Preferred K – Drug not on Formulary; Preferred N – Drug not on Formulary; Neutral P – Drug on Formulary Q – Drug not on Formulary T – Drug on Formulary; Preferred Y- Drug on Formulary; Neutral	S	P	A	1	14Ø	14Ø	
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is		S	P	A	1	141	141	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
		associated with a specific drug category.								
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank – Not Specified 1 – Schedule I Substance (no known use) 2 – Schedule II Narcotic Substances 3 – Schedule III Narcotic Substances 4 – Schedule IV Substances 5 – Schedule V Substances	S	P	A	1	142	142	
25Ø	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank – Not Specified Ø – Was Drug Efficacy Study Implementation (DESI) – At One Time But No Longer 1 – Drug Efficacy Study Implementation (DESI) Drug	S	P	A	1	143	143	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line	S	P	A	1	144	144	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – Nine-digit NDC A – American Hospital Formulary Service C – Contracting Organization G – First DataBank GCN Sequence Number H – First DataBank HICL Sequence Number M – Manufacturer (PICO) Assigned Code N – Eleven-digit NDC O – UPC							

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			P – Product group T – First DataBank Therapeutic Class Code, Specific U – Universal System of Classification Code V – All products used Z – Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		S	P	A	17	145	161	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the 'Product Code' (6Ø1-18) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier	S	P	A	1	162	162	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			8 – First DataBank Medication Identifier 9 – Nine-digit NDC A – American Hospital Formulary Service C – Contracting Organization G – First DataBank GCN Sequence Number H – First DataBank HICL Sequence Number M – Manufacturer (PICO) Assigned Code N – Eleven-digit NDC O – UPC P – Product group T – First DataBank Therapeutic Class Code, Specific U – Universal System of Classification Code V – All products used Z – Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		S	P	A	17	163	179	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the	Blank – Not Specified	S	P	A	1	18Ø	18Ø	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
		Product Code (6Ø1-18) field.	1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – Nine-digit NDC A – American Hospital Formulary Service C – Contracting Organization G – First DataBank GCN Sequence Number H – First DataBank HICL Sequence Number							

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			M – Manufacturer (PICO) Assigned Code N – Eleven-digit NDC O – UPC P – Product group T – First DataBank Therapeutic Class Code, Specific U – Universal System of Classification Code V – All products used Z – Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		S	P	A	17	181	197	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank – Not specified 1 – Yes 2 – No	S	P	A	1	198	198	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID	S	P	A	1	199	199	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization D – First DataBank Therapeutic Class code, Generic E – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICO) Assigned Code U – Universal System of Classification Code Z – Mutually Agreed Upon Code							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		S	P	A	17	2ØØ	216	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization	S	P	A	1	217	217	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			D – First DataBank Therapeutic Class code, Generic E – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICO) Assigned Code U – Universal System of Classification Code Z – Mutually Agreed Upon Code							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		S	P	A	17	218	234	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage	S	P	A	1	235	235	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization D – First DataBank Therapeutic Class code, Generic E – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICO) Assigned Code U – Universal System of Classification Code Z – Mutually Agreed Upon Code							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		S	P	A	17	236	252	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line	S	P	A	1	253	253	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization D – First DataBank Therapeutic Class code, Generic E – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICO) Assigned Code							

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			U – Universal System of Classification Code Z – Mutually Agreed Upon Code							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		S	P	A	17	254	27Ø	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	Ø – Not Specified 1 – Not Unit Dose – Indicates that the product is not being dispensed in special unit dose packaging. 2 – Manufacturer Unit Dose – A code used to indicate a distinct dose as determined by the manufacturer. 3 – Pharmacy Unit Dose – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose. 4 – Pharmacy Unit Dose Patient Compliance Packaging. 5 – Pharmacy Multi-drug Patient	S	C	N	1	271	271	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Compliance Packaging. 6 – Remote Device Unit Dose – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7 – Remote Device Multi-drug Compliance – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8 – Manufacturer Unit of Use Package (not unit dose) – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6ØØ -28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA – Each GM – Grams ML – Milliliters	S	C	A	2	272	273	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	ØØ – Not Specified Ø1 – Prior Authorization Ø2 – Medical Certification Ø3 – EPSDT (Early Periodic Screening Diagnosis Treatment) Ø4 – Exemption from Copay and/or Coinsurance Ø5 – Exemption from RX Ø6 – Family Planning Indicator Ø7 – TANF (Temporary Assistance for Needy Families) Ø8 – Payer Defined Exemption	S	P	N	2	274	275	
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank – Not Specified Y – Reduced to MAC pricing N – Not reduced to MAC pricing	S	P	A	1	276	276	
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted	Blank – Not Specified Ø1 – Average Wholesale Price	S	P	A	2	277	278	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
		is calculated based on client pricing.	Ø2 – Acquisition Cost (ACQ) Ø3 – Manufacturer Direct Price Ø4 – Federal Upper Limit (FUL) Ø5 – Average Generic Price Ø6 – Usual & Customary Ø7 – Submitted Ingredient Cost Ø8 – State MAC Ø9 – Unit 1Ø – Usual & Customary or Copay							
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank – Not Specified Ø1 – UPC Ø2 – HRI Ø3 – NDC Ø4 – HIBCC Ø6 – DUR/PPS Ø7 – CPT4 Ø8 – CPT5 Ø9 – HCPCS 11 – NAPPI 12 – GTIN 14 – GPI 15 – GCN 16 – GFC 17 – DDID	S	C	A	2	279	28Ø	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			18 – First DataBank SmartKey 19 – Truven/ Micromedex Generic Master (GM) 2Ø – ICD9 21 – ICD1Ø 23 – NCCI 24 – SNOMED 25 – CDT 26 – DSM IV 27 – ICD1Ø-PCS 28 – FDB Med Name ID 29 – FDB Routed Med ID 3Ø – FDB Routed Dosage Form Med ID 31 – FDB Med ID 32 – GCN_SEQ_NO 33 – HICL_SEQ_NO 35 – LOINC 37 – AHFS 38 – SCD 39 – SBD 4Ø – GPCK 41 – BPCK 99 – Other							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		S	C	A	19	281	299	
26Ø	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product, as defined by processor.		S	P	A	1	3ØØ	3ØØ	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank – Not Specified 1 – Medicare Part B (Plan Cutback) – A reduction in a quantity of a medical service covered by Medicare Part B. 2 – Medicare Part B with days' supply cutback – A reduction in the days' supply of a service/drug covered by Medicare Part B. C – Net Check limit cutback – A reduction in the net amount of a check. D – Days' Supply cutback – A reduction in the days' supply. I – Ingredient Cost cutback – A	S	P	A	1	3Ø1	3Ø1	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			reduction in the ingredient cost. Q – Quantity cutback – A reduction in the quantity.							
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter, from formulary file as defined by processor.		S	P	A	8	3Ø2	3Ø9	
2Ø9	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.		S	P	D	9	31Ø	318	
21Ø	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.		S	P	D	9	319	327	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.		S	P	D	9	328	336	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.		S	P	D	9	337	345	
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.		S	P	D	9	346	354	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	ØØ – Not Specified Ø1 – Ingredient Cost Paid as Submitted Ø2 – Ingredient Cost Reduced to AWP Pricing	S	C	N	2	355	356	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or 'Z' to put in the flat

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Ø3 – Ingredient Cost Reduced to AWP Less X% Pricing Ø4 – Usual & Customary Paid as Submitted Ø5 – Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary Ø6 – MAC Pricing Ingredient Cost Paid Ø7 – MAC Pricing Ingredient Cost Reduced to MAC Ø8 – Contract Pricing Ø9 – Acquisition Pricing 1Ø – ASP (Average Sales Price) 11 – AMP (Average Manufacturer Price) 12 – 34ØB/ Disproportionate Share/Public Health Service Pricing 13 – WAC (Wholesale Acquisition Cost) 14 – Other Payer-Patient Responsibility Amount							file created by the translator. Ø8 = 'C' which is for capitated Ø1 = 'F' which is for FFS 14 = 'T' which is TPL ØØ = 'Z' which is for Zero billed/Provider did not charge

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			15 – Patient Pay Amount 16 – Coupon Payment 17 – Special Patient Reimbursement 18 – Direct Price (DP) 19 – State Fee Schedule (SFS) Reimbursement 2Ø – National Average Drug Acquisition Cost (NADAC) 21 – State Average Acquisition Cost (AAC) 22 – Ingredient cost paid based on submitted Basis of Cost Free Product							
285	PATIENT FORMULARY REBATE AMOUNT	Credit that the patient receives on this claim from the drug manufacturer.		S	P	D	8	357	364	

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Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
SECTION DENOTES SECOND INGREDIENT: *SAME AS THE FIRST INGREDIENT*										
SECTION DENOTES THIRD INGREDIENT:										
SECTION DENOTES FOURTH INGREDIENT:										
SECTION DENOTES FIFTH INGREDIENT:										
SECTION DENOTES SIXTH INGREDIENT:										
SECTION DENOTES SEVENTH INGREDIENT:										
SECTION DENOTES EIGHTH INGREDIENT:										

4.2.2 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD2

Table 6 – Post Adjudication History Compound Detail Record2

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
PRMP only accepts Compound Detail Record1. *DO NOT SEND Compound Detail Record2.*										
SECTION DENOTES NINTH INGREDIENT:										
SECTION DENOTES TENTH INGREDIENT:										
SECTION DENOTES ELEVENTH INGREDIENT:										
SECTION DENOTES TWELVTH INGREDIENT:										
SECTION DENOTES THIRTEENTH INGREDIENT:										
SECTION DENOTES FOURTEENTH INGREDIENT:										
SECTION DENOTES FIFTEENTH INGREDIENT:										

4.3 POST ADJUDICATION HISTORY TRAILER RECORD

Table 7 – Post Adjudication History Trailer Record

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	PT – Post Adjudication History Trailer Record	M	P	A	2	1	2	
6Ø1-Ø9	TOTAL RECORD COUNT	Total number of records being submitted, including header and trailer.		M	P	N	1Ø	3	12	
895	TOTAL NET AMOUNT DUE	Summarization of Net Amount Due (281).		M	P	D	12	13	24	
693	TOTAL GROSS AMOUNT DUE	Total sum of the gross amount due fields on the claim level.		S	P	D	12	25	36	
694	TOTAL PATIENT PAY AMOUNT	Total sum of the patient pay amount fields on the claim level.		M	P	D	12	37	48	
	FILLER			N/U		A	3652	49	37ØØ	

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Appendix A: Discussion of MAO COB/TPL Reporting When:

MAO Only Paid

Table 8 – MAO Only Paid

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT		The amount submitted by the COB carrier.	If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT). If the MAO does not store the COB Carrier Amount, the field does not need to be completed.
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. If the MAO paid the drug in full, report '1'.
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
232	COB PRIMARY PAYER ID	Primary Payer ID associated with the Primary Payer.	Use one of the following Primary Payer IDs when submitting encounter claims to the PRMMIS for Platino Members: **MAOSNP** If the MAO pays for a drug, Field #232 must indicate Primary Payer ID MAOSNP	Field #232 (COB PRIMARY PAYER ID) is REQUIRED. If the MAO paid the drug in full, report MAOSNP.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			MAOSNP represents that the MAO paid for the drug/product. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID'. MEDICAID represents that Puerto Rico Medicaid paid for the drug. The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug before the MAO can consider payment of the drug/product, report 'COMMERCIAL' as the Primary Payer ID in Field #232. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim before the MAO can consider paying for the drug, Field #232 must indicate Primary Payer ID 'TRICARE'."	
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the payment associated to the primary payer reported in Field #232

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
				(COB PRIMARY PAYER ID). If the MAOSNP paid the drug in full, report the MAO paid amount.
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		Field #231 is situational. If the MAO paid the drug in full and the MAO cost sharing is negated ($Ø) or replaced by a nominal copay for a generic ($1) or brand name drug ($2), do not report.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #229 is situational. If the MAO paid the drug in full and the MAO cost sharing is negated ($Ø) or replaced by a nominal copay for a generic ($1) or brand name drug ($2), do not report.
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		Field #23Ø is situational. If the MAO paid the drug in full and the MAO cost sharing is negated ($Ø) or replaced by a nominal copay for a generic ($1) or brand name drug ($2) and the Platino member was charged a copayment, enter the nominal copay amount.
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	**MAOSNP** If the MAO pays for a drug as a secondary payer to a Commercial insurance plan or TRICARE, Field #238 must indicate Secondary Payer ID 'MAOSNP.' MAOSNP represents that the MAO paid for the drug. **MEDIGAP** If the Platino Member has a 'Medicare gap' insurance as a commercial insurance plan that covers Medicare or MAO cost sharing.	Field #238 (COB SECONDARY PAYER ID) is situational. If the MAO paid the drug in full as the primary payer, do not report.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Medicare gap insurance is always secondary to Medicare or an MAO. MEDIGAP represents an insurance plan that covers only Medicare/MAO cost sharing. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID.' MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product. The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug/product, report 'COMMERCIAL' as the Secondary Payer ID in Field #238. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #238 must indicate Secondary Payer ID 'TRICARE.'	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is situational. If the MAO paid the drug in full as the primary payer, do not report.
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is situational. If the MAO paid the drug in full as the primary payer, do not report.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is situational. If the MAO paid the drug in full as the primary payer, do not report.
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is situational. If the MAO paid the drug in full as the primary payer, do not report.
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other Coverage Billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.	Field #3Ø8-C8 is REQUIRED. If the MAO paid the drug in full, report Ø1.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan. 192Ø = Medicaid 193Ø = Medicare	193Ø – MEDICARE – The federal program providing health insurance for people aged 65 and older and for disabled people of all ages.	Field #6Ø1-Ø1 is REQUIRED. If only MAO funding is used to pay the drug/product, report 193Ø (MEDICARE). If the drug is a wraparound paid drug (Puerto Rico Medicaid funds are used to pay the drug/product), then report 192Ø (Medicaid).
393-MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	**393-MV BENEFIT STAGE QUALIFIER** Code qualifying the 'Benefit Stage Amount' (394-MW). Blank – Not Specified Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage limit and until the total out of pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan): • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5	Field #393 is situational. Use the applicable MV Benefit Stage Qualifier in Column D.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage. 6Ø – Not paid under Part D; paid as or under a supplemental benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit). • The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. • When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified, either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug.	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. • When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only. • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g., nonformulary, quantity limit, etc.).	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			• When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: • When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer Ø5 – Amount of Copay (518-FI) as reported by previous payer Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer 1Ø – Amount Attributed to Provider Network Selection	Field #351-NP is situational. Report the applicable value from Column D. If the MAO paid the drug in full, leave blank (Not Specified).

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MAO Paid & Wraparound Picked Up Copay

Table 9 – MAO Paid & Wraparound Picked Up Copay

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.		If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT).
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. The MAO SNP would be considered the primary payer when the Platino Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibles) and Puerto Rico Medicaid would be considered the second payer when no other insurance coverage exists.
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB. M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
232	COB PRIMARY PAYER ID	Primary Payer ID associated with the Primary Payer.		Field #232 (COB PRIMARY PAYER ID) is REQUIRED when both MAO funds and Medicaid funds were used to pay a drug/biological/item. Enter MAOSNP in Field #232 to represent that the MAO is the primary payer.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the payment associated to the primary payer report in Field #232 (COB PRIMARY PAYER ID). The MAO SNP would be considered the primary payer when the Platino Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibles).
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		Field #231 is required when the Primary Payer reported in Field #232 assessed deductible. Report the deductible associated to the primary payer reported in Field #232 (COB PRIMARY PAYER ID). If the Primary Payer reported in Field #232 did not assess deductible, leave blank.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #229 is required when the Primary Payer reported in Field #232 assessed coinsurance. Report the coinsurance associated with the primary payer reported in Field #232 (COB PRIMARY PAYER ID).
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		Field #23Ø is required when the Primary Payer reported in Field #232 assessed copayment. Report the copayment associated with the primary payer reported in Field #232 (COB PRIMARY PAYER ID).

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.		Field #238 (COB SECONDARY PAYER ID) is required when the MAO and another insurance plan or Medicaid paid for the drug or cost sharing. Enter MEDICAID when Medicaid funds were used secondary to the MAO funds to cover any portion of the payment for a drug/biological/item.
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is required when the Secondary Payer paid for the drug/product or the Platino Member's cost sharing (e.g., copayment).
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is required when there is a Secondary Payer deductible that was assessed on the drug/product. Report the deductible amount, if applicable.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is required when there is a Secondary Payer coinsurance that was assessed on the drug/product. Report the coinsurance amount, if applicable.
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is required when there is a Secondary Payer copayment that was assessed on the drug/product. Report the copayment amount if applicable.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other coverage billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection or network selection.	Field #3Ø8-C8 is REQUIRED. Report the appropriate code from Column D that represents other coverage for the drug/product.
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan: 192Ø = Medicaid 193Ø = Medicare Blank = Neither	193Ø – MEDICARE – The federal program providing health insurance for people aged 65 and older and for disabled people of all ages.	Field #6Ø1-Ø1 is REQUIRED. If the MAO paid as the primary payer and Medicaid was reported as the secondary payer, enter 193Ø. This field should be completed based on primary payer when more than one funding source is used in payment related to MAO/Medicaid dual eligible coverage (i.e., Platino members).
393-MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	**393-MV BENEFIT STAGE QUALIFIER** Code qualifying the 'Benefit Stage Amount' (394-MW). Blank – Not Specified	Field #393-MV is REQUIRED. Use the applicable MV Benefit Stage Qualifier in Column D.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage limit and until the total out of pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan): • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage. 6Ø – Not paid under Part D; paid as or under a supplemental benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			benefit is provided (drugs covered outside of the allowable Part D benefit). • The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. • When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. • When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			566-J5 Other Payer Amount Recognized) of the claim. 62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. nonformulary, quantity limit, etc.). • When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 –	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: • When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer Ø5 – Amount of Copay (518-FI) as reported by previous payer Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer 1Ø – Amount Attributed to Provider Network Selection	Field #351-NP is REQUIRED. Report the applicable value from Column D.

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Wraparound Paid (Medicaid Only)

Table 10 – Wraparound Paid (Medicaid Only)

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.		If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT). If the MAO does not store the COB Carrier Amount, the field does not need to be completed.
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. If Medicaid Wraparound paid the drug in full, report '1'
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB. M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the payment associated to the primary payer report in Field #232 (COB PRIMARY PAYER ID). If the Medicaid Wraparound paid the drug in full, report the MAO paid amount.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		Field #231 is situational. If Medicaid Wraparound paid the drug, deductible is not applicable. Do not report.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #229 is situational. If Medicaid Wraparound paid the drug, coinsurance is not applicable. Do not report.
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		Field #23Ø is situational. If Medicaid Wraparound paid the drug and a copayment is applied, report the copayment amount. If no copayment was applied, do not report.
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	**MAOSNP** If the MAO pays for a drug as a secondary payer to a Commercial insurance plan or TRICARE, Field #238 must indicate Secondary Payer ID 'MAOSNP.' MAOSNP represents that the MAO paid for the drug. **MEDIGAP** If the Platino Member has a 'Medicare gap' insurance as a commercial insurance plan that covers Medicare or MAO cost sharing. Medicare gap insurance is always secondary to Medicare or an MAO. MEDIGAP represents an insurance plan that covers only Medicare/MAO cost sharing. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID.' MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product.	Field #238 (COB SECONDARY PAYER ID) is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug/product, report 'COMMERCIAL' as the Secondary Payer ID in Field #238. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #238 must indicate Secondary Payer ID 'TRICARE.'	
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is situational. If the Medicaid Wraparound paid the drug in full as the primary payer, do not report.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient. Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other Coverage Billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists-payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.	Field #3Ø8-C8 is REQUIRED. If Medicaid Wraparound paid the drug in full, report Ø1.
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan: 192Ø = Medicaid 193Ø = Medicare Blank = Neither	192Ø – MEDICAID – A program, financed jointly by the federal government and the states, that provides health coverage for mostly low-income women and children as well as nursing home care for low-income elderly.	Field #6Ø1-Ø1is required. If the drug is a Medicaid Wraparound paid drug (Puerto Rico Medicaid funds are used to pay the drug/product), then report 192Ø (Medicaid).
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	**393-MV BENEFIT STAGE QUALIFIER** Code qualifying the 'Benefit Stage Amount' (394-MW). Blank – Not Specified Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.	Field #393-MV is situational. If Medicaid Wraparound paid the drug in full, do not report.

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan): • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage. 6Ø – Not paid under Part D; paid as or under a supplemental benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit).	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			• The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. • When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified, either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs, Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit, but is paid under the co-administered insured benefit. • When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit, but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g., nonformulary, quantity limit, etc.). • When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare.	

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NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: • When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer. Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer.	Field #351-NP is situational. Report the applicable value from Column D. If Medicaid Wraparound paid the drug in full, leave blank.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection.	

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Commercial Insurance as Primary and MAO as Secondary

Table 11 – Commercial Insurance as Primary and MAO as Secondary

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.		If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT).
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. When a Commercial Health insurance Plan is a primary payer to Medicare Advantage, report '1'.
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB. M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
232	COB PRIMARY PAYER ID	Primary Payer ID associated with the Primary Payer.	**MAOSNP** If the MAO pays for a drug, Field #232 must indicate Primary Payer ID MAOSNP. MAOSNP represents that the MAO paid for the drug/product. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID.' MEDICAID represents that Puerto Rico Medicaid paid for the drug.	Field #232 (COB PRIMARY PAYER ID) is REQUIRED. If a Commercial Health Insurance Plan is primary to Medicare Advantage, report 'COMMERCIAL'.

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug before the MAO can consider payment of the drug/product, report 'COMMERCIAL' as the Primary Payer ID in Field #232. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim before the MAO can consider paying for the drug, Field #232 must indicate Primary Payer ID 'TRICARE'	
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the Commercial Health Insurance Plan payment.
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		Field #231 is required when the Primary Payer reported in Field #232 assessed deductible. Report the deductible associated to the Commercial Health Insurance Plan reported in Field #232

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
				(COB PRIMARY PAYER ID). If the Commercial Health Insurance Plan did not assess deductible, do not report.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #229 is required when the Primary Payer reported in Field #232 assessed coinsurance. Report the coinsurance associated with the Commercial Health Insurance Plan reported in Field #232 (COB PRIMARY PAYER ID). If the Commercial Health Insurance Plan did not assess coinsurance, do not report.
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		Field #23Ø is required when the Primary Payer reported in Field #232 assessed a copayment. Report the copayment associated with the Commercial Health Insurance Plan reported in Field #232 (COB PRIMARY PAYER ID). If the Commercial Health Insurance Plan did not assess a copayment, do not report.
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	**MAOSNP** If the MAO pays for a drug as a secondary payer to a Commercial Insurance plan or TRICARE, Field #238 must indicate Secondary Payer ID 'MAOSNP.' MAOSNP represents that the MAO paid for the drug. **MEDIGAP** If the Platino Member has a 'Medicare gap' insurance as a commercial insurance plan that covers Medicare or MAO cost sharing.	Field #238 is required when the MAO is the secondary payer to a Commercial Health Insurance Plan to report payment of Commercial Health Insurance deductible, coinsurance, and/or copayment. If Medicare Advantage paid any portion of the Commercial Health Insurance cost sharing, then

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			Medicare gap insurance is always secondary to Medicare or an MAO. MEDIGAP represents an insurance plan that covers only Medicare/MAO cost sharing. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID.' MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product. The only time MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug/product, report 'COMMERCIAL' as the Secondary Payer ID in Field #238. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #238 must indicate Secondary Payer ID 'TRICARE.'	report the secondary payer ID as 'MAOSNP '

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is required when the Secondary Payer paid any portion of the drug or Commercial Health Insurance Plan cost sharing (i.e., deductible, coinsurance, and/or copayment). Report the amount that Medicare Advantage paid.
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is required when there is a Secondary Payer deductible that was assessed on the drug/product. When Medicare Advantage pays secondary to a primary Commercial Health Plan where no deductible is assessed, leave blank.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is required when there is a Secondary Payer coinsurance that was assessed on the drug/product. When Medicare Advantage pays secondary to a primary Commercial Health Plan where no coinsurance is assessed, leave blank.
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is required when there is a Secondary Payer copayment that was assessed on the drug/product. When Medicare Advantage pays secondary to a primary Commercial Health Plan where no copayment is assessed, leave blank.

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient. Ø1- No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other coverage billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.	Field #3Ø8-C8 is REQUIRED. Report the appropriate code from Column D that represents other coverage for the drug/product. When Medicare Advantage is secondary to a primary Commercial Health Insurance, report Ø2 when reporting the Commercial Health Insurance Plan as the primary payer.
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan: 192Ø = Medicaid 193Ø = Medicare Blank = Neither	Four spaces	Field #6Ø1-Ø1 is REQUIRED. When Medicare Advantage is a secondary payer to a primary Commercial Health Insurance Plan, report 193Ø (MEDICARE).
393-MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	**393-MV BENEFIT STAGE QUALIFIER** Blank – Not Specified Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage	Field #393-MV is REQUIRED. Use the applicable MV Benefit Stage Qualifier in Column D. When Medicare Advantage is responsible to pay Commercial Health Insurance cost sharing only as a secondary payer, report 'F9' (F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan): • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage. 6Ø – Not paid under Part D; paid as or under a supplemental benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit). • The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.	

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			• When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. • When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	

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NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g., nonformulary, quantity limit, etc.). • When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights."	

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: • When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Code qualifying the 'Benefit Stage Amount' (394-MW).	

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer. Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer. Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection.	Field #351-NP is REQUIRED. When Medicare Advantage is a secondary payer to a Commercial Health Insurance Plan and only responsible to pay Commercial Health Insurance cost sharing only as a secondary payer, report Ø6.

Appendix B: Change Summary

Version	Issue Date	Modified By	Comments/Reason
1.Ø	Ø2/16/2Ø17	Wil Joslyn	Original document with formatting updates.
2.Ø	Ø6/3Ø/2Ø17	Wil Joslyn	Page 159: Added the following text to the 897 – TRANSACTION ID CROSS REFERENCE field (PRMP Requirement column): "The 18-digit transaction ID of the NCPDP encounter that is being voided by this reversal is entered here." Page 162: Updated the 896 – TRANSACTION ID field (PRMP Requirement column) with "Every claim in the file must contain the unique 18-digit Transaction ID assigned by MC-21 during adjudication." Page 193: Removed "ORIGINAL TRANSACTION ID" and "VOIDED TRANSACTION IDENTIFIER" rows. Changed the following FILLER row values to: Length to 423. Start position from 3314 to 3296.
3.Ø	12/15/2Ø19	Wil Joslyn	Update for "Other Payer" reporting for MAOs and general clean up.
		Page 1	Text added to Section 1 Introduction.
		Page 3	Text added to Section 2 NCPDP Post Adjudication Transaction Standard Version 4.2 File Information.
		Page 4	Text added to Section 2.3 Additional NCPDP Post Adjudication Transaction Standard Version 4.2 File Information.
		Page 4	Transaction Specific Information Column header "Mandatory or Situational" changed to "Usage" and new usage type added "N/U" for "Fields Not Used" by PRMMIS. All fields that are used by PRMMIS during processing are identified as "Required". Column header "PRDOH Requirement" changed to "PRMP Comment."
		Page 7	Header Record Field 879 "Sending entity Identifier" value changed to "PRMP assigned six-digit trading partner ID."
		Page 8	Field 88Ø-K7 – "Receiver ID" value changed to "PRMMIS."
		Page 9	Detail Record starts.

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Version	Issue Date	Modified By	Comments/Reason
		Page 10	Field 3Ø2-C2 comment changed to "PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number."
		Page 10	Field 716-SY comment changed to "Required when available in the payer's adjudication system."
		Page 10	Field 717-SX comment changed to "Required when available in the payer's adjudication system."
		Page 11	Field 729-TA is not used by PRMMIS.
		Page 11	Field 214 is not used by PRMMIS.
		Page 11	Field 721-MD comment changed to "Required when available in the payer's adjudication system.
		Page 11	Field 274 is not used by PRMMIS.
		Page 11	Field 288 is not used by PRMMIS.
		Page 11	Field 331-CX has only one valid value (Ø6).
		Page 11	Field 332-CY comment changed to "PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number."
		Page 12	Field 716-SY is not used by PRMMIS.
		Page 12	Field 717-SX is not used by PRMMIS.
		Page 12	Field 729-TA is not used by PRMMIS.
		Page 12	Field 3Ø4-C4 comment changed to "Required when available in the payer's adjudication system."
		Page 12	Field 3Ø5-C5 is not used by PRMMIS.
		Page 12	Field 247 is not used by PRMMIS.
		Page 12	Field 2Ø8 is not used by PRMMIS.
		Page 13	Field 3Ø3-C3 is not used by PRMMIS.
		Page 13	Field 3Ø6-C6 is not used by PRMMIS.
		Page 13	Field 3Ø9-C9 is not used by PRMMIS.
		Page 13	Field 215 Comment changed to "PRMP assigned trading partner ID of MCO/MAO."

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Version	Issue Date	Modified By	Comments/Reason
		Page 13	Field 212 is not used by PRMMIS.
		Page 13	Field 279 is not used by PRMMIS.
		Page 14	Field 282 is not used by PRMMIS – all three.
		Page 14	Field 292 is not used by PRMMIS.
		Page 14	Field 3Ø8-C8 Comment changed to "If available, report the appropriate value that represents other coverage for the drug/product."
		Page 16	Field 6Ø1-Ø1 added value "If neither MAO nor Wraparound is the primary payer, enter four spaces" and Comment changed to "Use 193Ø (Medicare) when only MAO funding is used to pay the drug/product. Use 192Ø (Medicaid) when only Puerto Rico Medicaid funds are used to pay the drug/product. If neither, enter spaces."
		Page 17	Field 2Ø2-B2 Value shortened to "Ø1 – National Provider Identifier (NPI), Ø5 – Medicaid ID if atypical" and Comment shortened to "Required."
		Page 17	Field 2Ø1-B1 Comment shortened to "Required."
		Page 17	Field 2Ø2-B2 is not used by PRMMIS.
		Page 17	Field 2Ø1-B1 is not used by PRMMIS.
		Page 17	Field 727-SS is not used by PRMMIS.
		Page 18	Field 732 is not used by PRMMIS.
		Page 19	Field B1Ø-8A is not used by PRMMIS.
		Page 18	Field 15Ø is not used by PRMMIS.
		Page 18	Field 266 is not used by PRMMIS.
		Page 18	Field 466-EZ is not used by PRMMIS.
		Page 19	Field 411-DB is not used by PRMMIS.
		Page 19	Field 296 comment changed to "Required when available in the payer's adjudication system."
		Page 19	Field 295 is not used by PRMMIS.
		Page 19	Field 716-SY is required by PRMMIS.
		Page 19	Field 717-SX is required by PRMMIS.
		Page 19	Field 81Ø-8A is required by PRMMIS.

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Version	Issue Date	Modified By	Comments/Reason
		Page 22	Field 436-E1 has only one valid value.
		Page 23	Field 239 is not used by PRMMIS.
		Page 23	Field 3Ø7-C7 is not used by PRMMIS.
		Page 23	Field 384-4X is not used by PRMMIS.
		Page 23	Field 419-DJ is not used by PRMMIS.
		Page 23	Field 278 is not used by PRMMIS.
		Page 23	Field 217 is not used by PRMMIS.
		Page 24	Field 268 is not used by PRMMIS.
		Page 24	Field 1Ø2-A2 is not used by PRMMIS.
		Page 24	Field 216 is not used by PRMMIS.
		Page 26	Field 429-DT is not used by PRMMIS.
		Page 26	Field 6ØØ-28 is not used by PRMMIS.
		Page 27	Field 254 is not used by PRMMIS.
		Page 27	Field 996-G1 is not used by PRMMIS.
		Page 28	Field 492-WE PRMMIS will only use one Diagnosis Code.
		Page 28	Field 424-DO PRMMIS will only use one diagnosis Code.
		Pages 29 – 36	All 439-E4, 44Ø-E5, 441-E6, & 474-8E fields are not used by PRMMIS.
		Page 35	All 511-FB fields are not used by PRMMIS.
		Page 35 – 72	Fields 435-DZ, 434-DY, 532-FW, 397, & 261 are not used by PRMMIS.
		Page 36	Field 146 is not used by PRMMIS.
		Page 36	Field 297 is not used by PRMMIS.
		Page 37	Only one field, 42Ø-DK, is used by PRMMI.S
		Page 36 – 73	Fields 6Ø1-24, 243, & 425-DP are not used by PRMMIS.
		Page 36 – 74	Fields 273, 244, & 252 are not used by PRMMIS.
		Page 37 – 79	All occurrences of fields 6Ø1-19 & 6Ø1-18 are not used by PRMMIS.
		Page 38 – 85	All 6Ø1-26 & 6Ø1-25 fields are not used by PRMMIS.
		Page 38 – 91	Fields 257, 221, 889, 256, & 255 are not used by PRMMIS.

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Version	Issue Date	Modified By	Comments/Reason
		Page 40 – 91	Fields 572-4U, 519-FJ, 517-FH, 571-NZ, 133-UJ, 134-UK, 135-UM, 136-UN, 137-UP, 272, 223, 26Ø, 284, 2Ø9, 21Ø, 211, & 253 are not used by PRMMIS
		Page 43	Field 581-AZ is not used by PRMMIS.
		Page 45	Field 566-J5 is not used by PRMMIS.
		Page 47 – 91	Fields 522-FM, 346-HH, 347-HJ, 348-HK, 349-HM, 573-4V, 557-AV, 276, 275, 2Ø7, 461-EU, 462-EV, & 299 are not used by PRMMIS.
		Page 51	Field 225 has a new comment, "If available in payer's system."
		Page 52	Field 226 has a new comment, "If the MAO has COB Carrier Amount available."
		Page 53	Field 232 has new possible values.
		Page 54	Field 228 has a new comment, "Required – report the payment associated to the primary payer. The MAO SNP would be considered the primary payer when the Platino Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibility)."
		Page 54	Field 238 has new possible values and a new comment, "Required when the MAO and another insurance plan or Medicaid paid for the drug or cost sharing."
		Page 56	Field 234 has a new comment, "Required when the Secondary Payer paid for the drug/product or the Platino Member's cost sharing."
		Page 56	Field 237 has a new comment, "Required when there is a Secondary Payer deductible that was assessed on the drug/product."
		Page 56	Field 235 has a new comment, "Required when there is a Secondary Payer coinsurance that was assessed on the drug/product."
		Page 56	Field 236 has a new comment, "Required when there is a Secondary Payer copayment that was assessed on the drug/product."
		Page 58	Field 997-G2 is not used by PRMMIS.
		Page 58 – 59	Only the first pair of fields 393-MV & 394MW are used by PRMMIS.
		Page 60	Field 3Ø2-C2 is not used by PRMMIS.
		Page 60	Field 475-J9 is not used by PRMMIS.

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Version	Issue Date	Modified By	Comments/Reason
		Page 62	Field 351-NP has a new comment, "Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim."
		Page 67	Field A37 is not used by PRMMIS.
		Page 68	Field A73 is not used by PRMMIS.
		Page 68	New note added to end of detail record, "Note: "COB/TPL" Indicates that further directions can be found in Appendix A: Discussion of MAO COB/TPL Reporting When:"
		Page 74	Field 25Ø is not used by PRMMIS.
		Page 79	Field 251 is not used by PRMMIS.
		Page 88	Field 475-J9 is not used by PRMMIS.
		Page 90	Fields 476-H6 & 878 are not used by PRMMIS.
		Page 96	New Appendix A added "Discussion of MAO COB/TPL Reporting When:"
		DXC Technology	Formatting updated.
		DXC Technology	Appendix "Frequently Asked Questions" deleted.
4.Ø	11/19/2Ø2Ø	Gainwell Technologies	Gainwell Rebranding

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